

Control in childbirth. A material-discursive
evaluation with primiparous women and their
midwives

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Abstract

Current moves to give childbearing women more control over the birth process provided the impetus to explore the ways in which both midwives and their clients represented various aspects of control in childbirth. After an exploratory pilot study, two longitudinal studies were run in parallel. Both involved contact with primiparous women at 36 weeks antenatally and at 1 and 16 weeks postnatally. The first involved postal questionnaires sent to 126 women, and the second involved one-to-one semi-structured interviews with 15 women. In both studies the woman's midwife was also contacted shortly after the birth. Taking a material-discursive approach, background, demographic and birth related issues which predispose to expectations and experiences of control or its lack were explored as was the relationship between control expectations, experiences and postnatal psychological wellbeing; and how midwives and their clients' assessments of the childbearing woman's control and satisfaction compare. Although the questionnaire study demonstrated a relationship between high external locus of control beliefs and low expectations of control in childbirth, the interview study highlighted the importance of other birth-related issues, such as concerns for safety, in women's control expectations. Although neither study found any effects of social class (as measured by educational achievement) on general expectations of control in childbirth, interview participants with fewer educational qualifications were likely to have more specific birth plans. There were strong relationships between antenatal and postnatal control scores, although the interviews represented control-related issues as complex. The midwives' and the childbearing women's assessments of the women's satisfaction with the birth correlated significantly, but in terms of the women's expectations and experiences of control the midwives appeared to be assessing related variables, such as mood, rather than verbal reports of control. No relationship was found between unfulfilled expectations of control in childbirth and postnatal mood disturbance. High levels of control were associated with low levels of mood disturbance. Mood scores correlated across time, and although women's accounts of the birth became more coherent and detailed, they did not become more negative.

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Dedication

This thesis is about women. Paradoxically, it is dedicated to two men:

my husband, Colin, whose love and support has helped me persevere and finish,

my father, John Willmott, who sadly did not live to see its completion, but whose pride in my efforts continues to encourage me.

Table of contents

	Pages
TITLE PAGE	1
ABSTRACT	2
ACKNOWLEDGMENTS	3
DEDICATION	4
TABLE OF CONTENTS	5-10
INDEX OF TABLES	11-12
INDEX OF FIGURES	13
PREFACE	14-15
Chapter 1 - Literature review: childbirth and control	
1.1 INTRODUCTION	16-17
1.2 THE PAST	
1.2.1 Feminist history	17-18
1.2.2 Recent history	18-20
1.2.3 Concern for the mother and child?	21-24
1.2.4 Changing childbirth	24-25
1.2.5 Conclusion to section 1.2	25-26
1.3 THE ISSUE OF CONTROL	
1.3.1 Introduction to section 1.3	26-27
1.3.2 Psychological constructs of control	
1.3.2.1 Attribution theory	27-30
1.3.2.2 Locus of control	30-33
1.3.2.3 Self-efficacy	33-34
1.3.2.4 General criticism of psychological theories of control	35-36
1.3.3 Issues specific to control in childbirth	
1.3.3.1 Introduction	36
1.3.3.2 Control theories specific to childbearing	36-37
1.3.3.3 Aspects of control	37-38
1.3.3.4 Choice and control	39
1.3.3.5 Who controls the control?	39-40
1.3.4 Conclusion to section 1.3	40
1.4 RECENT RESEARCH AND ASSOCIATED TOPICS	
1.4.1 Introduction to section 1.4	40-41
1.4.2 The relevance of background/ demographic variables	
1.4.2.1 Social class	41-44
1.4.2.2 Age	44
1.4.2.3 Other issues	44-45

1.4.3	Expectations and experiences of control in childbirth	46-47
1.4.4	Communication and relationships in childbirth	
1.4.4.1	Communication and social class	47-48
1.4.4.2	Midwife/ client communication in general	48-51
1.4.4.3	The issue of language	51-52
1.4.5	Psychological outcome	52
1.4.5.1	Other psychological sequelae	52-54
1.4.5.2	The gap between expectations and experiences of control in childbirth	54-55
1.4.5.3	The timing of postnatal assessment, and the halo effect	55-56
1.4.6	Conclusion to section 1.4	56-58
1.5	EPISTEMOLOGICAL AND METHODOLOGICAL ISSUES	
1.5.1	Introduction	58-59
1.5.2	My ontological and epistemological position	
1.5.2.1	Realism and relativism	59-60
1.5.2.2	Christianity and social constructionism	60-62
1.5.2.3	Feminism	62-65
1.5.3	A material-discursive approach	65-67
1.5.4	An approach to researching control in childbirth	67-70
1.5.5	Reliability, validity and selection of data	70
1.5.5.1	Reliability and selection of data	70-71
1.5.5.2	Validity	71-73
1.6	CONCLUSION TO CHAPTER 1	73-74

Chapter 2 - Asking maternity service users: pilot study

2.1	INTRODUCTION	
2.1.1	Purpose of study	75-76
2.1.2	The research approach	76
2.2	METHOD	
2.2.1	Design	76
2.2.2	Procedure	77-78
2.2.3	Coding and analysis	78-79
2.2.4	Participants	79
2.3	RESULTS	
2.3.1	Introduction	79
2.3.2	Participant reflexivity and positioning of the interviewer	80-81
2.3.3	First question - What control in childbirth means to different childbearing women	
2.3.3.1	Past experiences and expectations	81-83

2.3.3.2	Women from different backgrounds	83-84
2.3.3.3	Antenatal classes	84-85
2.3.3.4	Facets of control	85-86
2.3.4	Second question - How control issues are dealt with by childbearing women and midwives	
2.3.4.1	Information and understanding	86-88
2.3.4.2	Birth plans	88-89
2.3.5	Third question - The psychological benefits and disadvantages of control or its lack	89-90
2.4	DISCUSSION	
2.4.1	First research question	90-92
2.4.2	Second research question	92
2.4.3	Third research question	92-93
2.4.4	General issues	93-94
2.5	CONCLUSION	94

Chapter 3 - Exploring the issues 1: questionnaire study

3.1	INTRODUCTION	
3.1.1	The research approach	95
3.1.2	Timing	95-96
3.2	METHOD	
3.2.1	Design	97
3.2.2	Measures	
3.2.2.1	Demographic and background information	97
3.2.2.2	Locus of control	97-98
3.2.2.3	Depression and mood	98
3.2.2.4	Labour agency	98-99
3.2.2.5	Assessment of labour	99-100
3.2.2.6	Midwives' questionnaire	100-101
3.2.3	Questionnaire development	101
3.2.4	Sampling and recruitment	101-102
3.2.5	Procedure	103
3.3	RESULTS	103
3.3.1	Uptake and response rates	103-105
3.3.2	Demographic characteristics of respondents	105-106
3.3.3	Summary statistics for scales	
3.3.3.1	Locus of control	106
3.3.3.2	Depression and mood	106-108
3.3.3.3	Labour agency	108-109

3.3.3.4	Assessment of labour	109-110
3.3.3.5	Midwives' questionnaire	111
3.3.4	Comparisons between antenatal and postnatal control and mood scores	
3.3.4.1	Profile of mood states	111-112
3.3.4.2	Edinburgh postnatal depression scale	112
3.3.4.3	Labour agency	112
3.3.4.4	Relationship between LAS and mood disturbance	112-113
3.3.5	Comparisons between 1 and 16 week postnatal scores	113
3.3.5.1	Control issues	113-114
3.3.5.2	Experience of labour	114
3.3.5.3	Satisfaction with the birth	115
3.3.5.4	Emotional reaction	115
3.3.6	Factor analysis	115-117
3.3.7	Correlations	
3.3.7.1	Between TMD, POMS subscales and EPDS	118
3.3.7.2	Between LAS and other control measures	118-119
3.3.7.3	Between antenatal and postnatal variables and TMD or LAS	119-120
3.3.7.4	Correlations amongst demographic and background variables	120
3.3.7.5	Correlations between childbearing women's and midwives' answers	121-123
3.3.8	Analysis of variance and non-parametric tests on antenatal and 1 week postnatal variables	
3.3.8.1	Labour agency	123-124
3.3.8.2	Total mood disturbance	124-125
3.3.8.3	Interrelationships amongst demographic and background, and 1 week postnatal variables	125-126
3.3.9	Multiple regression	
3.3.9.1	Antenatal LAS and TMD as dependent variables	126-128
3.3.9.2	1 week postnatal LAS and TMD as dependent variables	128-129
3.3.9.3	16 weeks postnatal LAS and TMD as dependent variables	129-131
3.4	DISCUSSION	131
3.4.1	Internal versus external and expected versus wanted control	131-133
3.4.2	Discussion relating to the first research question	133-136
3.4.3	Discussion relating to the second research question	137-138
3.4.4	Discussion relating to the third research question	138-140
3.4.5	Discussion relating to the fourth research question	140-142
3.4.6	General discussion	142-144
3.5	CONCLUSION	144-145

Chapter 4 - Exploring the issues 2: interview study

4.1	INTRODUCTION	
4.1.1	Purpose of study	146-147
4.1.2	The research approach	147-148
4.2	METHOD	
4.2.1	Design	148
4.2.2	Procedure	148-150
4.2.3	Coding and analysis	150-153
4.2.4	Participants	153
4.3	RESULTS	
4.3.1	Introduction	153-154
4.3.2	The presence of the interviewer in the texts	154-156
4.3.3	Influence on the interviews	157-158
4.3.4	Control in everyday life and in childbirth	
4.3.4.1	Control in everyday life	158-159
4.3.4.2	Control in childbirth	159-161
4.3.4.3	Images of the midwife	161-162
4.3.4.4	Connecting life control and childbirth control in the text	162-163
4.3.5	Childbirth control expectations and experiences	
4.3.5.1	Introduction	163
4.3.5.2	Expectations of control over self	163-165
4.3.5.3	Experiences of control over self	165-166
4.3.5.4	Different perspectives on control of self	166-167
4.3.5.5	Control over situation - generally	167-168
4.3.5.6	Control over situation - birth plans	169-170
4.3.5.7	Control over situation - pain relief	170-173
4.3.5.8	Control over situation - the handling of the baby at birth	173-174
4.3.5.9	Summary of subsection 4.3.5	174-175
4.3.6	Antenatal education classes	175-178
4.3.7	Other influences on women's experiences of control	178-181
4.3.8	Different aspects of control in childbirth	181-183
4.3.9	Psychological effects	
4.3.9.1	Introduction	184
4.3.9.2	Short-term emotional effects	184-185
4.3.9.3	Effects on self-image	185-186
4.3.9.4	Expectations for 'next time'	186-187
4.3.10	Halo effect	187-188
4.3.11	Comparing midwives and childbearing women	188-191
4.4	DISCUSSION	191-194

4.5	GENERAL DISCUSSION	194-196
4.6	CONCLUSION	196
Chapter 5 - Conclusion		
5.1	INTRODUCTION	197
5.2	RESEARCH FINDINGS AND THEIR IMPLICATIONS	
5.2.1	Starting point of research	197
5.2.2	First research question	198-201
5.2.3	Second research question	202-203
5.2.4	Third research question	203-205
5.2.5	Fourth research question	205-207
5.2.6	Summary of recommendations from findings	207-208
5.3	THE RESEARCH PROCESS AND ITS LIMITATIONS	208-211
5.4	ISSUES REQUIRING FURTHER CLARIFICATION	211-212
5.5	CONCLUDING COMMENTS	212
Appendices		
2.1	Pilot study interview schedules	213
3.1	Items for Multidimensional Locus of Control Scale	214
3.2	The Edinburgh Postnatal Depression Scale	215
3.3	The Profile of Mood States adjectives	216
3.4	The Labour Agency Scale	217
3.5	Midwives' questionnaire	218-219
4.1	Main study interview schedules	220-221
Bibliography		222-238

Index of tables

	Page	
2.1	Details of mothers and their children	79
2.2	Details of midwives	79
3.1	Interventions and areas of control assessed in postnatal questionnaires	99
3.2	Questions about woman's perceptions of labour	100
3.3	Highest educational level attained by respondents	105
3.4	Antenatal class attendance by level of education	105
3.5	Mode of delivery of women in study	106
3.6	Descriptive statistics for Levenson's locus of control scale	106
3.7	Descriptive statistics for LAS	109
3.8	Descriptive statistics for remaining control questions	109
3.9	Summary statistics for intervention and perception of labour questions	110
3.10	Summary statistics for satisfaction scores	110
3.11	Summary statistics for midwives' answers	111
3.12	Comparisons between POMS subscales	112
3.13	Comparisons between control related variables	114
3.14	Comparisons between experience of labour variables	114
3.15	Comparisons between satisfaction variables	115
3.16	Comparisons between variables for emotional reaction	115
3.17	Factor analysis of 1 week postnatal variables	116
3.18	Factor analysis of 16 weeks postnatal variables	117
3.19	Correlations between factor scores and 1 and 16 week LAS	117
3.20	Correlations between mood variables and Total Mood Disturbance Score	118
3.21	Correlations between antenatal LAS and control measures	118
3.22	Correlations between 1 week postnatal LAS and control measures	119
3.23	Correlations between 16 week postnatal LAS and control measures	119
3.24	Correlations between antenatal variables and antenatal and 1 week postnatal TMD and LAS	119
3.25	Correlations between antenatal and 1 week postnatal variables and 16 week postnatal TMD and LAS	120
3.26	Correlations between demographic and background variables	120
3.27	Correlations between midwife assessments	121
3.28	Comparable correlations for childbearing women	121
3.29	Correlations between midwives' answers and corresponding questions to childbearing women	122
3.30	Correlations between antenatal mood variables, LAS and midwife assessments	122

3.31	Correlations between 1 week P/N labour variables, TMD, LAS and midwife assessments	123
3.32	Correlates with midwives' assessments of expected control against women's antenatal reports of expected control	123
3.33	Correlates with midwives' assessments of achieved control against women's 1 week postnatal reports of control	123
3.34	Results of Kruskal-Wallis test for LAS at different levels of educational achievement	124
3.35	Results of Mann-Whitney test for LAS with binary variables	124
3.36	Results of Two-way ANOVA	125
3.37	Results of Kruskal-Wallis test for age and locus of control of women who achieved different educational levels	125
3.38	Results of Mann-Whitney U test for factor scores in women who experienced a spontaneous vaginal delivery or continuity of care and those who did not	126
3.39	Hierarchical multiple regression with antenatal LAS as DV, entering demographic and antenatal variables	127
3.40	Hierarchical multiple regression with antenatal TMD as DV, entering demographic and antenatal variables	127
3.41	Hierarchical multiple regression with 1 week postnatal LAS as DV, entering antenatal LAS, then demographic and antenatal variables	128
3.42	Hierarchical multiple regression with 1 week postnatal TMD as DV, entering antenatal TMD, then antenatal LAS	129
3.43	Hierarchical multiple regression with 16 weeks postnatal LAS as DV, entering antenatal and 1 week LAS, then demographic, antenatal and 1 week postnatal variables	130
3.44	Hierarchical multiple regression with 16 weeks postnatal TMD as DV, entering antenatal and 1 week TMD, then antenatal and 1 week postnatal variables	131
4.1	Participant details	153

Index of figures

	Page	
3.1	Flow diagram tracing the research procedure	104
3.2	Mean EPDS scores across time	107
3.3	Mean POMS scores across time	108
3.4	Summary of multiple regression findings (incorporating correlations between postnatal TMD and LAS)	132
4.1	The process of coding interview texts	151

Preface

My own background is in midwifery. After qualifying as a nurse, I trained in the mid-1970s when the development of labour ward technology was in the ascendant. The maternity unit where I did my training was comparatively small and behind the times, but midwives were still taught to concede to the wishes of the obstetricians regardless of whether the case was normal or not (paradoxically midwives were, and still are, defined as autonomous practitioners in the case of normal childbirth¹). Moreover the unit's lack of technology was seen as a deficiency, and the midwife tutor worked hard to ensure that, as pupil midwives, we were fully conversant, in theory at least, with all the latest methods and equipment. In the portion of my training devoted to gaining experience of community midwifery I did not see one home birth, because there were none. Being a very rural area with many remote farms and villages, it was not considered safe to let women give birth at home in case anything went wrong. As childbirth was only deemed normal in retrospect, every pregnant woman was considered a potential for complications, perhaps explaining why the definition of midwives as practitioners of the normal was so problematic at this time.

If midwives had little control under these circumstances, the childbearing women had less. The concept of choice was limited to some options over analgesia, and the woman's control was restricted to the use of psychoprophylactic techniques which were taught at antenatal classes. Pressure groups such as the National Childbirth Trust were considered 'cranky', and the few women brave enough to admit an association with such a group were treated with suspicion by both midwives and doctors.

I practiced as a midwife until 1991, and in that time saw the profession become almost swamped by obstetric technology and hospital policies made by doctors. Childbearing women stood little chance of any kind of choice or control when it was decreed, for example, that they should all have their membranes ruptured when the cervix was 4 centimetres dilated, and that every woman should be strapped to a fetal heart monitor for the duration of her labour. The midwife who found herself faced with a client (or 'patient' in those days) who refused such invasions was in an invidious position. If the woman was allowed her way, it was the midwife who would be reprimanded for failing to observe policy. Therefore, more often than not, the childbearing woman was put under a great deal of pressure to conform. Sometimes black pictures were painted of what could go wrong if she did not. In the mid 1980's the tide began to change, but I, like many other midwives, had too often suffered recriminations when I had tried to pursue a more liberal approach to obstetric care (risking a tear rather than doing an episiotomy, for example). I had also, by this time, lost confidence, not only in my ability to deliver a baby safely without the use of technology and the support of a doctor, but also in women's ability to give birth without this support. I no longer enjoyed delivering babies, and found the new power being given to both midwives and childbearing women threatening. I left midwifery.

¹ Midwives are trained to care for women with uncomplicated pregnancies and to assess risk factors and deviations from the norm (Kroll, 1994).

A three year degree course in psychology, and a lot of reading and thinking about the issues involved in historical and modern childbirth care, convinced me that it was right that the balance between the hegemony of the obstetric profession and the powerlessness of midwives and childbearing women should be redressed. However it also left me puzzled as to why, in the midwifery press, control should, more often than not, be represented unproblematically as something which should now be given to childbearing women, and given by midwives who, until not long before, had no control either. It seemed too simple that the historical legacy of powerlessness for both childbearing women and midwives could so easily be reversed. That, in many ways, was the starting point for this thesis.

Chapter 1

Literature review: childbirth and control

1.1 Introduction

During the 1970s and 1980s, the process of caring for a woman during labour and childbirth became increasingly dependent on the use of technology, and less upon the skills of the carer, namely the midwife (Walton and Hamilton, 1995). In the process, midwives became little more than handmaidens for the obstetricians and other medical specialists who ordered and controlled this 'active management of labour', and childbearing women lost control over what was once viewed as a natural process.

A consequence was that, alongside this advance of technological intervention, there developed a ground swell of opposition from midwives, and more importantly, from childbearing women themselves, who objected to their loss of control, and who questioned the necessity for many of the changes being made in childbirth care. This finally resulted, in 1993, in the Government's appointment of an expert Committee, whose task it was to review policy on National Health Service maternity care (particularly during childbirth), and to make recommendations. After long deliberations, gathering evidence from a wide variety of sources, not least from childbearing women themselves, the report of this Expert Maternity Group, 'Changing Childbirth' (Department of Health, 1993), advocated that women should have choice and control over the type of maternity and delivery care they received (Walton and Hamilton, 1995), and laid down a number of objectives which would result in this being achieved.

However, although the recommendations of 'Changing Childbirth' have been welcomed, the topic of control in childbirth is not as simple as it might at first seem. This review of the literature on the subject will ask three separate questions about the issue.

Firstly, it is important to ask why control in childbirth should be so important for childbearing women, and the first section of this chapter ('The past') will briefly consider the issue in the context of its history. Secondly there is a need to examine what has already been said about control, both in terms of recent research with childbearing women and in terms of general psychological theory. This question will be dealt with in the sections entitled 'The issue of control' and 'The present'. The final section, in

the light of those preceding, will ask how an understanding of control in childbirth might be taken forward, and will consider epistemological and methodological issues which impinge upon the way research into this subject might be handled.

This final section will highlight the value of a movement away from more traditional and realist perspectives which give research findings (as long as they are considered to be methodologically sound) the status of 'truth'. However this produces a dilemma: the problem of how to present, in this chapter, a review of research which, by and large, is produced within the very realist framework which comes under criticism. To avoid lengthy excursions into the status of individual studies I have, on the whole, chosen to review the literature in sections 1.3 and 1.4 as if it was epistemologically unproblematic, only raising questions about the stance of the researcher when it has direct relevance for issues addressed later in the thesis. I have then summarized some of the general problems with the epistemological assumptions of such research in subsection 1.5.4 (page 67ff) of this chapter.

1.2 The past

1.2.1 Feminist history

Literature which discusses the question of control in childbirth often begins with a description of the rise in power of the obstetrician, with the consequent loss of control not only by the childbearing woman herself, but also by the midwife, her advocate. However, it can be argued that childbirth has been the site of a struggle for control for much longer than this, for as long, in fact, as women have been oppressed through the control of their sexuality: a key theme of feminist history (Miles, 1989).

It was Foucault who discussed sexuality and reproduction in terms of control and oppression. He observed that in the 19th century women's bodies became hystericized: represented as saturated with sex, but also as inherently pathological. It was this hystericization which created spaces in which women's sexual desire could be controlled, and which gave justification for such a control, even although the ultimate aim was the regulation of family populations (Foucault, 1978; McNay, 1992). The power which wielded this control operated, not through repression, but through the construction of particular knowledges; the medical 'knowledge' of sex being one example (Foucault, 1978; Weeks, 1981). Such knowledges and mechanisms of control however, were not unique to the 19th century. They have operated in different ways at different points in history, and feminist historians trace some of those which impinge particularly upon women. Thus, misogynistic practices such as female circumcision and Chinese footbinding have been interpreted in terms of control of women through their sexuality (Daly, 1979; Ussher, 1991). The organized witch trials of the 14th to 17th century serve as a further example. They demonstrate how forms of knowledge might act as mechanisms of control, and illustrate how the control of childbirth could have already been an integral part of women's oppression long before obstetric technology.

In the two hundred years of anti-witch mania, a phenomenon unique to Western Christianity, many thousands (predominantly women) were put to death. One of the key figures in the reports of the witch

trials is the midwife, who at this time was usually a married older woman who had borne children herself, and who provided supportive attendance to the mother-to-be throughout her labour and usually for some time afterwards. The midwife was sometimes also a lay healer, wise in the correct use of herbs and poultices, and as such, frequently consulted over matters of sexuality and fertility (Ehrenreich and English, 1978). Rosen (1969) reports that the midwife was suspected of witchcraft more frequently than any other woman. The *Malleus Maleficarum*, the witch-finder's manual, written by Sprenger and Kraemer, two German members of the Inquisition, proclaimed the received view of the witch-midwife. She was the most dangerous of all the witches to the faith, having access to unbaptised infants, whose flesh she appropriated to use in devil worship (Donnison, 1988).

Such a 'knowledge' thus operated to generate fear in women - when they were cared for by midwives, needing their help and yet being afraid of the consequences to their new born child; and when, in later life they might act as midwives themselves, and risk accusation each time they attended a woman, especially if the infant died, something not uncommon then.

Today's more reasonable explanations for the witch persecutions include the theory that it was more probably the power of the midwife as the facilitator of childbirth (and also of the means to terminate pregnancy) that the churchmen of the middle-ages feared. As the all-powerful priests were intended to be celibate, childbirth was inclined to be viewed with great suspicion and mystery, almost as an 'unnatural practice' (Rosen, 1969).

Although the era of witches is long past, many aspects of the situation, as far as we understand it with limited historical evidence, resonate with later practices. The following subsections will describe more recent evidence of male curiosity with childbirth, and resultant harmful meddling; the control of childbirth to satisfy other, hidden, motives; and the development of a received view of childbirth which took its control away from the women who gave birth, and which put it firmly into the hands of others.

1.2.2 Recent history

In England, the medical profession was beginning to take control of childbirth away from the hands of the midwife as long as ago as the end of the 19th century. Oakley (1984) describes this takeover as a two stage process. The first stage, the redefinition of childbirth as a medical matter was, by the turn of the century, well advanced. The second stage, the new redefinition of childbirth as a pathological event, began in the 1950s. The recent burgeoning of technological interventions described in the introduction is, in fact, merely a natural progression from this, the quest to use new scientific discovery to render safe that which is now represented as a dangerous process.

In 1826 the Obstetrical Society was formed. The emergence of this new profession had several effects. Firstly, it took the ultimate responsibility for the care of pregnant and labouring women away from the midwife. Secondly, interference in the birth process began. Ehrenreich and English describe the early obstetrician as someone unprepared to wait for the slow processes of the first and second stage of labour to reach completion:

'Unlike a midwife, a doctor was not about to sit around for hours, as one doctor put it, 'watching a hole'; if the labour was going too slow for his schedule he intervened with knife or forceps, often to the detriment of the mother or child.' (Ehrenreich and English, 1978, p. 97.)

This tendency to put, often arbitrary, time limits on both the length of pregnancy and labour, is still at the root of many of the interventions which are used to control childbirth.

Another effect of the medicalisation of childbirth was the beginnings of hospitalization for women in labour. Oakley (1984) describes the development of the lying-in hospitals in the mid-eighteenth century, charitable institutions for the poor who could not afford a doctor to attend them at home. As such they served an important purpose at a time when the working-class woman often lived in appalling conditions in which childbirth was hazardous, and in which she would be expected to resume her daily labours as soon as she had given birth. However, the lying-in hospital was also a place where doctors could find plentiful material upon which they could gain experience, and served to reduce competition for the doctors from midwives (Lewis, 1990). Lewis describes hospitalization as the most important step on the road to medicalising childbirth, and again it is an issue which has persisted, in the form of the home versus hospital birth debate.

Despite the ascendancy of the obstetrician, childbirth at this time was still seen as a natural process, to be considered normal unless proven otherwise. Midwives did still deal with normal cases. However, with the development of various techniques of intervention this situation began slowly to change.

Oakley (1984) describes the development of these early interventions, firstly in the production of drugs to induce both labour and abortion (although the women healers of long ago had already known about these substances), and then in the development of measuring devices to monitor the contractions of the uterus. Some of these early devices must have been painful in the extreme for the woman, involving the introduction of needles and rubber bladders into the abdominal cavity or the uterus itself. Many of them must have led to fetal distress and death. Doctors also found that they could induce labour using an inflated animal bladder or bougie to dilate the cervix, risking intrauterine infection and maternal death in the process. As a paradox to this forced invasion and dilatation of the cervix, the definition of 'incompetent cervix' was pronounced, when a woman repeatedly miscarried because her cervix opened in each pregnancy as the fetus began to grow. The Shirodkar suture was devised, and is still used today, despite its dubious effectiveness, to hold the cervix closed until term.

These early interventions continued something which had already begun when the midwife was usurped by the obstetrician who resented his remit to stand 'watching a hole'. The childbearing woman herself continued to disappear. She became of secondary importance to the whole process - a 'walking incubator' (O'Driscoll, 1994). Martin (1987) claims that the medicalisation of childbirth alienated women from their wombs, taking away, not only their control, but also their satisfaction in giving birth. She explains the dominant metaphor of the early days of childbirth medicalisation as that of the body as a machine. The doctor was the mechanic. The description of a cervix as 'incompetent'; of a labour as 'good' or 'poor' according to its length; the talk of 'progress' in labour, all reflected the

machine analogy, and the power of the doctors, those who operated the machinery. The owner of the womb was ignored.

However, if the analogy of early medicalisation was that of the doctor as a mechanic, then the analogy of childbirth from the 1950's onwards must be that of the doctor as an engineer (Campbell, 1990), a change which arose largely from the increase in hospital births (Schwarz, 1990). Campbell charts the shift in the perception of childbirth as a normal event which may occasionally go wrong, to its definition as an event which can only be defined as normal in retrospect. Whereas once the doctor's task was to monitor the labour and correct any faults, now his task was to take charge of the smooth running of all the systems so that faults did not even occur.

The important issue here is to note that, with the redefinition of labour as abnormal until proven otherwise, women's loss of control of the childbirth process was taken a step further. Her body became redefined as faulty, not to be trusted. Now, not only was her womb metaphorically separated from her body, but it was also redefined as an unreliable womb, a situation which resonated strongly with the Victorian hystericization of women's bodies.

Control was exerted in yet another way as childbirth became a pathological issue. The midwife of former years had been a friend and a part of the same community as the women she cared for. Childbirth was a shared event within a family, and information about the process and about necessary mothering skills was naturally dispensed between family members and the midwife herself. With the separation of the childbearing woman from her family and from herself, this process of information exchange became damaged. Woman had to rely more and more on professional people to explain what was happening to them and to teach them the skills they needed (Shapiro, Najman, Chang, Keeping, Morrison and Western, 1983), although, as Shapiro et al. have demonstrated, women generally fail to obtain the information they want from doctors.

To-day many women attend antenatal education classes to obtain knowledge. However, Storch (1984) points out that these classes frequently teach women how to conform to medical control, rather than supply them with the necessary information they need to achieve a fulfilling delivery². Kirkham (1986) makes a similar observation, and comments that such classes are usually taught using the language of obstetrics. Women learn about the way the objective process of labour is measured, for example about cervical dilatation, not about what they will perceive or experience themselves.

Such classes are usually taught by midwives, who, it must be noted, have not always been the innocent victims of the medical profession that some accounts would suggest. Kitzinger (1992) points out that midwives have also been known to control childbearing women, or to collude with medical control, as in the case of antenatal classes. Both doctors and midwives have frequently argued that such control is for the safety of both the mother and baby. However there is evidence that this has not always been the primary motive.

² Not all antenatal education classes are in this mould. Some, such as those run by the National Childbirth Trust, encourage childbearing women to take control themselves.

1.2.3 Concern for the mother and child?

Childbearing was only singled out as an issue of interest to the state towards the end of the last century, in part from the discovery of the low standard of health in the male population recruited to fight in the Boer War (Arms, 1994). Maternal and child welfare became an issue, not because there was concern for the mother and her child, but because there was a fear that the nation may not be able to procure a fit fighting force at a time of national emergency (Oakley, 1984).

Since Haig Ferguson, in the late nineteenth century, had found that outpatient antenatal care for unmarried pregnant girls improved the gestation and survival of their infants, there had been growing pressure to extend this care to all pregnant women. This concern over the health of the nation's fighting force was the final incentive to do this, from 1914 onwards. Following this move, infant mortality began to decline, and this was seen as proof of the efficacy of antenatal care (Oakley, 1984).³

It was not until 1925 that the Women's Co-operative Guild petitioned for the welfare of the mother to be considered before that of the child as, despite the drop in infant mortality, maternal mortality at childbirth was not falling. Moreover, when maternal mortality was attended to, the figures were manipulated to support the status quo. Oakley notes that between 1921-22, 380 maternal deaths were investigated. Of these 256 were the result of puerperal fever, a condition frequently caused by poor obstetric care and hygiene, and much more prevalent in hospital rather than home deliveries. Despite this, it was noted that of these 380 women, only 48 had elected to receive any clinical antenatal care. This was therefore deemed to be a contributory factor, although no comparison was made with antenatal clinic attendance of women who did not die. Similarly, although from 1935 to 1945, several programmes of dietary vitamin supplements correlated with a drop in both infant and maternal mortality, the increasing provision of antenatal care, and the increasing numbers of women hospitalized for childbirth were usually hailed as causal factors⁴.

Around the 1930s a different mortality rate began to be noted, the perinatal mortality rate. This is defined as the number of stillbirths plus the number of infant deaths which occur in the first week of life, a more useful estimate of the effects of pregnancy and childbirth. More recent assessments of the effectiveness of maternity care have therefore claimed this figure as support. The perinatal mortality rate has, on the whole, continued to fall over recent years, although there is still no real evidence that this fall is due to the increased medicalisation of childbirth or to rising rates of intervention (Savage, 1986). Better maternal health due to improved living standards and easier access to contraception and abortion also correlates with the decrease in these figures (Wagner, 1994; Tew, 1995). However,

³ It is worth noting that the pattern followed by the supporters of Haig Ferguson will become a familiar one when the introduction of recent technical interventions is discussed later. This is the pattern of recognizing that an intervention has been useful for one small and specialized group of people, and for this reason alone, extending it to the whole population (Richards, 1982).

⁴ Whatever the reason, the maternal mortality rate began to fall rapidly after a peak in 1934, and has continued to do so ever since, to the extent that it is now so low that it is seldom cited in relationship to current innovations in maternity care.

despite this, the perinatal mortality rate has continued to be used as justification for medical interventions and technology, like the maternal and infant mortality rates before it:

'In 1966 the perinatal mortality was 26.7 per thousand births, by 1992 this had been reduced to 7.7 per thousand. Looked at in another way in 19 out of every 1000 deliveries the baby today owes its life to the improvement in obstetric care in the past thirty years, of which ready access to caesarean section has contributed much.' (Stuttaford, The Times, December 6th 1994. p 19.)

Charles (1992) points out that the preoccupation with reducing the perinatal mortality rates is the effect of a society which expects perfection. If perfection was achievable, and if the control of childbirth enabled this, then there might be some justification in it. However, as it has been shown above, the link between intervention and control, and perinatal survival is dubious in the extreme. What is more, because the two major determinants of perinatal death are lethal congenital malformations and the pathology associated with low birth weight (Campbell, 1990), it seems very unlikely that the perinatal mortality rate can continue to fall indefinitely. Moreover, perinatal morbidity is as relevant as mortality (Iliffe, 1982). The concern to promote fetal survival does not, of course, imply that the medical profession are not concerned with the quality of life of the child. However, the preoccupation with statistics of quantity, and the lack of attention to morbidity figures seems illogical.

Apart from antenatal care, another early form of medical consideration for the labouring woman was in terms of relieving her pain. However, this move was not without its critics. Anaesthesia was developed in the late 1840's, and used initially in dentistry, and then surgery. However, it soon began to be used by some accoucheurs, either to produce unconsciousness, usually for operative deliveries, or to reduce the woman's level of awareness of pain. There was enormous opposition to the provision of pain relief for women in labour, not only from some churchmen who proclaimed that labour pain was divinely ordained, but also from medical men, who argued that such pain was natural and should not be interfered with. In their support, it has to be conceded that chloroform, the anaesthetic of the time, was a very dangerous substance, and more than a few women died in childbirth as a result of its use. However, in 1853, Queen Victoria's decision to use this analgesic in the birth of her eighth child, somewhat quieted the critics (Donnison, 1988). Pain relief was something most women wanted, even although its effects resulted in a lack of control. However its use was strictly limited to the wealthy, the general use of pain relief for childbirth not arriving until the mid-twentieth century (Donnison, 1988), by which time attention was also being given to non-pharmaceutical methods of pain control, such as psychoprophylaxis, developed in the 1930s by Dr Grantley Dick Read (Dick-Read, 1954). The mother-to-be was taught to reduce anxiety and relieve labour pain with breathing techniques, or visual and auditory self-distraction, along with relaxation (Beischer and Mackay, 1986). However, Oakley (1984) observes cynically that psychoprophylaxis was embraced by the obstetric and midwifery professions because anxiety had been found to impair the mechanics of reproductive performance. In other words, the woman was being taught to control herself, because this contributed to the overall control of her labour.

Despite this, psychoprophylaxis was accepted gratefully by many women for the very fact that it did give them control of themselves during labour. Women were, and are, afraid of 'showing themselves up', or of making fools of themselves, because they cannot cope with the symptoms of labour (Graham, 1982). It is this self-control, rather than being able to control the experience of pain, which matters to many women (Humenick and Bugen, 1981), and indeed, psychoprophylactic techniques have been shown to be limited in terms of pain reduction, but effective in maintaining self-control (Copstick, Taylor, Hayes and Morris, 1986).

In the 1960s and early 1970s, the concept of natural childbirth gradually began to take over from psychoprophylaxis: the ethos of minimal medical intervention, with the parturient woman and her partner assuming maximum responsibility for the decisions which are made, that is, external control of their situation. It also usually includes the presence of the partner at the birth, and parent-infant contact (to facilitate parent-child bonding) immediately after delivery (Stewart, 1985).

One problem with this concept was the adjective 'natural', which implied that childbirth with pharmacological pain relief was unnatural. It thus polarized the majority of women, who were unable to cope with labour without analgesia, placing them firmly back in the arena of medicalised childbirth (Hewison, 1993).

Since the early 1980s, the concept of active birth has, to some extent, succeeded natural childbirth. Active birth embraces all of the sentiments of natural childbirth, but emphasizes the importance of movement and posture during labour, and the need for the labouring woman to follow the natural instincts of her body (Balaskas, 1983).

In the early days natural childbirth was viewed with suspicion by many members of the medical profession, and active birth has also been received with misgiving in some quarters, not only amongst doctors, but also amongst some midwives and mothers themselves. One of the main charges which have been leveled at women who embrace these new approaches is that they are putting their own emotional experience before the safety of the fetus. Women wanting home births have been accused of the same crime:

'It may not be right and proper to expect the hospital team to suddenly abrogate their responsibility to their hospital patients and to dash to a patient who, of her own volition has decided to jeopardize her own life and that of her baby in order to have a home confinement against the advice of her medical attendants.' (Booth, 1981. p 231.)

In reply several authors have pointed out that every pregnant woman wants her child to be healthy above all else (for example: Martin, 1987 and Walton and Hamilton, 1995), but that women are still made angry that their experience of the birth frequently counts as nothing against the welfare of the child.

Another criticism which has been raised is that these changes have been founded on a middle-class model of birth experience, a result of the 1970's convergence of natural childbirth, feminism, consumerism and 'back-to-nature' romanticism (Nelson, 1983). As such they have little to offer the working-class woman who does not necessarily have as much control of her life in other respects and

who therefore may not be able to identify with, or be helped by, these more middle-class ideals of childbirth. Entwined with this argument is the stereotype of the working-class woman who cares nothing for an 'experience' of childbirth, but who wants it to be over with as quickly and painlessly as possible (Green, Coupland and Kitzinger, 1988; Green, Kitzinger and Coupland, 1990). This argument will be addressed further in the subsection devoted to current research (subsection 1.4.2.1).

It is interesting that criticisms such as these have served to delay the move to allow all women to take as much control as they want to in childbirth. Paradoxically, as already intimated, many obstetric interventions, which deprive women of control, have been instigated on the weakest of justifications, their inefficacy only being demonstrated after their widespread adoption (Donnison, 1998).

1.2.4 Changing childbirth

Donnison (1988) notes that one of the main contributory factors in the move to hospitalised maternity care was the obstetricians' growing advocacy of the 'active management of labour'. The term, coined in the 1970s, embodied everything opposed to allowing labour to follow its natural course. It epitomised the concept that childbirth was only normal in retrospect and that women's bodies could therefore not be allowed to labour or give birth unsupervised and uncontrolled. Earlier textbooks describe active management in glowing terms:

'The unpredictability of the onset of labour has been eliminated: the negative attitude of watchful expectancy throughout labour which often culminated in a prolonged exhausting experience has been superseded by a planned positive approach. Greater maternal and fetal safety has been achieved by the use of continuous electronic monitoring devices. More frequent use of epidural analgesia, caesarean section, forceps, episiotomy and controlled cord traction all have a bearing on the active management of labour.' (Myles, 1975. p 254.)

All of these interventions, plus others, continue to be used today. For example, Garcia and Garforth (1989) describe the use of electronic fetal monitoring in 99% of the 220 consultant maternity units they surveyed. In some units it is used on every labouring woman. The fetal heart rate is recorded either using an electrode attached to the baby's scalp (necessitating artificial rupture of the membranes), or by a belt around the mother's abdomen, whilst a second abdominal transducer monitors contractions. Movement is restricted for the woman, thus slowing her labour and rendering it more painful (movement allows the woman to find a comfortable posture, and facilitates fetal descent). Despite Myles' assertion, electronic fetal monitoring has been found to be no more accurate in assessing fetal wellbeing than the traditional hand held fetal stethoscope (Donnison, 1988; Walkinshaw, 1994).

Eliminating the unpredictable onset of labour has meant inducing labour, usually for post maturity, but sometimes for 'social' reasons. This is achieved by artificial rupture of the membranes which, although it stimulates labour, can lead to compromise of the fetal blood supply and more painful contractions (Henderson, 1990), and by an intravenous infusion of syntocinon, an oxytocic drug which further stimulates uterine contractions. Syntocinon also intensifies labour pain and carries a concomitant risk of overdose and tonic contractions. It is also thought to contribute to neonatal jaundice (Enkin, Keirse, Renfrew and Neilson, 1995). Because of its dangers, women receiving syntocinon are electronically monitored and, once again, confined to immobility. Syntocinon is also used to accelerate a labour which is deemed to be progressing too

slowly. As mentioned earlier, this concept of clock watching (and calendar watching, in the case of induction for post maturity) was originally a consequence of the doctors' impatience with the slow process of labour. It is now claimed that induction and acceleration has helped to reduce the perinatal mortality rate, but, as has been already seen, there is no empirical evidence for this (Tew, 1995).

Similar evidence of lack of effectiveness, or of serious side effects, can be found for other interventions. These include: episiotomy, cutting the perineum to enlarge the vaginal opening at delivery; epidural anaesthesia, an infusion of local anaesthetic into the epidural space around the lower part of the spinal cord, to eliminate labour pain; and caesarean section (Walkinshaw, 1994; Hammett, 1997). Moreover, the use of one intervention tends to lead to the use of several others. For example, because of the increased amount of pain incurred from induction of labour, recipients are more likely to require epidural anaesthesia. The resultant lack of sensation combined with the slower progress caused by the immobility of continuous electronic monitoring increases the likelihood that delivery of the baby will necessitate the use of forceps, this in its turn requiring episiotomy, thus increasing maternal and fetal trauma. In this sense the control of childbirth is insidious. It is no wonder that some women do now refuse to give birth in hospital, for fear that they will be talked into agreeing to one intervention after another (Donnison, 1988).

Government instituted advisory committees in the 1980s did not reflect this growing concern over medicalised childbirth, but other organisations did - both consumer groups such as the National Childbirth Trust, and professional organisations such as the Association of Radical Midwives. As a result of pressure from such groups, and of NHS reforms committed to consumer choice and participation, by 1990 the time was right for a radical review of maternity care. The resultant report, the Winterton Report (House of Commons, 1992), gave an extensive critique of the way in which maternity care was conducted, both before, during and after childbirth, and recommended that the service be reappraised with the pregnant women and her child at the centre, and with her needs and wishes given full consideration. The Changing Childbirth Report (Department of Health, 1993), described earlier, was the outcome. The word 'control' is not used in the report, but its sentiments can be enshrined in such a concept. It speaks of a maternity service which is regularly adjusted to meet the needs of the women it serves; of clear, unbiased advice for all women, giving them a full range of choices in terms of where they would like their baby to be born (including at home), and in their plans for labour and birth. It stresses that reasonable effort should be made to accommodate the wishes of every woman and her partner. It also encourages carers to offer women continuity of care - the same carer, as far as possible, throughout pregnancy; and delivery by someone already familiar to the woman (Department of Health, 1993).

1.2.5 Conclusion to section 1.2

Five years on, there are still difficulties in implementing these ideals (Lewis, 1997). Taking into consideration the historical legacy of powerlessness for childbearing women and their midwives described in this section, this is hardly surprising. What is probably more surprising is that it should ever be imagined that control could be handed over unproblematically. Moreover, when this legacy is contemplated, many questions arise which are still pertinent today. The first is rooted in the heterogeneity of childbearing women:

the fact that, although the control of women through childbirth has been present in one guise or another from the time of the witch trials or even earlier, the number of women who have resisted has always been comparatively small. What is more, it has usually only been the privileged few who have been able to avail themselves of whatever type of childbirth care was considered empowering at the time, for example, chloroform, at the end of the 19th century. The accusation that childbirth reform is based on middle-class ideologies must therefore be taken seriously and examined. The first question then is what control in childbirth, as an issue, means to different women.

A second question concerns the power issues involved. It has been shown in the preceding section that the loss of control over childbirth impinged, not only upon childbearing women, but also upon their midwives, who were almost always women as well. Even the areas of childbirth care that midwives were allowed to continue to control were overshadowed by the pathologisation of birth: its definition as a process which could only be considered normal in retrospect, and by the labelling of women's bodies as inefficient and liable to fail in the procedure of giving birth safely. Thus the second question is how control in childbirth can be outworked between two groups of females: parturient women, and midwives, both until recently oppressed.

Thirdly, it appears to be assumed that to achieve control will carry certain psychological benefits for childbearing women. The history of women's loss of control over childbirth has helped to formulate it as something to be desired, but this does not automatically make it something beneficial. The accusation that women who demanded control were putting their own emotional experience before their own and their baby's wellbeing, has probably helped serve to promulgate control as something of psychological benefit. However the exact nature of those benefits must be explored.

Current research which answers, or which goes some way to answering, the three questions posed here will be examined in section 1.4 of this chapter. The next section will ask what psychological theory has to say about the issue of control, and whether it facilitates an understanding of control in childbirth.

1.3 The issue of control

1.3.1 Introduction to section 1.3

The recommendations of the 'Changing Childbirth' report appear to rest on the assumption that childbirth control is something which will be intrinsically good for all women, that:

'...genuine involvement in decision making is likely to have a psychologically positive effect.' (Page, 1994. p91).

However, an examination of the psychological constructs of control, and of the questions raised by this literature, suggests that the issues involved are far less clear cut than they at first seem, and thus the implied simplicity of control in childbirth must also be open to question.

This critical examination of the psychology of control will firstly consider the ways in which psychologists have attempted to conceptualize and contain the notion of control, relating the

problematic nature of such concepts to practical issues concerning control in childbirth. Some of the intricacies of control as it specifically relates to childbearing women will then be discussed.

Wallston, Wallston, Smith and Dobbins (1987) use the dimension of time to categorize the various psychological theories which address control issues. When the individual is inferring causes for past events, the processes involved can be described using attribution theory (Harvey and Weary, 1984; Kelley and Michela, 1980). Expectancies about future control are dealt with using social learning theory, namely locus of control (Rotter, 1954), or self-efficacy theory (Bandura, 1977).

1.3.2 Psychological constructs of control

1.3.2.1 ATTRIBUTION THEORY

The attribution theory of depression (Abramson, Seligman and Teasdale, 1978) blends cognitive and learning elements, and essentially describes how causes are attributed to different events. Thus it is concerned with the way a person explains failure or success. Attribution theory postulates that it is the nature of the explanation that will determine subsequent psychological effects. As such it can be seen that, despite the useful time dimension categorization of psychological constructs of control made by Wallston et al., and described above, the distinction between past and future control is not totally separate. Although attributions are inferred from an assessment of past events, they then become determinants of subsequent expectations.

Control-related issues become more apparent in later formulations of attribution theory, such as the 'hopelessness theory of depression', which suggests that some forms of depression are caused by an expectation that desirable outcomes will not occur and that the person has no resources available to change the situation: in other words, by feelings of lack of control (Abramson, Metalsky and Alloy, 1989). Hopelessness could be caused by an interaction between negative life events and an attributional style which attributes failure to global, stable and internal inadequacies.

Such a theory has some bearing upon control in childbirth. It suggests that loss of control, if it is attributed by the parturient women to her own failings or to her helplessness in an uncontrollable situation, might have some consequence upon whether she becomes depressed postnatally. Oakley (1980), Day (1982), Green, Coupland and Kitzinger (1988) and Oakley and Rajan (1990) have all shown a relationship between feelings of lack of control in labour and reports of postnatal depressed mood. Jacoby (1987) noted that women who had experienced certain disempowering procedures, like epidural anaesthetic or induction of labour were more likely to be depressed postnatally. Similar findings to Green et al. were made by Thune-Larsen and Møller-Pedersen (1988). Romito (1989) pointed out that women having planned caesarean sections were less depressed afterwards than those requiring the operation as an emergency, and suggests that when the procedure is pre-planned, women are more likely to have played a part in the decision to operate. Elliott, Anderson, Brough, Watson and Rugg (1984), did not find relationships between obstetric intervention and postnatal blues or depression. However they suggest that a key issue for postnatal psychological well-being might be how the woman perceives the intervention, rather than the intervention itself. They also acknowledge the possible inadequacy of

some of their measures of obstetric outcome, a potential explanation for the differences between their results and those of Oakley. Whiffen (1992) also observes that women's perceptions of their delivery appear to be as important as objective measures of the stressfulness of events in predicting postpartum depression.

Despite the suggestion that attribution theory might provide some helpful insights into the effects of control in childbirth, some of the criticisms made against the theory also have important implications. For example, Wallston, Wallston, Smith and Dobbins (1987) make a distinction between the attribution of control over the cause of a problem and attributions of responsibility for solutions to the problem. Sometimes, in terms of control in childbirth, this is helpful. For example, a woman may perceive that she did not have control over whether she actually experienced labour pain. She may consider this to be due to her low pain threshold, or to the nature of labour itself. However, she may consider that she did have control over how she responded to that pain, in terms of perhaps using relaxation techniques, or maybe asking for drugs to alleviate it. Thus these two issues could be entirely separate for her. However, they could also be identical. If the woman felt anxious and had been taught, as many women are, that tense muscles make the pain of labour worse, she may perceive her experience of pain to have been due to her own tension and thus, in theory at least, under her control. In this case she may believe that she had as much control over the cause of the pain as she did over her reaction to it, that in both cases she should have been able to exercise control by relaxing her muscles. In other words, the distinction between control over onset and reaction is necessary, but the concepts can, at times, blur together. This is the problem of attempting to compartmentalize abstractions which are, in practice, very fluid.

Stam (1987) highlights another questionable aspect of attribution theory. He points out that the core theoretical notion is asocial. When associations are made between depression and attribution, the implication for therapy is that the individual's unattainable goals or unrealistic attributions must be changed. Stam points out that therapy seldom, if ever, involves giving, or trying to give the depressed person more control over their contingencies. The social origins of hopelessness are not addressed.

Such an accusation can also be leveled at 'Changing Childbirth', which examines ways in which women may be given more control at the time of labour and delivery, but overlooks the social precursors to both that individual woman's powerlessness (or power), and to the whole history of the development of a system of obstetric care which deprives women of control (see section 1.2, page 17ff). As argued earlier (subsection 1.2.3, page 23) if a woman has experienced low levels of control in her life prior to childbirth, she is unlikely to feel comfortable with the prospect of taking control at a time when she is experiencing something totally different to anything she has encountered previously, most probably in an environment which seems alien, surrounded by medical professionals, people whom she assumes to be experts in the subject. In other words, a woman's experiences in life will be carried with her into the birth experience. Even if a woman wants to take control, she is still going to find herself in a culture which, until recently, was designed specifically to give control of her body to others. The vestiges of such a system are likely to be slow to die away, something made evident in the discussion

about the disempowering nature of many obstetric interventions in subsection 1.2.4 (page 24). Even the terminology of childbirth is reminiscent of the age of control of the woman. She is 'confined' and 'delivered' (Peterson and Cefalo, 1990), a community midwife might call her 'my lady' to her colleagues, or afterwards give her a 'day off' from postnatal visits, as if she was, in the first case a possession of the midwife, and in the second case an employee (Walton, 1995)⁵.

Another problem raised by the concept of attribution is addressed by Miller and Ross (1975), who highlight the self-serving bias, the tendency for individuals to explain success in terms of internal causes, and failure in terms of situational, or external, causes. It is uncertain what causes this bias, but it has been suggested that individuals may be attempting to protect their self-esteem when they fail, or to enhance their public image if they succeed. In a study of control in childbirth this may mean that women who have uneventful deliveries may be more likely to perceive themselves as having had control, and women who develop complications more likely to believe that they had not had control, purely because of the objective nature of their experience. At the same time it must be remembered that women who have uncomplicated experiences may have very legitimate reasons for perceiving greater control, as the wheels of medical technology, which is renowned for depriving women of control, are far more likely to be put into motion once complications arise. It is also at the point of any departure from 'normal labour' that a woman begins to experience a disruption in the care from her midwife, as more senior midwives and doctors begin to intervene. At this point any rapport with her own midwife, from whom the woman may have experienced a sense of strength and advocacy, is more likely to be lost.

Another issue associated with attribution theory is the actor-observer bias (Jones and Nisbett, 1971), the tendency for individuals to attribute their own behaviour to external or situational causes, but that of others to internal ones. Such a bias is thought to arise in part because people are aware of the situational factors affecting their own actions, but not necessarily of those affecting the actions of others. This has some relevance for the study of childbirth control, because it suggests that childbearing women themselves are likely attribute different explanations to their control, or its lack, than would their carers. To understand childbearing women's perspective on control in childbirth it is therefore necessary to consider their accounts carefully. This however, does not mean that the accounts of carers should be ignored. Again the situation is not as cut and dried as some psychological theorists would have us believe, as in many 'real-life' situations the observers are also actors. Such is the case in childbirth where carers will have their own part to play, and therefore their own understanding of the circumstances.

In summary, there are several problems with the concept of attribution, many of which have implications for the study of control in childbirth. One of the most important issues is the asocial nature of the theory: its lack of acknowledgment of the relevance of social issues to the attributions

⁵ Earlier reference was made to the 'language of obstetrics' used in antenatal classes (subsection 1.2.2, page 16). These associated issues of language and communication are important to the notion of control in childbirth, and will be discussed at length later in this chapter (subsection 1.4.4).

made by individuals. This theme recurs in the discussion of other psychological theories of control, such as locus of control, described next.

1.3.2.2 LOCUS OF CONTROL

Unlike attribution theory which centres on past experiences, locus of control measures are concerned mainly with expectations of future events. Locus of control is the generalized outcome expectancy construct from Rotter's social learning theory (Rotter, 1954), based on an individual's beliefs about the effects of their own behaviour. According to this theory, those with an internal locus of control orientation believe their own behaviour determines their reinforcements or outcomes, whilst those with an external locus of control believe their reinforcements are controlled by powerful others or by random occurrences such as fate, luck or chance. The individual's locus of control, it is postulated, is one of the variables which determine whether the behaviour under consideration occurs. Locus of control is believed to be a relatively stable characteristic (Wolfle and Robertshaw, 1982), although change can be brought about deliberately if individuals are taught that they are able to have some control over what happens to them (Reimanis, 1971). Some theorists and researchers have subdivided the concept of external locus of control. For example Levenson (1974), differentiated between an external belief in fate and an external belief in the control of powerful others, and found the distinction a valid and useful one.

Locus of control became widely adopted as an experimental concept, and Rotter became concerned about possible misuse and misunderstanding of his internal/external (I/E) scale (Rotter, 1975). He pointed out that other determinants of behaviour such as the value of the reinforcement, the psychological situation, and the choice of alternative behaviours available were of equal importance to locus of control. These points have relevance for control in childbirth. Whatever a woman's belief about the power of her own behaviour, if natural childbirth, for example, is unimportant to her, she is unlikely to be assertive over achieving it. The value of the reinforcement in this particular area is low for her, and this affects her behaviour more than her locus of control. In terms of the psychological situation, if she feels exhausted and frightened, this could affect her behaviour as much, or more, than her locus of control. Finally, to predict whether she is going to exercise control over her carers, one has to know what alternatives she is going to be presented with. In an emergency they will be few and limited, and she is likely to behave quite differently to the way she will if she is presented with a full choice in safe, non-threatening circumstances, regardless of her locus of control orientation.

Rotter also criticizes the value judgments which are sometimes given to internality and externality. The implication is that internality is good and externality bad. Rotter points out that, although some locus of control scales do correlate with self-report scales of anxiety or adjustment, suggesting that internals may be less anxious or better adjusted, there are also several studies which suggest that it is typical of internals to repress or forget failures and unpleasant experiences - something which is unlikely to be psychologically healthy. Alternatively individuals with an internal locus of control may be subject to psychological trauma when they discover that they cannot control certain aspects of their lives, for example, their health. Rodin (1986) also observes that perceived control which is related to excessive

feelings of responsibility can be negative in effect, a view echoed by Folkman (1984). The well-worn stereotype of the childbearing women with excessively high expectations of control who is doomed to disappointment and consequent psychological trauma could be based, to some extent, on premises such as these (Stewart, 1985; Green, Kitzinger and Coupland, 1990; Marshall, 1994).

Furnham and Steele (1993) argue that an individual's beliefs about their influence on larger systems or institutions might be independent of their beliefs about events within direct personal experience. This may be one of the underlying reasons for the increasing demand for home birth amongst women. It is probably easier for a woman to envisage her behaviour controlling the outcome in her own home than in a large, alien institution like a hospital. Indeed, this is usually one of the key points made in pro-home birth literature (for example: Rankin, 1981; Flint, 1990)

Furnham and Steele also distinguish between beliefs about the cause of future events, and beliefs about responsibility for these events. They state that locus of control is usually associated with perceived cause but not responsibility, although the two concepts are closely related. In terms of childbirth control this raises an important point. A woman may perceive a link between her behaviour and her experiences in labour. However she may not believe that she is responsible for what happens to her. Thus, if the outcome is adverse, she will still feel able to litigate against those she holds accountable for the calamity. Indeed, in the eyes of the law the difference between control and accountability is also recognized. Although women in labour are seen as having a right to refuse treatment, it is the hospital which is held responsible for any financial consequences from a bad outcome (Page, 1994).

Wallston, Smith, King, Forsberg, Wallston and Tong Nagy (1983) distinguish between expectancies of control and preference for control. Locus of control relates to what the individual believes, or expects, but not necessarily to what they want. However, Wallston et al., and Fitzpatrick (1984) found that expectations of control over health were related to preferences for control. Green, Coupland and Kitzinger (1988) specifically noted an association between preferences and expectancies of control in childbirth although, conversely, Beaton and Gupton (1990) found that some pregnant women expressed expectations of obstetric procedures which they did not want.

A major subject for debate in the locus of control literature is the issue of domain specificity. Rotter's locus of control scale was developed to measure only generalized expectancies for control, and as such has frequently been misused in an attempt to obtain predictions about specific behaviours. However, since the original I/E Scale, many others have been produced which are designed for particular domains. One scale which was designed specifically to measure locus of control in childbirth contained three scales: Internal; External-Powerful Others; and External-Chance (Schroeder, 1985). Questions were directed to three areas: beliefs about the control of pain, control of emotions, and control of interpersonal relationships with staff. Schroeder implies that her scale would be of practical use in providing a measure of expectation for control during childbirth, so that women could be helped to achieve their goals for control. However, as already explained, to claim that a locus of control measure is a gauge of behavioural goals is to go beyond the scope of the concept. It seems that there must be far more practical ways of finding out how much control a woman wants if the intention is to try to give

her that control. To ask her what interventions she particularly wishes to avoid, where she would like to give birth, who she would like to deliver her baby, and so on, seems a more simple way of achieving this aim.

Another area of debate within the locus of control literature is the relationship between locus of control orientation and social class. Argyle (1994) explains that, although many studies have found that members of the middle-class are more internal, and the working-class more external, the greatest class differences are actually work-related. However it is not easy to discern whether certain types of work predispose towards internality or externality, or whether certain types of individuals, for example those with high levels of self-direction, look for self-directing jobs. Argyle also notes that locus of control appears to be related to amount of education, which again has a confounding relationship with social class. The relationship between control in childbirth expectancies and social class, alongside the problematic nature of the concept of social class form major topics, and will be discussed at length later (subsection 1.4.2.1).

Research which has related locus of control to various aspects of childbearing has been ambivalent as to whether internality, measured in the antenatal period, predicts postnatal satisfaction with the birth. Willmuth, Weaver and Borenstein (1978) and Marshall (1994) both produced data which confirmed such a relationship. However Knapp (1995), who studied an apparently similar sample to Marshall, found no such association. This difference might, in part, be due to the problems associated with the measurement of childbirth satisfaction, which will be discussed in the subsection on psychological outcome (subsection 1.4.5.1).

Two more studies produce findings which are difficult to explain. Crowe and von Baeyer (1989), found that women who, in the antenatal period, expressed the belief that much of labour and delivery was controlled by chance, reported lower levels of labour pain postnatally. The authors find no satisfactory explanation for this. However, it is possible that women who did not believe that they or that powerful others were capable of controlling their pain were more relaxed, more able to take the situation as they found it. One of the key tenets of antenatal education is that relaxation reduces labour pain.

Reisch and Tinsley (1994) found that pregnant women from low income backgrounds, with a high belief in the controlling influence of powerful others with respect to their infant's health, were more likely to attend antenatal clinics regularly. In other words, they appeared to be more anxious for the hospital to monitor fetal wellbeing. Women with high levels of internality were poor attenders. The authors claim that, with a middle-class sample, internality would predispose to high attendance. They postulate that, in poorer classes, the only chance of control in every day life is via powerful others, and that this lead to beliefs which permeate behaviour in pregnancy. This finding connects with the suggestion, made in the last subsection, that women take their experiences from the rest of their lives with them into the experience of childbearing.

In summary, locus of control is a much narrower concept than is sometimes acknowledged. It is defined as an individual's belief that their behaviour can control outcomes, and does not take into

consideration such issues as the value of the reinforcement. A discussion of the limitations of locus of control, however, resonates with several pertinent issues for the study of control in childbirth.

1.3.2.3 SELF-EFFICACY

Self-efficacy is the conviction that one is able to execute successfully a specific, required behaviour (Bandura, 1977).

Although motivation and skills are also required, self-efficacy expectations are considered necessary cognitive factors to precede behaviour change. The strength of self-efficacy expectancies helps to determine whether an individual will both initiate, and persist in, a coping behaviour. Bandura outlines the dimensions of efficacy expectations, such as magnitude, generality and strength, and their sources: performance accomplishments; vicarious experiences; verbal persuasions and emotional arousal. In other words, individuals can increase in self-efficacy from their own achievements, from watching others achieve, from verbal encouragement or from feeling emotionally involved or happy about the task to be encountered.

Manning and Wright (1983) stress the difference between self-efficacy expectancy and outcome expectancy, which is defined as the belief that a particular behaviour leads to a certain outcome⁶.

The concept of self-efficacy is seldom specifically applied to control in childbirth. However, Manning and Wright (1983) used pain control during labour and birth⁷ as the context in which to study self-efficacy in 52 primiparous women, and found that self-efficacy expectancy contributed more to the prediction of persistence in pain control, than all other measures, for example, length of labour or locus of control. Influenced by this study, Lowe (1991) suggested that self-efficacy to cope with labour pain might be enhanced by experience of pain in other situations (enactive experience); by seeing others perform in labour, for example through books and videos about childbirth (vicarious experience); by childbirth classes (verbal persuasion); or that efficacy might be diminished via internal messages of fear or panic that might occur during labour (emotional arousal).

Lowe makes the point that the specific expectancies a woman feels are the result of her personal evaluation and integration of information from all sources. She adds that the unique qualities of childbirth contribute extra information about self-efficacy, and it is this information in particular that can be highly negative. Unlike many aspects of life, childbirth, especially a first birth, is essentially an unknown situation. The onset, duration and intensity of labour are unpredictable, and there is little or no escape once the process has begun. Many unusual situational or contextual factors are involved, for example: medical procedures; loss of privacy; and interpersonal conflicts which can arise from the decisions made by doctors or midwives. Although none of these issues is unique to childbirth, it is unusual for them to all occur together, especially in the lives of healthy young women who may never have even been in hospital before. Therefore, although enactive experience, vicarious experience and

⁶ Outcome expectancy is not to be confused with locus of control which is an individual's belief that their behaviour can control the outcome.

⁷ That is, coping with labour and birth without the use of medication for pain relief.

verbal persuasion prior to the event are all important to the woman's self-efficacy expectancy, the emotional and visceral cues from the situation as the woman experiences labour are liable to undermine the effect of all the prior preparation. Lowe concludes therefore by observing that confidence building must go beyond childbirth preparation classes and be taken into the delivery room itself by the carers. She suggests that carers ask women how confident they feel during labour and that they provide interventions related to the woman's fears and anxieties, and instruction in behavioural techniques to assist the unprepared woman. Although Lowe's use of the self-efficacy concept appears logical, these final recommendations are vague, and seem to be technique orientated. Some women may not gain confidence from being taught techniques, and may not even be able to assimilate the information given if they are in a state of extreme arousal from fear. A woman must first be given the opportunity to decide whether she wants to learn such techniques, and to select interventions after being told what is available. What is more, confidence in childbirth is derived from more than the kind of self-control that might be required to cope with labour without pharmaceutical pain relief. It also involves the woman feeling in control of the situation and over what is done to her (Green, Coupland and Kitzinger, 1988).

Lowe positions the relationship between self-efficacy and interpretation of painful stimuli as a central issue in women's management of childbirth. However, others have suggested that pain in childbirth is not the prime issue for many women. It is a stressor, along with other stressors such as fatigue, loneliness and loss of dignity which, if not offset by support to the woman from, for example the presence of others; taught understanding of the situation and coping skills; and intervention if needed, can affect the woman's perception of mastery of her experience (Humenick, 1981; Humenick and Bugen, 1981).

Lowe postulated that childbirth classes will help to enhance self-efficacy, through both vicarious success, that is, hearing about successful coping, and through verbal persuasion. The fact that antenatal classes can be shown to increase both knowledge and confidence concerning labour, has been demonstrated by Hillier and Slade (1989), although Hallgren, Kihlgren, Norberg and Forslin (1995), using a qualitative approach, demonstrated the varied effects the same antenatal classes can have upon different women. However, Slade, MacPherson, Hume and Maresh (1993) showed that attendance at antenatal education classes had little impact on women's experiences of labour (including control). Although Lowe could counter this argument by pointing out that the autonomic responses to labour could detract from any positive effect wrought by classes, another explanation might be in the evidence that pregnant women obtain information about labour and birth from a wide range of sources, not just from antenatal classes, and the perceived benefit of classes as a major source of information might, therefore, be erroneous (Jacoby, 1988; Sargent and Stark, 1989; Woollett, Dosanjh, Nicolson, Marshall, Djhanbakhch and Hadlow, 1995).

In summary it seems that the concept of self-efficacy is of limited use in the study of control in childbirth. Moreover, there are several general criticisms which can be made of all the theories of control so far discussed. These will be addressed next.

1.3.2.4 GENERAL CRITICISM OF PSYCHOLOGICAL THEORIES OF CONTROL

It was demonstrated in section 1.2 (page 17ff) that childbearing women's lack of control can, generally speaking, be traced back to the medico-social climate, rather than the personality traits of individual women. Theories which examine control only at the level of the individual (as does locus of control theory, attribution theory and self-efficacy theory) are therefore of limited value.

Stam (1987) notes that despite the asocial aspect of psychological control theories there is a tendency for the individual constructs to be translated at the social level. For example, Bandura (1982) raises a notion of collective efficacy: the strength of groups to improve their lives through concerted effort. Such collective efficacy, he claims, is rooted in self-efficacy. A second problem, highlighted by Stam, therefore, is that in doing this, theories of control tend to simplify social structures. The fact is overlooked that sometimes power and control issues involve oppressed and ignored sub-groups who cannot even get their concerns onto the agenda, let alone find an equitable resolution. In the past this has tended to be the case for patients in the doctor-patient relationship, where an interaction involving mutual participation, where participants have equal power and are mutually interdependent, has been foreign to medicine (Szasz and Hollender, 1956). In terms of childbirth control it must be questioned firstly whether all women will find the courage and confidence to insist on control, and if they do not insist, whether they will still be offered it. Secondly it must be asked whether all women will be offered control equally, regardless of ethnic or social background, or whether childbirth control is, as some have argued, the prerogative of the middle-class woman (Nelson, 1983).

Stam also points out that control theories fail to acknowledge the interaction between the personal and the institutional. Yet such interactions are important. In the case of control in childbirth, it must be recognized that the woman's perception of control will be based on a complex interaction between the situation itself, the woman's understanding of it, her emotional state and the manner and bearing of those around her. Folkman (1984) also describes this person-environment relationship, in which control is always embedded, as a dynamic that is constantly changing. Relationships are bi-directional, with the person and the environment acting upon each other. Control theories seem to imply a largely static state within the individual. Walker, Hall and Thomas (1995), describing their findings from interviews with women and their partners noted the importance, for the women, of a balance between personal control and support from their carers. What is more, as theorized by Folkman, this balance fluctuated throughout the course of their labour.

Finally, Stam highlights the tendency of control theories to remove control from its historical context, to present it as a basic human need, whereas in actuality it is better understood as a prevailing cultural ideal. As far as childbirth control is concerned it again raises the issue of whether all women really want control, and whether in the future women are going to have difficulty in refusing control when they do not want it. In other words, they will be given no control over whether they take control. Green, Kitzinger and Coupland (1994) noted this problem in a forward-thinking maternity unit which, in 1987, was already offering women a degree of control. Just as some midwives expressed anxiety when women wanted control, so others expressed disappointment when women did not.

Stam points out that there are fundamental questions of control that psychology should be asking, questions derived from the contradiction in society today which, on the one hand gives the illusion of autonomy, in terms of choices to be made in the family, personal life, careers and consumption, whilst on the other hand there is increasing intervention and dictation over what was once considered personal and private. It is exactly this insidious exercise of power which tells women they have control only under certain circumstances (if things are 'normal') and within certain parameters (if she selects from 'safe' options). Ultimately the woman's control is controlled.

1.3.3 Issues specific to control in childbirth

1.3.3.1 INTRODUCTION

It has been shown that attribution theory, locus of control and self-efficacy theory each describe quite narrow concepts of control: something frequently acknowledged even by their proponents (Rotter, 1975). For example, locus of control: the individual's beliefs about the effects of their own behaviour says little about belief in what one should do (Wallston, Wallston, Smith and Dobbins, 1987). Neither does it address beliefs related to what the individual might want to do. As already discussed it also does not take into account such issues as the value of the outcome to the individual, the psychological situation and the choices of alternative behaviour available in that situation (Rotter 1975). Unfortunately many of these same criticisms can be raised at the two theories described in the next subsection, which are specific to childbearing. The main problem, it seems, with theories of control, is that they set out to simplify a complex concept, and subsection 1.3.3.3 will consider some of these complexities: the different facets of control. It was explained in the introduction to this chapter that the Changing Childbirth report (Department of Health, 1993) advocated both choice and control for childbearing women, and subsection 1.3.3.4 will discuss how choice and control are different, yet related. The final subsection will consider the environment in which childbearing women seek to exercise control: the ways in which midwives, as advocates of control for parturient women, are also controlled.

1.3.3.2 CONTROL THEORIES SPECIFIC TO CHILDBEARING

The concept of mastery has already been mentioned (subsection 1.3.2.3, page 34). Humenick (1981) implies that mastery and control are one and the same: a working alliance between a woman and her carers, resulting in the childbearing woman's continued ability to be able to influence the decisions made and the responsibilities taken. Humenick proposes that mastery is a better predictor of childbirth satisfaction than pain control. Humenick and Bugen (1981) set out to support this proposal with a longitudinal questionnaire study involving 33 primigravid women. They claimed some support for their mastery model after finding that scores on the instrumental scales of the Personal Attributes Questionnaire (which include such items as confidence and independence) increased significantly after childbirth, this increase being associated with women's raised perception of active involvement with the birth. However, Humenick and Bugen acknowledge that this study has many problems, the sample being small, and from a highly select group of well motivated women, without a suitable control group.

Moreover, despite setting up the mastery model in opposition to the pain management model, Humenick and Bugen did not actually compare the two models in the study by including pain and pain management as factors. Empirical evidence for the mastery model is, therefore, not at all strong at present.

A different contribution to psychological concepts of control in childbirth is made from a psychoanalytic perspective. Raphael-Leff (1991) identifies two different general approaches made by parturient women towards pregnancy, birth and motherhood. The Facilitator is a woman who, absorbed by the process of pregnancy and birth, wants nature to be allowed to take its course as far as possible throughout. She is therefore keen to have a natural childbirth and worries that she may not be allowed to do this. Conversely, the Regulator dislikes being pregnant, and has fears that the pain of labour may overwhelm her. Thus she is determined to use everything available to ensure minimum discomfort, and maximum self-possession. In their own ways both groups of woman require control during childbirth. The Facilitator wants to be able to control and prevent unnecessary intervention, whilst the Regulator wants to be able to control the pain and her own reactions to it. Although Raphael-Leff points out that there are few women who fit either of these models perfectly, she claims that most women gravitate towards one type or the other. She suggests that it is useful for professionals to distinguish between Facilitators and Regulators so that they can understand the issues of importance to them. However, if most women do not entirely fit one or other description, there will surely be risks in making assumptions from such categorizations about which issues might matter to any one woman.

1.3.3.3 ASPECTS OF CONTROL

Control in childbirth is difficult to theorize because it is complex. Green, Coupland and Kitzinger (1988) point out that the concept has more than one root, and consequently, more than one meaning. In relation to childbirth control, they defined two types of control: internal control, essentially the development and maintenance of control over ones own behaviour; and external control, the individual's control over the environment and what is done to them. Similar differentiations have also been made by Annandale (1987) and DiMatteo, Kahn and Berry (1993). Green et al. did find that women in their study who felt in control of what the staff did to them were significantly more likely to feel that they had experienced internal control as well. However, it was found that concern about making a lot of noise in labour was not particularly relevant to the other aspects of internal control, namely control of one's behaviour and feeling in control during contractions. In other words, although external and internal control seem to be related, internal control is probably not a unitary concept.

The philosophy of active birth suggests that the woman who is in labour should not try to control herself, but should 'let go': go with the natural instincts of her body (Balaskas, 1983). In many ways this exemplifies a third type of childbirth control, the control of the body over the process: the control which women lost when labour was defined as abnormal until proven otherwise, and women's wombs were implicitly labeled as deficient and unreliable. Perhaps this type of control could be labeled 'physiological control', because fundamentally it is the woman's faith in her physiology, her belief that women's bodies are capable of unassisted birth, that is important.

Bluff and Holloway (1994), in a qualitative analysis of interviews with 11 early postnatal women, noted that they all expressed a need for their carers to be in control of what happened during their labour, but at the same time expressed a need to be in control of events themselves. Such an apparent contradiction makes sense if handing over control is an element of control, if the woman is in control of whether she takes control or not, something which will be discussed in subsection 1.3.3.5. However, another way to look at this phenomenon is to define another type of control: joint control, where the woman positions herself and her carers as a team, working together to deliver her baby. The concept of joint control is supported by the findings from other research (Brewin and Bradley, 1982; Niven, 1994; Walker, Hall and Thomas, 1995). Both Brewin and Bradley, and Niven found that childbearing women expressed the belief that both they and their carers could be in control over the childbirth process, whilst Walker, Hall and Thomas found that the balance between personal control and support from those around varied considerably both between women and for individual women at different times in the course of their labour. Many reasons for these variations can be suggested. However one factor must be the type of decisions being made. Todman and Jauncey (1987) observe that there is a difference between control over 'technical'⁸ decisions (for example, whether an episiotomy is performed and whether fathers are allowed to deliver their children) and non-technical (such as the presence of fathers at the birth and the place of delivery).

Green, Coupland and Kitzinger (1988) make a further distinction between aspects of control when they comment on the difficulty, in practice, of distinguishing between perceived control and objective control. This issue will be raised again in subsection 1.5.3, where material-discursive approaches to research will be discussed. Suffice it to say here that any assessment of control is subjective to a certain degree, and therefore the concept of objective control is highly questionable. Despite this, control does not occur in a vacuum, and although many other issues are involved, a woman's embodied experience is going to be a factor in the production of her subjective feelings.

The difference between desired and expected control was discussed in subsection 1.3.2.2 (page 31). Furthermore, women may have general control requirements for childbirth. For example, a woman may want everyone to ask her permission before administering any sort of care or help. However control might apply differentially to emergency and non-emergency situations (just as a distinction was drawn between technical and non-technical situations), or the woman may have different views about controlling the actions of different people. Control, for a labouring woman, could also have more or less to do with controlling her self-esteem, her pain levels, her feelings of security about her baby's safety, or her behaviour. Her attitude towards different outcomes could also vary. The woman may, for example, believe she can control whether she receives pain relief, but not the type of delivery she has.

⁸ The term 'technical', although used by the authors of this paper, is misleading, it refers here to decisions which are thought to require training and experience.

1.3.3.4 CHOICE AND CONTROL

Although choice and control are related, they are not synonymous. Wallston, Wallston, Smith and Dobbins (1987) point out that choice alone does not necessarily increase the level of perceived control. The nature of the choice is important. Two negative alternatives are not necessarily viewed as choice. If a woman wanted to give birth at home, to be given the choice between delivery in a large maternity unit and delivery in a small GP unit may, to her, seem no choice at all. Green, Coupland and Kitlinger (1988) comment on the fact that although control is achieved in part through active participation in decision making, and an absence of choice implies an absence of control, choice can also decrease a women's sense of control by increasing her anxiety levels. This can happen in at least two ways: some women may feel threatened by the responsibility of having to make a choice; whilst others might feel swamped by all the options. Moreover, control does not necessarily imply choice. A woman may be given her own notes to look after, thus having control of them. However, she may not be given a choice as to whether she wants to do this.

1.3.3.5 WHO CONTROLS THE CONTROL?

Mander (1993) asks the question, 'Who chooses the choices?', and points out that adherence to the sentiment of choice in childbirth is becoming the ultimate test of the political correctness of maternity carers. She questions who selects the choices which a woman is allowed to make. At present, there are areas of choice which are considered to be exclusive to carers, others which midwives are happy to negotiate, whilst another group of choices are strenuously avoided by midwives, and given over totally to the woman. The point is that midwives still withhold from the woman the ultimate sanction, to decide which areas of choice will be made available to her.

This limitation on the part of midwives means a limitation of the areas of choice which women are given. Mander argues that each woman must be empowered to choose which choices she wants to make for herself. The same must apply to control. Hunt (1995) argues that full choice and control includes the woman being able to choose the 'wrong' things. It has sometimes been assumed that all women who want control will want the things which, historically, women were denied for so long: natural childbirth; alternative delivery positions and home birth, for example. However, full control should include allowing women to have elective caesarean sections, elective episiotomies, epidurals on demand as well, and most of all, allowing them to choose not to take control when they do not want to. Ultimate control must include the woman's freedom to relinquish control exactly when she wants, and to take it back again when she wishes. It means that midwives and doctors must allow the woman control even if what she wants is contrary to their own beliefs (Floyd, 1995)⁹. This will also apply to

⁹ However carers must, of course, maintain their responsibility to explain why they do not recommend certain courses of action, for example when something might not be entirely safe for the woman or her baby. Nevertheless this must not be done coercively. The ultimate choice is the woman's, as was demonstrated recently when a court established that women who have been forced, against their will, to have caesarean sections have a right to sue the hospital, even when the operation was deemed essential to preserve the life of mother and child (The Times, May 8th 1998, page 1).

internal control. A woman needs to feel free to relax and 'go with her body' when she chooses and to control herself with breathing, or pharmacological assistance when she wishes.

However, inevitably there are problems with this ideal. As shown in section 1.2 (page 17ff), it is not just childbearing women who have a legacy of being controlled but also midwives. Midwives still frequently complain of being controlled - by obstetricians; senior midwifery staff; or hospital management - to limit childbearing women's control (Hall, 1993; Rosser, 1998). In other words, if the midwife's control is limited, she will probably be unable to give the woman full control, or will fear that if she attempts to do so, her decisions may be undermined by those in authority over her.

1.3.4 Conclusion to section 1.3

Section 1.3 has explored psychological theories of control and some of the broader issues that impinge upon the practical considerations of control for childbearing women. Each of the psychological theories has been shown to be narrow, and this narrowness contrasts strongly with the complexity of control in childbirth, which can involve control of the self or the environment; a theoretical objective control versus perceived control; desired or expected control; joint control; an acknowledgment of the body's control of the birth process; and control with, or without, choice. Psychological theories also ignore the historical context and social structures which underpin power and powerlessness, investing attention solely in the individual. Again this runs counter to the underlying historical issues of control in childbirth already discussed, and to such questions as who controls the control which childbearing women are allowed to take. However, this is not to say that psychological theory does not help to inform issues around control in childbirth. The association between lack of control and depression, made by attribution theory is important to note, as is the question of whether childbearing women's experiences of control or its lack in their past lives influence their control in childbirth. Another issue raised in the discussion of attribution theory, the importance of childbearing women's own account of control, is also highly pertinent. Although it did not raise many new issues, the discussion of locus of control theory provided a reminder of the importance of background issues such as social class in any consideration of control, whilst the discussion of self-efficacy theory raised questions as to whether control could be taught, for example, through antenatal classes.

1.4 Recent research and associated topics

1.4.1 Introduction to section 1.4

In the concluding comments to the second section of this chapter (page 26) three questions were raised, each of which had its roots in the historical legacy of control of childbirth by the medical profession. The first asked how different women operationalised the concept of control in childbirth: whether it meant different things to different women. The second question asked how control issues were outworked in the relationships between childbearing women and their carers, namely midwives. The third question asked what the psychological value of control in childbirth might be.

This section (1.4) will explore what is already known about control in childbirth, discussing research which helps to answer certain aspects of these questions whilst highlighting areas in which more research and understanding is required.

Subsection 1.4.2 will address the first question by asking which factors might contribute to childbearing women's reports of control or lack of control. Whether such issues as social background, age and antenatal class attendance have been shown to have any relevance for women's control in childbirth will be discussed. It is important to note here that the issue of cultural or ethnic background will not be addressed in any detail in this thesis. It is beyond its scope. This is not to say that this topic is unimportant, indeed, on the contrary, it is its complexity that makes it worthy of research in its own right, and not merely eligible as a variable amongst many others. Existing research has shown both the differences between women of different cultures in terms of their reactions to labour and birth (Scopesi, Zanobini and Carossino, 1997), and the differences within various cultural groups (Marshall, 1992).

Again related to the question of how different women conceptualize control, mention was made in subsection 1.3.2.2 (page 31) of the claim that some women with exceptionally high control expectations might be setting themselves up, not only for dashed hopes, but also for concomitant postnatal psychological disturbances. In subsection 1.4.3 research which has related childbearing women's expectations to their experiences will be discussed.

Communication and language are important issues. In subsection 1.3.2.1 (page 29) it was pointed out that the vestiges of a system in which childbearing women were almost completely controlled live on in much of the language of obstetrics. The issue of social class also raises the question of whether women from certain backgrounds appear to want less control only because they have more difficulty in articulating their requirements. This latter topic, which relates to the first question, will be addressed first in subsection 1.4.4, which deals with communication. Then more general midwife/ client communication issues, which relate to the second question, will be addressed, both in terms of overall communication and the language of obstetrics and midwifery.

An important assumption of the Changing Childbirth report (Department of Health, 1993) is that control in childbirth will be good for childbearing women. Otherwise its pursuit is of little value. In the final subsection the third question, that of psychological outcome will be explored, taking into consideration how such outcomes have been assessed.

1.4.2 The relevance of background/ demographic variables

1.4.2.1 SOCIAL CLASS

An important problem with almost any research that incorporates social class as a variable is how this factor is quantified. For example, in terms of childbirth related issues, Green, Coupland and Kitlinger (1988), took three indicators of social class: partner's occupation; the woman's own best ever job; and the age at which the woman completed full-time education. They found that the age of finishing full-

time education was the most significant determinant of the women's desire for control during childbirth, and that all three indicators gave different results.

There is a plethora of literature which criticizes the use of the Registrar General's Social Class categories (RGSC), the most frequently used measure of social class. The RGSC is especially problematic in relation to the classification of women (Abbott and Sapsford, 1987; Arber, Dale and Gilbert, 1986; Carr-Hill and Pritchard, 1992; Hamilton and Hirszowicz, 1993). The main criticisms are that the measure was designed to be applied to the male 'head of the household', to determine the social class standing of the whole family. However as many of these authors point out, partner's occupation is not a good indicator of the woman's own social class. What is more, not all women have partners. According to the RGSC, women who do not live with men should be categorized on the basis of their own occupations, but to do this with some women in a sample, and not with others (i.e. those who live with men) is to render the way in which the sample is categorized inequitable. Arber, Dale and Gilbert (1986) also point out that even when such systems as the RGSC are used on all the women in a sample, they provide less differentiation for women's occupations than they do for men's. Carr-Hill and Pritchard (1992) suggest that a relatively suitable gauge of individual position is education. However they warn that it is not a smooth measure in terms of the numbers in each category, as the bulk of the population leaves school at the minimum age. Nelson (1983) also found education a useful indicator of social class when researching with pregnant women, observing that women's occupations did not always reflect their level of education and social standing. Some women took lower paid jobs when they married, whilst others became 'voluntary poor', for example, some highly educated women who chose subsistence farming or craft work as a way of life.

As described earlier (page 23), an objection to the concept of increasing women's control in childbirth has been that it is an alien concept to working-class women (Nelson, 1983). However, Green, Coupland and Kitzinger (1988), taking age of finishing full-time education as a determinant of social-class, using questionnaires, and a sample of 710 primigravid and multigravid women, found that, although well educated women were more likely than less educated women to want and expect a high level of control over decision making in labour, the majority of well educated women (79%) did not want high levels of control. Similarly, although more women with fewer educational qualifications wanted no control, 83% of less educated women wanted at least some control. What is more, maintaining control of themselves was not more important to highly educated women than the rest, although they were more confident than less educated women of their ability to control their behaviour during childbirth. In other words, although there were differences between women from high education backgrounds and others, Nelson's objections were not upheld.

Other research has supported Green, Coupland and Kitzinger, for example Cartwright (1979) and Shepperdson (1983). However Martin (1990) suggested that, whatever their requirements, working-class women might, for various reasons, be less able to make their views heard when decisions about the woman's care are being made, an issue which will be reviewed later (subsection 1.4.4.1). Other studies appear to support Nelson. For example, Lazarus (1994), in an American interview study, found

that middle-class women wanted more control than working-class women, although one problematic aspect of this study was that the working-class women were interviewed several years earlier than the middle-class women, over which time attitudes towards control in childbirth might have changed. However, Hubert (1974), McIntosh (1986) and Machin and Scamell (1997), have all made similar observations. Woollett, Lyon and White (1983) suggested that the differences between working-class and middle-class women might be because working-class women were slower to accept current changes of attitude towards childbirth.

Despite these findings, in many of these studies there is the suggestion that, as Green, Coupland and Kitzinger have intimated, the situation is not as simple as being able to claim that middle-class women want to be in control of the birth whilst working-class women do not. For example, Nelson comments that 54% of the working-class women in her sample agreed that a natural childbirth would be best for their baby, only 15% fewer than the middle-class women. This suggests either that many working-class women did have some degree of allegiance to the concept of control, or possibly that natural childbirth is not the indicator of a woman-controlled birth that it is often taken to be. Another study (Sargent and Stark, 1989), found that their informants, middle-class women, generally welcomed medical interventions and pain relief, demonstrating again that not all middle-class women want natural childbirth. Also, to want, for example, pain relief, as did many of Nelson's working-class women, need not be interpreted as having no desire for control. To want to control pain pharmaceutically can be to want control of a different nature. There are comparable examples of working-class women wanting control in McIntosh's interview sample, where the participants were deeply concerned about whether they would be able to stay in control of themselves during childbirth. A similar fear of losing control because of the pain was apparent in the, mainly working-class, sample of East London women interviewed by Woollett, Lyon and White (1983).

As well as the complexity of their findings, there are several aspects of the studies described above which render them difficult to compare with each other, and it is probably this difficulty which, at least in part, explains the disparity of the results. Firstly, very few of these studies were set up specifically to examine social class differences, and the centrality of class issues varies greatly from one study to another. Moreover, not all of the studies made direct comparisons between women from different backgrounds. Some (for example: McIntosh, 1986) examined women from only one background, making assumptions (albeit research based) about women from other backgrounds as a comparison. Some studies (for example: Cartwright, 1979) studied a wide ranging sample, whilst others examined populations within a discreet geographical area. Most of the studies were carried out in the UK, but some (such as Nelson, 1983) took place in the USA where the concept of 'class' has a different meaning. As already intimated, they did not all use the same indicators of social class, some (for example: Green, Coupland and Kitzinger, 1988) concentrating on education, whilst others (such as Martin, 1990) used the RGSC, and yet others (for example: Hubert, 1974) appeared to make assumptions about the background of their sample, based on their place of residence.

Many studies were interview or observation based (examples being: McIntosh, 1986; Lazarus, 1994; and Machin and Scamell, 1997), and it was these which have tended to demonstrate social class differences in women's expectations and experiences of childbirth, whilst those which have found no difference have tended to be questionnaires or surveys (for example: Cartwright, 1979; and Green, Coupland and Kitzinger, 1988). It is possible that it is in qualitative research that shades of meaning are more likely to emerge which cannot be elicited by questionnaires, that the shared understandings developed between the interviewer and the interviewee create space in which different positions taken by women of different backgrounds can emerge. Moreover it is probable that the relationship between social class and control expectations and experiences is not a fixed one, and it is, perhaps, only when research methods allow flexibility (as do interviews in which the respondent can elaborate on issues of their choice) that it begins to become possible to explore a relationship which is reported differently under different circumstances, or in which women from different backgrounds use similar sounding concepts in a different way.

1.4.2.2 AGE

The issue of age is somewhat confounded with that of social background, because existing research shows that women who are older when expecting their first babies are more likely to be highly educated and of a higher socio-economic status than younger primiparous women (Berryman, Thorpe and Windridge, 1995). This questionnaire and interview study, based in Leicester, compared older childbearing women (aged 35 or more) with younger women (aged 20-29), and commented that very few studies have examined how age might or might not influence women's expectations about labour and birth. There was some suggestion from the study that older first-time mothers might have higher expectations of personal fulfillment during labour than younger women expecting their first babies, although the researchers do point out that older and more educated women might also have higher expectations of themselves more generally. Despite this, there was no evidence that age made any difference to the amount of control the Leicester women said that they had experienced and the majority of the women, both older and younger, did not feel that they had lost control of the way they themselves had behaved during labour. However, older first-time mothers were more likely to say that they had 'definitely never lost control' than younger first-time mothers.

1.4.2.3 OTHER ISSUES

The effect of attendance at antenatal classes, on women's perceptions of control in childbirth, was discussed under subsection 1.3.2.3 (page 34). However an ongoing problem with studies in this area is that women who attend such classes are more likely to be middle-class (O'Brien and Smith, 1981; Nolan, 1995), and it could, once again, be the class/ education issue which is affecting findings.

A second issue which might influence women's statements about their perceived experiences of control is bound up with the outcome of the labour and delivery itself, and the woman's feelings about what she has experienced. For example, when the relationship between obstetric procedures and postnatal depression was discussed earlier (subsection 1.3.2.1, page 27), it was suggested that discrepancies

between the findings of different researchers might, in part, be due to the lack of attention given to the way in which different interventions are perceived by childbearing women (Elliott, Anderson, Brough, Watson and Rugg, 1984; Oakley and Rajan, 1990; Salmon and Drew, 1992). Some difference might be due to whether the woman feels she has been given a choice over whether she has a certain intervention or not. The Audit Commission's recent survey of women's views of maternity care showed that with some interventions such as fetal monitoring, episiotomy and suturing fewer than 23% of the women who were asked felt they had been involved in the decisions made (Garcia, Redshaw, Fitzsimons and Keene, 1998). It is also possible that some interventions might be more disempowering than others. Green, Coupland and Kitzinger (1988), noted that women had more negative opinions about forms of pain relief which had caused them to feel out of control than those which had not. Despite this they also noted that an experience of lack of control was associated with both major interventions (such as Caesarian or forceps delivery) and minor (for example, perineal shaves and enemas), although the use of the interventions themselves did not correlate with low emotional wellbeing unless the women deemed them to be unnecessary. McIntosh (1988) also observed that relatively minor interventions were less likely to be explained to women by their carers, which of itself may render them unnecessarily distressing.

Besides the mechanics of the birth experience, the nature of the care given during labour and birth is another potential influence on women's reports of control or its lack. As well as advocating choice and control for childbearing women, the Changing Childbirth report (Department of Health, 1993) also advocates continuity of carer: that women should, as far as possible, be cared for and delivered by a midwife whom they already know. Continuity of carer certainly has practical implications. A midwife who knows her client will more easily be able to recognize changes in her as labour progresses (Lewison, Page and Spencer, 1994). Because many clinical judgments are subjective, she will also be aware of her previous assessments and be able to see more clearly whether her client is progressing (Clement, 1994). Both these factors should help to minimize the necessity for recourse to disempowering technological interventions.

This aside, the question still remains as to whether continuity of carer helps childbearing women to maintain control. Lee (1994) suggested that knowing the midwife removed fear of the unknown for women anticipating labour and birth. However, others have argued that continuity of carer does not necessarily equate with good quality care (Sandall, 1995; Walsh, 1996). In a similar vein, Lee (1993) found that women felt 'more comfortable' with a midwife they knew, but that they expressed a preference for care from a good unknown midwife rather than a midwife known to them who gave neutral care. Walker, Hall and Thomas (1995) observed that, although women who received continuity of care appreciated it, many of those who did not were unconcerned. Critics of the concept point out that women may be more inclined to feel the need to 'keep up appearances' with a midwife they know, and thus experience more tension in labour (Hofmeyr, Nikodem, Kramer, Wolman and Chalmers, 1991), and that by advocating continuity of carer, 'Changing Childbirth' has set up a gold standard by which women who do not experience it feel that they have received substandard care (Stewart, 1995).

1.4.3 Expectations and experiences of control in childbirth

In subsection 1.3.2.2 (page 31), mention was made of current stereotypes within midwifery and obstetrics which position pregnant women with high expectations of the birth as unrealistic, and as people doomed to disappointment, who are likely to experience psychological problems in the postnatal period as a result of their dashed expectations (Stewart, 1985; Green, Coupland and Kitzinger, 1988; Green, Kitzinger and Coupland, 1990). Similarly, Beaton and Gupton (1990) discuss the dangers of women setting themselves up for failure by planning the 'perfect' birth.

There has been considerable interest in the relationship between childbearing women's expectations of control in childbirth and their experiences. However research findings have been contradictory. For example, Slade, MacPherson, Hume and Maresh (1993), found that antenatal expectations of personal control were elevated in relation to early (within 72 hours of birth) postnatal descriptions of experience. Nevertheless the women's expectations and experiences of some aspects of control did correlate significantly: the women's sense of control over the duration of labour; and staff control over the pain being the two highest correlations. Davenport-Slack and Boylan (1974), Hutton (1985), Pilkington (1987), Scott-Heyes (1982) and Hodnett (1989) all found that high antenatal expectations of control were associated with postnatal perceptions of a high level of control during the birth, but Stolte (1987) found that only 33% of her sample of 70 women found their experiences of coping with labour to be similar to their expectations. The retrospective nature of this latter study might have had some bearing upon the nature of the findings.

Green, Coupland and Kitzinger (1988) also examined the relationship between women's childbirth expectations and their experiences, looking not only at control issues, but also at issues like pain and the use of pain relief. They found that for the various control issues they examined - involvement in non-emergency decision making, control of what staff did to the woman, the woman's control of her own behaviour, control during the contractions, and whether the woman felt she made a lot of noise - there was a significant and positive relationship between what the woman said she expected and her report of events. Therefore, although the issue of control was broken down into smaller factors, expectations and experience were still related. However, Hodnett (1989) maintains that it is an oversimplification to conclude from such findings that expectations alone are the key to experiences of control. She suggests that the birth environment plays an important role, finding significantly higher levels of perceived control in women who gave birth at home than in those who delivered their infants in hospital.

Annandale (1988) conducted research in a USA birth centre, which was staffed by midwives who were highly motivated towards giving their clients control. These midwives appeared to be heavily influenced, in their approach to care, by their awareness of the expectations of the women they cared for. In other words, it seemed that the midwives were correctly assessing the expectations of their clients and then working to meet those expectations. Such a finding might help to explain why control expectations and experiences are related. This finding also emphasizes the importance of the issue of

communication between midwives and childbearing women, which will be discussed in the next subsection. It begs associated questions about whether midwives' constructions of what is important to childbearing women, in terms of control, always coincide with those of the women. There is, apparently, no direct research in this area. However, there is evidence that midwives and childbearing women have very different views about which features of obstetric care influence parturient women's satisfaction with the birth experience (Drew, Salmon and Webb, 1989), whilst Bradley, Brewin and Duncan (1983) and Cartwright (1979) highlight a more general ignorance of childbearing women's views on the part of both obstetricians and midwives.

1.4.4 Communication and relationships in childbirth

1.4.4.1 COMMUNICATION AND SOCIAL CLASS

As described in subsection 1.4.2.1 (page 42), Martin (1990) postulated that, although working-class women might have the same preferences for control in childbirth as middle-class women, they may have more difficulties in making their views heard. Other research also implies that working-class women cannot, or choose not to, communicate their views to their carers to the same extent as middle-class women. Green, Kitzinger and Coupland (1994) noted that women with higher levels of education were more likely to write down their birth requests, and to realize the importance of not assuming that hospital staff should understand their requirements without being told. Bluff and Holloway (1994) observed that working-class women appeared less likely than middle-class women to be able to explain their trust in their midwives and suggested that the problem for working-class women was one of language, that they found it more difficult to articulate their feelings.

Communication problems for working-class women may, in part, lead to, and arise out of, poorer access to information. Quine, Rutter and Gowen (1993) found that working-class women felt that they had been less well prepared for the experience of birth than middle-class women. Path analysis of this data showed that social class significantly affected both the social support and information women received around the time of birth. Both Hubert (1974) and Woollett, Lyon and White (1983) observed that the working-class women they studied found that some of their dissatisfaction with their birth experiences was rooted in a lack of understanding of interventions and routine birth procedures. Nolan (1995) noted that working-class women were under-represented at antenatal education classes where, it is assumed, such an understanding might be gained¹⁰. Cliff and Deery (1997) found that this lack of attendance in young, single, working-class women was due to their fears that antenatal classes would be 'too much like school', and not suitable for people like them. Cartwright (1979), Shapiro, Najman, Chang, Keeping, Morrison and Western (1983) and Jacoby (1988) also observed that working-class women were less likely to report that they had been given the opportunity to discuss aspects of labour care with a caregiver in the antenatal period. What is more, Martin (1990) and Fleissig (1993) observed that the level to which childbearing women were educated was not related to the level of their

¹⁰ Although it has already been noted that childbearing women obtain information from other sources as well as antenatal classes (subsection 1.3.2.3, page 34).

requirements for information, in other words, that working-class women wanted information as much as middle-class women.

Reisch and Tinsley (1994) suggest that for working-class women, who might be too educationally and financially disadvantaged to have much control over various aspects of their lives - for example, their type of employment and their place of residence - it could be adaptive to have an external locus of control, a belief that 'powerful others' determine the outcome, in keeping with their situation. However, such a position seems somewhat fatalistic and simplistic. It would appear more important to consider research which studies the communication between women from different social class backgrounds and their carers, to look for explanations (apart from lower antenatal class attendance) for why working-class women should feel less well informed. Although some of the research findings described above could be explained by arguing that working-class women might be less skilled communicators and thus have problems in expressing their wishes and information needs to their carers, an equally compelling explanation is that carers communicate differently (less adequately) with working-class clients, compared with those from middle-class backgrounds; in other words, that the communication problems are driven, not by poor communication on the part of working-class women, but by stereotypical assumptions made by carers about the lower information requirements of these women. This latter explanation is supported by additional research which highlights the way in which midwives automatically volunteer more information to middle-class women, and tend to find working-class women who ask exactly the same questions a threat to their composure and the smooth running of the labour ward (Kirkham, 1989). In these studies, working-class women were often not given explanations that were afforded to middle-class women, the midwives in the studies arguing that, being less intelligent, the working-class woman would not understand (Kirkham, 1989; Hunt and Symonds, 1995). Similarly, Graham and Oakley (1990) noted that some doctors used medical terminology with middle-class women (such as 'vaginal examination'), whilst with working-class women they used potentially patronizing 'lay' language (such as 'examine you down below').

In other words, that working-class women have communication problems appears to be undisputed in the research literature. What is highly questionable is whether such problems stem from working-class women themselves, rather than from carers who make certain assumptions about their requirements.

1.4.4.2 MIDWIFE/ CLIENT COMMUNICATION IN GENERAL

Regardless of social background, good dialogue between the childbearing woman and her carer is needed if the woman is to make her needs and feelings known, and if the carer is to be able to relate these to her knowledge and experience. In other words, communication is essential to achieve the joint control described in subsection 1.3.3.3 (page 38). However, as intimated in the previous subsection, current research suggests that communication between midwives and their clients is frequently designed to keep the midwife in control.

Zambrana, Mogel and Scrimshaw (1987) and Walters and Kirkham (1997) discuss communication problems instigated by the growth in obstetric technology, which has reduced the importance of the

flow of verbal information from client to midwife. So much information about the condition of the mother and the fetus can now be obtained by machinery instead. However, as already described, there are also breaches in the communication flow in the opposite direction, from midwife to client.

Ralston (1994) describes the language of consent, the way in which acquiescence is frequently gained from childbearing women by instilling fear, for example, suggesting that non-compliance may bring harm to the baby. Alternatively technical terms are used, or most commonly of all such techniques as tacking an 'OK' on to the end of a statement of intent (ie. 'I'll just examine you, and then break your waters, OK?'). The midwife perceives that she is giving the woman the option to say 'no', but from the woman's point of view this is simply a statement of what the midwife intends to do.

Garforth and Garcia (1987) examine the subtleties of the language of consent, and the ways in which a woman's control can be ever more deeply undermined, from the open question which truly gives the woman a choice (ie. 'Would you like to do this or would you prefer to do that?'), through the statement ('We usually do it this way. '), the nominal choice ('I'll do this, all right?'), the warning ('I'll just do this because....'), to finally, the expression of intent which offers no choice at all ('The next thing I'm going to do is...'). Draper (1996) observes that manipulative pressure to comply can occur through non-verbal, as well as verbal, signals. For example, a 'non-compliant' client might be treated more brusquely until they agreed to whatever was required.

Sometimes formulae are introduced with the intention of giving women control, for example, the policy that carers should knock and request admission before entering their client's labour room. However, Flint (1990) points out that such an action becomes no more than a formality if, as so often happens, the carer knocks and then immediately walks in. In other words, such formulae can also become part of a language of consent. Another formula is the birth plan, the idea that women can gain control by making a written record of their childbirth requirements before labour begins. Again, there is a danger that this becomes a gesture, that women write out plans, which are then ignored (Garforth and Garcia, 1987). Another problem with such formulae is that they introduce a rigidity which, to some extent, defeats their object. In the case of birth plans, if women are held to these regardless of what they later find they want when actually experiencing labour, they in fact achieve less control than they might have had without a plan¹¹.

Language is not only used to manipulate women into compliance, however. Lomax and Robinson (1996) observe that, during postnatal consultations, midwives have primary control over the topics which are discussed and when such discussions are terminated. Similar findings have been made concerning labour and birth. Graham and Oakley (1990) note that many doctors assume pregnant patients ask questions out of anxiety and thus aim their explanations towards allaying any fears, perhaps by turning the woman's concerns into a joke, rather than towards supplying them with information. Kirkham (1989) describes the ways in which women who request information during

¹¹ The important element in a good birth plan is obviously flexibility (Swain, 1987), but the point here is that it is easy to introduce an illusion of control whilst actually achieving the opposite.

labour can be controlled, by blocking of the conversation, as the midwife changes the subject or denies the woman's worry or concern. Sometimes apparent reassurance works as a powerful block. The words, 'You must not worry' to a woman who is obviously very concerned simply denies her apprehension. To the midwife the woman has been reassured, but the woman might take it to mean that she is doing something wrong, and after this she is unlikely to raise those concerns again.

Because of its ramifications for control in childbirth, the restriction of information given to women in labour is a crucial element in the exercise of power over them. Robinson (1995) expresses the opinion that the manner of a midwife towards her client can, of itself, lead to psychological trauma, even when a birth is totally uneventful from a physiological point of view. Ballard, Stanley and Brockington (1995) support this empirically with case studies in which postnatal women diagnosed as suffering from Post-traumatic Stress Disorder (PTSD) ascribed all or much of their trauma to the way in which they were dealt with by birth attendants. Similarly, Menage (1993) found associations between PTSD, in some gynaecological and obstetric patients, and various aspects of poor communication and disempowerment from their carers. However, Nelson and McGough (1983) observe that women whose requests are ignored or over-ridden, or who experience procedures that they do not want, still frequently express a high degree of satisfaction with the care they have received. This apparent anomaly probably has as much to do with the questionable nature of the assessment of satisfaction with childbirth than with women's control requirements. Satisfaction as an outcome measure will be discussed in subsection 1.4.5.1.

Perhaps one reason why communication between childbearing women and their carers is so problematic is that, as already mentioned earlier (subsection 1.3.2.2, page 31) ultimately the midwife and the obstetrician are still legally accountable for anything which goes seriously wrong. This means that a midwife has to distinguish between a woman's preferences when they are clearly not in the best interests of herself and her baby, and those which she simply does not like. In the first case she must give firm professional advice, or she would be held accountable if the woman experienced some physical or psychological damage to herself or her baby because of her chosen course of care, and then claimed she had not been informed of the risks of her choice (Floyd, 1995, Stapleton, 1997). In the second case she must not try to manipulate the woman's choice (Harmond, 1994).

Further evidence that midwives and childbearing women do not communicate well comes from Bradley, Brewin and Duncan (1983), who found that midwives' ratings of their clients' experiences were significantly different to those of their clients. The midwives underestimated the unpleasantness of the experience for their clients, and this included reporting that the women had more control than the women themselves reported. Graham and Oakley (1990) observed something similar between obstetricians and childbearing women: their different ideologies informed different approaches to the issues raised, and consequently led to miscommunication. For example, many of the women in their study complained of pain and discomfort during pregnancy, but such complaints were either ignored by the doctors or dismissed as clinically unimportant. Because the doctors operated within a medical model, only those complaints which might have been indicative of underlying pathology were attended

to. For the pregnant women, however, such discomfort was a very real problem. Woollett and Marshall (1997), however, also note how the medical language and definitions of childbirth infiltrate childbearing women's own accounts and create tensions with the descriptions of their own bodily experiences.

1.4.4.3 THE ISSUE OF LANGUAGE

In terms of the language used by midwives, three issues can be identified. Each of these has already been alluded to in preceding sections. Here they are brought together to consolidate them under one heading and to elaborate on them further.

The first issue is the use of the language of obstetrics to describe women's experiences. This was raised in subsection 1.2.2 (page 20), in terms of the way in which antenatal classes fail to describe to pregnant women what they can expect in terms of embodied experience. Kirkham (1989) illustrates this neatly, with the concept of transition, the point between the first and second stage of labour when women often experience strong emotions and mood swings. When transition is mentioned at all in obstetric or midwifery textbooks, it is described in terms of the physical signs: the cervix being fully dilated; a trickle of blood; or the woman defecating, never in terms of the emotions involved. This medical view of transition is often the one which women are taught at antenatal classes.

The second issue is that, because of the heritage of control, the disempowerment of the childbearing woman is inherent in the language of obstetrics (see subsection 1.3.2.1, page 29). Thus childbearing women are described in terms more suited to prison inmates. They are 'monitored', 'observed', given a 'trial of labour', and 'confined' (Peterson and Cefalo, 1990). The language also reflects the ethos which positions women's bodies as deficient: the labour 'fails' to progress, contractions might be 'inadequate', the cervix could be 'incompetent' (Bastian, 1992). Furthermore, women who do not comply with the obstetric regime are defined in the terms of moral failure. Non-attenders at antenatal clinic are 'defaulters' (Rothwell, 1995). Such terminology resonates with the language of failure used to describe the menopause and criticized by Martin (1987). It is difficult to engender an atmosphere of empowerment for childbearing women as long as this type of language persists.

The third issue, already mentioned in subsection 1.4.4.1 (page 48) above, is the use of 'lay' language with childbearing women (Graham and Oakley, 1990). Although working-class women are particularly subject to such demeaning treatment, such euphemisms as 'tail end' for perineum and 'waterworks' for urinary tract tend to be used all the time by some midwives, as do belittling terms of endearment such as 'dear' or 'pet', used instead of the woman's own name (Garforth and Garcia, 1987; Bergstrom, Roberts, Skillman and Seidel, 1992; Leap, 1992). It might seem paradoxical to highlight objections to such language, whilst also finding fault with obstetric terminology and the way in which it is used. However whilst nothing justifies the patronizing tone of such 'lay' language, which typically underestimates women's understanding and knowledge (Bastian, 1992), it should be possible to find viable alternatives to all, or nearly all, of the obstetric terms which impute powerlessness or

fault to the childbearing woman. For example, an 'incompetent cervix' could be described as 'elastic', 'defaulting' as non-attendance, and so on.

Thus although, as the preceding subsections have shown, communication between carers and childbearing women is an important issue, with much room for improvement in practice, it is of as much, or probably more, importance to also address the building blocks of communication: the language used. A childbearing woman might be told she has choice and control, and indeed genuinely be offered the same, but if she addressed using patronizing or disempowering language throughout her pregnancy or labour¹² she is still unlikely to feel her views are being taken completely seriously.

1.4.5 Psychological outcome

The possibility of a relationship between lack of control in childbirth and postnatal depression was discussed in subsection 1.3.2.1 (page 27), whilst in subsection 1.4.4.2 (page 50) the work of Menage (1993) in linking lack of control with Post-traumatic Stress Disorder was described. However there is every possibility that if control in childbirth, or its lack, has a bearing upon whether postnatal women report feelings of depression and trauma or not, it will also have other psychological sequelae. Therefore, in this subsection, three issues will be considered. The first is whether other psychological effects have been found to be connected with control in childbirth. Included under this heading is a discussion of the problematic nature of measures of postnatal satisfaction. The second issue is whether psychological sequelae can be shown to arise out of a differential between expectations of control and experience, or whether any effects are purely a product of control in childbirth or its lack. The third issue is that of timing: how soon or late after the birth that assessments of the effects of control should be made.

1.4.5.1 OTHER PSYCHOLOGICAL SEQUELAE

Oakley (1980) followed the progress of 55 primigravid women from early pregnancy until 5 months postnatally, interviewing them at intervals. Instead of taking postnatal depression as a unitary concept, as have many other researchers in this area, she differentiated between four elements of psychological disturbance which her respondents experienced after childbirth: postnatal blues, anxiety, depressed mood and depression. Of these two were related, at least in part, to aspects of the woman's birth experience. Postnatal blues were related to instrumental deliveries and the use of epidurals, as well as to the woman's dissatisfaction with the management of the birth itself. Depression was associated with a moderate or high use of technology during the labour, the woman's perception of having had a low degree of control, and her dissatisfaction with the way the birth was managed.

Rather than, like Oakley, taking satisfaction with the birth as a predictor of outcome, other researchers have used it as an outcome in itself. For example, Green, Coupland and Kitzinger (1988) found that

¹² A woman I once cared for in the postnatal period had experienced a difficult labour and birth. Although she might have had many grounds for unhappiness about her experience, her main complaint was that the midwife caring for her had called her 'poppet' throughout, thus, she felt, treating her like a child. The midwife concerned, a caring and motherly person, was almost certainly totally unaware of the distress she had caused.

women who did not feel in control, either of themselves or of what happened to themselves, were least likely to say that they felt satisfied with, or fulfilled by, their experience of labour and birth. Green, Coupland and Kitzinger also pinpointed several other pieces of research which make some connection between control during childbirth and postnatal satisfaction, for example, Davenport-Slack and Boylan (1974), Humenick (1981) and Humenick and Bugen (1981). Since Green et al. published their findings, other research has also supported this connection. Séguin, Therrien, Champagne and Larouche (1989), for example, found that participation in the decision making process was the main component of satisfaction with medical care during delivery for 1,790 postnatal women from Montreal. In a sample of 80 primigravid women, all of whom had experienced a vaginal delivery, Knapp (1995) found that perceived control accounted for more variance in childbirth satisfaction than any other aspect of the birth experience, with higher levels of perceived control being related to more satisfaction. Very similar findings were made by Bramadat and Driedger (1993). Simkin (1991) also noted that, of a cohort of 20 women, talking about their birth experiences 20 years previously, those with the highest long-term satisfaction ratings felt, amongst other things, that they had been in control. Slade, MacPherson, Hume and Maresh (1993) found an association between satisfaction and various aspects of personal control in labour, whilst Marshall (1994) found that, of a sample of 56 primigravid women who experienced spontaneous vaginal delivery, satisfaction with the birth was associated with higher levels of both personal control and compliance. Marshall suggests that these women appreciated feeling responsible for participating in the birth and yet at the same time being able to trust their obstetricians to offer them expert guidance, a finding which resonates with the description of joint control in subsection 1.3.3.3 (page 38).

Despite the significant relationships found between control in childbirth and postnatal satisfaction, it is also necessary to highlight the problematic nature of this construct - the tendency for women to feel loyal to their own birth (Shearer, 1983), and for there to be a 'ceiling effect'¹³, with all, or most, women rating their experiences very highly (Lumley, 1985; Shearer, 1987; Jacoby and Cartwright, 1990). Lumley also observes that satisfaction with childbirth is not a static concept for the postnatal woman, but one that will change over time. Despite these problems, Green, Coupland and Kitzinger (1988) conclude that it is still a worthwhile exercise to attempt to measure 'soft outcomes' such as this.

Despite their obvious usefulness, it is questionable whether postnatal psychological outcome is being assessed comprehensively by measures of this kind. Salmon, Miller and Drew (1990) identified two dimensions upon which postnatal women assessed their birth experience: fulfillment and achievement; and emotional feeling, and although satisfaction and postnatal depression are elements of those dimensions, they are considerably more narrow. It also appears from the literature that there might be other possible psychological effects of childbirth, for example: fear of further pregnancy (Niven, 1988, Charles and Curtis, 1994), effects on sexuality (O'Driscoll, 1994) and body image (Price, 1993), and it could be postulated that lack of control might contribute to at least some of these. However, although such effects are described, they are seldom, if ever, subjected to empirical investigation. To a large

¹³ A phenomenon which is not peculiar to childbirth (Fitzpatrick, 1984).

extent this is because quantitative assessment of many of these factors is difficult, if not impossible. However this does not preclude taking a more global assessment of women's psychological wellbeing in both the antenatal and postnatal period, instead of concentrating on depression or satisfaction. More complex issues can also be explored qualitatively.

1.4.5.2 THE GAP BETWEEN EXPECTATIONS AND EXPERIENCES OF CONTROL IN CHILDBIRTH

In subsection 1.3.2.2 (page 31) mention was made of the stereotype of the childbearing woman with excessively high expectations of control who is doomed to disappointment and consequent psychological trauma. Although such fables live on in midwifery lore (Green, Kitzinger and Coupland, 1990), few studies have sought a differential between expectations and experiences of control and then related this to postnatal psychological well-being. In a sample of 98 primiparous women, Knight and Thirkettle (1987) found that whether the birth was as expected did not predict postpartum blues, although control was only one factor amongst many which were assessed together. Affonso and Domino (1984) include unmet expectations regarding labour and delivery in their list of factors which might increase vulnerability to postnatal depression, although they also do not discuss control issues as such, whilst Affonso (1977) suggests that women who have discrepancies between their expectations of labour and their actual experiences may fail to integrate and remember large portions of the birth experience. However this study is based on interviews with women in the early postnatal period, 48 to 72 hours after delivery, and no follow-up was made to examine whether these problems persisted at a later stage. Stewart (1985), described a series of case studies concerning women who aspired to natural childbirth and who failed to achieve it. She claimed that they had more feelings of guilt and failure, and a higher rate of psychiatric symptoms attributed to the birth, than those who had no such ambitions. Stewart's findings were based on the observation that, in a Canadian general hospital in 1981 and 1982 there was an increase in the number of women, referred for psychiatric care, who attributed their symptoms to their birth experience. However it is worth noting that it was the attribution which changed, not the overall numbers of psychiatric referrals. It must also be noted that the women in Stewart's case studies did appear to experience a particularly extreme form of natural childbirth education, which was given by non-medical personnel who advocated non-intervention regardless of the circumstances of the birth. Few, if any, antenatal education schemes in the UK today would encourage pregnant women to hold such unrealistic expectations of birth.

Therefore, although it can be argued that certain psychological sequelae might ensue when women experience disempowering obstetric procedures and practices (subsection 1.3.2.1, page 27), the evidence is more tenuous as to whether the problem lies in the procedures themselves, or in the differential between the woman's expectations and her experiences. However the findings of Green, Coupland and Kitzinger (1988), that high expectations for control tend to engender experiences of greater control, and that women who experience more control tend to have a better postnatal psychological outcome, does suggest that to have high expectations of control does not set women up for a poor experience and ensuing psychological problems. Nevertheless, what Green, Coupland and Kitzinger failed to do was to juxtapose experiences of control with expectations and then consider the

differential in relation to psychological outcome. Neither did Green, Coupland and Kitzinger take into consideration the woman's antenatal psychological state when considering postnatal psychological well-being, despite the fact that there is evidence that antenatal depression is as prevalent as postnatal depression (Green and Murray, 1994), and that at least some women who suffer affective disorders antenatally will continue to do so in the postnatal period (Paykel, Emms, Fletcher and Rassaby, 1980; Watson, Elliott, Rugg, and Brough, 1984).

1.4.5.3 THE TIMING OF POSTNATAL ASSESSMENT, AND THE HALO EFFECT

Another important issue in research which studies the effects on women of the childbirth experience, is the timing of postnatal assessments. Many of the studies described above measured the psychological effects of control during labour within a few weeks, or even a few days, of childbirth. However Simkin (Simkin, 1991, 1992) examined the long term impact of birth experience on 20 women, comparing written accounts from soon after the birth with those produced 15 to 20 years later. She found that the women could be divided broadly into two groups, those who remembered childbirth as highly satisfying, and those who remembered it as less satisfying or dissatisfying. The two groups described very similar experiences of delivery, except that the dissatisfied group had used more pain medication. However in semi-structured interviews, the satisfied group all described feelings of control, whilst the low satisfaction group spoke of lack of control, and after so many years, still expressed disappointment and anger over this. Simkin also found that, over time, negative aspects of the birth had remained negative, but positive aspects had become less so. She dubbed this the 'halo effect', postulating that after delivery women are relieved that it is all over and are, to some extent, euphoric. This tends to colour their representation of their experience. After time this euphoria wears off, then representations become more negative.

Although not referring directly to control, and albeit within a shorter time scale, similar findings were made by Bennett (1985). Bennett compared women's ratings of satisfaction with their labour and delivery at 3 weeks postnatally with ratings made two years later, and found that there was significantly less satisfaction with all aspects of obstetric intervention at 2 years postnatally. Kitzinger (1992) described a woman who found childbirth highly traumatic but who only realized the enormity of her ordeal a year after the experience, whilst Erb, Hill and Houston (1983) found that women who had experienced birth by caesarean section were more likely to express disappointment, failure and anger over their experience 7 to 12 months after the birth than they were in the first 6 months. Dreidger (1991), however, found no difference in women's satisfaction ratings at birth and at 3 to 4 months postpartum, whilst Séguin, Therrien, Champagne and Larouche (1989), claim not to have found any support for the concept of the halo effect at 4 to 7 months postnatally, although the authority of this finding is somewhat dubious, being based on postnatal assessment on a single occasion. Woollett, Lyon and White (1983) point out that, postnatally, women's preoccupations change as time passes, and their attitudes towards the birth become reorganized. The birth is sometimes represented as less important as the demands of motherhood take hold.

Although satisfaction with the birth might change, other aspects, for example memories of the level of pain, have been shown to be generally consistent over very long periods of time (Niven, 1988; Simkin, 1992).

Finally, Kumar (1982) mentions the fact that childbirth has different significance for different women. For this reason even if account is taken of such phenomena as the halo effect, and even if provision is made to deal with the issues raised in the preceding subsections, quantitative research must have its limitations. If childbearing women are treated as a homogenous group, then attempts can be made to correlate an intervention such as caesarean section with satisfaction or emotional wellbeing. However, if to one woman, caesarean section is seen as a reason to escape the actual delivery, which she fears, it might have a totally different effect on her than it will on a woman who views it as her failure to do something which she sees as a fundamental part of womanhood.

1.4.6 Conclusion to section 1.4

In this section of the thesis research was discussed which addressed three questions which had been derived from the historical issues raised earlier. The first question, how different women operationalise the concept of control in childbirth, is not a straightforward one to answer. Current research is inconclusive as to whether social class affects the type and amount of control women want or receive. The problematic nature of the concept of social class and the difficulties of assigning women to such categories probably add to the contradictory findings in this area (see subsection 1.4.2.1, page 41ff).

Both antenatal class attendance (subsection 1.4.2.3, page 44) and age of giving birth (subsection 1.4.2.2, page 44) are issues which are liable to be confounded with social class, and are therefore confusing in terms of whether they differentiate between the control requirements or experiences of different women. When research which centres on issues of communication and language was discussed (subsection 1.4.4, page 47ff) there was some evidence that working-class women were less able to articulate their control requirements to their carers than middle-class women, partly perhaps because of poorer access to information (subsection 1.4.4.1, page 47). This might arise from lower attendance at antenatal classes, although the evidence that pregnant women obtain information about labour and birth from many sources, not just formal antenatal education (subsection 1.3.2.3, page 34) suggests that the issue is more complicated than this. It seems, from the research examined, that at least part of the problem lies at the feet of midwives and obstetricians who treat middle- and working-class women differentially in terms of the amount of information they volunteer and the language they use.

Questions around the relationship of women's expectations and experiences of control in childbirth have also been posed, and it seems that, in general, women are liable to experience levels of control in keeping with their expectations (subsection 1.4.3, page 46). However the part which expectations play alongside other issues in determining experiences is ill defined. As far as the question of whether different birth experiences might affect women's reports of control, it seems that, although the number and type of interventions encountered by individual women have been taken into account, too little

attention has been paid to how disempowered or otherwise each intervention makes women feel (subsection 1.3.2.1, page 27). Moreover the possibility has not been fully explored that individual women might react differently to the same intervention, according to their expectations for labour and birth.

As it was pointed out at the end of the last subsection, childbirth has a different significance for different women. However a balance has to be struck between the search for broad categorizations: for example, exploring whether women from different social backgrounds have different aspirations for control, and the examination of differences between women. Both perspectives are important, particularly in terms of their ramifications for providing the best possible maternity care service for childbearing women. Why this is so, and how a balance between both concerns might be achieved, will be discussed in subsection 1.5.4 of this thesis.

The second question was concerned with the way in which control issues are worked out between midwives and childbearing women. There is evidence that, regardless of the socio-economic status of the woman, carers still exercise a subtle form of control, not only in the language they use, but also in the way that they carry out the very practices which were designed to give control (subsection 1.4.4.2, page 49). The responsibility that midwives have to take for things that go seriously wrong, and the ever present possibility of litigation must be partly to blame for such manipulative attitudes, as are the apparent problems in finding an intermediate between the 'language of obstetrics' and an infantilising lay language. However, the net result is poor communication, and the subsequent danger of a disjunction between midwives' and their clients' representations of the woman's control.

The third question addressed the psychological value of control in childbirth (subsection 1.4.5, page 52ff). Connections between lack of control in childbirth and postnatal depression (subsection 1.3.2.1, page 27) or post-traumatic stress (subsection 1.4.4.2, page 50) appear clear-cut, although it seems probable that post-traumatic stress only affects a very limited number of the women who experience a severe lack of control in childbirth. Although several authors have found that women who report control in childbirth are also more likely to report satisfaction, the problematic nature of assessments of childbirth satisfaction (subsection 1.4.5.1, page 53) suggests that findings have to be treated with caution.

The main deficiency in the research which addresses this third question, is the paucity of outcome measures which have been considered. There is a need to examine other possible psychological effects of control in childbirth or its lack, and also to take into account important issues such as the timing of any such measures, antenatal mood state and expectations of control. A second issue is the probability that the psychological effects of control in childbirth, or its lack, are multiple and contradictory, with different women reacting to similar experiences in different ways. Thus, as explained above, there is a need to address these issues using research methods which allow for the exploration of diversity, as well as those which allow the development of broad categorizations.

In terms of the three questions addressed in this section, the research provides as many points of inquiry as it does answers. However, if a study into control issues as they impinge upon childbearing women is to be meaningful, it must not merely address questions which arise out of the literature. It must also ensure that these questions are relevant to the ways in which childbearing women represent control. It would be a pointless exercise to impose questions which bore no relationship to women's own experiences. The pilot study described in the next chapter is, therefore, aimed at exploring how childbearing women and midwives themselves negotiate the issues raised here. However before this study is discussed, one final set of issues and tensions must be addressed. The issues are those around ontology, epistemology and methodology: the world view and theory of knowledge that inform my own approach to the research process, and the ways in which these, combined with requirements arising out of the nature of the subject matter, have informed my choices of research method.

1.5 Epistemological and methodological issues

1.5.1 Introduction

Section 1.2 of this chapter discussed the historical legacy of disempowerment which, still today, impinges upon childbearing women, and also upon the midwives who usually care for them. It is within this legacy that a certain set of meanings have been created for childbirth, for example the hazardous nature of labour and birth and the fallibility of women's bodies. It is these meanings which have tended to be given precedence over other possible meanings: childbirth as a natural process, and women's bodies as capable, more often than not, of giving birth unaided.

The research process is also capable of ascribing meaning to the phenomenon it studies, and just as the historical meanings given to childbirth have been deeply entwined with the agenda and motives of those who made the ascription, so it is an impossibility for the research process to be totally objective about the meanings it creates (Burr, 1995; Prilleltensky and Fox, 1997). Because it is not possible to move beyond such subjectivity, rather than treat it as an obstacle, it is best acknowledged and its place in the data examined (Banister, Burman, Parker, Taylor and Tindall, 1994; Kidder and Fine, 1997). This process involves two things. Firstly there must be an acknowledgment of the researcher's own interests in the study: any personal background which bears on the way the matters under investigation are approached, or affects the way in which respondents position themselves towards the researcher. Secondly there must be an explication of the researcher's own ontological and epistemological perspectives. Once these things are acknowledged, the way lies open to discuss the pertinent issues for investigation and to determine the best way to set up appropriate research into them.

The first issue was addressed partially in the preface to this thesis. In the next subsection (1.5.2) I will explicate my ontological and epistemological position, and refer again to the personal views and experiences that have led to my interest in control in childbirth as a topic for research. In subsection 1.5.3 I will take this position forward by discussing the tension between materiality and discourse. I will show how a material-discursive approach can be employed to render such tension productive rather than problematic. Although my own beliefs and background are discussed in these two

subsections, I will leave any detailed exploration of my own part in the creation of the meaning of control in childbirth with women having their first babies to the relevant interview chapters, where I shall compare the different positions afforded me by the childbearing women and their midwives.

In subsection 1.5.4 I will deal with the first of two sets of methodological issues. Here, taking into account some of the criticisms of traditional research made in subsections 1.5.2 and 1.5.3, I will raise a set of general criticisms about the research literature which was described in section 1.4 and discuss the requirements for meaningful research into control in childbirth. I will then delineate and justify the methods which I have chosen to meet those requirements.

In subsection 1.5.5 I will deal with a second set of methodological issues: reliability, validity, generalizability and the selection of data, all of which relate strongly to the epistemological understandings discussed previously and to the status afforded to the data. The concluding section will continue in this vein of practicality by drawing together the main threads of this chapter to create a starting point for the pilot study described in chapter 2.

1.5.2 My ontological and epistemological positions

1.5.2.1 REALISM AND RELATIVISM

Guba and Lincoln (1994) state that any enquiry paradigm is based on ontological, epistemological and methodological assumptions. The ontological question, which to a large extent underpins the other two is:

'What is the form and nature of reality and, therefore, what is there that can be known about it?' (Guba and Lincoln, 1994. p108.)

- and it is this challenge which must be addressed before questions about control in childbirth can be answered meaningfully. Guba and Lincoln describe a paradigm as essentially a world view: a set of basic beliefs. They reason that these sets of beliefs must be accepted on faith: their ultimate truthfulness cannot be established.

For most of this century, and indeed for the preceding 400 years, the 'received view' of science has been a positivistic paradigm. Positivism embraces a realist ontology, wherein an objective, knowable reality is assumed: a reality that is external to the observer, and that is driven by an immutable set of natural laws and mechanisms (Guba and Lincoln, 1994; Charmaz, 1995; Pidgeon and Henwood, 1997). Positivism makes the assumption that research can verify or falsify the 'true' state of affairs. It remains the dominant paradigm within academic psychology (Prilleltensky and Fox, 1997). Because of its allegiance to a tangible, demonstrable reality, positivistic thinking cannot accommodate the view of subjectivity expressed in the introduction to this subsection of the thesis (subsection 1.5.1, page 58). Positivism posits subjectivity as a source of bias, whilst reifying the principles of detached observation and rigorously controlled variables (Henwood and Parker, 1994).

Over the past three decades, however, 'new paradigm' psychologists such as Harré and Secord (1972) have supported the general critique of positivism, which has also arisen in other academic disciplines,

arguing that a positivist methodology does not automatically produce reliable knowledge; that the objectivity of scientific enquiry is an illusion; and that results produced from experiments are not necessarily generalizable to explanations for human behaviour in the world. The upshot of such criticism is that various alternative paradigms to positivism have arisen which, despite their differences, commonly assume the value-determined nature of enquiry (Guba and Lincoln, 1994). Within such paradigms, therefore, is an ontological shift towards a relative, or more relative, perspective.

Within a relativist ontology, the claims to universal, timeless truths, made within the positivist paradigm, are disputed. Meanings are seen as inextricably bound up within the space and time in which they occur (Parker and Burman, 1993). 'Reality' is replaced by series of numerous and conflicting mental constructions, each of which is no more or less true in any absolute sense (Guba and Lincoln, 1994).

1.5.2.2 CHRISTIANITY AND SOCIAL CONSTRUCTIONISM

My own ontological assumptions are strongly influenced by two sets of beliefs, which impinge upon both my outlook on life and my approach to research. The first set revolve around my Christian commitment. The second set arise out of my interest in social constructionism. Also highly relevant to my approach to the topic of control in childbirth are my feminist inclinations. I will, therefore, discuss each of these in turn, and explain their importance and inter-relationship.

In terms of my Christian beliefs, I refer to something more than the nominal Christianity of much of the Western world. Mine is an active faith which I have held for the past 25 years. This is not the place to explicate that faith, and indeed, as explained above, such beliefs cannot be 'proven', however well they might be argued. However, as an aside, I would point out that I do not consider my position as a Christian incompatible with my position as a feminist. Indeed, although both theological and feminist polemic frequently position the two movements at odds with each other, modern feminism has some of its roots in both the Christian church and various Christian social action initiatives (Witherington, 1990).

The tenets of the Christian faith centre on its truth:

'Then you will know the truth and the truth will set you free.' (John 8v32, The Bible, New International Version)

This makes it impossible for me to reject the concept of a (theoretically) knowable reality. Yet at the same time, I recognize that whatever the 'real' might be that is under consideration: the reality of God, or the reality of what happens to women's bodies when they give birth, the only medium we have for mediating, interpreting, and recreating our thoughts and experiences is discourse: communication via speech, action or imagery (Parker, 1997). This communication might be between one person and another, or it might be our own interpretation to ourselves, but the crux of the matter is that the way in which individuals construct meaning thus becomes all important. This presents no problem to my

Christian faith. Although it lays claim to the truth, Biblical teaching also renders the knowing of that truth problematic, at least in this world, albeit not in the next:

'Now I know in part; then I shall know fully, even as I am fully known.' (1 Corinthians 13v12b, The Bible, New International Version)

In other words, my Christian outlook leaves me no more able to position myself within the naive realism of positivism than it allows me to align myself to an ontological standpoint of out and out relativism, where nothing exists beyond the text (Edwards, Ashmore and Potter, 1995).

My allegiance to social constructionism arises largely out of my interest in the social processes which shape our understanding of the world (Burr, 1995). This supposition, that it is through the interactions in which people constantly engage that understandings of the world are formulated, is one of the central assumptions of social constructionism. Other key assumptions, identified by Burr, are a critical stance towards positivism, encompassing the criticisms of the 'new paradigm' psychologists described in the last subsection; a recognition of the historical and cultural specificity of the ways in which the world is said to be understood; and an awareness of the different kinds of social action sustained by the different forms these understandings can take. However, although these assumptions can be used to identify a loose group of different approaches that might be identified as social constructionist, it is important to note that social constructionism does cover a wide variety of different approaches and methods. Although social constructionist work is predominantly qualitative, it has been established that there is a potential in pursuing representation by number as well as by text (Henwood, 1996), and thus some social constructionists do employ quantitative methods (for example: Kitzinger and Stainton Rogers, 1985; and Lamiell, 1995). Moreover, the qualitative approaches embraced by social constructionists cover a broad range of traditions and procedures, including social theory, discourse analysis, symbolic interactionism and grounded theory research (Burr, 1995; Yardley, 1997a).

The acknowledgment, made by social constructionists, of the historical situation of the interchanges between individuals which produce the terms in which the world is understood (Richardson and Fowers, 1997), is important in the context of control in childbirth. As has already been explained, the history of childbearing is relevant to childbearing women's current representations of control. It has created a set of meanings which cannot be easily shaken off, just as a different set of meanings are being created by current changes to childbirth care. History, however, is important at another level, the level of individual women, whose past experiences might help shape the way they construct what happens during labour and birth. Hence the importance, in this thesis, of beginning with history, and of addressing issues of communication - the point at which language and practice interact (Shotter, 1993). This is because control not only arises out of what individual people both say and do: with language shaping practice and vice versa, but because it also arises out of the interactions between individuals: in the case of control in childbirth, the speech and actions of both carer and client.

Yet another strand of social constructionist thought has relevance to the issues around control in childbirth, and that is the concept that discourse (in the form of language and practice) is embedded in power relations (Burr, 1995): that the ways in which people are represented often serve to support and

perpetuate inequalities between them, whilst promulgating the illusion that such inequalities are fair. That control in childbirth is sometimes represented as something acceptable only between certain predefined boundaries (see subsection 1.3.3.5, page 39), illustrates such a power inequality. Under these conditions control in childbirth is not really full control for the childbearing woman. It is something under the control of the carer who decides where the woman's control can be taken.

Despite my broadly social constructionist position, I find problematic the wholesale relativism embraced by many social constructionists. There are three reasons for this: my own world view, which I have already discussed; the apparent denial by extreme relativism of any material base to life; and the problem relativists find in acknowledging certain accounts as of more importance or moral value than others (Burr, 1995). It would be possible to take up a less constructionist and more realist approach, such as critical realism (Guba and Lincoln, 1994; Pilgrim and Rogers, 1997) to address my difficulties. However, I prefer to stay within the world of constructionism, which has much to offer in the understanding of a concept such as control. Instead I choose to position myself, alongside others (for example: Parker, 1992; Malson, 1995; Cromby and Standen, 1996; Swann, 1996) who acknowledge the importance of material aspects of experience, whilst continuing to work within a social constructionist framework. This then allows me space to acknowledge the material as well as the discursive elements of control in childbirth, and the ways in which these two elements of control in childbirth coalesce will be the subject matter of subsection 1.5.3.

A social-constructionist approach also persuades me to consider the part I play in the construction of control in childbirth. In other words, my reading of the text might differ to that of another person (see, for example: Potter and Wetherall, 1987; Finch, 1993; Griffin and Phoenix, 1994; Marshall, 1996). This is something I can only acknowledge, making no pretence that my reading is in any way totally objective or value-free. Alternatively my influence on the women's construction of the issues might be in the way the women themselves position me in the interviews, something which will be considered in more depth at the beginning of the two interview studies in chapters 2 and 5.

1.5.2.3 FEMINISM

As already mentioned, overlaid on my Christian beliefs is a feminist perspective, and it is largely from this standpoint that I have already represented the history of control in childbirth in the earlier part of this chapter.

In terms of political activism, feminism is a broad term which encompasses many different strands of thought and argument (Rollins, 1996). Tong (1989) identifies liberal, Marxist, radical and socialist feminisms amongst others, all of which have their own representations of the causes of women's oppression and of the solutions to their problems. However Unger and Crawford (1992) observe that, in their most general sense, all political feminist perspectives acknowledge two themes. The first is the high value of women, making them worthy of study in their own right. The second theme is the need for social change that will benefit women.

Although political feminism has a longer history, Nicolson notes that feminist research in psychology only developed its own identity during the 1980s (Nicolson, 1995). Nicolson explains how British feminist psychology took various philosophical and interdisciplinary concepts and wove them together to underpin theory and methods which would be particularly relevant and useful in understanding women's experience. Like the political facet of feminism, there is no one form of feminist research (Griffin and Phoenix, 1994). Ussher (1998) identifies four broad feminist standpoints: feminist empiricism, post-modernism, critical realism and feminist standpoint approaches. However Ussher points out that, although different in many ways, these various epistemological and methodological positions are all agreed on certain central issues, not least when their gaze is directed towards feminist issues within health psychology. These issues are a critical stance towards the gender relationships which exist implicitly, and sometimes explicitly in both research and theory; an acknowledgement of the way in which patriarchal power and control has precluded gender-parity within systems of both academic theory and professional practice; a recognition of the moral and political dimensions of research; allegiance to the belief that women are worthy of being researched in their own right and a recognition of the need for social change to improve the lives of women (Ussher, 1998). Feminist research can be defined as research for women, rather than on women (Ussher, 1998), and as such it can employ any of a full range of research methods (Banister, Burman, Parker, Taylor and Tindall, 1994; Griffin and Phoenix, 1994).

It can be seen how the precepts of political feminism: the high value of women and their worthiness of study in their own right; and the need for social change, underpin the research priorities of feminist health psychology, to the extent that social change is acknowledged as an aim in both cases. As the central research issues defined above imply, feminist research is also based, like social constructionism, on a critique of the positivist paradigm (Henwood, 1996). Malson (1995) identifies three features of the masculine/ androcentric bias of positivism which elicit criticism. Firstly, the 'rational' thought of scientific enquiry is aligned with the imputed characteristics of the objective, value and emotion-free male (Squire, 1989), whilst 'woman', as the 'Other', is associated with subjectivity and emotion (de Beauvoir, 1953). Secondly, just as the older psychological theories have been developed from wholly male samples, and their findings then ascribed to women: the 'male as norm' principle (Griffin, 1986), so also have traditionally male-identified topics been given precedence, both in terms of attention and importance, over woman-identified issues like the family and childbirth (Squire, 1989). Thirdly, this supposedly value free science has been used in the interests of (white, middle-class) men to construct masculinity and femininity in particular ways: representing women as emotionally weaker and generally less functional than men (see, for example, Ehrenreich and English, 1978; Sayers, 1982; Ussher, 1991).

As Ussher (1998) observes, such male-orientated principles have their own particular ramifications for health research and health care (although this is not to imply that they are unimportant in other realms). The construction of woman as 'Other' in traditional research has resulted in women being positioned as a unitary category, the differences between women being ignored in every respect, not only in terms of differences between women from different social classes, ethnic groups, sexual orientations and levels of physical ability/disability, but also in terms of differences within these groups. Moreover, as already demonstrated in subsection 1.3.2 (page 27ff), traditional psychological theory tends to locate psychological problems within

the individual. Thus women are pathologised whilst the socially constructed nature of health and illness is ignored, resulting in wholly inappropriate treatment, and sometimes additional distress for the woman when her interests and needs are disregarded. The resonance with a medical model of childbirth, which represents women's bodies as inefficient in giving birth unaided, is only too apparent.

My own feminist perspective is in line with the feminist themes described above. I believe that women are entitled to equality with men. In terms of control in childbirth this means that, as owners of their bodies, and the fetus within, childbearing women have as much, or more, knowledge about themselves and their needs as do those who care for them. Moreover, as an intrinsically woman-identified topic, childbirth is as eligible for psychological enquiry as any male-identified issue - more so, in fact, to redress the neglect it suffered in the earlier years of psychological research. Alongside other feminists I deplore the patriarchal expropriation of women's bodies (Rollins, 1996), both in terms of a past in which childbearing women were considered no more than incubators for the fighting men of the next generation, and more recently in terms of a system which pathologises childbirth, the most significant achievement in many women's lives, and labels it as something that can only function smoothly under the watchful eye of the medical profession¹⁴. I have already, in the preface to this thesis, explicated my own interests in the topic of control in childbirth, not as a childbearing woman myself, but as a midwife who has both witnessed the lack of control of women giving birth, and experienced my own oppression by the obstetric system. Thus I have, at times, felt both controlled, and unable to give control.

It is these experiences which fire my feminist concerns and fuel my belief in the need to explore the meaning of control in childbirth for childbearing women, in order to ensure that the changes being made within obstetric care are informed changes which will benefit the maximum number of women: both parturient and midwives. Taking both a social constructionist and a feminist perspective in my research allows room to acknowledge the historical legacy and power issues around control in childbirth and the way in which it has been studied. Analysis of the texts of both childbearing women and their midwives can draw upon the issues of the past to help to explicate the present, and can deconstruct the ways in which childbearing women and midwives negotiate the power dynamics of the control issue. However, this aside, I still find I need to establish a research approach which will allow me to acknowledge both the materiality of women's bodies which change during pregnancy, and which open up and expel a baby during birth; and the discursive practices which give meaning to these processes, both to the women who give birth and those who are employed to assist them. Thus I arrive, epistemologically (albeit via a route that many would consider unusual), at a position from which a

¹⁴ To discuss the medicalisation of childbirth in terms of patriarchal expropriation might be grounds for debate. It could be argued that medicine and patriarchy are not coterminous. I concede this to be the case, but a strong patriarchal bias still exists (or did until recently) within obstetrics. In 1986 88% of consultant obstetricians were male (Savage, 1986), and given the slow turnover of senior medical posts, this figure is unlikely to have altered drastically in the past 12 years. Moreover such a bias has, at least until recently, been only too apparent to women within the profession, like Wendy Savage, when they have tried to practice care centered on the needs of their clients (Savage, 1986).

material-discursive approach seems most appropriate (Radley, 1997; Stoppard, 1997; Ussher, 1997), from within which I take the social constructionist position which I have already intimated. Moreover my feminist and my Christian positions, I believe, both provide ethical justifications for giving precedence to some accounts above others, an issue with which wholly relativist social constructionists struggle (Burr, 1995).

1.5.3 A material-discursive approach

Material things happen to women's bodies when they give birth, although ultimately my interest is in the way in which the woman constructs these things and her control over them, and in how she positions the effects such control or its lack has had on her. However this does not mean that women's embodied experience should be ignored. The tension between the material and discursive aspects of women's experiences is increasingly being recognized as important, whether it is explicitly labeled as a 'material-discursive' issue or not, and I will begin by describing research which has addressed these tensions, using this as a basis upon which to develop an argument to support and explain what I mean by the term 'material-discursive'.

Malson (1995), for example, took a 'realist' post-structuralist stance to explore women's discursive constructions of anorexia nervosa. Thus she was able to assume the existence of the material extra-discursive reality of women's bodies, whilst still acknowledging the socio-historical situation of any such 'real'. Swann (1996) adopted social-constructionist and post-structuralist methodological concerns over the construction of gender and menstruation in her study of self-reported Pre-Menstrual Syndrome (PMS), yet integrated these with the broader epistemology of feminist standpoint theory to allow her to account for the experience of the body (for example, the hormonal and physiological changes over the menstrual cycle) as well as the actions of the social world (for example, which associates menstruation with psychological disturbance). Swann pointed out that to take a standpoint which denies materiality was to be guilty of the same essentialism for which positivistic paradigms have received so much criticism. In a similar vein, Ussher (1997) observed that many women who suffer from PMS adopt a biological explanation for their distress. For such women, analyses which argue that PMS is created purely by negative social constructions, which therefore stand in opposition to what they 'know', will be rejected as suggesting their distress is 'all in the mind'. Similarly, for a childbearing woman, to highlight her representation of a distressing birth experience as just that: a representation, is to deny material practices which could be inherently disempowering, and to imply that the woman's distress is due to some weakness: some inability to cope. In parallel with Swann's arguments about essentialist practices it could be argued that such reductionism is as asocial as the psychological control theories, described earlier, and so readily criticized by social constructionist thinkers.

It might be argued that the research described above addresses material and discursive aspects of human experience as separate issues. However other researchers are explicit about the interrelated nature of the two elements. Stoppard (1997) specifically aligned her efforts to understand depression in

women with a material-discursive approach. She highlighted the need for a theoretical perspective which encompasses both the material and discursive dimensions of women's lived experience. However she also criticized the dualistic assumptions perpetuated through biopsychosocial models of depression which differentiate psychological processes, the biological body and the social environment, and then postulate interactions between these entities to explain depression. Instead Stoppard proposed a material-discursive perspective which posits the material and the discursive as fundamentally inseparable: constantly in reciprocal interaction with each other. Kirmayer (1994) suggests something similar with respect to disease occurrence and diagnosis:

'Patients are not inert objects of interpretation - they are themselves interpreters of experience who have their own constructions of meaning that not only affect their account of symptoms and events but, to varying degrees, influence the nature and course of the illness. This introduces a sort of feed-back loop between interpretation and event.'
(Kirmayer, 1994, p. 190.)

Yardley (1997b) takes this concept of the inextricable reciprocity between the material and the discursive aspects of life a step further with the argument that the material and the discursive both always contain aspects of the other, and that, in fact, it is impossible to consider the two aspects as discrete issues. She argues that all experience and knowledge has material roots and consequences, whilst embodied experience cannot be separated from its discursive representation (Yardley, 1997c). Thus, discourse can be shown to have both material origins and ramifications (Yardley, 1997b), whilst materiality, in the form of embodiment, can be used discursively, to express things which cannot be said (Yardley, 1996). The material can be reconstituted in talk, for example when a speaker describes an embodied experience (Yardley, 1997b), whilst the discursive is frequently invested in the material: can be physically manifested in fashion, architecture and myth (Yardley, 1996). Discursive research can have material consequences, indeed, it is only carried out to have an effect, to challenge existing practices, or to create alternative meanings that might prove helpful or liberating (Yardley, 1997b). Moreover such material-discursive relationships are dynamic. As with Kirmayer's 'feed-back loop', there is a constant shaping and reshaping of both the material and psychosocial aspects of the world (Yardley, 1995).

Thus material-discursive approaches could almost be conceptualized on a continuum, with the 'material and the discursive' at one end and the 'material-discursive', as inseparable aspects of human experience at the other. However, for pragmatic purposes, the space between the two ends of the scale is perhaps not so great. Most certainly, in the case of control in childbirth, it is helpful to talk about both material and discursive aspects as if they were separate entities. Yet it is plain that they are intimately interrelated. For example the embodied experience of the pain of childbirth can be discursively represented as something unpleasant, or as something positive. Such representations affect carers as well as childbearing women. As an example, Flint (1986) urges midwives to examine their own feelings of inadequacy to help before they automatically administer analgesia to the woman pleading for help; and to try to imbue their clients with some of their own strength:

'I often say, ... "The reason it's so painful is because it's progressing quickly. Everything is fine, you're doing wonderfully. You are so clever, you look so good, you are so relaxed..."
(Flint, 1986, p. 64.).

The objective is to help the woman and the midwife reinterpret the embodied pain of childbirth as something natural and positive. Yet because of the association between muscle tension and pain discussed in subsection 1.3.2.1 (page 28), such a strategy, if it does work, is liable not only to help the woman to discursively re-evaluate her pain, but might also help her relax: another material effect, which also works at a neurophysiological level, by reducing the activity of the sympathetic and motor nervous systems (Melzak and Wall, 1988). Moreover, if the midwife represents the woman's expressions of pain positively she is less likely to impose unwanted analgesia upon her: one more material effect.

To enable me to deconstruct some of these complexities, I will take up a position in which I recognize the 'material-discursive' as a dynamic, integrated entity, but in which I choose, at times, to tease out material and discursive aspects of control in childbirth to examine their inter-relationship.

1.5.4 An approach to researching control in childbirth

Within a material-discursive approach both qualitative and quantitative methods are considered acceptable, using the same arguments as social constructionists: that phenomena can be described with numbers as well as words (Stoppard, 1997; Yardley, 1997b). The key question is which methods are the most appropriate for the issues under scrutiny.

In selecting the best methods for exploring issues around control in childbirth, within the epistemological parameters discussed in the previous subsections, it is useful to examine some of the general problems with existing research in this area. Such a critical examination points the way to a suitable research approach.

Much of the research described in sections 1.3 and 1.4 of this chapter was carried out within the positivistic paradigm. As explained in subsection 1.5.2.1 (page 59), positivism assumes that research can verify or falsify the 'true' state of affairs. As such this research seldom questions such issues as the effect of the research and the researcher on the investigation. For example some of the studies described earlier in this chapter involved several contacts with the same group of women, never taking into consideration the fact that this, in itself, is liable to constitute an intervention, and thus affect the findings. As described in subsection 1.5.2.2 (page 62) such processes are inevitable, but they should be acknowledged as part of the research, as indeed they will be in the studies which follow.

Another problem with existing research into control in childbirth was addressed in subsection 1.3.2.1 (page 28) in terms of the psychology of control. Much of it is asocial. It considers the childbearing woman without taking into consideration her social circumstances or the power issues inherent in obstetric care, and their effects upon her. Sometimes background and demographic issues, such as social class, have been taken into consideration but, as described in subsection 1.5.2.3 (page 63), the differences amongst women within these categories has less often been addressed. Similarly the

diversity of women's experience is seldom addressed: the possibility that what objectively appears to be a similar experience can mean something different to different women.

This heterogeneity of childbearing women is an important issue. Because midwifery and obstetric care is concerned with individual women, something more is needed beyond an understanding of general trends: the type of information that is often obtained from large-scale surveys. Such information does not help a carer to know how to handle the expectations of the particular client with whom they are faced, who may or may not be the exception to the rule. An added drawback with large scale surveys that have sometimes been used in research into control in childbirth is that they often involve closed-ended questions which are couched in the language of the researcher. There is a need to create space wherein childbearing women can use their own language to represent their experiences in the way they choose. The topic of control should, above all other topics, be explored in a way which leaves room for those being researched to take some control. This suggests that open-ended, or semi-structured, interviews might be a helpful vehicle for exploring control in childbirth.

As described in subsection 1.5.2.3 (page 63) feminists have drawn attention to the moral and political dimensions of all research, and to the need for feminist research to lead to social change for women. Again, such dimensions were missing from much of the research discussed earlier in this chapter. The need for social change arises out of the historical legacy of women's disempowerment. Although, as described above, an acknowledgment of heterogeneity is important, it could be argued that this legacy, described in relation to control in childbirth in the second section of this chapter, transcends the concerns of individual women. It is deeply political, not only in the governmental sense, in terms of allocation of resources and legislative policies, but also in terms of the societal rules and mores which govern the arenas in which women are able to operate. In other words, as the earlier part of this chapter demonstrated, control in childbirth is just one facet of women's struggle to take responsibility for a set of issues which involve them deeply, and yet which, until recently have been constructed as none of their business. It is because of this legacy that, not only do we need research which empowers women, which gives them space to make their voices heard, but we also need research which will reinforce the importance of such issues as control in childbirth¹⁵ for all women. Thus rigorous, large scale, replicable studies are still necessary: studies which can provide findings capable of fueling and justifying societal changes and political policies, which will utilize the techniques (scientific terminology, quantitative measures and statistical procedures) which are found to be persuasive in modern society (Griffin and Phoenix, 1994). In such studies it is necessary to explore linkages between predefined constructs, and to seek responses to standardized questionnaires, because it is only then that it can be demonstrated that certain issues are of importance to the majority of women.

As well as maintaining a tension between the issues of women's heterogeneity and their universal disempowerment, research into control in childbirth must acknowledge power-related issues: both the power of the carers, who can deprive childbearing women of control, or alternatively empower them

¹⁵ This is using the word 'control' in its broadest sense, by including control over where and when the control is taken.

(bestow power, rather than acknowledging that they might have any power of their own (Hunt, 1995)); and the potential power of the childbearing woman, her agency to negotiate, for example, by resistance or compliance (Kirkham, 1989). The different levels at which power can operate (Stam, 1987) must also be taken into consideration: the superindividual level, the historical/ political level already described; the individual level, in which childbearing women themselves should be given a voice, and control not defined only in the language of the medical/ scientific model; and the intra-individual level which acknowledges women's control experiences in their entirety and does not fragment them, in other words, which integrates childbirth control issues with other issues in the woman's life, for example, her experiences of control in her job and within her family. Much of the research discussed in sections 1.3 and 1.4 failed to acknowledge these issues.

Folkman (1984) suggests that the person-environment relationship, in which control is always embedded, is a dynamic that is constantly changing. It is therefore also important, where possible, to represent this dynamic, as well as one can, rather than merely to seek a 'snapshot' picture which fails to acknowledge any ebb and flow of the childbearing woman's representations of control. Thus a longitudinal study, which involves contact with participants on more than one occasion, is helpful and will be utilized here. This is not to say that 'snapshots' cannot (or will not) be used, but when they are obtained, for example, in measurement scales which ask the woman to rate control for the whole of the labour, or indeed for her life, it is important that their limitations are recognized.

It would be impossible to meet all the demands outlined above with one particular research technique. A large scale questionnaire study can be designed to ask standardized questions of a group of women, but to explore how individual women represent control in childbirth, an interview study is more helpful, using open ended questions, and a small enough number of participants to allow a detailed, in depth, analysis. Both approaches will be taken in this thesis. Each will explore the various aspects of control in childbirth, but in different and complementary ways. As Alderson (1990) observes, a qualitative analysis is able to address related aspects of an issue, promoting an understanding of these aspects by placing them alongside each other. It highlights complexity and interactions, as people are studied in context. However, equally importantly, quantitative analysis can promote an understanding of the separate parts of an issue, these parts being explored after dissection out from the issue as a whole, and precise examination. Milburn, Fraser, Secker and Pavis (1995) point out that, when the issues being researched are of a sensitive nature some respondents will find the lack of face-to-face contact and the fixed choice responses of the tools of quantitative analysis, such as questionnaires, less embarrassing than interviews. This could be the case with research related to childbirth. The birth experience can involve intimate procedures and be highly personal. However childbirth is also likely to be a complicated experience, and the interview situation will allow participants to express complexities and nuances of meaning that could not be represented in fixed choice responses.

Whatever methods are to be used, it is important, as Yardley (1997b) points out, to avoid reifying results: treating the findings as precise representations of some immutable reality. This, Yardley suggests, is achieved by reflecting upon the scientific process itself, both in terms of the researcher's

personal and ideological interests in the topic under scrutiny (referred to by Banister, Burman, Parker, Taylor and Tindall (1994) as personal reflexivity), and in terms of an exploration of how the context of the study might have affected both the material obtained and its analysis (also termed functional reflexivity (Wilkinson, 1988)).

This stance towards the status of research findings is part of the move away from positivism, described in the preceding subsections of this chapter. Such a move means that other research criteria, which are usually applied unproblematically in traditional research must also be reconsidered. This will be the subject of the next two subsections.

1.5.5 Reliability, validity and selection of data

In the last subsection I explained why I intended to use both qualitative and quantitative methods to explore some of the issues surrounding control in childbirth. It was argued that such different approaches might be expected to complement each other in terms of their findings. However for this to be the case the research and findings from both approaches must be given equal importance and value. Yardley (1997a) observes that the traditional parameters for judging the excellence of empirical studies are well-established: criteria such as reliability and validity. However if qualitative findings are assessed using the same principles, they may be found lacking, not because the research is in some way inferior, but because the criteria are not entirely relevant to the approach. Nevertheless this is not to imply that assessment of quality should be disregarded in qualitative research. It is important, instead, to establish criteria which are suitable. In the next two subsections some of the major issues of research quality assessment will be explored in terms of how they might be applied to both quantitative and qualitative approaches. Related issues which appertain particularly to qualitative research, and which sometimes elicit criticism from researchers working within a traditional paradigm, such as selection of data, and the generalizability of findings will also be addressed.

1.5.5.1 RELIABILITY AND SELECTION OF DATA

The notion of reliability encompasses a sense of the replicability and stability of the research findings (Kirk and Miller, 1986; Guba and Lincoln, 1994), something which qualitative researchers seldom set out to demonstrate, and indeed, which most consider inappropriate to their approach (Banister, Burman, Parker, Taylor and Tindall, 1994), being part of the rhetoric of positivism (Burr, 1995). Another objection to these concepts is that, in quantitative research, the notion of reliability is often obtained at the expense of treating important inconsistencies and idiosyncrasies as 'error' (Yardley 1997b). Kirk and Miller (1986), however, distinguish between different types of reliability, and such a distinction is helpful when considering an appropriate standpoint on the issue for those using a mixture of qualitative and quantitative methods. Firstly they identify quixotic reliability, where a single method of observation continually yields an unvarying measurement. In both qualitative and quantitative methods, such reliability is problematic. In qualitative approaches, it can simply mean that the researcher is eliciting the 'party line' or rehearsed information on a particular topic, whilst in quantitative research such reliability says nothing about validity. Kirk and Miller posit the example of

a faulty thermometer which would give the same reading each time, but not give any indication of the temperature that would be obtained were a different instrument to be used. They thus pronounce such reliability as trivial and misleading. Secondly they identify diachronic reliability: the stability of observations across time, but point out that such reliability is of little use in the investigation of changing entities in a changing world. The third type is synchronic reliability: the similarity of observations within the same time period. Such observations need not be identical, but are consistent. However, the failure of synchronic reliability in a particular case, when it has been identified elsewhere within the same analysis, does not necessarily mean the disconfirmation of a particular theory, because such failures open up the possibility that other interpretations might simultaneously be applicable, and this possibility can be explored. This latter reliability is the only one of the three that can be usefully sought in both qualitative and quantitative research, and therefore is applicable to the studies which follow.

The issue of confirming or disconfirming cases of synchronic reliability raises the question of selection of texts in qualitative research. Yardley (1997b) observes that qualitative researchers tend to select texts which they consider interesting in relation to the subject matter under investigation. Such a selection is informed by just such notions of consistency or reliability, in so much that material that is deemed interesting will be so considered because it either exemplifies or contradicts what is seen as typical. The important issue then becomes to state clearly the status of any quotation, in other words, whether a selected piece of text demonstrates or challenges what appears to be typical. This will be done in the qualitative studies which follow. Synchronic reliability carries with it a notion of quantity: the 'typical' will generally be considered as such because the number of instances in which it occurs are high (Bryman, 1984). As such it is also a suitable notion in quantitative research, where such typicality is formalized through statistical procedures which set out to identify where a significant majority of findings adhere to one particular perspective, whilst acknowledging that any measurement is only as good as the instrument used to measure it. In other words, a questionnaire, because it relies on the responses of participants, can only reflect the way in which the majority of those participants represent themselves.

1.5.5.2 VALIDITY

The concept of validity addresses the notion that what has been measured should be authentic and should correspond with other independent measures obtained by different research tools (Banister, Burman, Parker, Taylor and Tindall, 1994). Although such a notion is not easily adapted to qualitative research, attempts have been made to produce criteria suitable for establishing validity, and thus a limited objectivity, in qualitative research, such as triangulation of data and inter-rater reliability (Miles and Huberman, 1994). However such techniques are open to criticism.

Yardley (1997b) points out that, although the extensive discussion of interview transcripts with colleagues required to provide an inter-rater reliability can be highly profitable, it is important not to confuse this with objectivity, as it is almost inevitable that the discussion involved will result in both analysts learning to employ the same criteria in classifying data, and no more. Similar problems arise

when objectivity is attempted by triangulation: using a variety of methods to investigate a single topic with the intention that this will overcome bias in the data from respondents whose accounts misrepresent the phenomenon under investigation. Yardley (1997b) not only questions the ethics of setting out to verify or disconfirm participant accounts, but also points out the weak realism implied by such a strategy, which suggests that there is a truth to be discovered if only the bias in the analysis is reconciled. Silverman (1993), meanwhile, points out that by counterposing the different contexts in which such research occurs, the important context-bound issues, which are a relevant part of the analysis, are lost. Both authors acknowledge the value of approaching a topic from multiple perspectives to obtain a multi-faceted understanding of the issue under investigation, but warn that this must not be confused with objectivity.

Despite these problems, several researchers have suggested useful criteria for validating the findings from qualitative research, whilst recognizing that their analysis should not be expected to reproduce a single 'correct' view, or to be without contradictions or tensions. My analyses, described in the chapters which follow, draw upon these.

One such list of criteria was produced by Potter and Wetherell (1987), for use in discourse analysis. Their first criterion is coherence: the analysis should demonstrate how discourses, or repertoires, within a text fit together, both in terms of broad patterns and micro-sequences. When cases do not fit with the standard explanation this should be for demonstrable reasons. The second criterion is participant orientation. The variabilities and consistencies of cohesive explanations should not only be a feature of the analysts ingenuity, they should also be confirmed by the orientation of the participants. The next criterion is the recognition of the development of new repertoires and positions which resolve the dilemmas created when the meeting of two discourses creates tensions. These new discourses need to fit in with the overall coherence. The fourth, and final criterion of validity is fruitfulness, the scope of the emergent analysis to point to new explanations.

Mason (1996) suggests two criteria of validity. The first is the validity of the methods of data generation. Researchers must ask how well matched the logic of their method is to their research questions, and to the kind of social explanations they are developing. The second criterion is the validity of interpretation. The quality and rigour with which data has been analyzed and interpreted must be demonstrated. For example, methods and methodology must be justified.

Yardley (1997a) suggests another set of criteria with which qualitative research might be judged, giving the reminder that any such criteria are not rigid rules, but guidelines to be drawn upon and interpreted flexibly. The first criterion is sensitivity to context: firstly the context of theory and related research. In this respect the qualitative researcher needs a working knowledge of the philosophy of the approach they have adopted. Secondly an awareness of the socio-cultural setting of the study is required: an awareness of the various normative, ideological and socioeconomic influences, not only on the study participants, but also on the researcher. Thirdly the researcher must demonstrate an awareness of the ethical and power issues surrounding both their research topic and the process of its

investigation. Finally, a sensitivity to the research data is imperative: so that the researcher does not merely look for expected effects, but also seeks out and examines unexpected findings.

Yardley's second criterion is commitment and rigour, involving a thoroughness in data collection and analysis, and a completeness of interpretation, addressing all the variation and complexity observed. The third criterion is transparency and coherence. Transparency is achieved by such practices as detailing the rules by which the data was coded, presenting excerpts of texts to illustrate from where various patterns have been derived, and disclosing all relevant aspects of the research approach. Coherence is demonstrated when there is an appropriateness between the research questions asked, the philosophical perspective adopted, and the investigative and analytic approaches selected.

Yardley's final criterion is impact and importance: whether the researcher's ideas have the potential to influence the beliefs or actions of others, or whether they present a new perspective which has the capacity to challenge the existing understanding of a topic.

It is this last criterion which raises a second, but associated, issue concerning data validity. Perhaps a good illustration of the value of qualitative research can be drawn from the example of the medical or nursing case study, which sets out to describe the course of an illness and its treatment in a specific individual. Readers of such a study are informed about that particular illness, and gain useful insights which might help them to consider different approaches when they encounter an individual with the same condition. However there is no suggestion that the case study lays down the exact course which that illness always follows, any more than it is taken to specify the only correct way of treating the condition. Similarly the findings from this thesis will, hopefully, allow the formation of a deeper understanding of the control issues which childbearing women face: an understanding which will be added to the existing body of knowledge about the issue and ultimately help to inform policies about obstetric care and the practices of individuals. The utilization of quantitative methods as well as qualitative is intended to enhance this process. However this is not to suggest that the participants from the two studies which form the basis of this thesis are typical in every way of all childbearing women, and that the control issues thus raised should be assumed to be the most important issues faced by women living in, and giving birth under, different conditions.

1.6 Conclusion to chapter 1

The account of the history of control in childbirth, made in the early part of this chapter, traced the progressive medicalisation and then pathologisation of women's birth experiences. It demonstrated that, although much of this 'progress' was represented in terms of concern for the wellbeing of the mother and child, most measures of maternal and fetal wellbeing were, and are, based on mortality rates rather than psychological measures or even morbidity. Indeed the importance of psychological wellbeing has almost been trivialized, in so much that women who have been concerned about such issues have been accused of putting their own need for a satisfying experience above issues of physical wellbeing. Measures of mortality have also, more often than not, been used to justify the status quo of the current medical climate, conflating the correlation of falling mortality rates and rising intervention

with a causal effect. Historically, obstetric care did not set out to benefit mother and child, but rather it was fired by such issues as the need for a fit fighting force. Neither have most obstetric interventions been as beneficial to mother and infant as they were firstly purported to be.

The next section of the chapter considered whether the psychological theories associated with control might be helpful in explaining or exploring control in childbirth. However these were found to be limited when related to complex situations, because the constructs they described were narrow. They were also criticized as asocial. Moreover, when extrapolations were made from the individual to the social, there was a tendency to simplify social structures, and a failure to acknowledge the interaction between the personal and the institutional. Finally they also overlooked the part played by cultural ideals. The discussion around these psychological theories did highlight some important aspects of control in childbirth, for example, the association between lack of control and depression; and the question of whether childbearing women's past life experiences influenced their control in childbirth. However because of their lack of acknowledgment of the kind of social and historical factors described in section 1.2 such psychological theories are of limited usefulness in answering questions about control in childbirth.

Three questions, drawn from a discussion of the historical issues in section 1.2, were given consideration in the next section which examined current research which addresses childbirth control and associated topics. The first question asked what control in childbirth might mean to different women, and various factors which might predispose towards control or its lack were considered, for example: social class, expectations of control, and the use of interventions. The second question examined issues of communication between midwives and childbearing women to explore how control issues are dealt with between the two groups of women, both of whom, until recently have been deprived of control. The third question asked what psychological benefits there might be to childbearing women who achieved control, and vice versa. Measures of outcome were considered in this section, both in terms of nature and timing. The importance of comparison with equivalent antenatal measures was also discussed.

A discussion of ontological, epistemological and methodological issues followed in section 1.5. The Christian, social-constructionist and feminist influences upon my outlook were described, and it was argued that a material-discursive approach was a useful one for exploring issues related to control in childbirth. The use of longitudinal studies, both qualitative (interview-based) and quantitative (questionnaire-based) were justified, and it was argued that together they would elicit complementary information about the issues.

Although, in section 1.4, the existing literature was shown to be informative in refining the three questions raised, it was also argued, at the end of the section, that the formulation of final research questions needed to be relevant to the ways in which childbearing women and midwives themselves addressed control issues. Therefore the pilot study in the next chapter was structured to take and explore the three questions with women who had experienced childbirth and with midwives.

Chapter 2

Asking maternity service users: pilot study

2.1 Introduction

2.1.1 Purpose of study

The main purpose of the pilot study was to refine the questions around control in childbirth which were developed in chapter 1 by exploring the ways in which both childbearing women and midwives represented the issues in their talk, thus ensuring that the final research questions used in this investigation were relevant to women who actually used the maternity services.

The first question asked what control in childbirth might mean to different childbearing women. It was shown in the last chapter that, historically, the majority of women have accepted the control (in whatever guise) that has been imposed upon them. How much this has been a matter of choice and how much an issue of powerlessness is open to conjecture. Current research was shown to be inconclusive as to whether demographic issues such as social class, age and education affect the type and amount of control women want or receive, although there was some evidence that midwives might treat middle- and working-class women differentially in terms of the amount of information they volunteer and the language they use. The material practices which might evoke a sense of control or its lack: the effects of interventions and physical aspects of the birth, also remain relatively unexplored.

The second question concerned the relationships between childbearing women and their midwives: how issues of control were both represented and communicated. It was shown in the last chapter that, historically, the loss of control over childbirth impinged upon both groups of women. In terms of current research, topics of communication and language were discussed and the specific question considered in this pilot study was whether midwives and childbearing women represented control related issues in such a way that they were likely to be able to communicate effectively.

The third question involved the psychological benefits, or otherwise, of control in childbirth or its lack. The research literature showed connections between lack of control in childbirth and postnatal depression,

and between control and satisfaction, but few other outcome measures had been considered by previous research. Neither had such issues as the timing of postnatal assessments and baseline antenatal measures been considered to any great extent. In this pilot study, therefore, it was important to explore any psychological effects that midwives and childbearing women considered might arise, and when they thought any such effects might become apparent.

2.1.2 The research approach

A semi-structured interview format was chosen in order to give the participants as much freedom as possible to raise issues which concerned them, whilst still ensuring that specific points were covered. Semi-structured interviews are based on a series of questions which can be used flexibly: either omitted, adapted or elaborated upon during the interview process. Thus the questions can be presented in a different way to suit each respondent, and an environment can be created in which interviewees are able to expand on issues where they wish, and where the researcher can depart from the set questions to explore any unexpected topics of interest that arise (Hayes, 1997; Banister, Burman, Parker, Taylor and Tindall, 1994).

Because the aim was to explore, not only childbirth, but also its longer term ramifications, it was appropriate to recruit women who had given birth some time previously to this study. There is evidence that, in many ways, women's memories of the events of their birth remain consistent over time (Niven, 1988; Simkin, 1992) (although there is some suggestion that they may become more critical of their experience (Bennett, 1985; Dreidger, 1991)). Therefore mothers who had experienced a first birth a year previously were recruited to take part. Thus they would still be able to remember the events, and yet it would be easy, at this stage, to find women who had not embarked on any subsequent pregnancy, which might have served to colour their views.

The focus on women expecting a first birth was in anticipation of the main research studies. Parity is a variable which has been shown to affect women's experiences of control in childbirth (Green, Coupland, and Kitzinger, 1988). It was not anticipated that the main studies would have sample sizes large enough to allow the consideration of parity as a separate variable, so the intention was to concentrate throughout on one group: primiparous women.

2.2 Method

2.2.1 Design

This was an interview study, consisting of one-to-one semi-structured interviews with women who had given birth to their first child approximately a year previously, and with midwives who had been in practice for some time. The purpose of this study was to explore the issues surrounding control in childbirth, as described in subsection 2.1.1, and to use the information thus obtained to formulate research questions for the main studies.

2.2.2 Procedure

Two sets of questions were compiled around the subject of control in childbirth, a different set being used for mothers and midwives. The mothers' questions were designed to explore the women's impressions of their experiences of childbirth in general, and to give them space to talk about control issues in relation to specific aspects of the labour and birth, for example: the events, their care, and the choices. Several questions also gave the women the opportunity to talk about their emotional state after the birth; about the opportunities they might have had to discuss what had happened; and about what they felt they had learned from their experience. The midwives' questions asked about their general midwifery experience and their attitudes towards giving childbearing women control. Their feelings about taking control themselves in the hierarchical environment in which they operated was also explored, as were their views of the long-term effects of the birth experience on childbearing women. The interview questions are reproduced in appendix 2.1.

University Ethics Committee approval for this study was sought and obtained. The interview questions were printed, a separate sheet being used for each interview, so that notes could be made if questions were omitted or the order changed. Participant details and field notes about each interview were also recorded on these sheets.

The participants were contacted through acquaintances and a snowballing technique. In the first instance each woman was sent or given an information sheet, containing details of the research, and explaining how it would be conducted, assuring that her identity would be protected with a code number and a pseudonym. In every case consent was obtained from the woman before her interview was commenced.

All of the interviews were on a one-to-one basis. Those with the mothers took place in the women's own homes. Three of the midwives also elected to be interviewed at home, whilst the other three chose locations within the hospital, and were either interviewed after work, or during a break. It was stressed that the women should choose an arrangement with which they would feel at ease, and that they should not inconvenience themselves unnecessarily. As the interviewer, I introduced myself to both the mothers and the midwives as an ex-midwife who also had a degree in psychology. I explained that the research I was conducting was towards my Ph.D., and that I had no children of my own.

A standard portable tape recorder was used to record the interviews. Those with the midwives ranged in length from 35 to 80 minutes (mean length 62 minutes). The mothers' interviews were longer, ranging from 70 to 90 minutes (mean 82 minutes).

After the interviews each tape was played back and transcribed, with the help of a compact cassette transcribing system. It took approximately 7 hours to transcribe every hour of interview time. The basic

text of the interview was reproduced, and annotations made for pauses, hesitations, and intonations which might indicate a different meaning to the text than the obvious one¹⁶.

2.2.3 Coding and analysis

Several levels of analysis are possible with interview data. For example, in conversation analysis participants' linguistic conduct is scrutinized using micro-sequences of conversational text (Drew, 1995), whilst at other levels of research entire life history narratives might be studied (Smith, 1995). In this pilot study analysis was at a thematic level (Plummer, 1995). Although the participants were given the space to speak for themselves, the purpose was to collate a series of themes which could inform the substance of the final research questions. At this stage of the overall research project the requirement was to extricate theory which was grounded in the data, rather than to try to fit interview data into some predetermined, theory driven, framework. However, as described in the introduction to this chapter, there were specific areas of interest, for example, whether the mothers described any psychological sequelae from the birth itself, or more specifically, from their experiences of control or its lack. Therefore a level of analysis was required which would allow the themes and ideas represented within these areas to be explored and developed. To this end the transcripts were coded in similar way to that suggested by Potter and Wetherell (1987) and Pidgeon and Henwood (1997).

Firstly, each transcript was read carefully and paragraphs in which any of the specific areas of interest were raised were separated out and categorized according to the themes contained therein. However unlike the authors cited above, who used manual records during this process, in this pilot study the relevant portions of text were transferred to separate files in a standard word processing package, one for each code or category. Integral to this exercise was a continual process of readjusting and further dividing the categories if they emerged as more complex than first envisaged. All the instances which might have any bearing on a category at all were included in it, resulting in some text portions being inserted under several categories.

Once coding was complete the categories were examined very closely for patterns both within and across them. Themes which were shared by several categories were noted, as were differences within and between categories. Mothers and midwives were initially considered as separate groups for this, and then the groups were examined together. Thus it was possible to observe thematic repertoires shared by both groups, as well as those which were peculiar to just one.

At each point of the analysis, the text was checked against the original transcripts to ensure that it was not being taken out of context. In cases of serious doubt, the recorded interviews could have been consulted, although in reality, this only happened upon one occasion. In keeping with the epistemological ideals expressed in the previous chapter, it was recognized that what was being studied were not a set of immutable truths reproduced in the women's texts, but rather their representations of

¹⁶ In the interview text reproduced in this and following chapters, the following annotations are used: short pauses {(.)}, long pauses {(..)}, hesitations {..}, segments of omitted text {...}, emphasis {Why me?}, other notes, for example {(laughs)}.

issues. However it was also recognized that how the women chose to represent their experiences to others, in this case myself, the interviewer, would have some bearing upon how they represented the same issues to themselves. Such representations would, therefore, not be without their effects upon the individuals who made them.

2.2.4 Participants

Eleven women were interviewed. Five were mothers, all with only one child of 11 to 14 months of age. Their details are given in table 2.1.

Table 2.1 Details of mothers and their children

Pseudonym	Age	Occupation	Child
Laura	18	Telephonist	Girl, 11 months
Mary	30	Credit controller	Girl, 14 months
Anna	34	Local authority employee	Boy, 11 months
Freya	30	Actor	Boy, 12 months
Emma	27	Administrator	Girl, 12 months

The remaining 6 women were midwives, whose details are given in table 2.2. The midwives worked at 3 different hospitals in or around the same city. These hospitals were part of the same NHS Trust, and some midwives had experience of working at more than one of them.

Table 2.2 Details of midwives

Pseudonym	Age	Place of work
Beth	36	Delivery ward sister
Debra	46	Day assessment unit
Cassie	54	Relief work
Helen	49	Antenatal clinic
Jill	31	Management
Gaye	51	Community

The mothers were all Caucasian and British. The midwives had all trained in Britain, and worked within the British maternity system for at least ten years. The mean age of the mothers was 28 years, and of the midwives was 44 years.

2.3 Results

2.3.1 Introduction

The first part of this results section will consider issues of subjectivity and reflexivity. The following three subsections will take each of the research questions in turn and explore portions of text which elucidate the participants' representations of relevant issues.

2.3.2 Participant reflexivity and positioning of the interviewer

The importance of acknowledging potential effects of the researcher and the research on participants was explained in the last chapter (subsection 1.5.1, page 58). As described in subsection 2.2.2 (page 77), in this pilot study I positioned myself as an ex-midwife with a degree in psychology and no children. The midwives responded to my positioning as a midwife by using professional terminology and jargon in their replies, suggesting that they accepted the presence of certain shared meanings. For example:

Midwife Jill: 'She decided that she'd have a DOMINO delivery ... Typical red head, fair skin, and natural sort of third stage and ends up tanking it out, sort of thing.'

Here Jill positions me as someone who understands such acronyms as DOMINO (standing for 'domiciliary in and out': the practice of a community midwife taking her client into hospital to deliver the baby and then returning home with her a few hours later). She also infers our shared understanding of the supposed risks of postpartum haemorrhage with a physiological (or 'natural') delivery of the placenta (or 'third stage'), and of midwives' mythology which ascribes a high risk of haemorrhage to women with red hair. Thus I am invited to share her lack of surprise that the woman in question bleeds heavily, with her use of the word 'typical'.

Similarly, the mothers were inclined to use obstetric terminology without any explanation of its meaning, suggesting that they had also located me as a midwife:

Anna: 'And I said, "Well no, I'd like a DOMINO please", because people at work had told that that was something that they had had, and were very happy with.'

Anna's work colleagues had explained to her what a DOMINO was, but clearly she did not feel the need to pass that explanation on to me. However, despite this, the mothers did take pains to explain their feelings and reactions to situations, and it was clear that at this level I was not positioned as someone who could automatically share their understanding. In the following extract Laura struggles to explain how she could remember the intensity of the labour pain but not its nature. That she assumes I will not automatically understand is indicated by her use of an analogy to clarify the issue:

Laura: 'I remember the labour, what actually went on, really clearly. But I don't remember what it felt like, if you know .. if you know what I mean. I don't remember what the actual pain felt like. 'Cos I mean, if you think um about stubbing your toe, and you think, "Oh I don't want to do that", 'cos you remember, don't you, what .. what the pain was like. But I can't really .. I know it hurt a lot, but I can't remember what it actually felt like.'

Neither the midwives or the mothers appeared to acknowledge my qualification in psychology to any great degree. Only one mother represented her experience in 'psychological' terminology:

Freya: 'I think I'd been, I think the expression is 'in denial' for a long time that I .. that it was going to be OK and it was going to be very easy.'

Although this portrayal might have been for my benefit, it did work for Freya in terms of her search for a resolution to the tension created between her representation of early labour as a time of total

calmness, and of confusion and coping problems in the later stages. In other words it is possible that she might have provided such an explanation whoever I was.

Towards the end of several of the interviews with the mothers, the women began to reflect upon how talking to me had altered their perception of events they had been describing:

*Freya: 'It's quite good actually, talking like this about it, because it's made .. it does make you realize that, you know, I should perhaps advocate it (**home birth**) more.'*

Emma: '... having talked to you now, I think .. I think (.) there isn't much else that could have happened. So I think I probably did get the best possible care that I could have, you know.'

The midwives showed no tendency to be reflexive in this way, demonstrating the main difference between the two sets of accounts: the mothers were describing an event, a deep personal experience, whilst the midwives were talking about a job, however committed they were to it. This helps to explain why the mothers, although they demonstrated certain shared understandings of obstetric terminology with me, had still been at pains to describe their feelings in some detail, something not evident in the midwives' texts. It was this personal element which they did not expect me to understand as a midwife, perhaps particularly because I had no children. Whether they would have found it necessary to make such explanations to another mother is open to question.

The mothers thus represented their experience as something still open to reinterpretation. Therefore, as suggested in chapter 1 (subsection 1.5.4, page 67), if childbearing women are to be asked to give several interviews about their birth experience, the cumulative effects of the interviews themselves must also be acknowledged.

2.3.3 First question - What control in childbirth means to different childbearing women

2.3.3.1 PAST EXPERIENCES AND EXPECTATIONS

In the last chapter the possible effects of such variables as age (subsection 1.4.2.2, page 44) and social class (subsection 1.4.2.1, page 41) on expectations and experiences of control in childbirth were discussed. Because the number of mothers interviewed in this pilot study were small it was inappropriate to try to draw any assumptions about relationships between such issues here. However another issue which was raised in chapter 1 (subsection 1.3.2.1, page 28) could be addressed. This was the possibility that childbearing women might take experiences of control from the rest of their lives into the birth situation.

Several of the mothers described such experiences which, they reported, had coloured their expectations of the birth. For example, Freya decided she wanted a home delivery. Initially, she said, she was influenced by two things, the death of her brother's child at birth due, she claimed, to hospital error; and her GP's skepticism about whether she was pregnant, when her home pregnancy test was positive but the hospital test result was negative:

Freya: 'Those two things didn't .. didn't give me a lot of confidence in um hospitals, procedures, doctors and so on.'

Freya's disquiet over hospitals was further reinforced by her experience of the hospital booking clinic. It was at this point she decided to ask for a home birth:

Freya: 'I went to my um .. the booking in sessions, and it was grim, grim, grim ... you know, the usual story really, queues and um procedure and that first blush of sort of, "Isn't this sort of quite wonderful that you're about to have", you know, "Have a baby", sort of given .. given an illness label, I made up my mind there and then in the .. in that booking session ... that I wasn't going to have a hospital birth.'

Freya's experience of an ultrasound scan, where the technician addressed herself to Freya's husband the whole time, rather than her, was a confirmation to her that she had made the right decision.

Although Freya positioned the experiences of her brother's wife as the starting point of her mistrust of doctors and hospitals and her eventual decision to ask for a home birth, she went on to highlight other events which helped influence that decision: her experience with her GP and at the antenatal clinic. Finally she selected yet another experience, the ultra sound scan, which confirmed to her that she has made the right choice. Similar progressions were apparent in some of the other mother's stories, although the nature of the incident represented as the starting factor varied. For example, Anna's relevant past experience was her job, which she described as concerned with empowering a section of society which are usually seen as disadvantaged. She felt justified in expecting the same sort of empowerment herself from the maternity services:

Anna: 'It's quite important in a sense what my work is ... basically enabling people to take control and make choices, and to be empowered to do those things. So er I suppose I .. I saw an analogy with how I should be treated, if you like ... I kind of felt that I should expect the same thing back.'

Some of the midwives also recognized the relevance of past experience to childbearing women's expectations. Jill felt that women who insisted on control were almost certainly influenced by past experiences:

Midwife Jill: 'If they come in (..) and sort of start demanding their rights from the beginning, I think it's very important to find out why they're coming in with that reaction. Um and it .. as I said before it may well be something to do with past experience or what they've heard of, or fear of hospitals, or whatever.'

Despite the apparent similarity between Jill's acknowledgment of the importance of past life influences and that of the mothers, there was a difference in the way in which the effects were represented. The mother's positioned the outcome of such influences as unproblematic. Anna felt she should expect control, for example, whilst Freya spoke of making up her mind to ask for a home birth. However the midwife, Jill, implied that such expectations might lead to childbearing women 'demanding their rights', or having a 'reaction', as if these 'rights' or 'reactions' could be something unreasonable. The representation of the midwife as someone who needs to 'find out why' the woman is reacting thus helps to position the midwife as rational and the childbearing woman as potentially unreasonable. Moreover the use of the word 'reaction' implies a sudden decision on the part of the childbearing woman: something belied in the mothers' accounts of their long journey of confirmatory experiences

which preceded their decisions to assert control. All the midwives who spoke of childbearing women's expectations described how they might negotiate with the parturient woman when her requests were not considered appropriate in some way.

In summary, the relevance of childbearing woman's experiences prior to the birth was acknowledged by both midwives and their clients. However midwives were more likely to position the resultant requirements for control as something not entirely reasonable, whilst to the childbearing women they were positioned as carefully thought out, rational decisions.

2.3.3.2 WOMEN FROM DIFFERENT BACKGROUNDS

Although there was no possibility, in this study, of examining the relevance of such variables as age and social class with the mothers, the midwives who were interviewed tended to subscribe to the notion described in subsection 1.2.3 (page 23) of the first chapter, wherein working-class women were positioned as those who did not know control in the rest of their lives and who would therefore not want control during childbirth, whilst middle-class women were described as used to control in their lives and anxious for the same in childbirth:

JW: (In response to Beth's previous comments) 'What makes some women want a lot more control than others do you think?' | Midwife Beth: 'I think women .. sort of intelligent women, well educated women, um professional women, they're in control of their lives anyway, in a big way, you know, in their career or at home or whatever. And so they .. that obviously runs over into what they expect when they're pregnant and during delivery and so on. But I think a lot of the women that we get are, you know, are perhaps young, they're perhaps unemployed and never had a job. They're, you know, sort of fairly socially deprived. Um and as result, you know, th .. they haven't been able to make demands in any areas of their life in the past. Um because, you know education sort of it hasn't been, you know perhaps hasn't been very good ... So they, you know their general expectations of their life and the quality of their life is less. And so that runs then on into when they're pregnant.'

Midwife Hannah: 'Changing Childbirth seems to be geared for the er professional people and the upper social classes that can choose what they want to a certain extent.'

Thus the same attribution of life experiences to control requirements, made in the previous subsection, was here related to class issues. Again the tendency to position women with expectations of control as unreasonable was also apparent. In the following portion of text Beth, like Jill in the last subsection, described women's control requirements as 'demands', but then quickly corrected herself:

Midwife Beth: 'I'm sure if I was working somewhere else ... where the women were different, predominantly white, middle-class, I suppose, um, you know they .. their demands would become um .. or their expectations would become um, they'd be able to voice them really.'

It is also interesting to note, in the portions of text cited above, that being middle-class is bracketed with being white and well-educated, whilst being working-class is associated with being young, poorly educated, unemployed and socially deprived. In subsection 1.4.2 (page 41ff) of the previous chapter, age at the birth of the first child, level of education and social-class were shown to be related issues in the research literature. However associations between social background and expectations of control in childbirth are, according to the research literature, questionable.

Five of the 6 midwives subscribed to these stereotypes to a greater or lesser extent, but one midwife's account stood out in contrast. Gaye, a community midwife, described a recent experience:

Midwife Gaye: 'Some people say that it's only um well educated women and .. and the middle classes or upper classes that are more in tune with their body. But I had an eighteen year old, who went two weeks overdue, she wanted a home confinement and they told her she should come in for induction. The night that she came in ... she started labour ... She's just picked her bag up and said, 'I'm going home now. I'm in labour, and I'm booked for a home delivery'. You see. I mean she wasn't a highly educated or middle-class women, you see. And I think if women are informed of what they can have, they're going to accept it better.'

On other occasions the midwives illustrated their accounts with descriptions of individual cases, but these were always used to confirm the stereotypes. Gaye's example was, on the face of it, different. However it is interesting to note that initially the woman was simply described as 'an eighteen year old'. It was only later that Gaye pointed out that she was not highly educated or middle-class. Once again, the assumed relationship between age, education and social class was made, and the description 'eighteen year old' was allowed to imply the other conditions. Moreover the point of the story, as the last line shows, was not so much that younger, working-class women can have expectations of control themselves, but rather that they can be 'informed' so that they can 'accept' control. Thus although Gaye presented an account which initially appeared contradictory to the others, on closer examination, it did not undermine the stereotypes, but confirmed the images. Working-class women might take control, but only after it is offered, in the guise of information.

In summary, the midwives supported the social-class stereotypes which are described in the research literature (Green, Kitzinger and Coupland, 1990). The one account which apparently contradicted these stereotypes, on closer examination, was found to support them.

2.3.3.3 ANTENATAL CLASSES

One of the ways in which pregnant women can gain the sort of information alluded to by Gaye in the last subsection is via antenatal classes. Although all the mothers positioned information as important they reported mixed feelings as to how helpful such classes had been:

Laura: 'Because I'd been to parentcraft classes I think I knew all the choices that I could have had.'

Anna: 'The antenatal sort of um, local health clinic, preparation for birth things were just such crap ... well, they described the .. the .. an epidural as an injection into your back. But, you know, I mean it's like a lot more than that ... It's like over protecting you, 'cos she thinks that's what .. you know you might worry otherwise. But it's terribly patronizing.'

The midwives' texts placed a different emphasis on information. Although they positioned working-class women as generally uninformed, this was not represented as a major drawback. Having the wrong kind of information, that is, the kind which gave the woman unrealistic expectations was described as the problem. Several of the midwives implied that such information was more likely to be obtained from non-medical sources, such as NCT (National Childbirth Trust) classes, or by the woman herself:

Midwife Jill: 'She'd looked up a whole load of research for herself. But where she had got it from, it was so radical, so biased. If she'd only come to me before and said, "Look, what do you think of it?", you could have gone through it with her ... But certainly I felt she had incredibly unrealistic expectations and didn't want this, that and the other, and did want this.'

In subsection 1.3.2.3 (page 34) of chapter 1 it was noted that research has shown that although antenatal classes can increase women's knowledge and confidence towards labour, they have little impact upon their actual experience. It can be assumed that the information gained from classes might be important for the very fact that it does give women confidence to know what might happen, rather than lead them to expect that certain things will happen. The midwives, however, in this context, spoke about information and expectations as if they were almost coterminous. According to their interviews, women who sought out high levels of information were likely, as a result, to develop unrealistic expectations of control over what they had and did not have during labour, and these expectations, as it will be seen in a later subsection, were represented as the inevitable precursor to dashed hopes and concomitant psychological problems.

In summary, antenatal classes were not implicated directly by either the mothers or the midwives in terms of any effects on control in childbirth. To the mothers they were represented as a potentially useful source of information, whilst the midwives expressed more general concerns about childbearing women who sought knowledge which led to unrealistic expectations.

2.3.3.4 FACETS OF CONTROL

Subsection 1.3.3.3 (page 37ff) of the previous chapter postulated several different aspects of control in childbirth. The possibility of a joint, or negotiated control was mentioned, and although this type of control is not one which has been discussed in the literature of childbirth control, the concept is supported by the findings from several pieces of research (Brewin and Bradley, 1982; Niven, 1994; Walker, Hall and Thomas, 1995). Laura described just such a negotiated control, with the midwives being in control at appropriate times, whilst leaving her to her own devices when required:

Laura: 'I think the midwives I had were good because they just sort of left us alone. They were only there when they had to be there. You know, but then when .. when I did need them, when I was pushing, I needed a bit of like shouting at, if you like, you know, to keep pushing. I think they were there at the right times, instead of at the wrong times.'

Similarly, Freya, who gave birth at home, described needing her midwife's control in the latter stages of labour, yet even at that point also positioned herself as in control:

*Freya: 'And then she (**midwife**) did take control then, in .. in a sense. I mean I felt I was in control. I felt incredibly powerful at that moment. But she was really, 'cos she was telling me to slow down and so on.'*

Concepts of internal and external control were also apparent in the mothers' interviews. In contrast to Freya's description of advanced labour, in the earlier stages, external control, being in control of what was happening to her and around her, was described as important:

Freya: 'I felt it was very much just, you know, me and Andrew and Nina. Um, and .. and mainly me telling people what to do, you know.'

Emma raised problems of self-control (internal control) much more than the other mothers:

Emma: 'Five minutes later I was screaming in agony, being like um really undignified, like hauled across the corridor ... and they got me into this bath and I was just screaming 'cos it was just so painful. And I just fe .. the whole thing felt so ridiculous, you know.'

Another type of control that was postulated in chapter 1 was physiological control: the woman's faith in her body to give birth unassisted. Of the 5 mothers, only Emma's transcript referred to such a control, in the context that she had not been able to achieve it, largely because of the intensity of the pain. Emma also felt that her personality made 'letting go', and going with the flow of the labour, difficult:

Emma: 'I think I'm quite a shy person anyway and to be in that situation where ... you have to lose control a bit ... You've got to let go and .. and um go with it. But at the same time you're embarrassed.'

In summary, the mothers' texts indicate that different aspects of control are positioned as important both by different women, and at different stages of labour.

2.3.4 Second question - How control issues are dealt with by childbearing women and midwives

2.3.4.1 INFORMATION AND UNDERSTANDING

In the subsections above it became apparent that the midwives subscribed to a different set of themes around the subject of information giving than did the childbearing women. The mothers' talk centred upon such issues as whether the information they were given was adequate, and how the knowledge derived from past life experiences motivated them to seek certain elements of control during labour and birth. The midwives' texts positioned information, if obtained from a non-medical source, as something with the potential to raise unrealistic expectations of control, whilst past experiences might lead women to 'react' and to make 'demands'. It was shown that the midwives' representations were closely bound up with stereotypes, identified elsewhere in the research literature, of middle-class, well-educated women who held high and possibly unrealistic expectations of labour and birth, against working-class, young, uneducated women who were uninformed and who had few, if any, expectations for childbirth.

However the midwives did not represent all information giving as potentially problematic. Just as non-medical information was implicated as a source of unrealistic expectations, so midwives represented themselves as a source of 'correct' information:

Midwife Beth: 'Our training has allowed us to .. to give the correct advice, and the correct information on .. on normal labours and stuff.'

This midwife-information was, in contrast to the information supplied by NCT classes or obtained by the woman herself, represented as eminently reasonable, able to facilitate the childbearing woman in taking a safe level of control:

Midwife Debra: 'If the woman says to you um, "I want to deliver this baby in water", and they've got late decelerations etcetera, if they are aware of the problems, then they will probably make their own decision not to go into the water.'

The illustration used by Debra appears straightforward. If there were signs of fetal distress (late decelerations), she could legitimately suggest to the labouring woman that her baby would be safer in a situation where it could be constantly monitored, and where emergency action could be taken if necessary, neither measure being practical in water. However a problem arose when the midwives spoke of their handling of situations in which the dangers were not clear cut, but in which they held personal doubts:

Midwife Cassie: 'I'm not going to go into the um birthing pool with the mother because I don't want to be accountable for whatever happens to the baby, you know ... I'm not sure I'd be happy (.) to deliver a live baby in the bath. But um if she insists, "That's what I want to do", God help me (laughs). I don't know. Really.'

Cassie's problem was the she did not, personally, feel that waterbirths were safe, despite working on a Unit with a policy which said that they were. Since the recommendations of the Changing Childbirth Report (Department of Health, 1993) have begun to be implemented, carers are meant to give women all the available options, and in theory at least, after the correct training, Cassie should have been willing to conduct a waterbirth for any client who asked for it. However, initially Cassie reported categorically that she was not willing to allow a water birth, and then she modified her position to some extent, by saying that she did not know what she would do if the woman insisted. It is easy to imagine how she might, consciously or otherwise, put pressure on the woman to concede to a birth on 'dry land', and her use of the word 'insist' suggests that it would only be a very determined woman who would get the waterbirth she wanted. The communication techniques which midwives can use to ensure a client's acquiescence have already been discussed in section 1.4.4.2 (page 49) of chapter 1.

Herein lies a problem with the 'reasonable' information supplied by midwives. Like the women they cared for, they too may have had past experiences which coloured their personal views of childbirth. However unlike childbearing women, professionally, they were not meant to use such experiences in ways which might restrict the control of the women for whom they cared. However it was evident from some of the midwives' texts that such restrictions did occur, and that, in its own way, the information midwives gave could be as 'unrealistic' as that obtained from non-medical sources.

As already shown in Anna's text on page 84, the mothers were aware of sometimes being given limited information. Take, also, Freya's experience at the antenatal booking clinic:

Freya: 'And then um at the end I said, they just booked me in at the hospital, and I said, "Actually, I don't want to come to the hospital", and it was, "Oh! Oh, right. Oh right, well we do have a birth .. home birth unit". But they weren't going to say, "These are your options, what would you like to do?"'

However although information was a high priority for the mothers, it was not the only issue of importance as far as their interaction with the midwives went. To be understood was also represented as a necessary element in feeling in control:

Anna: 'I wondered why she wanted to be a Community Midwife really, 'cos she came in and was sort of, quite sort of pat .. well not patronizing but (.), well assuming I knew nothing ... I felt she should come in and sort of (.), well not assess me, but do you know what I mean, get some sense of where I was at.'

When the midwives spoke of information giving they spoke about helping the woman to understand them much more than about their trying to understand the woman:

Midwife Debra: 'I always say to them, "I'll give you as much information as I know, and then you can make decisions as well as I can, and we can work together".'

Midwife Gaye: 'But I always say to them, "You have to know what I'm going to do, because it's your body I'm doing it to", you see. And some women are very scared if you say to them, "I'm going to break your waters", and say, "Is it going to hurt?". And I say, "No, it won't hurt, but I'm doing it to your body, so you need to know what I'm going to do".'

It is interesting that both these pieces of text begin with the phrase, 'I always say to them'. Other midwives used this phrase too, implying a set pattern or approach to their clients which, although they positioned themselves as informative, suggested that the individual needs of their clients might be of limited importance.

In summary, the midwives represented themselves as being a source of realistic information to childbearing women, despite the suggestion in their interviews that the information they gave might reflect their own biases. Moreover their emphasis was on the dissemination of information, whilst the mothers also spoke of a requirement for understanding.

2.3.4.2 BIRTH PLANS

Another area of difference between the midwives' and the mothers' representations of control was the writing of birth plans. Beth, one of the midwives, alluded once again to the type of woman who held unrealistic expectations of childbirth, and who expressed these in her plan:

Midwife Beth: 'Again it's the .. it's a certain type of woman generally that fills that in and adds, you know, sheets. And we have, you know, big pages of A4 to read through. And obviously we go along as .. as far as we can within the constraints of policies and procedures and safety, along with their wishes.'

Interestingly, however, Anna's account suggested that, rather than it being high and very specific expectations that spurred her to write a long birth plan, it was the opposite, the unpredictability of labour and birth and her desire to be flexible, to take into account every eventuality:

Anna: 'Oh, the birth plans. We had thought about what would happen if, you know, I had a caesarian or I .. if we needed assistance, whatever.'

On the contrary, Emma who had written a short ('sensible', according to the midwife) birth plan, found that events rapidly moved too far away from the contingencies she had considered for it to be of any use:

*Emma: 'The first midwife, she read it (**birth plan**) and she said, "Oh this is very good" (**laughs**), "Yeah, it's quite sensible". But ... even after an hour I was in pain and .. and after another hour I was in even more pain and I .. and it just was so far from the birth plan by that point anyway ... in the end it um it doesn't really help.'*

Therefore it can be seen that, as a mechanism to give women control, birth plans were positioned as very limited unless labour and delivery were straightforward, or unless the woman wrote a long plan that covered every eventuality. What was less clear was why midwives viewed long birth plans with so much suspicion¹⁷. It is possible that there are two types of long birth plan, the very demanding, in which the woman lists many requirements and the very detailed in which she tries to make plans to cover anything that might happen. It is also possible that the long birth plan is threatening to midwives who are busy and may have little time to read through it all to find the part which appertains to the woman's current situation. It is also possible that midwives might find it harder to envisage women having control when complications arise, and are unhappy about birth plans which attempt control under all circumstances.

In summary, as instruments of control, birth plans can be positioned very differently by childbearing women and by their midwives.

2.3.5 Third question - The psychological benefits and disadvantages of control or its lack

In the majority of the research studies, described in the last chapter, in which women's expectations and experiences of childbirth were compared (subsection 1.4.3, page 46), the two issues were found to be positively correlated. In section 1.4.5.2 (page 54) it was argued that most of the studies which showed that a differential between expectations and experiences of childbirth was related to postnatal psychological sequelae were flawed. Despite this, some of the midwives¹⁸ interviewed for this study positioned women with high expectations of control over the birth as doomed, not only to dashed hopes, but also to resultant psychological problems:

Midwife Beth: 'I suppose the ones that are wanting a natural childbirth with as little intervention and as little pain relief as possible. Um and really wanting that and really believing that they can achieve that. And if they don't and they can't, which obviously happens quite often um then they must feel, you know, they must feel quite bad about it ... it's the problems that they have with it afterwards, rather than the problems that we have ... And we don't get feedback from that, you see. So I don't know. I don't know how they .. you know, the community midwives only see them for ten days.'

Midwife Jill: 'I think there's quite a strong onus on us as midwives to educate women properly ... Certainly to ensure that their expectations are realistic. Um 'cos certainly, picking up the pieces afterwards, when people have had very unrealistic expectations, not only of the birth experience, but also of parenting ...'

The implication in both of these texts is that psychological problems do result from unrealized expectations. Beth spoke of women 'feeling bad', whilst Jill referred to 'picking up the pieces'. However the texts also indicated that such problems were likely to be long lasting. Beth's text suggested that they might occur after the final visit of the community midwife at 10 days postnatally, thus depriving the hospital midwives of feedback as to how the woman had fared. Jill implied that the

¹⁷ Green, Coupland and Kitzinger (1988) also discuss midwives' negative stereotyping of childbearing women who write long lists of their requirements for labour and birth.

¹⁸ The remaining midwives did not raise these issues.

effects of unrealistic expectations for the birth and parenthood might be cumulative, thus suggesting that they could still be in evidence when parenting was quite well established.

All of the mothers described a failure to achieve their expectations at some point in their pregnancy or labour. Amongst many other surprises, Mary described finding both the length of each stage of labour and the location of the pain quite different to what she had imagined:

Mary: 'I really thought that um .. See when I actually went into labour I never had any pains in my tummy. At all. All the pain I had was in me back ... And I don't ever think that I really understood quite how long each stage might be ... But I really really thought that I would have like tummy pains. And like I say, I never, ever had, ever had a pain in my tummy.'

Some of the mothers did describe reactions to finding childbirth different to their expectations:

Emma: 'It was a .. a very big shock, because I did expect it to be so easy.'

Freya: 'But it all got very serious suddenly at about eleven ... I suddenly was in a real panic actually ... I think I'd been, I think the expression is 'in denial' for a long time that ... it was going to be OK and it was going to be very easy. And suddenly it wasn't easy, and it was very painful.'

Generally such negative reactions were positioned as short-term. As seen here, Freya spoke of panic, and Emma of shock, and later she described feeling both terrified and angry. Long-term negative effects were less evident from the mothers' texts. In fact Freya and Anna spoke of predominantly positive long-term effects from their experience:

Freya: 'I suppose the thing is ... having a very positive experience, you do feel you're sort of slightly invincible.'

Anna: 'I don't feel put off by it at all. I'd want to kind of do it again ... Once you've done it, you just think, "Well no, I could enjoy it more, I could, you know kind of refine it a bit the second time".'

It was only Emma who spoke of any long-term negative effects: a growing suspicion that her labour could have been managed differently, and fear of future childbirth, although she denied ever feeling depressed about what had happened.

In summary, the midwives subscribed to the stereotypes reported elsewhere in the research literature (see subsection 1.3.2.2, page 31), that women with high expectations of the birth were likely to find these dashed. Moreover some of the midwives implied that the psychological effects of such dashed expectations were likely to last well into the postnatal period. The mothers, however, although they all experienced some disappointments, described mainly short-term negative effects. Only one woman spoke of longer-term negative consequences.

2.4 Discussion

2.4.1 First research question

The first research question asked what control in childbirth might mean to different women. In this study it was shown that one of the ways in which women differed was in the experiences that they took

with them into labour and birth. Some of the women positioned these experiences as significantly influential in their plans for the birth: such plans being represented as carefully thought out and rational. Not all the mothers talked about such formative experiences, however, and there is a need to explore just how significant a place such issues do take in childbearing women's plans and expectations for the birth. This is doubly important because of the different emphasis put on such experiences by some of the midwives in this study. Although these midwives represented childbearing women's embodied experiences as influential upon their choices for labour and birth¹⁹, they coloured the effects much more negatively, implying that such influences were unhealthy, resulting in childbearing women making 'demands' or having 'reactions'.

As it was explained, it was not possible, in the interviews with the mothers, to explore the possible relevance of such issues as age, education and social background upon their expectations and experiences of control in childbirth. However, the midwives did make such associations. These mirrored the stereotypes described in the research literature and formed part of a large, recurring theme, that of middle-class, well-educated women, highly informed about labour and birth, and their 'rights', holding high expectations for the birth. Such women were also represented as doomed to disappointment and consequent psychological problems. This representation was set against that of working-class, young, poorly educated women, uninformed about the processes of childbirth, with low expectations, who were therefore less likely to be disappointed. All the midwives interviewed in this study subscribed to these images to a greater or lesser extent. To be uninformed was represented as less of a problem than to know 'too much'. Notwithstanding this, all the mothers in this study positioned themselves as needing information, and antenatal classes were judged according to the amount they supplied.

That the midwives were still subscribing to negative stereotypes that have been, to a large extent, discredited in the research literature (as discussed in the previous chapter), warranted further exploration of the issues in the main research studies. Moreover, because midwives identified social class as an underlying factor in women's expectations of childbirth, it became clear that it would not be helpful to consider expectations of control alongside demographic and background variables. It would be more appropriate for the effect of expectations upon experiences to be separated out and considered in a separate research question when the other issues had been taken into account. The importance of considering the effect of background and demographic variables, upon both expectations and experiences of control in childbirth also became apparent.

¹⁹ In the interviews both expectations for the birth and experiences tended to be discussed in more general terms rather than specifically applied to issues of control. However, control issues were frequently implicit in what was being discussed. For example, expectations were related to the things that childbearing women wanted or did not want to happen, and therefore whether such expectations were realized or not tended to be a matter of whether the woman was able to have control: to get what she wanted. Because control issues formed an integral, if often unspoken, part of the talk around expectations and experiences, conclusions drawn from the more general issues are transferable to the more specifically control related issues dealt with in the main research studies.

Another set of issues raised in the literature review of the last chapter which were present but less clearly defined in the texts and analysis discussed above, were the material events of labour and birth, for example, the way different interventions might be discursively represented by different women. These issues will be addressed in more depth in the main interview study.

2.4.2 Second research question

The second research question asked whether there were differences in the ways in which midwives and childbearing women evaluated issues around control in childbirth. That there were differences became apparent in the ways in which the effects of past experience on women's expectations were represented in the last subsection. There were also differences in the ways in which the mothers and the midwives spoke about the importance of information about labour and birth. Midwives positioned themselves as a source of 'correct' information, although there was evidence that, under certain circumstances, such information might be biased. They also expressed fears about information from non-medical sources which might cause women to develop unrealistic expectations. The mothers' talk around the issue centered on their requirements for high levels of information prior to the birth and for being understood by the midwives who cared for them: something to which the midwives attached less importance. The material practice of writing long birth plans was also interpreted differently by mothers and midwives. One mother represented the long plan as an attempt to be reasonable, to make allowances for the possibility that things might go wrong. Midwives, however, spoke of women who wrote long plans in the context of those with unrealistic expectations, who wanted control over even the minutiae of their labour and birth.

Such differing interpretations indicate that control itself was also being represented differently by the two groups of women. For the midwives the connotations were generally negative, bound up, for example, with talk about the wrong sort of information leading to unrealistic expectations. However for the mothers there were positive undertones: control was the outcome of a following through of their thoughts and feelings, supported by the information they had obtained. It seems reasonable to ask whether such differing representations are underpinned by the same material and discursive issues or whether both the midwives and the mothers were talking about something different when they referred to control. Therefore the pertinent questions to take into the main studies were firstly whether a childbearing woman who positioned herself as having high, or low, expectations of control, would be thus positioned by her midwife. Secondly it was important to ask whether midwives recognized whether individual childbearing women had positioned themselves as having achieved a certain level of control or not. Thirdly, because of the midwives' references to unrealistic expectations and dashed hopes, it was also valuable to ask whether midwives recognized when a childbearing woman positioned herself as satisfied with her experience.

2.4.3 Third research question

Another difference in the representations of the mothers and the midwives was around the issue of whether any psychological effects of unrealized expectations were in the short-term or the longer-term.

This was related to the third research question concerning the psychological concomitants of control in childbirth or its lack. Some of the midwives positioned psychological sequelae as something lasting beyond when women left their postnatal care, whilst the mothers, on the whole, represented any problems as short-term: shock or panic around the time of birth, for example. Moreover, the one mother who positioned herself as somewhat traumatized from the experience of birth, denied feeling depressed. Thus, as well as a need to consider psychological outcome measures around the time of birth and considerably later, there was also a need, already discussed in the previous chapter, to examine a range of possible psychological effects of control in childbirth or its lack. The importance of taking antenatal baseline measures of mood into account in such evaluations was also considered in chapter 1 (subsection 1.4.5.2, page 54).

2.4.4 General issues

In section 1.5.4 (page 67ff) of chapter 1, an argument was propounded for the use of both qualitative and quantitative research to explore the issue of control in childbirth. It was at the end of this pilot study, in the light of the findings, that the soundness of this argument could be reconsidered, and the format and programme for the main studies finalized.

To follow a pilot study such as this with another interview study risked the possible danger of simply replicating the themes uncovered here. A more useful next step, it seemed, was to firstly study the issues using questionnaires with a much larger group of childbearing women: such a study lending itself to quantitative techniques and analysis. This would allow the relevance of variables such as social class and age, issues which could not be addressed in the pilot study, to be explored, and for relationships between constructs, such as control and mood-state, to be examined more formally.

Nevertheless this pilot study confirmed the value of interview data in fleshing out somewhat simplistic assumptions: highlighting their complexities and the contradictory positions sometimes taken by individuals. An interview-based main study, using its findings to explore and fill in some of the questions which it would not be possible to address in the quantitative study, still appeared to be an appropriate second study for the main phase of the research.

It is important, however, to stress that, although the two proposed studies were intended to complement each other in terms of the information they provided, it was not assumed that the findings from one would necessarily be supportive of the other. As described in subsection 1.5.5.2 (page 71) the use of multiple methods should not be employed to try to create an illusion of objectivity - hence the avoidance of the label 'triangulation' for the approach taken in this thesis. Moreover, as noted by Pilgrim and Rogers (1997) and Ussher (1997), social science research which deals with the complexity and fluidity of human behaviour can only describe and explain, not predict²⁰. The overriding objective of the two studies which follow was a deeper understanding of the issues around control in childbirth, not the determination of causal factors.

²⁰ Unlike research within the closed systems of the natural sciences which can do all three.

One major drawback to this retrospective pilot study was that the mothers' representations of antenatal and intrapartum events might have been coloured by subsequent events and opportunities to talk and think about their experiences (Jacoby and Cartwright, 1990). As described in subsection 1.5.4 (page 69), for the main research studies a prospective approach was chosen, making it possible to explore both antenatal, and early and later postnatal data.

2.5 Conclusion

In the light of this pilot study the research questions for the main study were defined as follows:

1. Do certain demographic and background variables such as education, social class, age, and general control expectations, relate to women's expectations and experiences of control in childbirth; and are features of the birth, such as its difficulty, pertinent in terms of women's experiences of control?
2. How do childbearing women construct childbirth control both before and after the birth? In other words, what is the relationship between their reported expectations and experiences?
3. Are there differences between the woman's and the midwife's configuration of how much control a certain woman has expected and achieved, or of how satisfied she is with her experience?
4. Does the level of childbirth control which women claim to a) expect and b) achieve appear to have any bearing on their short and long term psychological well-being?

These questions will be addressed in the longitudinal questionnaire study described in the next chapter.

Chapter 3

Exploring the issues 1: questionnaire study

3.1 Introduction

3.1.1 The research approach

In the pilot study it was argued that the most useful first step in the main research would be to address the research questions which were raised with a larger group of childbearing women and midwives. A quantitative analysis using data from postal questionnaires was, therefore, selected as a suitable approach. Previous studies have demonstrated that it is possible, in this way, to elicit the help of childbearing or postnatal women from a wide range of social backgrounds (for example, Morgan, Bulpitt, Clifton, & Lewis, 1984; Green, Coupland and Kitzinger, 1988). To fulfill the requirement for a prospective approach (chapter 2, subsection 2.4.4, page 94), a longitudinal research study was designed, involving both antenatal and postnatal contact with childbearing women.

In chapter 1 (subsection 1.5.3, page 66) it was recognized that embodied experience cannot be separated from its discursive representation. Therefore the participants' responses in the following study were positioned as reports, or constructions, which provided a semblance of the woman's experiences, rather than as evidence of some immutable set of truths.

3.1.2 Timing

In a prospective study on expectations and experiences of childbirth, Green, Coupland and Kitzinger (1988) favoured collecting women's antenatal views at 36 weeks gestation, in recognition that women's attitudes and expectations can be expected to change as the pregnancy progresses and as women gain more information about what the birth entails. They calculated that this was as late in the pregnancy that it was safe to leave data collection without running the risk that a large number of women would have given birth before they could be contacted.

If the assessments of the birth made by childbearing women and their midwives were to be compared, each woman's midwife also had to be approached. It seemed that the only practical time to obtain this

assessment without running the risk of the midwives having forgotten the details of the case, was immediately after the birth.

To compare early and later postnatal effects of control in childbirth or its lack, two postnatal assessments were required from the new mothers. In view of the desire to compare the midwives' constructions of control with those of the women, it was felt important to obtain as early a first assessment of women's descriptions of their actual experiences as possible, to enable a reasonable comparison to be made. Because of the logistical problems of finding out when each woman had given birth and then making contact with her, the earliest date at which it was likely that the majority of the women could be contacted was 1 week postnatally. It was also hoped that, at that this stage, some of the initial exhaustion after the birth would have abated and that the women would be able to find the time to complete the questionnaire. One problem with the second assessment would therefore be administering the questionnaire long enough after the first one to preclude the woman being unduly influenced by her memories of what she had written or said on the previous occasion. A second requirement was to allow the woman time after her delivery experience to become more used to motherhood and to be able to differentiate between feelings towards having her new baby and towards the birth experience itself. Séguin, Therrien, Champagne and Larouche (1989) suggest that within 4 to 7 months postnatally is a suitable period for women to be able to distinguish between these two issues, although Cartwright (1979) found that women contacted 3 to 5 months after delivery were often unable to recall all the details of their labour and deliveries. This, however, is challenged by more recent research (Simkin, 1992), which shows that women can have accurate memories of their birth experience as long as 20 years after the event, and that any memory lapses are generally minor, whilst the work of Bennett (1985) shows accuracy of memory after 2 years. A final influencing factor was that one of the required measures would be reports of antenatal and postnatal dysphoria, so that this could be related to the women's reported expectations and experiences of control. Cooper, Campbell, Day, Kennerley and Bond (1988) suggest that the majority of cases of postnatal non-psychotic psychiatric disorder arise in the first three months after the birth²¹, and that rates of disorder are similar at 3 and 6 months postpartum. This suggests that an assessment of postnatal mood between these times is most likely to identify the maximum number of women with postnatal psychological disturbances. On balance therefore, it was decided that the second postnatal assessment should be made at 16 weeks postnatally, the lower of the parameters suggested by Séguin et al.. For the practical consideration of completing the research within its allotted time, this was also as late a follow-up as it was reasonable to make.

²¹ As described in chapter 1, it has been suggested that depression is as prevalent before the birth as afterwards. Green and Murray (1994) observe that some cases of antenatal depression resolve by the postnatal period whilst others continue, and new postnatal cases arise.

3.2 Method

3.2.1 Design

The purpose of the study was to examine the demographic features, psychological wellbeing, generalized control expectancies, and labour and birth control expectations of a group of expectant women, and to compare these with the women's control experiences and psychological wellbeing in both the early and later postnatal period. The study also set out to compare assessments of the woman's control made by her midwife with her own. A longitudinal design was used, consisting of four postal contacts with each childbearing woman, and one contact with her midwife via the woman herself. The first contact with the childbearing woman was for recruitment purposes. Self-administered questionnaires were then completed by the childbearing women at 36 weeks antenatally and 1 and 16 weeks postnatally. The midwife's questionnaire was also self-administered and was completed as part of her routine paperwork, immediately after the woman had given birth.

3.2.2 Measures

3.2.2.1 DEMOGRAPHIC AND BACKGROUND INFORMATION

The antenatal questionnaire requested certain demographic information, such as the women's age, employment status and ethnic background. An indicator of social class was also required. As described in the literature review (subsection 1.4.2.1, page 42), although there are problems with all methods of assessment of social class, education is a better measure of individual social position than others (Carr-Hill and Pritchard, 1992). Therefore the women were asked for the highest educational qualification they had achieved. This question was chosen over asking for the age of finishing full-time education to avoid problems with women who had returned to education after they had left school, or who had gained further qualifications on a part-time basis after they had begun full-time work. The sample was then divided into three categories: those who had gained the minimum educational qualifications (i.e. GCSE or equivalent) or none at all; those who had attained qualifications equivalent to 'A' levels; and those who had been educated to degree level or equivalent and beyond. The women were also asked whether they had attended antenatal education classes at the time of completing the questionnaire.

3.2.2.2 LOCUS OF CONTROL

As described in the last chapter, some childbearing women described control-related experiences from their lives which influenced their expectations for control in childbirth. Levenson's Multidimensional Locus of Control Scale was selected as an approximation for women's representations of their control in everyday life (Levenson, 1974). This scale purports to measure the extent to which people believe they exercise control over their lives (internal locus of control), or the degree to which they feel their destinies are beyond their own control and are determined by either fate and chance, or by powerful other people (external locus of control). Responses are measured on a six point Likert scale, according to how much the respondent agrees or disagrees with each of the statements. It can be self administered

and consists of 24 items. These items are reproduced in appendix 3.1. Eight relate to each dimension (internal control, external-chance, external-powerful others). The scale has been shown to have concurrent, construct and discriminant validity, a test-retest reliability of .62 - .91, and a split-half reliability of .62 - .64 (Furnham and Steele, 1993). This scale was administered to the respondents once, in the antenatal questionnaire.

3.2.2.3 DEPRESSION AND MOOD

Mood state was measured using both the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden and Sagovsky, 1987) and the Profile of Mood States (POMS) (McNair, Lorr and Droppleman, 1992). The EPDS has been validated against clinical diagnosis of depression amongst both antenatal and postnatal women (Green and Murray, 1994). It is a self-report check list, which asks women to select one of 4 responses to each of 10 short statements, to indicate their feelings over the preceding week. The EPDS is reproduced in appendix 3.2. The split-half reliability is 0.88 and the standardized alpha coefficient 0.87 (Cox, 1994). Cox warns that the EPDS is not a measure of general psychiatric morbidity, that it will not, amongst other things, detect anxiety states. Because the EPDS items would encourage respondents to think about their emotional wellbeing, a statement was inserted at the end of the scale reminding the participants of the sources of help available to them should they be feeling depressed or unhappy.

The POMS was designed to identify and assess transient, fluctuating affective states. It was selected for use in this study as a measure which could be utilized to explore a wider range of affective states than just postnatal depression. The POMS consists of 65 five-point adjective rating scales, designed to measure six identifiable mood or affective states: Tension-Anxiety, Depression-Dejection, Anger-Hostility, Vigour-Activity, Fatigue-Inertia, and Confusion-Bewilderment. Respondents are asked to report how much they feel that each of the adjectives has applied to themselves over the past week. The POMS adjectives are reproduced in appendix 3.3. The scores on the six mood subscales can be combined to produce a Total Mood Disturbance Score (TMD). Again, the POMS can be self-administered. The alpha reliabilities for an adult normative sample (n=2,360) ranged from .83 on the Confusion-Bewilderment scale for males to .93 on both the Depression-Dejection and the Fatigue-Inertia scales for females. The POMS scales also correlate well with instruments designed to measure similar constructs to those represented by each of the sub-scales (McNair, Lorr and Droppleman, 1992). Both the POMS and the EPDS were included in all three of the questionnaires.

3.2.2.4 LABOUR AGENCY

Expectations and experiences of control during childbirth were measured primarily using the Labour Agency Scale (LAS) (Hodnett and Simmons-Tropea, 1987). This scale was designed to assess women's perceptions of personal control in childbirth both in terms of their control of themselves and of their environment. It can be used to assess what women expect before the birth and what they feel they have experienced afterwards. The LAS is a self-administered 29 item summated rating scale, each item being rated on a scale of 1 to 7, according to how often the woman felt or expects to feel in

accordance with the item, making a range of possible scores between 29 and 203. Low scores indicate a woman's low expectancies/ experiences of control over herself or her environment during the labour and birth whilst high scores indicate high expectancies and experiences. The LAS exists in two versions, to enable it to be administered on subsequent occasions without the confounding effects of the influence of memory. The items from both versions of the LAS are reproduced in appendix 3.4. An unweighted least-squares factor analysis indicates that both versions of the LAS are unifactorial, the one factor model explaining 73.7% of the variance of the antepartum version, and 79.7% of the variance of the postpartum version. Cronbach's alpha reliability coefficients have ranged from .91 to .98 (Hodnett, 1989). The LAS was also included in all three of the questionnaires.

The LAS is designed to assess expectations of control, but the antenatal questionnaire also contained two questions, asking women about wanted control: how much control over themselves they wanted (internal control), and how much control they wanted over what was done to them in labour (external control). In both cases the question was reinforced by the comment, 'This is what you would like, not necessarily what you expect to get'. The women were given 5 point scales ranging from 'no control' through 'a moderate amount of control' to 'complete control' for their responses. Also because, despite its claims, the LAS questions appeared to concentrate more on women's feelings of self-control (internal control), the antenatal questionnaire contained a similar question asking the women how much external control they expected.

In the two postnatal questionnaires the women were asked to assess how much internal and external control they felt they had experienced during the labour and birth, and how much of both types of control they felt they had compared with other women. These questions used a 7-point scale, because they were included with the 7-point perceptions of labour questions described below (table 3.2, page 100).

3.2.2.5 ASSESSMENT OF LABOUR

The 2 postnatal questionnaires also listed 26 of the most common childbirth interventions, and aspects over which a woman might expect to have some control. These interventions are shown in table 3.1.

Table 3.1 Interventions and areas of control assessed in postnatal questionnaires

1. Prostin induction	13. TENS analgesia
2. Artificial rupture of the membranes to induce labour	14. Epidural analgesia
3. Artificial rupture of the membranes to accelerate labour	15. Choice of position in which to give birth
4. Intravenous infusion to induce labour	16. Ventouse delivery
5. Intravenous infusion to accelerate labour	17. Forceps delivery
6. Vaginal examinations	18. Episiotomy
7. Intermittent cardiotocograph monitoring	19. Sutures (excluding those for a caesarean section)
8. Continuous cardiotocograph monitoring	20. Elective caesarean section
9. Use of pool for part or all of labour but not delivery	21. Emergency caesarean section
10. Use of pool for delivery	22. Caesarean section under general anaesthetic
11. Pethidine or Meptid analgesia	23. Caesarean section under epidural anaesthetic
12. Entonox analgesia	24. A general anaesthetic for any other reason
	25. Vaginal breech delivery
	26. Syntometrine

The women were asked to indicate which of the situations they had experienced, and then for these items they were asked to indicate, on a 5 point scale, how much control they felt they had over whether or not they experienced that particular treatment. Thus it would be possible to gain an indication of the type of labour any women had experienced and of her construction of how much control she had exercised in individual situations. The women were also, in each postnatal questionnaire, asked to answer 7 questions assessing their experience of labour. These questions were adapted from those used by Hofmeyr, Nikodem, Wolman, Chalmers and Kramer (1991), in a study of the effects of companionship on women's perceptions of labour. As the general pattern of the questionnaires was the use of Likert-type scales, the women were asked to respond to these questions on a 7-point scale. These questions are reproduced in table 3.2.

Table 3.2 Questions about woman's perceptions of labour

1. How difficult was it?	Not at all _ _ _ _ _ Extremely difficult
2. How do you feel you coped?	Extremely well _ _ _ _ _ Not at all
3. How painful was it?	Extremely _ _ _ _ _ Not at all
4. Did you feel anxious/ tense?	Not at all _ _ _ _ _ Extremely anxious/tense
5. Did you feel distressed?	Not at all _ _ _ _ _ Extremely distressed
6. Was your labour better or worse than expected?	Much better _ _ _ _ _ Much worse
7. Overall was labour a positive or negative experience?	Very positive _ _ _ _ _ Very negative

The women were also, in the 1 week postnatal questionnaire only, asked to give yes/no answers to whether they had previously met the midwife who cared for them in labour, and whether they had the same midwife throughout the birth. Finally, they were asked, in both postnatal questionnaires, how fulfilling an experience they had found the birth, how satisfied they were with it, and their satisfaction with the overall care they had received from the midwife who had delivered their baby or who had cared for them around the time of birth. The format for the questions about fulfillment and satisfaction with the birth experience were taken from Green, Coupland and Kitinger (1988). The women were given three options in terms of whether they had felt fulfilled: yes, no, and not sure. Satisfaction with the birth was assessed on a scale of 0 to 10, with a score of 0 indicating a thoroughly unsatisfactory experience, and 10 indicating an experience that could not have been better. The question about satisfaction with the midwife's care used a similar format.

3.2.2.6 MIDWIVES' QUESTIONNAIRE

The midwives' questionnaire was to be completed by the midwife who either delivered the woman's baby or who, in the case of a doctor's delivery, gave the bulk of the intrapartum care. It consisted of three questions, each of which asked the midwives to rate their answer on a scale of 0 to 10. These questions asked how much control over what was done to her the midwife felt the woman had expected, how much control the midwife felt the woman had achieved, and how satisfied she felt the

woman was with the experience of labour and birth. In each case the higher the score, the more positive the midwife believed the woman's experience to be. In other words, a high score indicated that the women had expected or achieved a high level of control, or that she was highly satisfied with her experience. (See appendix 3.5).

3.2.3 Questionnaire development

Permission to use the various rating scales was obtained from the appropriate authors and copyright holders. The three questionnaires were made up into A4 sized booklets, whilst the midwife's questionnaire was printed on coloured paper, in A5 format, that is, by folding a sheet of A4 paper into two. Thus instructions could be printed on one side of the paper, with questions and space for comments on the other. The questionnaire was the right size to fit into the woman's notes, which she carried herself.

The questionnaires were discussed at length with the midwives and consultants of the hospital where they were to be used. Minor changes were made as a result, for example, allowing space on the midwives' questionnaires for comments. Hospital ethics committee approval was sought, and obtained, after additional supervision for the project was elicited from one of the consultant obstetricians at the hospital. Each general practitioner who had antenatal patients, and who might therefore have clients involved in the study, was written to and asked to respond if they did not want their patients included. Two GPs responded and asked for their patients to be omitted from the study, one without giving a reason, and the other because the health visitors in his practice used the EPDS as a screening tool, and felt that its administration in the antenatal period and at 1 week postnatally might influence the results they obtained when they administered it at 6 weeks postnatally. Two more GPs wrote giving positive support for the project.

Volunteers for the pilot phase of the study were recruited from the hospital antenatal clinics. 20 primiparous women were asked, at around 36 weeks gestation, to complete the antenatal questionnaire and to make comments about anything they felt was ambiguous or that they were unhappy about. These women were also sent the first postnatal questionnaire after they had given birth. The midwives of these women were not asked to complete a questionnaire as these had already been discussed at length in the meetings described above. Neither was the 16 week postnatal questionnaire administered to the women in the pilot study as it was almost identical to the 1 week questionnaire. As a result of this pilot study, a few minor changes were made to the wording of questions. No major alterations were required.

3.2.4 Sampling and recruitment

The participants were primiparous women: those experiencing a first birth, although not necessarily a first pregnancy²². These women were all patients of general practitioners within the catchment area of

²² In other words, some of the participants may have experienced spontaneous or therapeutic abortions of previous pregnancies.

a non-teaching NHS Trust general hospital in East Anglia, with a maternity unit which delivered around 2,000 babies per annum. The hospital was situated in a semi-rural area, covering three small towns and numerous villages of varying size. The main employment was light industry, agriculture, the armed forces and service industries. The area was also considered part of the commuter belt for those employed in London. The population was predominantly white, covering a wide social spectrum.

It was largely for convenience that women from one geographical area were recruited. This increased the likelihood that they would all give birth in the same hospital²³. It was felt that there could be disadvantages in this approach: for example, that this particular maternity unit may have a certain ethos which might affect the care of all women giving birth there (Green, Kitzinger and Coupland, 1994), making their experiences somehow different to those of women in other units. However such a constant, if it did exist, might equally be considered an advantage, obviating the need to consider the unit of delivery as a separate variable.

Permission was obtained to recruit pregnant women via their community midwives. It was thus hoped to avoid some of the problems reported in other studies where women who had miscarried or lost babies were inadvertently contacted. It was felt that as, in this geographical area, the community midwives tended to have frequent contact with their clients, they would be likely to know about such misfortunes. Letters were written to all the hospital and community midwives, informing them of the study and the part they might be asked to play. A poster was made for the delivery suite to remind staff about the study, and a folder was placed in a prominent place for the deposit of completed midwife's questionnaires. Key contacts were also established amongst the midwives: individuals who knew about the study in detail and who agreed to deal with any questions from the staff in the absence of the researcher.

The names and addresses of primiparous women were obtained from their community midwives via telephone contact. The women were contacted by letter at around 34 weeks gestation, detailing the study, and asking them to consider taking part. Two copies of the consent form required by the Ethics Committee were also enclosed, with the details of the study printed on the back: one for the women to sign and return should she be willing to take part, and one for her to keep. The women were also asked to complete a small proforma confirming their correct address and expected date of delivery, as these details, as obtained from the community midwives, were sometimes not fully accurate. The women were forewarned that they would be asked, at the end of the first questionnaire, whether they wanted to take part in the interview study. They were assured that they could refuse and that their help with the questionnaire study would still be greatly appreciated. At the time of recruitment, the women were assigned a number, and were from thence identified by this alone on their questionnaires.

²³ It was also hoped that some women who had booked home births would be recruited. Unfortunately this was not to be the case.

3.2.5 Procedure

Enclosed with each of the questionnaires was a pre-paid envelope for its return. The women were sent the antenatal questionnaire booklet at 36 weeks gestation, or if they responded later, as soon as their consent form was received. With the questionnaire they were sent a sticky label to affix to their copy of the hospital notes to identify them as participants in the study. They were also sent a copy of the midwife's questionnaire and asked to keep it in their notes and to point it out to their midwife when they were admitted in labour. It was thus hoped that these questionnaires would not be overlooked by the midwives.

Having obtained permission to do so, the record book on the delivery suite was then checked twice a week, to establish when study participants had given birth. At this time the folder containing the midwife's questionnaire was also checked and if the corresponding questionnaire had not been completed the midwife was contacted, either in person or via a note, with a second copy of the questionnaire enclosed for completion. In this way, only two midwives' questionnaires failed to be completed. In one case the midwife had left employment at the hospital a day or two after conducting the delivery and before she could be contacted. In the other case the midwife had gone on two weeks leave immediately after the shift in which the delivery occurred, and could not remember the details of the case on her return.

Having ascertained the woman's date of delivery, the second questionnaire was posted to reach her when her baby was 1 week old. The third (16 week) questionnaire was also sent at the appropriate time. Women who failed to return questionnaires were sent reminders on two occasions. If they still did not respond it was assumed that they had chosen to drop out of the study.

Figure 3.1 shows a flow diagram tracing the procedure for contacting the study participants.

The data from the completed questionnaires was computerized and analyzed using SPSS for Windows.

3.3 Results

This results section will begin by considering uptake rates and demographic information relating to the sample, then give summary statistics for the various questionnaire scales and items. Following this, the presentation of the findings from the analysis will be divided into sections, according to the statistical approaches used and referring back to the appropriate summary statistics where necessary.

3.3.1 Uptake and response rates

Of the 398 women who were approached, 149 agreed to take part in the study, an uptake of 37.72%. Of these women, 126 completed all three questionnaires, that is, 31.67% of the total approached and 84.56% of those who agreed to take part. Of these women's midwives, 124 completed an assessment of the woman's control expectations and experiences.

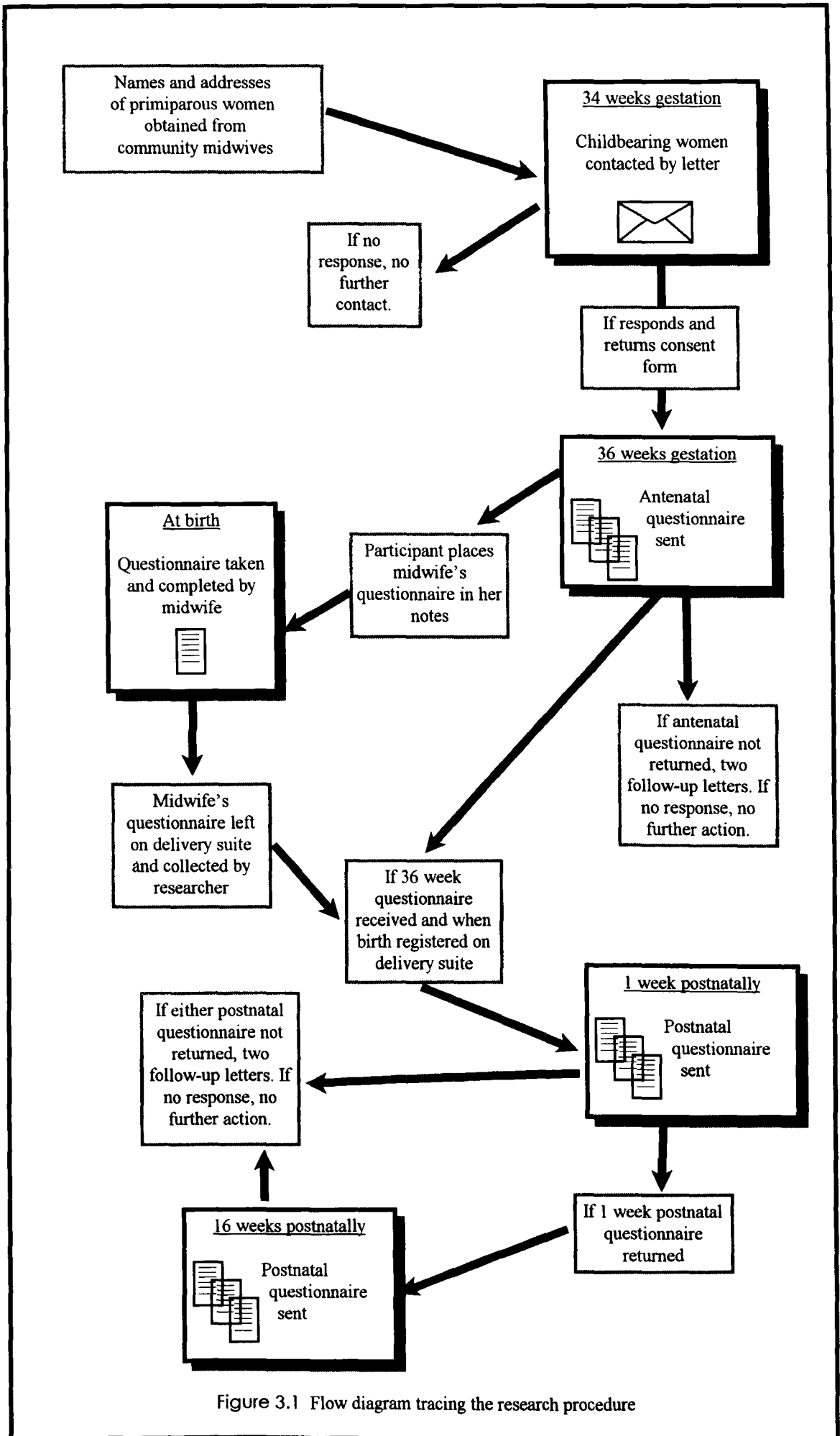


Figure 3.1 Flow diagram tracing the research procedure

Amongst the women who completed all three questionnaires, the response rate to individual questions ranged between 92% and 100%. The rate was lowest on the two postnatal questions concerned with women's comparison of their own control with that of other women. On the majority of the questions the response rate was above 98%. Missing data was dealt with throughout by using mean substitution.

3.3.2 Demographic characteristics of respondents

The women were aged between 16 and 41 years, with the mean age being 28.7 years. 125 of the women identified their predominant ethnic background as white, and one as Asian, a percentage approximately in keeping with that of the percentage population of women of colour in the area. Table 3.3 shows the highest educational level attained by the respondents.

Table 3.3 Highest educational level attained by respondents

	Frequency	Percentage
Basic level (no qualifications or GCSEs)	68	54%
'A' levels or equivalent	25	19.8%
Higher education (degree or equivalent)	33	26.2%

Four (3%) of the women described themselves as single, and the remaining 122 (97%) as cohabiting or married (they were not asked to differentiate which). 116 (92%) of the women were in full- or part-time paid employment during all or part of their pregnancies. 109 (86.5%) had attended at least some antenatal education classes at the time of completing the first questionnaire. 16 (12.7%) had not attended any classes, although some expressed a wish to do so. However, with only four weeks to go before their expected dates of delivery it was unlikely that many of these women would be able to complete a full 6 week course of classes. The frequencies and percentages attending antenatal classes at each level of education are shown in table 3.4. A Kruskal-Wallis test demonstrated a significant relationship between level of education and antenatal class attendance, with the more highly educated women more likely to say that they had attended classes ($\chi^2 = 6.50$, sig. $p=0.039$, $df=2$)²⁴.

Table 3.4 Antenatal class attendance by level of education

	Frequency	Percentage
Basic level (no qualifications or GCSEs)	55 *	82.1%
'A' levels or equivalent	21	84%
Higher education (degree or equivalent)	33	100%

* 1 respondent did not answer question about class attendance

²⁴ All statistical tests are two-tailed.

The number of women experiencing each of the various modes of delivery are shown in table 3.5. Only seven (5.6%) of the women had met the midwife who cared for them in labour prior to the event, and 47 women (37.3%) had the same midwife with them throughout the whole of their labour.

Table 3.5 Mode of delivery for women in study

	Spontaneous vaginal	Ventouse	Forceps	Elective Caesarean	Emergency Caesarean
Frequency	83	13	7	3	20
%	65.9	10.3	5.6	2.4	15.9

3.3.3 Summary statistics for scales

3.3.3.1 LOCUS OF CONTROL

The summary statistics for Levenson's locus of control scale, completed by the respondents at 36 weeks of pregnancy, are given in table 3.6. Higher scores represent higher levels of internality, in other words, more endorsement for the statements which support internal control, and less support for a belief in chance or the control of powerful others. These mean scores differ markedly from Levenson (1974), when scores for 96 male and female adults were 35.48, 13.94 and 16.65 for the internal, chance and powerful others scales respectively, and from Lester (1989), with 20 male and 40 female undergraduates, with mean scores of 11.7, 6.6 and 8.7 respectively.

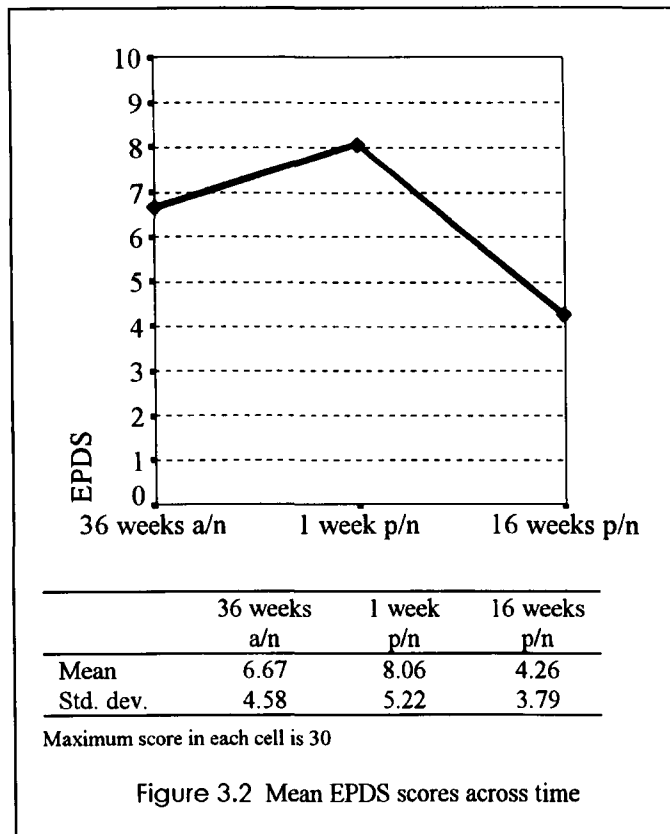
Table 3.6 Descriptive statistics for Levenson's locus of control scale

	Internal control	Chance control	Powerful others control
Mean	19.10	29.77	31.67
Standard deviation	4.71	6.03	5.29

Maximum possible score in each cell is 42

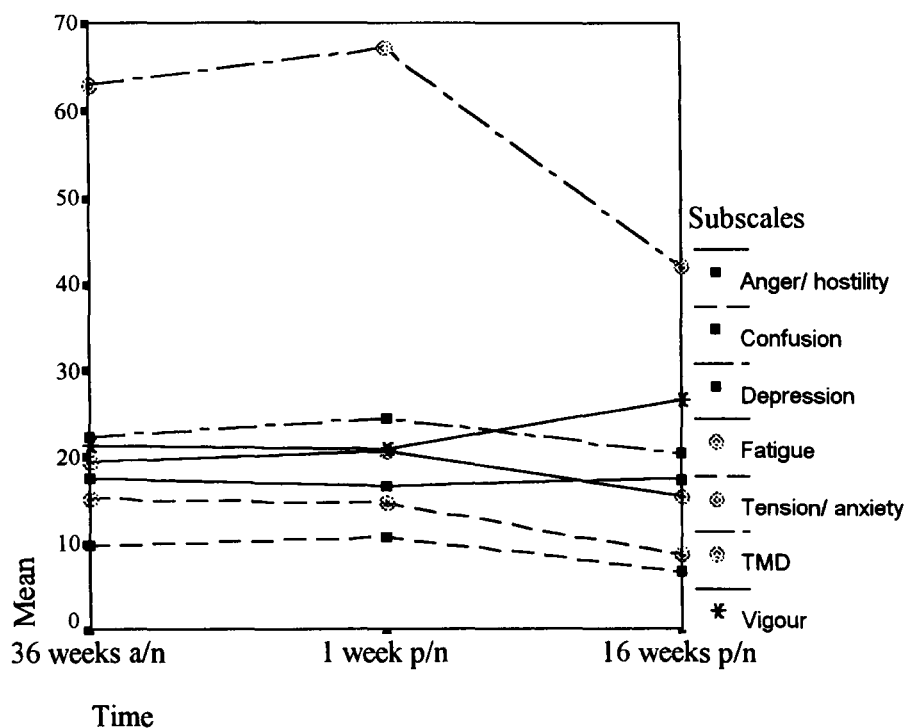
3.3.3.2 DEPRESSION AND MOOD

The mean scores and standard deviations for the EPDS on each of the three occasions are reproduced in figure 3.2. A higher score represents a higher level of depression. The means are slightly lower than scores obtained by Nieland and Roger (1997) at 20 weeks postpartum (n=152, mean score, 8.38), or by Green and Murray (1994) in a longitudinal study (n=1272) in which scores were obtained at 35 weeks gestation (mean = 8.75) and at 6 weeks postnatally (mean = 7.46). Green and Murray, used the same recommended cut-off criterion as this study to define antenatal and postnatal depression: 14/15 and 12/13 respectively (as recommended by Cox, Holden and Sagovsky, 1987; and Murray and Cox, 1990). In the study reported here, 6.35% of the women scored above the cut-off antenatally, and 20.63% and 3.97% at 1 and 16 weeks postnatally respectively. Green and Murray, however, found 12% of their sample to be above cut-off in the antenatal period, this figure rising to 14% at 6 weeks postnatally.



The means and standard deviations for the six POMS mood subscales and for the Total Mood Disturbance Score (TMD) are represented in figure 3.3. Higher scores represent greater experience of the mood the scale or subscale purports to measure. The means of the POMS subscales for Tension-Anxiety and Confusion-Bewilderment, on all three occasions are comparable with published scores for adults without any form of psychiatric complaint (McNair, Lorr and Droppleman, 1992), and for pregnant women seeking prenatal diagnosis due to a genetic risk (Tunis, Golbus, Copeland, Fine, Rosinsky and Seely, 1990), but the remaining subscale scores differed from published data on normal adults and pregnant women. In every case the mean scores in this study were higher than those published elsewhere: 7-7.91 points for the Anger-Hostility subscale, 7.08-12.18 for Fatigue, 6.09-11.72 for Vigour, and 10.16-14.31 for Depression-Dejection (McNair, Lorr and Droppleman, 1992).

The POMS subscales were highly intercorrelated. However these correlations were, again, comparable with the correlations found in published scores (McNair, Lorr and Droppleman, 1992). The antenatal and 1 week postnatal TMD scores were normally distributed. The TMD scores at 16 weeks, however, were somewhat skewed towards the low disturbance end. This non-normal distribution, was taken into account in later calculations.



	Anger-Hostility	Confusion-Bewilderment	Depression-Dejection	Fatigue	Tension-Anxiety	Vigour*	TMD
<i>Max possible score</i>	60	29	75	35	39	40	198
Mean	17.61	9.75	22.39	19.52	15.20	21.40	63.06
(SD)	(6.05)	(5.16)	(8.83)	(6.32)	(7.56)	(5.83)	(31.57)
1 week p/n	16.70	10.74	24.51	20.58	14.67	20.99	67.17
(SD)	(4.99)	(5.79)	(10.34)	(6.10)	(7.27)	(6.09)	(35.04)
16 weeks p/n	17.50	6.77	20.36	15.48	8.78	26.63	42.17
(SD)	(6.75)	(4.83)	(7.83)	(5.35)	(4.99)	(5.59)	(29.66)

* To obtain the TMD, the Vigour score is subtracted from the sum of the others.

Figure 3.3 Mean POMS scores across time

3.3.3.3 LABOUR AGENCY

Half of the sample were given LAS version A at 36 weeks antenatally and 16 weeks postnatally, and version B at 1 week postnatally, whilst for the other half of the sample, the order was transposed. The means and standard deviations for each version of the LAS scores on each occasion are reproduced in table 3.7. Higher scores represent higher reported levels of agency or control.

Despite the fact that versions A and B of the LAS are intended to be interchangeable, (Hodnett and Simmons-Tropea, 1987), in both the antenatal and 16 week postnatal data, the means of the two versions were significantly different (antenatal scores, $t_{124}=2.63$, sig. $p=.010$, 16 week scores, $Z=-2.00$, sig. $p=.045$). Homogeneity of variance between the two versions was also lacking in both the 1 and 16 week postnatal scores. The antenatal and 1 week postnatal scores obtained from this data are comparable with

published scores (Hodnett and Simmons-Tropea, 1987), but there are no published scores available for comparison with the 16 week data. The combined LAS scores on each of the three occasions were normally distributed, but lacked homogeneity of variance.

Table 3.7 Descriptive statistics for LAS

LAS	Time	Mean	SD
A	36 weeks A/N	148.93	26.26
B	36 weeks A/N	136.82	25.36
A	1 week P/N	153.60	33.42
B	1 week P/N	157.26	27.18
A	16 weeks P/N	163.69	26.88
B	16 weeks P/N	151.65	32.61

Maximum possible score in each cell = 203

The summary statistics for the answers to the remaining control-related questions posed to the childbearing women are shown in table 3.8. These questions were: antenatal questions asking the women how much internal and external control they wanted, and how much external control they expected; postnatal questions (asked at both 1 and 16 weeks) asking them how much internal and external control they felt they had attained; and questions asking them how much control they felt they had achieved compared with other women. In each case lower scores represent less control.

Table 3.8 Descriptive statistics for remaining control questions

	Max. possible score	Mean	SD
A/N. Wanted internal (self) control	5	3.87	0.68
A/N. Wanted external (situational) control	5	3.87	0.80
A/N. Expected external control	7	4.94	1.39
1 week P/N. Experienced internal (self) control	7	4.85	1.45
16 weeks P/N. Experienced internal (self) control	7	4.99	1.47
1 week P/N. Experienced external (situational) control	7	4.71	1.77
16 weeks P/N. Experienced external (situational) control	7	4.61	1.64
1 week P/N. Internal control compared with others	7	4.45	1.20
16 weeks P/N. Internal control compared with others	7	4.58	1.22
1 week P/N. External control compared with others	7	4.41	1.43
16 weeks P/N. External control compared with others	7	4.57	1.18

3.3.3.4 ASSESSMENT OF LABOUR

The control score for each of the interventions a woman reported having encountered were added together and divided by the number of interventions she had experienced, thus giving an intervention control score. The mean number of interventions and the mean control score for both the 1 and 16 week postnatal questionnaires are given in table 3.9. Also given are the summary statistics for the women's replies to the

perception of labour questions (listed in table 3.2, page 100) at 1 and 16 weeks. For the intervention control and perception of labour scores a higher score indicates a more positive reported perception.

Table 3.9 Summary statistics for intervention and perception of labour questions

	Max. possible score	Mean	SD
Number of interventions remembered at 1 week postnatally	*	8.76	2.72
Number of interventions remembered at 16 weeks postnatally	*	8.97	2.68
Control score divided by number of interventions - 1 week postnatally	5	3.42	0.86
Control score divided by number of interventions - 16 weeks postnatally	5	3.32	0.91
How difficult the experience of childbirth was - 1 week postnatally	7	3.44	1.84
How difficult the experience of childbirth was - 16 weeks postnatally	7	3.62	1.88
Whether woman felt she coped with childbirth - 1 week postnatally	7	5.16	1.59
Whether woman felt she coped with childbirth - 16 weeks postnatally	7	5.28	1.43
How painful childbirth was - 1 week postnatally	7	2.74	1.60
How painful childbirth was - 16 weeks postnatally	7	2.86	1.64
How anxious/ tense the woman felt - 1 week postnatally	7	4.10	1.87
How anxious/ tense the woman felt - 16 weeks postnatally	7	4.09	1.78
Whether the woman felt distressed - 1 week postnatally	7	4.30	1.96
Whether the woman felt distressed - 16 weeks postnatally	7	4.90	1.77
Whether labour was better or worse than expected - 1 week postnatally	7	4.10	2.13
Whether labour was better or worse than expected - 16 weeks postnatally	7	4.40	2.06
Whether, overall, labour was a positive experience - 1 week postnatally	7	5.19	1.71
Whether, overall, labour was a positive experience - 16 weeks postnatally	7	5.59	1.61

* Maximum score not given as some interventions were mutually exclusive- eg. a woman could not have both an elective and an emergency caesarean section.

Table 3.10 Summary statistics for satisfaction scores.

	Mean	SD
Satisfaction with birth - 1 week postnatally	7.03	2.44
Satisfaction with birth - 16 weeks postnatally	7.35	2.42
Satisfaction with midwife care - 1 week postnatally	9.43	1.16
Satisfaction with midwife care - 16 weeks postnatally	9.12	1.58

Maximum score in each cell = 10

The mean scores and standard deviations for the women's reported satisfaction with the birth experience and with the care they received from the midwife are reported in table 3.10. Higher scores represent more satisfaction.

At 1 week postnatally 93 women (73.8%) reported that the birth had been fulfilling, 11 (8.7%) reported not finding it fulfilling, and 22 (17.5%) were not sure. At 16 weeks 99 (78.6%) reported fulfillment, 12 (9.5%) reported not being fulfilled, and 15 (11.9%) were not sure.

3.3.3.5 MIDWIVES' QUESTIONNAIRE

The summary statistics for the three questions asked of the midwives are given in table 3.11. Higher scores indicate more control or satisfaction.

Table 3.11 Summary statistics for midwives' answers

	Mean	SD
Control women expected	6.31	2.30
Control women achieved	6.68	2.02
Women's satisfaction	6.73	2.05

3.3.4 Comparisons between antenatal and postnatal control and mood scores

3.3.4.1 PROFILE OF MOOD STATES

Because the TMD scores were not all normally distributed, a non-parametric analysis (Wilcoxon Matched-Pairs Signed-Ranked Test) was used to compare the antenatal scores with those at 1 week postnatally, and to compare the two postnatal scores (see figure 3.3, page 108, for summary statistics). No significant difference was found between antenatal TMD scores and those at 1 week postnatally ($Z=-1.5042$, sig. $p=.1325$). However the 1 week and 16 week postnatal scores did differ significantly ($Z=-7.0645$, sig. $p<.0001$). Thus, at 16 weeks postnatally, reported total mood was considerably improved from the early postnatal period.

When the changes in the individual subscales of the POMS over the three occasions were examined, interesting differences in pattern were found (see figure 3.3, page 108, for summary statistics and table 3.12 for results of analysis). Again non-parametric analysis (Wilcoxon Matched-Pairs Signed-Ranked Test) was used, as some of the subscale scores were not normally distributed, and it seemed preferable to use the same test on them all to render the results comparable. Bonferroni corrections were also applied to obviate the risk of type 1 error associated with multiple significance testing²⁵. The Anger-Hostility scores remained stable across the three occasions, whilst the Depression-Dejection scores were significantly raised at 1 week postnatally, then significantly reduced at 16 weeks. The remaining subscales were not significantly changed between the antenatal period and 1 week postnatally, but by 16 weeks postnatally the women were reporting significant improvements in mood: less tension, confusion and fatigue, and more vigour.

²⁵ A Bonferroni correction is made by dividing the critical significance level - $p\leq.05$ - by the number of statistical tests carried out in one block (Howell, 1987). The appropriate correction for each set of results is shown below the corresponding table.

Table 3.12 Comparisons between POMS subscales (Z scores)

POMS subscale	Comparing a/n and 1 week p/n scores	Comparing 1 and 16 week p/n scores
Tension-Anxiety	-0.4982	-8.1089 **
Depression-Dejection	-2.6747 *	-4.2524 **
Anger-Hostility	-1.5792	-0.6514
Vigour	-0.7058	-7.2620 **
Fatigue	-1.3553	-7.1233 **
Confusion-Bewilderment	-2.4634	-6.8566 **

Bonferroni correction for 6 variables: critical level $p \leq 0.008$. Sig. * $p \leq 0.008$ (2-tailed)** $p < 0.0001$ (2-tailed)

3.3.4.2 EDINBURGH POSTNATAL DEPRESSION SCALE

As with the POMS Depression-Dejection scores, Wilcoxon Matched-Pairs Signed-Ranked Test showed that the EPDS scores (see figure 3.2, page 107 for summary statistics) increased significantly between the antenatal period and 1 week postnatally ($Z = -3.3289$, sig. $p = 0.0009$), indicating that the women reported themselves as more depressed after the birth than they had been beforehand. However the 16 week postnatal scores were significantly reduced compared to 1 week postnatally ($Z = -7.1696$, sig. $p < 0.0001$), showing, as did the TMD Depression-Dejection subscale, that women's reporting of depression lessens significantly between 1 and 16 weeks postnatally.

3.3.4.3 LABOUR AGENCY

Due to the unequal variances, non-parametric analysis was also used to compare the women's LAS scores on the three occasions (see table 3.7, page 109 for summary statistics). Wilcoxon Matched-Pairs Signed-Ranked Test showed a significant difference between the antenatal and 1 week postnatal scores ($Z = -4.6593$, sig. $p < 0.0001$). This indicated that the women in this sample positioned themselves as having achieved considerably more control than they had expected. However there was no significant difference between the 1 week and 16 week postnatal scores ($Z = -1.2259$, sig. $p = 0.2202$), showing that the women's reports of how much control they felt they had achieved in labour remained comparatively stable over this time period.

3.3.4.4 RELATIONSHIPS BETWEEN LAS AND MOOD DISTURBANCE

The 8 women in the study who scored above the cut-off point for postnatal depression on the EPDS in the antenatal period had mean LAS scores which showed a similar pattern of change across the three questionnaires as the rest of the sample, as did the 26 women who scored above the EPDS cut-off at 1 week postnatally. However for both these groups of women the mean LAS scores upon each occasion were 20 to 35 points lower than for the rest of the sample. The LAS scores for the 5 women who scored above the EPDS cut-off at 16 weeks postnatally were not singled out because 4 of these women were amongst those who had scored above the cut-off at 1 week. Of the 26 women who scored above the EPDS cut-off at 1 week postnatally, 5 had been above cut-off in the antenatal period. However none of the women in the study scored above the EPDS cut-off on all three occasions.

The sample was divided into two, those women whose antenatal LAS score was higher than their 1 week postnatal LAS score (n=39) were compared, in terms of their postnatal TMD scores, with those women whose postnatal LAS scores were higher (n=87) than antenatally. In other words, women who reported achieving more control than they had expected were compared with women who reported achieving less control than expected. A Mann-Whitney U Test indicated no significant differences between the two groups in either the 1 week postnatal or the 16 week postnatal TMD scores. (1 week postnatally, $Z=-.4184$, sig. $p=.6757$. 16 weeks postnatally, $Z=-1.4978$, sig. $p=.1342$) In other words, there was no difference in short or longer term reported mood disturbance between women who positioned themselves as achieving more control than expected and those whose expectations were not met.

3.3.5 Comparisons between 1 and 16 week postnatal scores

Sixteen of the postnatal variables did not form part of any of the various rating scales. These variables were:

- Self-control (internal control)
- Situational control (external control)
- Self-control compared with other women
- Situational control compared with other women
- Number of interventions experienced
- Intervention control score
- Difficulty of the childbirth experience
- Whether woman felt she coped with childbirth
- Painfulness of childbirth
- Anxiety/ tension during the birth
- Distress during the birth
- Whether labour was better or worse than expected
- Whether, overall, labour was a positive experience
- Satisfaction with the birth
- Satisfaction with midwife care
- Fulfillment from the birth experience

Scores were obtained for each of these items at both 1 and 16 weeks postnatally, and their summary statistics are reproduced in tables, 3.8, 3.9 and 3.10, pages 109 and 110. Comparisons between the 1 and 16 week scores for each variable are given below.

3.3.5.1 CONTROL ISSUES

Six of these variables related specifically to control issues: intervention control score, internal and external control, internal and external control compared with others, and coping. Each of these scores was compared at 1 and 16 weeks postnatally, using Wilcoxon Matched-Pairs Signed-Ranks Test. As with

the LAS scores, there was no significant change in any of these scores between 1 and 16 weeks postnatally (see table 3.13), supporting the finding that women’s reported perceptions of control in labour remain stable from the early to the later postnatal period.

Table 3.13 Comparisons between control related variables (Z scores)

Variable	Comparing 1 and 16 week p/n scores
Intervention control scores	-1.1874
Internal control	-1.4540
External control	-.8124
Internal control compared with others	-1.3917
External control compared with others	-1.4451
Coping	-1.0479

Bonferroni correction for 6 variables: critical level $p \leq .008$. Sig. * $p \leq .008$ (2-tailed)

3.3.5.2 EXPERIENCE OF LABOUR

Five of the 16 variables related to assessments the women made about the experience of labour: whether it was better than expected; whether it was difficult; how painful it was; whether it was a positive experience; and the number of interventions the woman remembered having. Using a similar analysis to that used on the variables associated with control; assessment of pain, the difficulty of labour and the birth, and the woman’s memory of interventions did not change significantly over time. However, the women were significantly more likely at 16 weeks postnatally to rate labour and birth as better than expected than they were at 1 week postnatally, and they also rated labour as a significantly more positive experience at 16 weeks than at 1 week (see table 3.14). In other words, although the features of labour, the pain, the number of interventions and its difficulty were positioned in the same way in the later postnatal period as they had been soon after labour, the women began to represent their own experience in a more favourable light over time.

Table 3.14 Comparisons between experience of labour variables (Z scores)

Variable	Comparing 1 and 16 week p/n scores
Better/ worse than expected	-2.8444 *
Difficulty	-1.3956
Pain	-1.2801
Whether a positive experience	-3.0539 *
Number of interventions remembered	-1.2010

Bonferroni correction for 5 variables: critical level $p \leq .01$. Sig. * $p \leq .01$ (2-tailed)

3.3.5.3 SATISFACTION WITH THE BIRTH

A further three variables related to the women's rating of their satisfaction with the birth experience: how satisfied they were with the care they received from their midwives; how satisfied they were with the birth; and whether they found the experience fulfilling or not. Again a Wilcoxon Matched-Pairs Signed-Ranks Test was applied. Satisfaction with the birth and fulfillment did not change significantly between 1 and 16 weeks postnatally (see table 3.15). Women's reported satisfaction with the overall care they received from the midwives did decrease significantly between 1 and 16 weeks postnatally but the scores upon both occasions were very high. Out of a possible range of scores of 0 to 10, the mean score at 1 week postnatally was 9.43 and at 16 weeks was 9.12, suggesting that a ceiling effect was operating. The mean scores for reported satisfaction with the birth at 1 and 16 weeks postnatally were not problematic, being lower: 7.03 and 7.35 respectively.

Table 3.15 Comparisons between satisfaction variables (Z scores)

Variable	Comparing 1 and 16 week p/n scores
Satisfaction with midwife care	-3.7011 **
Satisfaction with birth	-2.2411
Fulfillment	-.8928

Bonferroni correction for 3 variables: critical level $p \leq .02$. Sig. * $p \leq .02$ (2-tailed) ** $p < .001$ (2-tailed)

3.3.5.4 EMOTIONAL REACTION

The remaining two variables related to the women's emotions during birth. They were asked whether they had felt anxious and tense, and whether they had felt distressed. Wilcoxon Matched-Pairs Signed-Ranks Test indicated that although the women's reported assessments of anxiety did not change over time, they were significantly less likely, at 16 weeks postnatally, to rate labour as distressing than they had been at 1 week (table 3.16).

Table 3.16 Comparisons between variables for emotional reaction (Z scores)

Variable	Comparing 1 and 16 week p/n scores
Anxiety/ tension during labour and birth	-.0190
Distress during labour and birth	-3.8119 **

Bonferroni correction for 2 variables: critical level $p \leq .025$. Sig. * $p \leq .025$ (2-tailed) ** $p < .001$ (2-tailed)

3.3.6 Factor analysis

Although, conceptually, the 16 variables described above could be subdivided into groups, it was important to explore, from an analytical point of view, the number of concepts they might be representing. Therefore for both the 1 and 16 week postnatal variables a factor analysis was carried out to explore their dimensionality. For both sets of variables a principal component analysis and scree plot was

used to identify the number of substantive factors. In the case of the 1 week variables two factors were distinguished (see table 3.17). The 16 variables were then subjected to a principal component analysis with extraction of the two factors and oblimin rotation, the latter manoeuvre being in recognition of the probability that factors associated with these variables would be correlated. The factor loadings were interpreted using the guidelines recommended by Tabachnick and Fidell (1996): that only factors with loadings of .32 and above on the pattern matrix should be interpreted. The suggestion of Comrey and Lee (1992) was also taken into consideration: that loadings in excess of .71 should be considered excellent measures of the factor, .63 very good, .55 good, .45 fair, and .32 poor.

Table 3.17 Factor analysis of 1 week postnatal variables

Variable	Factor loadings	
	F1	F2
Difficulty of the childbirth experience	.89	-
Whether labour was better or worse than expected	.89	-
Painfulness of childbirth	.82	-
Distress	.64	-
Whether, overall, labour was a positive experience	.61	-
Whether woman felt she coped with childbirth	.53	.39
Satisfaction with the birth	.50	.45
Fulfillment	.46	-
Number of interventions	.36	-
Situational control compared with other women	-	.87
Situational control (external control)	-	.85
Self-control compared with other women	-	.71
Intervention control score	-	.64
Satisfaction with midwife care	-	.55
Self-control (internal control)	.37	.48
Anxiety/ tension	-	.44

The first factor contained variables which appertained to the difficulty or complexity of the birth experience and accounted for 42.4% of the total variance. The second factor related to control over the experience. This factor accounted for 11.7% of the variance. The variables for coping in labour, satisfaction with the birth and internal control loaded onto both factors. There was an inter-factor correlation of .408.

At 16 weeks postnatally the same two factors could be identified, with an inter-factor correlation of .485. The same variables loaded onto each factor, except that the variables for satisfaction with the experience and internal control now loaded onto only one factor: satisfaction with the experience loading onto factor 1 and self-control loading onto factor 2 (see table 3.18). The variable for coping with the birth still loaded onto both factors, suggesting that a sense of coping is a composite of the reported difficulty of the experience and the amount of control the woman positions herself as having. In this analysis, factor 1 accounted for 43.9% of the variance and factor 2 for 11%. This stability of factor loadings between 1 and 16 weeks postnatally indicated a particularly reliable factor structure.

Table 3.18 Factor analysis of 16 weeks postnatal variables

Variable	Factor loadings	
	F1	F2
Painfulness of childbirth	.87	-
Whether labour was better or worse than expected	.85	-
Difficulty of the childbirth experience	.84	-
Satisfaction with the birth	.69	-
Whether, overall, labour was a positive experience	.68	-
Fulfillment	.61	-
Distress	.52	-
Number of interventions	-	-
Situational control (external control)	-	.85
Intervention control score	-	.83
Situational control compared with other women	-	.78
Self-control compared with other women	-	.73
Self-control (internal control)	-	.65
Anxiety/ tension	-	.52
Satisfaction with midwife care	-	.52
Whether woman felt she coped with childbirth	.43	.47

Factor scores were generated from these factors using the SPSS command, with a view to using the factors in later multiple regression analyses, rather than the individual variables. There were high correlations between both the 1 and 16 week postnatal scores for factor 1 ($r = .84$, $\text{sig.} < .001$) and factor 2 ($r = .86$, $\text{sig.} < .001$). Both sets of factor scores also correlated with 1 and 16 week postnatal LAS (table 3.19).²⁶

Table 3.19 Correlations between factor scores and 1 and 16 week LAS²⁷

	Factor 1 (1 wk P/N)	Factor 2 (1 wk P/N)	Factor 1 (16 wks P/N)	Factor 2 (16 wks P/N)
LAS 1 wk P/N	.5031 *	.6700 *	.5002 *	.7723 *
LAS 16 wks P/N	.4732 *	.6600 *	.5390 *	.8209 *

Bonferroni correction for 4 variables: critical level $p \leq .01$. Sig. * $p < .001$ (2-tailed)

²⁶ In the following correlation tables Bonferroni corrections are made by dividing the critical significance level by the maximum number of correlations made with data collected at any one time. Thus, in the case of this table, 4 variables are correlated with each of the postnatal LAS measures, but only 2 with each of the factor scores. Therefore the critical level is divided by 4.

²⁷ Because a linear relationship between variables could not be guaranteed under all circumstances, and because, strictly speaking, many of the variables in this study were ordinal rather than interval, Spearman's ρ was used in all correlation analyses.

3.3.7 Correlations

3.3.7.1 BETWEEN TMD, POMS SUBSCALES AND EPDS

To address the four research questions described in the first section of this chapter, both psychological wellbeing (assessed using the Total Mood Disturbance Scale) and labour and childbirth control expectations and experiences (using the Labour Agency Scale) were to be considered as outcome variables. However, as well as TMD, there were also other measures of mood: the various POMS subscales, and EPDS. Therefore, correlations between these mood variables upon each occasion were also considered (see table 3.20). Even after Bonferroni correction, all the measures of mood correlated strongly with the corresponding TMD score, indicating its suitability as a composite measure of mood state. Each correlation was positive, indicating that raised levels on the subscale were related to raised TMD scores, except for the vigour subscale, where an increase in vigour was related to reduced TMD scores.

Table 3.20 Correlations between mood variables and Total Mood Disturbance Score (TMD)

TMD	EPDS	Anger-Hostility	Confusion-Bewilderment	Depression-Dejection	Fatigue	Tension-Anxiety	Vigour
A/N	.7281 *	.7034 *	.8321 *	.8466 *	.7549 *	.8310 *	-.6732 *
1 week P/N	.8321 *	.7096 *	.8530 *	.8898 *	.6984 *	.8605 *	-.6964 *
16 weeks P/N	.7162 *	.7744 *	.7512 *	.8545 *	.6957 *	.7984 *	-.7036 *

Bonferroni correction for 7 variables: critical level $p \leq .007$. Sig. * $p < .001$

3.3.7.2 BETWEEN LAS AND OTHER CONTROL MEASURES

Table 3.21 shows the relationships between antenatal LAS and the measures of expected external and wanted external and internal control. There were significant relationships between LAS and expected external control, but not the measures of wanted control. The two measures of wanted control showed a significant positive correlation as do the two measures of external control.

Table 3.21 Correlations between antenatal LAS and control measures

	Expected external control	Wanted external control	Wanted internal control
Wanted external control	.3430 *	-	-
Wanted internal control	.1794	.4721 *	-
Antenatal LAS	.4757 *	.1820	.1088

Bonferroni correction for 6 variables: critical level $p \leq .008$. Sig. * $p < .001$

Table 3.22 shows the relationships between 1 week postnatal LAS and the 1 week assessments of achieved external and internal control. External and internal control correlated both with each other and with LAS.

Table 3.22 Correlations between 1 week postnatal LAS and control measures

	External control (1 week)	Internal control (1 week)
Internal control (1 week)	.4817 *	-
1 week LAS	.5813 *	.6738 *

Bonferroni correction for 3 variables: critical level $p \leq .017$. Sig. * $p < .001$

In table 3.23 the results of correlations between 16 week postnatal LAS and the corresponding assessments of achieved external and internal control are shown. Again, external and internal control correlated both with each other and with LAS.

Table 3.23 Correlations between 16 week postnatal LAS and control measures

	External control (16 weeks)	Internal control (16 weeks)
Internal control (16 weeks)	.4806 *	-
16 week LAS	.6577 *	.6570 *

Bonferroni correction for 3 variables: critical level $p \leq .017$. Sig. * $p < .001$

The analyses in this subsection indicated that LAS was a suitable indicator of women's reports of expected and achieved internal and external control. Therefore in the next subsection and in the multiple regression analyses which followed (subsection 3.3.9), LAS alone was used to represent control in childbirth.

3.3.7.3 BETWEEN ANTENATAL AND POSTNATAL VARIABLES AND TMD OR LAS

The primary purpose of this subsection was to identify, for the purpose of later regression analyses, variables which bore some relationship to TMD or LAS. Table 3.24 gives the correlations between antenatal variables with more than 3 levels and antenatal and 1 week postnatal TMD and LAS. Table 3.25 shows correlations between antenatal and 1 week postnatal variables with more than 3 levels, and 16 week postnatal TMD and LAS. Variables with 3 or fewer levels were dealt with by using ANOVA and non-parametric tests, and these will be presented in section 3.3.8.

Table 3.24 Correlations between antenatal variables and antenatal and 1 week postnatal TMD and LAS

	A/N LAS	A/N TMD	1 week P/N LAS	1 week P/N TMD
1 week P/N LAS	-	-	-	-.4923 **
A/N TMD	-	-	-.2897 *	.5023 **
A/N LAS	-	-.5400 ††	.4590 **	-.3667 **
Age	.1284	-.2008	.0578	-.0319
Chance locus of control	.3074 ††	-.2302	.2177	-.0385
Powerful others locus of control	.3330 ††	-.2421	.2018	-.1442
Internal locus of control	-.1609	.1797	-.0748	-.0024

Bonferroni correction for 9 variables: critical level $p \leq .006$. Sig. † $p \leq .006$ †† $p < .001$

Bonferroni correction for 13 variables: critical level $p \leq .004$. Sig. * $p \leq .004$ ** $p < .001$

Table 3.25 Correlations between antenatal and 1 week postnatal variables and 16 week postnatal TMD and LAS

	16 weeks P/N LAS	16 weeks P/N TMD
Age	.1094	-.0409
Chance locus of control	.2396	-.0594
Powerful others locus of control	.2720 *	-.1585
Internal locus of control	-.0612	.1173
A/N LAS	.4917 **	-.2799 *
A/N TMD	-.3980 **	.4771 **
Factor 1 (difficulty/ complexity of experience)	.4372 **	-.0131
Factor 2 (control over the experience)	.6600 **	-.1233
1 week P/N LAS	.8210 **	-.1931
1 week P/N TMD	-.4978 **	.4773 **
16 weeks P/N LAS	-	-.3448 **

Bonferroni correction for 21 variables: critical level $p \leq .002$. Sig. * $p \leq .002$ ** $p < .001$

All the TMD and LAS scores were significantly correlated except 1 week postnatal LAS and 16 week postnatal TMD. Correlations between LAS and TMD scores were negative, that is, the higher the women's labour agency, the lower their mood disturbance. There were also significant and positive correlations between the external locus of control scales (chance and powerful others) and antenatal LAS, indicating that the less belief the women reported in the control of powerful others or chance over their lives, the higher the expectations of labour agency they also reported. Similarly the powerful others scale correlated significantly with 16 week postnatal LAS. The two extracted factors from the 1 week postnatal variables correlated significantly and positively with LAS at 16 weeks postnatally, indicating that a more positive experience of labour in terms of lack of difficulty and in terms of control reported at 1 week postnatally was related to reports of higher levels of labour agency at 16 weeks.

3.3.7.4 CORRELATIONS AMONGST DEMOGRAPHIC AND BACKGROUND VARIABLES

Correlations amongst the demographic and background variables with more than three levels are shown in table 3.26. Relationships between demographic, antenatal and 1 week postnatal variables with three or fewer levels are examined in subsection 3.3.8.3. The main objective in examining these relationships was to be able to identify points at which problems of multicollinearity might occur in subsequent multiple regression analysis. The results indicated that the higher the age of the woman, the less likely she was to ascribe the outcomes in her life to chance, there being a positive correlation between Levenson's chance scale and age. There was also a positive correlation between Levenson's two scales of external locus of control.

Table 3.26 Correlations between demographic and background variables

	Age	Chance locus of control	Powerful others locus of control
Chance locus of control	.2842 *	-	
Powerful others locus of control	.0708	.4182 **	-
Internal locus of control	-.1219	-.2036	-.0443

Bonferroni correction for 6 variables: critical level $p \leq .008$. Sig. * $p \leq .008$ ** $p < .001$

3.3.7.5 CORRELATIONS BETWEEN CHILDBEARING WOMEN'S AND MIDWIVES' ANSWERS

There were significant positive correlations between the midwives' answers to all three of their questions (table 3.27). In other words, the midwives positioned the women who expected external control as more likely to have achieved it, and both women who expected and women who achieved external control as more satisfied with their birth experience. Most of these positive correlations were mirrored in the antenatal assessments the childbearing women made about their expectations of external control, and in their 1 week postnatal reports of their achievements of external control, and their satisfaction with the birth (table 3.28). However the childbearing women's answers about their expectations of external control and their satisfaction with their experience did not correlate significantly.

Table 3.27 Correlations between midwife assessments

	M/W assessment of woman's expected external control	M/W assessment of woman's achieved external control
M/W assessment of woman's achieved external control	.4623 **	-
M/W assessment of woman's satisfaction	.2256 *	.6473 **

Bonferroni correction for 3 variables: critical level $p \leq .02$. Sig. * $p \leq .02$ ** $p < .001$

Table 3.28 Comparable correlations for childbearing women

	Women's expected external control	Women's reported external control
Women's reported external control	.2238 *	-
Women's reported satisfaction with birth	.0992	.4314 **

Bonferroni correction for 3 variables: critical level $p \leq .02$. Sig. * $p \leq .02$ ** $p < .001$

When the midwives' answers and the corresponding answers given by the women were compared, the midwives' assessments of the women's satisfaction with their experience, and the women's 1 week postnatal reports of satisfaction were significantly and positively correlated (table 3.29). However the midwives' assessments of how much external control the childbearing women expected did not correlate significantly with the women's antenatal reports of expected external control. Neither did the midwives' and the childbearing women's descriptions of the amount of external control achieved correlate at any level of significance. What did correlate significantly with the midwives' assessments of the women's expected control over the birth situation were the antenatal Depression- Dejection, and Tension-Anxiety subscales, as well as the TMD scores (table 3.30). Lower levels of negative mood were associated with higher levels of expected control. (In fact prior to Bonferroni corrections, out of all the mood related scores, only the POMS subscale for Anger-Hostility, failed to correlate significantly with the midwives' assessment of expected control).

Table 3.29 Correlations between midwives' answers and corresponding questions to childbearing women

	Women's expected external control (A/N)	Women's reported external control (1 week P/N)	Women's reported satisfaction with birth (1 week P/N)
M/W assessment of woman's expected external control	.0173	.0709	-.0110
M/W assessment of woman's achieved external control	-.0091	.0604	.2121
M/W assessment of women's satisfaction with labour and birth	-.0452	.1560	.4645 **

Bonferroni correction for 9 variables: critical level $p \leq .006$. Sig. * $p \leq .006$ ** $p < .001$

Table 3.30 Correlations between antenatal mood variables, LAS and midwife assessments

	EPDS	Anger-Hostility	Confusion-Bewilderment	Depression-Dejection	Fatigue	Tension-Anxiety	Vigour	TMD	LAS (A/N)
M/W assessment of women's expected external control	-.2665	-.1331	-.2623	-.2781 *	-.2060	-.3058 **	.2393	-.3137 **	.1422
M/W assessment of women's achieved external control	-.1171	-.0279	-.2007	-.1254	-.0594	-.1195	.0031	-.1041	-.0119
M/W assessment of women's satisfaction with labour and birth	-.1406	-.1491	-.1880	-.2002	-.1405	-.1404	.0755	-.1665	.0449

Bonferroni correction for 27 variables: critical level $p \leq .002$. Sig. * $p \leq .002$ ** $p < .001$

The midwives' assessment of the women's achievement of control (table 3.31) correlated significantly and negatively with the number of interventions the woman remembered having: fewer interventions being associated with higher levels of assessed control. There was also a positive correlation between the midwives' assessment of achieved control and whether the woman positioned herself as having felt positive about the labour.

When the correlates for the midwives' assessment of the childbearing women's expected external control were compared with the women's measures of expected external control no significant relationships were found. However all the antenatal mood variables correlated negatively and significantly with antenatal LAS, the measure of expected self- and external control, meaning that higher levels of mood disturbance were associated with lower levels of labour agency (table 3.32). Of the correlates with the midwives' assessments of the women's achieved control, the women's 1 week reports of positive feelings about the birth correlated positively and significantly with both 1 week reports of control, whilst the number of interventions the women remembered at 1 week did not show any significant relationship (table 3.33).

Table 3.31 Correlations between 1 week P/N labour assessment variables, TMD, LAS and midwife assessments

	TMD	Anxious/ tense in labour	Labour better/ worse than expected	Coped in labour	Difficulty of labour	Felt distressed in labour
M/W assessment of women's expected external control	-.0535	.0875	-.0953	.0220	-.1114	.0331
M/W assessment of women's achieved external control	-.2826	.0068	.1502	.0411	.1346	.1562
M/W assessment of women's satisfaction with labour and birth	-.3243 **	.1546	.2970 *	.2346	.3450 **	.3475 **

Cont...

Felt positive about labour	Painfulness of labour	Number of interventions	Continuity of care in labour	Continuity of A/N and labour care	Spontaneous vaginal delivery or not	LAS (1 week P/N)
.0653	-.0306	.0168	-.0896	-.1360	.0096	.0764
.2826 *	.0582	-.3411 **	.0628	.0511	.2656	.1209
.3681 **	.1352	-.4225 **	.1101	.1943	.3934 **	.2973 *

Bonferroni correction for 39 variables: critical level $p \leq .001$. Sig. * $p \leq .001$ ** $p < .001$

Table 3.32 Correlates with midwives' assessments of expected control against women's antenatal reports of expected control.

	Expected external control	LAS (A/N)
Depression-Dejection (A/N)	-.1240	-.5016 **
Tension-Anxiety (A/N)	-.2229	-.5487 **
TMD (A/N)	-.1672	-.5400 **

Bonferroni correction for 6 variables: critical level $p \leq .008$. Sig. * $p \leq .008$ ** $p < .001$

Table 3.33 Correlates with midwives' assessments of achieved control against women's 1 week postnatal reports of control.

	Achieved external control	LAS (1 wk P/N)
Felt positive about the birth	.3812 **	.5881 **
Number of interventions	-.1206	-.0299

Bonferroni correction for 4 variables: critical level $p \leq .01$. Sig. * $p \leq .01$ ** $p < .001$

3.3.8 Analysis of variance and non-parametric tests on antenatal and 1 week postnatal variables

3.3.8.1 LABOUR AGENCY

As described in subsection 3.3.7.3, certain of the antenatal and 1 week postnatal variables had three or fewer levels: educational level, employment during pregnancy, antenatal class attendance, whether the woman achieved a spontaneous vaginal birth, whether she had known antenatally the midwife who was with her in labour, and whether she had the same midwife throughout her labour. However, only 10 women had been unemployed during pregnancy, and only 7 women had met the midwife who cared for them in labour during the antenatal period. In the case of these two variables the discrepancy between the

group sizes was too large to make comparisons meaningful. With the remaining 4 variables appropriate statistical tests were used to ascertain whether their different levels gave rise to differences in LAS or TMD, indicating that the variable should be incorporated into multiple regression analysis which explored the predictors of LAS or TMD.

In view of the lack of homogeneity of variance for LAS in some of these calculations, even after transformation, non-parametric tests were used throughout. LAS on the three occasions for women whose education stopped at a basic level, at 'A' level, and after further education, were compared using a Kruskal-Wallis H test. The results of these tests are shown in table 3.34. LAS for the binary variables of: antenatal class attendance, spontaneous vaginal delivery, and continuity of care throughout labour were compared using a Mann-Whitney U test (see table 3.35). Only one result is significant from these analyses. Women who had a spontaneous vaginal delivery had significantly higher LAS scores, when they recalled their labour agency at 16 weeks postnatally, than women who had other types of delivery (see table 3.5, page 106, for summary of other types of delivery experienced by this group of women). This means that women who had uncomplicated deliveries were more likely, at 16 weeks postnatally, to say that they had experienced a high level of both internal and external control during the birth.

Table 3.34 Results of Kruskal-Wallis test for LAS at different levels of educational achievement.

	Chi-square	sig.
Antenatal LAS	1.3392	n/s
1 week postnatal LAS	2.1543	n/s
16 weeks postnatal LAS	2.3624	n/s

Bonferroni correction for 3 variables: critical level $p \leq .02$.

Table 3.35 Results of Mann-Whitney test for LAS with binary variables

	Antenatal class attendance		Spontaneous vaginal delivery		Continuity of care in labour	
	Z	sig.	Z	sig.	Z	sig.
A/N LAS	-1.4145	n/s	-.0798	n/s	-.4768	n/s
1 week P/N LAS	-.1392	n/s	-1.8965	n/s	-1.6475	n/s
16 weeks P/N LAS	-.2308	n/s	-2.7713	.006	-1.1882	n/s

Bonferroni correction for 3 variables: critical level $p \leq .02$.

3.3.8.2 TOTAL MOOD DISTURBANCE

Homogeneity of variance was achieved for TMD scores in these calculations after square root transformations²⁸. The 4 variables described in the last subsection were subjected to two-way analyses of variance with TMD as the repeated measures factor. The findings are shown in table 3.36. The significant differences between TMD have already been addressed in section 3.3.4.1 (page 111). Apart from this

²⁸ With highly unequal group sizes such as antenatal class attendance, homogeneity of variance is essential before parametric analysis can be performed meaningfully (Tabachnick and Fidell (1996)).

there were no significant differences between TMD scores for women at different levels in any of the 4 variables. Neither were there any significant interactions.

Table 3.36 Results of Two-way ANOVA (F values)

	Within subjects (TMD)	Between subjects	Interaction
Educational level	42.83 (p<.001)	.38 (n/s)	1.26 (n/s)
A/N class attendance	26.56 (p<.001)	.01 (n/s)	.86 (n/s)
Spontaneous vaginal delivery	49.34 (p<.001)	1.76 (n/s)	.32 (n/s)
Continuity of care in labour	46.70 (p<.001)	.15 (n/s)	1.01 (n/s)

Bonferroni correction for 4 variables: critical level $p \leq .013$.

3.3.8.3 INTERRELATIONSHIPS AMONGST DEMOGRAPHIC AND BACKGROUND, AND 1 WEEK POSTNATAL VARIABLES

Relationships between the 4 variables described in subsection 3.3.8.2 and the remaining demographic and background, antenatal and 1 week postnatal variables were also explored, to supplement the correlational information of subsection 3.3.7.4. Due to the unequal sample sizes and variances, and non-normal distributions for much of this data, non-parametric analysis was the method of choice.

Kruskal-Wallis H tests were performed to look for differences of age or in locus of control score between women whose education was completed at different levels. The results are shown in table 3.37. These show that there were significant differences between women of different educational levels in terms of their age and their chance locus of control scores. More highly educated women were more likely to be older and less likely to ascribe the outcomes in their lives to chance.

Table 3.37 Results of Kruskal-Wallis test for age and locus of control of women who achieved different educational levels.

	Chi-square	sig.
Age	17.3527	.001
Chance locus of control	9.0916	.011
Powerful others locus of control	2.0602	n/s
Internal locus of control	1.6708	n/s

Bonferroni correction for 4 variables: critical level $p \leq .013$.

A Mann Whitney U test was performed on the 1 week postnatal data to examine whether there was a difference between women who had the same midwife with them throughout labour and those who did not in terms of whether they achieved a spontaneous vaginal delivery or not. The result was not significant: $Z = -1.1347$. Differences between women who had a spontaneous vaginal delivery and those who did not, and between those who experienced continuity of care throughout labour and those who did not, in terms of their factor scores, were also explored. The results are shown in table 3.38. There were

two significant results, indicating that women who have a spontaneous vaginal delivery score more highly (indicating more control) on factor 2, at 1 week postnatally, than women who do not; and that women who have the same midwife throughout labour and the birth report the birth to be less difficult (factor 1) than those who do not.

Table 3.38 Results of Mann-Whitney U test for factor scores in women who experienced a spontaneous vaginal delivery or continuity of care and those who did not

	Factor 1		Factor 2	
	Z	sig.	Z	sig.
Spontaneous vaginal delivery	-1.7468	n/s	-3.1464	.002
Continuity of care in labour	-2.5954	.009	-2.0254	n/s

Bonferroni correction for 4 variables: critical level $p \leq .013$.

3.3.9 Multiple regression

3.3.9.1 ANTENATAL LAS AND TMD AS DEPENDENT VARIABLES

Hierarchical multiple regression analyses were performed on the data in order to explore the predictors for the antenatal and both the postnatal LAS and TMD scores²⁹. For the purposes of selecting predictors to enter into the equations, only those with correlations of less than -0.2 or more than $+0.2$ with the appropriate dependent variable were used (see tables 3.24 and 3.25, pages 119 and 120), as an exploratory examination had shown that correlations between ± 0.2 were not significant in analyses using this data. For each of the analyses described in this and the following sub-sections, residuals were examined to ensure the assumptions of multiple regression were being met, and that the relationships between the predictor and dependent variables were indeed linear. Where necessary, outlying scores were omitted from the dependent variables to ensure a distribution more closely approximated to a normal curve.

For both of the equations based on the antenatal data, demographic and background variables were entered into the equation first, as potentially relevant underlying factors in the issues of interest. In the second step the remaining antenatal variables were entered. In the case of antenatal LAS the background variables were the two external locus of control scales (chance and powerful others) followed in the second phase by antenatal TMD. In the case of antenatal TMD the demographic variables were the two external locus of control scales and age, followed in stage 2 by antenatal LAS. The results of these analyses are reproduced in table 3.39 and 3.40. Each step of both procedures explained a significant increment in the variance of the antenatal LAS and TMD scores respectively. In the first procedure (table 3.39), each of the variables was significant in its own right, indicating that a low reported belief that powerful others or chance occurrences controlled one's outcomes (ie. external locus of control) had a

²⁹ Hierarchical regression allows predictors to be entered into the multiple regression equation in theoretically driven, ordered sets.

significant effect on raising antenatal reports of control expectations (antenatal LAS). Once these locus of control variables were taken into account, the women's antenatal TMD scores had a significant, and negative, effect on antenatal LAS. In other words, the more disturbed the women's reported mood, the less labour agency they expected to have.

Table 3.39 Hierarchical multiple regression with antenatal LAS as DV, entering demographic and antenatal variables.

Stage 1: Entry of demographic variables			
	B	Partial r	Sig
External locus of control - chance	1.019	.2223	.013
External locus of control - powerful others	1.067	.2051	.022

After step 1
 $R^2 = 0.13$, $F_{inc}(2,123) = 10.172$, $p < .001$

Stage 2: Entry of antenatal variables			
	B	Partial r	Sig
A/N TMD	-.436	-.5457	.000

After step 2
 $R^2 = 0.38$, change in $R^2 = 0.25$, $F_{inc}(1,122) = 51.76$, $p < .001$

Table 3.40 Hierarchical multiple regression with antenatal TMD as DV, entering demographic and antenatal variables

Stage 1: Entry of demographic variables			
	B	Partial r	Sig
Age	-1.252	-.2069	.022
External locus of control - chance	-.124	-.0241	.792
External locus of control - powerful others	-1.057	-.1848	.042

After step 1
 $R^2 = 0.08$, $F_{inc}(3,120) = 4.323$, $p < .01$

Stage 2: Entry of antenatal variables			
	B	Partial r	Sig
A/N LAS	-.597	-.5271	.000

After step 2
 $R^2 = 0.33$, change in $R^2 = 0.25$, $F_{inc}(1,119) = 45.78$, $p < .001$

In the second analysis (table 3.40) all the individual variables were significant except the Levenson's chance external locus of control score. Despite the high correlation of Levenson's chance and powerful others scales, the lack of significance of the chance scores was not a result of multicollinearity, as removal of the powerful others scale from the equation did not render the chance scale significant. These findings showed that age had a significant and negative effect on antenatal mood disturbance scores, that is, the older the woman, the less likely she was to report mood disturbance. Reports of a low belief in the ability of powerful others to control her outcomes also had a negative and significant effect on antenatal mood

scores, meaning that the less the women reported beliefs that powerful others controlled their outcomes, the less disturbed were their reported moods. Once the effect of these two variables were taken into account, antenatal labour agency scores related significantly and negatively to antenatal total mood disturbance, as already demonstrated in the previous analysis. However, although it is possible that a low reported expectation of control might be instrumental in causing increased mood disturbance scores, it seems more probable that the relationship is the other way around.

3.3.9.2 1 WEEK POSTNATAL LAS AND TMD AS DEPENDENT VARIABLES

The results of the analysis taking 1 week postnatal LAS as the dependent variable are reproduced in table 3.41. The first predictor variable in this computation was antenatal LAS. This allowed the subsequent steps in the analysis to explore the variables relating to the change in LAS between the antenatal period and 1 week postnatally. After entry of antenatal LAS, the two external locus of control scales were brought into the analysis. In the third step antenatal TMD was entered. Antenatal LAS was significantly and positively related to 1 week postnatal LAS, indicating that a reported antenatal expectation of control in labour significantly predicts the woman's assessment of being in control when she is asked at 1 week postnatally. Once this was taken into account, none of the other demographic or antenatal variables (that is, the external locus of control variables or TMD) were any longer significant, even after allowing for correlations and possible multicollinearity effects. In other words, none of these variables can be held responsible for the change in LAS between the antenatal period and 1 week postnatally.

Table 3.41 Hierarchical multiple regression with 1 week postnatal LAS as DV, entering antenatal LAS, then demographic and antenatal variables

Stage 1: Entry of antenatal LAS			
	B	Partial r	Sig
A/N LAS	-.435	.4414	.0000
After step 1 $R^2 = 0.18$, $F_{inc}(1,119) = 28.791$, $p < .001$			
Stage 2: Entry of demographic variables			
	B	Partial r	Sig
External locus of control - chance	.178	.0413	.6558
External locus of control - powerful others	.335	.0692	.4548
After step 2 $R^2 = 0.18$, no change in R^2 , $F_{inc}(2,117) = .58$, n/s			
Stage 3: Entry of antenatal variables			
	B	Partial r	Sig
A/N TMD	-.029	-.0316	.7348
After step 3 $R^2 = 0.18$, no change in R^2 , $F_{inc}(1,116) = .02$, n/s			

The findings from the regression in which 1 week postnatal TMD was taken as the dependent variable, are shown in table 3.42. The predictor variables used in this computation were antenatal TMD in the first

step, followed by antenatal LAS. Both were significant. Antenatal TMD had a large and positive effect. Once this was taken into account, antenatal LAS had a negative effect, meaning that the higher the scores for antenatal expected control, the lower the mood disturbance scores at 1 week postnatally. However LAS only accounted for a small change in variance.

Table 3.42 Hierarchical multiple regression with 1 week postnatal TMD as DV, entering antenatal TMD, then antenatal LAS

Stage 1: Entry of antenatal TMD			
	B	Partial r	Sig
A/N TMD	.511	.5265	.0000

After step 1
 $R^2 = 0.27$, $F_{inc}(1,120) = 46.014$, $p < .001$

Stage 2: Entry of antenatal LAS			
	B	Partial r	Sig
A/N LAS	-.245	-.2064	.0231

After step 2
 $R^2 = 0.30$, change in $R^2 = .03$, $F_{inc}(1,119) = 5.29$, $p < .025$

3.3.9.3 16 WEEKS POSTNATAL LAS AND TMD AS DEPENDENT VARIABLES

Table 3.43 represents the results of a hierarchical regression which took 16 week postnatal LAS as its dependent variable. The predictor variables and order of entry were: firstly, antenatal LAS; then 1 week postnatal LAS (so that the subsequent steps could explore the variables which related to the change in LAS between 1 and 16 weeks postnatally); followed by the antenatal background variables (the two external locus of control scales); then antenatal variables (antenatal TMD); followed by the 1 week postnatal variables (the two extracted factors and 1 week TMD). Also entered at this last stage was whether the woman had achieved a spontaneous vaginal delivery or not, as the Mann Whitney test (table 3.35) had shown a significant change in 16 week postnatal LAS for this variable. It was found that antenatal expectancy of labour agency, and then 1 week postnatal experience of labour agency, took up a considerable amount of the variance accounted for by the labour agency score at 16 weeks postnatally. This meant that antenatal reports of expectations of control were still affecting the woman's assessment of how much control she actually had at 16 weeks postnatally, although her assessment at 1 week postnatally of how much control she had was also having a significant effect. Once this was taken into account, then antenatal measures of external locus of control were not significant, even when their correlation with each other was taken into consideration. However antenatal total mood disturbance accounted for significantly more of the variance, although the corresponding increase in variance was very small, indicating that the effect was not strong. Once these things had been accounted for, of the measures taken at 1 week postnatally, only the factor scores which covered the variables concerned with a perception of control during labour showed a significant effect, despite exploration of the data to exclude

the possibility of multicollinearity effects. So it was these issues, rather than the woman's assessment of the difficulty of labour or the type of delivery which influenced her longer term perception of whether she felt in control or not.

Table 3.43 Hierarchical multiple regression with 16 weeks postnatal LAS as DV, entering antenatal and 1 week LAS, then demographic, antenatal and 1 week postnatal variables

Stage 1: Entry of antenatal LAS			
	B	Partial r	Sig
A/N LAS	.518	.4902	.0000
After step 1 R ² = 0.23, F _{inc} (1,121) = 38.27, p<.001			
Stage 2: Entry of 1 week postnatal LAS			
	B	Partial r	Sig
1 week postnatal LAS	.694	.7454	.0000
After step 2 R ² = 0.66, change in R ² = .43, F _{inc} (1,120) = 150.03, p<.001			
Stage 3: Entry of external locus of control variables			
	B	Partial r	Sig
External locus of control - chance	-.134	-.0450	.6255
External locus of control - powerful others	.405	.1202	.1908
After step 3 R ² = 0.66, change in R ² = .00, F _{inc} (1,118) = F _{inc} (2,117) = .87, n/s			
Stage 4: Entry of A/N TMD			
	B	Partial r	Sig
A/N TMD	-.115	-.1844	.0447
After step 4 R ² = 0.67, change in R ² = .01, F _{inc} (1,117) = 4.12, p<.05			
Stage 5: Entry of 1 week postnatal variables			
	B	Partial r	Sig
Factor 1 (difficulty/ complexity of experience)	2.736	.1498	.1100
Factor 2 (control over the experience)	5.670	.2651	.0042
1 week P/N TMD	-.026	-.0475	.6145
Spontaneous vaginal delivery or not	3.931	.1210	.1979
After step 5 R ² = 0.70, change in R ² = .03, F _{inc} (4,113) = 4.39, p<.005			

Table 3.44 shows the final hierarchical regression, taking the 16 week TMD scores as the dependent variable. As with the preceding analyses, predictor variables were only entered if they showed a .2 correlation or above with the dependent variable. These variables were firstly antenatal, then 1 week postnatal, TMD, followed by antenatal LAS. Antenatal TMD related significantly and positively to TMD at 16 weeks postnatally, as did the 1 week postnatal TMD when the antenatal TMD had been taken into

account. The antenatal LAS scores did not have a significant effect on the change between 1 and 16 week postnatal TMD.

A summary of the composite findings from the multiple regression analyses is shown in figure 3.4.

Table 3.44 Hierarchical multiple regression with 16 weeks postnatal TMD as DV, entering antenatal and 1 week TMD, then antenatal and 1 week postnatal variables

Stage 1: Entry of antenatal TMD			
	B	Partial r	Sig
A/N TMD	.339	.3613	.0000

After step 1
 $R^2 = 0.12$, $F_{inc}(1,124) = 18.620$, $p < .001$

Stage 2: Entry of 1 week postnatal TMD			
	B	Partial r	Sig
1 week postnatal TMD	.302	.3246	.0002

After step 2
 $R^2 = 0.21$, change in $R^2 = .09$, $F_{inc}(1,123) = 14.48$, $p < .001$

Stage 3: Entry of A/N LAS			
	B	Partial r	Sig
A/N LAS	-.045	-.0365	.6877

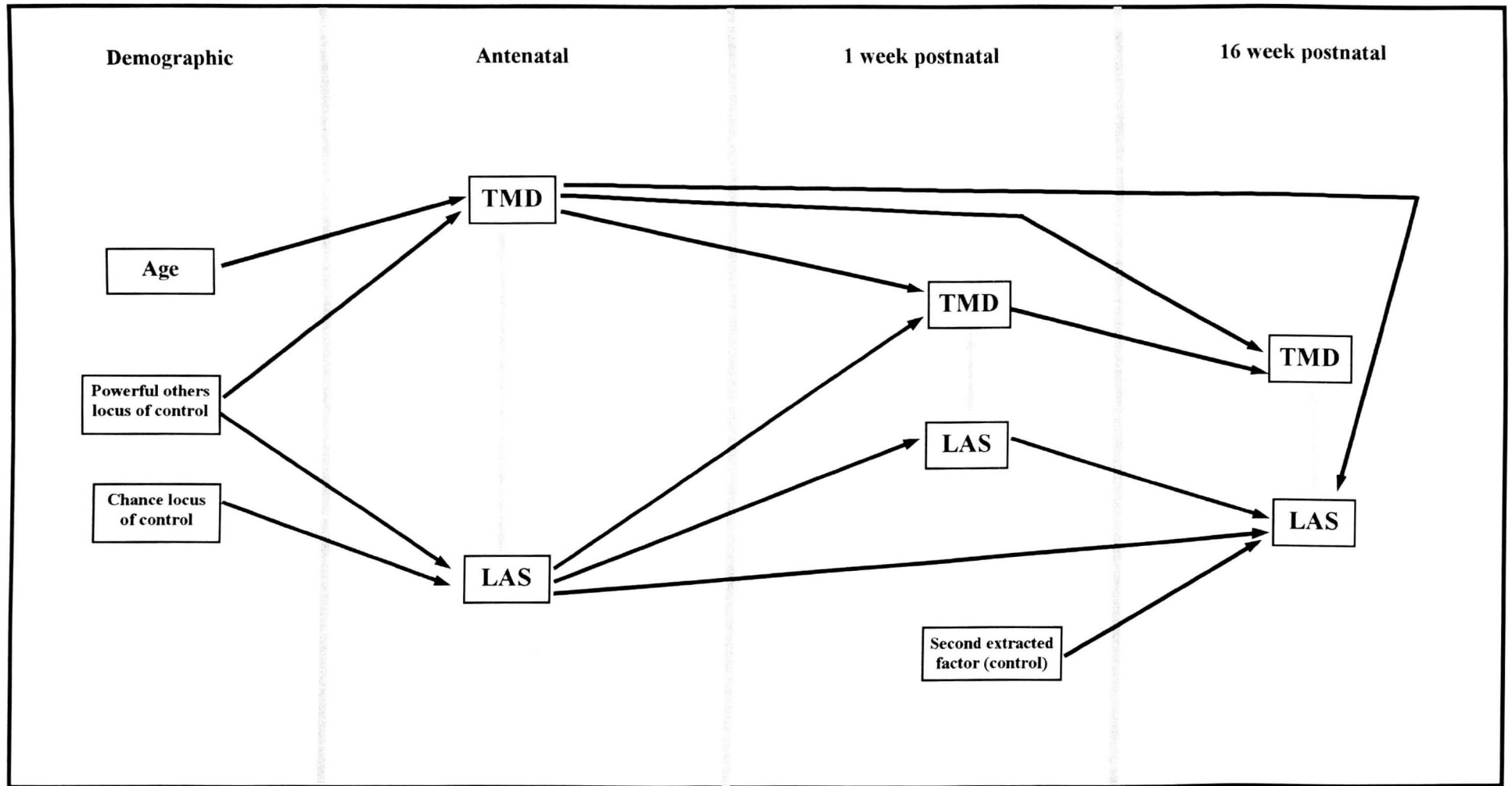
After step 3
 $R^2 = 0.21$, change in $R^2 = .00$, $F_{inc}(1,122) = 0.16$, n/s

3.4 Discussion

This section will begin with some comments about control in childbirth. After this it will deal in turn with each of the research questions postulated in section 1 of this chapter, and then make some general comments about the study described above, concluding with a summary of the more problematic issues arising out of this study which will be explored in chapter 4. Because this discussion does not draw upon the preceding results in the order in which they were presented, data and tables from the results section which are relevant to the issues under discussion will be identified.

3.4.1 Internal versus external and expected versus wanted control

It was noted in the literature review in chapter 1 that some researchers have made a distinction between parturient women's expectations and experiences of control over themselves (internal control) and of their environment (external control), although these two measures have been found to be significantly related (Green, Coupland and Kitinger, 1988). The Labour Agency Scale purports to measure both types of control (Hodnett, 1989), although there was some concern prior to this study that the questions in the scale might be biased towards a measure of internal control. However the two postnatal LAS measures



Key: Items at arrow heads are independent variables, and those at arrow ends are predictor variables. Only significant relationships are shown.

--- = Correlations

Figure 3.4 Summary of multiple regression findings (incorporating correlations between postnatal TMD and LAS).

correlated strongly with measures of external and internal control made at the same time (subsection 3.3.7.2, page 119). This suggests that postnatal LAS was a reasonable indicator of women's reported experiences of both types of control. Antenatal measures of expected external control also correlated with antenatal LAS. A relationship between antenatal expectations of internal control and LAS could not be ascertained directly as expected internal control was not measured in the antenatal period. That antenatal LAS embraced internal as well as external control could be assumed because a) the LAS questions were more obviously directed at internal control issues and b) the antenatal questions were the same as the postnatal questions, apart from a change in tense. Therefore it was likely that the postnatal relationship of both internal and external control with LAS mirrored antenatal relationships.

The correlation coefficients for the relationships between external and internal control on the postnatal questionnaires (tables 3.22 and 3.23, page 119) were, on both occasions, lower than those for either measure with the corresponding LAS score. This suggests that, despite the tendency for women who positioned themselves as expecting one type of control to also say they expected high levels of the other, they were not conflating internal and external control. The lower correlation coefficient indicates that there were fewer similarities between the two measures than there were between either of the measures and LAS with which they were both associated.

The issues of expected versus wanted control were also raised in the literature review. The limited research in this area failed to agree as to whether these two aspects of control in childbirth were related (section 1.3.2.2, page 31). In this study table 3.21 (page 118) shows that women who said they wanted high control over what was done to them during labour and birth also said that they expected it. Women were also more likely to say they wanted internal control if they also said that they wanted external control. Wanted internal and external control did not correlate with antenatal LAS, although expected external control did, thus supporting the classification of the LAS as a measure of expected, rather than wanted, control (Hodnett and Simmons-Tropea, 1987). Although the measures of wanted and expected external control correlated significantly, the coefficient was nevertheless comparatively small. This suggests that, although women who report wanting external control are more likely to say that they expect it, the two issues are not being confused.

Although the findings of this section indicate that various aspects of control in childbirth are related, yet not identical, it seems reasonable to suggest that there might be more subtle differences in the way women represent different control issues that might be less easily elicited by quantitative approaches. To some extent this has already been shown in the various aspects of control identified from the literature reviewed in chapter 1 (subsection 1.3.3.3, page 37ff) and in the pilot study (subsection 2.3.3.4, page 85). Therefore the way the interview women represented control in childbirth will be explored in more depth in the next chapter.

3.4.2 Discussion relating to the first research question

The first research question asked: do certain demographic and background variables such as education, social class, age, and general control expectations, relate to women's expectations and experiences of

control in childbirth; and are features of the birth, such as its difficulty, pertinent in terms of women's experiences of control?

Age and level of education (as an indicator of social class), did not relate to expected or achieved LAS (tables 3.24, 3.25 and 3.34, pages 119, 120 and 124). In terms of the issue of the possible effects of social class, therefore, the work of researchers like Shepperdson (1983), Green, Coupland and Kitzinger (1988), and Martin (1990) is supported: social background (as far as it is indicated by educational level) did not predict reports of expected or achieved control. In keeping with the suggestion of Woollett, Lyon and White (1983) that, at the time of their research, working-class women were lagging behind middle-class women in taking control of their births, it could be argued that working-class women have now caught up. However other recent research is still identifying differences (Machin and Scamell, 1997). Therefore it is possible that the disparity between the findings of different researchers might owe more to the nature of their research than to questions about the compatibility of their results. As described in chapter 1 (subsection 1.4.2.1, page 43), there are several sources of difference between the various research studies: the country in which the research took place; the way in which social class was determined; the research approach, whether interview or questionnaire based; the sample taken, whether all the respondents were from one social background or not; and the centrality of the class issue in the research. However it was noted that the studies cited in chapter 1 which highlight class differences in expectations and experiences of control in childbirth have more commonly been interview or observation based, whilst those which have found no difference have tended to be questionnaires or surveys. It was suggested that qualitative research might be a more sensitive tool for eliciting social class differences. Therefore this will be examined in the next chapter and more general issues around expectations and experiences of control will also be explored.

In the hierarchical multiple regression external locus of control variables showed a significant and direct relationship with antenatal LAS (see figure 3.4, page 132). However internal locus of control showed no such relationship. In other words, women's reported beliefs about their own control did not appear to be connected with their reported control expectancy for childbirth, but how women reported beliefs in control which came from outside themselves did. A high belief in powerful others or chance was related to low expectations for control in childbirth, whilst low beliefs in external control resulted in reports of high expectations of labour agency. It might be the fact that birth is an unknown situation, particularly for the first-time mother, which renders internal control belief as non-significant. Whatever a woman might believe about her ability to control outcomes under normal circumstances, she simply does not know whether such an aptitude will be of use in childbirth. However, what she believes about the control of others over her life can affect her outlook on childbirth. As shown in chapter 1, medical rhetoric has positioned birth as a time when many things can go wrong, and as a situation in which the childbearing woman can expect to be surrounded by medical expertise. If her tendency is to believe that outcomes occur by chance, or that powerful people control her destiny as a general rule, she is more likely to assimilate these images of birth and expect little or no control herself. Conversely, if she is able to reject such images because they contradict her general beliefs, she leaves herself open to expect a degree of control.

Although a direct relationship between social class and control in childbirth was not found in this study, level of education was not completely independent of all control issues. Tables 3.26 (page 120) and 3.37 (page 125) indicated that younger women, and those who were less educated, were more likely to express a belief in chance locus of control. A relationship between lower levels of education and higher external control beliefs has been noted in research elsewhere (Argyle, 1994).

The significant relationship between education and age (table 3.37, page 125) meant that, as suggested in chapter 1, older women expecting their first babies were likely to be more highly educated, probably because they had left childbearing until they had completed their education and established their careers. The multiple regression (figure 3.4, page 132) also showed that age was related to antenatal mood, that is, older women in the study were less likely to report raised mood disturbance. This might have been because, through greater maturity, their moods were less likely to fluctuate, or because older women might have felt more reticent to admit to negative moods.

The two external locus of control scales behaved differently in so much that only the powerful others scale related to higher levels of antenatal TMD: a high belief in powerful others resulting in higher levels of mood disturbance. The lack of relationship of the chance scale with antenatal TMD may have arisen because chance is, by definition, not something which can be altered by personal effort. It is possible that the women varied as to whether they found such a position problematic from a psychological point of view. Some women who positioned themselves as having a high belief in chance might have felt that they were simply being realistic, and have been quite resigned to the prospect and not unhappy about it, whilst for others it might have been a source of fear and anxiety. A reported belief in the power of others, however, may have been less contradictory. In the current climate of encouragement of personal control and autonomy, such beliefs are more likely to be experienced as problematic. If it was felt that powerful others might prevent a person's rightful control, this could have been a source of anger, tension or depression.

In chapter 1 (subsection 1.3.2.2, page 30), locus of control was defined as an individual's beliefs about the effects of their behaviour on outcome. It was shown that such a concept is narrow, not tapping such issues as beliefs about responsibility for events, and the value of the reinforcement. As such it must be stressed that locus of control beliefs are unlikely to represent the full importance of the influence of childbearing women's past lives upon them. It was therefore important to explore the issue of past life experience and its relevance to childbirth more fully in the interview study.

There was no significant difference, in terms of LAS on each of the three occasions it was assessed, between women who attended antenatal classes and those who did not (table 3.35, page 124), supporting the findings of Slade, Macpherson, Hume and Maresh (1993), that antenatal classes have little influence on women's experiences of labour. However the level of class attendance in this group was high, at 92%. Many other studies report a lower percentage attendance amongst primiparous women, for example the 62% in the study by Slade et al.. It is possible therefore that women who attended classes in this geographical area were not typical of those living elsewhere. Although there were significant differences in class attendance for women at different levels of education (table 3.4,

page 105), the percentage attendance was still high (82.1%) for the least educated women. Antenatal education has become increasingly popular in recent years (Enkin, Keirse, Renfrew and Neilson, 1995), but it is possible that in populations where women are more cautious about class attendance there are greater differences between those who attend and those who do not. It is also possible that, despite the wide education and age range in this sample, the women were not a true cross section of the primiparous childbearing population for the area, but were particularly motivated to both attend classes and volunteer for questionnaire studies. Because there were a variety of sources of antenatal education open to women living in the area from which the sample was taken, it would not be easy to ascertain the percentage uptake in general, to make comparisons and to decide whether this was the case. The way in which the interview women positioned antenatal classes, in terms of their helpfulness in preparing them to deal with control related birth issues, will be discussed in the next chapter.

Another set of issues which, it was postulated, might relate to control were the features of the birth itself. The factor analysis (tables 3.17 and 3.18, pages 116 and 117) suggested that the questions the women were asked about the birth experience tapped two key issues: how difficult the woman found it, and how much control she felt she had over the experience. Moreover the factor structure was extremely reliable, changing very little between 1 and 16 weeks postnatally, suggesting that the women continued to identify two clearly distinctive factors throughout. Although both these factors, at 1 week postnatally, when converted to variables by using factor scores, correlated with 16 week postnatal LAS (table 3.19, page 117), it was only the second factor (concerned with control issues) which, in the multiple regression, related significantly to the change in the women's reports of LAS between 1 week and 16 weeks postnatally (table 3.43, page 130). Thus the only meaningful relationships between difficulty of the birth (indicated by factor 1) and labour agency were the correlations between measures taken at the same time point. The problem with these relationships was the impossibility of postulating any cause and effect. The women's representations of control in childbirth were as likely to influence their reports of the difficulty of the birth as vice versa.

There was also no significant difference in labour agency between women who had the same midwife throughout labour and those who did not (table 3.35, page 124), although women who had continuity of care in labour reported the birth to be significantly less difficult (table 3.38, page 126), indicating that support from the same midwife is not without advantageous effects, even if these do not feed directly into control related issues.

In summary, the first research question has been answered in so much that the only background variables, out of those explored in this study, which appear to relate significantly to women's expectations of control in childbirth are the external locus of control scales. However because of the limitations for quantitative research in covering every possible mediating variable, this issue will benefit from further exploration using interviews. There is also a need to explore the question of what control means to different women with different backgrounds, expectancies and birth experiences, and there is the question of the place, if any, of antenatal class attendance in the picture of women's control aspirations and achievements. These issues will be explored further in the next chapter.

3.4.3 Discussion relating to the second research question

The second research question was: how do childbearing women construct childbirth control both before and after the birth? In other words, what is the relationship between their reported expectations and experiences?

In terms of LAS, the women reported achieving significantly more control than they had expected (section 3.3.4.3, page 112). In other words, in this study, reported high expectations did not result in dashed hopes. It is also important to note that, as the 1 and 16 week postnatal LAS scores were not significantly different, the women's postnatal reports of control remained relatively stable over time, something which was supported further by the stability of the postnatal variables associated with control between 1 and 16 weeks postnatally (table 3.13, page 114). It was also notable that women who were depressed, according to the EPDS, both antenatally and in the early postnatal period, had LAS scores which were considerably lower than those of women who were not depressed (section 3.3.4.4, page 112). In other words they reported both lower expectations and achievement of control, but still, at 1 week postnatally, reported experiencing more control than they had said they expected.

An examination of the multiple regression findings (figure 3.4, page 132) revealed that the women's reported expectations of control (antenatal LAS) not only had an effect on the way they positioned their experiences at 1 week after the birth, but also had a direct effect on the change in LAS between 1 and 16 weeks postnatally. The triadic configuration of LAS might, it could be argued, be indicative of a trait effect. However this explanation has reductionist undertones which are not in keeping with the material-discursive approach taken in this thesis. A more acceptable explanation might be that, after the birth, women set out to promote an image consistent with their claims of antenatal expectancies. Although there might be some logic in a woman doing this to save 'face' if she had positioned herself as expecting high levels of control, it is more difficult to see why women at the opposite end of the scale, who did not claim to expect much control, should also feel the need to be consistent. Two alternative explanations seem more probable. The first is that women who have the ability to articulate high expectations on a questionnaire will also be able to articulate and thus obtain the kind of support and autonomy they desire when in labour. The second is that women who have the ability to be optimistic about the likelihood of control during labour and birth, also have the ability to be optimistic about what happened and vice versa. This latter explanation seems the more likely: firstly because of the negative association between external locus of control variables and labour agency (see figure 3.4, page 132), suggesting that a certain outlook upon life is related to expectations of control in childbirth; secondly because to tick the appropriate boxes in a questionnaire to indicate a high level of control requires little in the way of high verbal communication skill; and finally because of the significant correlations between LAS and TMD on each questionnaire (tables 3.24 and 3.25, pages 119 and 120), indicating that LAS and mood are related at each point in time. Despite this it is important to note that, as observed by Hodnett (1989), expectations alone are not the key to experiences of control and this is supported by the fact that, in the multiple regression (table 3.41, page 128) only 18% of the

variance of the 1 week postnatal LAS score was accounted for by antenatal LAS. This suggests that other factors are involved, something which will be explored further in the next chapter.

In summary to this section, therefore, there was a relationship between these women's reported expectations of control in childbirth and their reports of their experiences, supporting the work of Davenport-Slack and Boylan (1974), Green, Coupland and Kitzinger (1988), Hodnett (1989) and others, and possible explanations for this relationship were put forward. However reports of the amount of control experienced during the labour and birth did not change significantly between 1 and 16 weeks postnatally. It was also suggested that reported experiences of control were influenced by more than expectations, an issue which will be explored in depth in the next chapter. The relationships between the three LAS scores, and their links with assessments of mood, suggest that the solution to making women feel in control during childbirth will not be found in building up their expectations alone. However the women in this study also reported more control than they had expected, even when they reported antenatal and postnatal depression and their LAS scores were reduced.

3.4.4 Discussion relating to the third research question

The third research question asked whether there were differences between the woman's and the midwife's configuration of how much control a certain woman had expected and achieved, or of how satisfied she was with her experience? Only external control was examined in addressing this question.

Table 3.27 (page 121) shows correlations between all three of the questions asked in the midwives' questionnaires. However table 3.28 (page 121) indicates that the primiparous women's reported satisfaction with the experience did not correlate significantly with their reports of expected control, although expected control and experienced control correlated, as did experienced control and satisfaction.

The midwives and the childbearing women appeared to be agreed as to whether the woman had constructed her birth experience as satisfying (table 3.29, page 122), and although the midwives' construction of satisfaction also correlated with several other variables, for example, difficulty of labour, and the number of interventions (table 3.31, page 123), the correlation between the midwife's and the woman's report of the woman's satisfaction was the highest. It is interesting that such a reasonable correlation should be attained despite the problems, highlighted in the literature, and discussed in chapter 1, associated with assessment of satisfaction with birth (Shearer, 1983). It is also interesting that, although, as could be predicted from the literature, the women did rate their satisfaction with their birth experiences highly, the ceiling effects, apparent when the women rated their satisfaction with their care (table 3.10, page 110), were not evident here. Finally, the correlation between the midwives' and the childbearing women's satisfaction might have been even higher had they both been asked exactly the same question. However the midwives were asked to rate the women's satisfaction with labour and birth, whilst the women were only asked to rate satisfaction with the birth. It is possible that, for many women, the term 'birth' did include the labour, but this cannot be assumed.

Although the midwives' assessments of the women's satisfaction were correlated with the women's own reports, the midwives appeared less accurate at assessing expected or achieved control (table 3.29, page 122). The midwives' reports of the women's expected control correlated with the antenatal Depression-Dejection and Tension-Anxiety subscales and also with antenatal TMD scores (table 3.30, page 122). However the women's reports of expected external control did not correlate with any of these mood related variables, although their reports of expected labour agency correlated strongly with all of them (table 3.32, page 123). This suggested that the midwives might be basing their assessments more strongly on their appraisals of the women's self-control: the second component of LAS, rather than external control. However if this was the case, it is interesting that antenatal LAS itself did not correlate with the midwives' assessments of expected control (table 3.30). This suggests that, if self-control was the issue to which the midwives were sensitive, it was non-verbal indicators of this control which influenced the midwives' assessments, rather than the women's reports. In other words the childbearing women may not have reported the same level of expected self-control that was implied by their mood levels. One problem with this hypothesis is that the midwives were making their assessments at the time the women gave birth, whilst the women's TMD scores had been collected up to 6 weeks previously. However lack of significant change in TMD and the Tension-Anxiety subscales between 36 weeks antenatally and 1 week postnatally (subsection 3.3.4.1, 1st paragraph, page 111; and table 3.12, page 112), suggests that these variables were still likely to be at around their antenatal levels at the time of birth. Reports of Depression-Dejection did become significantly lowered between the two assessments however, although it was possible that this was largely as a result of the elements of the early puerperium: tiredness and soreness, rather than a change which occurred before the birth.

Although the midwives' and women's assessments of achieved control did not correlate either, both correlated with the women's estimates of whether the birth was a positive or negative experience: a high level of positive feeling about the birth being associated with high assessments of both 1 week postnatal LAS and achieved external control (tables 3.31 and 3.33, page 123). However it is interesting that the midwives also associated achieved external control with whether a high number of interventions were used, the direction of the correlation indicating that higher numbers of interventions were associated with less control. Number of interventions was not an indicator of the childbearing women's reports of achieved control (table 3.33, page 123), supporting the suggestion made in chapter 1 (subsection 1.3.2.1, page 27), that it is how disempowering or otherwise a woman perceives an intervention to be that is the important issue, rather than the intervention itself. Therefore, despite the midwives' inability to assess directly the amount of external control the women would report, it seems that they were aware of at least one factor which related to the women's assessments: the woman's positivity towards the birth, suggesting once again a sensitivity to non-verbal indicators on the part of the midwife. However the midwives also appeared to misconstrue the number of interventions as an indicator of control.

In summary: the midwives and childbearing women agreed on whether the woman positioned herself as satisfied with her birth experience, but not on how much external control the woman claimed to expect or achieve. There were underlying mood variables common to both the midwives' assessments

of expected control, and the women's antenatal assessments of labour agency, suggesting that the midwives were showing more sensitivity to non-verbal indicators of control, particularly self-control, than they were to the desired amount of external control reported by the women. There was evidence that a similar process was operating in the midwives' evaluations of the women's achieved external control, although there was no evidence, in this case, that the midwives were basing their assessments on the women's internal control. The differences and similarities of midwives' and women's accounts will be explored further in the next chapter, alongside other issues associated with the women's relationships with their carers.

3.4.5 Discussion relating to the fourth research question

The fourth research question asked: does the level of childbirth control which women claim to a) expect and b) achieve have any bearing on their short and long term psychological well-being?

As explained in the first chapter, few studies have related expectations of control to experiences, and then related the differential between the two to postnatal psychological wellbeing (subsection 1.4.5.2, page 54). When women, whose antenatal LAS scores were higher than their 1 week LAS scores, were compared with women in which the position was reversed, there was no significant difference in either 1 week or 16 week TMD between the two groups (section 3.3.4.4, page 113). In other words, to report dashed expectations did not affect women's accounts of postnatal TMD any more than the reporting of expectations which were exceeded.

An examination of the findings from the multiple regression (figure 3.4, page 132) shows that, although LAS and TMD correlated at each point, the only effect of LAS on TMD across time was the effect of antenatal LAS on 1 week postnatal TMD, where reports of higher expected control resulted in less reported mood disturbance. Moreover, this effect was very small (accounting for only 3% of the variance in table 3.42, page 129). Nevertheless this relationship linked the two triads: the effect of antenatal TMD on 1 and 16 week TMD, and the effect of 1 week TMD on 16 week TMD: and a similar effect of antenatal LAS on postnatal agency scores. A second, and even weaker, link (accounting for 1% of the variance in table 3.43, page 130) between the triads across time was provided by the relationship between antenatal TMD and 16 week postnatal LAS. Thus, although the pilot study midwives predicted that control would affect mood, the effect can also work in reverse, as was postulated in subsection 3.4.3 (page 137).

Therefore, as far as the way in which the women reflected their experiences was concerned, reported expectations of control related not only to both postnatal measures of achieved control, but also, much less strongly, to postnatal mood. Raised expectations of control led to better experiences of control, and less mood disturbance at 1 week postnatally, supporting the findings of Green, Coupland and Kitzinger (1988). The pilot study midwives were correct that expectations of control have an important effect on women's experiences of control, but this effect is positive, and a differential with experience does not affect mood. Moreover, with the correlations, at each point, between TMD and LAS, the situation was dynamic, with the woman's antenatal mood state and expectations of control as critical components

(figure 3.4, page 132). The question of what women report as influences on these components, therefore, warrants further exploration, and as already explained, this will take place in the next chapter.

Another important question, which was raised in the chapter 1 (subsection 1.4.5.1, page 53), was whether women position control issues as having other psychological effects than those measured here. This issue will also be explored in chapter 4.

TMD across the three assessments was correlated (tables 3.24 and 3.25, pages 119 and 120), supporting the research which links some cases of antenatal affective disorder with that occurring in the puerperium (Watson, Elliott, Rugg, and Brough, 1984; Green and Murray, 1994), and transient depression occurring in the early postnatal period (postnatal 'blues') with more persistent depression a few weeks later (Hannah, Adams and Lee, 1992). The fact that depression is so prevalent amongst women, particularly those of childbearing age, and that pregnancy and childbirth herald a time of gross hormonal changes, and perhaps more seriously, enduring social consequences (Bebbington, 1996), suggest that it is unsurprising that women who report feelings of depression in the antenatal period can sometimes report similar feelings postnatally (Green and Murray, 1994). However the degree to which such reports are pregnancy and birth related is difficult to determine and beyond the scope of this thesis³⁰. Notwithstanding this, the correlations between mood and agency in this study suggest that if women are to be helped to take control in the ways advocated by the Changing Childbirth Report (Department of Health, 1993), their antenatal emotional well being, regardless of its origins, must be given as much consideration as their stated aspirations for control: something already suggested by the findings of the previous subsection.

Although depression is represented in the TMD assessment by the Depression-Dejection subscale, the other components must not be overlooked, as not all the mood subscales showed the same pattern of change over the three assessments. The Depression-Dejection scores increased significantly in the early antenatal period, perhaps as a result of the women's mixed positive and negative feelings towards the birth and early motherhood, and the postnatal 'blues', and had reduced by 16 weeks (table 3.12, page 112). The EPDS scores followed a similar pattern (section 3.3.4.2, page 112). The Anger-Hostility subscale remained unchanged over the three assessments (table 3.12, page 112), suggesting that the events of birth and the puerperium might generally have little or no effect on how this mood was reported, or perhaps that any effect remained unaltered over the period under study (as this score was still raised in comparison with adult norms). The remaining mood scores were unchanged between the antenatal period and 1 week postnatally, and showed a significant improvement by 16 weeks postnatally. The lack of significant change in the antenatal to 1 week scores can probably be explained

³⁰ It is possible that aspects of the late antenatal period, the birth and the early postnatal period might be positioned as grounds for unhappiness by some women. Nevertheless, Green and Murray (1994) have demonstrated that many women who give high EPDS scores in later pregnancy are already showing signs of unhappiness and low emotional well being in early pregnancy, although it would be very difficult to ascertain whether such women were also depressed before pregnancy occurred.

in terms of the anxieties and tensions over the forthcoming birth being replaced by the effects of the birth.

Certain of the variables which represented the women's rating of the birth experience also changed for the better between 1 and 16 weeks postnatally (section 3.3.5, page 113ff). It is interesting that these variables: whether the birth was better than expected, whether the birth was a positive experience, and whether the woman felt distressed (tables 3.14 and 3.16, pages 114 and 115), all loaded onto the first extracted factor, relating to the difficulty of the birth (table 3.17 and 3.18, pages 116 and 117). The women did not categorize these as control issues; the control related issues remained stable over time, suggesting that it is reports of these aspects of the birth which are more likely to endure unchanged.

In summary therefore, this study showed no direct relationship between unfulfilled expectations of control and raised mood disturbance. What it did show was that reports of high expectations of control were associated with less reported 1 week postnatal mood disturbance and reports of higher levels of achieved control. There was a significant and positive relationship between reports of control at 1 and 16 weeks postnatally. There were similar relationships between the postnatal measures of total mood. Antenatal mood also had a significant, but much weaker, relationship with 16 week control scores. Mood scores (apart from Anger-Hostility) improved significantly between 1 and 16 weeks postnatally, as did certain measures related to women's reports of how difficult they found the birth. Reports of the amount of control experienced however did not change. These were important findings, demonstrating that, in this study the women reported no 'halo' effect, apart from the decrease in satisfaction with care, which could be attributed to ceiling effects (section 3.3.5.3, page 115). It is possible that any such effect had already taken place when the woman was discharged from hospital, before the first postnatal questionnaire was completed, or that the effect was going to occur later: after 16 weeks. However like the research which suggests a relationship between social-class and women's expectations for control in childbirth, the studies cited in chapter 1 which have supported the concept of the 'halo effect' have tended to be interview based (for example: Bennett, 1985, and Simkin, 1992). Because interviews more easily allow an exploration of women's representations of individual procedures, this issue warrants further attention in the next chapter.

The results reviewed in this section also included the strong relationships between the antenatal, 1 week postnatal and 16 week TMD scores, and the need for carers to monitor the antenatal, as well as postnatal, psychological wellbeing of their clients was acknowledged.

3.4.6 General discussion

The fact that the A and B LAS scores proved not to be fully interchangeable created undesirable noise in the data. However, despite this, the correlations between the scales on the three different occasions were high (see table 3.24 and 3.25, pages 119 and 120), especially between the 1 and 16 week postnatal scores, when each participant would have completed a different version of the questionnaire upon each occasion. This suggests that the findings have not been unduly weakened by this problem.

The high scores on the POMS subscales, compared with other populations (section 3.3.3.2, page 107), should not go without comment. As noted earlier, the means for the Tension-Anxiety and Confusion-Bewilderment subscales, were comparable with published scores (McNair, Lorr and Droppleman, 1992), but the remaining subscale scores: Depression-Dejection, Anger-Hostility, Vigour, and Fatigue differed considerably from published data. This suggests that late pregnancy and the postnatal period up to 16 weeks might be a time of more general mood disruption, and although most of the subscales of reported mood showed more positive states by 16 weeks, this is no reason to assume that all the causative factors would have dissipated. It is however interesting that both the Vigour and Fatigue scales were raised above reportedly normal levels. McNair, Lorr and Droppleman (1992) do comment that these two factors are independent and not opposite poles of a single, bipolar factor, and they postulate that Vigour might represent a positive affect factor. As such it perhaps relates to such emotions as excitement about the prospect of seeing the baby for the first time and the pleasure and love that most new mothers express towards the baby.

Despite the fact that the POMS Depression-Dejection subscales were raised above population norms, the EPDS means were slightly lower than published scores, and a lower percentage of the sample scored above the EPDS cut-off point in the antenatal period and at 16 weeks postnatally than in other published studies. However these published rates were obtained at different times to this study: at 6 weeks postnatally in the case of the study by Green and Murray (1994). It could be argued that Green and Murray's finding of 14% of their sample with EPDS scores above cut-off at 6 weeks postnatally falls neatly between this study's findings of rates of 20.63% and 3.97% at 1 and 16 weeks postnatally respectively. It is possible that depression levels, which are high after the delivery, then fall gradually. Nonetheless, this does not explain the reduced antenatal levels of depression in this study, compared with others, or the lower mean scores overall. It is possible that women who were more depressed in the antenatal period would have been less inclined to volunteer for such a study, thus, because of the strong relationships between antenatal and postnatal depression, reducing the overall incidence.

There was also a disparity between the locus of control scores of the respondents in this study and published means. The childbearing women expressed lower levels of belief in their own control than Levenson (1974), but also less belief in chance and the control of powerful others. However the internality scores for the sample described in this chapter were higher than those given in a more recent study by Lester (Lester, 1989). Part of the discrepancy with Levenson's work might be due to the age of the study. It is quite possible that the present social climate, in which the rights of the individual have more prominence than before, produces a greater awareness of the limitations for internal control, whilst also engendering a lack of faith in external control. Moreover many of the published studies in which mean scores are stated, thus giving the opportunity for comparison, are based on mixed, male and female, samples. The current 'post-feminist' ethos which suggests that women should take control of their lives, whilst recognizing how difficult this is to do, provides another possible explanation. Nevertheless this does not explain the lower internality scores obtained by Lester. This might be due to the fact that his respondents came from an American student population who might be expected to have a different outlook on life to British women.

The two external locus of control scales were correlated (table 3.26, page 120), meaning that women who reported high scores on one locus of control scale were more likely to report higher levels on the other, a characteristic of the Levenson scale noted by the author (Levenson, 1974).

A problem with the interpretation of the data derived from this study lay in the many correlations and relationships between variables. The resultant diagram depicting the multiple regression findings (figure 3.4, page 132) was thus almost saturated, making it very difficult to identify the possible direction of relationships. Further analysis, perhaps with additional respondents, is required in future research, using a more sophisticated analytical technique, such as structural equation modelling. This is beyond the scope of this current project.

Many of the midwives commented on the difficulties involved in completing their questionnaire if they had only taken over the woman's care in the later stages of labour. If this study was to be replicated it might be better to ask each of the midwives involved in a woman's care to complete a questionnaire, or to suggest that the questionnaire is completed by the midwife who provides the bulk of the intrapartum care. It had been hoped that, when handing over the care of the labouring client to a new shift of staff, the midwives would also have passed on any impressions of her in terms of control expectations and achievements, but this seems not to have been the case, even although the midwives knew the women were taking part in the study³¹.

Another problem related to the logistics of setting up and executing a project such as this, is the need to avoid questionnaires which are so long that respondents are unwilling to complete them. For this reason many of the nuances of control in childbirth were not explored in any detail. However, shades of meaning that the women ascribed to the issue of control will be addressed in more detail in the next chapter.

Another issue is the possibility that any piece of research which involves several contacts with respondents, might in itself constitute an intervention. Indeed two women commented on their questionnaires that completing them had helped them organize their thoughts and feelings about the birth, and one woman had sought help from her GP after realizing from her responses that she was feeling depressed. This problem appertains as much, or more, to qualitative research, and will therefore be discussed in the next chapter (subsection 4.3.3).

3.5 Conclusion

To summarize the findings of this chapter: the women's reported external locus of control beliefs were significantly related to their expectations of childbirth control. However there was no relationship between internal locus of control and labour agency. Older women and those who had attained a higher educational level were less likely to concede that chance occurrences were likely to control their lives. Reported control expectancies and experiences were strongly and positively linked. There was no evidence that high expectations of control led to dashed hopes and psychological problems. However

³¹ The disturbing inference from this is that it thus seems highly unlikely that other women, not taking part in the study, would receive continuity of care in regard of their control requirements.

control expectations and experiences were correlated with mood state, which itself showed strong relationships across the three occasions it was assessed. There was an improvement in mood scores over the postnatal period studied, and also over this time participants began to record their birth experience as less difficult. Their assessments of how much control they had achieved, however, remained highly stable.

Although the women's midwives accurately assessed their clients' satisfaction with the birth experience, they appeared less adept at predicting how much control the woman would report expecting and achieving. However there was evidence that the midwives' assessments were not completely unrelated to those of the women, as they tapped many of the same variables that correlated with the women's control reports. This suggested that the midwives might be identifying non-verbal indicators of the women's control.

Throughout this study areas were highlighted where it would be helpful to make further exploration, going beyond the boundaries of the quantitative analysis. Such explorations will be made in the next, interview-based chapter, which will examine the following issues:

- The ways in which the childbearing women spoke about control in their lives and how such control, or its lack, might be related to control in childbirth.
- The issues surrounding control expectancies and experiences, taking into account social background where relevant.
- How women positioned the usefulness of antenatal classes in terms of preparation for dealing with the control related issues of labour and birth.
- Other factors, alongside expectations, which women positioned as influencing their experience of control.
- Whether women spoke about different aspects of control in childbirth.
- Whether women positioned control issues as having other psychological effects than those already examined.
- Whether, when interviewed, women did describe a 'halo effect' - feeling less happy about certain aspects of the birth over time.
- Differences and similarities between midwives and childbearing women's accounts, and issues associated with carer-client relationships.

Chapter 4

Exploring the issues 2: interview study

4.1 Introduction

4.1.1 Purpose of study

The main purpose of this interview study was to explore the 8 issues raised at the end of the previous chapter: issues which were complex, and where the use of interviews and a qualitative analysis could be expected to complement the information provided by the questionnaire study.

The first issue concerned the way in which the women spoke about control in their lives. There was a need to explore how such constructions might be related to their representations of control during the birth. The measure of locus of control beliefs used in the questionnaire study had, by its nature, only highlighted one facet of the women's general representations of control, so more information was required.

The second issue was the question of how women represented their control expectations and experiences, and whether social background appeared to be relevant to the way these representations were made. The questionnaire data showed no direct relationship between social class, as measured by education, and women's expectations or experiences of control in childbirth. The possibility was discussed that interviews might elucidate similarities and differences between women of different backgrounds.

The third question was concerned with antenatal class attendance: how the women positioned the value of antenatal classes in helping them prepare for the control related issues of labour and birth. The questionnaire data showed no correlation between antenatal class attendance and any of the control variables. However antenatal class attendance was high in these studies. Several possible explanations for this were suggested, one being that class attenders in the catchment area for these studies might be atypical of those in other geographical areas. It was therefore helpful to explore how some of these women described the classes and their usefulness.

The fourth topic was concerned with other factors, alongside expectations, which women might position as influences on their experience of control in childbirth. In the questionnaire study only antenatal expectations related significantly to postnatal experiences, but the possibility of other influencing issues was supported by the fact that only a small amount of the variance of the postnatal labour agency scores was accounted for by the variables representing antenatal control expectancies.

In the questionnaire study relationships were found between the women's reports of wanted and expected control, and internal and external control. However it was suggested that there might be other aspects of the women's representations of control that could not be elicited from questionnaires. In chapter 1 various other aspects of control were postulated: for example, joint control and physiological control, both of which were discussed to a limited extent by the women in the pilot study. The fifth issue, therefore, was the need to explore how control issues were represented discursively.

The sixth question was concerned with whether the women positioned control issues as having other psychological effects than the mood variables examined in the previous chapter. As suggested in chapter 1, the relevant literature postulates various possible psychological effects from childbirth, some of which, it might be argued, could be influenced by control issues. However, the complexities of these effects cannot be easily elicited using a questionnaire.

The seventh issue is the question of whether, when interviewed, the women demonstrated a 'halo effect': whether they became more critical of certain aspects of the birth over time. The questionnaire data gave no evidence of such an effect, in fact, although assessments of control remained unchanged across the postnatal period, mood, and reports of the difficulty of the birth improved. However, as it was noted in the previous chapter, many of the research studies which have supported the notion of a halo effect have been qualitative, and therefore the possibility exists that any such outcome might only be evident when interview texts are examined.

The questionnaire study showed that the midwives and childbearing women agreed upon whether the woman positioned herself as satisfied with her birth experience, but the midwives' assessments of how much control the women had expected or achieved did not correspond with the women's own reports. However, neither were the midwives' assessments completely irreconcilable: there was evidence that they might be basing their evaluations upon underlying mood and birth assessment variables. The final issue therefore was the requirement to explore differences and similarities in the midwives' and childbearing women's accounts, and other issues appertaining to the relationships between carer and childbearing woman.

4.1.2 The research approach

Because the objective of this study was to elaborate upon issues raised during the analysis of the questionnaire data, it was decided that it was appropriate to interview a subsection of the women who had already agreed to complete the questionnaires, rather than a different sample, and to conduct interviews at approximately the same time as the women completed questionnaires. This avoided the conflation of different perspectives arising from the different research formats with the effects of

differences between participants or within the same participants at different times of pregnancy and the postnatal period. However, because recruitment to the interview study could not begin until women had returned their first questionnaire, on which they indicated whether they might be interested in taking part, the antenatal interviews tended to occur later than 36 weeks: usually between 37 and 38 weeks gestation.

The 8 issues, raised in the introduction to this chapter, only became apparent after the quantitative analysis of the previous study had been completed. Therefore, although the data collection phases of the questionnaire and interview studies were carried out in parallel, the analysis of the interview study was only finalized after the statistical analysis had been completed³². The questions used in the interviews and the coding frames described below were, therefore, constructed before the 8 specific issues had become apparent, and were of a more general nature.

The midwives of the interview participants were also contacted and interviewed. To enable this to take place as soon as possible after each woman had given birth, the midwives' interviews were designed to be very short, taking no more than 10 minutes. Thus it was possible to conduct a midwife interview at a convenient point during her shift, without having to encroach upon her off-duty time. This approach not only elicited the approval of the midwives, it also avoided what might have been a considerable time lapse whilst a mutually convenient arrangement was made.

As with the pilot study, a semi-structured interview format was chosen to both ensure that specific issues were covered, and to allow the participants the space to develop themes of interest or importance to themselves.

4.2 Method

4.2.1 Design

This study consisted of one-to-one semi-structured interviews with 15 primiparous (but not necessarily primigravid) childbearing women at 37-38 weeks antenatally, and 1 and 16 weeks postnatally. The midwife who delivered the woman's baby, or who attended the birth (in the case of a delivery by a doctor) was also interviewed. The purpose of the study was, in the antenatal period, to explore control related issues from the women's past lives and early pregnancy, and their expectations for control during and after the birth. Postnatally the interviews were designed to elicit the woman's own account of the birth: how she represented various control issues, whilst the midwives were asked to give their assessments of their clients' control expectations, experiences, and satisfaction.

4.2.2 Procedure

Four sets of questions were compiled, three for use with the childbearing women at the 3 interviews, and one set for the midwives. Antenatally the childbearing women were asked general questions about

³² However transcription and coding began as soon as all the interviews had taken place.

their past lives, for example, where they had grown up and been educated; questions concerning their assertiveness and control with other people and in difficult situations; about their reaction to pregnancy; their impressions of antenatal classes; their expectations for childbirth in terms of the things they wanted and how they hoped to conduct themselves; and about what they expected motherhood to be like. In the early postnatal period the interviews were designed to be shorter, as it was envisaged that the women might be very tired. At this point they were asked about what happened generally in labour; whether they felt their care had been helpful; whether they were happy about the way they coped; whether they had control; which things were easy to control; how they felt about the birth; and about the baby. At 16 weeks postnatally they were asked these questions again, but also whether, if they could repeat the experience, they would do things differently; whether they had the opportunity to discuss what had happened with others; whether they planned to have any more children; whether they felt the birth experience had changed them as people, had any long-term emotional effects or affected their relationships with others; and how they were finding motherhood.

The midwives were asked five questions: to give a description of the woman's labour and birth; to say how much control they felt she had expected; and whether they thought she had achieved the control she wanted; how satisfied she was; and how the midwife gauged the control a woman wanted. The main questions used in each interview appear in appendix 4.1. The interviews with the childbearing women lasted for up to 1½ hours, whilst the midwives' interviews lasted from 10 to 20 minutes.

Hospital ethics committee approval for this study was sought and obtained. The participants were recruited via the questionnaire study. At the end of the first questionnaire there was a space for the women to write their telephone number if they thought they might be interested in being interviewed. Those who completed this section were contacted by telephone and the interview study was explained to them. If they continued to show an interest they were sent two copies of the appropriate consent form, with the details of the study printed on the back: one to be signed and returned at the time of the interview, the other to be retained by the woman for further reference. Once the requisite number of participants had been recruited, the first questionnaire was amended to avoid further women volunteering their help and having to be refused. All the interviews were arranged by telephone contact. As these women were also part of the questionnaire study, their actual date of delivery was ascertained using the procedure described in the previous chapter, allowing the first postnatal interview to be arranged for the appropriate time. Participants were asked to try to complete the appropriate questionnaire prior to the interview.

All the childbearing women were interviewed in their own homes whilst the midwives were interviewed on the delivery suite of the hospital where they worked, either in a quiet moment during their shift or immediately before or after they commenced duty. On five occasions the partners of the childbearing women chose to be present at the interview as well. They were neither encouraged nor discouraged from doing this, and all contributed to the interviews which they attended, but some to a greater extent than others. Four of these interviews were those held in the early antenatal period, when the women's partners were on leave from work. One partner, who worked shifts, also attended an

antenatal interview. In several other cases the women's partners were at home at the time of the interview, but chose not to be present in the room where it was taking place.

The interviews were tape recorded, and the tapes were later transcribed. Transcription was verbatim, and the annotation of intonational features was kept to a minimum, using the same devices as in the pilot study³³. Each woman was offered a copy of her interview transcriptions. Eleven of the women chose to accept these but, although invited to, none of them gave any feedback after receiving them.

4.2.3 Coding and analysis

As with the pilot study, analysis was at a thematic level, meaning that explanations and interpretations given by the participants were categorized in terms of systems of apparent meaning (Bannister, Burman, Parker, Taylor and Tindall, 1994; Smith, 1995; Hayes, 1997). However, unlike the pilot study the process was less 'grounded' in the data, as the areas of interest had now been predetermined by the 4 main research questions (see chapter 2, subsection 2.5, page 94). The themes were sometimes drawn from within the same topic, and upon other occasions were recognizable across several different issues. Once identified, the way in which several themes operated together, or pulled against each other, was explored. These interactions between themes sometimes helped to explain the positions taken by the participants, whilst upon other occasions it was by exploring the complexity of one particular theme that explanations emerged (Smith, 1995).

The first step in the identification of themes began once all the interviews were transcribed, when the interview texts were read closely, and using the 'copy and paste' facility of a standard word processing package, all the text with even the remotest connection to control issues was selected from each interview. In other words, each interview was effectively edited into a new file.

The process of reading and coding the texts, described below, largely follow the system described by Malson (1995) in her analysis of interviews with women with a history of anorexia nervosa. Because of the predetermined research questions, the starting point for analysis was, unlike the pilot study, a preliminary coding frame. Both Smith (1995) and Mason (1996) recommend the development of such codes, although in both cases they discuss its development purely from the close reading of one or more of the interview texts. Following Malson, this skeleton coding frame was based on a reading of the historical and research literature concerned with control in childbirth, and from impressions gained from various sources: the interviews themselves; listening to the tapes; a discussion of some of the transcripts with various colleagues; and a careful re-reading of them all (see figure 4.1). At this stage the frame consisted of several key topics which either appertained directly to control in childbirth or which when discussed by the respondents, or addressed in the literature, tended to raise control related arguments, examples of codes being: control issues (C); and the medical profession (D). In some cases, topics were subdivided, e.g. control of past life (C1), expectations of control in childbirth (C2), experiences of control in childbirth (C3). As in the pilot study, computer files were then created for

³³ As a reminder, the annotations used were: short pauses {(.)}; long pauses {(..)}; hesitations {..}; segments of omitted text {...}; emphasis {Why me?}; other notes, for example {(laughs)}.

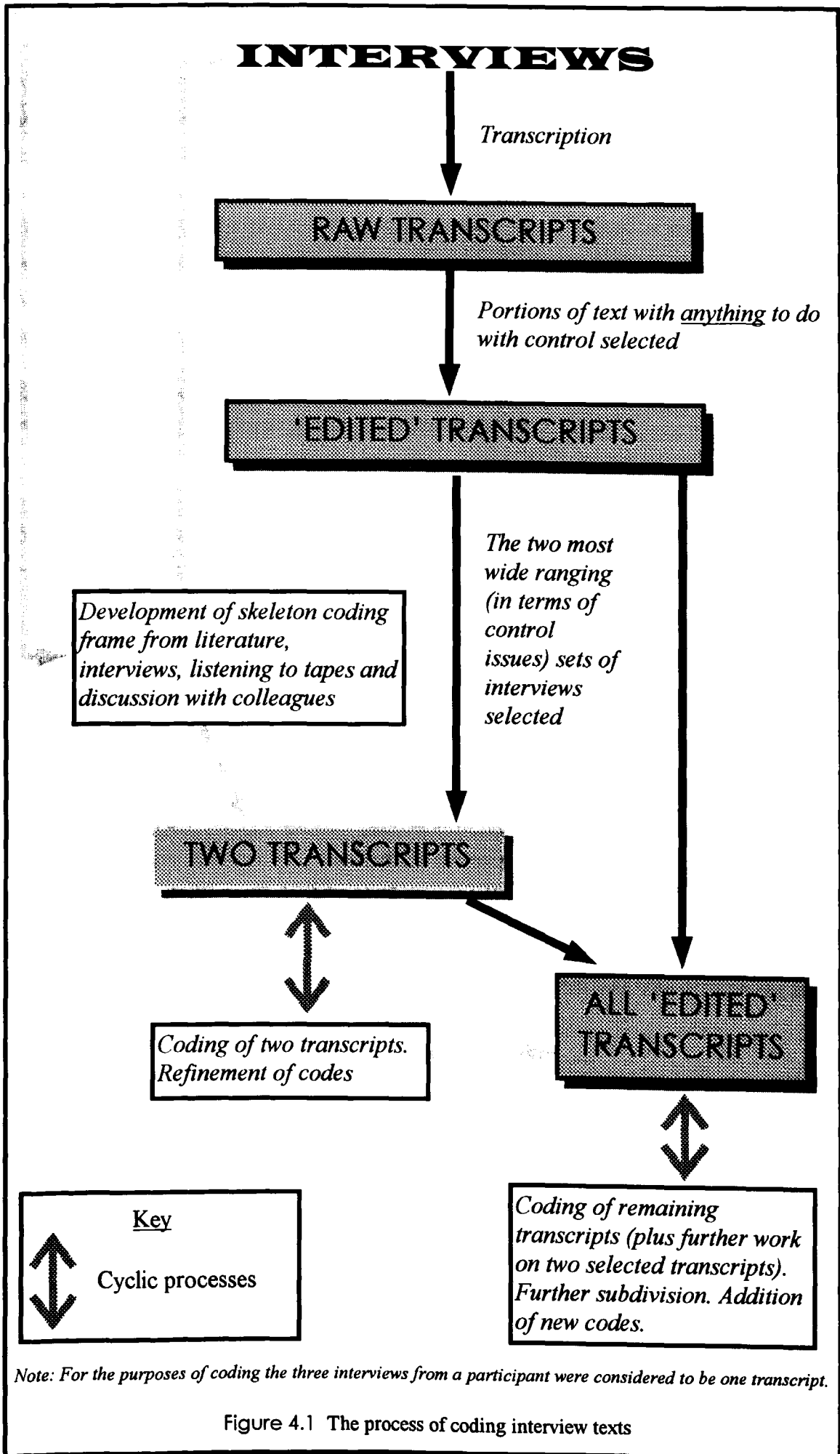


Figure 4.1 The process of coding interview texts

each subtopic. The two most complex and wide ranging (in terms of issues covered) sets of interviews were selected, and pieces of text from the interviews which appertained to the subdivisions were copied and pasted into the appropriate files. During the process of reading the interviews to do this, new topics became apparent, and these were added to the coding frame, and corresponding files were created. Some of the subtopics rapidly became large and wide ranging, and these were further subdivided, and again, appropriate files were created. For example, experiences of control (C3) was further divided into: control of self (C3a); control of body (C3b); control of situation (C3c); joint control (C3d); control related to circumstances (C3e); control over baby at birth (C3f). Control of situation (C3c) was even further divided into: generally (C3c1); pain relief (C3c2); cardiotocograph monitoring (C3c3); intimate procedures (C3c4); complicated deliveries (C3c5).

This redivision of subtopics often necessitated a return to, and recategorization of, earlier parts of the texts: resulting in a cyclic process of analysis similar to that described by Malson. Malson also noted that the processes of reading, selecting and analyzing texts were all informed by her theoretical framework and earlier reading, and such is also the case here. Without the feminist and constructionist influences described in chapter 1, a very different set of codes and texts were likely to have been selected.

After the development of the coding frame using the first two sets of interviews, the main structure of the frame was not rearranged as the content of the remaining interviews was cut and pasted into the subtopic files in a similar manner. However new files were opened up in the analysis of subsequent interviews, if topics arose which had not been encountered before, and any topics or subtopics which became too large and which appeared to cover several issues were subdivided and the texts in that topic file were split up accordingly.

Once all the interview texts had been examined and subcategorized into the various files, the material in each file was examined closely for linkages of overt or underlying meanings between text fragments. The files were dealt with as follows:

- a) Files which contained texts with a coherent theme were retained and named according to the theme.
- b) Files which contained text with no apparently consistent themes were discarded.
- c) Files which contained texts in which several thematic strands could be discerned, were subdivided and renamed according to the themes. Sometimes a strand which was evolved from one file could also be traced in others, and in these cases the texts from each file were merged and placed under a new heading.
- d) Cross referencing notes were made on files when themes appeared related.

At this point further analysis was suspended until the statistical analysis of the previous chapter had been finalized and the topics of enquiry for this study determined. The themes which centred upon, or which elucidated, the issues raised at the end of the last chapter were then identified. These themes

were examined and reflected upon, to determine how they functioned in terms of the women's descriptions of their birth experiences and the midwives' accounts.

4.2.4 Participants

Fifteen primiparous women took part in this study. These were the first 15 participants from the questionnaire study to indicate an interest in being interviewed on their antenatal questionnaire and to consent to taking part when subsequently contacted by telephone. All the women were white and British, and had male partners. Their names were altered to preserve anonymity. Further participant details are reproduced in table 4.1, alongside the pseudonym given to each woman's midwife.

Table 4.1 Participant details

Pseudonym	Most recent occupation	Age	Educational level achieved	A/natal classes	Midwife's pseudonym
Caroline King	Weaver	33	Postgraduate	Yes	Alison
Wendy Heaton	Shop assistant	32	GCSE	Yes	Bronwen
Christine Simpson	Quality controller	24	GCSE	Yes	Chris
Tania Anderson	Sales administrator	32	GCSE	Yes	Danielle
Theresa Lister	Shop assistant	24	GCSE	Yes	Ellie
Alice Mathers	Security checker	22	GCSE	Yes	Fay
Diana James	Assistant marketing manager	30	BTEC	Yes	Gill
Andrea Styles	Company secretary	34	Degree	Yes	Hannah
Barbara Newman	Nurse	28	GCSE	Yes	Ingrid
Lisa Smedley	Hairdresser	23	GCSE	Yes	Jenny
Suzannah Fletcher	Occupational therapist	28	Degree	Yes	Kim
Eliza Allen	Naval officer	29	A levels	Yes	Lynne
Cara Kendrick	Building society cashier	20	GCSE	Yes	Maggie
Linda Temple	Shop assistant	25	GCSE	Yes	Nina
Marna Drayton	Bar attendant	19	GCSE	No	Olivia

4.3 Results

4.3.1 Introduction

As intimated in chapter 1 (subsection 1.5.5.1, page 71), pieces of text were selected for inclusion in this results section because they either exemplified or contradicted what was found to be typical. In most cases the texts were exemplifications, but where they were not, this will be stated clearly.

Another issue raised in chapter 1 (subsection 1.5.5.2, page 72) was the need for qualitative research to be context-sensitive, for the setting of the study and potential influences at work within it to be acknowledged. Such influences are likely to be manifold but the place of the interviewer and the interview questions in the text are key considerations. The former issue is addressed below (subsections 4.3.2 and 4.3.3). These subsections reflect upon the research process itself (as described in chapter 1, subsection 1.5.4, page 69), how this might have affected the material obtained; and upon the effects of multiple contact with participants (mentioned briefly in the last chapter (subsection 3.4.6, page 144)).

The latter issue (the place of the interview questions in the text) will be addressed by including the interview question in the quoted extracts when this helps to explicate the response.

The first subsection (4.3.2) will explore the way in which I, as the interviewer, positioned myself and was positioned by the respondents. Subsection 4.3.3 will explore how these positions might have influenced the interviews. The following subsections will take each of the 8 issues, raised in the introduction to this study, in turn and discuss themes, arising from the analysis, which relate to them. In the discussion section the interrelationships between all the themes and issues will be explored.

4.3.2 The presence of the interviewer in the texts

As in the pilot study, I introduced myself to both the childbearing women and the midwives as an ex-midwife who also had a degree in psychology, and I explained that the research I was conducting was towards my Ph.D. I told the women that I do not have children of my own.

I was acquainted with some of the midwives prior to this research, having worked with them in the past. Neither they, nor the childbearing women, made any obvious moves to acknowledge my interest in psychological issues. The only possible exception was one midwife, Ellie, who elaborated her account of the birth with additional information concerning her client's emotional state. For example:

Midwife Ellie: 'That was another interesting thing as well. She talked about how it had totally scared her to death, I'll say this in proper language for you, um when the consultant had asked .. he .. he felt that she was large for dates and he'd wanted um an ultrasound doing on the 26th.'

Ellie then went on to explain how she felt that her client's fear of having a large baby had influenced the progress of the birth. She reported several other incidents in a similar way, exploring the possibilities of a relationship between the client's psychological state and the events of her labour and birth. However, I was not certain that such talk was for my benefit as a psychologist. I had worked with Ellie in the past, and knew her to be a particularly experienced and deep-thinking midwife who liked to explore the possible causes of events. I felt that she could have sought and offered such explanations regardless of who her listener might be. Nevertheless where my presence was explicitly acknowledged in the text quoted above was where Ellie said, 'I'll say this in proper language for you'. She had already, before the tape recorder was switched on, raised the issue of her client's fears of having a large baby. At this time she had described her client as 'scared shitless'. It was therefore interesting that, despite knowing me, once the tape recorded interview began, she should consciously select different terminology, to position herself more formally with me.

A parallel formality was apparent in some of the other midwife interviews when they were asked to give an account of their client's labour and birth. However in these cases it seemed to me more obvious that, as in the pilot study, I was being positioned as a fellow midwife. Sometimes, as in the pilot study, this position was apparent simply from the use of obstetric terminology. However upon other occasions the interviews, or at least the part that dealt with the details of the labour and birth, took up the familiar (to me) pattern of a ward report given to staff beginning their shift. Sentences were clipped

with a heavy use of abbreviations and midwifery jargon. My input was minimal until the account had concluded, as it would have been in a ward report:

Midwife Jenny: 'Um she had er SRM, if I remember rightly, yes, SRM and meconium stained liquor ... First VE at ten past er one. Cervix was fully effaced, 3 centimetres dilated. Fresh meconium liquor. CTG was satisfactory. During the course of the afternoon she had some meptid and phenergan for pain relief, and she progressed very quickly.'

Such patterns were equally common whether I had previously worked with the midwife or not. However they were more likely to occur if she had insisted on using the client's notes as an aide memoir. This mode of representation probably arose because, unlike the pilot studies, when the midwives were being asked to talk about their care in general, here they were being asked to give account of a specific case, for which they had taken responsibility. If, as it appeared, I was positioned as a fellow midwife, the situation was mirroring the kind of handover situation in which the care of a client was transferred to a new midwife at the end of a shift.

That I did identify with the midwives as a midwife myself also occasionally became apparent in the text:

Midwife Alison: 'The last few deliveries they haven't been straightforward. I said that funnily enough before I went off the other morning. I said 'Oh, I just haven't had, you know, somebody just is able to do what they want really. Just totally what they want.' But that's just how it goes, isn't it really?' | JW: 'It does. Yeah. It's horrible, though, isn't it?' | Alison: 'It is. It is.' | JW: 'Because you begin to think it's you.' | Alison: 'Well I know. That's it.'

Here Alison's 'isn't it' positioned me as someone who would be able to identify with her experience, and my response was to not only concede this, but to develop the concept. Interestingly I found myself colluding with this sense of comradeship even when privately I did not agree with the midwife concerned.

I have already observed that the childbearing women tended not to refer to my background in psychology very much. Like the midwives, and as in the pilot study, they also, in general, appeared to position me as a midwife. However in this study I found myself more prone to responding at length in this position and to positioning myself thus even when the woman did not appear to be specifically seeking such a response:

Tania: 'I just couldn't push any more. I was thinking, 'Maybe I should have gone and got fitter', and 'It's all my fault'. But I'm thinking now, 'What will be, will be''. | JW: 'A big baby that's lying posteriorly, I mean very often, you know, without the long labour and the epidural, you'd have still probably had a lot of trouble pushing him out if you'd managed at all.' | Tania: 'Really?' | JW: 'Mmm. Yeah. 'Cos if they're posterior, t.. to.. they've either got to rotate, they've got to turn all the way round so that they can come out, or sometimes they.. they're actually born sort of facing the ceiling instead of facing the bed.'

Some of this, I think, was fueled by sympathy for the woman. I found I was more prone to this kind of response if women positioned themselves as badly treated or traumatized by their experiences, and especially when their accounts carried elements of self-blame which I felt were unjustified. I was also conscious that many of these women were putting themselves in a vulnerable position by disclosing their fears and inadequacies to me. This is a problem which can easily arise when women interview

women (Finch, 1993), and can leave respondents open to exploitation. However I felt I wanted to try to allay some of the woman's distress, although, I was also, in retrospect, responding in an archetypal fashion. Lupton (1994) describes the ideology that positions nurses as empathetic: that expects them to look beyond the external features of the patient's body to their innermost thoughts, feelings and fears. I think it was also this obligation to address what I felt were the women's underlying concerns that often led me to step outside of the role of interviewer and into the role of midwife. Such accounts perhaps also resonated with my own feelings of inadequacy and failure, described in the preface to this thesis, when faced with many of the situations which arose on the delivery ward. As childbearing woman and midwife we shared, to some extent, a historical and personal legacy of oppression.

The traditional positivist view of interviewing is that the interviewer must pretend not to be in possession of information that the interviewee might want, because to disclose such information might bias the interview (Oakley, 1981). However Oakley observed that, when interviewing women, especially on repeated occasions (as I did here), and when dealing with highly personal experiences such as pregnancy and birth, it was problematic and unhelpful to avoid personal involvement. In Oakley's case this involvement often included giving information, as honestly and as fully as possible. She found that unless the interviews offered some personal satisfaction to the participants, they were unlikely to be willing to continue in the longitudinal study. Although I could not claim that the women in my studies would have refused subsequent interviews if I had been less involved, the rapport which developed between us over the course of the three interviews was most certainly valuable.

Some of the women appeared to have problems categorizing me. One, to whom I had carefully explained my background, and my current non-involvement with the local maternity unit still, when the interview was interrupted by the telephone, told the caller that she had 'the lady from the hospital' with her. However as the interview proceeded she appear to begin to locate me similarly to the other women in the study. Another was notable in that, unlike the majority, she was distant and formal. I became used to being made welcome in the women's homes, being offered a drink perhaps, and asked a little about myself or the research before the interview began. This, of course, gave me the opportunity to reciprocate and to ask the woman some general things about herself, to admire her home or baby. However this particular woman did not offer even to take my coat. I was shown to a chair and asked what it was I wanted to know. The woman's replies were, in general, stilted and formal, as if she was answering questions to a government official or the like. The interviews with this woman were short and to the point, and I wondered whether she had really wanted to take part in the research, or whether she had felt obliged to do so for some reason.

In summary, therefore, I felt that, more often than not I was positioned as a midwife by both midwives and childbearing women. Considering that I tended to introduce myself as an ex-midwife with a degree in psychology, as if midwife was my primary identity, this is perhaps not surprising, and it was probably the feeling that it was this identity which would be best understood that led me to position myself in this way in the first place.

4.3.3 Influence on the interviews

Also of interest is the influence my position as a midwife had on the interviews. Taking the midwives' interviews first, as already shown, their texts had spaces in them, in terms of jargon or acronyms, where I was expected to fill in the gaps from my own professional understanding. I tended not to be aware of this process during the interviews, probably because I did share the midwives' perspective. However on later examination of the transcripts I found I needed to make assumptions, no matter how likely to be accurate, about what this 'shared knowledge' was meant to be. However despite this, and the formality of many of the interviews, I felt, on the positive side, that the midwives spoke more openly to me than they might have to someone without 'shared knowledge'. There was no sense that information was being withheld from me. Also, because of their assumptions about the knowledge we shared, their talk flowed easily. There was no need for them to stop and explain things. Like Valach (1995) I found that, because the environment was ecologically valid to the midwives, I was the beneficiary of representations which were functionally equivalent to those they might use with their colleagues.

With the childbearing women I was, as has been seen, far more ready to volunteer information in my position as midwife. One possible drawback of my input, it could be argued, was to influence the course of subsequent interviews with that woman, my information constituting an intervention. However I would argue that every participant's encounter with a research study has the potential to act as an intervention, and it is therefore better to acknowledge this than to pretend otherwise. By illustration, Holden, Sagovsky and Cox (1989) showed that 'therapeutic listening' from health visitors had the potential to ameliorate symptoms in postnatally depressed women, whilst Green, Coupland and Kitzinger (1990) found that completing a questionnaire about their experiences in labour helped women to evaluate their satisfaction with the event. In other words just being listened to, or just filling in a questionnaire has some effect on the respondent, so it can be argued that providing information in an interview is not going to create a new problem. In fact Oakley (1981) argues that the pretence of neutrality in the interview situation is not only a fallacy, but is also counterproductive. Involvement of the interviewer is essential if the interviewee is to be enabled to share intimate aspects of their lives, and perhaps disclose information that they would not usually discuss. Moreover neutrality only helps to promulgate the power differential in the researcher/ researched relationship that feminists have been at pains to overcome (see chapter 1, subsection 1.5.2.3, page 63).

This issue aside, the women nearly all spoke very highly of their midwives. The small amount of criticism that arose was reserved almost entirely for the doctors. This positive gloss might have been the effects of being interviewed by someone they knew to have midwifery experience, although the tendency for patients to express satisfaction with their care is well documented both generally (Fitzpatrick, 1984) and specifically in obstetrics (Shearer 1983, 1987). Moreover the tendency for the women to be more critical of the doctors than the midwives could be put down to the fact that doctors were only likely to be directly involved in a delivery when there were complications. In these cases the

situation was more likely to be stressful and unpleasant for the woman, so the potential for her to be dissatisfied might have been higher.

As with the midwives, the women sometimes left spaces in their texts where, presumably, my midwifery knowledge was meant to fill the gap. For example:

Lisa: 'And they couldn't take it (fetal monitor) off because of her heartbeat. They wanted to know what was going on because she'd er opened her bowels.'

However with the childbearing women these gaps were smaller, in that they required less interpolation on my part, and did not, I felt, constitute the same problems as the midwives' texts. Again they were indicative of functionally representative talk for childbearing women with health workers who had some understanding of obstetrics (Valach 1995; Yardley and Beech, 1997). Thus I had to acknowledge that my position as a midwife probably resulted in a different interview than would have taken place had I been positioned as a doctor, another mother, or had I been a male scientist, for example. Interviewees will position the interviewer in a different way depending upon who they are and what they represent, even if they remain completely silent (Potter and Wetherell, 1995). This is not to argue that one interviewer might obtain a better interview than another, but simply to acknowledge that there is always an influence.

4.3.4 Control in everyday life and in childbirth

4.3.4.1 CONTROL IN EVERYDAY LIFE

The first issue concerned the ways in which the childbearing women spoke about control in their lives and how such control, or its lack, might be related to control during the birth.

The interview women positioned themselves as complex individuals in their day to day lives, dealing with different situations in different ways. For example:

JW: 'What about if things don't go the way you want them to?' |Christine: 'Um well hopefully .. hopefully I'd try to make them go how I want them to. You know, if I want something, then I'll try and do it or try and get it or whatever. I don't get annoyed if I don't.'

Of her home life Christine said:

Christine: 'But I'm very happy at home. I'm a homely person. You know, I like to cook for (partner) and basically wait on him.'

Therefore, although Christine positioned herself as someone who, in general, tried to take control, she immediately also pointed out that not being able to get control was not problematic to her ('I don't get annoyed if I don't'). She also positioned herself as someone who chose not to be in control in certain situations, for example, at home, although it could be argued that, as this lack of control was by choice, it was, as described in chapter 1 (subsection 1.3.3.5, page 39) control of a sort: a control over whether control was taken. Elsewhere she reported that she had not been happy in her new job, although this had not caused her to take control and leave. She stayed there for 3 years, only resigning when she was well advanced in her pregnancy.

Like Christine, most of the childbearing women described different approaches to different situations in which they had the potential to take control. In some cases they also positioned themselves differently towards the same situations at different points in the interview. Such shifts mirror the changing flow of subject positions which are frequently documented in interactions between individuals (Burr, 1995) and as such are not so much a sign of inconsistency on the part of the interviewees, but rather a negotiation of their subjectivity in a set of representations which are, to them, not necessarily commensurate.

Despite these shifts, the predominant theme, in the women's talk around the subject of control over their lives, was around the uncontrollability of much of their existence:

Tania: 'I believe everything happens for a reason whether you understand it or not. I think it's something you've got to accept.'

Theresa: 'I think if things don't go your way, you just have to put up with it, don't you? Unless you've got the ability to actually change what's happening. And I think a lot of what happens to people in life is fate.'

Such a position was more likely to be taken when the subject under discussion was generalized control, rather than control in specific situations. Within this position, as in the texts quoted here, there was frequently a juxtaposition of the active nature of events, which 'happened' or went a certain 'way', with the passive involvement of the subject: the woman, who had to 'accept' them or 'put up with it'. Implicit in the unfolding of the events was an unpredictability or inexplicability, as exemplified by Tania's reference to not always being able to understand why things happen. However, even without this reference, the active mode of representation of events carried a sense of their almost maverick nature, to go where they chose. In contrast the woman was positioned as having no choice but to allow them to unfold. However, despite the uncontrollability and unpredictability of events to the woman, there was also an impression in these texts of some overarching power, also beyond the woman's control, which ordered them. Thus Tania talked of everything happening for 'a reason', whilst Theresa referred to 'fate': by definition a power which is able to predetermine events and render them unalterable.

It can be argued that the lives of every human being are subject to events which cannot be controlled. However as well as explicating something which is common to human experience, it could be argued that this positioning of life events as something uncontrollable might have had a function in the women's talk. It justified situations where the women had found themselves to be powerless.

4.3.4.2 CONTROL IN CHILDBIRTH

The women's talk about their expectations for the birth served to function in a similar way. This was most powerfully demonstrated at the juncture of three particularly recurrent themes, the first of which was the women's tendency to position labour and birth as an unknown, and therefore unpredictable, situation:

Lisa: 'My friend said to me, like, 'Have you got your head round it? The birth and that?' Well how the hell can I get my head round it, I've not experienced it yet. I don't know what to expect.'

Diana: 'I mean it's .. it is difficult when it is this unknown.'

As described in chapter 1 (subsection 1.3.2.3, page 33), Lowe (1991) discusses the unknown situation of the first birth at length. Apart from the few women who are booked for elective caesarean sections, this unpredictability begins with uncertainty as to how or when labour will start. It is compounded by medical rhetoric, also discussed in chapter 1 which positions birth as something fraught with hidden dangers, necessitating a close surveillance of the woman in a clinical environment (Francis, 1985; Stuttaford, 1996). One particularly important aspect of the fear that such rhetoric can engender in childbearing women is concern for the safety of the woman herself and her baby. As discussed in chapter 1 (subsection 1.2.3, page 23), every childbearing woman wants her baby to be born safe and well, despite the contention of some medical authorities that women who want a satisfying birth experience are happy to jeopardize the wellbeing of themselves and the fetus (Booth, 1981; Macdonald, 1987). Thus the second theme in this triad revolved around the paramount importance of the issue of safety:

Diana: 'But the main thing to me is to have a healthy baby at the end of it. That is the most important thing.'

Suzannah: 'I think I need to keep in my mind my ideal of healthy baby, healthy me at the end of it, really.'

When the two discursive themes of the unknown nature of the birth and the need for safety were placed side by side they left a void which the childbearing women needed to fill with the representation of an agent which understood the course and nature of labour and birth and which could be invested with the necessary ability to ensure the mother and child were unharmed at the end of it. Such a representation was provided in the third theme: the expertise of the hospital staff. Either one of the two themes discussed above might have created the necessity for such a representation, but it was the combination of the two which rendered the need inevitable. A concern for safety would be less problematic if birth was predictable and problems always foreseen. The unknown nature of birth would be less worrying if one of the unknowns was not whether the baby would be born healthy and the mother kept safe. However, to acknowledge the presence of experts was not enough. To fill the space between the unknowness of birth and the fear for the baby's safety, these staff also had to be positioned as in control:

JW: (In response to Cara's last comment) 'Right. So you're saying that you wouldn't necessarily do exactly what she (midwife) thinks you need to do?' |Cara: ... 'Um unless it come to the point where it's like an emergency. Obviously then you'd do as you were told really then, 'cos all you're worried about is that the baby and you're all right.'

Andrea: 'I don't know what to expect and I don't know how I will cope, so I expect the professionals to .. to almost be making decisions for me ... I don't think that I would put myself or my baby at risk by not following their advice.'

It could be argued, as in the previous subsection, that these women were choosing not to be in control, and therefore controlling where they took control. However the pattern of the texts renders this unlikely. In the previous subsection Christine spoke of staying at home and waiting upon her partner as something she liked to do, whereas in these texts the women positioned themselves as passive. Their

representations resonated with the descriptions of uncontrollable life situations depicted earlier. The situation or events were active: an emergency could arise, and unpredictable events would unfold, whilst the women were submissive. Christine spoke of doing as she was told, whilst Andrea expected the professionals to (almost) make decisions for her. It was this passivity in the face of the unknown nature of birth that rendered the control of the carers so welcome. Thus, as with control in their lives, it created a sense of the situation being in the thrall of some greater power.

The women tended not to differentiate between the experts and their expertise. In other words they did not make a direct connection between the problem: the emergency, or the unexpectedness, and the agent which would alleviate that problem. For example, Cara did not say how doing as she was told would help her, and Andrea did not clarify the relevance of the professionals making decisions to her not knowing what to expect. (She also misses the irony of saying in the same breath that she did not know what to expect, and that she expected the professionals to make decisions.)

For the women in this study, therefore, the meeting point of the three themes made problematic the taking up of a position of expected control, at least in situations where safety was positioned as an issue. How the women dealt with this tension will be discussed in later subsections. However, it also meant that, just as in their accounts of control in their lives, the women were left with the space to justify any apparent lack of control over the birth. An example of this justification will be described next.

4.3.4.3 IMAGES OF THE MIDWIFE

As demonstrated in subsection 4.3.4.1, the women positioned their control in everyday life as variable, depending upon the situation. Their representations also differentiated between the people with whom they interacted:

Tania: 'In my personal life I don't feel pushed around at all, no.' |JW: (*referring back to previous comment of Tania's*) *'So how do you deal with it, when, you know, like .. like at work when you find they're..'* |Tania: *'It depends who's doing it. If it's the managing director, I won't say anything, I'll do it. If it's my boss, I'll question it. I'll say 'Why do I have to do that?'. And I'll make sure that I understand why. And he'll know that I'm not happy. But I will do it.'*

In other words, there were people whose decisions Tania felt she could question, and those whose position in the employment hierarchy precluded such challenges. Similarly most of the women reported that, at certain points in their labour, they felt compelled to acquiesce to the authority and experience of their midwife:

Caroline: 'And I think, to a large extent er we did have control over what they did to us up until the midwife told me to push. And by then er (.) I just felt that um her authority and her experience were telling me that er I shouldn't quibble, I shouldn't question. Rightly or wrongly.'

Here then is an example of how, in the unpredictable nature of birth, with its safety issues, the expertise of the professionals can be used to justify the woman's lack of control. In this extract Caroline explicitly described feeling that she could not question what she was being told to do. The

midwife had 'experience', which by implication, Caroline did not. At the same time Caroline's unhappiness with this feeling of powerlessness was conveyed in the simple phrase 'rightly or wrongly'. However, it is also notable that the way in which Caroline positioned herself as capitulating to her carer is commensurate with the account, given above, of the women's control relationships with those who were in positions of seniority over them. Caroline's midwife not only had 'experience', she also had 'authority'. In other words, like a managing director, the midwife, under certain conditions, is positioned as someone not to be argued with. This is hardly compatible with the popular images of the midwife, as the woman's advocate, skilled adviser and support (for example: Flint, 1986; and Kitzinger, 1988). The tension between these two images of the midwife will be illustrated in later subsections.

4.3.4.4 CONNECTING LIFE CONTROL AND CHILDBIRTH CONTROL IN THE TEXT

The parallels drawn so far between control in the woman's everyday life and control in childbirth are at the analytic level rather than acknowledged by the women. However two of the women did make comparisons in their interviews:

Alice: 'I mean that's one thing I'm hoping not to get, like, you know, when I go into hospital is like too much attention ... I generally don't panic and I'm not like a fussy person ... Um, and I don't know whether that's got anything perhaps to do with Mum. 'Cos my Mum's not a panicky person. I mean if one of us .. if one of us fell off our bikes and cut out knees, I mean we'd be screaming. And she'd be the one going, 'Now shut up, it's nothing to scream about', you know (laughs), 'It's just a little nick', you know, 'That's all you've got', you know, 'Be quiet'.'

Diana: 'Nothing is straightforward in my working day. I don't go in and know that I'm going to do this at 10 o'clock, this at 11 o'clock and .. things just change all the time ... So I'm quite used to being very flexible and adaptable. 'Cos I've had to be. And I suppose I see my labour (laughs) going the same way. I'll try and adapt to how it goes. And er what I need and .. and what the baby needs.'

One interesting feature of these two extracts was the way in which they were so firmly grounded in practical aspects of the women's lives. In fact, in the text omitted, Diana went to some lengths to describe the kinds of distractions and changes that might occur in an average day at work, whilst elsewhere Alice depicted in graphic detail one particular incident when, as a child, she fell off her bicycle and hurt herself, to her mother's complete lack of sympathy. Moreover the women incorporated these aspects of their lives into their representations of themselves. Alice positioned herself as 'not a fussy person' as a possible result of her mother's upbringing, whilst Diana described herself as flexible and adaptable. However the representation of how this might influence childbirth was highly tentative. Alice spoke of hoping not to get too much attention, whilst Diana supposed her labour would go the same way and would try and adapt. Thus, despite the fact that the women positioned such past life incidents as engrained enough to affect the sort of people they were, the unknown and unpredictable nature of childbirth was still, implicitly, stronger. The women could not be certain of what they would have and how they would behave. At another level below that one at which the women were operating the same themes of the unknown nature of childbirth and also, taking into account Diana's reference to the baby's needs, the safety of the baby, were still predominant.

In summary of the subsections which have dealt with the first issue of investigation: control in everyday life was not represented by the women in this study as something unitary. It was positioned differently according to the situation. However, in general terms everyday life was represented as something frequently outside of women's control. Such representations often also implied the presence of some overarching power or rationalism, in terms of 'fate' or things happening for 'reasons'. Talk of this nature functioned to allow the women to position life's uncontrollability as not through any fault of their own. Childbirth was represented, like everyday life, as frequently unpredictable. Added to this were fears and uncertainties about the safety of the baby and mother. As with everyday life situations this left a need for the women to invest faith in some sense of a greater authority, in this case the expertise of the carer. This expertise was represented as powerful, something not to be questioned. Faced with this expert knowledge the women were able to justify any loss of control on their part. However such images also resonated with an authoritarian connotation which was incompatible with popular representations of the midwife as the woman's friend and advocate. Similar themes of unpredictability and safety operated when the women themselves made connections between how their past life experiences might influence their conduct and experience of childbirth.

4.3.5 Childbirth control expectations and experiences

4.3.5.1 INTRODUCTION

The second issue which this analysis set out to explore was the way different women represented their control expectancies and experiences, taking into account their social backgrounds where relevant. This section will be subdivided into the woman's control over herself and various aspects of her control over the situation: general issues, the use of birth plans, pain relief, and the handling of the baby at birth, these being some of the control related issues which were raised most frequently by the interview participants. It is important to note that, although expectations and experiences of control were to be explored in this section, the unknown and unpredictable nature of birth meant that, on many occasions the participants positioned themselves as not knowing what to expect. Thus they could only discuss what they would like. Moreover in some cases expectations and requirements were positioned as inter-related. For example, Diana (on page 170) spoke of expecting (being sure she was going to need) pain relief, but then went on to say that she did not really want an epidural. In other words, wants and desires could be located within expectations. Because it was almost impossible to dissect expectations from requirements both will be considered together here in terms of the way in which the women envisaged the birth beforehand.

4.3.5.2 EXPECTATIONS OF CONTROL OVER SELF

Most of the women were asked antenatally how important to them was the way that they behaved when they were in labour. Some of them answered in terms of things that might happen to their bodies, for example, several women responded by saying that they were worried that they might inadvertently open their bowels during the birth. Of the ten women who answered the question directly, two main concerns were raised, a fear that they might generally become upset and shout or swear:

Barbara: 'So I hope I shall .. I shall cope appropriately. (laughs)' |JW: '(laughs) So how do you define appropriate behaviour then?' |Barbara: '(sighs) Not too much screaming, not too much shouting and ver.. very few obscenities if you can get (laughs) away with it.'

and a fear that they might say unpleasant things to their partners:

Caroline: '(.) The only thing that really worries me is the .. is the possibility of being horrid to my husband (laughs). Um, because, you know, you hear about people going wild a .. at the transition stage and saying all sorts of nasty things to their husbands, which they may or may not mean at the time.'

In the antenatal period the former fear was expressed far more frequently than the latter. Again a key thread running through the theme was that labour with one's first child was an unknown situation. In some texts this was made explicit, but always it was there. For example, in the two quotations above, Barbara could only hope about her behaviour, whilst Caroline spoke of the possibility of being unpleasant to her husband. Because of this uncertainty the women could only try to imagine how they would feel or react. As in the women's concerns for safety, described in previous subsections, there was also an element of fear. Such fear is exemplified in Barbara's talk of hoping to cope appropriately, implying the converse, that she also hoped that she would not cope inappropriately. Caroline speaks of being worried about how she might behave. Once again at the meeting point of these themes of uncertainty and fear was an image of powerlessness. Barbara's reference to whether she could get away with it, implied a lack of control over whether she would achieve what she hoped to, whilst Caroline's fears revolved around the idea that people said things they did not always mean when in labour, suggesting a loss of control over what was said.

These texts raise the question of why women should position themselves as feeling that they must remain quietly behaved during childbirth and why they should talk about feeling embarrassed if they do not achieve this. Green, Coupland and Kitzinger (1988) found that making a noise in labour was not particularly relevant to women's sense of internal control, which suggests that women do not want to remain quiet purely to feel control. However many of the taught methods for coping with labour, although aimed at pain reduction, also have the side effect of reducing the amount of noise a woman is likely to make whilst in labour (see, for example, Livingston, 1987). In this way, self-control and remaining quiet are linked implicitly. Only a few proponents of the more 'natural' forms of childbirth encourage women to make a noise in labour if they so wish (for example, Kitzinger, 1978; and Odent, 1984). However, it is possible that the pressure for women to remain quietly behaved before their partners and carers has other origins. It may be as much to do with a cultural legacy which has tried to silence woman, whether it be by redefining her emotions and feelings as pathological (Ussher, 1991), or by drawing her into a complicity of submission to those who are more powerful (Coward, 1993). The paradox then is that perhaps the women who are 'in control' of themselves in keeping quiet are really the ones who are being controlled by some image which defines the standard they feel they ought to attain.

Although some of the women reported fear of causing themselves embarrassment as a result of their behaviour during labour and birth, others used a series of discursive techniques by which such fears

were either minimized or discounted. For example, some of them pointed out that the staff would have seen such distress before :

Marna: 'I mean like you see the pictures in the magazines, all women pulling horrible faces and whatever. But it doesn't bother me. Not at all. I don't think about that. Yes it .. well happens don't it? I mean how many millions of women have babies. So it's not as if they (the hospital staff) haven't seen anything before anyway.'

Others claimed that they were not the sort of people to lose control, or that they did not feel constrained to behave in any particular way during labour. Another discussed how, in such an alien situation, she might take on a different persona, for whom she could not take responsibility. In many ways such strategies are reminiscent of the strategies the women used in rationalizing, deflecting or distancing themselves from any embarrassment they might experience from the intimate procedures involved with childbirth (Weaver, 1997). These strategies can be positioned as resistance to a concept: here that women must remain quietly behaved during labour and birth. However, as with the talk around intimate procedures, the very fact that the women did resist implies the problematic nature of the thing they were resisting. In other words, if there were not sexual connotations to intimate procedures which childbearing women found problematic, and if the pressures to remain quietly-behaved during labour and birth were not societally prescribed, such strategies would not be necessary.

4.3.5.3 EXPERIENCES OF CONTROL OVER SELF

After delivery the women said they had been very concerned, during labour, about not swearing at their partners. This issue was raised more frequently than it had been in the antenatal interviews, although it was reported by the women, or sometimes the partners themselves, that it was not a serious problem if the woman did swear at them:

Linda: 'I mean it .. it was sort of the joke that you always curse your husband, isn't it? A bit .. but not much.' |Linda's partner: 'Well very mildly. (laughs)' |JW: '(laughs) Did you?' |Linda: 'When you started telling me to breathe. Mmm ...' |Linda's partner: 'Er she sw .. she swore at me once (laughs). Yeah nothing too .. nothing too serious.'

Occasionally the concern was with not swearing at the midwife rather than the partner:

Alice: 'So .. but, yeah that was about the only time I swore, and was like at (partner) rather than a midwife. I was really paranoid that I was going to swear at a mid .. be really horrible (laughs) to her. But no I wasn't actually.'

Quite often the woman now related loss of self-control specifically to swearing. If she shouted or protested without swearing, this was not represented as a problem:

Marna: 'I kept telling her um, 'Help me. I can't ..', you know, 'I can't do it no more'. Screaming the place down ... I was really chuffed with myself that I didn't lose that much control to start swearing at everybody.'

Again, therefore, the women's talk implied that women in labour (and elsewhere) should behave in a certain way. They must not swear at anyone. Whilst it can be argued that the women probably would not want to be abusive towards those doing their best to help them, it is interesting that swearing is positioned as problematic. Again this carries overtones of the societal mores which say that it is permissible for a man to show violence (or to use violent language), at least under certain

circumstances. This is considered 'natural' (Walkerdine, 1981). But such behaviour is not usually sanctioned in women. An interesting parallel is found in the literature concerned with pre-menstrual syndrome (PMS). Many women who position themselves as PMS sufferers describe times of impatience with their families when they are more likely to be verbally abusive:

'The strain is very great and well nigh unbearable during the premenstrual time. I do not batter my children physically, but I do verbally, and I think that that can be almost as damaging, although I do try to explain to them why I behave as I do and apologize for it.'
(Dorothy, a PMS sufferer, quoted in Dalton, 1983. p37)

Dalton describes such irritability as a 'symptom' of PMS. Yet at the same time Dorothy positioned her behavior as something which must be explained to her children and apologized for. Such verbal behaviour is therefore not only positioned as pathological in a woman, it is also a sign of 'badness or madness' (Ussher, 1989). It is interesting to speculate whether men would recount the same reticence about swearing if they had to experience labour and birth.

The women reported feeling proud of themselves if they did not shout or swear, and disappointed if they did, again reinforcing the position that such behaviour is deemed inappropriate for women, even when in the throes of labour:

Alice: 'I didn't swear. I was really impressed with myself. (laughs) I do, I pride myself on that.'

Lisa: 'I was quite chuffed afterwards. I thought, 'I didn't swear at him (partner) ... And I was really chuffed with myself. (laughs) Bit of dignity.'

Alongside the above, the women often represented their sense of self-control as something that had waxed and waned through the labour. Although it was more common for women to recount feelings of less self-control as the labour progressed, sometimes they positioned themselves regaining control at a later date. This suggests that, certainly as far as the women's own accounts are concerned, self-control is not something fixed. As with the issue of control in everyday life, dealt with in the last section, the women negotiated different control positions when talking about different times in their labours. Apart from the discursive rationale for such accounts of shifting control, there is also some explanation at a cognitive level. As described in chapter 1 (subsection 1.3.2.4, page 35) Folkman (1984) claimed that a person and their environment have a dynamic relationship which changes continuously. Folkman observed that when the person-environment relationship is stressful, then appraisals of personal control will change as the relationship shifts. Because, by its very nature, childbirth involves stresses, already demonstrated in the women's concerns with the well-being of themselves and their babies, it can therefore be expected that a woman's perception of control over herself will ebb and flow as labour progresses and her level of reliance upon those caring for her, and supporting, her changes.

4.3.5.4 DIFFERENT PERSPECTIVES ON CONTROL OF SELF

In subsection 4.3.5.2 (page 164) the work of Green, Coupland and Kitzinger (1988) was referred to, which suggested that making a lot of noise in labour was not necessarily indicative of a lack of internal control or vice versa. Wendy's text supports this suggestion:

Wendy: *'I can remember my Mum saying, 'Oh you've coped very well. You're so brave. You did it.'* I said, *'I'm not'.* She says, *'Well you didn't scream the place down in hospital'.* I says, *'Yeah, only because I was so frightened (laughs) I couldn't open me mouth.'*

However, as shown, there was a tendency for the childbearing women and midwives to make connections between not making a noise and being in control. Thus, like Wendy, women who did not comply with these stereotypes positioned themselves as misunderstood:

Caroline: *'I did remember that I'd read somewhere that women often cry out and scream and make a lot of noise because for some reason making a lot of noise actually helps reduce the pain level. It produces endorphins or something in the .. in the blood. Um so when it um .. when she (midwife) told me to push and it got extremely painful, I started screaming (laughs), thought, 'This is going to help'. And she got really cross ... She said, 'Now stop being hysterical, Caroline'. Um and she was .. she was a real battleaxe about it. And that's when she said, 'Look, you're the only one that's going to get this baby out, and you've got to just get on with it and um stop being silly'. Um which is fact was probably right, because I think when I started screaming, I started feeling as though I was losing control.'*

One interesting aspect of this piece of text is that Caroline began by positioning her decision to make a noise as a controlled one, but then goes on to describe a feeling of loss of control when she made a noise and was reprimanded for it. Thus she positioned herself as coming into line with her midwife's view of the situation, accepting the 'expert' verdict. This illustrates the kind of problem which might arise when midwives represent, or appear to represent, control differently to the women they care for, something which will be referred to again later in this chapter. Moreover, as has been demonstrated from the literature review in chapter 1 (subsection 1.3.2.1, page 27) feelings of lack of control in labour have been significantly related to reports of postnatal depressed mood (for example: Oakley and Rajan, 1990). Similarly in the last chapter (subsection 3.3.7.3, page 119) measures of labour agency and mood correlated at each point of measurement: high levels of agency being associated with low mood disturbance, and vice versa. Therefore to redefine a woman's level of control, as did Caroline's midwife, might, it could be argued, also have ramifications for the woman's emotional wellbeing.

4.3.5.5 CONTROL OVER SITUATION - GENERALLY

Just as self-control was not represented simply as control over making a noise, so control over the situation was not usually positioned as a straightforward choice over interventions and treatment. This was largely due to the work of the major three discursive themes raised in section 4.3.4: the unknown and unpredictable nature of a first birth; the paramount importance of the safety of the mother and baby; and the positioning of the hospital staff as experts. As already discussed, the meeting point of these three themes was a place in which the women could not take up a position of overall control. Most of the women negotiated this problem by positioning themselves as expecting a high level of interaction with the staff:

Barbara: *'I would imagine, at this stage, I will be heavily guided by what they say. 'Cos they are more expert in that field than I am. (laughs) Even though, you know, I know I have the final say, because at the end of the day, it's still my body. But um I shall be very much guided by what .. what they say. And of course what is best for the baby. At the end of the day I don't want anything to be detrimental to the babe.'*

The concept of joint control has been discussed in chapter 1 (subsection 1.3.3.3, page 38). Evidence for such control was also found in the texts of women interviewed for the pilot study in chapter 2 (subsection 2.3.3.4, page 85). Another position which would reconcile the three discursive themes described above would be to abrogate all control. However the women in this study took this stance only occasionally. Regardless of social background, the theme of joint control was predominant in their talk about control of the situation, both before the birth, in the form of expectations and desires, and afterwards when the women described their experiences:

Tania: 'I thought it was a .. like a two way thing. She listened to what I wanted, and I'd listen to her advice. So I felt it was um a two way communication thing, really. I didn't feel like she was saying, 'You've got to do this, because'. She said, 'Would you like to do this?', or, 'Do you want this?' So um I was listening to her, I think, just as much as she was listening to me.'

Alongside descriptions of this interactive control often ran an account of open mindedness, as demonstrated by Barbara's text. Nevertheless Barbara also expected to be listened to, to have the 'final say'. It can be argued that joint control would only be effective if the midwife was to listen as well as to give advice, as in Tania's description. However, as shown in chapter 1 (subsection 1.4.4.2, page 48ff), and also in the pilot study in chapter 2 (subsection 2.3.4.1, page 86ff) midwife/client communication is seldom so balanced, and in some of the women's postnatal interviews it was implied that such a position of shared power might be an illusion:

Barbara: 'She was making suggestions and giving me the options. And therefore I could choose. But it's what she would have chosen. That's how I felt.'

Cara: 'I mean like they knew they had to cut me but they still said like, you know, 'We're going to ha .. going to cut you', um, 'Is that all right', kind of thing. And she said, you know, even if I'd said, 'No', they would have had to done it, 'cos I'd split, so .. but um they just made me feel like I was being in control as well at the time.'

Despite this, several women, like Tania, did say that their midwives listened to them. Moreover it is possible that childbearing women gain a sense of coping because they believe that the midwife, who is powerful, also has their interests at heart. A similar discovery, in a different context has been made by Welton, Adkins, Ingle and Dixon (1996), who found that, for religious individuals a belief in 'God control' could be isolated as a facet of locus of control separate from the other internal and external dimensions. Although 'God control' was, in effect, the belief that a supernatural power controlled outcomes, it did not equate with the other external locus of control dimensions. 'God control' was indicative of an active rather than a passive coping style. Belief in a powerful, personal, involved, reasonable and caring being was a variant of internal locus of control. Others have suggested that in 'God control' coping comes from a sense of collaboration with a powerful force (Furnham, 1982; Spilka, Shaver and Kirkpatrick, 1985), and it is perhaps a similar sense of alliance with the power of the midwife which gives childbearing women a sense of control in situations where the midwife does not necessarily communicate as effectively as she might.

4.3.5.6 CONTROL OVER SITUATION - BIRTH PLANS

Although the women's social background was not an issue when talking about internal control or when external control was being discussed in general terms, when the women began to talk about what they expected or wanted in specific situations, some differences became apparent between women from different educational backgrounds. For example, all the women had the opportunity to make a birth plan. There was a space in the woman's hospital notes, which she kept in her care, for her to write down any special requests or ideas she had about what she might want for her birth. Antenatally, the women who had been educated beyond GCSE level were far more likely to speak about keeping their plans concise but general:

Suzannah: 'I mean we haven't .. we thought about doing a birth plan. Um and I think it would be useful to do one. Um but I want it to be very general. 'Cos I don't want to .. to be too influenced by it and, you know, people to think I'm really sort of closed as to what I want and don't want.'

Some of the women who completed their education at GCSE level expressed doubts or uncertainties about writing in their notes. They were also more likely to discuss their birth plans in terms of very specific requests:

Wendy: 'When you're first pregnant people ask you all the questions and they start filling in forms. The after a while I kept looking at that page thinking, 'Nobody's asked me about this birth plan' ... So I actually wrote down on the page in the book that um I'd like to think about the pool and music to start with. Then um I said about, was it Pethidine, and then the, was it the other two injections that they say ... I actually said in my notes, 'But if it gets unbearable, I want an epidural'.'

It is possible that less educated women were not as confident as the others to contend with the authority of the hospital. Although the women were given their notes to look after, these notes were still essentially the property of the hospital. They were written in the 'language of obstetrics' (Kirkham, 1997), and were taken away from the women after the birth. Wendy's phrase, 'nobody's asked me about this birth plan' suggests that she was waiting for someone to complete it for her, following the pattern of asking questions and completing forms followed in the early part of her pregnancy. Her use of the word 'actually' when she spoke of completing the birth plan added emphasis to her action of writing on that page, as if it was something slightly daring or out of character for her to do. Such uncertainties on the part of the childbearing woman to some extent exemplify the way in which, as described in chapter 1 (subsection 1.3.3.5, page 39), carers still choose which choices childbearing women can take and control where they can take control. To set aside one page of the notes in which the woman can write her requests for the birth might, in the light of all the medical information that needs to be included, seem reasonable. But this marks out the notes as one of the areas which are controlled by the doctors and midwives and it is only if the use of the birth plan is spelled out to the woman (as it clearly was not to Wendy) or if the woman is assertive enough to risk trespassing the boundaries of medical control that she will feel able to use it.

It was the women from more educated backgrounds who, when they did complete plans, were reticent to make detailed requests. Suzannah, in the text quoted above, cited two reasons for this: to not feel too

influenced by the plan herself, and so that the staff would not think that she was too rigid over what she did and did not want. On the contrary Wendy lists several specific requests. It is interesting that, in the pilot study in chapter 2 (subsection 2.3.4.2, page 88), the midwives positioned women with high expectations (who were also described as educated and middle-class) as the ones who wrote long birth plans. In this study it appears that less educated women were more likely to have the longer plans. As noted in subsection 1.4.4.1 (page 48) of chapter 1, both doctors and midwives have been shown to be more forthcoming with explanations and information to better educated women (who are usually also positioned as middle-class) than they are to women with less education. Moreover, Kirkham (1989) demonstrates that middle-class women are more skilled at conversational strategies to elicit support and information from their carers. It has to be remembered that, at the time of completing their birth plans, most of the women in this study would have already had considerable contact with midwifery and obstetric personnel. It is possible that such an effect had been operating, giving the more highly educated women more confidence to leave requests, or even decisions, about their specific requirements until the birth, whilst the less educated women, aware of the problems they might have communicating their needs, became more anxious about spelling them out. Such a theory is also in keeping with the more general observation that middle-class, educated people find it easier to assert their right to good service (Townsend and Davidson, 1982). Kirkham's findings also suggest that withholding specific requests in the birth plan might even be a strategy on the part of the middle-class women to elicit cooperation from their carers.

Although different approaches could be traced in the antenatal plans women with different educational backgrounds made for the birth, after the birth when they spoke about their experiences, women from all educational backgrounds were equally as likely to report that they had used a plan or that they had decided not to bother. Thus it appears that, under the stress of the actual labour and birth the requirements of working-class and middle-class women become more similar.

4.3.5.7 CONTROL OVER SITUATION - PAIN RELIEF

Two of the main issues that the women reported writing about in their birth plans were the analgesia they wanted to use and their wishes for how the baby should be handled after the birth. Although some of the working-class women spoke of requesting specific pain relief in their birth plans, when describing their requirements for analgesia more generally the talk of all the participants tended to be peppered with conditions and possible exceptions. Regardless of social background, they almost always represented a tension between what they might want, based on what they had heard about, and what they might 'have to have':

Diana: 'I mean with .. with regard to pain relief, yes I'm sure I'm going to need some. Um the only conscious decision that I've made is that I really would prefer not to have an epidural. But if the need arose, then, you know, I'd assess that when it came ... But um if I needed .. if I needed a caesarean section, and they said, 'Well you're going to have to have an epidural', then well that would .. they would go together, or they might say I need a general anaesthetic.'

Diana's use of the word 'need', which occurred several times in this piece of text, implied a limited choice on her part. Although it could be argued that this 'need' might arise out of some complication or emergency, or out of unbearable pain, as suggested by Wendy in the last subsection, such talk also once again implied the presence of the staff, the 'experts', who knew what was best, exemplified in Diana's use of 'they', who might tell her she had to have an epidural or general anaesthetic. As described in the pilot study (subsection 2.3.4.1, page 87), alongside the power represented in such expertise and ability to advise, there ran the danger of coercion to support the 'experts' own views or preferences. Thus the fear was also expressed that the staff might try to persuade the woman to have something that she did not want:

Theresa: 'I wouldn't like to think they were trying to push me into anything. Saying, 'Oh', you know, 'This one is the best', you know.'

This demonstrates the women's recognition, not only of the skills of their carers, but also of their power, resonating with the subsection in which the women positioned themselves as capitulating to their carers in the same way that they would to a senior manager at their place of work (subsection 4.3.4.3, page 161). However, the women's representation of themselves as subject to powerful influences was also extended to their lack of power within the hospital system. They expressed the fear that they might have certain pain relief imposed upon them, or withheld, not because of any physiological constraints, but because of deficiencies in the hospital's arrangements:

Andrea: 'But at (hospital) they've got birthing pools, and I'm dead keen to use those ... and it would be nice to be able to spend the whole labour in there, and give birth in there. But as um (community midwife) says that er you've got to have 2 midwives there and it depends on how busy they are.'

One of the problems with such situations: a midwife who is imposing unnecessary pain relief upon a woman (or withholding pain relief), or a situation in which the woman's choices are limited because of logistical constraints within the hospital or system of care, is that the woman frequently has little way of knowing whether the reasons she has been given for a course of action are legitimate. Although, after the birth, many of the women represented their choice of analgesia as something highly limited by the contingencies of their labour, they also almost always represented their carers actions as plausible, and therefore acceptable:

Theresa: 'And then like I was saying, 'I want drugs. I want drugs'. And they were saying, 'No you can't have drugs'. So I was thinking, that ... you know, I thought it was a conspiracy, everyone was out to like make it as painful as possible, 'cos it was my first one. But obviously they knew what they were doing, they knew I couldn't have any. And they obviously had baby's and my interest at heart by sort of saying, 'No'.'

It is particularly interesting in Theresa's statement, above, that she described feeling at the time that she was the subject of a conspiracy. However she represented herself as, by the time of the interview, able to rationalize that the midwives had her interests and those of her baby at heart. Once again the issue of safety is drawn upon to justify the position of power taken by the midwives. The question is whether Theresa reinterpreted her distressing experience because, after the event, she became more objective about what occurred, or because to continue to represent the situation as one in which she was

totally powerless was psychologically painful for her. It is possible that, as in subsection 4.3.5.5 (page 168) above, to position the carers as experts, working for her own good, for reasons with which she could sympathize, was to embrace an active coping style. It is possible that a similar explanation could be given to the suggestion in some of the texts of a potential for control:

Alice: 'I mean like I knew in the back of my mind that, I mean, OK, I did have the epidural. But in the back of my mind I knew that if I really didn't want it, I don't think she would have done it.'

In this text Alice talked of her surrender of control in having an epidural, but at the same time also positioned this as something which she could have controlled had she wanted to. In other words she was in control over whether she took control. However the phrase 'I don't think' also introduced an element of doubt. Just as Theresa's reinterpretation of the midwife's actions was open to some question, so was this.

Alongside the issues discussed above, the women represented pain relief as a source of loss of control in two other ways. Firstly the analgesia did not always work as expected:

*Cara: 'And then um I woke up at about half 7, and they gave me, is it Meptid? And that didn't do nothing ... And um I think it must have been about five to 8, something like that, and I just ended up screaming at (**partner**), saying, 'Call her', because I was in so much pain.'*

But secondly, it sometimes worked almost too well, and made the women feel 'drugged up', 'out of it', or just unable to tell what was going on:

Cara: 'When you have the epidural you can't feel what's going on, which is nice, 'cos it gets rid of the pain. But you can't really feel what .. what is going on and like sometimes they was having to tell me when to push because I couldn't feel the contractions, but they could see it on the monitor. Um that was the only thing .. and that wasn't such a bad point, you know. That was good in the sense I couldn't feel the pain. But um that was the only time I'd say that I didn't really have any control.'

Past research shows that both obstetric staff and childbearing women consider choice over the type of analgesia used to be important to women during labour and birth (Drew, Salmon and Webb, 1989). However, here this issue was represented as a difficult one for childbearing women to control. Apart from the issues discussed above, part of this difficulty must also lie in what pain relief signifies for childbearing women. It could be associated with the unpleasantness of the sensation of pain itself, and thus be a source of fear (Rich, 1977), or it could be associated with images expressed in the literature. However these images contradict each other. Pain relief can be represented as the means to an 'enjoyable and emotionally satisfying labour and delivery' (Macdonald, 1983), in keeping with the women of the latter part of last century, described in chapter 1 (subsection 1.2.3, page 22), who saw the campaign for a pain-free labour as part of the larger campaign against the oppressive circumstances of women's lives (Kohler Reissman, 1983), or pain relief can be represented as the source of loss of control (Fisher, 1986; Priver, 1986), and undesirable side-effects (Wagner, 1994). Moreover women who give birth in hospital are in an unfamiliar environment in which the staff feel at home and know the routines and rules whilst they do not (Jowitt, 1993). Therefore, as shown here, childbearing women are also relatively powerless, against both their carers and the vagaries of the hospital system.

In summary, the women dealt with lack of control over their choice of pain relief by highlighting the issue of necessity: positioning their carers as taking control only when it was essential, implicitly subscribing once again to the discourse around the importance of safety, and the consequent connotations of birth as something hazardous. They also reported a sense of potential control, by arguing that they could have taken control if they so wanted, thus alleviating their position of disempowerment. Some participants did position themselves as in control of their pain relief, and these women tended to be those who had shorter, less complicated labours. However most of the women subscribed to the themes of uncontrollability presented in this section, regardless of their social background.

4.3.5.8 CONTROL OVER SITUATION - THE HANDLING OF THE BABY AT BIRTH

Many of the women's reported requirements for control over what happened to the baby at birth were to do with whether they expected or wanted themselves or their partner, to hold the baby immediately after delivery. Two issues appeared to be important here, the idea that the baby would be messy or dirty after birth, and the women's associated repulsion, and the idea that the partner, who had not had the same intimate knowledge of the baby during pregnancy as the woman, should be able to relate to it first after birth:

Tania: 'I can't imagine wanting to hold the baby as soon as it comes out. I know that sounds strange but um I don't want all its bits and pieces and blood and liquid and stuff.'

Christine: 'I've um written in that the baby to be given when it's cleaned, you know, and checked and everything, to be given to um (partner), and for (partner) to tell me the sex of the baby. 'Cos I think then he's first to know what sex it is. And it's just that something little special for him. I've f.. felt the baby move inside me and everything for 9 months and so he's not left out, so he's not left in the dark.'

However, it is interesting that all comments of this nature came from the women with lower levels of education. Most of the women with higher levels of education made no comments about how they wanted the baby to be handled although two of them discussed requirements which they positioned as purely for the well-being of the baby:

Suzannah: 'They're probably the .. the only things I do feel sort of very strongly about, that um as far as possible I don't want um the .. the baby to be overstimulated. Um 'cos um I think that .. that just the process of birth is very traumatic ... And they can very easily become overstimulated and quite traumatized.'

Andrea: 'There's only one thing I'm going to write down on my birth plan, and that's, 'I do not want my baby to have any SMA. It's to only have breast milk'. Because of um .. my husband's got asthma. Er because of the allergies.'

After the birth, many of these issues were positioned as less important than the women had envisaged:

Cara: 'And um like when I had him, and like they lifted him up and showed him like I was just like screaming, 'It's a boy. It's a boy', 'cos I was so excited, and the fact that we'd got it right and that ... And um like they were saying about cleaning him up, and I said, 'No I just want to hold him'.'

Suzannah: ''Cos I remember when we talked before, I talked at length about what I wanted for her. So immed .. immediately when she was born, it didn't seem so important in a way.'

Therefore, as with the issue of birth plans, the different accounts of their requirements made by women with different levels of education were no longer apparent when the women spoke about their experiences. In terms of their expectations and requirements, the less educated women expressed different concerns to women with higher levels of education. The latter concentrated on issues concerning the wellbeing of the baby, or more commonly did not raise such issues at all. It is possible that, as with birth plans, the more detailed stipulations of the less educated women were due to their lower confidence in being able to communicate effectively with their carers at the time of birth, rather than in any actual difference in requirements. The exceptions: the issues raised by the two more highly educated women were matters about which they felt particularly strongly, and it was perhaps this strong feeling that over-rode any reticence to wait until the birth to make requests or decisions. Suzannah, quoted above, had worked with children damaged by over stimulation and had thus seen its effects. Andrea had a history of asthma in her family and knew the associated risks from artificial baby milk. Moreover both of these issues connect with labour ward practice which was once commonplace. Birth did frequently take place in noisy, brightly lit environments, where the baby was stimulated to cry vigorously (Arms, 1994), and breast fed babies were sometimes given bottled milk, without the mother's consent, if they were slow to feed (Myles, 1975). It is possible that these women had heard about such practices from older members of their families and that this reduced their confidence to negotiate with the midwives in these particular areas.

The experience of birth appeared to iron out any apparent differences between women from different backgrounds. If the requirements of the two groups were in actuality similar, this is not surprising. Moreover the issues concerning the handling of the baby would have arisen after the birth was safely completed. It is possible that relief, exhilaration, and exhaustion, as common experiences to all the women, also helped to dissolve any differences in requirements.

4.3.5.9 SUMMARY OF SUBSECTION 4.3.5

This section explored the participants' expectations, requirements and experiences, taking social background (in terms of level of education achieved) into account where relevant.

A strong theme in terms of the women's internal control centred upon their reports of not wanting to shout or swear, or make an undue noise, during labour and birth. Such issues were both expressed as antenatal concerns and described in terms of the women's experiences, although the emphasis shifted. Before the birth the prevalent issue was not wanting to make too much noise, whilst afterwards it was described as the avoidance of swearing. However both issues could be discussed in terms of social and cultural mores which do not expect women to shout or swear, although such behaviour is more acceptable for men. It was also shown that those around the woman sometimes associated being noisy with being out of control, and vice versa, regardless of how the woman positioned herself.

In terms of external control there was a tendency for nearly all the women to represent the expectation or desire for, and the achievement of, a joint control with their carers. This was interpreted in terms of the midwife's power, and the advantages to the woman of allying herself with this power. Because of

their better communication it might have been a closer alliance with such power for the more highly educated women that enabled them to remain ostensibly more open minded than less educated women, in terms of their birth plans and their requirements for the way they baby was to be handled. However the fact that such differences disappeared postnatally suggested that all the participants, regardless of level of education actually might have held more similar expectations for the birth than were expressed.

Perhaps because of its complex nature, and because of the fears involved, issues concerning pain relief were not associated with educational differences. Despite differences in this issue in terms of what they wrote, or intended to write in their birth plans, most of the interviewees expressed similar views in terms of their 'needs' for pain relief being determined, not only by their experiences of pain, but also by what the staff, the 'experts' advised them to do. Another concern around the issue of the use of pain relief was the possibility that the midwife might coerce the woman into having analgesia she did not want. Similarly the women were aware that they were subject to the exigencies of the labour ward staffing and structuring in terms of what they might be 'allowed' to have. However the women appeared to need to position their midwives' actions as rational and in their best interests, perhaps because, once again, they required a sense of trust in their carers to maintain the alliance and concomitant joint control described earlier. A position of potential control: not taking control but being able to had they wanted might also have been part of the avoidance of a representation of powerlessness.

A final issue that should be addressed before this section is concluded is the difference between what the women said they had written in their birth plans (or what they said they planned to write) and what they said they actually wanted or expected. At times the two were the same. For example, Christine's description of how she wanted the baby to be handled (page 173) is a reflection of what she said was written in her plan. However, upon other occasions the woman might, for example, talk about quite specific birth plans which were not reflected in their talk about their 'actual' requirements. To a large extent this reflects the shifting subject positions discussed in subsection 4.3.4.1 (page 159). However this apparent anomaly also suggests that the birth plan was positioned as a vehicle for communication, thus subject to strategies and techniques which might serve the childbearing woman in achieving not only any specific requirements, but also a sympathetic rapport with her carers. Such strategies would not necessarily be reflected in the women's talk of their 'actual' requirements.

4.3.6 Antenatal education classes

The third issue is how the women positioned the usefulness of antenatal classes in terms of the preparation they provided for dealing with the control related issues of labour and birth. Attendance was high in this group of women, all except one attending at least some classes. There were, however, differences in how helpful they were reported to be:

Linda: 'They were very good in the parentcraft classes, so we sort of knew like what all the drugs were, what they did, what the side effects were. So we sort of knew what .. almost what we wanted to know.'

Andrea: 'Obviously she went through all the .. the various forms of pain relief. What she didn't give was the .. the side effects, which is what I was interested in.' | *JW: 'Right. She didn't mention side effects at all?'* | *Andrea: 'She did a bit. But not in the detail I would have wanted.'*

Not all the interview women would have attended the same antenatal classes. In the area in which they gave birth classes were organized on a geographical basis, many of them being held at small venues in the community rather than all women attending at the hospital. Moreover, because the entire cohort of interview participants gave birth over a period of several months, even if they had lived in the same area, they would not have necessarily attended classes at the same time. Despite this, the differences in the way the classes were positioned by the women appears to owe as much to the different expectations and requirements of the women, as to differences in the classes themselves. In many cases, what one woman criticized about the classes would be something that another woman would praise. Thus in the texts quoted above, one woman positioned the things she was taught about drugs and their side effects as 'almost what we wanted to know', whilst the other reported that she was not taught in the detail she would have wanted. Whilst it is possible that the separate classes these women attended gave information in different depths, it is equally likely that Andrea wanted more detail about side effects than Linda. Moreover, other women were overwhelmed by all the information they were given on drugs:

Theresa: 'And she was telling you all the different methods of pain relief during childbirth. And there was loads and loads of different things. And she was like going on and on and on and on and then the next week when we went back, she was sort of asking us loads of questions about it and I couldn't even remember one of them. And I thought, 'Oh my God, I must be really thick or something' ... So they d .. they didn't benefit me at all. I can safely say that.'

One criticism which has been leveled at antenatal education is the school-like nature of its structure and content (Cliff and Deery, 1997; Dallas and Deery, 1997). Dallas and Deery point out that working-class girls who find a large differential between the structure of their home lives and school tend to feel alienated from the process of education. Because of its comparable nature, working-class women can also find antenatal classes threatening. It is interesting, therefore, that Theresa, who was overwhelmed by all the information she had been given in the antenatal class, had found school, and her relationship with her teachers problematic:

Theresa: 'I've never been one for sort of, you know, learning or st .. sticking at school ... Authority figures used to annoy me at school. You know, where they used to, sort of, talk to you like a bit of dirt ... They always used to d .. drag one parent families down at school. They always used to think we'd just end up nowhere.'

Dallas and Deery comment that, to the working-class women in their study, the midwives who ran antenatal classes tended to be likened to censorious and distant teachers. Theresa's representation of being 'treated like a bit of dirt' by her school teachers and of being 'dragged down' because she was a child from a one-parent family possibly helped to fuel her image of the antenatal class midwife as someone alien who was out to test whether she had learned what she was meant to. Her despairing 'Oh my God, I must be really thick or something' resonated with the struggle she had to achieve at school and her decision, described in her interview, to give up and leave at the earliest opportunity. However,

despite this she persevered and attended all of the antenatal classes. When, in the interview, she was commended for this, she remarked, '*At least I showed my face*', implying that by her attendance she had acted in such a way as to appease her midwives and doctors, rather than gaining any real benefit of her own. Indeed, as she reported in the text quoted above, she felt she had gained nothing from the classes.

The different requirements of the childbearing women meant that it would have been impossible for the midwives to arrange classes that suited everyone:

Christine: 'And the last one was baby care, like just bathing and changing a baby's nappy, and things like that. And I said to (partner), 'Well', you know, I didn't really think that was necessary. (.) You know, I think is .. think it's common knowledge really.'

Linda: 'It was all emotional and pain relief. But really what some of us wanted to know was um how do you bath 'em, how do you dress 'em, how do you feed 'em?'

The helpfulness of the classes was also limited for many of the women by practical issues. Classes were often positioned as unfriendly, or too big, whilst the other attendees were sometimes considerably older or younger than the woman concerned, making her feel out of place. Dallas and Deery comment that one of the most helpful aspects of antenatal classes to pregnant women is the social aspect: the opportunity to meet women in a similar situation. In this study large age gaps sometimes detracted from the sense of camaraderie that other women expressed when their classes consisted of women in a similar age group and situation to themselves:

Eliza: 'And we were all over 30, or in that region, with older husbands or whichever way round. And it .. you suddenly thought, 'Oh this isn't so unusual', you know?'

The timing of classes was also sometimes identified as a problem, and again this was more of an obstacle for working-class women who might have transport problems and be limited by bus times, or reliant on their partners to drive them to classes.

Despite there being variations in how helpful the women reported the classes to be, as suggested in chapter 1 (subsection 1.3.2.3, page 34) classes were almost always positioned as just one source of information about what to expect, amongst many others, for example: books, magazines, films, friends and family. As in the pilot study, the value of such sources was not always recognized by the midwives, who tended to use antenatal class attendance as a gauge of how informed a woman was:

Midwife Olivia: 'She hadn't been to any parentcraft lessons. And she .. she was young. She was very young. So we just briefly went through a quick session of .. of what labour would be like, and what she could .. what she could expect.'

Midwife Maggie: 'She was quite g .. she was a young girl, and I .. and I don't mean this sort of stereotyping, but she was quite well informed. She'd gone to classes.'

In the first piece of text a direct association is made between lack of attendance at parentcraft classes and the need for the midwife to explain what labour would be like. There is no suggestion that between determining that the woman had not attended classes and explaining about labour the midwife had set out to ascertain what her client did know. However the other interesting element about these two quotations is the association of youthfulness with ignorance, in the first instance made directly, as if

the women's young age was an additional handicap to her on top of that of not having attended classes. In the second quotation the midwife acknowledges an incompatibility, 'she was a young girl ... but she was quite well informed' and in her rebuttal of the use of the stereotype, acknowledged that such a stereotype exists. Such an association of being young with being uninformed was seen in the pilot study (subsection 2.3.3.2, page 83), and in the stereotypes discussed in the literature review, and identified by Green, Coupland and Kitzinger (1988, 1990). These stereotypes identify working-class women as 'willfully ignorant', whilst better educated, middle-class women attend classes, write birth plans and want control. It is interesting that the converse appeared to be true in this study. As opposed to being willfully ignorant, at least one working-class woman persevered at class attendance even when it was not helping her. In the stereotypes young, unmarried women are also often represented as more likely to be working-class and less educated, and the associations made by the midwives between youthfulness and being uninformed, not to mention the allusion to stereotyping in that text, suggests that it is not a mistake to implicate such a cliché here. This is not to imply that the midwives' interviewed here consciously ascribed to such stereotypes. Indeed Maggie positioned herself as trying to avoid them. But the images are powerful ones, and it is clear that they have subtle influences. However, as the discussion above has shown, such representations are out of line with those made by the women themselves. Whether women were young or older, whether they attended classes or not, they were well-informed, having read books and magazines, watched films, and spoken to friends and family to get information.

4.3.7 Other influences on women's experiences of control

The fourth issue is concerned with factors, alongside expectations, which women position as influences upon their experience of control in childbirth. Certain other influences on the woman's control have already been put forward in the earlier sections of this chapter: that of the presentation of a first birth as an unknown situation (as indeed are subsequent births to a lesser extent); of the safety of the baby and the woman as of paramount importance; and of the midwife (and doctor, if involved) as the expert with knowledge of birth, who can keep the woman and her infant safe. Because of these issues it was difficult for the women to develop clear-cut expectations or to position themselves as in control during childbirth. Moreover, labour was represented as uncontrollable from the beginning, in so much that the women could not predict when it would start³⁴:

Andrea: 'None of the books, none of the magazines, or the midwives, or anybody will tell you how labour starts. They say, 'Women always know'. And you think, 'Do they?''

The women reported that their uncertainties about whether labour was starting or not were not always acknowledged or appreciated by the hospital staff:

Wendy: 'I had an appointment at the hospital anyway with (consultant). And I got there and I said to (consultant), 'I think I .. I think it's started'. And by the time (consultant) had

³⁴ If the beginning of labour was rendered predictable either because it was induced or because an elective caesarean section was arranged, the woman still could not claim control, because such interventions were under the direction of the medical profession.

finished poking me around, they'd written me in my notes, 'Thinks she's started', exclamation mark. So I.. I knew (consultant) was a bit funny anyway.'

Christine: 'So I rang the hospital ... And they said, you know, er 'Are they contractions' I said, 'Well I don't know', you know, 'They're not painful'. And they said, 'Well', you know, 'Stay at home until you can'.'

Thus the labour was represented in terms of a power differential between the women and her carers from the outset. The midwives and doctors had to be relied upon to tell the woman whether she really was in labour or not. In both of these texts the women's moves to identify their experience as the start of labour were tentative in the extreme. Wendy thought she'd started, whilst Christine was unable or unwilling to identify her sensations as contractions. Some of this uncertainty probably arises from the woman's fears of going to hospital and finding that her supposed labour is a 'false alarm': that the contractions stop and she is sent home. Several of the women spoke of worrying, when they thought labour was starting, whether it was 'the real thing'. Hunt and Symonds (1995) document the hostility women in 'false labour' can experience at the hands of labour ward staff who position them as 'time wasters' and as ignorant for not recognizing what is labour and what is not. Such women are identified as 'bad patients', and it is interesting that, in the texts discussed above, both the women reported a less than enthusiastic reaction to their tentative claims of possibly being in labour. Wendy interpreted her consultant's reaction as sarcasm, exemplified by her observation of the exclamation mark at the end of the statement written in her notes, and by the remark, 'I knew (consultant's name) was a bit funny anyway'. Christine reported being asked whether the sensations she was experiencing were contractions, and when she expressed uncertainty was told to stay at home, despite the fact that she had been concerned enough about the way she felt to telephone the hospital in the first place. Interestingly both these women turned out to be in labour and gave birth some hours later.

It was not only in the anticipation of labour that issues of control arose. There were aspects of the process of labour itself that were, after the event, represented as intrinsically uncontrollable. References have already been made to the way in which the women positioned certain aspects of pain relief in terms of things they 'had to have' because of the exigencies of the situation, and similarly the experience of vomiting during labour was always portrayed as something outside of the women's control. However the issue of pushing the baby out appears more complex.

Generally speaking, the practice of urging parturient women to make sustained pushing efforts in the second stage of labour has been shown to fulfill no advantages over allowing the woman to follow the involuntary urges to bear down that accompany full dilatation of the cervix (McQueen and Mylrea, 1977; Caldeyro-Barcia, 1979; Maresh, Choong and Beard, 1983; Knauth and Haloburdo, 1986). In fact there is some evidence that sustained bearing down efforts, associated with maternal breath holding, compromise fetal well being and increase the risk of perineal damage (Bassell, Humayun and Marx, 1980; Caldeyro-Barcia, 1986; Simkin, 1986; Enkin, Keirse, Renfrew and Neilson, 1995). Despite this, the women frequently positioned themselves as expected to push:

Marna: 'And um the hardest thing is, they're telling you to push. And you have to hold your breath at the same time. You're running out of breath, you're going red in the face, and they say, 'Don't stop'. You take a breather in and they say, 'No, don't stop pushing'.'

and sometimes expressed a sense of failure that they had not pushed better:

Tania: 'I just couldn't push any more. I was thinking, 'Maybe I should have gone and got fitter', and 'It's all my fault'.'

Thus active³⁵ pushing efforts were positioned as outside of the woman's control whether they were achieved or not. If achieved, the process was represented as under the total control of the midwives. Marna described being urged to push almost to the point of not being allowed time to stop and catch her breath. However if pushing was not achieved the woman might blame herself. Tania reported that she felt exhausted and thus was unable to push. She implied that by 'getting fitter' she might have been able to bear down for longer. Thus she positioned her lack of control over her body as her own fault. Such talk resonates with Malson's work with anorexic women (Malson, 1998), who describe the uncontrollability of their bodies when positioned as overweight as something intrinsically bad: the body being construed as alien. This is offset against the triumph of mind over the body in the women's descriptions of their control of their bodies through starvation and weight loss. However the paradox is that anorexia itself can also be positioned as a loss of control: a condition over which the woman has no power (Dunbar, 1987). Similarly the paradox in the childbearing women's talk of pushing was that to become fit and in control of their bodies enough to sustain pushing efforts was to become subject to the control of their midwives over them.

At a material-discursive level pushing is a paradoxical issue. Although it is always the physical act of expelling the baby, there is a tension between active pushing, described above, something the woman has to do, and the concept of involuntary pushing as something controlled by the woman's body:

Lisa: 'You've got to do it when your body does it, and you can't not do it. You've got to do it.'

Caroline: 'But the third midwife that I had told me in no uncertain terms that I was the only person that was going to be able to push this baby out and that I had to push.'

The issue of the body's control over the birth process will be discussed at length in the next section of this chapter. However, yet another paradox is control over pushing vested in the woman, whether in her efforts or in her body's control, as described above, set against the representation of the second stage of labour as something very much the province of the midwife, the point at which she can exercise her craft:

Midwife Ingrid: 'And um (.) y .. you know when people are flagging, and you say, 'If you can just get it a little bit further, I can help you', you know, by doing an episiotomy.'

Midwife Kim: 'By 4.30 she was fully, and by 5.15 she pushed the baby out. She squatted for me.'

Both these extracts acknowledge that the childbearing woman has some input into the second stage, but the underlying inference is the midwife as the orchestrator of events. For example, Ingrid's use of the 'If you .. then I' construction could be taken to suggest that her action was dependent upon her client. However it can also be argued that it positions her client's compliance as the deed that would

³⁵ As opposed to involuntary bearing down.

effect the midwife's help. Similarly although Kim talks of her client pushing the baby out, the use of the phrase 'she squatted for me' again suggests that Kim is managing the situation. This resonates with the discussion in subsection 4.3.4.3 (page 162) of the two different images of the midwife: the caring advocate, and the 'managing director' - not to be argued with. Here both can be seen to be operating together in the two midwives' representations of themselves as the woman's helper, and yet as someone who is also in charge.

Thus, in terms of pushing the baby out, childbearing women are caught in a mesh of material-discursive meanings in which the material act of expelling the baby can be positioned as something only the woman can do by exertion, and as something her body does, over which she has no control. It is represented as something she does alone and yet also as a facet of the second stage of labour which is controlled by her midwife. Moreover both pushing as directed by the midwife and not 'being able' to push are equally as likely to be positioned as lack of control. Underlying these issues is the tension between the recommended research-based practice of allowing spontaneous bearing down against the apparently common practice (from these interviews) of urging women to make active efforts to push.

In summary, therefore, the women did report various influences on their experiences of control. Three of these influences were dealt with in earlier sections: the unknown nature of a first birth, the safety of the baby and the expertise of the midwife. In this section it was seen that the women's representation of birth as an unknown began with not knowing how labour would start. Combined with this was an element of fear of not being able to discern the difference between true and false labour. The obstetric staff, who knew how to recognize labour, were positioned as sometimes patronizing or dismissive towards women who were uncertain whether 'real' labour had begun. However the individual specifics of labour were also areas in which the dynamics of control were positioned as operating. The need for pain relief was described earlier. Vomiting, a problem which many women encountered, was largely presented as uncontrollable, whilst the control dynamics of the relationship between the midwife and the woman in the second stage of labour were represented as far more complex. Other aspects of labour, not discussed here, in which control issues arose, included tiredness, intimate procedures, pain sensations, fetal heart monitoring and complicated deliveries. To conclude this section it can be argued that many, if not every, aspect of labour can be represented as a control issue. It is the complexities of some of these issues that made it difficult for the childbearing women to represent control as something straightforward.

4.3.8 Different aspects of control in childbirth

The questionnaire data revealed relationships between the amount of control different women expected and wanted, and between the amount of internal and external control they required. As explained in subsection 4.3.5.1 (page 163), in the interviews expectations of, and requirements for, control could often not be teased apart. However, as shown in subsections 4.3.5.2 to 4.3.5.9 (page 163ff), the women who were interviewed positioned self-control and control over the situation differently, although how they dealt with the latter depended upon the issue under discussion. The theme of joint control was a

very strong one when the women spoke about control of the situation, as was potential control, the women's position of not being in control but feeling that they could take control should they want to do so. Both joint control and potential control were strategies the women used to deal with the dilemma of finding themselves in situations which contained elements of uncontrollability.

However, apart from self-control and control of the situation with its various nuances, the women also raised another aspect of control, that of the body's control over the situation: the physiological control discussed in chapter 1 (subsection 1.3.3.3, page 37) and the pilot study (subsection 2.3.3.4, page 84). Again this issue has been implicit in much of what has already been considered. For example pushing, discussed in the last section, was represented at times as something the body did which the woman could not control. Sometimes the body's control was discussed in more general terms:

Lisa: 'I suppose your body .. a lot of it takes over. I suppose the brain's telling it what to do, but I suppose it's a natural reflex. It already knows what to do. And it was just doing it, without me doing it. It was just doing it on its own. And .. and that was really strange.'

This notion is not a new one. As described in chapter 1 (subsection 1.2.3, page 22) one of the underlying principles of the concept of natural childbirth is that the woman must relax and allow her body to perform its natural function (Dick-Read, 1954), whilst the more recent notion of active birth encourages the woman in labour not to try to control herself, but to 'let go': go with the natural instincts of her body (Balaskas, 1983). In this study the women tended to position the natural function of the body during labour as something they could not control, although this was not presented as something concomitant with the woman's disempowerment, so much as a dynamic of its own, another type of control, albeit one that came from within themselves rather from any conscious effort of their own. Thus statements like, 'it was just doing it' or 'you've got to do it when your body does it'³⁶ did not function to represent the woman as helpless, rather as empowered by her own body's 'knowledge' of the right thing to do. However, despite this, some of the women questioned whether their bodies could be trusted to be in control:

Andrea: 'The lasting effect of the miscarriage was that um I didn't trust my body to actually sort it out right the second time.'

This relates strongly to medical discourse around the unreliability of women's bodies, not only in obstetrics, as described in chapter 1 (subsection 1.2.2, page 20), but also in terms of other reproductive functions, for example the 'raging hormones' of menstruation and menopause (Ussher, 1989). A milder, and more frequent, formulation of this sentiment was the suggestion that the woman's body might need some help:

Tania: 'I know you've got to .. your body knows best and things, nature takes its course. But I think there's a time when your body needs drugs and needs a bit of help.'

Thus, whilst representing their bodies as able to control the labour process, the women also continued to subscribe to the medical model which positions the body as:

³⁶ See Lisa's comment page 180.

... imperfect or even corrupt, and health is obtained only with help from the outside.
(Wagner, 1994. p 28.)

The tension between these two, essentially opposing, themes was apparent in some of the women's statements:

Caroline: 'I mean however much reading I've done, and however familiar I might be with how my body is and, I'm the only one that actually knows how my body feels at the time, at the end of the day, I'm not an expert in childbirth. So, to a large extent I do have to expect to take a midwife's advice as to what's going on.'

Cara: 'I mean I'd listen to what she's got to say ... Obviously she's got experience, she knows what's going on with your body and that, whereas more than what you do. Um but also if I have a strong feeling about something then I will listen to that as well.'

This tension is also represented in terms of ownership of the body. The phrase '*it's my body*' occurred several times in the women's texts. Therefore although, as described earlier, the body can be positioned as being in control of the birth process, it is a control that is represented as coming from within the woman because she does own its sensations, as Caroline suggests. But in questioning the efficiency of the body, the medical model sets up the medical professional as the expert. Thus the woman's confidence in her own body, and her confidence in the things it is 'telling' her is brought into question (Graham and Oakley, 1990). She must acknowledge this medical expertise whilst trying to maintain her ownership of her body, as does Caroline, or she must bring into question her own knowledge of what her body is doing, as did Cara. However these strategies are not mutually exclusive. Despite ascribing the experts with a better knowledge of her body than she had herself, Cara immediately went on to say that she would listen to her own strong feelings. In other words, she still could not abrogate her ownership of the way she felt entirely.

That a tension does exist between childbearing women's knowledge of their bodies and medical expertise is illustrated in the literature. Hunt and Symonds (1995), in an ethnographic study of midwives at work in a hospital, observed many an interaction like the following:

Woman: 'I'm having terrible contractions, they are really strong.' | *Midwife: 'Feel quite weak to me.'* (Hunt and Symonds, 1995. p94)

Positioning their bodies as something about which they knew therefore provided these women with more discursive problems than their representation of a first birth in its entirety as something unknown. In the former case the expertise of the midwife or doctor had to be somehow integrated with the woman's own position of expertise about herself. However in the latter case the woman could use the discursive strategy of joint control to embrace the expertise of her carers without hindrance, and to draw on it to her own ends.

In summary, therefore, the childbearing women positioned control issues as highly fragmented and sometimes contradictory. Previous sections of this chapter have discussed such issues as internal and external, joint and potential control. This section dealt with the issue of physiological control. The tensions between medical rhetoric which positions the woman's body as unreliable and the woman's knowledge of her body and its sensations appeared to provide the women with greater problems when representing their control in childbirth than did the position of joint control with the 'experts'.

4.3.9 Psychological effects

4.3.9.1 INTRODUCTION

The sixth issue was concerned with whether the women positioned control issues as having other psychological effects than the mood disturbance examined in the previous chapter.

In this study the women seldom reported direct associations between control issues and their postnatal psychological states. However, when they did it was mainly in respect of positive control experiences and feelings of happiness or satisfaction:

Suzannah: 'It was amazing, so it was so exciting. It was excellent ... But now I think it was an incredibly powerful thing to do, really. Um most definitely. Yeah. 'Cos um being in .. being able to be in a position where you felt in control as well, and where it felt right. Very empowering, definitely.'

However it is notable that most of the women who described such feelings had experienced short labours and particularly straightforward births. More often the women's narratives of their experiences implicated the birth and early motherhood more generally in its psychological effects, and the place of control in these accounts can only be postulated. When these more general accounts were examined, three clear themes emerged: short-term emotional effects; effects on self-image; and expectations for 'next time'.

4.3.9.2 SHORT-TERM EMOTIONAL EFFECTS

In the 1 week postnatal interviews, or sometimes retrospectively at 16 weeks postnatally, the women talked about feelings of euphoria, or being 'high' in the first few days after the birth, or conversely about being tearful at this time.

*Eliza: 'Now I've been very lucky, I think I only had one day when I felt a bit sort of, you know (*imitates a crying noise*) 'I'll just cry at the motor racing', (*laughs*) you know, and I'll cry at the horse racing ... You know, literally. I did have one afternoon like that. My husband and my mother went out and I sort of sat here and watched the Grand National in tears, you know, thinking, (*laughs*) 'This isn't quite right'.'*

*Cara: 'But it weren't 'till the next morning that .. that I felt on a high again. They took the catheter out and that so I could get up and about and um look after him myself. And that made me on a high again. When (*partner*) seeing him smiling all over him, that .. that made me on a high again as well. And that las .. I mean that definitely lasted all the time I was in hospital. It was um that was brilliant, yeah. Yeah.'*

Emotional changes in the early postnatal period, particularly when negative, are often attributed to the 'postnatal blues', a fleeting phenomenon, characterized by mood swings or tearfulness. Such changes can last from a few hours to a few days (Pitt, 1973), although O'Hara and Zekoski (1988) maintain that the differences between the three affective disorders which follow childbirth: the 'blues'; postpartum depression and postpartum psychosis are differences of degree rather than of quality. Many possible aetiological factors for these disorders have been studied including obstetric complications, biological and social factors, but O'Hara and Zekoski point out that there is little strong evidence to link any of these with postpartum dysphoria. In this study, many of the women who reported emotional

changes in the early postnatal period associated these experiences with the upheaval of new motherhood:

Christine: 'And we were sitting in the chair, and I just went over and gave him (partner) a cuddle, and I said, 'I'm going to have to cry' ... And I explained to him, you know, that just things like bathing him (baby), is he going to get a cold? And, you know, just things like that really. I think I was like that for a couple of days. You know, and also the fact of, you come out of hospital and you've had people round you, lots of people that care very deeply, and um, you know, you come home and that's it, you have to start all over again.'

Quite often, as in the quotation above, the factors the women positioned as the cause of their emotions were related to their uncertainties about coping with the new baby, especially once the support of the hospital was withdrawn. Feeding problems and the baby crying excessively were particularly likely to be positioned as triggers for emotional distress. Tiredness and a feeling of not coping were also associated with unhappiness in the early postnatal period. Although many of the women represented the problems in terms of losing the support of the postnatal ward, others complained of lack of support with the new baby whilst they were in hospital. This was sometimes contrasted with the care and constant attention they had received whilst on the labour ward:

Barbara: 'Labour ward they .. it was as though they couldn't do enough ... And, you know, they just looked after you so well. Y .. when you got on to the postnatal ward it was, 'OK', you know, 'Well you're a fit woman and now you've got your baby and get on with it' (laughs).'

Recent moves to give women control over the birth process (Department of Health, 1993) have tended to concentrate on care of the woman during labour and birth. Large amounts of effort have been expended in attempts to provide childbearing women with continuity of carer, to be looked after in labour by a midwife they have met before, in the belief that this would enable each woman to more easily negotiate the kind of birth she wanted. However this, it has been acknowledged, has tended to be at the expense of fragmenting postnatal care, so that the women are less likely than ever before to be seen postnatally by the same midwife each day after the birth (Fleissig and Kroll, 1997; Perkins and Unell, 1997). Christine represented part of her problem as due to the fact that she had come home from hospital where the staff 'cared deeply' for her, and that she now had to cope without this support. Continuity of carer into the postnatal period would mean that she would have been able to maintain contact with at least some of these carers. However, alongside continuity of carer, the two women quoted above also required continuity of care, consistent care and advice in the postnatal period (Stock and Wraight, 1993). Although as mothering skills developed they could expect this care to be withdrawn gradually, the sudden disjunction in care on removal to the postnatal ward, in Barbara's case, and on discharge home for Christine, was positioned as anxiety provoking. Again, the concentration of resources on labour and delivery increases the likelihood of poorer staffing levels and thus less support in the postnatal period.

4.3.9.3 EFFECTS ON SELF IMAGE

Some of the women reported that the birth had somehow made them stronger people. Sometimes this was positioned as a practical issue. They had experienced, and coped with, more pain than they had ever

encountered before, and as a result represented themselves as less afraid of the prospect of painful experiences:

Marna: 'I'm more tolerant of pain. Definitely ... I went to the dentist ... And I dragged (partner) with me, 'cos I was getting a bit worried. And then I sat there and thought, 'Well if I can have a baby, I can have a filling'.'

However upon other occasions the women positioned their experience of dealing with the birth as something of deeper significance, which had made them feel somehow complete as a person:

Marna: 'It gave me a lot more confidence .. you know, 'cos I accomplished something. I mean I know thousands of millions of women do it, but to me it was something really big ... I was like, 'If I can do that, I can do anything. I can take on the world'.'

Eliza: 'I feel a complete person now. Which .. I don't know how to describe it, I mean .. I don't know. But um I certainly feel as though I've sort of experienced everything in life but death really (laughs).'

Part of the sense of 'completeness' or 'accomplishment' reported by both Marna and Eliza might have its origins in the societal conflation of motherhood with womanhood, noted by many researchers and commentators who have explored the meanings of motherhood (for example: Sharpe, 1984; Woollett, 1991; Nicolson, 1993; Coward, 1993). In many societies to become a parent is to register a change of status (Raphael-Leff, 1991), and to some extent the women quoted above were expressing some parallel fulfillment of their womanhood. Entwined with this was a sense of relief, of passage through a dangerous or difficult process, exemplified in Eliza's talk of having experienced 'everything in life but death'. Again the theme of childbearing as a time of danger is found in other societies (Raphael-Leff, 1991), and again it has parallels in western society in the almost imprecatory warnings made against women who are represented as putting their lives and those of their infants at risk by not taking medical advice, described in chapter 1 (subsection 1.2.3, page 23). Thus the woman who has 'survived' can feel powerful, almost invincible, a word used by Freya in the pilot study interviews (subsection 2.3.5, page 90), and particularly apparent in Marna's text when she speaks of feeling able to 'take on the world'.

4.3.9.4 EXPECTATIONS FOR 'NEXT TIME'

Allied with the last theme, many of the women reported that their birth experience had made them think forward to what it might be like if and when they had another baby. Sometimes, especially if the first birth had gone smoothly, the women positioned themselves as facing the prospect of having another baby positively:

Diana: 'But sort of the next day, people were saying, 'Oh how did it go? Was it all right?' 'Yeah, fine. I'd have another one'.'

However other women positioned themselves as put off from having any more children, or afraid about what might happen a second time:

Marna: 'Bloody horrible and it bloody hurt. (laughs) It was horrible. And I don't want to do it again, I tell you.'

Associated with these issues was another facet of the theme of the first birth being something unknown. In many of the antenatal texts there was the implication that with the next birth the woman would have a better idea of what to expect:

Eliza: 'At the end of the day you're not in a position of strength, because when it's your first child you do not know.'

However some of the women reported that they had come out of their first birth experience with nearly as many questions as before, usually because the first birth had not gone as planned:

Andrea: 'The only thing that does worry me is that if I have another baby, I don't know what the beginning bit's like, 'cos I was induced, and I don't know what the end bit is like 'cos I never got that (laughs) far ... It's like having a baby the first time again. I don't know the beginning bit, and I don't know the end bit.'

In other words, although many of the control issues represented by the women in this study were underpinned by the theme of the first birth being something they had never experienced before and therefore a source of uncertainty, there was every indication that such uncertainties did not always dissipate after the birth of the first baby: that at least some women would still subscribe to some of the themes reflected here in subsequent births.

This section demonstrates that the women positioned control as just one aspect of their whole experience. It was not often singled out as the cause of postnatal psychological effects, and in fact was only likely to be if the woman's control experience was positive. Nevertheless it might be postulated that control issues were part and parcel of the effects of the birth and associated care represented by the women in this study, effects which had ramifications for postnatal support, the women's self-representations, and for her expectations for subsequent births.

4.3.10 HALO EFFECT

The seventh issue was the question of whether, when interviewed, the women demonstrated a 'halo effect': whether they became more critical of certain aspects of the birth over time. The women did not represent themselves as notably less happy with the events of the birth or the care they had received in the second postnatal interview. However, when the 1 week postnatal and 16 week postnatal accounts of individual women were compared, it became apparent that the women's narratives did become more detailed and coherent across time, and that sometimes this resulted in the women's later accounts positioning certain aspects of their care as less optimal than those given earlier:

Alice: 'Cos they wouldn't let me come home, 'cos of my waters breaking.' (1 week Postnatal interview)

Alice: 'My waters broke at, I think it was 3 o'clock Sunday morning ... I think I was only one centimeter dilated ... And er I asked to come back home again, and they wouldn't let me. Which I thought was really odd, 'cos every piece of literature that I'd read said that, if you're not 3 centimetres, they will send you home. So .. and I asked them why and they said purely because my waters had broken, that's why I was staying in. But .. which really didn't mean an awful lot to me (laughs). My reaction was, 'So what, they've broken', you know, 'Can I still go home?' (laughs). So .. they didn't really tell me why, you know, in why my waters .. you know, just 'cos they're broken, why I couldn't go home'. (16 weeks postnatal interview)

In the earlier interview Alice presented the situation of having to stay in hospital once her membranes had ruptured as relatively unproblematic, although it might be argued that by stating that ‘they’ would not let her go home, she was, even at this point implying a degree of tension in the situation. However at 16 weeks postnatally Alice elucidated the source of this tension: her belief that women in very early labour were invariably sent home from hospital. She also isolated the fundamental flaw in the way she had been treated at this time: nobody explained to her why having ruptured membranes meant that she had to stay in hospital.

It could be argued that in the early postnatal interviews the women might have been tired from the birth and, although aware of the more complex nature of the issues they represented, they chose not to make the effort to go into that much detail. However, that many of the women seemed keen to talk at length about their birth experiences at this point, yet still did not provide the same amount of coherent detail as in later interviews, belies this theory. What is more, it might be argued that even if this voluntary withholding of detail was the case, that the women chose to represent their experiences thus to an interviewer would have, to some extent, mirrored the way they represented the issues to others. In other words, that this is how women chose to represent their experience at this time, compared with their later detail, was in itself significant. However the change in women’s reports over time could also be explained if the women had consolidated their memories of their experience between 1 and 16 weeks postnatally, or perhaps simply become more adept at putting all the nuances of the situation, as they wanted to recreate it, into words. Thus the potential for them to be able to represent parts of their experience more negatively increased over time, although the women tended to use these representations in terms of a clarification of positions that they had held all along rather than as new criticisms.

If, in other studies, increased coherence and detail in the narrative around the subject of childbirth is closely associated with the ability to be more negative about the experience, this might help to explain why the halo effect is more commonly found in qualitative rather than quantitative studies on the birth experience, where the opportunities to elaborate on the answers to questions are more likely to be available.

4.3.11 Comparing midwives and childbearing women

The final issue was an exploration of the differences and similarities in the midwives’ and childbearing women’s accounts, and of other issues appertaining to the relationships between carer and childbearing woman.

Retrospectively the midwives and the childbearing women sometimes represented the control dynamics of the same situation differently:

Midwife Ellie: ‘Um and then at that point she just .. she actually gave me a little push, just, and the head came down beautifully. But at that point she just totally lost it.’

Theresa: ‘And she was sort of losing her rag a bit, you know. ‘Cos she knew the baby had to come out and she didn’t want me to stop. And so by this time I’d got really aggroed.’

(laughs) And I was swearing at her and everything. And like I was saying, you know, 'You bloody get on here and push then'.'

Both Theresa and her midwife positioned the other as losing control. Theresa described Ellie as 'losing her rag a bit' although she also reported being angry herself. Ellie's use of the term 'lost it' could imply anger or panic. Again these two images mirror, at one and the same time, the two different representations of the midwife discussed in subsection 4.3.4.3 (page 162) and referred to again in subsection 4.3.7 (page 181). Ellie's 'she ... gave me a little push', whilst implying a cooperation between the two women also carries undertones of the midwife's orchestration, or attempted orchestration, of events. Theresa's text more strongly suggests Ellie's attempts to control her in that she 'didn't want' her to stop pushing, although again the image of the caring side of the relationship is, to some extent implied in 'she knew the baby had to come out', suggesting that Ellie's actions had Theresa's interests and those of her baby at heart.

Another version of this type of situation was the scenario discussed in section 4.3.5.4 (page 166) where the woman positioned the midwife as unaware of her feelings of self-control. However in this situation there was no comparable text from the midwife to ascertain her representation of the situation. Another variant to this theme was the midwife's misinterpretation of a woman's awareness of the situation, and thus an apparent lack of understanding of her struggle to maintain a sense of self-control:

Midwife Jenny: 'I don't think she was quite aware, you know, of what was going on. She knew that, you know, she was going to have an instrumental delivery.'

*Lisa: 'But she (**the baby**) was distressed, her heartbeat had halved and it had gone down to 70, I think. And before it was 140, I could see it on the monitor. And I heard them say like, 'The heartbeat's like ...' I thought, 'Just don't look at the monitor and you'll be all right', sort of thing. 'I'll panic and it will make her worse'.'*

It is important to note that it was not just the midwives who represented situations differently to the childbearing women. Several of the women also reported a lack of acknowledgment of their feelings by the doctors:

Eliza: 'He was doing the epidural and I'm saying, 'Ouch'. And he was saying, 'What do you mean, "ouch"?' I'm saying, 'Ouch. It hurts'. He was saying, 'Well you can't feel that', I was saying, 'Yes I can'.'

Such texts resonate with Graham and Oakley's observation that antenatal patient's statements of pain are often ignored or dismissed by doctors (Graham and Oakley, 1990). Such interactions are, they argue, symptomatic of conflicts between the doctor-as-expert and mother-as-expert. This can be seen clearly in the example above, where the doctor initially denied the woman's own sensation of pain, because his 'expertise' said that patients having epidurals should not feel pain at that point in the procedure.

The doctors were also implicated in some of the situations in which the women reported the greatest loss of control. For example, two women reported having an episiotomy performed by a doctor during an instrumental delivery, and not being informed of this. In both cases they thought they were being sutured because they had torn, and only found out about the episiotomy when they later looked at their notes themselves. In both these cases the women also reported that the doctor concerned (a different

one in each case) had not spoken to them throughout the delivery, but had addressed themselves to the woman's partner:

Tania: 'But I didn't like (doctor). Didn't like him at all, 'cos I thought he had an attitude problem. (laughs) He didn't s... he didn't talk to me, he talked to (partner). I don't think he thought I was with it. But I.. I heard and understood everything that he said. But he just didn't talk to me.'

Lisa's partner: 'Well he (doctor) was turning round and sort of explaining it to me more than anything, 'cos he could see me. He couldn't see you (laughs) could he?' |Lisa: 'That's it, he couldn't see my face, yeah. 'Cos they put me on the stirrups.' |Lisa's partner: 'You had your legs up didn't you?' |Lisa: 'So I couldn't see.'

Both these texts are interesting in that the women position themselves as insignificant to the doctor concerned: in Tania's case because the doctor, she reported, felt that she was not 'with it', in other words that she was not consciously aware of what was going on; and in the case of Lisa because he could not see her face, an image conjured up by her partner but supported by Lisa herself. Yet in both cases these doctors were dealing with an intimate part of the woman's body. Kitzinger (1992) describes the trauma that such dissociation can cause to childbearing women, when attention is concentrated on her genitalia to the exclusion of her personhood. Some women resort to the language of rape and violation when describing such experiences.

Despite such disturbing accounts, there were also situations in which the midwife's report bore many similarities to that of her client, and the general undertones were highly positive:

Midwife Hannah: 'I found that Andrea was just happy for me to do whatever I thought was best. I think she'd got the impression that, you know, I was the midwife, and I was going to do what was best for her.'

Andrea: 'I had trust in the midwife that did the majority of the work... The one that took me through the night was very calm and quiet and I had confidence in her. And the way she handled it was such that I didn't feel that I needed to make decisions. It just sort of happened. I'm sure she asked, but I don't necessarily remember that.'

However, accounts like these are more difficult to find. When they do occur they often centre on the subject of the relationship between the woman and her midwife rather than interpretations of events or the woman's control of herself.

Therefore, when the texts of the childbearing women and the midwives are examined, it is easy to locate differing representations of the same situation, just as the findings of the questionnaire analysis revealed different assessments of the women's control expectations and experiences. Moreover it is possible from the women's texts alone to identify situations in which carers, particularly doctors, were positioned as greatly out of step with the woman's view of the situation. However it must be asked whether, in an interview study such as this, it is right to expect childbearing women, midwives and doctors to position the woman's experience in the same way.

Potter and Wetherell (1987) highlight various important aspects of language. For example, talk has a function, and it cannot be assumed that the childbearing women and the midwives were necessarily trying to achieve the same things with their representations. In fact it is likely that many different influences were at work in the way the interview participants chose to represent themselves, and that

some of these influences would be different for the midwives and the childbearing women. For example, the childbearing women were interviewed on three occasions, and it can be assumed, and to some extent concluded from their texts, that one of the functions of their talk would have been to present a consistent picture of themselves over time. The midwives, who were only interviewed once, did not have to work within this constraint. Moreover, Potter and Wetherell point out that people's accounts of events are built out of various pre-existing linguistic resources. To some extent midwives and childbearing women have available quite a different set of resources, not only from the availability to the midwives of a set of technical and professional terms to which the childbearing women would have had only limited access, but also from the childbearing women's unique knowledge of their bodies and what was happening to them, discussed earlier.

However, despite this, the essence of good midwifery care is meant to be good communication skills (Kitzinger, 1988). Midwives are meant to be able to understand the feelings of the woman in labour, mediate between the obstetrician and the woman, cope with the anxiety of the woman in labour, with:

... careful observation and sensitive awareness ... helping the labouring woman to have confidence in herself and the power of her uterus... (Kitzinger, 1988, p.18.)

Thus it would be hoped that throughout labour the communication between the midwife and her client would be good enough for their accounts to bear certain similarities. In some of the examples cited here this is the case, although in others the differences are wide, and a cause for concern.

4.4 Discussion

The eight individual issues, raised at the end of the last chapter and discussed in the results section of this chapter, have already been dealt with in some depth. Here, rather than continue to unravel their meanings, I intend to try to pull them together into a larger picture, less detailed, but in which the various themes which have been identified can be regarded as different aspects of the one story: the story of childbearing women's struggle for control in childbirth. The final chapter of this thesis will then integrate the quantitative findings and some of the issues raised in the literature review into this story, drawing out areas for further research and issues for debate.

My assertion that for childbearing women to attain control is a struggle lies, not in the difficulties that have been identified in implementing the 'Changing Childbirth' report (Department of Health, 1993), difficulties ranging from lack of funding (Rosser, 1997) to the disruption of the midwife's personal life (Sandall, 1995; Rothwell, 1996), but in the material-discursive elements of childbirth which, by their very nature, make control problematic. Such elements do not always have their origin in the process of birth itself. They can also be found in the uncontrollability of much of women's everyday lives; in the societal mores by which women are controlled; and in the myths which establish much of the rhetoric around labour and birth as immutable fact.

The notion of control in childbirth is, by and large, just that: a notion or construction. However it grew out of both material and discursive practices: interventions and attitudes which established childbirth as a medical situation in which childbearing women were powerless. The 'Changing Childbirth' report

suggested that the return of control to the parturient women would be implemented via a new set of material practices: choice over their carers and type of care, and responsibility for the safekeeping of their own notes, to give some examples (Department of Health, 1993). However such material practices also carry discursive weight of their own, and it is this weight which can mitigate against the very concept which the practices were set up to support. For example, it was shown in this study that carrying their own hospital notes did not automatically mean that women had the confidence to write a birth plan in them. The notes were still, in effect, the property of the hospital, written in medical terminology and to be relinquished and filed after the birth. The woman had material control over them: they could handle them physically, but discursively this control was in question³⁷. From the point of view of the carers the requirement to retain some control over what is sometimes the only complete record of the woman's progress is understandable. It is from this record that developing problems might be identified, and background information is given to prevent some error being made that might endanger the woman. However this does not alter the paradox: that the notes are at one and the same time under and not under the woman's control.

The discursive concept of control in childbirth, therefore, can be undermined even when both carers and childbearing women are committed to its ethos, and this study has highlighted many of the ways in which women's potential for control in childbirth is represented as limited, mirroring her limited control over the rest of her life. At the root of these limitations are two issues: the unpredictability of birth, especially a first birth; and the woman's fears around the subject of safety. Whatever material practices are introduced to give childbearing women control over the birth process, nobody can forecast beyond all doubt the course that labour and birth will take, and nobody can promise categorically that woman and baby will emerge from the process unharmed. This has two effects: a space is created in which those who label childbirth as 'only normal in retrospect' can claim exceedingly more credibility than should be allowed, considering the potential for birth to be uneventful; and the 'expert' carer who promises not to be taken by surprise by whatever arises, and who has the wherewithal to help mother and child should complications develop, is given centre stage.

Both of these effects have material and discursive consequences for the processes of labour and birth. As intimated above, the assertion that birth is normal only in retrospect is wholly true. However as a justification for interference and disempowerment it becomes a complete misrepresentation of what, if not tampered with, is highly likely to be a straightforward event. Thus the assertion continues to throw doubt upon the ability of the woman's body to give birth unaided, and to create a tension, as shown in this study, with her trust in her body to do what is right. This mistrust extends to what the woman's own body is telling her, as exemplified in the women's fears that their contractions might not be indicative of the start of labour. It is tempting to ask why it should matter if women go into hospital with contractions which then stop. This does not discredit the fact that they had contractions in the first place. However the tensions between the 'woman's body as expert', and the 'hospital staff as

³⁷ This point was illustrated beautifully some years ago when, whilst working on the labour ward, I observed the admission in labour of a woman whose dog had chewed her notes beyond recognition. The ward staff were visibly annoyed that, in not taking better care of them, she had allowed their records of her progress to be lost.

expert' serve to place the woman, under these circumstances, as having failed or having proved herself inadequate against those who know better. That staff do fall into the trap of positioning themselves as knowing more about the woman's body than she does herself is exemplified by the texts in which the staff were reported to have denied the woman's pain or discomfort as if they knew what she was feeling better than she did. In this study such phenomena were reported via the women themselves, but they are also supported by such researchers as Graham and Oakley (1990) and Hunt and Symonds (1995) who observed similar interactions directly. However, despite this, there were times when the woman's body was represented as in control of the birth process implying a certain empowerment for the woman. Similarly the women sometimes appropriated discursively what was, materially, already theirs in such phrases as 'it's my body'. At first sight such an appropriation sounded incongruent. Even given the doubts cast over the woman's body to give birth unaided and to supply the woman with accurate information, it seemed improbable that anyone would bring into question whether her body really belonged to her. However reports of medical staff who manipulated the woman's body whilst giving a running commentary not to her, but to her partner, gave the lie to this supposition. As the women who recounted such experiences suggested, as people in these situations they were positioned as absent. Thus their bodies became represented almost as empty shells to be handled and manipulated without the necessity to refer to the material owner.

The discursive and material centrality of the 'expert' carer is, to some extent, implicit in the 'woman as expert' versus 'hospital staff as expert' tension described above. However it has separate manifestation in many of the processes of the birth itself. The paradoxes of 'pushing' for example reflect both the midwife's role as orchestrator of the second stage of labour, in urging the woman to 'push' and finding ways to expedite the birth, if the woman complies; and the childbearing woman's lack of control, whether she pushes or not. The interview texts suggest that women are seldom left to push as and when their bodies 'tell' them to, despite every evidence that this approach is better for both mother and baby: again implying the 'expert' lack of trust in the woman's body. Another set of paradoxes surround the issues of pain-relief. Here the women's representations reflected a double-bind: the needs of their bodies for analgesia if the pain became too much to bear, and needs which might be imposed upon them by the staff, for their own good: an epidural anaesthetic to effect a caesarean section, being an example. A second double-bind was apparent in the analgesic effect itself which threatened to result in a lack of control if it did not work or if it worked too well and left the woman feeling dissociated from her surroundings. However whatever the course of labour there was the tendency afterwards for the carer to be positioned as having acted only in the woman's own interests. Herein lies one of the several ways in which the childbearing women ameliorated any apparent lack of control, something which will be discussed later. Apart from the ramifications of positioning childbirth as potentially hazardous and the carers as the experts, certain aspects of childbirth were positioned as intrinsically disempowering in themselves, regardless of the presence or absence of the staff. Vomiting was one such example, an embodied process over which the women described having no control.

Other issues which had material and discursive consequences for women's control included the societal mores which did not 'allow' women to shout or swear, and which, therefore coloured their reports of

self-control in childbirth. A second set of issues were those around social background and the women's expectations of their ability to communicate with their carers. It was suggested that experiences in the antenatal period might have laid the grounds upon which the women based these expectations: that by late pregnancy working-class women might have already begun to have problems making their wishes known, and have thus arranged their birth plans with this in mind. Moreover, it was postulated that working-class women's disempowering experiences of school could have coloured adverse impressions of antenatal classes in which the 'expert' carer was positioned in the guise of a teacher. Midwives also appeared not to recognize the value to childbearing women of sources of information other than antenatal classes.

However, although control in childbirth could be represented as problematic in both material and discursive terms, the discursive nature of the concept also opened up opportunities for childbearing women to render many of the situations described above as less disempowering than they have been represented here. One such opportunity has already been described: the tendency for childbearing women to represent their carers as acting in the woman's best interests. This was closely associated with the representation of joint control, the women's alliance with their carers to gain a position of shared power. Another powerful technique was a position of potential control: that the woman had no control because she so chose, and that she could have taken control at any time had she wanted to. Other techniques were specific to certain situations, for example, the women dealt with their fears of making a noise or swearing during labour in a variety of ways: by reasoning that the staff would have seen it all before; or that they would not be 'themselves' in labour, to give two examples.

Thus control in childbirth was not the impossible ideal for these women that, at first sight, it seemed to be. However it was complex: a continued negotiation of different issues in which the potential to feel more or less in control was likely to vary, sometimes from moment to moment, mirroring the women's representations of control in their past lives. Moreover because, ultimately, control in childbirth works at a discursive level, there was an opportunity for the women's representations of this dynamic experience to crystallize over time. Thus later representations of the birth experience were more detailed and coherent, as if the woman had found the time to put this mass of experience into some sort of order and, although control issues were seldom singled out, the overall long-term psychological effects of childbirth were often positioned as positive: an increase in self-esteem. Negative effects were more likely to be in the short-term, although some of the women also expressed fears that a subsequent birth would be almost as much an unknown as the current one had been, suggesting that many of the control issues which appertained to the primiparous women in this study would recur in any subsequent births.

4.5 General discussion

It was argued in chapter 1 (subsection 1.5.5, page 70) that the principles by which qualitative research is sometimes judged are not always entirely relevant to the approach. However this is not to argue that qualitative studies, such as the ones presented in this chapter, are somehow above criticism, and indeed

the analysis in this chapter has been carried out with reference to many of the validity and reliability related criteria discussed in subsections 1.5.5.1 and 1.5.5.2 (pages 70ff).

But these issues aside, there still remain huge areas of debate and controversy around qualitative analysis, which serve to highlight its limitations. However the purpose of this thesis is not the deconstruction of methodological assumptions. Moreover such issues have been dealt with more than adequately by other authors (for example: Parker and Burman, 1993). Nevertheless it is important to acknowledge some of the more important drawbacks to discursive/ thematic analysis, such as that presented here.

One problem with discourse analysis, and similar approaches to qualitative research, concerns the part played by the researcher in both the research and the analysis. In both the interview studies reported in this thesis efforts have been made to acknowledge the presence of the interviewer in the text. However it is important to recognize that such acknowledgment, alongside the analysis itself, is also the researcher's construction. Parker and Burman (1993), moreover, warn of the dangers of shifting the focus to the account rather than what is being accounted for. Apart from the absurdity of an infinite regress in which the researcher ends up contemplating their account of their account, and so on, this can also detract from the importance of the topic and weaken any arguments which point towards the need for political intervention. The material-discursive position explicated in subsection 1.5.3 (page 65ff) is an attempt to overcome such problems - to acknowledge the embodied experience of childbirth. Yet such experience is always viewed through the double-discursive lens of both the interviewee's and researcher's representations and the tension is that the presence of the lens must be acknowledged, and its effects recognized without these things becoming the central focus.

There are also problems around the use of interviews and transcripts. The problem of power relations between researcher and researched was considered briefly in subsection 4.3.2 (page 156) of this chapter, in terms of a justification for the interviewer's personal involvement in the interviews. However, although this might negate any power differential at the time of the interview (and this cannot be assumed) it does not neutralize the fact that the researcher has the ultimate power to represent the researched as they see fit (Parker and Burman, 1993). Thus this becomes another facet of the reflexivity issue described in the previous paragraph, and can only be acknowledged.

A second issue concerning transcription is that much is always lost in the process of tape recording interviews and reproducing them in a written form. Inflections of the voice, gestures and facial expressions are all part of the process of communication, but none of these are discernible from the reading of a transcript. Vocal devices can, to some extent, be accounted for by annotation (and were in the two interview studies described in this thesis), but gestures and facial expressions are totally lost unless the interviewer makes copious notes throughout the interview - something which, in itself, serves to accentuate the power differential between researcher and respondent and which was, therefore, not done in these studies. A more sophisticated solution might be the videotaping of interviews, but this would introduce a third party, the camera-operator, into the interview situation, which,

alongside the reticence many people feel in front of a camera, might serve to make the situation more intimidating for interviewees.

In terms of reporting the research another set of problems arise, revolving around the issue of selecting relevant data from the transcripts, already dealt with to some extent in chapter 1 (subsection 1.5.5.1, page 71). An issue not covered there is the danger of taking portions of text out of context. As far as possible, in this study and the one described in chapter 2, this problem was avoided during analysis by referring back to the original transcripts, or even the interview tapes themselves in times of doubt. Similarly the question asked of the respondent was reproduced in the research report when it shed light on the participant's comments. Nevertheless such questions were part of the ongoing interview process, and in themselves could seem strangely disembodied if the reason why they were asked was not also recorded. This was done where it was considered completely necessary.

The list of limitations could continue. Parker and Burman (1993) identify 32 problems with discourse analysis, but acknowledge that there might be many more. Nevertheless such criticisms must be placed in the context of the advantages of such research in giving participants a voice, and most of all, in even attempting to address some of the drawbacks of positivism raised in subsections 1.5.2.1 (page 59) and 1.5.2.3 (page 63), drawbacks which are seldom raised by researchers themselves working within this paradigm. The willingness of many qualitative/ discursive analysts to acknowledge the limitations of their methodology must therefore, in itself, be a strength.

4.6 Conclusion

Subsection 4.4 of the chapter began by describing control in childbirth as something over which childbearing women had to struggle. It is important, in concluding, that this struggle is identified, not as a tension between the individual childbearing woman and her carer, but between the material-discursive constructions of the embodied experience of childbirth and of control in childbirth. Some of the childbearing women in this study did sometimes describe poor care, but the midwives and doctors were also frequently positioned as empathic and supportive. What has been described in this chapter are issues which are often underlying - present in the texts, even when the care being described is positioned as good. It is these issues which are central to control in childbirth yet are sometimes difficult to acknowledge and always difficult to alter. In the next chapter, after the various aspects of this thesis have been integrated, some positive changes will be suggested which might enhance women's control.

Chapter 5 - Conclusion

5.1 Introduction

This chapter will consist of three main sections. In the first section the main findings from the two research studies will be considered together and related to the literature review of chapter 1. However, to avoid excessive repetition, issues which have been discussed in depth in the relevant research chapters will only be raised again here in brief. The findings will be considered in terms of the four research questions which were asked at the beginning of chapter 3. In the case of each question, they will be discussed in terms of what they add to an understanding of control in childbirth. The implications of these findings for the way in which childbearing women are cared for will be discussed. The second section will evaluate the research process as a whole, and discuss some limitations of the approaches which have been used here. The possibilities and disadvantages of alternative approaches will be considered. The third section will identify issues in the studies reported in this thesis which might require further clarification. Recommendations will be made for further research.

5.2 Research findings and their implications

5.2.1 Starting point of research

The starting point for this thesis (the preface) was a questioning of the unproblematic way control in childbirth has been represented in the midwifery press: as something which could be 'given' to childbearing women. The legacy of powerlessness of both childbearing women and midwives, discussed in the early part of chapter 1, suggests that the return of control to childbearing women via their midwives will not be a straightforward matter. A discussion of the current research around control in childbirth and associated issues, made in chapter 1, gave rise to 3 key questions which were modified by the findings of the pilot study (chapter 2) into 4 more specific research questions. In the analysis of the questionnaire study, reported in chapter 3, these 4 questions were considered. This synthesis gave rise to 8 associated issues which would be better explored using interviews. In chapter 4, therefore, these issues were addressed from an analysis of the interview study.

In the subsections below, each of the 4 research questions will be considered in turn, in terms of both the quantitative and qualitative analyses.

5.2.2 First research question

The first question asked whether certain demographic and background variables such as education, social class, age, and general control expectations, had any bearing on primiparous women's expectations and experiences of control in childbirth, and whether features of the birth, such as its difficulty, were pertinent in terms of women's experiences of control.

In the analysis of the questionnaire study (table 3.24, page 119) external locus of control scores were shown to be significantly correlated with expectations of control in childbirth. High levels of belief in the chance occurrence of outcomes and in the control of powerful others were more likely to be associated with low expectations of control in childbirth and vice versa.

In the interview study there was a general tendency for women to speak about occurrences in their everyday lives in terms of fate or chance, and yet to also imply the existence of some overarching power that caused things to happen for 'reasons' (subsection 4.3.4.1, page 159). In a parallel manner the women's talk about labour and birth suggested a high level of uncontrollability. A first birth was represented as an 'unknown', and they also reported fears for their safety and that of their baby (subsection 4.3.4.2, page 159ff). As with their talk about the uncontrollability of everyday life, this also again left a space for a powerful force to be represented as in control, thus rendering the situation less alarming. In the case of labour and birth such a force was the 'expert' carer, who might be represented as a skilled adviser and supporter or, more negatively, as an authoritarian force, not to be questioned.

Thus, the questionnaire studies showed an association between external locus of control and control in childbirth, whilst the interview studies hinted at a degree of parallelism between the ways in which control in everyday life and control in childbirth were represented. However it is understandable that general control beliefs cannot be expected to explain all the variance of specific situations, whether childbirth related or not. For example, in the interview studies, as far as control in their lives was concerned, the women represented different situations in very different ways (subsection 4.3.4.1, page 158). In other words the context of the situation was important. This was also the case when control in childbirth was discussed. Thus expectations of control over the use of analgesics were described differently in relation to different possible courses that the labour might take, for example, whether a caesarean section became necessary or the carers advised pain relief (subsection 4.3.5.7, page 170). Moreover, as Rotter (1975) observed, determinants of behaviour, such as the value of the reinforcement, can also over-ride locus of control beliefs. For the childbearing women, as already shown, safety was given a very high priority (subsection 4.3.4.2, page 160), and was probably more important to them than their control beliefs.

Although the participants in these two studies did appear to position control-related life and childbirth experiences in parallel ways, direct associations between the two were only occasionally made in the women's interviews. Moreover internal locus of control did not correlate with labour agency in the questionnaire studies (table 3.24, page 119), and it was suggested that the unknown nature of a first

birth rendered the level of general belief in one's own control over outcomes even less consistent in its effects than levels of belief in external control.

Social-class effects were not apparent in the interview women's talk of their expectations, wants and experiences of self-control in childbirth (subsections 4.3.5.2 and 4.3.5.3, page 163ff), where the issues of not swearing or making undue noise in labour appeared to concern many of the participants. Such issues were discussed in terms of societal pressure upon women to behave in a constrained way. Social class effects were also not apparent in the women's talk around their general expectations of control of the situation (subsection 4.3.5.5, page 167). However social-class effects became apparent in certain specific situations: the women's wants and expectations concerning the handling of the baby, and in the way they reported completing their birth plans (subsections 4.3.5.6 and 4.3.5.8, pages 168ff and 173ff). In both cases less educated women tended to be much more specific and detailed about their requirements. It was suggested that these differences might have been due to the working-class women's lower confidence in communicating effectively than directly to their control requirements. That the questionnaire research showed no direct relationship between educational level and control expectations tends to support the suggestion that any apparent educational differences in control-related issues are mediated via other issues, or that because they only apply in certain specific situations, it is a general relationship that is lacking.

Antenatal class attendance was shown to have no effect on labour agency in the questionnaire study (table 3.35, page 124). One reason for this might have been that no differentiation was made between women who attended a full course of classes and those who only went to one or two sessions. Many of the interview participants did highlight practical obstacles to regular attendance and it can be postulated that, although overall attendance was high, regular attendance may not have been (subsection 4.3.6, page 177). Moreover, as shown in the interview study, accounts of the usefulness of classes varied. One interview participant reported not being helped by them at all, despite attending the whole course, and it was suggested that the school-like nature of classes could be disempowering for some working-class women. The important issue may not have been whether classes were attended but how helpful they were perceived to be. It was therefore a cause for concern that some of the midwives appeared to associate class attendance with the desire for control, and also to fail to recognize that childbearing women obtained information about labour and birth from a variety of other sources.

Although, in the questionnaire study, younger women were more likely to express a high belief in chance locus of control (as did less educated women) (tables 3.26 and 3.37, pages 120 and 125), there was no direct relationship between age and childbirth control expectations or experiences (tables 3.24 and 3.25, pages 119 and 120). Neither were there any obvious age effects in the interviews.

Taking the findings described thus far, and relating them to the literature, the lack of any direct general relationship between social-class and control in childbirth supports the work of Green, Coupland and Kitzinger (1988). The work of Green et al. refuted the stereotype of the middle-class, educated woman with unreasonably high expectations of control, who wrote a long birth plan, and it is

interesting that, in the current studies, lower levels of education appeared to predispose to the writing of more detailed birth plans.

The lack of a direct relationship between age and experiences of control in childbirth confirms the findings of other researchers, discussed in chapter 1 (subsection 1.4.2.2, page 44), as does the lack of relationship between antenatal class attendance and control experiences (subsection 1.3.2.3, page 34). However Hillier and Slade's observation that class attendance increased confidence concerning labour (Hillier and Slade, 1989) was not supported in so much that attendance did not affect expectations of control. Although it is arguable whether expectations of control are comparable with a generalized confidence concerning childbirth, a more obvious explanation for this discrepancy was the high class attendance in this sample, combined with the variable impact the classes made upon the attendees (discussed above).

Although the factor scores related to the difficulty of the birth correlated with control in childbirth measures made at the same time (table 3.19, page 117), causality could have been in either direction, and may have been in both. The difficulty of the birth might have affected estimations of how much control the woman had, or the level of control the woman experienced might have influenced how difficult she perceived the birth to be. The multiple regression analysis showed no significant relationship between 1 week reports of difficulty and 16 week LAS once antenatal and earlier LAS scores had been taken into account (table 3.43, page 130). However notwithstanding overall assessments of difficulty, and their effects on reports of control, it was noted in the literature review that some individual interventions might be more disempowering than others, and furthermore that the way an intervention was applied might either increase or decrease the woman's experience of control. This was supported, to some extent, by the interview study. The women's descriptions of pain relief highlighted not only their fears that they might be coerced into having things they did not want, but also how pain relief could be disempowering if either it did not work or if it worked too well. However it was suggested that pain relief might, to other women, be a source of power in removing their pain and giving them the labour they wanted. The women's descriptions of doctors who dealt with them without speaking to them (subsection 4.3.11, page 189) gave another example of how a procedure could be rendered more disempowering than necessary by the actions of the carer.

As discussed in chapter 4 (subsection 4.4, page 192) certain broader material-discursive aspects of childbirth also appear to be inherently disempowering. It is difficult to see how these aspects: the unknown nature of the birth, and fears around the issue of safety can be changed to any great extent. As it was argued, nobody can forecast exactly the course of labour and birth or promise categorically that the mother and baby will be safe, although it is possible to change the way such issues as safety are represented, putting the risks into perspective and emphasizing that, as a rule, birth is safer the less it is interfered with. To some extent this is now being done (for example: Wagner, 1994 and Tew, 1995), although the findings from the research reported here suggest that such information needs to be much more widely disseminated amongst both carers and childbearing women. However it should also be possible to change many of the issues discussed above which, it has been suggested in these studies,

impinge upon women's expectations and experiences of control in childbirth, for example: communication, the way interventions are applied, and the structure of antenatal classes. It was suggested in subsection 1.3.2.2 (page 30) that even locus of control beliefs can be changed if individuals are taught that they can take control under certain circumstances. It was also suggested in chapter 4 that by the late antenatal period working-class childbearing women would have already begun to experience the type of communication problems discussed in chapter 1 (subsection 1.4.4.1, page 48ff), being more likely than middle-class women to receive limited information or to be spoken to in a patronizing way. Such experiences in the antenatal period can augur no good for the woman who hopes to communicate a need for control during the birth itself. It is therefore possible that positive attempts to empower all childbearing women, but especially working-class women, prior to the birth will raise beliefs in the effectiveness of their ability to communicate during the delivery. This requires a concentration on teaching better communication skills to staff at all levels, from consultant obstetricians to receptionists in surgeries and clinics. It is also important that antenatal classes increase in informality, friendliness and flexibility to the needs of their clients: initiatives already suggested elsewhere (Viccars, 1998). This will not only facilitate control and communication issues but will also address the issue of unhelpful and disempowering classes.

The way in which childbirth interventions are applied is, again, largely an issue of communication. Teaching better skills would, hopefully, help childbearing women to feel that they do have some control when intervention is proposed and used. However it is also important to note that observations about disempowering care were based on the women's representations. It is possible that carers, if asked, might position the same actions in a more positive light. Thus, as well as teaching better communication to carers, childbearing women must also be encouraged to speak about how they feel at the time, and given an opportunity to express their thoughts about their care afterwards, so that their reactions to various situations can be fed back to carers. However it has been noted by other authors that postnatal debriefing soon after the birth by the midwife who attended might not always be helpful for the childbearing woman. Some will feel ambivalent about discussing issues which make them feel angry or distressed with the person they see to be the perpetrator. Others will not feel ready to discuss the issues so soon after the birth (Lyons, 1998). As shown in this study women's accounts often become more coherent over time, and it is perhaps at a later date, for some women, that enough distillation of the issues of concern will have occurred for discussion with medical personnel to be mutually profitable. It is therefore important that all childbearing women be offered a service in which they can make arrangements to talk about their experiences with the practitioner of their choice at any time after the birth. Such a service has been set up in some areas (Charles and Curtis, 1994; Allott, 1996), but has yet to become widespread. Moreover such services are still, in general, regarded as a panacea for distressed women, or those with unanswered questions. Although this is admirable justification in itself, they must also be seen as an opportunity for information to be gained about what, in the eyes of childbearing women, constitutes good care.

5.2.3 Second research question

The second research question asked what the relationship was between childbearing women's expectations and their experiences of control in childbirth. From the questionnaire study it was shown that women who reported expectations of a high level of control in childbirth were more likely to also report that they had achieved a high level of control (tables 3.24 and 3.25, pages 119 and 120). Moreover the sample as a whole reported achieving significantly more control than they had expected (subsection 3.3.4.3, page 112). Even women who reported symptoms of depression reported having achieved more control than they had expected, although all their scores were lower than those of the women who did not report feeling depressed (subsection 3.3.4.4, page 112). However assessments of the amount of control experienced did not change significantly between the early and later postnatal period.

In the discussion of the strong relationships between antenatal and postnatal control scores (subsection 3.4.3, page 137) it was suggested that women who have the ability to be optimistic about the likelihood of control during labour and birth were also likely to be able to be optimistic about what happened. That there might be some association between control and mood was also supported by the correlations between labour agency and total mood at each point of contact with the participants (tables 3.24 and 3.25, pages 119 and 120).

These findings run counter to the stereotypes described in chapter 1 and the pilot study, which position high expectations as a recipe for dashed hopes (subsection 1.3.2.2, page 31). They also contradict the work of Slade, McPherson, Hume and Maresh (1993) who found that antenatal expectations of control in childbirth were elevated in relation to experiences. However, Slade et al. made postnatal assessments of control during the birth at 72 hours postnatally, earlier than in the current study. It is possible that aspects of the birth: tiredness or pain, for example, had more effect on the women's assessments at 72 hours than they did at 1 week postnatally, in the current study. As reported in chapter 1 (subsection 1.4.3, page 46), several other authors did find positive correlations between expectations and experiences of control, supporting the findings here, although none of these studies report experiences which exceed expectations, a phenomenon which will be discussed later.

The interview study explored aspects of labour and birth which childbearing women also reported to be influential upon their experiences of control (subsection 4.3.7, page 178ff). Here it was demonstrated that the dynamics of control were complex. Some experiences, such as vomiting, were positioned by all the childbearing women as uncontrollable. In other situations, such as pushing, it was almost impossible to tease apart the aspects controlled by the carer and the element controlled by the childbearing woman or by her body. To a large extent, it could be argued (and was argued in the discussion of chapter 4, page 191ff) that, overall, childbirth is not an easy situation for parturient women to control. From the unpredictability of the onset of labour through to the second stage which midwives represent as their particular province, there is often little the childbearing woman can do materially to assert control. However, as also described in chapter 4 (subsection 4.4, page 191), the

notion of control has many discursive elements, and at this level (that is, in how the woman represents the situation to herself) there is much more that she can do. She can position herself as allied to her carer: a participant in the power of the 'expert'. She can position the carer as acting in her best interests, or she can concentrate on her potential for control, to give just 3 examples. That the women in the questionnaire study could position their experiences of control as so much greater than their expectations says much for the power of such representations.

Another reason why experiences of control should exceed expectations, despite the disempowering nature of birth, might be found in the women's uncertainties before parturition. That they did not know what a first birth would be like, and that they feared for their safety and that of their baby (subsection 4.3.4.2, page 159ff), and wondered how they would know when labour was starting (subsection 4.3.7, page 178), may have meant that the relief of being helped and guided through the process, of emerging safe at the other end, and possibly of not having gone into hospital with a 'false alarm', gave both labour and the part they played in it a more positive gloss than their expectations had predicted.

Despite the assertion, made above, that childbearing women can position childbirth as controllable at a discursive level, this is not to argue that the practices of carers are unimportant and that control is all in the childbearing woman's mind. In terms of maintaining or even increasing women's expectations and experiences of control there is a need for carers to recognize the potential for disempowerment in the birth situation. They need to become more aware of women's uncertainties over, for example, the onset of labour. They must learn how to act to affirm women and dispel their fears of rejection or ridicule if their contractions stop after they have arrived at the hospital. In particular, the woman's own bodily sensations and experiences should be respected, not dismissed. The more supportive carers thus position themselves to be, the more childbearing women will be able to tap into a sense of shared power, potential control, and of being cared for in a manner which supports their best interests. Moreover, as already suggested in the last subsection, such affirming attitudes towards childbearing women must begin early in the antenatal period. If, as suggested in the questionnaire study, the correlations between expectations and experiences of control in childbirth are due to the degree of positive attitude a woman is able to take towards the birth both before and afterwards, it is incumbent upon carers to give pregnant women grounds for confidence. This will be done by giving them positive care throughout the antenatal period, not just in terms of good communication, as described in the last subsection, but also by treating each woman with respect, and giving regard to her individual needs.

5.2.4 Third research question

The third question asked whether there were differences between the midwife's and the childbearing woman's representation of how much control individual women expected and achieved, and of how satisfied the woman was with her experience.

The midwives' and the childbearing women's assessments of the woman's satisfaction correlated moderately well (subsection 3.3.7.5, page 121ff). However the midwives appeared less expert at predicting their clients' reports of expected and achieved control over the situation, supporting, to

some extent, the findings of Bradley, Brewin and Duncan (1983) that midwives' ratings of their clients' experiences are significantly different to those of their clients. The midwives' reports of the women's control expectations correlated significantly with various antenatal mood measures: Depression-Dejection, Tension-Anxiety and the antenatal Total Mood Disturbance score. Because these mood measures also correlated significantly with the childbearing women's reports of expected labour agency, which represented both internal and external control, but not with reports of expected external control, it was suggested that the midwives might have been basing their assessments upon the woman's internal, rather than her external, control. Moreover, because the midwives' assessments did not have a significant correlation with labour agency itself, but only with its mood-related correlates, it was suggested that the midwives might have been influenced by non-verbal indicators of self-control rather than by the childbearing women's own expressions of control.

The midwives' assessments of the women's achieved control over the situation also failed to correlate significantly with the women's own assessments of achieved external control. However both midwives' and women's assessments correlated with the women's estimates of whether the birth was a positive or negative experience. Thus it appears that the midwives were aware of at least one aspect of the birth which related to the women's assessments of control. However the midwives' assessments also correlated significantly with the number of interventions the women experienced: a high number of interventions being associated with less control. As discussed in the last subsection this was not an issue of importance to the childbearing women's own estimates of control.

Midwives were not, therefore, sensitive to either verbal or non-verbal indicators of expected external control. This suggests that communication between the childbearing woman and the midwife was not all it could have been. The interview study suggests areas where communication between carer and client was most likely to be discrepant. Perhaps the most important was the gap between the woman's knowledge and ownership of her body and the carer's expert knowledge of the normal course of labour. Thus the childbearing women represented themselves as having access to certain unique knowledge which went beyond anything the midwife or doctor might know about childbearing women in general (subsection 4.3.8, page 183). As also discussed, such a representation tends to come into conflict with the expert discourse which positions the carer as the one who 'knows best'. In subsection 4.3.11 (page 189) it was shown that the women's statements about their bodies - the experience of pain for example - were sometimes dismissed by their carers (in this study the carer in these situations was always a doctor). Such cases were discussed in terms of the mother-as-expert versus doctor-as-expert conflicts identified by Graham and Oakley (1990). In a similar vein were the occasions when the carer misinterpreted, or was positioned as misinterpreting, the woman's awareness of what was going on (subsection 4.3.11, page 189). Such situations served to reduce the woman's potential for control in that situation.

It was suggested that, although the nature of talk is such that it should not be expected for childbearing women and their carers to position the woman's experience in exactly the same way, the essence of good midwifery care is frequently represented as good communication skills. The differing

representations of the woman's expectations of external control are therefore an issue of concern. This, to some extent, resonates with the observations made in discussion of the literature related to communication between childbearing women and their midwives (subsection 1.4.4.2, page 48), pointing out that the flow of information from client to midwife has become less necessary as obstetric technology has continued to provide more information about the progress of labour, alongside data representing maternal and fetal wellbeing. Whilst the need for good communication in general was raised in subsection 5.2.2, the findings discussed in this subsection highlight the need for those who care for women during labour and birth to learn, particularly, to listen to what they say. That listening is the least well developed of some midwives' communication skills was also suggested in the pilot study (subsection 2.3.4.1, page 87).

The literature review also isolated research which demonstrates the communicative dominance carers have over childbearing women, both in terms of the appropriation of topics of discussion and their use of coercive techniques which give only a semblance of control to their clients, if even that (subsection 1.4.4.2, page 49). This predisposition will also stem the spontaneous flow of information from client to carer, and more dangerously, can still give the carer the illusion that they are in touch with the childbearing woman's real feelings and requirements. Specifically, midwives should be taught to ask the right questions and to listen to the answers. Nevertheless it must be remembered that some of the women in the interview study did consider their midwives to be good communicators, in tune with their requirements. It is clear that some midwives require such training more than others.

Despite this it is important to note that the midwives were aware of what were probably non-verbal indicators of the women's achieved external control. It is possible that the non-verbal (or material) expressions of control that the midwives were registering were sometimes contradicting the verbal discourse of the childbearing women, that perhaps despite subscribing to the discourses of control (or compliance) which they felt were expected of them in that situation, the women's apparent demeanor suggested they were feeling something different. If this is the case then it could be argued that midwives' observational skills are more highly developed than their listening skills, or possibly that, although they listen, they give more importance to what they observe. It can be reasoned that both should be essential to good obstetric and midwifery care.

5.2.5 Fourth research question

The fourth question asked whether the level of childbirth control which women claimed to expect and achieve had any bearing on their short and long term psychological well-being.

The findings from the questionnaire study demonstrated no direct relationship between unfulfilled expectations of control and raised mood disturbance. On the contrary reports of high expectations of control were associated with higher reported levels of achieved control and lower mood disturbance in the early postnatal period. It was, therefore, women who reported lower levels of expected control who were more likely to describe having achieved little control and who were also more likely to report high Total Mood Disturbance scores at 1 week postnatally. Early postnatal scores of achieved control

and mood were then strongly correlated with scores in the later postnatal period, whilst all the mood subscales, except Anger-Hostility, improved significantly between 1 and 16 weeks postnatally. The women's reports of whether the birth was better than expected, whether it was a positive experience, and whether they felt distressed all became more favourable between 1 and 16 weeks postnatally, but reports of the amount of control experienced did not change (tables 3.13, 3.14 and 3.16, pages 114 and 115).

As explained in the discussion to the questionnaire study (subsection 3.4.5, page 142), these findings do not support the concept of a 'halo effect', in which women become more negative about their birth experiences over time. In respect of control issues, the women's reports did not change, whilst their assessments of other aspects of the birth became more positive. However, when the interview data were examined the most obvious difference between the women's 1 and 16 week postnatal accounts was that over time they became more coherent and detailed. This sometimes had the effect of making their reports sound more negative, but the women themselves did not appear to be using these clarificatory techniques in this way. Rather they were used for elaboration. The fact that, as the questionnaire study shows, such elaboration was accompanied by an increase in positivity over certain aspects of the birth, and by the improvement in most of the mood subscales, suggests that the women might have been helped by repeating their birth stories, probably not only in the interviews, but to friends, family, and to themselves. This fits with the observation made by Woollett, Lyon and White (1983) that women's attitudes towards the birth become reorganized as time passes, although in their study the women appeared to become engrossed in caring for their babies to the extent of appearing less concerned about their delivery experiences in the later postnatal period. In the present study, the women knew they were to be interviewed about the birth again at 16 weeks postnatally, and it was perhaps this which kept the issues at the forefront of their minds. Another possibility is that by 16 weeks postnatally, when the women in the current study were re-interviewed, they had begun to establish a routine in childcare, so that it seemed less overwhelming than it had at 4 to 6 weeks when Woollett et al. made their final interview. Thus childcare featured less extensively in these women's accounts

The analysis of the data relating to this research question also demonstrated strong relationships between antenatal, 1 week and 16 week postnatal mood scores, which correlated with measures of expected and achieved control. The existing literature points to occasions where control might influence mood, for example, the association between disempowering childbirth procedures and postnatal depression (see chapter 1, subsection 1.3.2.1, page 27). However it is likely that the relationship between measures of mood and control, taken at the same time, is reciprocal. As discussed in the conclusion to chapter 4, control and uncontrollability are both material and discursive, and if, as described in subsection 5.2.3 (page 203), a childbearing woman, through good care, can be enabled to feel happy and positive about her experiences, her sense of control will be enhanced. For this reason, and because of the association between antenatal and postnatal mood, antenatal emotional well being, regardless of its origins, must be given as much consideration as women's stated aspirations for control.

In chapter 4 other effects of the birth, apart from mood, were examined. It was noted that short-term emotional effects were often attributed to the pressures of new motherhood, despite the literature which discusses such issues in terms of the 'postnatal blues' (subsection 4.3.9.2, page 185). It was also noted that lack of postnatal support was sometimes implicated as the cause or as an exacerbating factor in the woman's problems. Thus, good postnatal care, in which women are allowed to gradually gain control over the complexities of infant feeding and motherhood, is important, and the current trend to treat it as the poor relation to intrapartum care (Hadikin, 1998) must be reversed.

Fears associated with the next birth were also apparent (subsection 4.3.9.4, page 186ff), especially when women's first birth had not gone as planned. Again this suggests the need for an adequate postnatal counselling service, to be available for women even as long after the birth as their next pregnancy.

5.2.6 Summary of recommendations from findings

This thesis has demonstrated the inherently disempowering nature of many aspects of the embodied experience of childbirth, alongside the discursive techniques used by childbearing women to render their experience controllable to a greater or lesser extent. Thus it can be seen that control is not something which can, unproblematically, be given to childbearing women, as the literature on midwifery care sometimes implies. The essence of controllability will always be something created between the childbearing woman and her midwife: a material-discursive intermesh of embodied experience and its representation through talk and action. Thus communication, whether verbal, via action or imagery, becomes a vital element in childbearing women's achievement of control. As demonstrated in this thesis it is the way in which antenatal education classes are structured or interventions applied that determines the likelihood that the woman experiencing them will position them as a source of control. However this is not to overlook the individuality of the woman concerned, the need for her voice, her representation of the situation to also be accounted for.

As suggested in the preceding subsections of this chapter, good communication has to begin in the antenatal period. Pregnant women, especially working-class women, need to be nurtured and cared for in a non-threatening clinical environment from long before they experience labour and birth. However it is important to note that communication is more than talk. The material aspects of the antenatal clinic environment also have their discursive element. Its layout and procedures, as well as the manner of non-clinical personnel all speak volumes to the woman attending for the first time, and can drown out the rhetoric of control if they indicate the opposite.

As well as addressing communication issues early in the woman's pregnancy, carers have to make sure that the exchange of information is a two-way process. As already described each woman is an individual and it is only by listening to her views that her unique needs can be catered for. Both antenatally, during and after the birth, childbearing women need to be given opportunities to speak about their care, both for their own benefit and to provide feedback which will help to improve the maternity services. It is especially important that some kind of postnatal follow-up service be made

available for women so that they can contact someone who is able to access their notes and discuss their experiences with them at any time after the birth.

However, in the questionnaire study the childbearing women did report achieving more control than expected. Two reasons for this were suggested: their ability, already described, to represent their experiences in ways which render the material uncontrollability of labour and birth as controllable in a material-discursive context, and their relief when their fears of the level of uncontrollability of the birth were not fully realized. However despite this women who reported low expectations of control in childbirth also described experiences of less control than women with higher expectations. Thus these findings do not obviate the need to address the low control expectations of some childbearing women. Again the solution, at least in part, must rest in communication: a need for carers to be aware of each woman's uncertainties (something which will only occur if they listen to their clients), to seek to affirm her bodily sensations and experiences, not just during the birth but beforehand, to enable her to gain the expectation that her feelings, both physical and emotional, will be respected, and that she will be given the potential to achieve shared control with her carers.

The midwives' lack of ability to predict their clients' reports of expected or achieved control, whilst accurately estimating their assessments of satisfaction, suggest the need for improved communication specifically over control issues. However it is clear that some midwives communicate better than others, so this is not to suggest that all midwives need such re-education equally.

Just as antenatal expectations for control must be addressed, so also must antenatal mood. The close relationship between mood and labour agency raises the possibility that enhancing one may help to improve the other. Control in childbirth is such a serious issue because of its associations with emotional wellbeing. However, as intimated at the end of the previous subsection, this is not to suggest that psychological wellbeing arising from postnatal issues should be overlooked. Current moves to enhance women's control in childbirth have tended to result in a concentration of resources and support on the intrapartum period, to the expense, particularly, of postnatal care. This trend has to be reversed. Efforts to enhance women's control in childbirth must embrace the antenatal, intrapartum and postnatal periods.

Finally it is important to disseminate to both carers and childbearing women the real risks (and lack of risk) associated with childbirth, to give both mother-to-be and carer more confidence around safety issues. However, it is understandable that this will never stop individual women from worrying that, however low the risk, their baby could still be the unlucky one. Therefore there is also a need to give accurate, research based, information, as it becomes available, on the value of various procedures and interventions, to help women and midwives understand when such interferences should be avoided.

5.3 The research process and its limitations

In subsection 1.5.4 (page 68) it was claimed that a fundamental objective of feminist research must be that it leads to social change for women. It was also acknowledged that, because midwifery and

obstetric care is concerned with individual women, it is important that research addresses the heterogeneity of childbearing women. This second issue formed a justification for the use of qualitative methods in the research described in this thesis, which allowed individual representations to be unraveled. The first objective could only be addressed by a larger scale, replicable study which allowed the general trends in women's representations of their control requirements to be confronted.

The use of both qualitative and quantitative approaches thus allowed the individuality of women to be recognized but also took into account the need for action for the greater good. It drew attention to the need to listen to women as individuals in terms of their control requirements, and yet also to move to provide better communication for all childbearing women. It suggested a reallocation of resources so that all women receive better postnatal support and care, but also suggested that availability be made for follow-up and counselling services to meet the specific needs of individuals.

It was also noted in subsection 1.5.4 that research into control in childbirth had to take into account the levels at which power can operate: superindividually (at the level of the historical and political), individually (involving the concerns of individual women), and intra-individually (acknowledging women's control experiences in their entirety).

Again, to a large extent, this has been achieved. At the superindividual level the historical legacy of uncontrollability for childbearing women has been considered, whilst the needs of individual women have been described in the paragraphs above. At the intra-individual level women's control in childbirth experiences have been considered in the context of their rest of their lives. The latter has been the most difficult. Once individual issues began to be explored it was found that representations of control in the women's lives were fragmented, although when talking in more general terms the women tended to acknowledge an uncontrollability in much of their day to day experience.

The diverse but incomplete picture of women's control experiences from day to day raises the need to somehow explore in more depth how each woman's life inter-relates with her expectations and experiences of control in childbirth. Diary studies documenting the woman's thoughts about the birth and what has influenced those thoughts might have been appropriate here. However such studies demand a high level of commitment from their participants, and although it is possible that another group of women might have been willing to complete diaries had there been the time and resources available to implement such a project, it would not have been practicable to expect the participants in these studies, who had already been asked to complete questionnaires at intervals, and in some cases also to be interviewed, to take upon themselves any further obligations. An in-depth case study approach, looking at the experiences of one or two women, would also have been useful, and was considered for this thesis, but rejected due to lack of space.

Subsection 1.5.4 also pointed out the dynamic of the person-environment relationship as far as issues of control were concerned: that 'snapshot' pictures of the situation would not do full justice to the unfolding and developing scenario of labour and birth, as the relationship between carer and client developed, the course of labour imposed its own set of constraints upon that relationship, and as the

woman made decisions which impinged upon her environment and the environment predisposed her to make certain choices. Despite attempts to obtain an account of labour and birth from interview participants which reflected such dynamics, this was still a retrospective report, coloured by the woman's knowledge of events subsequent to those she was describing. Thus some of the sense of unfolding of circumstances was lost. To some extent a diary study might have again been helpful here, although to expect a woman to complete such a document when in the throes of advanced labour is certainly asking far too much of her. An observational study of some of the participants throughout labour and birth would have been more useful, but was rejected because of its intrusive nature, necessitating the presence of yet another individual in the intimate, and hopefully private, atmosphere of the birthing room. Another practical objections to such a study was the problem for the researcher of being constantly available over a period of several weeks, to be certain of being free to attend the woman's labour. Yet another drawback to observational studies is the danger of investing them with a semblance of objectivity: forgetting that the observer's perspective is just another representation, alongside those of other actors.

Apart from the practical objections to both diary and observational studies, making them, although useful methods in themselves, inappropriate for inclusion in the research described here, the overarching drawback, if they had been included, would be to add yet further to a mass of data which, even from the two studies which did take place, threatened at times to be overwhelming. This, in essence, has to be the main criticism of this thesis - the magnitude of the subject. Although it was anticipated from the outset that control in childbirth would not be the simple issue it was sometimes represented as being, quite how complex it would be, especially in terms of the issues raised in the interviews, was overlooked. Because of this, many important, but less central, aspects of women's accounts of control have had to be glossed over. For example there has not been the time or space to explore the part played by the woman's partner, her reactions to procedures which involve intimate exposure, issues around continuity of care and carer, to name but a few. If further research into control in childbirth is to take place, on the basis of the findings of this study, a much narrower range of research questions could be selected.

Another issue which relates directly to the complexity of control in childbirth and the magnitude of this study is the somewhat confusing web of relationships between the variables in the questionnaire study. This raises questions about the most efficient approach to quantitative data analysis. As noted at the end of chapter 3 (subsection 3.4.6, page 144), a more sophisticated analytic technique, such as structural equation modelling, may, in future studies, help to identify the model which fits the data the best. However such a procedure was beyond the scope of this thesis.

Many research studies argue the case for a larger sample, or in the case of longitudinal studies, for coverage over a longer period of time. As with other studies the constraints upon such issues were both in terms of cost and time available. However a larger sample and a longer study may have helped to clarify certain topics, for example, the place of antenatal depression in the overall picture of women's control-related mood changes over time; and the importance of factors such as employment and having

a partner, both of which were not explored because the numbers of unemployed or single women were too small. Particularly important omissions were the effects upon women from different ethnic groups, from different hospitals, and the question of whether the issues are the same for multiparous women as for the primiparous women studied here. Such issues must be considered seriously before assumptions are made from these studies about how childbearing women in general represent control issues.

5.4 Issues requiring further clarification

Several issues which require further clarification, if control in childbirth is to be better understood, have already been raised in the last subsection: further exploration of the relationship between women's control in everyday life and during childbirth, perhaps using diary studies; a quest to understand the dynamics of the carer-client-environment relationship during labour and birth, perhaps by using observation; and study of the effects of control or its lack upon multiparous women, women from different ethnic backgrounds, and those giving birth at different hospitals.

Further work also needs to be done on the effects that different childbirth-related interventions can have upon women in labour, and how such interventions can be applied in ways which still maintain the parturient woman's sense of control over them.

An issue which arose in conversation with some of the midwives who were interviewed was a degree of confusion over control in childbirth and consent. They argued that no procedure or intervention could take place unless the woman had first consented to it. Because she could always refuse to give her consent, they suggested that this constituted a level of control over the situation. However childbearing women might consent to procedures for all kinds of reasons: fears for their own or their baby's safety, for example, and may feel at times that they cannot refuse. Nevertheless, it would be helpful to explore the relationship between consent and control and to examine what constitutes consent.

In subsection 5.2.6 (page 207), it was suggested that it might be possible to modify a childbearing woman's expectations of control, at least in part, by paying attention to the implicit messages she receives about control during the antenatal period. It was suggested that these messages might be carried, not only by the doctors and midwives who staff antenatal clinics and who teach antenatal classes, but by other personnel in the hospital and in the doctor's surgery with whom pregnant women come into contact, and by the organization and layout of the surroundings. Therefore there is a need to study such issues as the way receptionists and auxiliary nursing staff communicate with childbearing women, to ascertain whether their practices are empowering to the woman, and if not, how they can be changed. Observational studies, as well as interviews and surveys exploring women's views of particular antenatal clinics and education classes would be helpful in the quest for such information. Such studies are important if, as has been shown in this thesis, women's antenatal mood state and expectations of control in childbirth have such a strong relationship with postnatal mood and estimates of achieved control.

This thesis has not addressed another set of fundamental issues which can affect communication: the amount of time a midwife has to spend with her client and whether she has met the woman prior to the labour. If midwives do not have the opportunity to get to know their clients before they become overwhelmed by strong contractions, or if a midwife is rushing from one labour room to another trying to look after several women at once, the possibility of effective communication is likely to be limited. Attempts to provide continuity of carer for childbearing women have had mixed success, and this is not the place to discuss why this might be the case. Suffice it to say that, if the sample in this research is typical, most women are still not cared for in labour by a midwife they know. There is a need to explore the effects of continuity of care and carer, both in terms of the continuous presence of a midwife during labour and in terms of the presence of the same midwife throughout, perhaps one already known to the woman. The effects of such care upon both communication and control in childbirth must be explored in more depth, to establish exactly what place such issues play in women's birth experiences, and how important it is to spend time, money and effort setting up schemes which aim to give such care.

5.5 Concluding comments

This thesis began with my own feelings of disempowerment as a midwife and the concomitant lack of control over the birth process for the childbearing women I attended. I, then, along with midwives today, wanted to do the best I could for my clients. However the concept that childbearing women's views should be heeded was alien when I trained, and although I know I spoke to my clients I am less certain that I ever really listened to their views.

With the advent of the Changing Childbirth report, and everything that has developed out of it, childbearing women's requirements have been given a central place on the agenda of maternity care. Many, maybe most, midwives do try to give their clients the opportunity to request the type of care they want. Their communicative abilities are probably greater than mine ever were.

This thesis, therefore, does not denigrate the efforts made by today's midwives. Rather it highlights the context in which they work - largely medically orientated - and the extent of the damage caused by the legacy of disempowerment that both they and their clients have inherited. That midwives do not always recognize the need for an improvement in the care they give to childbearing women is a reflection of how deeply entrenched this disempowerment has become. A wedge has been driven between midwives and their clients over the years and there is still work to do and improvement to be made to bring together these two groups who both have the wellbeing of the childbearing woman and her baby at heart. For example, the ethos behind the vast improvements that have been made in intrapartum care in recent years must now be carried forward and backwards into antenatal and postnatal care. Good communication must be redefined in terms of listening as well as giving information, asking the right questions as well as giving the right answers. That communication between midwives and their clients could be better is not to suggest that midwives do not already try to communicate well, but it is hoped that this research will contribute to a steady move forward in the process of yet further improvement.

Pilot study interview schedules

MOTHERS' INTERVIEW

1. How old is your little boy/girl now?
2. Can you remember many details about your labour?
3. What sort of things can you remember?
4. What were the best things about your labour?
5. What were the worst?
6. Did you feel in control of yourself/ the situation? Was this important to you?
7. What or who helped you to feel in control? How did they do this?
8. Were there things which did not help your control?
9. Were there things which you would have liked done differently?
10. Did you feel you had much choice about what happened to you?
11. Can you remember how you felt immediately after you had him/her?
12. Did those feelings change as time went on?
13. What sort of advice about labour would you give to a woman in late pregnancy?
14. Do you think your experience was very different to that of other women?
15. Have you had many chances to discuss these experiences with other people? What were their reactions/responses? Were they supportive?
16. Are there any other issues concerning labour and delivery which you think I should ask women about in these interviews?

MIDWIVES' INTERVIEW

1. For how long have you been doing midwifery?
2. What sort of areas have you worked in?
3. Have you had much delivery suite experience?
4. How do you feel about working on the delivery suite?
5. Do you think that 'Changing Childbirth' is going to affect delivery suite practice?
6. In what ways? Do you think this is a good thing?
7. What sort of things do you do to make women feel supported during labour?
8. Do you think it is possible to give most women the amount of control they really want?
9. Do you think a woman's childbirth experience has any long term effects on her? What sort of effects?
10. Do you think that some women expect too little/too much from their midwives?
11. Do you think that some midwives cope better than others with women who want a high level of control?
12. How do midwives these days integrate their professional judgement with hospital policies and women's requirements?
13. How do you feel about home births?
14. What sort of advice do you give to antenatal women about control during labour and delivery?
15. What would you say to someone wanting to train as a midwife?
16. Are there any other relevant issues which you think I should ask midwives about in these interviews?

Items for the Multidimensional Locus of Control Scale (Levenson, 1974)

1. Whether or not I get to be a leader depends mostly on my ability.
2. To a great extent my life is controlled by accidental happenings.
3. I feel as if what happens in my life is mostly determined by powerful people.
4. Whether or not I get into a car accident depends mostly on how good a driver I am.
5. When I make plans I am almost certain to make them work.
6. Often there is no chance of protecting my personal interest from bad luck happenings.
7. When I get what I want it's usually because I'm lucky.
8. Although I might have good ability, I will not be given leadership responsibility without appealing to those in positions of power.
9. How many friends I have depends on how nice a person I am.
10. I have often found that what is going to happen will happen.
11. My life is chiefly controlled by powerful others.
12. Whether or not I get into a car accident is mostly a matter of luck.
13. People like myself have very little chance of protecting our personal interests when they conflict with those of strong pressure groups.
14. It's not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad fortune.
15. Getting what I want requires pleasing those people above me.
16. Whether or not I get to be a leader depends on whether I'm lucky enough to be in the right place at the right time.
17. If important people were to decide they didn't like me, I probably wouldn't make many friends.
18. I can pretty much determine what will happen in my life.
19. I am usually able to protect my personal interests.
20. Whether or not I get into a car accident depends mostly on the other driver.
21. When I get what I want it's usually because I worked hard for it.
22. In order to have my plans work, I make sure that they fit in with the desires of people who have power over me.
23. My life is determined by my own actions.
24. It's chiefly a matter of fate whether I have a few friends or many friends.

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The Edinburgh Postnatal Depression Scale (Cox, Holden and Sagovsky, 1987)

1. In the past week, I have been able to laugh and see the funny side of things
 - As much as I ever could
 - Not quite so much now
 - Definitely not so much now
 - Not at all
2. In the past week, I have looked forward with enjoyment to things
 - As much as I ever did
 - Rather less than I used to
 - Definitely less than I used to
 - Hardly at all
3. In the past week, I have blamed myself unnecessarily when things went wrong
 - Yes, most of the time
 - Yes, some of the time
 - Not very often
 - No, never
4. In the past week, I have been anxious and worried for no good reason
 - No, not at all
 - Hardly ever
 - Yes, sometimes
 - Yes, very often
5. In the past week, I have felt scared or panicky for no very good reason
 - Yes, quite a lot
 - Yes, sometimes
 - No not much
 - No, not at all
6. In the past week, things have been getting on top of me
 - Yes, most of the time I haven't been able to cope at all
 - Yes, sometimes I haven't been coping as well as usual
 - No most of the time I have coped quite well
 - No, I have been coping as well as ever
7. In the past week, I have been so unhappy that I have had difficulty sleeping
 - Yes, most of the time
 - Yes, sometimes
 - Not very often
 - No, not at all
8. In the past week, I have felt sad or miserable
 - Yes, most of the time
 - Yes, quite often
 - Not very often
 - No, not at all
9. In the past week, I have been so unhappy that I have been crying
 - Yes, most of the time
 - Yes, quite often
 - Only occasionally
 - No, never
10. In the past week, the thought of harming myself has occurred to me
 - Yes, quite often
 - Sometimes
 - Hardly ever
 - Never

Appendix 3.3

The Profile of Mood States adjectives (McNair, Lorr and Droppleman, 1992)

1. FRIENDLY
2. TENSE
3. ANGRY
4. WORN OUT
5. UNHAPPY
6. CLEAR HEADED
7. LIVELY
8. CONFUSED
9. SORRY FOR THINGS DONE
10. SHAKY
11. LISTLESS
12. PEEVED
13. CONSIDERATE
14. SAD
15. ACTIVE
16. ON EDGE
17. GROUCHY
18. BLUE
19. ENERGETIC
20. PANICKY
21. HOPELESS
22. RELAXED
23. UNWORTHY
24. SPITEFUL
25. SYMPATHETIC
26. UNEASY
27. RESTLESS
28. UNABLE TO CONCENTRATE
29. FATIGUED
30. HELPFUL
31. ANNOYED
32. DISCOURAGED
33. RESENTFUL
34. NERVOUS
35. LONELY
36. MISERABLE
37. MUDDLED
38. CHEERFUL
39. BITTER
40. EXHAUSTED
41. ANXIOUS
42. READY TO FIGHT
43. GOOD NATURED
44. GLOOMY
45. DESPERATE
46. SLUGGISH
47. REBELLIOUS
48. HELPLESS
49. WEARY
50. BEWILDERED
51. ALERT
52. DECEIVED
53. FURIOUS
54. EFFICIENT
55. TRUSTING
56. FULL OF PEP
57. BAD TEMPERED
58. WORTHLESS
59. FORGETFUL
60. CAREFREE
61. TERRIFIED
62. GUILTY
63. VIGOROUS
64. UNCERTAIN ABOUT THINGS
65. BUSHED

Appendix 3.4

The Labour Agency Scale (Hodnett, and Simmons-Tropea, 1987)

VERSION A

When I am in labour:

1. I will feel confident
2. I will feel defeated
3. I will feel important
4. I will feel tense
5. I will have a sense of understanding what is happening
6. I will feel insecure
7. I will feel relaxed
8. I will feel competent
9. Someone or something else will be in charge of my labour
10. I will feel inadequate
11. I will experience a sense of distress
12. Everything will seem unclear or unreal
13. I will be completely aware of everything that is happening
14. I will feel panicked
15. I will feel as if I am falling to pieces
16. I will have a feeling of constriction and of being confined
17. I will feel in control
18. I will experience a sense of being with others who care
19. Everything will make sense
20. I will feel as if I am dying
21. I will feel I did everything I should have been doing
22. I will feel helpless
23. Everything will seem peaceful and calm
24. I will experience a sense of success
25. I will feel powerless
26. I will experience a sense of failure
27. I will accept what happens
28. I will feel capable
29. I will feel bad about my behaviour during labour

VERSION B

When I am in labour:

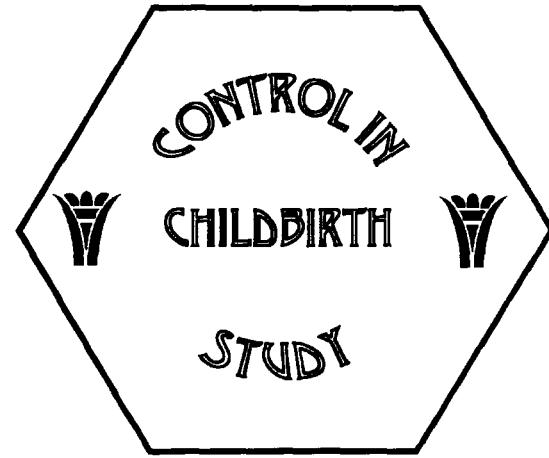
1. I will feel competent
2. I will deal with labour
3. Everything will make sense
4. I will feel very responsible
5. I will feel incomplete and like I was going to pieces
6. I will feel secure
7. I will feel incapable
8. I will experience a sense of great anxiety
9. I will feel adequate.
10. I will feel open and receptive
11. I will feel good about my behaviour during labour
12. I will feel powerless
13. I will experience a sense of being with others who care
14. I will not know what to expect from one moment to the next
15. I will experience complete unawareness of everything that was happening
16. Everything will seem unclear and unreal
17. I will feel relaxed
18. I will experience a sense of conflict
19. I will feel fearful
20. I will have a sense of not being in control
21. I will feel important
22. Everything will seem wrong
23. I will feel victorious
24. I will experience a sense of active striving
25. I will have a feeling of constriction and of being confined
26. I will feel awkward
27. Someone or something else will be in charge of my labour
28. I will experience a sense of success
29. I will have a sense of perspective on what is happening.

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INSTRUCTIONS

This questionnaire is for the midwife who delivers your baby, or the one who looks after you immediately prior to delivery. I am trying to find out whether your midwife's perception of what you expected and what you wanted was the same as your own. Therefore it is important that you do not discuss with your midwife how she should complete this questionnaire.

Please fold this questionnaire so that the part entitled "Midwife's questionnaire" is on the outside, clip it inside your notes and point it out to the midwife who looks after you in labour. Many thanks.



Jane Weaver
University College London

Midwife's questionnaire - Control in Childbirth Study

This should be completed by the midwife who delivered this woman, or who provided the bulk of the intrapartum care around the time of delivery. Please use your own judgement to make this assessment. If you wish to discuss what you have written with the woman concerned, please do so after you have completed this questionnaire. If you wish to write additional comments please feel free to do so. There is more space on the side with the logo in the right hand corner.

1) Please give your assessment of how much control this woman expected generally over what was done to her during labour and delivery, by grading her expectations out of ten. Ten-out-of-ten would mean she expected total control. Nought-out-of-ten would mean she wanted you, or somebody else, to take total control.

Amount of expected control (out of 10)

2) Now please give your assessment of how much control this woman actually achieved overall over what was done to her during labour and delivery, with a similar grading out of ten. Ten-out-of-ten would mean she achieved total control. Nought-out-of-ten would mean you, or somebody else, took total control.

Amount of achieved control (out of 10)

3) Finally, please assess how satisfactory an experience the labour and birth was, as a whole, for the woman, in your estimation, by giving a mark out of 10. Ten-out-of-ten would mean she appeared to have an absolutely wonderful experience that could not have been better. Nought-out-of-ten would mean a thoroughly unsatisfactory experience with nothing good to be said for it.

Marks out of 10

WHEN YOU HAVE COMPLETED THIS QUESTIONNAIRE, PLEASE PLACE IT IN THE FOLDER PROVIDED ON DELIVERY SUITE. THANK YOU FOR YOUR HELP

No. _____



Midwives' questionnaire - side 2

Main study interview schedules

ANTENATAL INTERVIEW

1. Tell me a bit about yourself: where you grew up and went to school.
2. When did you leave school? What did you do after that?
3. What jobs have you had? What made you choose those sort of jobs? Did you enjoy them?
4. What sort of things annoy you?
5. Do you ever feel that people are trying to push you around? How do you deal with them?
6. Do you ever feel that things aren't going the way you want them to? When this happens, what do you do about it?
7. How did you feel when you found out you were pregnant?
8. Have you been to any antenatal classes? What were they like?
9. What sort of things do you want or not want when you are in labour?
10. How important to you is the way you behave in labour?
11. How much say do you want to have in the things that are done to you in labour?
12. What are your views on Natural Childbirth? Home Birth?
13. What do you imagine childbirth will be like?
14. What sort of qualities do you think you want the most in the midwife who delivers your baby?
15. What sort of things have influenced the choices you have made for having your baby?
16. What impact do you think the baby will have on your life?

ONE WEEK POSTNATAL INTERVIEW QUESTIONS

1. Tell me what happened to you in labour?
2. Were you pleased with the way you were looked after. What sort of things did your midwife do to help you? What sort of things were unhelpful?
3. Did you feel that people told you everything you wanted to know?
4. Did you feel that people understood what you wanted and how you felt?
5. Do you feel happy about the way you coped with the labour?
6. Did you feel you were able to have the things you wanted?
7. Which things were easy to control, and which were difficult?
8. How did you feel about it all at the time?
9. How do you feel about it all now?
10. Tell me a bit about your baby.

SIXTEEN WEEK POSTNATAL INTERVIEW QUESTIONS

1. Can you describe to me again what happened to you in labour?
2. Looking back on it now, how do you feel towards the people who looked after you? In what ways were they helpful? Unhelpful?
3. Did you feel that people told you everything you wanted to know?
4. Did you feel that people understood what you wanted and how you felt?
5. When you think about it now, do you feel happy about the way you controlled yourself during labour?
6. How much control do you think you had over the things that were going on around you?
7. How did you remember feeling about it all at the time?
8. How do you feel about it all now?
9. Knowing what you know now, what sort of things, if any, would you do differently?
10. Do you talk to other people about what happened? Do they show an interest in it?
11. What are your thoughts about having any more children?
12. Do you think your experience has made any difference to you as a person?
13. Do you think your experience has had any long term emotional effects on you?
14. How are you finding motherhood? What sort of things have changed in your life because you have had a baby?
15. Has experiencing labour and childbirth affected your relationships with other people? Friends? Family?
16. Has motherhood affected your relationships with these people?

MIDWIFE'S INTERVIEW QUESTIONS

1. Could you give me a brief description of how this woman's labour and delivery progressed?
2. How much control do you think this woman expected to have in labour?
3. Do you think she achieved the control she wanted?
4. How satisfied do you think she was with how things went?
5. What sort of things help you to decide how much control a woman in your care might want during labour and birth?

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