

Engaging with the 'modern birth story' in pregnancy:
A hermeneutic phenomenological study of women's
experiences across two generations

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DECLARATION



STUDENT DECLARATION FORM

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

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

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ABSTRACT

This in-depth qualitative study considered how women from two different generations came to understand birth in the context of their own experience but also in the milieu of other women's stories. For the purposes of this thesis the birth story (described as the 'modern birth story') encompassed personal oral stories as well as media and other representations of contemporary childbirth, all of which had the potential to elicit emotional responses and generate meaning in the interlocutor. The research utilised a hermeneutic phenomenological approach underpinned by the philosophies of Heidegger and Gadamer. This methodology allowed the significance of the experience of engaging with stories to be grasped, and in-depth insights into the meanings and lived experience for women of the phenomenon to be made.

Twenty participants were purposively selected, recruited and interviewed. In phase one ten women who were expecting their first baby in 2013 were recruited in order to explore how they understood birth prior to the event and in the light of other women's stories. Birth stories were revealed as one of many 'voices' offering 'advice' to women about birth. The women also talked about classes they had attended, books they had read, websites and online forums they had accessed, as well as television programmes and films they had watched.

The conversations with the first cohort of women led to further questions about whether the information gleaned from media and virtual birth story mediums creates meaningful knowledge about birth for women. The second phase evolved from this thinking. In phase two interviews with an older cohort of women (who were pregnant in the 1970s –1980s) were undertaken to determine whether women from a different era were more able to translate knowledge into meaning. This was based on the belief that, for this

generation of women, stories were mediated by personal contact and not through virtual technologies as in the previous generation of women.

Phenomenological conversations with the participants took place in the iterative circle of reading, writing and thinking. This revealed the experience of *'being-in-the-world'* of birth for the two generations of women and the way of communicating within that world. From a Heideggerian perspective, the birth story was constructed through 'idle talk' (the taken for granted assumptions of how things are which come into being through language) and took place across a variety of media accessed by women, as well as through face to face conversations.

Five central and interrelated interpretive findings emerged. Firstly the stories the women engaged with, had a significant role to play in their understanding and expectations of birth. The 'norm' as portrayed in the stories circulating in 2013, for instance, was one which perpetuated what one participant described as the *'drama of birth'*. Secondly, the modern 'landscape' of birth (populated with many media representations) created and perpetuated fear of childbirth for many of the women. The stories shared were lacking in detail about women's lives, and did not necessarily help them to become 'knowers' and gain wisdom about birthing. Thirdly, the women birthing in the present day were overloaded with information amassed in an attempt to manage their anxieties about birth as well as to fit the role of the informed patient, and demonstrate their competency as mothers. Fourthly the cultural and spiritual significance of birth was not shared in the circulating stories in either generation. Finally, some of the birthing women felt secure in the 'system' of birth as constructed, portrayed and sustained in the stories widely circulated.

The data revealed that the lifeworld of birth being sustained in stories (for both generations) was one of product and process, concentrating on the stages and

progression of labour and the birth of a healthy baby as the only significant outcome. Taken as a whole this thesis revealed that the information gleaned from birth stories did not in fact create meaningful knowledge and understanding about birth for these women.

The study is unique in that no other published research has explicitly identified the premise of the 'modern birth story' or the notion of 'idle talk' in relation to childbirth. Further no other study has considered the phenomenon of engaging with these types of stories whilst pregnant. This study reveals how engaging with the 'modern birth story' and the 'idle talk' of birth may influence women's expectations and consequent experience of birth.

TABLE OF CONTENTS

ABSTRACT	3
ACKNOWLEDGEMENTS	13
CHAPTER 1 - INTRODUCTION: 'THROUGH THE LOOKING GLASS'.....	15
1.0 Introduction to Chapter	15
1.1 Origin and Essence	17
1.2 Birth and the Birth Story	22
1.3 Key Aims	24
1.4 Original Contribution	27
1.5 Childbearing and Midwifery in the UK Today	29
1.6 The Significance of the Study to Contemporary Practice.....	30
1.7 Architecture of Thesis	31
CHAPTER 2 - BACKGROUND: THE CONTEXT AND LANDSCAPE OF BIRTH.....	33
2.0 Introduction to Chapter	33
2.1 The Sociological Context of Birth	34
2.2 Childbirth as a Personal and Public Experience	35
2.3 The Midwifery Model	36
2.4 The Medical Model.....	37
2.5 Childbirth Discourse.....	40
2.6 Medical Childbirth Discourse	41
2.7 Natural Childbirth Discourse.....	43
2.8 Birth Prior to 1900.....	44
2.9 1902 Midwives Act.....	45
2.10 From Home to Hospital	46
2.11 The Foundation of the NHS	48
2.12 The 1970s-80s.....	49
2.13 'Changing Childbirth'	51
2.14 Birth in the 21 st Century.....	52
2.14.1 Government Policy and Practice Reality	52
2.14.2 Choice and the Childbearing Woman.....	54
2.14.3 Authoritative Knowledge and Birth	55
2.14.4 The Commodification of Birth.....	57
2.14.5 The Threat of Litigation and the Professional Response	59
2.14.6 Centralisation and Standardisation of Care	61
2.14.7 Continuity of Care	62
2.14.8 The Birthplace Study	64
2.14.9 Rising Birth Rate	65
2.14.10 Staffing Pressures.....	66
2.14.11 Growing Complexity.....	66
2.14.12 Human Rights.....	67
2.14.13 Women and Midwives in the Modern Climate of Care.....	67
2.15 Chapter Summary	68
CHAPTER 3 - BACKGROUND: STORIES	69
3.0 Introduction to Chapter.....	69
3.1 What is a Story?	69
3.2 How are Stories Told?.....	71
3.3 What are Stories For?	73
3.4 The Capacity and Power of Stories.....	74
3.5 The Social Nature of Stories.....	75
3.6 Chapter Summary.....	76

CHAPTER 4 - LITERATURE: 'PROVIDING CONTEXT AND PROVOKING THINKING'	77
4.0 Introduction to Chapter	77
4.1 Qualitative Meta-Synthesis	78
4.2 Tensions and Challenges of the Methodology	78
4.3 Searching the Literature	80
4.4 Inclusion and Exclusion Criteria	81
4.5 Literature Search Strategy	81
4.6 Protocol Driven Search	83
4.6.1 Database Searches	83
4.7 Snowballing Techniques	84
4.7.1 Backward Chaining	84
4.7.2 Forward Chaining	84
4.8 Personal Knowledge	84
4.9 Instigating the Database Searches	85
4.10 Search, Retrieval and Results	90
4.11 Thought Processes and Decision Making Around Study Selection	90
4.12 Insights from the Two Studies Informing My Thesis	92
4.13 Quality Appraisal or Not?	95
4.14 Two Lone Studies	95
4.15 A Relevant Study	96
4.16 The Move to a Hermeneutic Review of the Literature	97
4.16.1 Implications of a Hermeneutic Review	98
4.17 Re-viewing Literature: Understanding as Participation	99
4.18 My Understanding as Participation	100
4.19 Literature Considered in the Hermeneutic Review	102
4.19.1 The 'Feast' of Related Literature	102
4.19.2 The 'Famine' of Phenomenon Related Literature	104
4.19.3 Inclining Towards	105
4.19.4 Moments of Vision	106
4.20 Coming to Understand	109
4.20.1 Women's Stories as a Way of Knowing	109
4.20.2 Women's Stories as Influencing Decision Making for Childbirth	112
4.20.3 Women's Stories in Response to Childbirth	114
4.21 Chapter Summary	115
CHAPTER 5 - METHODOLOGY: 'WINDING MY WAY'	117
5.0 Introduction to Chapter	117
5.1 Choosing the Theoretical Approach	118
5.1.1 Aims of Research	118
5.2 Addressing Philosophical Dimensions	119
5.3 My Philosophical Stance	120
5.4 Positioning of the Research	121
5.4.1 Interpretive as Opposed to Positivist	121
5.5 Determining the Interpretivist Approach	123
5.5.1 Choosing Not to Adopt a Narrative Methodology	123
5.5.2 Choosing Hermeneutic Phenomenology	124
5.6 Hermeneutics and Midwifery	124
5.7 Phenomenology	125

5.8	Hermeneutics	127
5.9	Hermeneutic Phenomenology.....	128
5.10	Martin Heidegger (1889-1976).....	129
5.11	Hans-Georg Gadamer (1900-2002)	130
5.12	Heideggerian Notions.....	132
5.12.1	Dasein	132
5.12.2	Being-in-the-World.....	133
5.12.3	Care	135
5.12.4	Temporality.....	135
5.12.5	Historicity and Repetition.....	136
5.12.6	Authenticity and Inauthenticity	136
5.13	Philosophical Concepts.....	137
5.13.1	Language and Linguisticity.....	137
5.13.2	Understanding, Tradition and Interpretation.....	139
5.13.3	Fusion of Horizons	140
5.13.4	The Hermeneutic Circle.....	141
5.14	Reflexive Positioning and Pre-suppositions.....	141
5.15	Chapter Summary	143
CHAPTER 6 - METHOD: 'A STARTING POINT'		144
6.0	Introduction to Chapter.....	144
6.1	Programme of Works	148
6.1.1	Master of Philosophy (MPhil) Phase	148
6.1.2	Doctor of Philosophy (PhD) Phase.....	149
6.2	Ethical Issues	149
6.3	Respect for Persons.....	150
6.4	Beneficence.....	151
6.5	Justice.....	152
6.6	Participants and Setting	153
6.6.1	Phase One	153
6.6.2	Phase Two	154
6.7	Sample Size and the Hermeneutic Study	154
6.8	Introducing the Participants	155
6.8.1	Phase One	155
6.8.2	Phase Two	156
6.9	Maintaining Confidentiality and Preserving Anonymity	156
6.10	Developing the Phenomenological Conversation.....	157
6.11	The Interviews	158
6.12	Interpretation	165
6.13	Rigour and Trustworthiness.....	169
6.14	Chapter Summary.....	174
CHAPTER 7 - ALETHEIA: 'STORIES ARE DIFFICULT LIKE THAT'		175
7.0	Introduction to Chapter.....	175
7.1	Being-in-the-World of Birth	176
7.2	'Horror Stories'.....	181
7.3	The Media Portrayal of Birth.....	183
7.4	Societal Expectations.....	188
7.5	'Too Perfect and Wonderful'	189
7.6	'Being Economical with the Truth': Protecting or Neglecting?	191
7.7	Living in a 'Polite Culture': The 'Rules of Sharing'.....	193
7.8	Chapter Summary.....	195

CHAPTER 8 - ALETHEIA: 'IT'S A GENERATIONAL THING'	196
8.0 Introduction to Chapter	196
8.1 Preparing for Birth: <i>'It was all a Bit Shrouded in Mystery'</i>	197
8.2 Preparing for Birth: Information Seeking and Saturation	200
8.3 Preparing for Birth: Acquiring Knowledge in the Virtual Community	202
8.4 <i>'Letting it take its Course and Coming out the Other Side'</i>	205
8.5 <i>'Looking Back as a Mature Woman'</i>	206
8.6 <i>'Doing Better'</i>	210
8.7 <i>'Taking Control and Going the Opposite Way'</i>	211
8.8 <i>'This Generation Nothing's Private to Them'</i>	213
8.9 Fear of Birthing	215
8.10 Chapter Summary	217
CHAPTER 9 - ALETHEIA: 'BIRTH IN THE TWILIGHT OF CERTAINTY'	219
9.0 Introduction to Chapter	219
9.1 Being <i>'In the System'</i> on the <i>'Conveyor Belt of Care'</i>	221
9.2 <i>'Birth as a Technological Feat'</i>	223
9.3 <i>'Being a Good Patient and a Good Parent'</i>	230
9.4 Birthing 'Know How'	234
9.5 Chapter Summary	239
CHAPTER 10 - DISCUSSION: SEEING THE BIG PICTURE	240
10.0 Introduction to Chapter	240
10.1 Initial Objectives and Underlying Methodological Assumptions	241
10.2 The 'Modern Birth Story'	243
10.3 Telling the Story	243
10.4 Central Interpretive Findings	245
10.4.1 The Birth Stories Heard Influenced Women's Understandings and Expectations of Birth	246
10.4.2 The Modern Landscape as Depicted in the Stories Being Shared Created and Perpetuated Fear of Childbirth	250
10.4.3 The Women Birthing Today Felt Overloaded with Information	255
10.4.4 The Cultural and Spiritual Significance of Birth Was Not Being Shared in the 'Modern Birth Story'	258
10.4.5 Women Felt 'Secure' in the 'System' of Birth	260
10.5 A Unique Contribution in the Horizon of Other Voices	261
10.6 What do the Findings Mean?	262
10.7 Implications for Practice	266
10.7.1 Implication One	266
10.7.2 Implication Two	268
10.7.3 Implication Three	270
10.7.4 Implication Four	271
10.8 Study Limitations	272
10.9 Recommendations for Further Research	273
10.10 My Impact on the Research and My Experience of the PhD Journey	274
CHAPTER 11 - CLOSING: THE END OF A JOURNEY	275
11.0 Introduction to the Chapter	275
11.1 Synthesising the Threads	276
11.2 The Thesis of the Thesis	277
11.3 Significance of my Findings	277
REFERENCES	279
APPENDIX 1A - DIAGRAMMATIC INTERPRETATION OF INCLUSION PROCESS	298
APPENDIX 1B - SATISFYING INITIAL INCLUSION CRITERIA	299
APPENDIX 2 - CONCEPTUAL GRID	307
APPENDIX 3A - MPHIL APPROVAL	311
APPENDIX 3B - PHD APPROVAL	312

APPENDIX 3C - AMENDMENT APPROVAL.....	313
APPENDIX 4A - MPHIL PARTICIPANT INFORMATION SHEET (MARCH 2012).....	314
APPENDIX 4B - PhD PARTICIPANT INFORMATION SHEET (JANUARY 2014).....	317
APPENDIX 5A - MPHil CONSENT FORM.....	321
APPENDIX 5B - PHD CONSENT FORM.....	323
APPENDIX 6A - NCT RESEARCH AUTHORISATION LETTER	325
APPENDIX 6B - STUDENT RESEARCHER REGISTRATION FORM	327
APPENDIX 7A - MPHIL RECRUITMENT MESSAGE	329
APPENDIX 7B - PHD RECRUITMENT MESSAGE.....	330
APPENDIX 8A - MPHIL SUGGESTED INTERVIEW SCHEDULE	331
APPENDIX 8B - PHD SUGGESTED INTERVIEW SCHEDULE.....	332
APPENDIX 9 - STEPHANIE'S CRAFTED STORY.....	333
APPENDIX 10A - ALETHEIA ONE - MAPPING DOCUMENT.....	345
APPENDIX 10B - ALETHEIA TWO - MAPPING DOCUMENT	348
APPENDIX 10C - ALETHEIA THREE - MAPPING DOCUMENT.....	350
APPENDIX 11 - TRANSCRIPT EXEMPLARS	353
APPENDIX 12 - DISSEMINATION PLAN.....	356

LIST OF TABLES

Table 1: Models of Maternity Care	39
Table 2: Database Search Strategy	87
Table 3: Search, Retrieval and Results of Database Searches	88
Table 4: The Belmont Report Principles and Applications	150
Table 5: Non- Structured Interviews: ' <i>Asking Hermeneutical Questions</i> '	160
Table 6: ' <i>Getting Going with Hermeneutics</i> ' (Smythe, 2003 and 2011).....	167
Table 7: Rigour and trustworthiness utilising de Witt and Ploeg (2006, p. 215-229)	171

LIST OF FIGURES

Figure 1: ‘Alice Going through the Looking Glass’ (Tenniel, 1976)..... 15

Figure 2: ‘To Give Birth is a Fearsome Thing’ (Elder, 2009)..... 108

Figure 3: ‘Special Delivery’ (Miller, 1955) 219

Figure 4: ‘dis chord’ (Calonder, 2015) 229

Figure 5: ‘Pregnant Woman’ (Chagall, 1913) 233

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CHAPTER 1 - INTRODUCTION: *'THROUGH THE LOOKING GLASS'*

"All too much here and barely there, birth stories embody in miniature long and wide histories of sometimes violent knowledge practices. They reproduce maternal subjects." (Pollock, 1999)



Figure 1: 'Alice Going through the Looking Glass' (Tenniel, 1976)

1.0 Introduction to Chapter

This thesis introduces the findings of a hermeneutic phenomenological study which sought to determine how other women's birth stories construct and reconstruct the

meaning of birth for childbearing women. The study was unique in that it considered how women from two different generations came to understand birth in the context of their own experience but also in the milieu of other women's birth stories.

The study is relevant and significant as childbirth is a momentous event in a woman's life and one that can assume enormous psychological importance (Callister, 2004). Further the birth story as '*a feminine, woman-to-woman legacy*' is understood as a crucial source of knowledge about childbirth for mothers, (Savage, 2001; Humenick, 2006; Nichols, 1996). My interest started with the idea that birth stories must *surely* have a positive or negative influence on listeners, and those stories, and the messages they transmit, must therefore have the potential to steer women either towards or away from medical and/or midwifery-led models of care.

The picture of 'Alice Through the Looking Glass' personifies this chapter as the 'window' to my thesis and epitomises my experience of stepping into the confusing world of research where I was tasked with unearthing both a research question and a methodology by which to address my question. I chose to use the picture because when I was grappling with complex philosophical concepts and later with difficult Heideggerian notions it was pictures like this and stories like those of Lewis Carroll which helped me make sense of the complexity. Art and literature as ways of 'seeing' helped me to understand my philosophical stance, to identify my theoretical perspective and to understand complex notions such as the notions of '*temporality*' and '*spatiality*'. Throughout I use examples from poetry and prose as a means of understanding and illustrating my thesis.

In this chapter I 'paint a picture' of myself, describing my relationship with my study and explaining its origin and essence. I examine the study's key aims, reveal its originality and give a brief background to the subject matter. The study is placed in the context of

childbearing and midwifery in England in the United Kingdom (UK) and its significance to contemporary practice is made out. Finally the architecture of the project and an overview of its presentation in this thesis are presented.

1.1 Origin and Essence

I have always loved reading and writing and the power of stories and storytellers to capture the imagination has always intrigued me. As a child you would always find me in a corner 'lost in a book'. When I left school I studied for an English degree. I was taken with the power of poetry and prose to speak directly to the reader and to illuminate different parts of life. Whilst studying I developed my own writing and expressive skills.

I decided I wanted to be a midwife after my own experiences of birth. When I had my first baby I was left with many unanswered questions about birth; I wanted to find out why my birth was as it was as well as *how birth could be*. I realised the significance of the journey I had made from woman to mother and the value of a midwife who could lead women on that journey. I was interested in the role of the midwife as both a clinician and as a nurturer.

From the very beginning I was interested in the 'art' of midwifery; as a student whilst studying for a module called '*Images of Women in Childbirth*', as a community midwife listening to women tell me the '*story*' of their birth and as a lecturer utilising art, poetry and film as a way of embracing, understanding and facilitating learning about women's lives, birth, motherhood and midwifery.

The starting point for my study came out of my thinking around meaning, stories and the utter possibility of birth. An excerpt from my supervisory record highlights my thinking at the beginning of my PhD:

"I need to engage with words, feelings, behaviours, stories, language, getting to the crux of things as women understand them.....and in women's 'capacity', midwives as facilitators of birth, birth as an epiphany experience...and birth as all-consuming and self-transcending." (Supervision record 19/11/10)

My thinking evolved and I started to consider the idea of the mother 'being birthed' and of the various influences on a woman as she anticipates birth. Another excerpt gives an insight into my ideas at this time:

"How do women 'frame' birth? Do different groups of women frame birth differently? How do women 'understand' birth? Does it matter how birth is framed and understood? How do women tell their 'story'?" (Supervision record 18/01/11)

Later I consider these ideas in more depth:

"Generally stories have been used as a means of understanding and learning; the story and the teller influences us as we try to 'make sense' of a situation. The story we are told may help us to 'move directions', towards what we perceive as 'good' and away from what we perceive as 'bad'. How then does engaging with birth stories influence women? How does the telling of these stories change the conversations around what the meaning of birth is?" (Supervision record 14/07/11)

At this stage I knew that my research would encompass the notion of the birth story as well as the notion of women's experiences in the light of birth stories. I started to engage with the idea of hermeneutic phenomenology. The methodology (and certainly the philosophical underpinnings) was not something I was overly familiar with but on cursory inspection seemed a perfect fit, for me as a researcher, for the notion of birth stories as well as a perfect fit for midwifery. Hermeneutic phenomenology it seemed

offered a means of 'grasping' the significance of engaging with stories of birth whilst at the same time allowing my perspective to form part of the 'meaning' (I discuss my rationale for adopting this methodology and its 'fit' with midwifery research in more detail in chapter four). At this stage one of my main motivators was that in offering '*my interpretation*' I would have the opportunity to produce an '*evocative piece of writing*' that potentially would grab the attention of the reader (Smythe, Ironside, Sims, Swenson and Spence, 2008).

My ideas around the notion of the 'birth story' and its potential relationship to birth were cemented after my exploratory interview with two of my supervisors (conducted to determine my pre-suppositions prior to data collection and based on the premise described by Smythe et al., 2008) and by my expression of these ideas in a poem (written as part of the interpretative process). After transcribing and reviewing my interview I wrote an '*I poem*' inspired by the work of Gilligan (1982) who speaks of '*voice as the core of self, a powerful psychological instrument and channel*' in her work on identity and moral development. I found using the '*I poem*' concept extremely powerful as a means to unearth meaning and reflect on my own experience. I have included my poem; '*I remember my mother's story*' in this thesis as I believe it speaks of me as a person and of my journey to this space.

I remember my mother's story

*I was a difficult birth
I remember my aunt's story; she very nearly died
I wanted to be a mother
I wanted a baby
I knew nothing about birth
I didn't know how it all worked
I didn't trust my body
I felt unprepared
I felt unsupported
I went in too early
I immediately lay on the bed
I remember having my eyes closed
I never knew
I think the memories will be with me forever
I remember the midwife was a big, black, directive woman
I heard her tell me to stop screaming
I was frightening my own baby
I wanted someone human
I thought my husband was laughing; he was crying
I was in so much pain
I was frightened
I felt alone
I wanted to go home
I didn't want my baby
I remember asking them to cut me; I wanted it to stop
I was traumatised
I wasn't good enough
I didn't want to hold him
I deeply regret that
I thought I would die when I got pregnant again
I was selfish to have another baby
I didn't find anything out
I didn't ask questions
I didn't know why I was doing the things I did
I did what I did to keep me and my baby safe*

*I was at home
I walked around
I had a bath
I was on my hands and knees
I didn't go in until late
I went in an ambulance
I remember the midwife was watching ice-skating
I did it in my time
I did it my way
I was behaving intuitively
I had him on my skin
I felt amazing
I felt proud
I was good enough
I wanted people to know
I thought about the last time
I was angry
I was distraught
I had wanted someone to tell me
I had wanted someone to help me
I had wanted someone
I wish I had known
I wish I had believed
I wish I had wanted to hold him*

Having effectively '*set the scene*' and introduced myself as the '*voice*' of this thesis (Clare, 2003) I continue by giving a brief background to the study, introducing the key aims and presenting its original contribution to the literature.

1.2 Birth and the Birth Story

Birth can be seen as an inspirational spiritual and affecting experience beyond that of the physical, (Callister, 2004). There is a suggestion in the literature that a woman's birth experience may have long term and wide-ranging implications for her sense of self-efficacy and her ability to form relationships with others, including her infant (Callister, 2004; Savage, 2001).

Walsh (2006, p.662) suggests that women should have the opportunity to find '*meaning and purpose*' in the act of giving birth as opposed to being focused on '*getting through the labour as though it is a foreign or 'unnatural' state*'. Savage (2001) is of the same mind arguing that birth is not just about delivering babies but is about women's lives. The premise is that as women make meaning of giving birth they will become aware of personal growth, feel '*at one*' with and fully appreciate life, develop new priorities and achieve an overall sense of well-being (Skaggs and Barron, 2006).

Women are often eager to speak about their experience of birth. Sullivan (1997, p. 22) argues that such storytelling arises from an intuitive urge to share important events in our lives; our detailed account is an '*ancient method of coming to terms with our own experience*'. Telling stories about birth enables women to sort out their memories of this transformative event and to integrate their feelings. This may be especially pertinent if the reality of a woman's birth experience is not as she imagined it would be. Davies (2004, p. 22) speaks of the place of stories in '*fostering healing*'; telling stories may have a healing or cathartic effect for women whose experience has been disappointing or traumatic.

When a woman recounts her birth story she decides which pieces of the story to share and in doing so may construct a new understanding of the experience, (Savage, 2001).

Likewise because story telling depends on *'fluid'* spoken communication its subject matter may shift over time (McHugh, 2001). Leamon (2009, p. 171) argues that within each woman's story of childbirth lies a *'complex combination'* of factors involving the storyteller, her sense of self, the birth and her reflections about the experience. The listener is also important subtly influencing the way in which the story unfolds with each listener taking something unique from the story.

Banks-Wallace (2002) maintains that every storytelling episode is unique, influenced by social dynamics and more importantly, storyteller and *'storytaker'* (listener) characteristics. In describing the significance of the listener in a storytelling situation Leamon (2009) suggests that the way in which the story is received and understood will depend on a number of factors; who the listener is, their relationship with the teller, how they engage with the story and the relevance of the story to their life.

Farley and Widmann (2001, p. 22) describe birth stories as *'symbolic representations of birth through words'* and argue that articulating the birth experience into a story gives it structure; *'an onset, a climax, and a resolution'*. Once the experience has a structure meaning can be determined and emotional responses considered and handled. Livo and Ruitz (1986) maintain that in the *'narrative exchange'* that takes place when a story is told, the *'learner'* reconstructs knowledge amassed from the story. The shared story therefore becomes a *'vicariously learned experience'* (Savage, 2001). During this learning process there is a potential opportunity to lessen fears about birth and to amass a sense of control but there is also an opportunity to increase fears and make women feel essentially powerless (Zwelling, 2000).

This argument is pursued by Savage (2001) who maintains that when positive stories are shared women hear stories about strength and power in birthing and are assured of the capacity of women to birth physiologically. Conversely if women hear negative

stories which focus on the medicalization of the birthing process they associate birth with difficulty and suffering and the process with risk and fear. Arms puts this idea into perspective when she speaks of young women birthing in an environment built on a '*toxic legacy of attitudes about childbirth*' (1994, p.26).

This thesis is concerned with the way in which women share their experiences of birth and engage with the many story mediums at their disposal; the thesis considers the possibility of a relationship between birth stories and women's expectations and experiences of birth. In conducting this study and formulating this thesis I was interested to learn more about how women communicate birth stories and how pregnant women make sense of the birth stories they encounter.

1.3 Key Aims

My initial objectives in carrying out this research, therefore, were to establish the constructs, norms and meanings that underline the birth stories women tell and, to understand how women make sense of the stories they are told. I hoped to uncover the meanings in and around birth which are rooted in the "*moral, political and intellectual traditions we share*" (Warnke, 1993, p86). I wanted to find out what these traditions imply about the norms of action that are appropriate to us in our '*world of birth*' and in so doing consider the conditions that construct and shape meaning around birth.

As the project developed the objectives were refined into questions such as; how does hearing birth stories influence women's choices and decision making around birth? Does the telling of birth stories change the conversations around what the meaning of birth is? Based on these questions my ultimate research question at the outset of the study was: '*How does listening to stories of birth help pregnant women to understand what their experience of birth may be?*'

As the study moved forward my understanding of the concept of a birth story evolved necessitating a change to the research question. The next part of the chapter describes my thought processes and decision making at this time.

When designing the study and prior to the interviews I had a very naïve and narrow understanding of the concept of a birth story. I had been clear that a ‘story’ was ‘*the depiction of an event or series of events*’ (Banks-Wallace, 2002, p. 411) and that, traditionally, storytelling in relation to birth was the way in which women prepared for the birth experience (by *talking to each other* and by making sense of the experience from the reflections of those who had been there already).

At the outset of this journey my understanding of ‘storytelling’ was as a ‘*speaker enrapturing an immediate audience*’ and of stories being spoken and heard in a ‘classic’ model where the story is a ‘*personal, intimate, analog thing*’ (Alexander, 2011, np). However as I started data collection with the women birthing in the 21st century I was forced to question this, as the women talked about groups they had attended, books and newspapers they had read, forums they had accessed, websites they had used and television programmes and films they had watched. In my research journal I jotted down some thoughts:

“Two women interviewed to date – their sense of what a birth story is appears different to mine, is it what somebody tells you face to face? Is it what you read on a blog? Is it something you read in a newspaper or watch on the news? Is it the recounting of a birth or is it something about a particular aspect of birth? Do I need to reconsider my ideas?” (Journal entry 05/11/12)

As I struggled to get to grips with what I was eliciting I found myself worrying that I was ‘going in the wrong direction’. I was anxious that the study would lose the sense of ‘story’ and continued with my musings:

“Is the virtual community more real to them than concrete one? We no longer live in communities of extended families – am I idealising the idea of community – support – conversation – story? Is sense of speaking to other women about birth lost?” (Journal entry 05/11/12)

One of my supervisors helped get me ‘back on track’ assuring me that everyone ‘*feels a wobble*’ as they start to engage with the data and reassuring me that I was eliciting some “*great insights into what and who influences women as they consider their birth*”. Perhaps what I was encountering (what I initially perceived as ‘non-story’ sources) were in fact the ‘*modern birth story*’?

At this stage I looked to the literature for direction and guidance about *what a story is* and *what it is not* and in doing so encountered the ‘Freytag pyramid’; a pictorial tool devised by the German novelist Gustav Freytag in 1863, and used by him to describe and analyse plot structure. The pyramid refers to five dramatic story arcs in a customary sequence; exposition or introduction, rising action, climax, falling action, and a conclusion or denouement (Alexander, 2011). I read about the sense of story as a ‘*meaning-vehicle*’ which has engagement at its core; where stories are that which pull in the viewer/listener/reader and I read about stories as consisting of ‘*selections from the set of available cultural practices, crafted to represent events*’ (Alexander, 2011, np).

As I read I recognised that stories in the twenty first century could be fashioned from a single medium or could stretch across a myriad of mediums; I started to understand that people in the world today tell stories ‘*with every new piece of communication technology we invent*’ and that as such stories are ‘*events conveyed to an audience through the skilful use of media*’ (Alexander, 2011, np).

For the purposes of this thesis I determined that a story was ‘*simply a thing, any media object, which demonstrates this clear (story arc) sequence*’ and which has the capacity

to engage its audience (Alexander, 2011, np). The focus of the study, originally pivoting purely on what women hear from one another in the form of a personal oral story, widened to reflect the variety of different story mediums women share and use to prepare for birth and, in doing so, potentially 'construct' their own birth story. In the context of these musings my research aim evolved:

My research aim is to describe and consider how engaging with stories of birth influenced expectations and experiences of childbirth for two generations of women. For this purpose, birth stories encompass personal oral stories as well as media and other representations of contemporary childbirth, all of which had the potential to elicit emotional responses and generate meaning in the interlocutor.

1.4 Original Contribution

Contemporary literature relating to childbirth appears to be primarily concerned with issues of safety and risk and/or place of birth (Sandall, Hatem, Devane, Soltani and Gates, 2009; Wax, Lucas and Lamont, 2010). A smaller number of studies consider the meaning of birth and its impact on women's lives (Callister, 2004; Dahlen, Barclay and Homer, 2010; Humenick, 2006; Nichols, 1996). Of these few question how women understand the meaning of birth prior to the experience and there is little consideration of the influence that other women's stories may have on primigravid women's understanding of birth. This in-depth qualitative study was unique in that it considered how women from two different generations came to understand birth both in the context of their own experience as well as in the context of birth stories.

Two generations of women were included as I was interested in the notion of shared understandings around birth and where they might come from. I wanted to learn something about '*women's ways of knowing*' about this significant life event (Belenky,

Clinchy, Goldberger and Tarule, 1997), and about the transmission of birth stories from one generation to the next. I imagined the varying *landscapes of birth* between the generations; the differing conversations that may have taken place, the different story mediums they may have relied on and the different expectations and experiences that may have played out.

As the first phase of the study came into being the second phase started to evolve; the conversations I had with the first cohort of women (first-time pregnant women giving birth in 2013) and the interpretations I made led to more ideas to follow up. Specifically I started to think about whether the information gleaned from the modern birth story creates meaningful knowledge about birth for women. I was especially concerned that the women of today rely heavily on virtual sources of information (including the internet and popular reality television programmes) which could be described as disembodied mediums. I wasn't sure whether these mediums help women to foster real knowledge.

I wanted to find out what types of stories an older cohort of women (who were pregnant in the 1970s –1980s) used to try and understand what their experience of birth might be. I wanted to know whether women in this era shared and learnt from stories of birth and what types of story medium they might have relied on. I felt it would be valuable to find out how this group of women understood information gleaned from stories in their pregnancies; to see how they translated information into knowledge and whether they were able to subsequently turn that knowledge into meaningful understanding.

I was interested in determining how effective the information that women access is in increasing their knowledge and fundamental understanding of birth. Ultimately I wanted to establish whether the information women get from the stories they engage with creates meaningful knowledge for them.

The study is unique because very few researchers have studied pregnant women as seekers of information and none, to my knowledge, have considered whether information delivered via a story medium (virtual or otherwise) has the potential to increase knowledge and understanding. This is surprising in a context where women are exposed to media representations of childbearing and parenting and where many believe that being informed is *'foremost among the responsibilities of pregnancy'*, (Browner and Press, 1997, p. 117).

1.5 Childbearing and Midwifery in the UK Today

The world we live in today is a complex one; a world fashioned by science and technology, mass communication, a world with a global economy, a world where living patterns are more and more varied, and where a dependence on consumerism and material fulfilment may impact on our emotional and spiritual wellbeing (Pilley Edwards and Murphy Lawless, 2006). These complexities, according to sociologists, constitute a *'risk society'* within which each new development brings a different set of risks (Beck, 1992; Bauman, 1992).

Childbirth and midwifery are in a relatively unique space in this 'risk society'; rates of mortality and morbidity have been cut dramatically in the post-industrial world but at the same time the ascendancy of medicalised birth has brought with it a huge emphasis on risk. According to Scamell (2011, p. 987) midwives in contemporary practice are tasked with *"attempting to instil a sense of confidence in the mother's embodied ability to give birth to her baby spontaneously while concurrently attending to an array of risk focused tests and measurements"*. The notion of risk and childbirth is explored further in chapter 2, section 2.14.5 page 59.

Alongside the concept of risk, childbirth in the UK today is also faced with an increase in '*human agency and choice*' (in the childbearing mother) and with an increasingly more complex maternal population; an ethnically diverse and medically complicated group of women many of whom will require tertiary level care (Scamell and Alaszewski, 2012, p. 208; Coxon, Sandall and Fulop, 2014). Further our world of birth is faced with a woman's growing expectation of both the '*perfect baby*' and the '*perfect labour*' (Surtees, 2010). Notions of choice and the commodification of birth are explored in chapter 2, section 2.14.2 page 54 and section 2.14.4 page 57.

The information landscape surrounding birth is also far more complex than in previous generations. Women in the 1970s and 1980s for instance, shared and heard stories, read books and attended classes. Women today share stories (both in person and 'virtually' on internet forums and blogs), attend classes, receive literature (and in some cases DVDs) from health professionals and Hospital Trusts, utilise 'Apps' on their smart phones, access websites, watch TV programmes and buy magazines full of stories about celebrity mothers and their babies.

In my thesis I consider how pregnant women in a previous generation (and differing childbirth landscape) prepared to birth and to mother and how pregnant women today do the same. I wanted to understand these women's experiences and determine whether anything could be learnt to inform and improve antenatal education and potentially women's representation of and experience of birth.

1.6 The Significance of the Study to Contemporary Practice

My study is a small part of a jigsaw which seeks to improve the picture of birth in the modern Western world. The medicalization of birth and the discourse around the medical and midwifery models of birth has been debated long and hard and yet the

dichotomy continues. At the beginning of my study I had a strong sense that *the way we talk about birth has a huge impact on the way women experience birth*. These ideas are explored in the body of this thesis; in my conversations with the research participants and in my interpretation of their experience of engaging with stories of birth in pregnancy.

1.7 Architecture of Thesis

This thesis consists of eleven chapters:

Chapter one is a 'window' to the thesis exploring my starting point, the aim and relevance of the study and its context and significance. The architecture of the thesis is presented.

Chapter two provides the background to the study in terms of the landscape of birth in the UK both in the 1970s-80s and today. An introduction to the history and prevailing narratives of the world of birth is given and key concepts and areas for discussion are introduced.

Chapter three develops the background to the study by exploring the place of stories and storytelling within our culture; the notion of the 'story' is defined, and the function, structure, capacity and power of stories are discussed.

Chapter four considers the study in the context of the literature and explores the idiosyncrasies of engaging with the literature in a hermeneutic study. The concept of '*inclining towards*' the literature is explained and reviewing as '*moving thinking*' discussed.

Chapter five justifies decisions made in relation to the design and organisation of the study, introduces the methodological framework and explores my presuppositions. The two main philosophers guiding the study are introduced and key philosophical concepts and Heideggerian notions are introduced.

Chapter six discusses the methods used to bring the study to life and the interpretive process employed in the study. The chapter closes by introducing the three 'aletheia' chapters which present the emergent meanings and understandings evoked in this thesis.

Chapter seven uncovers the aletheia '*Stories are difficult like that*'.

Chapter eight uncovers the aletheia '*It's a generational thing*'.

Chapter nine uncovers the aletheia '*Birth in the twilight of certainty*'.

Chapter ten is the discussion chapter. The central interpretive findings are presented and explored and the unique contribution of the thesis to midwifery knowledge is considered. The strengths and weaknesses of the study are discussed, including how the limitations of the study may affect the usability of its findings. Implications for practice are determined and I make recommendations for further research highlighting what remains unknown about the phenomenon. I close by considering my impact on the research and my experience of the PhD journey.

Chapter eleven is the conclusion synthesising the threads across the chapters and highlighting the thesis of the thesis.

CHAPTER 2 - BACKGROUND:

THE CONTEXT AND LANDSCAPE OF BIRTH

“Before they’d left the inspection room Jay had surrendered her clothes and changed to a white hospital gown, willingly agreed to a pain-killer, an injection of diamorphine. Their midwife said that was the sensible thing. Disposing of her plastic gloves to a pedal bin, she told them Jay was four centimetres dilated and doing very well, but the baby would now need to be monitored; it might also become drowsy, forget to breathe when it was born.”

“He stood close to Ella’s clipboard and read through their ‘Birthplan’. There was to have been no medication, and no technology; Jay was to be free to move around, unattached to any machine”.

(Excerpts from ‘Common Ground’ by Andrew Cowan, 1996, np)

2.0 Introduction to Chapter

This chapter provides the background and context for the study depicting the history and landscape of childbearing and maternity care in England in the UK; throughout the chapter the emphasis is on the experience of childbearing women rooting the thesis firmly in their domain. Chapter three, which follows, develops the background in terms of the place of stories and storytelling within that culture.

The chapter starts with an introduction to the sociological context of birth and maternity care and the private and public nature of the birthing experience. Next an outline of the midwifery and medical models of care is given demonstrating the context of care for women. The more persuasive discourses underpinning and sustaining the world of birth

are considered. An outline picture of birth prior to 1900 is presented, and significant moments in the history of maternity care are highlighted illustrating the context of practice for midwives as ‘*attendants at the entrance to society*’ (Kirkham, 2015) and the realities of birthing for the childbearing woman. Finally the chapter considers the two eras from which the participants for this study were recruited and ends by exploring key drivers and pressing issues in modern maternity care.

2.1 The Sociological Context of Birth

“The experience of maternity, whether as a mother or as a care giver, has never existed in a social vacuum” (McIntosh, 2012, p. 12).

Pregnancy and birth are biological experiences which occur in a defined socio-cultural context. This context is complex and multi-faceted; how a woman experiences birth will depend on societal values, viewpoints and fundamental belief systems. Ideas and beliefs about matters such as, family, ritual, health, technology, medical control, gender, women’s rights, and professionalism, capitalism, power, risk, ‘surveillance’, the concept of ‘good’ and ‘bad’ births and ‘good’ and ‘bad’ mothers, and the corporeality of women’s bodies, will all have a bearing on the expectation and experience of birth for individual women (McIntosh, 2012; Kingdon, 2009). MacIntyre (1977, p. 18) explains this further highlighting that pregnancy and parturition are ‘governed’ by societal ‘rules’ and norms:

“Where the birth is to take place, who is to be present, the position in which the woman labours and delivers, how she is to behave during childbirth - these matters are rarely left to the discretion of the parturient woman but are the subject of social controls and sanctions”.

In this sense the economic and social climate, and cultural context in which a woman lives will, in fact, to a degree ‘*mediate her biology*’ (Smolek, 2004, p. 1).

2.2 Childbirth as a Personal and Public Experience

“My neighbours - the people I didn’t know and would never know who nonetheless used the same dry cleaners and waited at the same stoplights - tended me with fascination. They traded benevolence for participation. As I later learned was so common, they felt the uncommon suspense of an imminent birth and wanted to be in on the drama.” (Pollock, 1999, p. 2).

Childbirth is a profoundly personal experience which normally takes place in a very public sphere. In pregnancy women’s bodies and lives become almost unwittingly part of the accepted rhetoric; without invitation people comment on and touch women’s abdomens (normally offering opinion on the size of the woman’s bump and her expected due date), speculate on the baby’s gender (based on their observations), ask intimate questions about how the woman is experiencing her pregnancy, offer unsolicited advice about birthing, and share stories of their own experiences. Women are asked questions about their working lives, their relationships, their choices during pregnancy (for instance about whether they have opted for ultrasound scans and screening) and their plans for labour, birth and mothering. Often the people asking the questions will offer (and at times impress on women) their personal opinions about those matters.

I would suggest that in these exchanges and observations societal norms and conventions about birth and mothering are reiterated and reinforced (I explore this idea in further detail in the findings and discussion chapters pages 175-274). This idea is considered in the chapter *‘Does the world move after women talk?’* written by Bastos, Chaves and Calaca (2012) as part of the *‘The Cultural Dynamics of Women’s Lives’* book:

“Throughout their conversational flow, women exchange information. Change ways of viewing, and understanding the world surrounding them, and establish the possibility of construction of new meanings and understandings of the world. Therefore, women’s conversations and their narratives not only provoke

the emergence of new meanings in the individual sphere, but they also promote the construction of shared/collectivized meanings". (Bastos et al, 2012, p. 554)

It seems clear that women do not experience pregnancy and birth in seclusion. Instead they experience this fundamental life event as a member of the society in which they live; a society which 'dictates' conventions and in which a profoundly personal event becomes part of the collective experience.

Having established the wider context of birth I move on to consider the two main models underpinning the care offered to women in England in the UK.

2.3 The Midwifery Model

The starting point of the midwifery or social model of care is that pregnancy and childbirth are normal life events. The model is directed at healthy women experiencing low-risk pregnancies. The model has the woman at the centre and the midwife providing continuity of care. According to the 2011 Position Statement of the International Confederation of Midwives (ICM) in most areas of the world midwives are the acknowledged autonomous health professional for childbirth. The ICM define the midwife's scope of practice in the following terms:

"The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for new-born and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures". (ICM, 2011)

The midwife has a duty to monitor the physical well-being of the woman and fetus/neonate but also a duty to monitor the woman and her family's psychological, spiritual and social wellbeing throughout the childbearing period (Hattem, Sandall, Devane, Soltani and Gates, 2009).

Midwifery models may vary according to institutional policies and guidelines however they will all have a philosophy of normality and a belief in the natural ability of women to experience birth without routine intervention at their core. Care in this model engages with the idea of childbirth as a 'social' entity, recognising it as an immensely personal experience, a significant life event which encompasses much more than the outcome of a healthy baby (Bryers and Van Teijlingen, 2010).

2.4 The Medical Model

The basis of the medical or scientific model of birth is a belief that 'normal' childbirth requires medical control to guarantee safety (Van Teijlingen, 2005). In this model birth is only 'normal in retrospect' and, as a process needs to be monitored to enable early intervention in the face of any complications (Percival, 1970; Savage, 1986; Bryers and Van Teijlingen, 2010). Earle (2005) argues that the medical model assumes that the female body is likely to fail, whilst Hunter (2006, p. 120) maintains that the medical model operates on the basis of '*three Cartesian principles*': that the mind is separate from the body, that the body can be 'fixed' like a broken machine, and that the 'science' of medicine and disease are based on logic and reasoning rather than on emotion and on sociocultural context.

In the medical model birth is managed by obstetricians; doctors who deal with pregnancy and childbirth and whose practice is grounded in science and pathology. Van Teijlingen (2005) explains that from this perspective risk assessment, statistical

measurement (through mortality and morbidity figures) and 'disease' management are paramount. Pregnancy is treated as an illness and birthing women are classed as patients under the care of a doctor.

Table 1 gives an overview of the two models of care and is sourced and adapted from Bryers and Van Teijlingen (2010).

Table 1: Models of Maternity Care

<i>Midwifery or social model of birth</i>	<i>Medical or scientific model of birth</i>
<i>Physiological/natural</i> - all will be well until something goes wrong	<i>Scientific</i> - can only be normal after the event when nothing has gone wrong
<i>Intuitive</i> - rely on experience, relationships and instincts as to what is right or wrong	<i>Medical</i> - aims to reduce maternal and infant mortality and cure rather than prevent
<i>Social</i> - family and community orientated	<i>Medically-led</i> - professional in charge
<i>Holistic approach</i> - link between social structures and health to attain state of wellbeing	<i>Control</i> - birth in hospital enabling medical staff to be in control
<i>Qualitative</i> - importance of a good experience for women and their families	<i>Quantitative</i> - task orientated, checking observations
<i>Subjective</i>	<i>Objective</i>
<i>Spiritual</i> - part of wider culture	<i>Treat the problem</i> - treat disease (pregnancy) rather than care of the whole - anticipate problems
<i>Environment</i> - central to model	<i>Environment</i> - peripheral to model
<i>Local community focus</i> - women give birth at home or in a local community, supported by family and friends - her choice	<i>Centralised hospital maternity services</i> - birth in hospital seen as the safe option
<i>Feminine</i> - woman-centred, respectful and empowering, woman feels in control	<i>Masculine</i> - paternalistic, empowerment of the medical profession

<i>Outcome</i> - aims at live healthy mother, baby and satisfaction of mother/family	<i>Outcome</i> - aims at live healthy mother and baby
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There is a vast amount of discourse in the literature on the two models of care. Almost without exception the midwifery model is presented as the best possible model for the childbearing woman and her family whilst the medical model is associated with negative connotations of service provision and care (Thomson, 2007). The basis of these perspectives is discussed in the next part of the chapter which considers the more pervasive narratives underpinning and sustaining the world of birth.

2.5 Childbirth Discourse

“Language is not an abstract system of normative forms but rather a concrete heteroglot conception of the world. All words have the ‘taste’ of a profession, a genre, a tendency, a party, a particular work, a particular person, a generation, an age group, the day and hour. Each word tastes of the context and contexts in which it has lived its socially charged life” (Bakhtin, 1981).

It is clear that the language and terminology we use to describe childbirth influences our understanding of the phenomenon. Further the discourse pervading birth is a significant factor in determining how the phenomenon is socially constructed and lived in our society (Hewison, 1993). McIntosh explains this concept in her text on the social history of maternity and childbirth arguing that *“the way maternity is viewed by Society has a huge impact not only on the way that the service has developed but also the kinds of stories which are told about it”* (2012, p. 6).

In her formative work, *‘Women writing childbirth’*, Cosslett (1994, p. 4) outlines *‘medical discourse’* and *‘natural childbirth discourse’* as the two most influential and socially accepted discourses in our culture arguing that both have *‘the power to shape the way*

childbirth is conducted and organised'. These discourses of birth epitomise opposing interests; very broadly obstetricians with the former (who view childbirth as potentially pathological and only normal in retrospect) and midwives with the latter (who view childbirth as a holistic, woman-centred event which is normal until it deviates from normal parameters). Both groups have the power to influence choices made and to exert an effect on the experience itself. Walsh (2010, p. 86) suggests that, unfortunately, women's experiences of birth fit somewhere in the '*uneasy space between the two*'.

2.6 Medical Childbirth Discourse

"Medicine has successfully laid claim to birthing power/knowledge and is thus constructed as a 'dominant discourse' in relation to maternity care. The substantial claim to birth expertise by the medical profession was founded, not in evidence, nor due to an inevitable scientific superiority of medical practice, but through a complex series of claims to power/knowledge." (Newnham, 2014, p. 256).

The medical discourse surrounding childbirth had its starting point in the scientific revolution of the seventeenth century. At this time nature was conceptualised as a machine that could be regulated by man. Descartes is considered the original source for the mechanization of the human body, arguing in his text '*Treatise of Man*' that, "*I suppose the body to be just a statute or a machine made of earth*", and ascribing a person's sense of identity to his mind; an idea known as 'Cartesian dualism' (Gaukroger, 1998, p. 99). Understood from the mechanized point of view the '*reduced*' body is an abstract, universal thing that is subject to physical and chemical laws and is, as a result, stripped of its lived context (Marcum, 2004, p. 313).

The mechanical metaphor particular to birth is believed to have started in seventeenth-century French hospitals when the uterus was described as "*a mechanical pump that in particular instances was more or less adequate to expel the fetus*" (Wertz and Wertz,

1977, p. 32). According to Martin (1989, p. 54) the medical metaphor continues to dominate obstetrics and both “*underlies and accounts for our willingness to apply technology to birth and to intervene in the process*”. In this analogy the woman’s body is the machine and the doctor the mechanic who ‘*repairs*’ it. Also relevant is the conception of the fetus as the ‘product’, “*the child is seen as an object created by the mother, in the same way as a commodity is created by a worker*” (Mitchell, 1971, p. 181).

Marcum (2004) considers the consequences of this mechanized understanding, suggesting that when a person’s body is fragmented into parts and standardised to conform to particular criterion (as deemed appropriate by the medical community), it becomes estranged from the self and from other people. In this situation the person no longer has control over their own body or experience. Further the feminist critique views the medicalisation of childbirth (and the place of male obstetricians within the medical system) as a means of controlling and wielding of power over women’s bodies and reproduction (Prosen and Krajnc, 2013).

In his critique of modern society, Foucault explores these ideas describing the human body as a ‘*subjected, practiced and docile*’ body which enters “*a machinery of power that explores it, breaks it down and rearranges it*” (1988, p. 138). Foucault maintains that within institutions such as schools, hospitals and prisons, the body’s time and space is rigidly controlled and regulated by the various activities of the institution. Certainly this fits in with the definition of medicalisation suggested by Brubaker and Dillaway (2009) who describe it as a mechanism of social control through medical scrutiny and surveillance.

2.7 Natural Childbirth Discourse

The term 'natural' childbirth is used to define a distinct system of ideological beliefs and practices related to childbirth. The notion of 'natural' was established in the 1950-60s in Europe when midwives, patient's rights organisations and feminists started to criticise the mechanistic understanding and treatment of the female body as well as the reproductive processes employed by the medical profession (Borozdina, 2014). 'Natural childbirth' and its supporters gathered momentum from the works of Grantly Dick Read (a British obstetrician and the first president of the 'National Childbirth Trust' in the UK) and Fernard Lamaze (a French obstetrician).

In his book '*Childbirth without Fear*' (2013) Dick Read maintained that extreme pain during childbirth results from muscular tension caused by fear; he argued that pregnant women should learn about the birth process and about breathing techniques and exercises to aid relaxation as a means of reducing their tension. Similarly Lamaze introduced the 'Lamaze method', the use of distraction techniques, to aid relaxation (Lamaze, 1956). Both men helped move the emphasis from a woman's '*objectified body*' (exemplified in the medical discourse) to her '*subjective state of mind*' (as epitomised in the natural childbirth discourse), (Cosslet, 1994, p. 9).

Although not immediately obvious, the 'natural' childbirth discourse has a number of likenesses with medical discourse. According to Arney (1982) both are grounded on a Cartesian dualism; the medical model concentrating almost entirely on the bodily dimensions of birth and the natural model on the psychological or emotional. Zadoroznyj (1999) argues that bodily control is fundamental to both models; in the medical model power is exerted by those in a position of medical authority and in the natural model power is exerted by the woman's own mind over her body. Belu (2012, p. 10) clarifies this further explaining how "*an ever-elusive 'nature' then is controlled and optimized*

through a personalized integration of technique rather than being externally regulated by technology”.

Having examined the more pervasive childbirth discourses I continue by giving a picture of birth in England from the 17th to the 21st century; tracing the social norms and conventions of the birthing culture.

2.8 Birth Prior to 1900

Most women in England prior to 1900 were attended in labour by an experienced but untrained female midwife (McIntosh, 2012). Indeed until the 17th century childbirth indubitably took place in an all-female domestic setting (Mcintosh, 2012; Cahill, 2001). Midwives were always women, both for the sake of modesty and respectability, but also because they generally had personal experience of birth (Cassidy, 2007). Although midwives at this time (as was indeed the case of many women) were often unable to read or write they were valued and respected members of their community. During this era women became midwives through ‘*an informal apprenticeship model*’ attending births with other midwives (McIntosh, 2012, p. 27). Those midwives, who were ‘licensed’, were licensed by the Church and the license affirmed to the ‘*good character*’, competence and experience of the individual (Forbes, 1971, p. 352; Arney, 1982).

Birth at this time was ‘*simply part of the moral order of the universe*’ and midwives were part of the institution of midwifery there ‘*to be with*’ women and support them as part of the natural childbearing process (Arney, 1982, p. 23). Although most mothers and babies survived birth there was a high possibility of poor outcomes. Loudon (1991) estimated that in the early eighteenth century, one thousand women died for every one hundred thousand births. At this time when a birth was not expedited within a timely manner, or when there were ‘complications’, a midwife would normally call a ‘surgeon’

to help manage the birth. These male 'barber-surgeons' (medical practitioners who performed surgery and were members of a professional guild) owned instruments which they used to extract babies from their mothers (Amey, 1982).

By the late eighteenth century men had started establishing themselves in various medical fields including midwifery, meaning that their involvement in birth became more commonplace. Their involvement was seen by many as part of the universal advancement of scientific enquiry and the wider development of medicine, instigated '*in the light of the quintessential Victorian belief that things could be improved*' (McIntosh, 2012, p. 27). At this time new ways of thinking about the body '*drawn from developments based on classification, measurement, mathematics and mechanics*' were becoming increasingly important (King, 2012, np). These early doctors were different to midwives as rather than having '*hands-on*' experience they were '*book-trained*' (Cassidy, 2006). Being cared for by a doctor (who was more expensive to engage than a midwife) soon became popular with middle class women who believed that being able to afford a doctor gave them a higher status (Cahill, 2001).

2.9 1902 Midwives Act

The 1902 Midwives Act formalised the regulation of midwives establishing a statutory body called the Central Midwives Board (Kirkham, 2010). The Board, populated nearly entirely by doctors, controlled entry to the profession through training and examination, (Pitt, 1997). Discourse about public accountability and concerns about the health of the population were fundamental in the development of the 1902 Midwives Act (McIntosh, 2012). It was noted at the time that maternal mortality was 1 in 200 where midwives were untrained, as opposed to 1 in 1000 when midwives had been trained (Turner, 1902). The Act was the first of a succession of different Acts '*increasing state involvement in public health, especially maternal and infant health*' (Kirkham, 1998, p.

127). State involvement saw the move of midwifery practice from the private to the public sphere and the workplace of the midwife increasingly move from home to institution (Marland and Rafferty, 1997).

2.10 From Home to Hospital

Originally hospitals for women were not proposed as places for labouring and birthing but as specialist sites with inpatient facilities for those women suffering from disease or trauma (McIntosh, 2012). In the eighteenth century, however, came the development of hospitals as a place for women to give birth. '*Lying-in hospitals*', generally charitable institutions such as the '*Lying-In Hospital for Married Women*' in London which opened in 1749, became more and more popular; the hospitals provided the poorest and usually most vulnerable women with somewhere to birth (King, 2012).

A reading of the literature on maternity care and place of birth illustrates that many take an essentially feminist view, arguing that hospital birth was engineered by doctors as a means of taking control of childbirth (Arney, 1982; Oakley, 1986; Martin, 1989; Donnison, 1988; Cahill, 2001). This argument sees the advent of forceps, and the ability of the male barber surgeons to potentially save the life of women and babies, as pivotal in the development of obstetrician roles with enhanced expert and subsequent power status over midwives, women and childbirth. The argument being that surgeons kept custody of, and further developed the medical knowledge attained at difficult and dangerous births; knowledge which began to systematically dispute and devalue midwifery knowledge (Wertz and Wertz, 1989, p. 30).

What this perspective neglects to explain is the fact that many women chose doctors to attend their labour and chose hospital as a place to birth (Wertz and Wertz, 1989). Many

women dreaded childbirth where pain and death remained realities and doctors, who were considered more knowledgeable, came to '*have the promise of more safety and even more respectability*' (Wertz and Wertz, 1989, p. 47). Women birthing at this time no doubt wanted "*freedom from the pain, exhaustion, and lingering incapacity of childbirth*" (Riessman, 1983, p. 52).

Childbearing problems in that era were exacerbated by difficult working situations and challenging, overcrowded housing conditions; hospitalisation for birth, in these circumstances, may well have been seen as beneficial. Indeed the lobbying organisation, 'Association for Improvements in Maternity Services' (AIMS) was set up as late as the early 1960's to fight for more hospital beds for childbearing women (Allsop, Jones and Baggottl, 2004).

Undoubtedly the move from home to hospital was also seen by many as an 'advance' in keeping with the scientific revolution. It was thought that obstructed labour and other birth complications could be managed more effectively in institutions (De Costa, 2002). However, despite claims and beliefs about the safety of birth in these early hospitals, perinatal mortality rates at this time were extremely high (Newnham, 2014). In England in the period 1870 to 1890 forty per cent of maternal hospital deaths were due to infection (Loudon, 2002).

Puerperal fever or 'childbed fever' as it was commonly known, was not understood and was mistakenly believed to be a condition 'peculiar' to women in labour (De Costa, 2002; Zwelling, 2008). There was no conception of the links between contamination from birth attendants to women through unwashed hands and dirty instruments meaning that the potential risk of infection to women birthing in a hospital setting was not recognised (Loudon, 2013).

By the early twentieth century the hospital had, little by little, become the favoured place for labour and birth. Davies (2013) describes how between 1963 and 1972 the rate of hospital deliveries in England and Wales rose from around sixty eight per cent to ninety one per cent, stressing that from 1975 onwards, it was never lower than ninety five per cent. According to McIntosh (2012) many women wanted to birth in hospitals promising the latest technology and means of pain relief. Unfortunately however, the reality of their experience was often different from what they had imagined and women found themselves *“left alone in labour, and encouraged to accept interventions that they did not necessarily want or need”* (McIntosh, 2012, p.158).

The move from home to hospital was pivotal in the history of birthing; birth as a normal, natural, and potentially life affirming event, requiring little intervention and taking place in the heart of the family was ousted and usurped. It was replaced by an understanding of birth as a medical event; an event which needed managing and ‘containing’ within a hospital setting (Zwelling, 2001; Newnham, 2014).

2.11 The Foundation of the NHS

The establishment of the NHS in 1948 meant that care for women and their families became free at the point of delivery and at the point of need (McIntosh, 2012). However other than the evident financial advantage (women did not have to worry about finding money to pay for their care) the founding of the NHS initially had little effect on maternity services; midwives were still the primary caregivers for women and birth still increasingly occurred in hospitals. Maternal and infant mortality continued to fall and despite rhetoric about obstetric intervention accounting for decreasing maternal mortality rates the literature indicates that increases in living standards and cleanliness as well as improved eating habits and nutrition levels were as important to this outcome (Newnham, 2014; Cahill, 2001).

In the period of 1948 to 1974 maternity services echoed the tripartite system of the NHS; accountability was divided between hospital services, General Practitioners (GPs) and local authority health services. There was no overarching policy for maternity services in place until the 1959 Report of the Maternity Services Committee (*'The Cranbrook Report'*) which set a target for seventy per cent of all births to take place in hospital (Davis, 2013). In 1967 the 'Maternity Advisory Committee' was asked to think about the future of maternity services. The committee published its report, the *'Peel Report'* in 1972, recommending that one hundred per cent of labours and births should take place in the hospital setting with care being provided by teams made up from consultants, GPs and midwives. Although it was not explicitly stated the suggestion of the report was that hospital was the safest place in which to birth. However there was no evidence to support this and the policy did not take into account what women wanted (Davis, 2013).

2.12 The 1970s-80s

"It may seem a strange principle to enunciate as the very first requirement in a hospital is that it should do the sick no harm" (Nightingale, 1863).

Maternity care in this era was driven by technological change and development. The era saw the introduction of new forms of antenatal testing including the ultrasound scan. Initially used as a diagnostic tool in high risk pregnancies, ultrasound, used to view the fetus, estimate gestational age and identify anomalies, quickly became a customary part of antenatal care; a part welcomed with open arms by the majority of women who saw it as an early opportunity to visualise their baby (Davis, 2013). Intervention in the normal progress of labour also became widespread at this time. Interventions such as induction, artificial rupture of the membranes, the use of oxytocic drugs and the incidence of episiotomy increased. Indeed in 1974 the number of inductions had jumped to forty one per cent from just fifteen per cent in 1965 (Davis, 2013).

The use of electronic fetal monitoring (EFM), which was initially conceived as a means of preventing adverse fetal outcomes such as cerebral palsy, also became part of the routine picture of care at this time. At the time of its inception no randomised controlled trials had been carried out on EFM; it was unilaterally adopted into practice on the theoretical understanding that it would drastically reduce fetal neurological injury (Martin and Chester, 1998). Incredible as it may seem, “*an entire generation of obstetricians, nurses, and midwives accepted the promise of experts that EFM placed them in control of the birth process and the baby’s neurologic viability and future. It was so simple: monitor, interpret the pattern, and quickly do a C-section or instrumental delivery on any baby experiencing an ‘abnormal’ pattern as defined by experts*” (Sartwelle, 2012, p. 319).

The first prospective randomized controlled trial (RCT) of EFM was reported in 1976 by Haverkamp, Thompson, McFee and Cetrulo. It studied 483 high-risk obstetric patients in labour and showed no EFM benefit compared to intermittent auscultation. What it did show, however, was a strikingly higher incidence of caesarean section (Sartwelle, 2012; Haverkamp et al., 1976). Sartwelle (2012, p. 325) reports that by 1995 twelve RCTs of EFM had been published and that ‘*all had concluded EFM had no measurable impact on morbidity and mortality*’ (with the exception of the ‘*questionable benefit*’ of a reduced rate of neonatal seizures).

During this time public opinion about increased interventions and their iatrogenic effect was mounting and various organisations, such as the ‘Association for Improvements in the Maternity Services’ (AIMS), built upon rising public opinion to push for a new approach to maternity care. Significantly at this time there was increasing public, media and eventually parliamentary readiness to debate childbirth (Davis, 2013). The National Childbirth Trust (NCT) for instance were especially virulent about the rates of intervention and the medicalisation of birth and, by the 1980s, “*explicitly espoused the*

'right to choose' in a way it had never done before" (Davis, 2013). McIntosh clearly vocalises the voice of many women at that time who felt that, *"their control over the experience of birth was being eroded by the emphasis on physical risk, on time limits and on statistical measurements of safety and success"* (McIntosh, 2012, p. 128).

Policy responses to public opinion about issues such as decreasing interventions, ending routine procedures, becoming more attuned to women's needs and, facilitating birth outside of the hospital setting, were often slow. The 1977 report *'Reducing the Risk'* was adamant in its assertion that even if a woman is 'low risk' one cannot be certain that birth will be normal until it is over. This and the claim that hospitals were better able to cope with emergencies and that potential delays in getting women between home and hospitals could be harmful were still very much part of the rhetoric of the Department of Health (DOH) and the drivers for services at the time (Davis, 2013). This remained the case into the 1980s.

2.13 'Changing Childbirth'

By the early 1990s there had been a notable change in policy thinking about maternity services. The *'Winterton Report'* of 1992 argued strongly that there was no evidence to support one hundred per cent hospitalisation for birth and criticised the fact that the medical model of care largely dominated clinical practice (Hunter, 2012). The *'Changing Childbirth'* report published in 1993 by the Expert Maternity Group built on the findings of the *'Winterton Report'*. The two reports were fundamental in shifting the perception of hospital being the safest place for birth. The reports *'enshrined'* the notion of woman-centred care and emphasised the importance of the psychological, social, spiritual and physical care of women. *'Changing Childbirth'* was seen by many as a 'watershed' in the history of maternity care; enabling women to start exercising *'choice' and 'control'* over their birthing experience (McIntosh, 2012, p. 140). This report is discussed in

further detail in section 2.14.7 (page 62) where the notion of continuity of care as an element of women's choice is discussed.

2.14 Birth in the 21st Century

In the next part of the chapter I outline a number of the key drivers and pressing concerns of maternity care in England in the present day. These undoubtedly impact on a woman's expectation and experience of childbearing and maternity care and this impact is considered in more detail in the findings and discussion chapters. My dialogue is a brief 'glimpse' rather than a comprehensive and exhaustive review and adds to the picture I began to paint at the end of the previous chapter.

2.14.1 Government Policy and Practice Reality

The strategic policy document for maternity services, '*Maternity Matters: Choice, access and continuity in a safe service*' was published by the Department of Health (DOH) in 2007. The document stressed the need to provide high quality, safe and accessible services that are '*both woman-focused and family-centred*' (DOH, 2007, p. 8). The key aim of the policy document was to:

"improve the quality of service, safety, outcomes and satisfaction for all women through offering informed choice around the type of care that they receive, and improved access to services whilst ensuring continuity of care and support" (DOH, 2007, p. 7).

The document spoke of improving performance '*against quality and safety indicators*' and on promoting public health (particularly in respect of vulnerable women and their families).

Despite the government's rhetoric a report by the Healthcare Commission in 2008 found that staffing levels in maternity services were inadequate, that in some trusts continuity of care was lacking for women and that women experienced poor communication and support after their babies were born (Healthcare Commission, 2008, p. 5). Similarly a report by the Care Quality Commission in 2013 found that continuity of care, although acknowledged as important for a positive experience, was only being achieved in 34% of cases in the antenatal period and 27% in the puerperium (Care Quality Commission, 2013, p. 8).

More recently the government Public Accounts Committee published its 2013-2014 report into maternity services in England (HMSO, 2014). The report provided a helpful synopsis of maternity services advising that having a baby is the most common reason for admission to hospital in England, that in 2012 there were somewhere near to 700,000 live births and that there had been a surge in the number of 'complex' births (for example those involving women over the age of 40). The report also advised that in 2012-13 maternity care cost the NHS approximately £2.6 billion.

The Public Accounts Committee reported that generally women have good outcomes from maternity services and rate most of their care as '*very good*' or '*excellent*'. However the report also noted that there is inconsistency in the quality of care between trusts and that there continue to be inequalities in the experiences of different groups of women. Further the rate of stillbirths and babies dying within the first week of birth is higher in England than in other parts of the UK. The report commented that the DOH strategy for maternity services ('*Maternity Matters*') still has '*little grip in key areas and little assurance about performance*'.

2.14.2 Choice and the Childbearing Woman

Choice has been part of the maternity services agenda since the '*Changing Childbirth*' Report in 1993 and government policy documents such as '*Maternity Matters*' (DOH, 2007) continue to promote choice and control for women. The concept of choice in the context of maternity care however, is a complex and convoluted one; in the literature there is much discussion about whether choice is wanted by and/or possible for women accessing maternity care and I give a brief introduction to these ideas here (Kirkham, 2004; Hunt and Symonds, 1995; Jomeen, 2011; Edwards, 2004).

In Western culture it could be argued that '*choice is considered to be fundamental to responsible personhood*' the suggestion being that choice is at the disposal of everyone and can be freely made (Edwards, 2004, np). From a socio-cultural perspective (as discussed earlier in this chapter in section 2.1, page 34) one might argue that rather than being at the discretion of the individual, choice is fabricated through value and belief systems and the availability of resources. Edwards (2004, np) takes this idea further suggesting that childbearing women's choices in Western culture are not only defined by socio-cultural factors but also limited by a '*predetermined, medically orientated menu*' of options over which they have limited control. This has led to claims by some that choice in maternity services (favouring a medically led ideology), rather than making people feel free, can instead be '*oppressive*' and '*potentially coercive*' (Edwards, 2004, np; Browner and Press, 1997; Wagner, 1994).

A supposition that medical ideology has a monopoly on notions of risk and safety similarly makes choices for women problematic as Jomeen explains:

"Despite a desire to articulate their wishes, the responsibility to their fetus invested from the earliest point in pregnancy and informed often by medicalised notions of risk, does not enable them to do so. It also leaves them

at risk of blame and censure if those choices made are perceived to be the 'wrong' ones, which in turn then engenders guilt and positions them as 'bad mothers'." (Jomeen, 200, p. 62).

McLeod and Sherwin (2000, p. 267) explain how, in a health care environment, a person's autonomy, and by association their choice, is often reduced to an exercise of 'informed choice' as opposed to 'real' choice:

"The information provided is restricted to that deemed relevant by the health-care provider (and by the health-care system, which has determined what information is even available by pursuing certain sorts of research programs and ignoring others). Even in 'ideal' cases in which patients have strong autonomy skills and full access to all the available information, it is important to recognise the influence that oppression may have on the information base and, thereby, on the meaningful options available to patients".

In these circumstances it is easy to see why women may go '*with the flow*' when it comes to making choices; making choices essentially reflecting the policies of their local unit and the preferences of their care givers (Kirkham, 2004, np). Subject to a myriad of different and opposing discourses and influences it may simply be easier for women to take up the '*offer of a package of care*' which is assumed to be of the highest quality (Kirkham, 2004, np).

2.14.3 Authoritative Knowledge and Birth

"Within any particular social situation a multitude of ways of knowing exist, but some carry more weight than others. Some kinds of knowledge are discredited and devalued, while others become socially sanctioned, consequential, 'official', and are accepted as grounds for legitimate interference and action" (Jordan, 2014, p. 95).

There is an understanding in the literature that a society's essential value and belief system is nowhere more transparent than in its cultural treatment of the body (Davis-Floyd, 1994; Martin, 1989; Jones, 2012). More specifically Davis-Floyd argues that the

'dominant mythology of a culture' is displayed in the *'rituals'* which surround birth; rituals which in the western world are derived from what she describes as the *'mythology of technocracy'* (Davis-Floyd, 1994, p. 1125). In her work Davis-Floyd describes how the technocratic or industrialised model prevalent in many western societies (specifically North America), operates as an authoritative means of social control, manipulating childbearing women's values, beliefs, and ultimately their behaviours.

The dominance of one body of knowledge, according to Jordan (2014, p. 96) may be related to its *'efficacy'* or its *'structural superiority'* (stronger power base). In the case of childbearing, it is the biomedical model spearheaded by science and rationality, in which interventionist management is justified by uncertainty and a perception of risk, which dominates the western world (Martin, 1998; Kitzinger, 2003; Davis-Floyd, 1994; Belu, 2012; Arms, 1996; van Teijlingen, 2005).

Jordan describes how authoritative knowledge is *'persuasive'* because it appears to be reasonable and *'consensually constructed'* (Jordan, 1997, p. 58). In her work Davis-Floyd suggests that a technocratic birth process has become western society's rite of passage in childbirth arguing that the messages associated with concepts of pathology, risk and routine interventions have operated to socialise women into cultural beliefs about birth:

"Obstetrical procedures are in fact rational ritual responses to our technocratic society's extreme fear of the natural processes on which it still depends for its continued existence" (Davis-Floyd, 1992, p. 2).

Jordan takes this idea further still claiming that people accept authoritative knowledge (and in doing so endorse and strengthen it) and without even realising are actively involved in its *'routine production and reproduction'* (Jordan, 1997, p. 58).

2.14.4 The Commodification of Birth

Women in this era have been described as ‘*active childbirth consumers and decision makers*’ (Jomeen, 2012, p. 60). Largely driven by the media and reinforced by the consumer culture in which we live, there is an argument that childbearing as an experience, has been commodified (Jomeen, 2010). Sharp defines the concept of commodification:

“Commodification insists upon objectification in some form, transforming persons and their bodies from a human category into objects of economic desire” (Sharp, 2000, p. 293).

Women are depicted as consumers of maternity services to the extent that making decisions and choices (in order to raise the quality of their birthing experiences and enhance their emotional outcomes) has become something they must ‘buy into’. Scourfield suggests that the recipient of care must become increasingly ‘*entrepreneurial*’; a ‘*rational, calculating consumer, able to shop around*’ for the package appropriate for them (Scourfield, 2007, p. 108). The concept is explained by Kightley (2007, p. 477):

“Commodification may extend to the experience of coming to hospital, getting into bed, being monitored, being scanned, vaginal examinations, and identity bands for mother and baby. Bounty bags and countless other commodities and rituals. Media portrayals also hold out the promise of emergency procedures, overworked but dedicated teams of staff and machines that go ‘beep’ if one attends hospital for birth. These images and expectations are also part of our culture and tradition of birthing and women may feel short-changed if they haven’t been close to, or even received such intervention”.

The idea of commodification and birth is problematic; as discussed earlier in relation to choice and birth (section 2.14.2, pages 54-55), the problem with being able to ‘shop around’ and/or make choices is the availability (or not) of ‘real’ choice but also the fact that the promise of an experience (for instance birthing at home) may not be realised

and met (perhaps because there are not enough midwives to populate the on-call rota or because the woman does not fit the clinical criteria for that choice of birth place). Unfulfilled choice may leave the childbearing woman and her partner/family feeling distressed and disappointed, robbed of an experience and/or dissatisfied with the service.

Antenatal scanning is perhaps the best example of the commodification of childbirth; initially offered as part of antenatal screening the ultrasound scan is now an 'essential' part of the experience of pregnancy; understood by many as a ritual or rite of passage on the pregnancy journey. Indeed the scan '*provides a visibility to the fetus through which it turns into a baby*' (Jomeen, 2010, p. 35). Women can now purchase 3D and 4D scans as part of a consumer experience, these scans 'sold' to them on the premise of prenatal bonding and a relationship with their baby leading to effective future parenting.

One of the difficulties of this understanding of birth is the idea of the 'objectification' of women and the potential for the woman's body to be fragmented in a host of ways through their reproductive potential. In relation to the ultrasound scan and the personification of the fetus to baby, for instance, the woman's body is objectified and broken down into parts; her uterus becoming a container for a precious cargo. Indeed as Sandelowski tells us:

"Although fetal ultrasonography requires a female body to see through, an additional effect of the fetal sonogram is to make pregnant women so transparent as hardly to be seen at all. The fetal sonogram depicts the fetus as if it were floating free in space: as if it were already delivered from or existed outside the mother's body. Fetal ultrasonography creates the fiction of the independently viable fetus by erasing the pregnant woman without whom the fetus cannot exist" (Sandelowski, 1994, p. 240).

Sandelowski argues that the ultrasound may enhance men's experience of pregnancy from a relation of disembodiment to a '*human-machine relation to embodiment*' whilst simultaneously weakening women's experience of pregnancy as an embodied relation with the fetus by adding '*relations with a machine*' (Sandelowski, 1994 p. 241). Commodifying childbirth, as Kirkham (2004) argues, displaces the childbearing woman and undermines the cultural and spiritual significance of birth; normalising instead notions of birth in an industrial model of care.

2.14.5 *The Threat of Litigation and the Professional Response*

According to Anderson (2013) maternity claims are the most costly clinical negligence claims reported to the NHS Litigation Authority and the second highest by volume. In a summary of the data Anderson reports there were 5087 claims with a total value of £3.1 billion between April 2000 and March 2010. At first glance these figures appear startling but, as Anderson explains, during this time period there were 5.5 million births in England and of these only 0.1% were subject to a claim; these figures support the view that most births do not result in a clinical negligence claim and that having a baby in the NHS in England can be considered 'safe'.

Despite this context birth in the UK is still framed in a culture of risk (Lane, 1995; Scamell, 2011; Bryers et al, 2010; Coxon et al, 2014). In a paper on childbirth in the 'risk society' Scamell (2014) explores this conception and argues that risk in the context of contemporary childbirth operates more as a '*moral discipline than a scientific calculation of probability*' (Scamell, 2014, p. 921).

Scamell maintains that notions of danger and uncertainty in relation to birth make people feel powerless denoting a future which is unknown and cannot be controlled. Thinking in terms of risk, however, allows people to take a more active stance; taking

control as they consider strategies to minimise risk and feeling more secure as they anticipate the future (Scamell, 2014).

Cartwright and Thomas (2001) outline the damning implications of risk management strategies and procedures:

“Once a particular technology is performed frequently and both the profession and the public believe that it generates predictable results and substantial benefit the rate of lawsuits increases....failure to diagnose and promptly treat foetal distress is the most common claim in obstetrical malpractice cases” (Cartwright and Thomas, 2001, p. 222).

Daellenbach (2000) suggests that interestingly risk based care continues even when the technology is shown to be ineffectual (for example using EFM to reduce fetal neurological injury), and it is shown that care based on predominant institutionalised protocols may comprise the ‘real’ risk to women by way of iatrogenic interventions. Such interventions described as long ago as 1973 by Haire as being:

“Like a snowball rolling down hill, as one unphysiological practice is employed, for one reason or another, another frequently becomes necessary to counteract some of the disadvantages, large or small, inherent in the previous procedure” (Haire, 1973, p. 189).

In her study of the culture of risk in the NHS Annandale (1996) discusses the way in which modern midwifery is increasingly marked by risk under the ‘*dual impact of patient consumerism and organisational accountability*’ (Annandale, 1996, p. 416). In the study the notion of the childbearing woman as a consumer translates into the notion of her as somebody who expects the best, envisages the perfect baby and perfect labour, is ‘*aware of her rights*’ and by default becomes a ‘*risk generator*’; a consciousness of which hangs over the caregiver as an ‘*omnipresent cloud*’ (Annandale, 1996, p. 422). Further bound by a professional and organisational accountability midwives are caught

in a cycle of '*looking over their shoulders*', '*watching their backs*' and '*covering themselves*' (Annadale, 1996, p. 447).

From the perspective of the care giver no matter how low-risk a woman's pregnancy may be, it is still defined biomedically within a background of risk. As Surtees advises '*there can be no category of no-risk*' (Surtees, 2009, p. 83). In this context action and surveillance, frequent monitoring and intervention on the part of the midwife are an expected part of care. A good example of this is evident in Surtees' study on midwifery partnerships in New Zealand where '*defensive practice in a culture of risk*' emerged as a strong theme (Surtees, 2009, p. 81).

The midwives interviewed in Surtees study spoke of having to '*cover themselves*' by '*playing it safe*' and working in a context of '*advance defence*'; thinking ahead anticipating '*what if*' there was an adverse outcome and leaving a visible trace of all their actions (Surtees, 2009, pp 81-91). In these circumstance there is an argument that the midwife cannot be seen to be '*doing nothing*' even if that may be the most appropriate midwifery action to take.

2.14.6 Centralisation and Standardisation of Care

According to Kirkham (2010, np) the organization of maternity services on an '*industrial model*' and the centralisation of services have '*proceeded apace throughout the industrial world*'. In this model efficiency is the main aim and hospital systems concerned with managing throughput by standardising care are the norm. Historically the potential for financial savings (by concentrating consultant-led obstetric services into fewer hospital sites) and an argument about improved safety (bringing the woman to the expert in the shape of the obstetrician) have been presented as the rationale for reconfiguration. A recent report into clinical services by the King's Fund, however,

argues that “*evidence to support the impact of large-scale reconfigurations of hospital services on finance is almost entirely lacking*” maintaining that smaller hospitals in England are not “*inherently less safe or less efficient*” (Imison et al, 2014, p. 95).

Cited in an article in the Guardian newspaper, ‘*Close small maternity units and centralise care, demands leading doctor*’ (Campbell, 2012), Mary Newburn, the then head of research and information at the National Childbirth Trust said:

“We are concerned that very large hospital units can seem like baby factories to parents: impersonal and preoccupied with pushing mothers and babies through the system, that people are processed like components in a factory, and that some don’t get personalised care. There’s a sense that a woman is a number in such places”.

What this comment highlights is that people using NHS services are at the centre of any reconfiguration. This being the case it is not enough to standardise care to the ‘*lowest common denominator*’; care must be individualised and personalised to particular needs, and the experience of those being cared for keenly protected (Kirkham, 2013, p. 4).

2.14.7 Continuity of Care

Continuity of care has been at the core of maternity policy since the publication of the ‘*Changing Childbirth*’ Report in 1993 with its emphasis on choice, continuity and control (the report was discussed earlier in section 2.13, page 51). The concept of continuity of care was defined by Haggerty et al in 2003 as:

“The relationship between a single practitioner and a patient that extends beyond specific episodes of illness or disease” (Haggerty et al, 2003, p. 1219).

Clearly this definition concerns the relationship between a patient and care giver (presumably in a medical setting) but the concept is transferable to a midwifery context where midwives can provide '*care over time*' and '*focus on individual patients*' (Jenkins et al, 2015, p. 25). In defining continuity Haggerty et al (2003) identified three types of continuity which can be translated into any discipline: informational, management and relational. In a midwifery context the opportunity to develop relational continuity with a woman over her childbearing journey, has been shown to reduce interventions and increase women's satisfaction in her care (Jenkins et al, 2015).

Moreover recent research conducted by Sandall et al (2013) and Sharp et al (2013) endorses earlier findings of the benefits of midwifery-led continuity of care (such as safety, lower intervention rates and a higher normal birth rate) as well as adding new evidence, such as reduction in the premature birth rate (Sandall et al, 2013) and lower costs of midwifery-led continuity of care when compared with standard care (Tracy et al, 2013).

Unsurprisingly in this context the National Institute for Health and Clinical Excellence (NICE) quality care standards state that women should have a named midwife in the antenatal period and a named midwife or health visitor in the postnatal period (NICE, 2012; NICE, 2013). Similarly the NICE intrapartum care guidelines incorporate the importance of one to one care in labour and birth (NICE, 2007). Despite this guidance and the increasing evidence around this model of care, midwifery-led continuity of care is still only offered to a minority of women (Page, 2013).

In 'News and Views' from a 'Birth Tank', undertaken as part of the information gathering for the National Maternity Review (still in publication and implemented to assess existing maternity services and consider the changing needs of women and babies),

discussions related to women-focused continuity models identified the NHS infrastructure as a barrier to implementing these models. In particular:

“The commissioning process, by commissioners who have no knowledge of maternity care and the different areas of the UK in respect of this commissioning....how services are funded and midwifery services integrated within obstetrics....was also identified as a barrier to implementing community-based, midwifery co-ordinated personalised care”. (Jervis, 2015, 3-4).

This argument intimates that the whole of the NHS infrastructure will need to be overhauled if the needs of the maternity service users are to be realised; something which cannot be achieved without the support of the ‘*host health service*’ (Page, 2013, p. 690).

2.14.8 *The Birthplace Study*

The ‘*Birthplace Study*’ (Brocklehurst et al., 2011) aimed to compare the safety of birth according to the place of birth as planned at the onset of labour. The study was unique as until this point data had customarily been collected in conjunction with the actual birth place (Walton, 2012). The study focused on birth outcomes in healthy women with straightforward pregnancies who were classed as ‘low risk’. Data was collected for over 64,000 ‘low-risk’ births in England and compared the safety of birth in four different settings: birth at home, freestanding birth centre (FBC), alongside birth centres (ABC) and obstetric units (OU).

The study found that for low risk, healthy women with uncomplicated pregnancies, the incidence of adverse outcomes is low in all settings (Brocklehurst et al., 2011). Despite this very positive finding the study also found that the risk of an adverse perinatal outcome for healthy nulliparous women is slightly higher for births planned at home (9.3 per 1000 births as compared to 5.3 per 1000 in an OU) and this was the finding that

was most widely reported in the media (Walton, 2012; Rogers et al, 2012). Unfortunately the finding that there is an increased likelihood of intervention when birth is planned in an obstetric unit compared to another birth setting (for the low risk, healthy woman with a straightforward pregnancy) was widely underreported (Rogers, Yearley and Littlehales, 2012).

The expectation that the publication of the Birthplace study would “*herald a major shift in the provision and organisation of maternity services*” has unfortunately not been realised (Rogers et al., 2012, p.28). In 2015 just ten per cent of women are choosing to birth in a midwife-led setting (Rogers et al., 2015). As Kightley suggested as far back as 2007 the reasons for women choosing to birth in obstetric led settings are complex and ‘*deep-rooted*’ and not something that can be easily changed:

“The majority of indigenous women of childbearing age will have been influenced by the experience of their mothers, who are likely to have birthed in the last decades of the twentieth century when the move to hospital birth was well established. These older women will have attended a hospital believing that this was the safest option for both them and their babies. Indeed, this was what they were ‘promised’ in the Peel Report.....Part of the birthing tradition of these women will be hospital birth and they may be suspicious of attempts to get them to choose home birth.” (Kightley, 2007, p. 477).

2.14.9 Rising Birth Rate

According to the 2013 ‘*State of Maternity Services Report*’ (Royal College of Midwives) the number of births in England continued to rise in 2012 reaching its loftiest level (694,241) since 1971. This was twenty three per cent higher than in 2001. The figures for the first half of 2013 suggested that the so called ‘baby boom’ was over and that the boom may turn into a ‘slump’ as the number of births in the first six months fell by 18,000 compared to 2012. However figures realised in the latest report (2015) revealed that in 2014 the fall was shallower than expected (with the fall in the number of babies born in the UK just 0.3% down on 2013) suggesting that the rate remains unpredictable and

posing the possibility that the rate could start rising again putting more pressure on already stretched maternity services.

2.14.10 Staffing Pressures

The RCM 2013 'State of Maternity Services Report', told us that that maternity services were '*stretched*' and that this was having an impact on care. Examples given were new mothers being sent home '*too early*' without feeling confident about feeding or caring for their new babies and midwives feeling '*powerless*' under mounting pressure to get their job done more quickly and with fewer resources (RCM, 2014) . According to the RCM 2015 'State of Maternity Services Report', NHS maternity services in England remain '*thousands of midwives short*'. The report calculates that 2,600 more midwives are required to manage the number of babies being born. The 2015 report examined the age profile of midwives in practice revealing what has been called a '*retirement time bomb*'. With 31% of midwives in England reported as aged 50 or older the RCM is understandably concerned that these midwives are replaced '*in good time before they retire*' otherwise newly-qualified midwives will not have chance to gain the necessary expertise and confidence before their more experienced colleagues leave the service.

2.14.11 Growing Complexity

Maternity services in England today are faced with providing care to women and neonates with increasingly complex physical needs. Key complicating factors are the rising number of births to older mothers and the incidence of maternal obesity. In the 2013 '*State of Maternity Services Report*' the RCM states that in 2012 there were eighty five per cent more babies born to women in England aged forty or over than there had been in 2001. Similarly the incidence of maternal obesity in the first three months of

pregnancy more than doubled between 1989 and 2007 which meant that an extra 47,500 women required more complicated and potentially time consuming care.

2.14.12 Human Rights

Maternity care in the 21st century continues to be an area steeped in opinion and debate. New public opinion groups such as 'Birthrights', committed to improving women's experience of childbirth, have been launched. 'Birthrights' which was founded in 2013 by a group of lawyers, was set up specifically to promote human rights in pregnancy and childbirth and has an international following; this organisation, amongst others, was born in an era when a women's right to choose has, at times, been overridden by '*fetal supremacy*':

"But by the end it wasn't about my baby – it was all about their control over me and their power," says Charlotte, whose waters had broken when she was three days overdue. "They didn't like it that I questioned them and they didn't like it when the evidence I asked for to support their case over mine wasn't good enough. I don't know if the consultant was on some kind of power trip because I challenged her, but the result was that I was bullied into something I didn't want because of their threats. Finally I turned my head away and said: 'Just give me the medicine'" (Carpenter, 2012).

2.14.13 Women and Midwives in the Modern Climate of Care

As discussed earlier in this chapter (section 2.10 pages 46-48) the move from home to hospital has been described as decisive in the history of birthing; with the understanding of birth as a normal, life event (taking place in a family setting) being replaced by an understanding of birth as a medical event (being managed within a hospital setting) (Zwelling, 2001). In her book '*The Midwife-Mother Relationship*' Kirkham speaks of the difficulties created as the work of midwives and the care of women became '*contained within the more immediate priorities of the hierarchical organisation*'; arguing that at

times the move inevitably put pressure on the priorities of providing the best care for each woman and the efficient running and delivery of the service (Kirkham, 2010, np).

Providing care which meets the need of an institution (for instance in managing the throughput of women through a hospital) can mean that care becomes rigid, formulaic and task orientated as opposed to woman centred and individual and ultimately that women do not feel cared for, supported or even heard (Dykes, 2009; Edwards, 2008). Similarly midwives may feel that they are nothing more than part of the workings of the institution, becoming demotivated, unsatisfied and possibly insensitive to the women's needs (Edwards, 2010, np).

In this climate of care the interactions between women and midwives may damage rather than enhance the woman's childbearing experience (Hunter, 2006). This idea is certainly supported by evidence which tells us that from the woman's standpoint it is not enough for midwives to provide clinically competent care; it seems that women value more highly the nurturing relationship of the midwife in their experience of care (Hunter, 2006; Edwards, 2010). Moving forward one has to hope that the Maternity Review will support service delivery which enhances the relationship between women and midwives allowing both women and midwives to feel safe, secure and improving their self-esteem and personal agency.

2.15 Chapter Summary

This chapter has formed the background to the study by introducing the sociological context, and the discourse, history and landscape encapsulating birth in England in the UK. The following chapter builds on this context by discussing the position of stories and storytelling in that space.

CHAPTER 3 - BACKGROUND: STORIES

“Stories may not actually breathe, but they can animate.”
(Frank, 2010, np)

“The archetypal story unearths a universally human experience, then wraps itself inside a unique, culture-specific expression” (McKee, 1997, p. 4)

3.0 Introduction to Chapter

The previous chapter presented the background to the study by depicting the context and landscape of childbearing and maternity care in England. The more persuasive ideologies underpinning this world and the narratives sustaining it were discussed. This chapter develops the background for the study by exploring the place of stories and storytelling within our culture. The notion of ‘story’ is defined, and the structure, function, capacity and power of stories are discussed. The chapter ends by considering the social nature of stories.

3.1 What is a Story?

The notion of a story is a complex one. According to the Collins English Dictionary (2011) a story is a *‘narration of a chain of events told or written in prose or verse’*. The word has its origins in the 13th Century Anglo-French word *‘estorie’* from the Latin *‘historia’* meaning *‘inquiry, knowledge acquired by investigation’* (Joseph and Janda, 2005, p. 163). A story as understood from this description is a vehicle which helps people to develop knowledge and understanding about life and living.

By tradition stories, as a source of knowledge and wisdom, were told by ‘elders’ in a community to prepare younger members of that community to live and function within their specific cultural context (Bowles, 1995). Frank (2010, p. 87) explains this further telling us that, “*stories work on people, affecting what people are able to see as real, as possible, and as worth doing or best avoided*”. Banks-Wallace (2002, p. 411) expands on this idea maintaining that as well as providing ‘*practical guidelines*’ stories “*help us to answer existential questions about the meaning of life in general or of our lives in particular*”.

In our culture stories are everywhere and are communicated in an endless array of mediums; orally, virtually, in literature, through art and performance, and in the media. Stories can be fictional, capturing our imagination and transporting us to other worlds, or factual reporting on what is happening in the world around us. Stories can be used in many ways; for instance from being read to a child at bedtime, to settle him or her for sleep, to being used as a research methodology, a means of understanding something from a person’s unique perspective.

We understand the concept of a story from a very early age as the following example will illustrate. I was having a meal in a café some time ago and next to me was a four year old girl with her grandfather. We got talking and she told me that she had been to the cinema to see the film ‘*Annie*’. I listened while she told me all about the ‘story’, about the characters (the ‘goodies’ and ‘baddies’) and its ‘happy ending’ (Annie got a mummy and daddy at the end). At the end of her ‘story’ the little girl turned to her grandfather and said, “*But what if the story doesn’t have a happy ending?*” She looked horrified at the prospect but her grandfather reassured her by saying, “*Well you wouldn’t come out of the cinema smiling then would you?*” This appeared to comfort her, because for her stories were always ‘*made up*’. Seemingly up until this point she had only been exposed

to stories with happy endings. However it had now dawned on her that all stories may not end happily and this idea clearly upset her.

3.2 How are Stories Told?

“Begin at the beginning,’ the King said, gravely, ‘and go on till you come to the end: then stop’” (Lewis Carroll ‘Alice in Wonderland’, 1865)

At this stage of her life the little girl in the example above had already learnt some of the ‘*principles*’ of stories. For instance about how stories are populated and how they might end. She seemed to know that one thing happens as a consequence of another. Frank Kermode, the British literary critic, used the metaphor of a ticking clock to explain the structure of narrative. He wrote,

“.....the ticking of a clock. We ask what it says: and we agree that it says tick-tock. By this fiction we humanise it, make it talk our language...tick is our word for a physical beginning, tock our word for an end. What enables them to be different is a special kind of middle” (Kermode, 2000, p. 44).

Although I did not ask, and she did not tell me, it is likely that the little girl I met also knew that typical stories have a ‘*beginning*’, ‘*middle*’ and an ‘*end*’. Kottler (2014, p. 22) describes this structure as three ‘*acts*’ telling us that “*there is typically an introduction that leads to some conflict, a series of actions that lead to a climax, followed by some resolution*”. This is a relatively straightforward structure but on further investigation there is more to a story than these three ‘*acts*’.

Maines (1993) suggests that ‘*narrative*’ is the literary ‘*master frame*’ that makes storytelling possible. In an attempt to determine how a story ‘*works*’ William Labov and Joshua Waletzky (1967) developed one of the most widely acknowledged structural models of narrative. Similar to the pyramid structure devised by Freytag in 1863,

describing five dramatic story arcs in a customary sequence (as discussed in chapter 1 on page 26), Labov and Waletzky's framework is a series of six stages which follow one after the other to form a '*fully formed*' narrative. Not all stories will follow this structure (although they are probably built around it); some will miss stages out and/or the stages may be followed but perhaps not in chronological order (Frank, 2010).

Elliott (2005) explains the stages of the framework; the telling begins with an '*abstract*' which alerts those listening that a story is about to be told. The abstract may summarise the content of the story and/or indicate what type of story is about to be told (for instance a family story). The '*orientation*' comes next and the listener learns a little about when and where the story takes place and who the characters are. Next comes the '*complicating action*' which gets to the 'hub' of the story; something has happened which needs to be resolved. The '*evaluation*' stage describes the relevance of the story to the story teller and the '*resolution*' moves the listener to the ending of the story. The final stage is called the '*coda*' and is the means by which the teller brings the story back to the time of telling and indicates that listeners may now take a turn at speaking (Frank, 2010).

So it seems that as story teller's human beings have all been socialized by repeated and timely exposure to stories (as in the example of the little girl I cited earlier) and thus into the formal and recognized structures of narratives (Maynes, Pierce and Laslett, 2007). These structures are the '*culturally specific rules*' which we adopt when we represent our experience (Banks-Wallace, 2002). Frank (1995, p. 3) takes this argument a little further by suggesting that these '*rules*' not only govern *how* we tell stories but also *what* we tell, "*from their families and friends, from the popular culture that surrounds them.....storytellers have learned formal structures of narrative, conventional metaphors and imagery, and standards of what is and is not appropriate to tell*".

3.3 What are Stories For?

But why do we put our experience into words in this way? Much has been written about the function of stories and the consensus is that we utilise them for a variety of reasons: to help us make sense of who we are and how we fit into the world, to teach us how to behave, to help us to remember and to help us heal (Frank, 2000; Yoder-Wise and Kowalski, 2003; Davis, 2004). It is probably true to say that storytelling came from our need to communicate and to comprehend the world. According to Berger and Quinney (2005, p. 8) storytelling '*secures and increases our consciousness and extends the reality of our experiences*'.

Frank (2010) discusses the '*inherent morality*' of stories; the ability of a story to apprise us about what is '*good*' and what is '*bad*' and thereby act as a guide to our behaviour. This capacity is based on the principle that people respond by relating the actions of the people in the story to the consequences of those actions. The significant point to note about this is the inherent responsibility it imbues; ideally the concepts of '*good*' and '*bad*' need to be learnt as moral principles by the storyteller so that the stories they tell can guide us in a positive direction.

Klingler (1997) adds something further maintaining that '*storying*' provides a means of communicating hopes, fears and aspirations whilst Simpkinson and Simpkinson (1993) suggest that it works through metaphors to reconcile disparate understandings of life experiences. Frank (2010) is very clear suggesting that ultimately stories work as a guidance system in the complex and confusing place which is our world. They do this by generating an '*intense focused engagement*' which '*affects the terms in which people think, know and perceive*' (Frank, 2010, np).

3.4 The Capacity and Power of Stories

The notion of a story as a *vehicle* or as *equipment* affording a sense of purpose is prevalent in the literature (Burke, 1957; Herrnstein Smith, 1980; Ewick and Sibley, 1995; Frank, 2010). Frank (2010, np) takes this idea further discussing the ‘*capacities*’ of stories; the notion of how stories work for people and on people. Frank considers numerous capacities in his text but suggests that not all capacities are necessary or usual in every story. A number of these capacities tally with the narrative structure I described earlier. One such capacity is the capacity to handle *trouble* (both as subject matter but also in relation to the story having the potential for ‘stirring up’ trouble). This capacity is synonymous with the ‘*complicating event*’ which in the context of a birth story, for instance, could be something like the baby’s head crowning in the car on the way to the hospital (a story told to me when I was working clinically as a midwife).

Another capacity is that of stories to demonstrate and test out people’s character. In the example given above the test of character might involve the reaction of the woman’s partner to the event; did he crash the car or did he manage to pull the car over and help guide his baby into the world? How this character responds may resonate or not with listener; making him or her imagine what they would have done in that situation. Making a certain point of view conceivable and at the same time captivating is also significant; in the ‘story’ above the panic which was no doubt felt and described by the woman and her partner as the baby started to appear is extremely plausible to the listener and as the story unfolds the audience would be enthralled as they wait to find out what happened. Suspense is an important capacity of any story (as highlighted above). Without a sense of drama and anticipation a story might purely be a chronology of events which may or may not engage the listener. Suspense builds up a certain amount of anticipation; what did happen but also what could have happened?

Whatever a story's capacity, and regardless of whether stories are used to tell us something whimsical and imaginary or to represent what has actually happened, the storyteller must '*create the body of the story...so that a human body's experience can be materialised*' in that story (Frank, 2010, np). This idea is crystallised by McKee (1997, np) who maintains that '*stories are the creative conversion of life itself into a more powerful, clearer, more meaningful experience*'.

3.5 The Social Nature of Stories

Stories are ultimately social and are therefore increasingly relevant to social thought. An interest in stories is finally being acknowledged in the field of sociology after initially being seen as significant in fields such as psychology, history, psychoanalysis and philosophy (Plummer, 2002, p.18). Stories are relevant because as human beings we inhabit a world which is a world of stories. As Rukeyser (1968, np) puts it, '*the universe is made of stories, not of atoms*'.

In our world we are made up of, participate in, and are encompassed by stories. Indeed there is an acknowledged understanding in the literature that our social and material situations are both the basis of our stories as well as the grounds we use for understanding them (Howard, 1991; Polkinghorne, 1988). What this means is that the stories people hear affect the way in which they behave in, and interpret their world, whilst the stories they tell are centred on what they do and understand; stories, actions and understanding are always interdependent.

Certainly stories are not told in isolation; they are born of our involvement in and experience of our specific socio-cultural context. Maynes et al. (2007, p. 2) explain this concept in more detail claiming that the '*stories that people tell about their lives are never simply individual, but are told in historically specific times and settings and draw*

on the rules and models in circulation that govern how story elements link together in narrative logics". Our stories and lives are '*situated*'; shaped within a distinct set of circumstances, by specific people, for certain listeners for very particular reasons (McLean, Pasupathi and Pals, 2007). In this sense stories can be understood as socially ordered phenomena depending on and calling on "*collective myths, archetypes, symbols, linguistic forms, and vocabularies of motive, without which their meaning would remain unintelligible and uninterpretable*" (Ewick and Silbey, 1995, p. 211-212).

This description suggests that stories are not told indiscriminately; rather there are specific situations when stories are anticipated and encouraged and others when they are discouraged and/or suppressed. The content of stories is also of importance in the social organisation of stories. Convention may dictate what are acceptable or appropriate content as well as stipulating what is relevant and credible. Finally, Ewick and Silbey tell us, storytelling is '*strategic*'; stories are told for a reason, '*to achieve some goal or advance some interest*' (1995, p. 208). Further consideration is given to the social nature of stories in the discussion chapter section 10.3 pages 243-245.

3.6 Chapter Summary

This chapter has explored stories and storytelling within our culture emphasising the social nature of stories. The next chapter considers the study in the context of the literature and explores the idiosyncrasies of engaging with the literature in a hermeneutic study. The concept of '*inclining towards*' the literature is explained and reviewing as '*moving thinking*' discussed.

CHAPTER 4 - LITERATURE: *'PROVIDING CONTEXT AND PROVOKING THINKING'*

"Re-viewing literature is to see through a lens that is always open to the possibility of finding afresh, re-connecting, and 'wondering' down new paths" (Smythe and Spence, 2012, p. 23).

4.0 Introduction to Chapter

This chapter starts by exploring my beginning point; the literature search I undertook with a view to writing a meta-synthesis. I examine the premise of the meta-synthesis, share my literature search strategy and discuss the inclusion/exclusion criteria for my proposed birth story meta-synthesis. I consider two key papers explaining how insights from these studies informed my thesis. I explain the decision taken to revert from a meta-synthesis to a structured literature review and ultimately the move from that approach to a hermeneutic review. I end this part of the chapter by discussing a paper which did not fit the initial inclusion criteria but which nonetheless has a bearing on this study.

I continue by considering the idiosyncrasies and implications of engaging with the literature in a hermeneutic way and the rationale behind this approach. I explore my experience of the phenomena by examining my personal interview (undertaken by two of my supervisors at the start of this process) before moving on to reveal '*glimpses*' found in the literature following the hermeneutic part of the review. The '*glimpses*' I describe are hints of the phenomenon providing context for the study and provoking thinking (Crowther, 2014, p. 87). Throughout I draw on the expertise of Smythe and Spence (2012) to structure my thoughts, my thinking and my '*conversation*' with the

literature. Overall the chapter provides an audit trail of my relationship with the literature and a catalyst of thinking for the thesis.

4.1 Qualitative Meta-Synthesis

According to Steen & Roberts (2011) a meta-synthesis is an in-depth, original and interpretive analysis of a number of qualitative studies on a given subject. This definition is supported by Noblit and Hare (1988) who maintain that by giving meaning to a set of studies a meta-synthesis becomes a study in its own right. Paterson, Thorne, Canam and Jillings (2001, p.5) agree describing meta-synthesis as '*research of research*' in which individual research studies are the primary data.

The premise of a meta-synthesis is to analyse and synthesize the interpretations of original studies and in doing so to generate new integrations and understandings of phenomena (Sandelowski, 2006). According to Bondas and Hall (2007) synthesizing qualitative studies is crucial to achieve fuller knowing. Meta-synthesis has the potential to increase the capability of qualitative research findings to make a difference in health care and to contribute to theory development (Sandelowski, 2006).

4.2 Tensions and Challenges of the Methodology

While some theorists consider meta-synthesis to be a credible research methodology allowing for integrative interpretation of findings others suggest that the synthesis of qualitative research is impossible and/or meaningless (Campbell et al., 2003). Synthesis can be viewed as an appropriate way of building up credible and usable knowledge of a subject; conversely it can be perceived as reductionist in its effect, a method of mere aggregation more in keeping with a positivist ideology which aims to

'find the truth' than with the philosophically interpretive nature of qualitative research which aims to *'reduce uncertainty'* and expand understanding (Downe, 2008, p. 5).

Sandelowski, Docherty and Emden (1997, p. 366) originally voiced concerns that any synthesis of qualitative findings could potentially destroy the integrity of individual studies and in doing so significantly lose the *'vitality, viscerality and vicarism of the human experiences'* represented. The challenge in any meta-synthesis of remaining faithful to the original interpretations and in retaining their individuality and holism is well documented in the literature (Jensen and Allen, 1996; Thorne, Jensen, Kearney, Noblit and Sandelowski, 2004; Finlayson & Dixon, 2008). The risk for qualitative researchers of increasing the gap between their work and the practice environment and /or policy makers if their research remains isolationist is similarly documented (Silverman, 1997; Fingeld, 2003; Walsh & Downe, 2005).

Another tension inherent in the methodology is the tenet of engaging with the studies as *'raw data'* in view of their distance from the original experiences (Sandelowski, 2006). Meta-syntheses are thrice removed from the lives of people participating in empirical qualitative research composed as they are from reviewers' transformations of primary research findings which in turn are composed of researchers' transformations of data they collected from or generated with participants, whose words are transformations of their experiences made in a *'remembering moment'* (Sandelowski, 2006). Furthermore the meta-synthesist faces the added *'handicap'* of being reliant on the primary research publications and not having been influential in the research design and data collection (Bondas and Hall, 2007, p. 116).

Despite these reservations an increasing number of meta-synthesis papers are appearing in the midwifery literature (Clemmens, 2003; Downe, Simpson and Trafford, 2007; Humphreys, Johnson, Richardson, Stenhouse and Watkins, 2007; Smith &

Lavender, 2011). This prevalence of meta-syntheses is suggestive of a growing appreciation of the methodology's potential to further develop understanding of midwifery and midwifery care (Steen & Robert, 2011).

4.3 Searching the Literature

According to Barroso et al (2003) the ultimate objective for the researcher undertaking a qualitative meta-synthesis is to unearth all the relevant studies on the topic of interest. Unearthing the relevant studies is far more involved and time consuming than one might assume as the '*search environment*' is increasingly complex in terms both of resources and search techniques and the actual number of articles is never known (Barroso et al., 2003, p. 156). Furthermore qualitative literature searching is fraught with difficulties related to the '*descriptive nature of the titles*' used in studies, the '*variable information provided in the abstracts*' of studies and '*the differences in indexing of the studies across databases*' (Evans, 2002, p. 290).

In order to make sense of the huge volume of literature that can be accessed and to begin the meta-synthesis project, I needed to have a clear understanding of the search objectives and have established firm inclusion and exclusion criteria. This process is clearly described by Barroso et al. (2003, p. 155) as "*defining the substantive, methodological, and temporal boundaries for the study*". I also needed to systematically manage the information found and establish a clear audit trail of the search process including "*procedural moves and decision-making points*" (Barroso et al., 2003, p. 172).

4.4 Inclusion and Exclusion Criteria

With the purpose of developing a meta-synthesis of birth stories the literature was searched with the following objective in mind: to establish the constructs, norms and meanings that underpin the stories women tell of childbirth. Inclusion criteria for the search were agreed with the supervisory team as: primary research studies, studies with a qualitative methodology such as narrative, biographical or other methods that seek 'whole stories', mother's stories (not midwives or partners), and studies designed to capture stories/narratives of birth experiences, either as told by those who had the experience directly, or the stories others have told of birth (as retold by childbearing women who have heard these stories). The decision was made not to restrict the search either by language, in order to look at the influence of culture and/or ethnicity, or date, in order to determine how stories change over time.

By limiting the studies to those with comparable theoretical assumptions (in other words those approached from a qualitative stance) I did not have to address the issue of commensurability. I determined that as long as the studies were based on interpretive frameworks then I would include them in the synthesis.

4.5 Literature Search Strategy

Steen and Roberts (2011, p. 41) define a literature search as an *"in-depth search for information using several resources and tools to provide knowledge and understanding"*. The emphasis of this statement is on the need to use 'several resources and tools' as searching is a complex and dynamic process which evolves and changes direction *"to follow up on various leads and shifts in thinking"* (Barroso et al., 2003, p. 157). In her seminal article on searching the online interface Bates (1989,

p. 407) describes an ever developing '*bit at a time*' '*berry picking model*' of literature searching. Bates maintains that researchers will rely on more than pure protocol-driven search strategies when undertaking a literature search and her model is testament to this. The supposition is that the researcher who utilises numerous and varied approaches will achieve more effective results (Bates, 1989).

Bates' model is highly iterative and suggests that rather than relying on a "*single time-bound conception of the research area*" (as in the traditional protocol-driven approach) the researcher is likely to follow up each new piece of information found meaning the search will be redirected as new material is accessed (Thomson, 2007, p.25). In order to follow up new information Bates advocates a number of strategies to compliment the classic protocol-driven model such as: footnote chasing (also known as '*backward chaining*' this approach involves following up on footnotes found in books and articles); citation searching (also known as '*forward chaining*' a technique which identifies literature which has cited articles of interest); journal runs (searching through key journals); area scanning (browsing materials in same area) and author searching (determining whether a known author has done any further work on a subject) (Bates, 1989, p. 412).

More recently Greenhalgh and Peacock (2005, p. 1064) advocated using three methods to search the literature: a '*protocol driven search*' (search strategy determined at beginning of study); '*snowballing*' (emerging as the study unfolds and including reference and citation tracking); and '*personal knowledge*' ('*what we knew and who we knew*'). An explanation of how the various strategies advocated both by Bates and by Greenhalgh and Peacock were utilised in the literature search for the birth story meta-synthesis follows.

4.6 Protocol Driven Search

4.6.1 Database Searches

The first phase of the search consisted of a classical bibliographic and abstract search across a number of principal databases; databases were chosen that were readily accessible, that covered a range of relevant disciplines, that were recommended by the supervisory team and that I presumed would yield reports of qualitative studies about birth stories (Barroso et al., 2003). Access to the databases was through the library computer network at 'Anglia Ruskin University' (which is where I was working at the time).

The databases accessed were as follows: '*Cumulative Index for Nursing and Allied Health Literature*' (CINAHL) a major bibliographic database for nursing and allied health; '*MEDLINE*' a key biomedical database for the biomedical sciences; '*Maternity and Infant Care*' an essential resource for academics and healthcare professionals involved in the care of women and infants; '*British Nursing Index*' (BNI) a premier database for the support of education, research, practice and development of UK nurses, midwives, health visitors and related staff; '*PsycInfo*' a major database in the field of psychology; '*Applied Social Sciences Index and Abstracts*' (ASSIA) a comprehensive source of social science and health information, and; '*Web of Science*' an arts and humanities citation index.

4.7 Snowballing Techniques

4.7.1 *Backward Chaining*

Reference lists of all the literature initially scrutinized for possible inclusion were scanned for appropriate studies. These studies were then pursued and considered and ultimately their reference lists were perused. The search therefore took on a cyclical nature which continued until no new articles were being found.

4.7.2 *Forward Chaining*

Citation tracking was undertaken through the '*Web of Science*' database; forward selection of significant papers was carried out with the aim of discovering articles in key journals that had subsequently cited those papers (Greenhalgh and Peacock, 2005).

4.8 Personal Knowledge

The supervisory team identified a number of potential texts and articles which they felt I should consider for potential inclusion (all of which were subsequently found in database searches). Attendance at national and international conferences meant that I was open to '*serendipitous discovery*' and that various potential lines of enquiry could be established and followed up (Greenhalgh and Peacock, 2005, p. 1064).

4.9 Instigating the Database Searches

The searches were started by identifying key concepts and by considering how the concepts might relate to one another; the population of interest was defined as 'mothers' or 'women' and the elements of interest were the woman's parity, her 'place' on the childbearing continuum and, of course, the notion of the birth story, (Table 2 below illustrates how the concepts were used in the search). I built a search term vocabulary for each concept by considering synonyms, by consulting a thesaurus, by considering variations in spellings and by consulting with the supervisory team. Truncation was used to find records that include any term starting with the word stem, for instance 'pregnan*' found 'pregnant', 'pregnancy' and 'pregnancies'.

Key word searching, which is the default search in most search tools, was used and helped to identify appropriate subject terms. Subject or index searches were used alongside key word searches in the 'CINAHL', 'MEDLINE' and 'Maternity and Infant Care' databases; these searched the key words, subject lists or index lists provided by the authors with their papers.

Subject or index searches are thought to be more reliable in a protocol driven search as they focus on the subject matter of the publication and often achieve more precise results (Walliman, 2005). As can be seen from Table 3 (which details the search, retrieval and results of the database searches) a basic key word search was used in the BNI database and this generated a substantially larger number of articles for consideration (most of which provided not to be relevant) than those generated in the CINAHL database where an index term search was used (32 results were retrieved as opposed to 820). The potential risk of using index terms is that relevant studies might be missed during the search because ill-fitting index terms have been used or the subject terms do not accurately reflect the contents of a study (Evans, 2002). The most

effective approach, according to Evans (2002) combines the use of both keyword and index term searches.

The 'Boolean operator' 'OR' was used at each stage of the process to combine the synonyms and broaden the search. The 'AND' operator was used at the end of the broader search to ensure that only records with all the terms were found; the purpose of this was to narrow the number of retrieved studies and ensure their potential relevancy.

Table 2: Database Search Strategy

<i>Population</i>	<i>Boolean Operator</i>	<i>Element One</i>	<i>Boolean Operator</i>	<i>Element Two</i>	<i>Boolean Operator</i>	<i>Element Three</i>
Mothers OR Women OR Female OR Lady OR Client OR Patients OR Service User OR Mum*	And	Primip* OR Nullip*	And	Antenatal OR Prenatal OR Antepartum OR Pregnant* OR Confinement OR Birth OR Parturition OR Delivery OR Childbirth OR Labour OR Labor OR Intrapartum OR Postnatal OR Puerperium OR Postpartum	And	Story OR Stories OR Narratives OR Storytelling OR Tale* OR Biograph* OR Memoir OR Chronicle

Table 3: Search, Retrieval and Results of Database Searches

<i>Database</i>	<i>Articles Retrieved</i>	<i>Excluded</i>	<i>Considered</i>	<i>Included in meta-synthesis</i>
CINAHL (published by EBSCO) (incorporating CINAHL headings/keywords)	32	21	11	0
MEDLINE (published by EBSCO) (incorporating MeSH headings/ key words)	41	35	6	0
Maternity & Infant Care (published by Ovid) (terms searched as keywords and mapped to subject headings)	180	173	7	0
BNI (ProQuest XML) (key word search)	820	815	5	0
PsycInfo (published by EBSCO) (key word search)	12	8	4	1
ASSIA (published by CSA/ ProQuest XML) (key word search)	7	5	2	0

Web of Science (published by Thomson Scientific) (key word search)	33	27	6	0
Additional Search Methods	1	0	1	1
Total	1124	1071 Abstracts reviewed	41 studies Found over 7 databases + 1 other = 42 After duplication = 20 full texts were reviewed 2 research studies reported in more than one journal = 16 original studies to consider for inclusion	

4.10 Search, Retrieval and Results

The total number of studies retrieved was 1124; of these 1071 abstracts were reviewed and of these 16 original studies were considered for inclusion.

4.11 Thought Processes and Decision Making Around Study Selection

At the outset the inclusion criteria as agreed with the supervisory team appeared robust and workable; in practice it proved difficult to determine which studies met the agreed criteria. One of the difficulties was in finding studies designed to capture stories as opposed to those where stories developed through the data collection process or emerged as a finding of the research; as in the study by Dahlen, Barclay and Homer (2008) where the women felt compelled to tell their stories as a result of being involved in the research study. Similarly it was difficult to find studies where stories were elicited without an overt 'agenda' (for instance in the study by Reese et al, 2008, where stories were used as a mechanism to determine correlations between maternal reminiscing and children's memory) or where the study was 'context free' without the researcher having super imposed a 'metaphor' on findings which made a 'story'; as in the study by Hanson, VandeVusse and Harrod (2001) which used an analogy between theatre and birth to describe birth from a fresh perspective.

The focus of the search and the inclusion criteria kept coming 'in and out of focus' as I struggled with concepts such as the purpose of stories (do they serve to entertain or do they function as a means of processing an experience), the telling of stories (are they told as a means of 'preaching' to the 'unconverted' or as a mechanism to debrief), listening to stories (how are they heard and understood and what does the audience

gain from listening) and, the construction of stories (do they have a common structure, narrative pattern and if so does it conform to the classic archetypes of storytelling).

The debate about whether a birth experience was a 'story' was one which was hotly debated amongst the team; I felt that it was necessary to be very specific about this and to clearly articulate that the meta-synthesis would focus on the 'story' rather than the 'experience' as the project needed to be achievable and realistic within the time constraints of a doctorate programme (the literature around women's birth experiences is vast). In order to try and make sense of the situation I developed a table highlighting the characteristics of each study (this also proved useful as part of the audit trail of my reasoning and decision making process) and a diagrammatic interpretation of the inclusion process. These documents helped me more easily identify which studies should be included. Both the table and the diagram are attached as Appendix One.

The more I considered the proposed focus of the meta-synthesis, the nearer I came to determining exactly what it was I wanted to establish; how does engaging with birth stories influence women, do women select and engage with stories that fit with their particular frame of reference and does the way a story is constructed create meaning? Ultimately I came to the conclusion that I wanted to determine how the telling of such stories changes the conversations around what the meaning of birth is.

After much 'shifting and swaying' and after determining that there was no literature explicitly and exclusively concerned about women's birth stories and their impact on pregnant women, I finally determined that the only way to make sense of the literature being found was to concentrate on those studies which considered the way in which the birth story is told, in other words on the birth story as a phenomenon of oral narrative. This meant that of the original sixteen studies considered for inclusion only two were

deemed suitable. The two studies, Leamon (2001) and Soparkar (1998) are both unpublished PhD theses (both of which I accessed in their entirety).

4.12 Insights from the Two Studies Informing My Thesis

During the meta-synthesis process I completed a 'conceptual grid' for the two studies designed to help me make sense of what I was reading. I detailed the concepts identified in the study and described what the studies told me about story construction and the process of narration. Finally I considered which insights I could apply (if any) to my own study and how these insights might help inform my interviews. A copy of the conceptual grid is attached as Appendix Two.

Both studies discussed story construction and narrative format in some detail. The study by Leamon (2001) spoke of '*sharing*' stories whilst in Soparkar's (1998) study the emphasis was on '*telling*' stories. Leamon's main aim was to consider how birth stories may inform the learning and development of midwives and their practice. Soparkar's study had two main aims; to determine whether the telling of childbirth stories exists as a phenomenon of oral narrative (and a narrative which is recognisable amongst women who have given birth) and to establish why women tell these stories. I found Soparkar's study most interesting because of my own interest in the notion of the birth story as a phenomenon of oral narrative.

Leamon suggested that story sharing could involve many mediums such as the spoken and written word, pictures, artefacts, sounds and drama. Leamon's thesis argued that story sharing occurs in a given time and place, meaning that stories have a subjectivity and temporality, and that sharing occurs within and across socially and personally constructed boundaries. Soparkar suggested that telling stories about birth was culturally concordant, that the telling could be triggered by birth memories (visual,

verbal, corporeal and aural) and that the main audience of the story was generally the person who told it.

In Soparkar's study the purpose of telling was around '*edification, entertainment, stimulation and rejuvenation*'. Interestingly Soparkar spoke a lot about women telling their stories (often repeatedly) in attempt to process the sense of '*primal*' within them; the part of themselves they encounter in the '*storm*' of the transitional stage of labour. Soparkar supposition being that women at this time are confronted by a sense of themselves as outside of their normal understanding; they are animalistic, primitive and not able to 'rationalise'. In that 'awful' place they have forgotten their sense of purpose and keep telling their story to try to process how they feel about it and to assimilate the experience into their perception of themselves.

Similarly in Leamon's thesis the purpose of sharing was disclosed as being about making meaning from experiences, increasing personal knowledge, cathartic release, a means of processing the past and a way of potentially informing future choices. Telling the stories was about hearing voices and attending to relationships, making transitions, crossing personal 'boundaries' and learning from the discourse. Leamon spoke of the stories having a type of genre; such as '*dramatic*' and '*magical mystery*'. Similarly Soparkar spoke of the stories being primarily '*action*' stories as opposed to '*affect*' stories, maintaining that the stories tell you what happened, when it happened.

For Leamon the stories were characterised by '*subjects*', '*players*' and '*context*', and the story sequence was not necessarily sequential to the events. The storytellers in Leamon's experience used different means to engage the reader such as, a '*wetting*' of the appetite, a '*clue*' to the storyline and a '*taste*' of the ending. In contrast Soparkar's experience was that the stories had a chronological presentation; a beginning, middle

and end involving a '*slow beginning*', a '*swell of excitement*', a '*dramatic climax*', a '*denouement*' and, finally, an '*epilogue*'.

The two studies told me a considerable amount about the birth story as a phenomenon of oral narrative. I learnt why stories were told, where they were told and how they were told:

- **Why** - as a means of processing the birth experience, making meaning and as a means of potentially preparing for the next birth by informing future choices
- **Where** - within and at times across social and personal boundaries and within specific and concordant cultural contexts
- **How** - by capturing the attention of the audience, relaying the story in a particular fashion (not always chronologically but within a 'framework' designed to engage the reader)

Significantly neither study told me anything about how women experience these stories. Nonetheless I recognised that what I had learnt from reading the studies could be used to inform the questions I asked the participants during the interviews. I determined to ask participants about:

- Why they shared/or think others shared their stories
- The situation in which the telling took place
- The narrative structure of the stories

- What it felt like to hear these stories whilst pregnant

I discuss the development of questions for the purposes of the interviews in more depth in the methods chapter.

4.13 Quality Appraisal or Not?

In the literature relating to meta-synthesis there is some debate about whether or not an assessment of quality should be made on the retrieved studies (Finfgeld, 2003; Finlayson & Dixon, 2008; Rolfe, 2006). Some writers promote the use of formal appraisal checklists stressing the importance of rigour (Thorne et al., 2004; Walsh & Downe, 2005) whilst others argue that eliminating studies on the basis of quality may mean that potentially significant findings are overlooked by skewed notions of worth, (Sandelowski and Barroso, 2003). At the outset of my meta-synthesis I had determined to use an appraisal checklist to help me facilitate a meticulous and critical evaluation of each study and for this reason I had decided to employ the checklist developed by Walsh and Downe (2005).

4.14 Two Lone Studies

During a supervisory meeting in March 2012 I spoke about the fact that I had identified only two studies that I could potentially include in a meta-synthesis. Further I raised concerns about the quality of the two studies. My main concerns were around methodological issues; neither researcher defined the philosophical dimensions of their study. This meant I was not clear of the assumptions underpinning the research or of the beliefs acting as a framework for the studies and potentially guiding behaviour during data collection. Similarly I found that discussion around the methodology

employed was limited in the Leamon (2001) study and missing entirely from that of Soparkar (1998). This meant that I could not be satisfied that either researcher had employed the best suited methodology to answer their research question.

On the basis of these factors a decision was made, after discussion with the team, to abandon the idea of a meta-synthesis and at this stage I determined to carry out a structured literature review instead.

4.15 A Relevant Study

One relevant study, which I found at the time I was searching the literature for the purposes of the meta-synthesis, was significant in the development of this thesis. The study, which was found as part of protocol driven search (but which did not fit the inclusion criteria as it did not consider the birth story as a phenomenon of oral narrative) was designed and carried out by Weston (2001) as part of her Master's degree.

Weston originally intended to examine the influence of birth stories on primigravid women but finding no references to primiparous women and their experience of listening to birth stories in the literature, changed her focus and instead considered birth stories as a means of '*generating knowledge*' and as a means by which "*women remember their own birth experiences*". In her discussion and summing up Weston concluded that very little is known about the practise of women sharing birth stories with each other; something with which I obviously agree and which was one of the springboards for this thesis.

4.16 The Move to a Hermeneutic Review of the Literature

“Writing with heart, body, soul, brain and mindfulness” (McIntosh, 2014, p. 3)

As I continued to read I became more and more uncomfortable about limiting myself to a structured review of the literature. As I understand it a structured approach is intended to be ‘*unbiased*’, ‘*complete*’, and ‘*reproducible*’ (Chalmers and Altman, 1995). My feeling is that this is potentially unachievable but also, in the case of hermeneutic phenomenology, not workable or valuable; as the researcher in this study I am part of the research process and my presuppositions and experiences contribute to the developing meaning and add to the phenomenological conversation.

By this stage I recognised that the approach needed to be dialogical in nature, generating “*new understanding through dialectical use of question and answer when engaging with the literature*” and underpinned by the philosophy of Heidegger and Gadamer (Smythe and Spence, 2012, p. 13). I understood that the review would be a dynamic and continuous process throughout the life span of the study and that in order to “*portray the taken-for-granted meanings that make up practice*” I would need to read outside of my own context and outside of the midwifery literature (Smythe, 2011, p. 50). Further I acknowledged that hermeneutic reviewing, as Crowther argues, requires “*an interpretive lens and way of attuning that invokes both creative and scientific thinking*” (2014, p. 158).

For these reasons I decided to continue my reviewing as a hermeneutic endeavour.

4.16.1 *Implications of a Hermeneutic Review*

In moving to a hermeneutic review I was mindful that the prime objective should be to *'provide context and provoke thinking'* and clear that the review would be open-ended; a process within which I would seek to increase understanding of how the literature and the research aim each informed the other (Smythe and Spence, 2012, p. 12). Modelling the review around the archetype of the hermeneutic circle, that is understanding the meaning and importance of individual scripts within the whole body of the relevant literature, (which is in turn built up through the understanding of individual texts) helped me to move forward in the process (Boell and Cecez-Kecmanovic, 2010).

I recognised that the review did not have to start by identifying all potentially relevant texts (although I had already identified in the structured search a number of pertinent texts) but instead had to move forward by reading the texts I had already collected to assist the pursuit of further literature and thereafter to *'successfully encircle relevant works'* (Boell and Cecez-Kecmanovic, 2010, p. 133).

Further I realised that as the approach was dialogic in nature I needed to understand and articulate how my orientation to the research area and aim (through socialisation and understandings derived from previous experiences) impacted on the review; how my prejudices contributed to my engagement with the literature, the creation of my understanding and my evolving interpretations (Smythe and Spence, 2012; Boell and Cecez-Kecmanovic, 2010). I discuss the notion of understanding as participation in the next part of the chapter.

4.17 Re-viewing Literature: Understanding as Participation

“Understanding is not, then, a purely individual achievement. It emerges from that unpredictable dialecticity of encounter between the linguistic and cultural horizons of individuals” (Davey, 2006, p. 10).

Engaging with the literature is an unpredictable, dynamic and highly iterative process which can be described as a process of understanding and intellectual development (Smythe, 2011; Crowther, 2014; Boell and Cecez-Kecmanovic, 2010). From Gadamer’s perspective the ability to ‘*listen*’ to what is read, to question what we are told and pose our own questions is a crucial part of the hermeneutic endeavour and one which enables us to find emergent meanings (Gadamer, 2004). In the reviewing I have found tentative meaning but also found many more questions. For instance following a supervisory meeting where we discussed the literature and the emerging data I recorded:

“How do women birthing in 1970s-80s frame their stories? In light of TV programmes such as ‘One Born Every Minute’ do these women feel redundant? Do they feel they have nothing to add? How is the historicity of older women’s birth stories being translated into the current ‘nowness’ of birth? Is the ‘wisdom’ of these women being suppressed because they feel they have nothing to add? How are their stories framed? How are their stories constructed? How are these women silenced and how are they heard? How do these notions construct the reality of birth for the next generation?” (Supervisory record 25/11/14).

Questioning the literature and myself in this way helped develop my understanding of what I already knew and what was still to be revealed. Similarly as I became ‘swamped’ by the ‘luscious mess’ of literature and data, the approach helped bring the research aim back into focus; reminding me that I needed to come back, again and again, to the stories being shared and the potential of those stories to elicit emotional responses and generate meaning in the interlocutor.

Reflecting back on the process reveals the extent of my participation; in the practice of thinking, rethinking, interpretation, writing and rewriting I would come across a paper, an academic text, a poem or a work of fiction and find it resonated with me and my findings in some way. Going back to my referencing software to search through my references, my vast stack of papers or my bookshelf, I would find the source and at that point remember seeking it out or buying it much earlier on in this journey.

Somehow I knew that at some point this resource would be useful or pertinent in some way and so I printed it out, bought it or saved it to my computer 'for later'. At times like this I found myself clearly within the hermeneutic circle; circling as a way to develop understanding by engaging with the transcripts, the literature, and everything around me.

4.18 My Understanding as Participation

The starting place of any review of the literature is with the reviewer; I came to the literature with a certain amount of '*fore-understanding*' about childbirth and about the experience of women engaging with birth stories whilst they are pregnant (Smythe and Spence, 2012, p. 16). At the outset of this process I was interviewed by two of my supervisors about my presuppositions. This excerpt from the interpretation of my interview reveals a starting point,

"Throughout my personal interview I assert that women are 'dictated to', 'fed' and 'subliminally told' about birth purporting my belief that childbirth in the UK is conducted and organised in an autocratic manner. I talk about 'the doctor', 'the hospital system', the concept of safety and medicine expressing the belief that birth is 'less and less about women', the suggestion being that the pervasive understanding of birth in this society is founded on a socially constructed, biologically determined and medically managed ideology". (Open interpretation of personal interview, November 2012).

At this point in the process I recognise that I am grounded in a particular conception of both birth and the birth story:

"I am grounded in my conception based on my experience of already being in the world of birth. I am woman who has heard stories of birth, a mother who has birthed, a midwife who has attended countless births and a lecturer who has read and taught around the subject of birth. I am skilled at existing in this world and am therefore caught in the swirl of existence I am hoping to understand." (Open interpretation of personal interview, November 2012).

From my practice as a community midwife, my own experience of birth as 'normal' and my belief that the majority of women if cared for appropriately can birth physiologically, my conception of birth is most definitely in the naturalistic 'camp' as opposed to that of the medical. Being grounded in a conception is not unusual; Heidegger reminds us that no interpretation of an object can ever be free of preconceptions because, without some preliminary orientation, it is impossible to grasp the object at all. Heidegger argues that *"every inquiry is seeking"* and that *"every seeking gets guided before-hand by what is sought"* (2012, p.24).

As I describe the types of stories women tell I emphasis the fact that women talk about the things that happened during their births in quite a structured way; discussing the process of birth and birth 'events' in an almost chronological fashion (as an action story as suggested by Soparkar, 1998). I argue that women very rarely tell the listener what the experience felt like. I tell my supervisors I am concerned that the stories being shared and that I think that somehow they do not reveal the real visceral and corporeal experience of birth,

"I am interested in how women feel when they birth, what they expect birth to be like, whether the experience changes them and how they feel afterwards. I am concerned that the stories told do not give a 'sense of it as personal'. I want to investigate the spiritual aspects of birth, the 'non-wordiness' of it, its intensity in women's lives and the concept of it as a rite of passage. Ultimately I am interested in what birth means to women." (Open interpretation of personal interview, November 2012).

In approaching and engaging with the literature then, I came to it from a very definite starting point and already had an idea of the direction I would be taking. I had to be careful that I did not restrict my reading to sources which would in some way merely affirm what I already thought I knew. Rather I needed to read widely and in non-obvious places to determine what was and wasn't said about engaging with birth stories whilst pregnant.

4.19 Literature Considered in the Hermeneutic Review

"The literature review is usually conducted in this later time slot....and my experience...suggests that there is an overwhelming feast of related literature, yet a famine of anything that closely relates to the experience itself" (Smythe, 2011, p. 50).

My search for literature was an '*embodied seeking*', a call to reading and to thinking which coincided with the data collection and analysis; I did not follow strict rules in my search for and engagement with the literature rather I read broadly and sought '*conversational partners*' with which to contrast and develop my thinking (Smythe and Spence, 2012, p. 21).

4.19.1 The '*Feast*' of Related Literature

At this stage a bounty of related literature helped me attune to the phenomenon of engaging with stories of birth and made me consider more carefully how we are all socialised into the world (how we learn to behave and to think) and consequently how we may become attuned to the world of birth. I give a number of examples here but consider others in the discussion chapter where I believe it is more pertinent (the sources were discovered as the data emerged rather than at the beginning of the process).

I found and read an anthology of poetry, '*In the Gold of Flesh: Poems of Birth and Motherhood*', celebrating the strong voices of women and reinforcing the value and significance of stories (Palmeira, 1990). I discovered and read '*Mythologies*' (2009) in which Barthes explores the falsehoods of mass culture; helping me appreciate that modern life is rooted in signs and symbols all of which hide beliefs and ideas which subliminally affect our thought and behaviour. I found myself reading Tempest's 2013 '*Brand New Ancients*' (a blend of street poetry, rap and storytelling) which helped me to appreciate the variety of storytelling mediums and the power of story to engage and enthrall. I stumbled on and read '*Misconceptions*' by Naomi Wolf (2002) which reminded me that many of the messages given to pregnant women through various story mediums are misleading, invasive and trivialising.

As the women I interviewed spoke of messages they received from the mass media I found literature around bodily change in pregnancy, body image and weight gain (Strang et al., 1985; Johnson et al., 2004; Chang et al., 2006; Clark et al, 1999; Bartky, 1990; Bordo, 1993. Similarly as findings emerged about the women's reliance on the virtual world as a means of acquiring knowledge I sought and found literature about pregnant women's use of the internet as a source of information (Deutsch et al., 1988; Wu Song et al, 2012; Bernhardt and Felter, 2004; Spink et al, 2004; Larsson, 2009; Lagan, 2006; Lagan et al, 2010). I consider this literature in the discussion chapter as I discuss its relevance and congruence with the findings.

As I started to unravel ideas about how women felt they should behave in labour I read about agency, self-efficacy and gender (Bandura, 1977; Martin, 1989; Oakley, 1980; Martin, 2003; Campero et al, 1998; Lowe, 1993; Hodnett and Simmons-Tropea, 1987). Similarly as data emerged about fear and birth I read about the medicalisation of birth, the use of technology, the concept of risk and the notion of fear (Belu, 2012; Melender, 2002; Otley, 2011; Wendland, 2007). All of these sources were part of my journey,

informing my thinking, my engagement with the women and my interpretation of the data and all are discussed in more detail in the discussion chapter.

4.19.2 The 'Famine' of Phenomenon Related Literature

"Two women were standing in shadow, one with her back turned. Their talk was a gesture, an outstretched hand. They talked to each other, and words like 'summer', 'birth', 'great-grandmother' kept pleading with me, urging me to follow" (Pollock, 1999).

I found very little literature directly related to the phenomenon of engaging with stories of birth whilst pregnant. At some stage I happened on a book called '*Telling Bodies, Performing Birth: Everyday Narratives of Childbirth*', in which Pollock (1999) examines the multitude of ways in which people communicate the act of giving birth, and which persuaded me that the phenomenon was real, worthy and significant.

In her introduction Pollock tells the reader something which I had always thought and which I hope my findings portray; that birth stories are '*mobile cultural fragments*' and that they '*echo*' and '*sap*' medical, media and commodity discourses (Pollock, 1999, p. 21-22). Further Pollock's text persuaded me that birth stories are indeed '*viscerally relational*' with a capacity to engage and open up a space to discuss issues such as the meaning of birth, maternity, motherhood, the female body, gender, class and race (Pollock, 1999, p. 25).

In my search for phenomenon related literature I found a paper by Regan et al (2013) about the factors that influence women's choices and decision making in childbirth. I discuss this study in more detail when I talk about the notion of '*coming to understand*' later in the chapter. I also found a number of studies about women's information seeking behaviours (Jacoby, 1988; Shieh et al., 2009; McKenzie, 2006) and women's

expectations and experiences of birth all of which I consider in the discussion chapter (Gibbens and Thomson, 2001; Beaton and Gupton, 1990).

Engaging with the literature I found myself captivated by particular texts and taken in certain directions, all in the process of coming to tentative conclusions. I describe this process in the next part of the chapter under the subheadings, *'inclining towards'* and *'moments of vision'*.

4.19.3 *Inclining Towards*

"We truly incline toward something only when it in turn inclines towards us" (Heidegger, 1992, p. 369).

I had a 'eureka' moment when I stumbled across an article entitled, *'Narrative Threads: Philosophy as Storytelling'*. I had been writing up the background chapter relating to stories and storytelling when I found it. As I read it suddenly everything I had been reading, thinking and writing started to make sense and to form some sort of coherent whole. As I read words leapt off the page at me and were at once incredibly significant; I read of the potential of stories to *"ethically expose unhinge, and orient us to the wider world"* (Craig, 2014, p. 438) and of the *"horror of what reasonable human beings have become"* distanced as they are from a *"fully embodied, feeling life"* (p. 444). I was suddenly questioning:

"Do women share stories in a certain structured way? Talk of birth in terms of action, what happened when in the chronology of their birth, rather than of feelings and experience because they are frightened to do otherwise? Are they afraid of showing themselves as vulnerable, as primal beings caught in the 'storm' that Soparkar describes and as such outside their rational understanding of themselves? Have women developed such powers of intellect (in an attempt to better 'understand' or prepare for birth) that they in seeking out information have become completely distanced from a sense of a fully embodied, feeling birth?" (Excerpt from research notes January 2015).

Later I engage with the idea of women *'insulating'* themselves from difficult realities once again; there is a reference in the text to the American philosopher Cora Diamond (2011) and her work *'Is nothing sacred anymore?'* in which she discusses the notion of *'being alive to the world'* and with it an awareness of the *'bodily sense of vulnerability to death'*. In my notes I scribble down something more:

"This vulnerability is capable of panicking us - in my reading I am getting a sense that women in our modern world do not want to be exposed to this type of vulnerability - it panics them - hence attempts to 'protect' themselves with knowledge (but paradoxically this is very often the very thing that frightens them). Also the idea that women in older generations seek to 'protect' by not sharing the 'gory bits' of their births and making their daughters/others vulnerable and panicked".

As I continue reading I read something of Miller (1992) who argues that the *'primal quality of being alive'* is discouraged in our society. Immediately on reading this I am thinking of Heidegger and his ideas about technology and the idea that technologisation serves to conceal the central existential questions about being and finitude.

4.19.4 Moments of Vision

"The thinking journey of hermeneutics seeks to open one to thinking again, to thinking afresh, to thinking around; a 'viewing' that seeks to extend one's horizon" (Smythe and Spence, 2012, p. 18).

Throughout my journey I engaged with poetry, fiction and the arts as a means of coming to understanding. As I alluded to at the beginning of the thesis I found reading fiction to be especially valuable in enabling understanding. Barnes explains why fiction is so valuable in an endeavour such as this:

"Fiction, more than any other written form, explains and expands life. Biology, of course, also explains life; so do biography and biochemistry and biophysics and biomechanics and biopsychology. But all the bio-sciences yield to fiction.

Novels tell us the most truth about life: what it is, how we live it, what it might be for, how we enjoy and value it, how it goes wrong, and how we lose it. Novels speak to and from the mind, the heart, the eye, the genitals, the skin; the conscious and the unconscious” (Barnes, 2012, p. ix).

I ‘found’ philosophical and Heideggerian notions everywhere and these furthered my understanding of the context of birth in a technological age and the telling of stories in that space. For instance in my thinking about the medicalisation of birth I started to consider Heidegger’s notion of machination and in Rilke’s *‘Sonnets to Orpheus’* I found a resonance:

*“The machine threatens all we have gained
Only so long as it is imagined, rather than obedient
It no longer flaunts magnificent gestures of exquisite hesitation
But resolutely works the mine, and polishes the gem more precisely”.*
(Mood, 2004)

In this excerpt I found a resonance with Heidegger who in his text *‘The End of Philosophy’* (2003, p. 106-107) speaks of the *‘raw material’* that is man and the *‘endless possibility of production’* where everything is ordered and arranged to guarantee *‘incessant, aimless activity’* but nothing brings us to the *‘fullness of being’*. I was equating this idea with birth and questioning the notion that as a society we have somehow ‘managed’ birth to such a degree that oftentimes women see it merely as a means to an end (to the polished gem that is the ‘perfect baby’). It brought me to thinking; has birth become such a medical event in this consumerist world that what is valued is an efficient process, a good outcome and as a consequence there is no worth or value in the experience of birthing? This could explain why the stories that are told are functional as opposed to visceral and real.

Similarly near the beginning of my study I happened upon an article in a Midwifery journal about an artist called Katie Elder (Kightley, 2010). Elder, an art student at Oxford Brooks University, had worked with acrylic and charcoal to produce a series of

'chimeras' showing the endurance and violence that women go through when birthing. Entitled '*To Give Birth is a Fearsome Thing*' (2009), Elder's paintings depict women as part woman/animal or part woman/ bird in the act of birthing. The paintings are incredibly powerful and for me capture the intensely personal, primal and animalistic power of birth. An example of one of Elder's paintings is captured below:

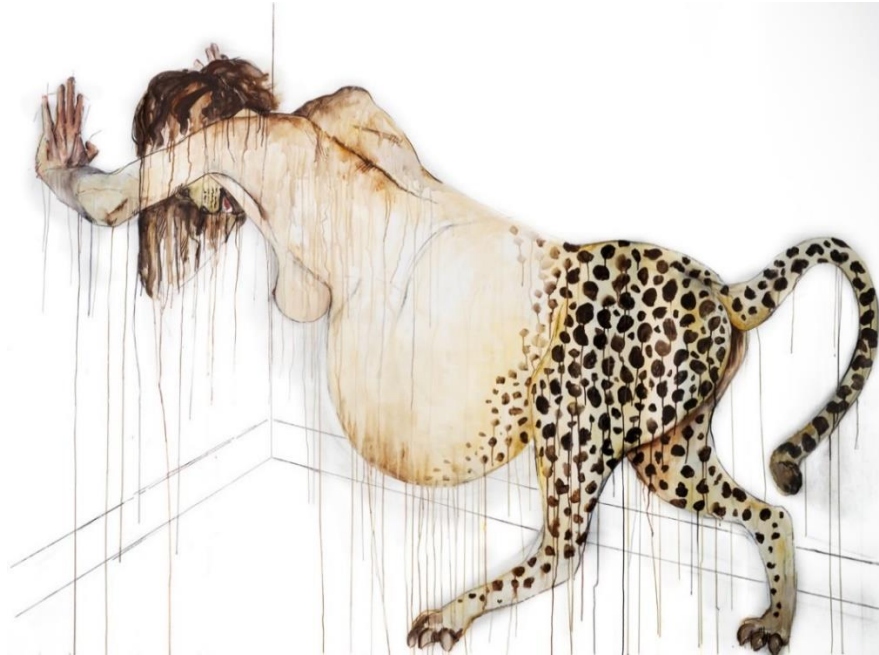


Figure 2: '*To Give Birth is a Fearsome Thing*' (Elder, 2009)

At the time I was working as a Midwifery lecturer at Anglia Ruskin University and I invited Elder to come and speak with the students; she very kindly agreed and I put up copies of her pictures (with her consent) to advertise the event. A few days later I was approached by one of the administrative staff at the University and asked to take the images down. I was told the nursing students found them offensive. I was shocked at the time but in thinking about it now, in the context of the literature, I wonder whether the students found them upsetting as they undoubtedly reinforce the primal nature of birthing and in doing so bring the idea of vulnerability and the sense of being out of control and in the '*storm*' that Soparkar spoke of to the fore; a space where women find

it very difficult to be as it does not resonate with their idea of themselves as reasoned, thinking beings. For me the paintings are a powerful and timely reminder of the reality of birth in an increasingly technocratic and medicalised age; an idea which Kightley argues persuasively in his article (2010, p. 158):

“These canvasses offer the viewer the opportunity to reconnect with an aspect of existence that is truly essential and fundamental. While the canvasses are themselves representations, they invite the viewer to consider what is primary and universal about physiological birth despite attempts to shape, control or profit from it”.

4.20 Coming to Understand

“In the interplay of seeking and waiting, of writing and pondering, of knowing and doubting, tentative understandings take shape” (Smythe and Spence, 2012, p. 20).

As I engaged with the literature I found evidence that the sharing of birth stories was construed as a way of knowing about birth, that birth stories influenced women’s decision making and choices in the childbearing period and that they were shared in response to childbirth (detailing the where, when and what of the birthing) as opposed to describing the lived experience of birth. I introduce these notions in the next part of the chapter.

4.20.1 Women’s Stories as a Way of Knowing

“The conversation between women is precisely the domain where the social role of being a woman - among women - could be established.....Conversation brings together culture and meaning, giving rise to the emergence of a story or narrative, which takes place according to what meanings are shared by the subjects who are part of the conversation” (Bastos et al., 2012, p. 552-554).

As discussed earlier in the thesis, human beings '*understand their experiences in and through the telling and hearing of stories*' (Churchill and Churchill, 1992, p. 74). It follows, then that stories similarly help us to understand what it is to be a woman, what it is to birth and how it is to be a mother. Society and those with whom we form relationships (either close or otherwise) will 'help us' to appreciate the meaning of birth and motherhood as it is understood in our particular socio-cultural context. As Olafsdottir and Kirkham tell us, '*mothers' stories....teach other women what is possible or to be expected. Women rarely expect services or practices that are not the experience of their peers*' (Olafsdottir and Kirkham, 2009, np).

The concept of 'relationality', women connecting with other women as a source of knowledge and knowing, was considered in a seminal study conducted by Belenky et al in 1986. Concerned that accepted conceptions of knowledge and truth have grown and been moulded throughout history by a male-dominated culture and that, as such they did not reflect women's experience of knowing, the researchers examined the epistemology, or 'ways of knowing', of a diverse group of women (Belenky et al., 1997).

The authors illustrated how the epistemological beliefs of the women were acutely connected to their perceptions of themselves and their relationship to the world. Each of the five knowledge perspectives developed in their model '*Women's Ways of Knowing*' represents a different point in the women's intellectual development, dependent on perceptions of self (self), relationships with others (voice) and understanding of the basis and identity of authority, truth and knowledge (mind).

Belenky et al (1997) argued that connecting with others and establishing understanding relationships were key factors in women's development. Connectedness has been coupled with a sense of meaning, wellbeing and worth (Jordan et al., 2004). The concept is defined by Langford et al (1997, p. 96) as a '*positive social climate*' that

includes emotional, instrumental, informational and appraisal attributes of support. Within this climate Langford et al (1997, p. 97) define a social network as the means by which support is provided (through an '*interactive field of persons*') and social embeddedness as the connectedness people have to others within their network (the '*depth and strength of relational ties*').

The concept of connectedness and the notion of relational ties fit with the idea that one of the main social functions of narratives is maintaining social bonds (Kvale, 1996). Indeed telling stories '*calls for other stories in which experience is shared, commonalities discovered and relationships built*' (Olafsdottir and Kirkham, 2009, np). In a study exploring the lived experience of knowing in childbirth Savage described the relationships between mothers and their daughters explaining that the connection (during the younger women's pregnancies) ranged from emotional to informational. The transmission of birth stories from mother to daughter was also considered in a study by Hayden et al who suggested that '*once a mother has shared the birth story with her daughter...the daughter may internalise it and make it her own*' (Hayden et al, 2006, np).

In the childbearing literature the experience of hearing birth stories is portrayed as relational and connected and as a means of learning about birth (Leamon, 2001; Soparkar, 1998; Reese et al., 2008; Savage, 2006; Callister and Vega, 1998; Munro et al, 2008; Savage, 2006). The idea is illustrated in studies such as that around childbirth expectations by Fenwick et al., (2005), where women described accessing the discourses of family, friends and acquaintances in preparation for birth:

"My mum had five children...my mum told us about being born...she had four home births and one hospital birth, so she told me what it was like and what she had gone through so I think that was a big influence" (participant in the study of Fenwick et al, 2005, p. 31).

Similarly it is emphasised in Weston's 2001 study about birth stories being shared as a means to convey knowledge about birth. In the study Weston described how the participants chose which stories to listen to and potentially adopt as their own. Weston also considered how memories were shared by mothers with their daughters, concluding that mothers appeared to try and protect their daughters from fear of birth either by talking about '*non-threatening details*' or by keeping their descriptions brief and to the point (Weston, 2001, p. 498).

The idea of 'knowing' and the birth story is clearly epitomised by a participant from Savage's 2006 study. The participant, given the pseudo name 'Harper', verbalised a desperate need for other women to share their stories saying:

"Tell your stories! This is how we decipher information. Then, after you finish yakking about it, write it down and leave a paper trail. I do not understand the keeping of the information. Locking it up and not saying anything. How are all the lay people supposed to know what the truth is?" ('Harper' in Savage, 2006, p. 17).

4.20.2 Women's Stories as Influencing Decision Making for Childbirth

As I read in and around the literature relating to women's preparation for birth I came across a study conducted in the USA by Regan, McElroy and Moore (2013). The study, a mixed-methods study about factors that influence women's decisions about birth, concludes that stories of birth and/or attendance at birth are '*the most commonly cited category*' of information (Regan et al., 2013, p. 174). I do not find this surprising in itself but what this finding does highlight is the definite need to understand how these stories are told and how they are received by women (if they are so persuasive). The finding illustrates the significance of my study in helping to fill the knowledge gap around this phenomenon.

The interesting thing about the findings in this study were that the participant's '*desired*' births were motivated by the birth stories and experiences that they identified with and valued the most; for instance women who wanted to birth at home recounted home birth stories and these stories were generally positive with good outcomes. Similarly women who wanted pain free birth or were amenable to interventions relayed birth stories involving intense pain or birth injury (during physiological birth) as a motivation to birth using an Epidural for analgesia or by elective caesarean section.

The researchers suggested that if the stories and experiences presented information at odds with the woman's desired option than these were often discounted (by disbelieving the information). In some circumstances the women '*disassociated*' themselves with the individuals whose ideas were at odds with their own. Others chose not to share their plans with people who had different viewpoints; this was more common with those who wished to pursue a natural birth and those interested in birthing at home (perhaps because they were expecting more dissenting voices?) Also of relevance was the finding that women who decided before pregnancy what they wanted for birth did not necessarily or actively seek out information about the risks and benefits of their desired option. This would suggest that these women were not actually making informed choices or decisions.

The study has some limitations; the most significant of which was that 11.5% of the sample had chosen to birth at home, a figure which is considerably higher than the national average at that time of 0.72% (Macdorman, Declercq, Mathews and Stotland, 2012). Similarly nearly 21% of the women had decided to use a doula for support which is not usual for the general population. These limitations affect the researcher's ability to generalise their findings to a different demographic of women. Nonetheless the study highlights that many women in this sample made decisions prior to birth by engaging with other women's stories; further these decisions were not necessarily based on

considered risks and benefits but rather on what fitted with the woman's preferred option. This is significant and suggests that education about birth choices may need to begin in the preconception period and that more research about how women experience stories and make choices and decisions is required.

4.20.3 *Women's Stories in Response to Childbirth*

When I was reading about the body and theories of embodiment I was captured by the idea that knowledge doesn't merely emanate from the mind; Grosz (1995) speaks of knowledge as dynamic and constructive implicating the body in its production. In my reading I had already identified that the birth stories women tell tend to be '*action*' stories and that these stories describe birth chronologically; the '*long and short of it*' type of story or the '*it's a matter of time*' story as described by Soparkar (1998). What was missing I felt (as discussed earlier in relation to my personal interview) was the '*lived experience*' of birthing (Walsh, 2009).

As I understood it the stories being shared were describing what happened in '*response to childbirth*' and this '*response*' was one which was bound to the socio-cultural context of the birthing woman (Davis and Walker, 2010, p. 459). I was suddenly questioning again: do women tell '*it's a matter of time*' stories because their understanding of birth and the birthing body is one that is born from science and rationalism? Has the industrial model of birth (with its notions of mechanisation, the separation of mind from body, ideas of control and measurement) become so engrained in our cultural understanding and belief system that we are no longer able to appreciate the whole of a woman and the whole of her experience? Are we so reliant on the body of knowledge emanating from medicine (and the accountability it appears to afford) that we are unable to think about birthing outside the parameters it affords? Is the notion of birth (identified by

Jordan in 1992) as '*socially marked and shaped*' by the discourse of authoritative medical knowledge so pervasive that we are unable to 'story' without it?

Certainly the language women encounter during pregnancy, birth and early motherhood may play a part in sustaining this model and understanding of birth. Hewison (1995, p. 228-32) argues that '*language at the micro level*' is hugely significant in determining a woman's experience of birth, telling us that, "*the perceived validity attributed to a particular account will determine the choices people make about childbirth, as well as exerting a profound effect on the experience itself*". Unfortunately very often the language which is used assumes that women's bodies are potentially flawed and cannot be relied on; terms such as '*unfavourable cervix*', '*failure to progress*' and '*inadequate contractions*' do not inspire confidence in a woman's ability to birth her baby, rather they suggest that her body will fail her. Maybe this language which has stealthily become part of everyday birthing has also become part of the storying of birth; with women telling and sharing stories which use this language and rely on this model.

4.21 Chapter Summary

In this chapter I have provided context for the study and provoked thinking. I have discussed the journey I made in reviewing the literature and told the 'story' of the review. I have explained how I read and engaged with various kinds of literature; at times catching sight of potential meaning but also identifying more questions and what remains hidden about the phenomenon. I have justified my research question and its exploration through my conversation with the literature, acknowledging that interpretation is both driven by and generated by its own '*incompleteness*' (Iser, 2001). I continue to pursue and explore the significance of the phenomenon throughout the thesis culminating in the aletheia and discussion chapters.

I move on in the next chapter to justify decisions made in relation to the design and organisation of the study. I introduce the methodological framework and the two key philosophers guiding the study. Essential philosophical notions and Heideggerian concepts are introduced and discussed.

CHAPTER 5 - METHODOLOGY: ‘WINDING MY WAY’

“Lived, breathed, and dreamt, felt, run-with, laughed, and cried” (Smythe et al, 2008, p. 1390)

5.0 Introduction to Chapter

In the previous chapter this study was placed in the context of the literature. In this chapter I justify decisions made in relation to the design and organisation of the study; defending my choice of paradigm, theoretical perspective and the methodology used to address the research question. In doing so I provide a context for the approaches used to bring the study to life and, by presenting my assumptions and view of the world, satisfy the reader that I have a keen awareness of these and the effect they may have on the process (Crotty, 1998). An outline of the aims of the research assists in contextualising the discussion.

The study uses an interpretive hermeneutic phenomenological approach and a rationale for this choice and its suitability as a framework for exploring midwifery phenomena is provided. The development of phenomenology and hermeneutics (incorporating the theories of the main philosophers; Heidegger and Gadamer) is considered, and fundamental Heideggerian notions and philosophical concepts discussed and referred to later in the thesis are introduced.

5.1 Choosing the Theoretical Approach

5.1.1 Aims of Research

As discussed in chapter one my initial objectives in carrying out this research were to establish the constructs, norms and meanings that underline the birth stories women tell and, to understand how women make sense of the stories they are told. As the project developed the objectives were refined into questions such as; how does engaging with birth stories influence women's choices and decision making around birth? Does the telling of birth stories change the conversations around what the meaning of birth is? My ultimate research question evolved from these to become: *'How do pregnant women come to understand what their experience of birth may be?'*

An interpretive methodology encapsulating individual perspective and considering socio-cultural context was considered appropriate to address the research question (Thomson, 2007). Further an interpretive phenomenological approach was chosen allowing *"the perspective of the researcher to form part of the development of meaning"* (Lee, Taylor and Raitt, 2011, p. 308). In other words the methodology allowed me to bring my own beliefs and understandings, which I would otherwise have struggled to suspend (particularly around birth), into the collection, interpretation and analysis of the research data. This was crucial because as a researcher I am not scrutinizing phenomena from outside but am *"inextricably bound into the human situation"* which I am studying (Walliman, 2005, p. 205). As a human being, a woman, a mother, a midwife and a researcher I am part of society and a member of a number of different 'cultures' within that society. I function in these cultures with and amongst a myriad of preconceptions, values, beliefs, understandings and viewpoints making it impossible for me to take a neutral and completely objective stance. Who I am and how I view the

world and its social reality impact on my research approach. I discuss this further when I explore my reflexive position later in the chapter.

5.2 Addressing Philosophical Dimensions

Research paradigms address the philosophical dimensions of social science research. A research paradigm is a set of elemental beliefs about how the world is realised and serves as a thinking framework that guides the behaviour of the researcher (Jonker and Pennick, 2010). Often implicit, the philosophical background nonetheless significantly influences how one undertakes a social study from the way of framing and understanding social phenomena (Wahyuni, 2012). The philosophical assumptions underpin the research; affecting the nature of the investigation, identifying worthwhile evidence and pointing to the kind of conclusions that can be drawn (Denscombe, 2010).

The two main philosophical dimensions used to distinguish research paradigms are ontology, “*the nature and existence of being*” (Lincoln and Guba, 1985, p. 108) and epistemology, “*the nature of knowledge, its possibility, scope and general basis*” (Hamlyn, 1995, p. 242). Denzin and Lincoln (2013) maintain that all qualitative researchers are philosophers directed by their beliefs about the human being, the nature of reality and the relationship between the inquirer and the known. Ontological and epistemological questions accentuate a person’s view of the world and the place of humanity in it (Dilthey, 2008). Each researcher, “*who speaks from a particular class, gendered, racial, cultural, and ethnic community perspective*” (Denzin and Lincoln, 2013, p. 23), will approach a research project in a different way, utilising different ideas and frameworks to address their questions. The study they produce will be guided and constrained by their perspectives which should be made explicit to the reader. The reader is then able to put the study into context and make a judgement about the quality of the inquiry and its findings.

5.3 My Philosophical Stance

My philosophical stance is based on a social constructionist view of '*meaningful reality*' (Crotty, 1998, p. 42). A belief that all knowledge, (and therefore all meaningful reality), is dependent upon our engagement with the world, and our relationships with the people in it. In this '*meaningful reality*' there is no tangible truth or certainty waiting to be discovered; meaning is not inherent in the object waiting for someone to reveal it, rather it emerges when consciousness engages with it (Crotty, 1998). We construct meaning by interacting with the world and the objects in it.

I believe my ways of understanding the world are products of the culture and history into which I have been socialised, and fit conceptual frameworks and categories that already exist (Burr, 1995). These categories constitute "*culture as an indispensable guide to human behaviour*" (Crotty, 1998, p.53) and suggest that we understand and interpret phenomena "*via socially constructed pre-conceptions*" (Thomson, 2007, p.17). Rather than attributing meaning as we encounter phenomena, we are all born into '*a world of meaning*' where a '*system of intelligibility*' prevails (Crotty, 1998, p. 54). Our world has already been interpreted; we see and understand this world through culturally specific lenses.

In this world language and thought are inseparable (Burr, 1995). Language provides a foundation for all our thought affording us with a "*system of categories for dividing up our experience and giving it meaning*" (Burr, 1995, p. 61). Language and our use of it does more than describe the world we live in, language constructs the world; concepts are developed as individuals begin learning and using language and are reinforced by the people within that language and culture (Crotty, 1998).

5.4 Positioning of the Research

5.4.1 *Interpretive as Opposed to Positivist*

The positivist and interpretive paradigms embrace different ways of viewing the nature of existence and diverse understandings of what they consider to be knowledge (Thomson, 2007).

Positivism promises unequivocal and exact knowledge of the world; centring on the idea of using scientific methods to gain knowledge (Crotty, 1998). From the positivist viewpoint objects in the world have meaning prior to and independently of any consciousness of them. The positivist researcher regards the observation and measurement of the properties of objects as crucial to the way we find out about social reality (Denscombe, 2010). Positivist researchers seek to obtain law-like generalisations by conducting value-free research to measure social phenomena (Neuman, 2011).

From the interpretivist viewpoint social reality is subjective; it is constructed and interpreted by people and does not have the *“tangible, material qualities that allow it to be measured or observed”* (Denscombe, 2010, p. 121). The interpretivist views knowledge of the social world as something that relies on our human ability to make sense of a reality that has no inherent properties. The knowledge we have of the world is something which is produced in the minds of people and reinforced through their interactions with each other. The interpretivist researcher recognises that *“individuals, with their own varied backgrounds; assumptions and experiences contribute to the on-going construction of reality existing in their broader social context through social interaction”* (Wahyuni, 2012, p. 71).

William Dilthey (1833-1911) was one of the first philosophers to question the use of natural scientific methods to study human phenomenon (Angen, 2000). Dilthey argued that natural reality and social reality are different kinds of reality requiring different modes of investigation. The sociologist Max Weber (1864-1920) had a similar view suggesting that human sciences are concerned with understanding (*verstehen*) as opposed to explanation (*erklären*).

The term *verstehen* means to understand, perceive, know, and comprehend the nature and significance of a phenomenon (Elwell, 2005). Interpretivists use this to comprehend the meaning intended or expressed by people. Interpretivism's main tenet, as already explained, is that research can never be objectively observed from the outside rather it must be observed from inside through the direct experience of the people. The role of the researcher in the interpretivist paradigm is to, *"understand, explain, and demystify social reality through the eyes of different participants"* (Cohen et al, 2007, p. 19).

An interpretivist epistemology accords with a constructionist ontology and thus suits me as a researcher. The interpretivist approach can manifest itself in many different ways and I chose to adopt a hermeneutic phenomenological approach in this study. In the next part of the chapter I explain the rationale for my choice including the reasons I elected not to employ a narrative approach which some may consider in keeping with 'stories' of birth.

5.5 Determining the Interpretivist Approach

5.5.1 *Choosing Not to Adopt a Narrative Methodology*

Narrative research is an interpretivist approach that relies on participants' stories about their experiences (Holloway and Freshwater, 2007). The primary data source in this type of research is some type of subject provided narrative; for example narrative interviews or oral stories, diaries, autobiographies, photographs and so forth (Mishler, 1991). Through narratives people give meaning to their experience and everyday lives. Narrative research tends to be used to capture the detailed stories of the life of an individual or the lives of a small number of individuals. Indeed narrative '*seeks to draw out the authentic story of an individual in his or her own words*' (Frost and Cliff, 2004, p. 173). A number of different ways of narrative analysis can be used to understand and attribute meaning to the stories.

My study was not concerned with the detailed birth story of an individual or those of a small number of individuals; rather it was concerned with the *experience of* engaging with stories. I wanted to find out *how it is* to engage with stories of birth whilst pregnant and from that knowing endeavour to grasp the nature and significance of experiencing stories of birth. I was not interested in individual or authentic stories in isolation. Rather I sought to 'borrow' other people's experiences and reflections on their experiences; as a means of coming to an understanding of the deeper meaning of engaging with birth stories in the context of the whole of human experience (Van Manen, 1984).

5.5.2 *Choosing Hermeneutic Phenomenology*

I trusted that a hermeneutic phenomenological framework would illuminate feelings and experiences of engaging with stories of birth, and would allow me to recognise each woman's experience as unique whilst at the same time allowing me to explore the ultimate essence of the experience. By utilising the framework I hoped to understand women from 'inside' their subjective experience and to find insights that applied more generally in order to emphasise what we may have in common as human beings. A hermeneutic phenomenological approach offered a methodology through which the significance of the experience of engaging with birth stories could be truly thought out and grasped (Van Manen, 1984). Furthermore the approach allowed me to use my preconceptions positively in the thinking of the research whilst becoming more experienced in the notion of engaging with stories of birth. I was thus better able to render the full significance of the meaning of the phenomenon (Van Manen, 1984).

5.6 **Hermeneutics and Midwifery**

Hermeneutics has been successfully utilised in a number of midwifery studies, (Crowther, 2014; Lee et al, 2011; Thomson, 2007; McAra-Couper, 2007; Hunter, 2003; Beck, 1994). In the studies the framework has been used to create a deep understanding of women's and midwives experiences as well as presenting insights into the '*humanistic aspects of midwifery*' (Miles, Chapman, Francis and Taylor, 2013). The approach has some resonance with the practice of midwifery which embraces a holistic philosophy in which midwives are encouraged to care for women within the context of their lives and according to their individual needs.

Midwives offer clinical expertise and care during pregnancy and birth and are privileged to accompany women on the journey from womanhood to motherhood; a time of

immense change which affects every aspect of their being (Davies, 2007). Heideggerian hermeneutic phenomenology enables the researcher *'to be with the data'* as the midwife is *'with women'*; much as birth does not happen in a vacuum separated from the world but is lived and breathed by the birthing woman and her midwife, thinking and writing for the hermeneutic researcher is *"lived, breathed, and dreamt, felt, run-with, laughed, and cried"* (Smythe et al., 2008, p. 1390). Approaching research from a hermeneutic perspective allows the midwifery researcher to adopt the same approach with her data as she would with the childbearing woman; grounded in an understanding of the social, emotional, cultural, spiritual, psychological and physical experiences of women, incorporating *"all that has come before in one's life, both the remembered and that which is known before knowing"* (Smythe et al., 2008, p. 1390).

In the next part of the chapter I explore the background and premise of hermeneutical phenomenology starting with an introduction to phenomenology and its founding father Edmund Husserl, (1859-1938).

5.7 Phenomenology

Phenomenology, from phenomena, speaks of the objects that reveal themselves to us as human beings. The German philosopher Husserl's theory of phenomenology was instrumental in the development of phenomenological hermeneutics. Although essentially a positivist Husserl believed natural science provided an incomplete understanding of human experience. In *'Ideas Book 1'* (1982) Husserl defined phenomenology as the science of the essence of consciousness; the study of the way things materialise in our experience as well as the ways we experience things in the world around us.

In phenomenological research Husserl seeks to understand human experience by exploring the lived experience or *'life world'* of the participants (Mapp, 2008). This is the world of the *'natural attitude of everyday life'* which Husserl described as the "*original, pre-reflective, pre-theoretical attitude*" (Van Manen, 1990, p. 7). Husserl's phenomenology aims to; "*demonstrate how the world is an experience which we live before it becomes an object which we know in some impersonal or detached fashion*" (Kearney, 1994, p. 13).

The term 'intentionality' is fundamental in phenomenology, (Moustakas, 1994, p. 68). Husserl embraced Brentano's interpretation of intentionality; that "*all mental phenomena are described as having reference to a content, direction towards an object*" (Brentano, 1973, p. 88); consciousness then is always consciousness of something. Intentionality conveys the relationship between us as human beings and our world; it is a "*referentiality, relatedness, directness, aboutness*" (Crotty, 1998, p. 44). It is out of the back-and-forth between humans and their world that meaning is created.

To understand experience Husserl intended to go *'back to the things themselves'* and uncover their 'essence' (Husserl, 1970, p. 252). Husserl reasoned that to reach the essence the researcher must suspend their perceived reality of the world (Cohen et al, 2000). 'Bracketing' was the term adopted by Husserl to describe the process by which researchers should abandon all prior personal knowledge and prejudices before engaging in a study (Crotty, 1998). Husserl argued that it was only after getting rid of everything else that it was possible for the researcher to make out the essences of the life world.

The idea that Husserl believed he could obtain 'fundamental knowledge' of phenomenon (the notion that the 'essence' of something is finite and open to discovery) is something which I grapple with. For me meaning does not inhere in the object; rather

we construct meaning and make sense of things in different ways. Ultimately there is *'no true or valid interpretation'*, rather there are *'useful interpretations'* (Crotty, 19998, p. 47).

Similarly I do not think it plausible (or advantageous) that a researcher could or should suspend their personal beliefs about the phenomena they are exploring (Mapp, 2008). Rather I see the qualitative researcher as the *'interpretive bricoleur'* who understands that research is *"an interactive process shaped by one's personal history, biography, gender, social class, race and ethnicity and those of the people in the setting"* (Denzin and Lincoln, 2013, p. 10). The study which is produced is therefore an *'emergent construction'* (Weinstein and Weinstein, 1991, p. 161), a dynamic entity which changes and takes different forms as different influences are added. For these reasons hermeneutic phenomenology (influenced by Heidegger and Gadamer) as opposed to descriptive Husserlian phenomenology was adopted.

5.8 Hermeneutics

The term hermeneutics is taken from the name Hermes (a winged messenger in Greek mythology) and was first used in the 17th century when it was introduced as a method for biblical interpretation (Dowling, 2004). German philosophers Friedrich Schleiermacher (1768-1834) and William Dilthey (1833-1911) were instrumental in the development of hermeneutics as we understand it today, redefining it into a more generalized view of human understanding (Porter and Robinson, 2011). The two emphasised the importance of considering the socio-historical context of both the author and the reader, determining that, *"interpretation involves historically conditioned and living beings, in terms of both the original creative act of a text and the current reader who tries to make sense of that intentional act"* (Porter and Robinson, 2011, p.

23). Hermeneutics, they maintained, could be used for clarification wherever there is communicative understanding, either verbal or written.

Contemporary hermeneutics “*refers to the science, theory, and practice of interpretation*” (Porter and Robinson, 2011, p. 2). In hermeneutic inquiry the principal basis of knowledge is taken to be “*practical activity: direct, every day practical involvement with tools, artefacts, and people*” (Packer, 1985, p. 1083). Hermeneutic interpretation sheds light on the phenomenon of interest by “*a process of contextualization and amplification*” rather than one of ‘*structural essentialization*’ as with descriptive phenomenology (Hein and Austin, 2001, p. 9).

Hermeneutics is a way of thinking about our being, can be used to describe human understanding, and provides a means of questioning existing notions of truth, reason, and knowledge (Porter and Robinson, 2011). Modern hermeneutics explores human phenomena by studying human experience as if it has a linguistic and textual structure; that is it tries to ‘read’ human practices, affairs and circumstances in ways that create understanding (Gadamer, 1975).

5.9 Hermeneutic Phenomenology

Hermeneutic phenomenology is ‘*a philosophical school of thought*’ primarily informed by the philosophers Heidegger and Gadamer (de Witt and Ploeg, 2006, p. 216). Heidegger and Gadamer both postulated that positivist methods could not effectively be used to understand experiences of phenomena. The two believed that understanding is not a process which can be managed and clarified by rules but rather that it is ‘*a very condition of being human*’ (Thomson, 2007, 111).

Heidegger and Gadamer clearly identified the *'innate intelligibility'* of the world suggesting that whilst we engage with the world from our own individual perspective the world has its own meaning which is presented back to us (Thomson, 2007, p. 116). Understanding and interpretation therefore function in an ongoing dialogue. For Heidegger and Gadamer the ontological is primary; *"meaning lies in the individual's transaction with a situation such that the situation constitutes the individual and the individual constitutes the situation"* (Annells, 1996, p. 708).

As a young man Heidegger was Husserl's pupil and his work has been described as a *'radicalised version'* of that of Husserl (Harman, 2007, p. 4). Whereas Husserl held that things are phenomena for human consciousness Heidegger maintained that understanding is worked out through our being in the world (as opposed to in the privacy of consciousness). Gadamer, a student of Heidegger, built on Heidegger's work suggesting that whilst all understanding is interpretation, it is guided by a *'fusion of horizons'*; anything which we interpret has its own horizon of meaning. Understanding from a hermeneutic phenomenological standpoint is therefore a *'mode of being'* as opposed to a *'way of knowing'* (Reeder, 1988).

5.10 Martin Heidegger (1889-1976)

Martin Heidegger questioned the certitude of scientific method; the world of subject and objects and the time-honoured beliefs of understanding and explanation as ways to categorise human experience. Heidegger argued that scientific research takes place *"within structures that have already been worked out before any genuine encounter with the facts/data being observed"* (Hock Chang and Horrocks, 2008, p. 385). Heidegger did not believe that the *'original experience of humanity'* could be determined within the analytical structures of scientific inquiry. Instead Heidegger endeavoured to get behind all epistemological distinctions to the lived roots of human experience.

Heidegger was not interested in the structures of consciousness or essences; rather he sought to answer the fundamental question of the 'meaning of being'. For Heidegger any analysis of consciousness misses the fundamental certainty that we are already being-in-the-world (Porter and Robinson, 2011). For Heidegger knowledge is less about seeing and more about interpreting; things are perceived and understood as they are encountered and practically used.

Heidegger maintained that life is marked by 'facticity' meaning that it cannot be described in purely theoretical terms; human life is always absorbed in a particular situation. For Heidegger human life must be seen in "*the very act, performance, or execution of its own reality, which always exceeds any of the properties we can list about it*" (Harman, 2007, p.25). For Heidegger a being's everyday existence, her orientation and relationships to others and herself must come into focus as that which grounds all understanding (Kogler, 2006).

5.11 Hans-Georg Gadamer (1900-2002)

Whilst Heidegger concentrated on how we make sense of being in the world Gadamer focused on the practical notion of understanding by asking "*How is understanding possible?*" (Fleming, Gaidys and Robb, 2003). In answering this question Gadamer presented two fundamental tenets of hermeneutics: prejudgement and universality. Prejudgement is the horizon of meaning or preconceptions that make understanding possible and universality is the suggestion that those who express themselves and those who understand are united by a shared human consciousness (Ray, 1994). Permeating his works is the deep seated belief that understanding and interpretation are '*indissolubly bound together*' making any concept of definitive interpretation both unworkable and undesirable (Annells, 1996, p. 707).

Gadamer places language at the core of understanding and suggests that the essence of tradition exists in the medium of language. This concept fundamentally draws on Heidegger's work; Heidegger saw language as the '*house of being*' suggesting that it is only through language that man can attempt to explain his own being and understand how he exists within his world (Kockelmans, 1980, p. 15). Heidegger believed that meaningfulness is more profound than the commonsensical system of language (Thomson, 2007). For Heidegger meaningfulness is anchored in the way language is used to achieve understanding within a specific cultural and historical context.

The linguisticity of understanding is more fundamental to Gadamer's thinking than to that of Heidegger; to Gadamer the '*understanding of transmitted messages and language are not two processes but one and the same*' (Annells, 1996, p. 707). Gadamer conceived that as beings we are 'in' the world through being 'in' language describing us as '*living in conversation*' (Gadamer, 2004, p. 26). Gadamer maintains that the meaning of a word is never completely separated from the multiple meanings it has in itself; words possess a '*fluctuating range of meaning*' and language is "*constantly building up and bearing within itself this commonality of world-orientation*" (Gadamer, 2004, p. 17). For Gadamer understanding is a '*language event*' (Gadamer, 2006, p. 16).

Gadamer laid emphasis on the concept of historical awareness, valuing it as a positive rider for knowledge and understanding and seeing consciousness as a synthesis of the individual's perspective within the '*prejudices of history*' (Fleming et al., 2003, p. 115). Gadamer postulated that it is impossible to lose one's pre-understanding of phenomena and argued that it is only through one's pre-understandings that understanding is possible. In actuality Gadamer sees humans as "*historically effected consciousnesses*" (Crotty, 2009, p. 101) and understanding "*less as a subjective act than as participating*

in an event of tradition, a process of transmission in which past and present are constantly mediated” (Gadamer, 2004, p. 291).

5.12 Heideggerian Notions

5.12.1 *Dasein*

Central to Heidegger’s philosophy is the concept of ‘Dasein’; he describes this as the human kind of being. Heidegger’s phenomenology of Dasein represents his *“phenomenological explication of human existing itself”* (Palmer, 1969, p. 42). A crucial element of Dasein is that this is an entity which to each of us is ourselves and includes *inquiring* as one of the possibilities of our being, (Heidegger, 1962). Dasein differs fundamentally from all other entities as *‘it can comport itself toward being’* (Wrathall, 2013, p. 5). Heidegger uses the term *‘existence’* to refer to Dasein’s mode of being; he calls the modes of being for entities other than Dasein *‘presence-at-hand’* and *‘readiness-to-hand’*.

Dasein has neither a distinct fundamental nature nor an array of attributes to be examined; rather it is made up of possibilities. As Dasein we are out in the world and by virtue of our own decisions *“we emerge as selves, realising and actualising our possibilities”* (Porter and Robinson, 2011, p. 64). Heidegger argues that we are not defined from birth despite being constrained by and reliant on our own historical and cultural situations.

The ‘Da’ in Dasein signifies the world human existence is in. Dasein is *“the situated meaning of a human in the world”* (Annells, 1995, p. 706). Dasein and the world belong together and so human existence and the world are interrelated. Heidegger maintains

that human beings cannot exist except in the framework of an encompassing world, although the world does not entirely make up or determine the human being; we do not experience ourselves as distinct from the world and others, rather we are engrossed in the world and as such cannot be divorced from it. For Heidegger being-in-the-world is our basic constitution; Dasein and the world are a 'unitary' phenomenon that can only be understood when seen as a whole (Heidegger, 2012, p. 76). For Heidegger the world is essentially '*a meaningful structure*' and only "*exists for entities like us who are capable of grasping meanings*" (Wrathall, 2013, p. 6).

5.12.2 *Being-in-the-World*

Heidegger chooses three main existentials as fundamental and essential to our understanding of being-in-the-world: *disposedness*, *understanding*, and *discourse*.

For Heidegger there is a notable reflexive property to being-in-the-world. Dasein finds itself already placed in a world that is organised in a distinct pattern and where certain things have already shown up as important (Wrathall, 2013). Heidegger describes this as '*thrownness*' (or facticity); "*the meaningful matrix of relationships, practices and language that humans live in by virtue of being born into a particular time and place*" (Parsons, 2010, p. 61).

Our thrownness is revealed to us through a particular way of being attuned to the world described as our disposedness; the backdrop against which we create our existence. As Wrathall (2013, p. 14) explains, "*our disposedness gives us a certain familiarity with our world – a certain sense of what's important and trivial, relevant and irrelevant, to be preferred or avoided*". We encounter the world as it matters to us and the way that we attune is known as our mood (Blattner, 2006, p.79). Heidegger's notion of moods constitutes how we find ourselves in the world; it contributes to the sense that we have

of belonging in the world (Ratcliffe, 2013). Our moods may change but we are always in some kind of mood and our moods therefore constitute a sense of belonging to the world.

Our understanding, according to Heidegger, opens up the opportunity for us to act on the basis of our disposedness; it is our underlying capability to be someone, to do things and to get by in the world. In other words it explains our ability to deal with situations and pursue meaningful projects (Wrathall, 2013). Further our act of understanding involves projection into the future as we “*reach ahead into the meaning of something in order to comprehend it*” (Healy, 2011, p. 222). We realise the actual in terms of the possible.

Discourse refers to the way in which Dasein expresses the meaningful structure of its world. Heidegger tells us that the human being is “*a living thing that has its genuine being-there in conversation and in discourse*” (Heidegger, 2002, p. 74). Discourse is the articulation of intelligibility; it is an existential. For Heidegger world is not an ‘object’ of speech rather the world makes itself known in discourse. Further according to Escudero (2013, p. 354) “*Rede establishes a boundary of meaning for Dasein’s understanding of the world*”.

The concept of a ‘*boundary of meaning*’ is an interesting one suggesting that Dasein cannot understand something within its world if it is not already established in the shared discourse. Knowles (2013) explains that the ultimate source of meaning for Dasein is ‘*das Man*’ and that Dasein encounters entities in a ‘*totality of relations*’; this means that to understand what something is Dasein must understand the specific ‘*reference relations*’ that embody it (Heidegger, 1962, p. 415). By sharing a way of speaking about ‘*things that can be shown*’, speakers can ‘understand’ something in the

world which is outside their own experience. Similarly, however, listeners can easily be 'misinformed' or 'misled' (Escudero, 2013, p. 9).

5.12.3 Care

Central to Dasein's being-in-the-world is the notion of 'care'. The world can be defined as what we care for, and we can be defined as what cares for the world (Ree, 1998). As care we *have* care and we *take* care. It is through care that we are able to understand ourselves and our existence. Care is the means by which facts, possibilities, people and events in the world matter to us. We are always concerned about something and so care is our basic way of being-in-the-world (Heidegger, 1962). "*Care is correlative to the significance of the world. Only if Dasein is care can it dwell in a significant world, and only if it dwells in a significant world can Dasein be care*" (Inwood, 2000, p. 59). Care explains the difference between things that immediately matter to us and those that do not. It explains our interest in other people and what they do (our 'solicitude') as well as concern for our situation and environment (Foulds, 2012).

5.12.4 Temporality

Heidegger points to temporality as the primordial meaning of Dasein's being. Temporality is viewed as a "*connectedness rather than as linear time*" (Annells, 1996, p. 706). Heidegger maintains that the temporal character of Dasein is derived from a tripartite ontological structure: *existence*, *thrownness* and *fallenness* (Heidegger, 1962). Dasein is *potentiality for being*; it projects its being upon various possibilities. Existence therefore represents the phenomenon of the future. As thrownness Dasein finds itself already in a certain socially and historically conditioned environment. In this environment possibilities are limited and this represents the phenomenon of the '*past as having been*'. Finally Dasein exists in the midst of things which are both Dasein and

not Dasein. The encounter with those beings, '*being alongside*' or '*being with*' is made possible by the presence of those beings in the world. This represents the primordial phenomenon of the present.

5.12.5 Historicity and Repetition

For Heidegger a sense of the historical is a feature of human existence: history (Geschichte) "*signifies a happening which we ourselves are and in which we are involved*" (Heidegger, 2002, p. 173). 'Thrown' into the world Dasein is enmeshed in an historical situation in which some opportunities are open and some are not; Dasein is in fact a "*powerless subject of history*" (O'Carroll, 2008, p. 53). Historicity, as Heidegger understands it, "*comprehends the way in which individuals relate to their own past and appropriate the tradition of which they are a part*" (Katz, 1982, np).

According to Heidegger the concept of repetition (Wiederholung) gives meaning to the past; repetition "*discloses to Dasein its own history*" (Schrage, 1970, p. 287). Heidegger does not present the concept of repetition as a re-enactment of something which has already occurred, rather he presents it as a means by which Dasein can reclaim possibilities; as Schrage (1970, p. 289) explains "*repetition thus occasions a reopening of the past by translating that which has been into possibilities to be chosen time and again*". Repetition, Heidegger argues, imbues the past with a meaning or significance helping us to understand it as part of our own personal past but also as part of the beliefs and customs of the time (Heidegger, 1962).

5.12.6 Authenticity and Inauthenticity

Heidegger believes that human kind has fallen into a disastrous state because of its dependence on scientifically conditioned ways of thinking. For Heidegger the crisis

manifests itself in technology and an attitude to life which is concerned with *'inauthentic'* routine (Porter and Robinson, 2011). He argues that humanity has forgotten what being *is* and in doing so a more *authentic* way of life has been neglected.

Heidegger maintains that we live inauthentically when we function in our everyday existence as part of *'the-they'*, *"...in the practical public environment, in utilising public means of transport and in making use of information services such as the newspaper, every other is like the next. One's own Dasein dissolves completely into the kind of being of 'the others'"* (Heidegger, 1962). In the everydayness of living our lives we just get on with and do the things that we need or want to do. Dasein loses sight of itself when it *'falls into'* and is immersed in the world, neglecting itself as an autonomous individual and interpreting itself purely based on its situation and preoccupations (Inwood, 2000).

In contrast living authentically means not fatefully assuming what is handed down to us but instead seeking our *'own-most potential to being'* (Heidegger 1962). To be authentic is to do find your own way rather than to become absorbed in your everydayness and to follow patterns of behaviour prescribed by *'the-they'*.

5.13 Philosophical Concepts

5.13.1 Language and Linguisticality

According to Heidegger: *"language belongs to the closest neighbourhood of man's being"*, (Heidegger, 1971). In *'Poetry, Language and Thought'* (1971, p. 191) Heidegger tells us that *'language speaks'*; he suggests that language speaks independently of man and that man speaks as he responds to language. By listening to what is spoken and

by relying on standard references man is able to define the world around him. Escudero (2013, p. 9) explains this further telling us that “*by sharing a natural language, speakers not only share a conventional system of signs, but, much more importantly, they share the same way of speaking about the things in their world that can be shown*”. The noteworthy part of this statement is ‘*the things that can be shown*’; what can be shown and what can be spoken are inextricably linked. Man is therefore ‘*dependent*’ on a language which is ‘*ready to hand*’ as a means of showing the ‘*as structure*’ of the world (Hirsch, 1978, p. 356).

Words as we know them are not completely in our control; we grow up with language and use it as a physical being in a socio-cultural context. For Heidegger words are historical with meaning derived from what came before and acquired within our customs and traditions. Understanding is worked out through our being-in-the-world as opposed to the privacy of our consciousness. It follows then that meaningfulness is anchored in the way language is used to achieve understanding within a specific cultural and historical context.

Gadamer maintains that we are always already involved with language; we are immersed in the world linguistically. Language depends upon activities, processes and practices that are intrinsically cultural and social. Language is ubiquitous and has an ‘*expressive potency*’, not from its power to represent, but from its activity within a ‘*language community*’, from which it develops and to which all humankind belong (Lawn, 2006, p. 15). Gadamer questions the rational method and rejects the view that reason stands before language. Cultural objects and the natural world are not objects for rational investigation but voices within the framework of a *never-ending conversation*. For him understanding is a language event which an individual is involved with rather than something determined by them.

5.13.2 *Understanding, Tradition and Interpretation*

“Understanding understanding requires coming to self-understanding, shedding light on assumptions which otherwise work ‘behind our backs’”
(Moran, 2000, p. 251).

For Gadamer all understanding is determined by ‘*prejudgement*’ and our pre-judgements are formed by our ‘*effective history*’; the historical working out of the consequences of actions in which we are unavoidably involved (Gadamer, 2004). Our mindfulness of being affected by history belongs to the manner in which we understand everything. The position of the person who seeks to understand is therefore not fixed but rather is part of a *tradition*, the effect of prior interpretation meaning there can be no unbiased position from which interpretation takes place (Lawn, 2006). For Gadamer there is a never ending dialogue at work in interpretation, a *dialogue* between the past and the present. This being the case there can be no meanings outside of our current consciousness as meaning is always produced by the coming together of the immediate and the point of tradition one seeks to understand.

Further there is also a dialogue between the interpreter and the text or person; as the interpreter (with his unique horizon) engages in dialogue with a text or another (with their own unique horizon) the former can think about his own horizon and in doing so realise a critical level of self-consciousness. As the dialogue continues a tussle for meaning will ensue; the interpreter may rework his horizon over and over again while at the same time pulling the other from its initial horizon until some sort of fusion of meaning is achieved (Demeterio, 2015).

For Heidegger we put our understanding to work by using it to do things. Understanding understood in this sense, as explained earlier, is our capability to do things and get by in the world. Heidegger argues that as we use our understanding we refine our ideas

and develop new ways of understanding things; we thereby make our own '*interpretation*'. Interpretation is therefore the '*working out of possibilities projected in the understanding*' (Heidegger, 1962, p. 188). Heidegger stresses that interpretation is not necessarily about gaining new information about what is understood, rather it is the opportunity of developing of new possibilities.

Heidegger maintains that as an interpreter a person is formed by the pre-suppositions of his own '*lifeworld*' making him incapable of reaching full self-consciousness and therefore attaining objective knowledge (Demeterio, 2015). Heidegger suggests that rather than being seen as a hindrance this characteristic should be usefully employed in the act of interpretation (rather than bracketed as Husserl suggests) and that the interpreter should *employ* their pre-suppositions as the starting point in understanding as, he argues, it is these biases and prejudices which will help the interpreter to capture meaning.

5.13.3 *Fusion of Horizons*

Gadamer builds on Husserl's metaphor of a phenomenological horizon by introducing the '*fusion of horizons*' to the process of hermeneutics. Gadamer speaks of the person inhabiting a '*horizon*' of understanding which has a history and a perspective rooted in a particular socio-cultural context (Lawn, 2006). Although the horizon is unique to each individual it cannot exist without other horizons. Acts of understanding call for what Gadamer calls the '*fusion of horizons*' where one engages the other in dialogue. For Gadamer our understanding of the world is '*dialogical as opposed to propositional*' (Lawn, 2006, p. 48). Understanding emerges as our horizon (located in our unique socio-cultural space) fuses dialogically with that of another within an already interpreted world; a world we share by means of the language we hold in common.

5.13.4 The Hermeneutic Circle

The process of Heideggerian hermeneutics as a method of enquiry is circular, highlighting the relatedness of the phenomena under investigation to its surroundings and its investigator (Healy, 2011). All questioning and attempts at understanding start with the researcher as an active participant and involve a moving back and forth between the self, the data and the literature. On entering the circle the researcher takes with them a number of presumptions which govern the enquiry and potentially what can be discovered. As Moran (2000, p. 237) suggests we “*disclose the answer in the light of what we already know*”.

Heidegger embraced the hermeneutic circle to make interpretation possible describing ‘*relatedness backward or forward*’. In the process Heidegger devised a three-fold structure he called the ‘*fore-structure of interpretation*’. Heidegger’s three-fold structure is made up of: *fore-having* which is the background context, *fore-sight* meaning that we enter a situation with a specific viewpoint and *fore-conception* which is an anticipated sense of the interpretation we will make (Heidegger, 1962). For Heidegger working out the fore structures is essential as a means of coming into the circle of understanding because interpretation is never a “*pre-suppositionless apprehension of something presented to us*” (Thomson, 2007, p. 116).

5.14 Reflexive Positioning and Pre-suppositions

At the outset I considered my pre-understandings of the phenomenon. As Van Manen (1990) explains, phenomenological research does not start in a ‘*disembodied fashion*’. Rather it is always “*a project of someone: a real person, who, in the context of particular individual, social, and historical life circumstances, sets out to make sense of a certain aspect of human existence*” (Van Manen, 1990, p. 31). An interview to explore my pre-

understandings was conducted with two of my supervisors prior to data collection. To start to understand the lives of others I felt I needed to explore myself. Similarly, to make sense of the meanings buried in the stories of my participants I needed to draw on my own understandings of the phenomenon. Smythe (2007, p. 401) recommends this approach suggesting that unless we consider what we bring to '*an encounter*' we will miss an essential step towards being open with the '*other*'.

I found that as a woman who has birthed and as a midwife who has experience of attending births I have certain preconceived understandings of the world of birth. My understanding is grounded in my own experience of birthing 'normally' and in my experience of working as a community midwife in a low risk setting with a fundamental belief in the ability of most women to birth physiologically. I am passionate about assuring the positive nature of the experience for women as I believe the experience will permeate the whole of the woman's life. These conceptions contribute to the emerging interpretation.

Explicated from Heidegger's viewpoint my background context as a woman, a mother, and a midwife and as someone with pre- understandings of womanhood, birthing, mothering and being 'with woman' make up my *fore-having*; it is the knowledge and understanding that I bring with me into this study. My *fore-sight* is the starting point of my research glimpsed but not fully formed at the outset; the sense of birth stories as significant in some way to the experience of birth and birthing. Finally my *fore-conception* is the way in which I approached the study and its interpretation, what I imagined I would find.

I therefore define the childbearing world I am part of with my own particular understanding, I am disposed to this world in a very specific way; for me the context of birth is part of who I am. As Crowther (2014) states, "*Who I am and how I respond to*

the phenomenon is thus part of the interpretation” and cannot be forced outside the process of the interpretive work.

5.15 Chapter Summary

This chapter has presented the theoretical perspective and philosophical foundation of my research and introduced the reader to the fundamental philosophical and Heideggerian notions which will be discussed and applied in my interpretation. In the text I have given the study a context and shared my understandings of and relationship to the world of birth highlighting how I envisage my pre-suppositions may impact on that interpretation.

In the next chapter I explain how I moved from a methodological framework, explicating and grounding the study, to a living breathing piece of research. I describe the ‘building blocks’ used to move from an outline idea to a phenomenological conversation.

CHAPTER 6 - METHOD: 'A STARTING POINT'

“All formulas are dangerous. They force whatever is said into the superficiality of the instant opinion and are apt to corrupt our thinking. But they may also be of help, at least as a promoting and a starting point”
(Heidegger, 1971, p. 197)

6.0 Introduction to Chapter

The previous chapter presented the methodological framework underpinning this study outlining the epistemological and philosophical approach. In the first part of this chapter I explain the study design. Decisions about the ‘*how to*’ of the study are contextualised by the hermeneutic philosophies discussed in the previous chapter. Later in the chapter I describe the interpretive processes; the act of ‘*seeing meaning*’ evoked by thinking and re-thinking, writing and rewriting (Van Manen, 1990, p.79). I consider issues of rigour and trustworthiness in the context of a hermeneutic study and close by introducing the phenomenological writing of the findings chapters. As a whole the chapter tells the ‘*story*’ of my research illustrating how it moved from a tentative idea to an experience of thinking, writing, and showing.

Clearly a researcher in any study is charged with carrying out a series of methods and procedures that ‘*satisfy the requirements of an organised, disciplined and systematic study*’ (Moustakas, 1994, p. 103) and any written account demands a ‘*breaking down and an order*’ of the research process (Smythe, 2005, p. 228). This chapter satisfies those prerequisites, describing issues such as the setting, ethics, participants, sample and data collection method, but at the same time reveals that enacting hermeneutic

phenomenology is a '*journey of thinking rather than a specific, pre-determined process*' (Smythe et al, 2008, p. 1390). This is because as an approach hermeneutic phenomenology is more of a dynamic and evolving activity rather than a clearly articulated method (Gadamer, 2004; Van Manen, 2014).

Without a clear set of procedures it follows that the process is enacted differently by every individual researcher; rather than being a series of steps to be followed the researcher is always in the '*midst*', working inside the '*hermeneutic circle*', going backwards and forwards between the literature, the participants, the '*stories*' and evolving insights. Smythe et al. (2008, p.1391) describe this space as '*the leeway*', the space '*between structure and freedom*'. In this space the research '*is the writing*' and in the thinking there are no '*subheadings*' by which to classify or arrange our thoughts (Smythe, 2005, p. 228). Indeed the work of hermeneutics as Gadamer clearly articulates, is "*not to develop a procedure of understanding, but to clarify the conditions in which understanding takes place*" (2004, p. 295). This chapter summarises the '*conditions*' I put in place to enable me to understand the experience of women engaging with birth stories whilst pregnant with their own child.

Before I consider these '*conditions*' I explain some of my early impressions about the approach I had chosen and the journey I was tasked with making.

At the outset of my PhD I knew very little about hermeneutic phenomenology but, as explained in the previous chapter, felt the approach was a good fit for midwifery and a good fit for both me and the phenomena. I was nervous about using the approach because of its strong philosophical foundation (which I felt I may not understand) and the fact that there was no fully developed and systematic method to employ. Nonetheless I liked the apparent '*freedom*' the approach promised and the opportunity for reflective thinking where "*something could be shown, revealed, or clarified in its*

essential nature" (Van Manen, 1990, p. 29). I was worried, though, about how I would 'know' what to do. How I would be able to design a study that would 'work'; that would be well organised and trustworthy?

One of my supervisors suggested attending the 'Institute for Heideggerian Hermeneutical Methodologies' (IHHM) at Indiana University, telling me that she had attended and that it was an incredible introduction to, and beginning experience in, designing and conducting hermeneutic studies. I attended the Institute in June 2012 and within a community of other beginners explored and learnt about the approach. By the end of the course I felt like I was beginning to understand the journey I had embarked on but I also recognised that the road I had chosen to travel would not necessarily be the fastest or most direct. I could see that the route was likely to be long and winding but I had learnt that, much like Dorothy in the 'Wizard of Oz', if I put my faith in the process and concentrated on my destination that I would surely get where I needed to be. I wrote an '*I*' *poem* (inspired by the work of Gilligan, 1982) to describe my feelings at this time and explain my experience. My poem, '*I have a voice*' is included as part of my thesis.

I have a voice

I see but do I see?

I am a fish but I do not see the water

I cannot hope to understand you because I know too much

I have my own 'gaze' but I also have a sense of 'it'

I am not the expert

I inhabit my world

I am engaged openness

I see through my past in the present and in my future

I am a living, ontological being

I am skilled at existing

I am ready to hand

I understand and yet I don't

I will come to understand

I am always already in the world

I am caught in the swirl of existence that I am trying to understand

I need to listen to what is said

I need to listen to what is not said

I am always already in the world of birth

I am a co-participant

I must ask the right questions

I will understand what I am thinking when I see what I write

I will have many conversational partners

I will get a glimpse

I will pull out what catches my 'gaze'

I will hammer out my idea

I am exposed, vulnerable, open and raw

I am excited by possibility

I feel it!

I get it!

I finally trust it
I am honoured to be part of it
I anticipate a 'luscious mess'
I must read into this
I must read out of this
I will reveal the concealed
I feel empowered
I will find meaning right in front of me
I will make a case and I will invite you in
I am open to possibilities and to mysteries
I will make an interpretive leap but will not have a firm footing
I am approaching an abyss
I am looking for what lies near
I want to share
I want to have a voice
I want to tell a story.

Having introduced the chapter and explained my views and impressions about my chosen approach and its impact on study design, I now move on to describe the 'conditions' I put in place to enable me to understand the experience of engaging with birth stories whilst pregnant.

6.1 Programme of Works

My study was conducted in two phases.

6.1.1 *Master of Philosophy (MPhil) Phase*

In phase one I considered how first-time pregnant women who would be giving birth in 2013 came to understand birth both in the context of their own experience but also in

the milieu of other women's birth stories. Ethical approval for this phase was granted by the University of Central Lancashire (UCLan) BuSH (Built, Sport and Health) Committee in April 2012 and the data was collected between October and December 2012.

6.1.2 Doctor of Philosophy (PhD) Phase

In the second phase I set out to determine what the information landscape was like for women who were pregnant in the 1970s –1980s and establish how those women came to understand what their experience of birth might be. Ethical approval for this stage was granted by the University of Central Lancashire BuSH Committee in January 2014 and the data was collected between October and December 2014. Letters of approval for both phases are attached as Appendix Three.

6.2 Ethical Issues

The Research Governance Framework for Health and Social Care (DOH, 2005) states that the dignity, rights, safety and well-being of participants must be the primary consideration in any research study. This framework and all publications relating to medical research had their genesis in the 'Nuremberg Code'; a document created by judges handing down a ruling in the trial of Nazi doctors accused of conducting human experiments in the concentration camps (Shuster, 1997). In the Code the judges acknowledged that the protection of human subjects in research was paramount. A set of guiding principles was devised which centred on the research subject; the requirement for informed consent and the right to withdraw from participation were fundamental to the Code.

‘The Belmont Report’ of 1978 (created by the ‘National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research’ in the United States of America) highlighted what have become the three basic ethical principles of research and their applications. These are illustrated in a customised table (utilising text from the Report)

Table 4: The Belmont Report Principles and Applications

<i>Ethical Principles</i>	<i>Applications</i>
Respect for persons	Informed Consent
Beneficence	Assessment of Risks and Benefits
Justice	Selection of Subjects

6.3 Respect for Persons

Respect for persons and their individual autonomy is paramount when conducting any type of research. In this study respect for individuals was assured by obtaining informed consent. In both phases a participant information sheet and accompanying consent form were designed outlining the nature and purpose of the study (the participant information sheets are attached as Appendix Four and the consent forms as Appendix Five). The consent asked the participants to confirm that:

- They had read and understood the information sheet
- They understood that they had the right to withdraw from the study at any time

- They were aware of and gave their consent for a digital recording of the interview to take place
- They were aware of and gave their consent to me to share details of the venue and timing for the interview with a member of the supervisory team (thereby ensuring my personal safety)
- They were aware that the results of the study might be published in a summary report, presented at conferences and published in peer reviewed journals and that they would not be identified in these publications

The participants were asked to sign two copies of the consent form, giving one to me and keeping one for their reference.

6.4 Beneficence

The protection of the participants is crucial in any research study; in a hermeneutic phenomenological study the main ethical consideration is “*the impact of having someone listen to one’s story*” (Smythe, 2011, p.39). In the everyday stories that are part of the phenomenological conversation people are likely to reveal their ‘story’ in detail and depth (more so than in a spur of the moment conversation) and in doing so potentially expose any vulnerabilities.

In my study I recognised the potential for the interviews to raise issues which might be sensitive, embarrassing or upsetting for the participants. Participants were advised that their involvement in the study would be on a purely voluntary basis. The participants had the right to refuse to answer any questions or withdraw from the interview situation.

Participants were also advised that they could withdraw their data from the study within a time frame of one month post interview. As a practising midwife, with experience of dealing with people in times of stress and distress, I was relatively confident that I could manage any situation as it arose. However participants were advised that they could meet with a member of the supervisory team (to debrief as necessary) and of the availability of a counselling service should they feel they needed it.

Similarly the participants were advised that whilst there were no direct benefits of participation involvement in the study would provide them with an opportunity to reflect on their experiences and beliefs about birth which they could find useful. They were also advised that their involvement would potentially enable greater appreciation of the factors which influence women's understanding and anticipations of the birth experience; appreciation of these contributory factors could then feasibly help to inform future antenatal preparation and education.

6.5 Justice

This principle concerns the unbiased treatment of those in a study. In my study participants were assured that if they chose not to participate or to withdraw (after initially deciding to participate) that they would not be compromised in any way. They were also advised (as indicated above) of the availability of counselling services should they experience any form of psychological harm.

6.6 Participants and Setting

6.6.1 Phase One

A purposive sampling method (and snowballing by word of mouth) was used to recruit women who were expecting their first baby. All participants were registered on a 'National Childbirth Trust' (NCT) antenatal course. This ensured that the women had an interest in the childbirth experience and the significance of birth. I was aware that choosing a sample from a specific demographic group had the potential for bias; nonetheless I was mindful that the project needed to be feasible within the time and resource constraints of a PhD study. I knew that I could consider sampling women from a different demographic in my post-doctoral work.

In this phase I joined the NCT (as dictated by their protocol for recruiting potential study participants) and registered the study with the organisation. I provided the NCT with the research protocol, written evidence of ethical approval, a copy of the proposed interview schedule, a participant information leaflet and a recruitment message.

After approving the study the NCT posted the recruitment message on their website and in their magazine. Interested members were advised to contact me directly either by email or telephone (the relevant NCT paperwork is attached as Appendix Six). After the initial contact I gave the member further details about the study and recruited them to the study (if they were still interested in participating).

6.6.2 *Phase Two*

A purposive sampling method (and snowballing by word of mouth) was also used to recruit women in phase two. I targeted women who were members of the 'National Federation of Women's Institutes' (NFWI) and the 'Cambridge Businesswomen's Network' (CBN). These organisations were chosen (after discussion with the supervisory team) as I wanted to ensure that the women I interviewed had a similar socioeconomic status as the women who had participated in the first phase. Interestingly most of the women I interviewed in phase two told me that they had indeed attended NCT classes when they were pregnant in the 1970s and 1980s.

In this phase the NFWI and the CBN agreed to post a recruitment message on their websites asking their members if they would like to participate. Interested members were asked to contact me. After the initial contact I gave the member further details about the study and recruited them to the study (if they were still interested in participating).

In both phases all potential participants were required to adequately understand verbal explanations and written information in English. This was important in terms of timely completion and because there was no funding available for translators. Recruitment forms for both phases are attached as Appendix Seven.

6.7 Sample Size and the Hermeneutic Study

In deciding on the number of participants I was guided by Smythe (2011) who maintains that the researcher should base the number of participants on the time available to pursue the study; thereby ensuring there is time to value each participant's story and

time for the researcher to work intensively with each participant's data. Smythe suggests that in a doctoral study somewhere between twelve to twenty participants "*are likely to yield as much data as one can think through*" (Smythe, 2011, p. 41).

In both phases of my study I aimed to recruit somewhere between eight to twelve women and in both phases I eventually recruited ten women meaning that I had twenty participants overall. Achieving the optimum number of participants was a balance between having 'enough' to ensure that I was able to reach a sense of meaning about the experience of engaging with stories of birth and too 'much' making me feel overwhelmed with and distanced from the data.

Despite my anxieties about the 'right' number of participants I found that as the interviews progressed similar ideas and meanings emerged and that less and less often new or different meanings were disclosed. Using Crowther's words I finally considered that I had enough data when "*interpretations were both explicit and visible and fewer fresh insights were surfacing*" (2014, p. 113).

6.8 Introducing the Participants

6.8.1 Phase One

In this phase all the women were recruited via the NCT classes. The women were all pregnant with their first baby; these women were targeted as I felt that they would very likely be gathering information sources for their impending births and may well invite stories. The women were aged between 27 and 39 years old. The average age was 30 years of age. Eight of the women were of white British origin and two were of Chinese

origin (both born in Hong Kong but living in the UK). All of the women were resident in the East of England.

6.8.2 Phase Two

In this phase I recruited eight women from the NFWI and two from the CBN. The women were aged between 52 and 67 years old. The average age was 57 years of age. Of these one woman had birthed in the 1970s, two in the 1970s and 1980s and seven in the 1980s. All of the women were of white British origin. Four of the women were resident in the East of England, three in the North East, two in Yorkshire and the Humber and one in the South East.

The women were recruited from different parts of the country after the NFWI posted my recruitment message to all of its members rather than to those purely in the East of England as I had requested. When I was contacted by women from other parts of the country I decided to include them as they were clearly interested in the study and I felt they could potentially offer slightly differing insights. However I was conscious that I would not be able to interview everybody in person (because of timing and cost restraints). After discussion with the supervisory team I amended my ethics application asking for the option to interview women over the telephone. My amended application was approved in November 2014 and the approval letter is attached in Appendix Three.

6.9 Maintaining Confidentiality and Preserving Anonymity

Confidentiality is a significant concern in any study. In this study I had control of and acted as custodian of the data. Digital recordings of the data were transferred to UCLan password protected/encrypted computer systems. Consent forms and data in note form

were stored in a locked filing cabinet in my home. Transfer of consent forms/data (e.g. digital recordings) during data collection was securely undertaken (e.g. under my constant supervision) and immediately transferred to the locked filing cabinet/saved onto the UCLan computer system on my arrival home. Access was only available to me and the supervisory team. It was agreed that all data would be retained for 5 years from the end of the project and then destroyed.

Anonymity of the participants was assured by giving each participant a pseudo name and by using this in the written report and in any presentation of the findings of the study. Further no potentially identifying details (such as personal characteristics or family details) were revealed at any stage.

6.10 Developing the Phenomenological Conversation

“Embracing Heidegger’s understanding of Dasein as being-there, being-open, being-in the-play, going with what comes, awaiting the moment of understanding” (Smythe et al., 2008, p. 1392)

In the hermeneutic interview the researcher is an integral part; a living, breathing part of the research process (Dinkins, 2005). The researcher and participant (described as the ‘*co-inquirer*’ by Dinkins, 2005, p. 113) engage in a dynamic conversation that develops and takes shape within the interview situation. In her text Dinkins describes the ‘*Socratic model of inquiry*’; in this mode inquiry is ‘*shared*’ and Socrates and his ‘*co-inquirers*’ are in the same space speaking, questioning, debating, challenging and ultimately searching for understanding. Dinkins describes Socrates as being ‘*never passive*’, and tells us that he “*never simply asks a question and lets the answer lie*” (2005, p. 116). The researcher in a hermeneutical inquiry is fully engaged in the interview situation, is open to what ‘*is*’ and open to ‘*the play of conversation*’ (Smythe et al., 2008, p. 1392).

In a phenomenological interview the researcher endeavours to create an environment in which the participant feels at ease and is able to share their experience of the phenomena. In seeking to understand the '*lived experience*' of the phenomenon the researcher hopes to capture the detail of the experience; for instance the context, depth, colour and feel of what it is like to experience stories of birth whilst pregnant (Smythe, 2011).

Storytelling is proposed by many as an effective way of reaching that lived experience (Van Manen, 1997; Smythe, 2011; Dinkins, 2005; Benner, 1994). The premise behind using storytelling is that in telling their 'story' participants concentrate and reflect on specific experiences and in doing so are less likely to speak of their generalised experience (Benner, 1994; Smythe, 2011). Generalised experience is not overly helpful to the phenomenological researcher as it is unlikely to get to the significance of the phenomenon; participants are likely to have reached some tentative conclusions and may offer their opinion of an experience as opposed to relating what actually happened (Smythe, 2011). Using an interview schedule and adopting a question and answer format is similarly unhelpful as it will undoubtedly lead the conversation into the subject area that the researcher is anticipating. The resulting transcripts will then appear tight and structured as opposed to dynamic and rich (Ironsides, 2012).

6.11 The Interviews

At the outset I was anxious about how to conduct the interviews in this study. Because of the nature of the ethics application and approval process I had been tasked with putting together a 'schedule' of potential questions for each phase of the study. These schedules are attached as Appendix Eight. From my reading I was aware that the interviews needed to evolve in the moment; that each one would be unique and that as I learned more about the phenomenon I would very likely start to think of other ways to

move the conversation forward. Nonetheless I put together a schedule of 'suggested questions' so that the ethics committee could see the areas I was interested in exploring and appreciate that I did not intend to intentionally cause any distress to the participants.

When it came to conducting the interviews I tried to follow the guidelines I had been given when I attended the IHM. I have incorporated these guidelines into a table for ease of reference:

Table 5: Non- Structured Interviews: ‘Asking Hermeneutical Questions’ (Ironside, 2012)

<i>Guideline</i>	<i>Habitual way of asking questions</i>	<i>Alternative hermeneutic questions to ask</i>
<i>Steering away from emotions and feelings - going beyond psychology</i>	How did that make you feel? How did that affect you?	What does it mean to you to have experienced....? Can you give me a for instance that would show me what you mean by ‘just getting through’?
<i>Going for the story: avoiding causal relationships and explanations</i>	Why do you thinkhappened to you? Why were you angry?	As you think back, can you describe how, in a future situation, you might know that a relationship or situation was ‘going downhill’? As you think about this situation can you tell me how you know this person wasn’t being fair?
<i>Avoiding explanations and quantifications</i>	How many times did you have to call before you got an appointment?	How did you know it was getting worse? What did it mean to you to know it was getting worse?

<i>Guideline</i>	<i>Habitual way of asking questions</i>	<i>Alternative hermeneutic questions to ask</i>
<i>Calling out stories: avoiding assumptions</i>	What do you mean 'it was going to get ugly'?	If I were new to this experience, how would I be able to tell that 'it was going to get ugly'? Can you tell me more about what was happening at the time?
<i>Calling out analyses: seeking meanings and significances</i>	Why do you think that happened?	If you were to speak to a young woman who was just beginning to date, how would you describe the warning signs that a relationship might become abusive?
<i>Staying away from leading or judging the participant</i>	Did you ever feel like you caused it? Sounds like an awful situation, did it not make you angry?	When you began to notice your husband was getting confused, can you describe for me what was 'running through your mind at the time'? How were you making sense of what happened?

<i>Guideline</i>	<i>Habitual way of asking questions</i>	<i>Alternative hermeneutic questions to ask</i>
<i>Clarifying what you hear</i>	A lot of the students told me they felt 'stuck'. Did you feel 'stuck'?	Many of the students I've talked with have described similar experiences and how it was like 'being stuck'. As I think about the story you've shared, was that about 'being stuck' or does 'being stuck' describe what the experience was like for you?

I interviewed each participant individually with the dual objective of finding out how they experienced birth stories whilst pregnant and also finding out what type of information they accessed when preparing for their experience of birth.

The interviews, which lasted between 45 minutes and 90, were carried out either face to face or over the telephone depending on participant preference and geographical location. In both instances I used the first few minutes to develop a rapport with the participants. I told them a little about myself; the fact that I was a mother with two children and that my interest in midwifery had started after my own experiences of birth. I also told them a little about my career as a midwife, lecturer and researcher; I felt they needed a sense of me as a person before we started the interview. I believed they needed to appreciate who they were talking to in order to feel safe enough and relaxed enough to share their experiences. This was generally successful.

As predicted the questions I asked evolved through the course of the study. This happened as I became more competent and confident, more attuned to the phenomena and to the women. After the first couple of interviews (when I felt I wasn't getting to the 'heart' of the phenomenon) I remembered some notes I had made at the IHM; I dug these out and found some suggested questions which had been offered by group members during one of the seminars. I found using these questions more effective:

- What do you anticipate this experience will be like?
- How do you understand your impending birth?
- How is it that you came to think this?

- What is your experience of birth?
- Tell me what birth means to you.
- Tell me how you are preparing for birth.

I also incorporated suggested questions from the supervisory team (who had been asked to critique my interview technique and feedback):

- How did this story make you feel about your pregnancy?
- What aspects of this story felt surprising/are relevant for you personally?
- How would you/do you tell your birth story (ies) to someone you care about?

These questions were generally more successful but the interviews and interviewees were each unique and at times unpredictable! Nevertheless I felt that I managed to engage well with the participants and to capture some important insights about the phenomenon.

In all cases the interviews were digitally recorded and later transcribed verbatim. Field notes were made during and immediately after each interview enabling me to capture any unspoken narrative. Analysis of the transcribed data and field notes informed the data collection and subsequent interpretations throughout the study. I kept a reflexive journal throughout the study duration meaning that I could demonstrate a positioning of myself, and provide a clear description of the way that meaning has been ascertained.

6.12 Interpretation

“Working with the data is an experience of ‘thinking’. We are called by a particular story, just as one stops in front of a particular painting in an art gallery” (Smythe et al., 2008, p. 1392).

I love this explanation of working with the data; it explains how I felt when listening to or reading the records of the conversations I had with the participants. My eyes would fix on a couple of words or sentences; they would capture me in that moment and almost immediately my thoughts would jump to another transcript, another conversation, something I had read in the literature, or seen, a poem or a memory or a film. I would be held in the spell of thinking, lost in that space, until I had made the connections that my brain had started to recognise. Often I would not understand the significance of what I had read until I had started to write it down and then suddenly it would start to make some sort of sense. Almost impossible to put into words, my experience of interpreting the data proved to be dynamic and complex. Unpacking the meanings hidden in the women’s stories was an enormously iterative process in which I moved between the interviews, the transcripts, my thoughts, conversations with the supervisory team, the literature, poetry and prose (Van Manen, 1990).

My interpretative process like that of many other researchers was a messy and time consuming one; it was not linear or sequential but rather more inclusive and integrative as described by Thomson (2007). There was no uniform or predefined method of analysis or interpretation I could rely on to help me but instead the freedom to loose myself in the data and let it take me where I felt it needed to go. My approach was an eclectic one informed at times by Van Manen’s phenomenological approach. Van Manen maintains that making something of a lived experience by interpreting its meaning is “*a process of insightful invention, discovery or disclosure*”, (Van Manen, 1990, p. 79). The process he describes is an act of ‘*seeing meaning*’; a process

whereby the interpretation is developed simultaneously as the researcher reflects and writes. It is therefore a never ending process, a process which relies on the reader to add the final layer to the interpretation.

Alongside Van Manen I relied on the guidance of Smythe (2011) to '*bring the unsaid into an open space*'. The guidance is a series of questions which are intended to stimulate thinking and writing, and help the researcher find a way through the huge volume of data that is generated in this kind of study. Using the guidance meant that I could provide an audit trail of the ways in which the emergent meanings came to light.

I have presented the guidance in a table for ease of reference. The guidance is based on and adapted from Smythe's unpublished work 'Getting going' (2003) and her chapter 'How to do hermeneutic interpretive phenomenology' (2011).

Table 6: 'Getting Going with Hermeneutics' (Smythe, 2003 and 2011)

<i>Working with the data in a hermeneutic phenomenological study</i>	
<i>What is my response to this transcript? What things jump out?</i>	<p>Feel the bits you respond to</p> <p>Recognise the phrases that leap out and grab you</p> <p>Be open to interpretations that differ from your own</p> <p>Find what matters</p>
<i>Dwelling with the data</i>	<p>Stay orientated to the research question</p> <p>See the connections</p> <p>Find the stories that have something important to say</p> <p>Gather the meaning together</p>
<i>Finding resonance in the literature</i>	<p>Understand that what you are interpreting has its own context</p> <p>Appreciating the context will help you to see the meaning and the significance</p> <p>Read the literature but also read fiction; poetry and prose can sometimes help us understand and conceptualise ideas and notions</p>
<i>Helping the data to speak: writing a summary</i>	<p>Find the meaning threaded through</p> <p>Pluck bits from here and there</p> <p>Give the reader a brief summary of what the person said so that they can share your focus</p>

<i>Working with the data in a hermeneutic phenomenological study</i>	
<i>Helping the data to speak: move to interpretation</i>	<p>Interpret from your perspective, the meaning that lies behind the saying</p> <p>Craft a story from the transcript</p>
<i>Helping the data to speak: invite other voices in</i>	<p>What does the literature say about what is being said?</p> <p>Are there any exemplars in art, poetry or prose?</p> <p>What do members of your supervisory or research team see in the data?</p> <p>Write in response to your growing understandings</p> <p>Rewrite the story</p>
<i>Helping the data to speak: bring in philosophical and phenomenological notions</i>	<p>Add a philosophical lens</p> <p>Make an interpretive leap</p> <p>Shed more light on the possible meaning by relating it to Heideggerian notions</p> <p>Write in response to your growing understandings</p> <p>Rewrite the story</p>

<i>Working with the data in a hermeneutic phenomenological study</i>	
<i>Pulling it all together</i>	<p>Write in response to your growing understandings</p> <p>Keep writing</p> <p>Let the themes emerge</p> <p>Decide on the best stories that ‘show’ a theme</p> <p>Write drawing on the selected stories, interpretations, voices from the literature and phenomenological notions to inform your thinking</p> <p>Form a concise argument that will articulate the meaning of your chosen phenomenon</p> <p>Allow the data to take the lead</p> <p>Take the reader to the experience, point to what you see, invite them to think along with you</p> <p>Write clearly and simply to allow the meaning to leap off the page</p>

An example of the interpretation process utilising one of the transcripts is attached as Appendix Nine.

6.13 Rigour and Trustworthiness

“To be judged valid, a phenomenological study must take into consideration methodological congruence (rigorous and appropriate procedures) and experiential concerns that provide insight in terms of plausibility and illumination about a specific phenomenon” (Pereira, 2012, p. 19).

According to Pereira (2012, p. 16) “*relevance and rigour are the pillars that support the research process*”. Certainly a reader of any study needs to be assured that it has been carried out in an organised fashion; there needs to be an effective audit trail, the reader must be reassured that the research has been carried out responsibly and, of course, find it plausible and convincing (Koch, 1996).

A reading of the literature, however, highlights the difficulties in utilising a generic set of qualitative criteria of rigour in phenomenological research (Koch, 1996; Koch, 2006; Koch and Harrington, 1998; Annells, 1999; Caelli, 2001; de Witt and Ploeg, 2006). The use of a generic framework is seen as philosophically incongruent with this type of methodology primarily because the credibility and confirmability criteria do not apply. Hermeneutic phenomenology seeks to increase understanding of many interpretations of the meaning of human experience rather than find a solitary truth situated in an objective world (Sandelowski, 1993; Guba and Lincoln, 1994; Annells, 1996; Van Manen, 1997). Further the findings of phenomenological research are not ‘*neutral or value free*’ as demanded by many qualitative approaches, rather they are informed by and enhanced by the researcher’s presuppositions (de Witt and Ploeg, 2006, p. 222).

From my reading I determined that the adapted framework devised by de Witt and Ploeg in 2006 was the most comprehensive and most suited to assuring rigour and trustworthiness in my study. The framework encapsulates five characteristics: ‘*balanced integration, openness, concreteness, resonance, and actualization*’ (de Witt and Ploeg, 2006, p. 215). I discuss these characteristics, described as ‘*practical expressions of rigour*’ by de Witt and Ploeg, in relation to my study in the following table.

Table 7: Rigour and trustworthiness utilising de Witt and Ploeg (2006, p. 215-229)

<i>Practical expression of rigour</i>	<i>Characteristics of expression</i>	<i>Application in this study</i>
<i>Balanced integration</i>	<p>Intertwining of philosophical concepts in the study methods and findings (pages 117-144, pages 175-240).</p> <p>Balance between the voices of the participants and the philosophical explanation (section 4.18, pages 100-102, section 10.5 pages 264-265 and section 10.10 pages 271-274).</p>	<p>I convey the general philosophical theme in chapter five and describe its fit with myself as the researcher and with the phenomena under investigation; these ideas are developed further in the methods and findings chapters.</p> <p>Throughout I demonstrate how my voice, that of the participants, voices from the literature and philosophical and phenomenological notions give voice to the experience of engaging with birth stories whilst pregnant.</p> <p>I demonstrate reflexivity throughout, discussing my personal interview to determine my presuppositions and using excerpts from my supervisory and field notes to further my argument.</p> <p>I consider reflexivity in further detail in the discussion chapter demonstrating my place in the study and my experience of conducting the study.</p>

<i>Practical expression of rigour</i>	<i>Characteristics of expression</i>	<i>Application in this study</i>
<i>Openness</i>	Systematic, explicit process of accounting for the multiple decisions made throughout study (section 1.1 pages 17-22, section 4.17 page 99-100, section 5.14 pages 141-3, section 6.0 pages 145-148, and section 10.5 pages 261-262).	<p>Throughout my thesis I discuss how and why I reached decisions about the design and evolution of the study.</p> <p>I include details about my visit to the IHHM and three of my '<i>I</i>' <i>poems</i> which describe the process of discovery I engaged with in the context of this study.</p> <p>The process is meticulously detailed in my Supervisory records, my field notes, and in email exchanges with supervisors as well as in this thesis.</p>
<i>Concreteness</i>	Usefulness for practice of study findings (chapter 1 pages 17-31, chapter 2 pages 33-68 and chapter 10 pages 240-275).	<p>I present my experience as a birthing woman, a mother, a midwife, an educator and a researcher and in doing so demonstrate my place in the world of birth.</p> <p>I situate my study in its historical context and introduce the reader to the landscape of birth in both the 1970s-80s and today.</p> <p>I make recommendations for practice based on the study findings and discuss the study limitations.</p>

<i>Practical expression of rigour</i>	<i>Characteristics of expression</i>	<i>Application in this study</i>
<i>Resonance</i>	Experiential or felt effect of reading study findings upon the reader.	<p>This characteristic can really only be seen or understood by you the reader. I hope that as you read the phenomenological descriptions you feel an ‘<i>ahh</i>’ moment or give a ‘<i>phenomenological nod</i>’ as described by Smythe (2008 and 2011).</p> <p>From my perspective resonance was acknowledged by my supervisors in our conversations and their feedback and at local and national presentations as I witnessed the experiential effect of my findings on others.</p>
<i>Actualisation</i>	Future realization of the resonance of the study findings.	Acceptance of papers at peer reviewed conferences and a comprehensive dissemination plan (as stipulated in the conclusion chapter of the thesis) actualise the findings.

6.14 Chapter Summary

In this chapter I have conveyed the 'story' of my research describing how it moved from an idea to an experience of thinking, writing, and showing. Throughout I have demonstrated how and why I designed the study as I did and how it evolved from a messy PhD study concentrated around a huge volume of data into a piece of phenomenological writing.

In the next three chapters I present the emergent meanings and understandings of the phenomenon. Rather than describing the chapters as 'findings' chapters the chapters are presented as 'aletheia'. This is based on Heidegger's understanding of the term aletheia as 'unconcealedness'; the chapters are a space in which understandings of the phenomenon, glimpsed and brought into view in the interpretative thinking and writing, are shared with the reader (Heidegger, 1992).

In the aletheia chapters I '*offer*' an insight into the phenomenon and an opportunity to think and '*wonder*' about the meaning and significance of engaging with birth stories whilst pregnant (Smythe et al., 2008, p. 1393). Further I invite you to be a part of this study and, in doing so, to add another layer to the '*luscious mess*' I have been exploring and to make your own interpretations.

CHAPTER 7 - ALETHEIA: *‘STORIES ARE DIFFICULT LIKE THAT’*

“Careful the tale you tell, that is the spell, children will listen.” (Sondheim and Lapine, 1990)

7.0 Introduction to Chapter

My thesis suggests that birth stories are a significant part of the landscape of birth for childbearing women; my conversations with the women and my dialogue with the literature, examined within the iterative circle of thinking, writing and showing, help reveal a common experience of engaging with birth stories whilst pregnant. This chapter uncovers the *‘presence’* of the phenomenon and *‘claims that it is worthy of attention’* (Crowther, 2014, p. 130).

Appendix Ten maps my ideas and provides an audit trail for the three aletheia chapters, highlighting the meanings that emerged from the transcripts, detailing what ‘other voices’ from the literature and the arts added to those emergent meanings and illustrating the philosophical and Heideggerian notions which helped the meanings to show themselves. Appendix Eleven identifies each transcript with a primary aletheia and gives an exemplar from each woman’s story (providing a ‘flavour’ of the conversation). This document helped me to keep each participant and the essence of each story in mind (as parts of the larger whole of the phenomenon).

In this first aletheia chapter I examine the notion of the birth story as ‘problematic’ for many women and consider the significance of the phenomena in shaping both the meaning and experience of birth.

I start by examining the childbearing woman’s place in the world of birth. I move on to consider the prevalence of ‘*horror stories*’ in relation to birth, the media portrayal of birth and societal expectations of the childbearing woman. I continue with the idea of the positive birth story as ‘*too perfect and wonderful*’, the notion of ‘*being economical with the truth*’ when telling a story and the idea that we live in a ‘*polite culture*’ making it difficult to share positive stories.

7.1 Being-in-the-World of Birth

My thesis begins with an appreciation that women’s pre-understandings about childbirth are rooted in their experience of ‘*being-in-the-world*’ of birth; women experience aspects of this world in relation to other people in that world. Often these people are members of a woman’s family and her close friends. In their pregnancies women find themselves in a world that appears to operate in a certain way and where certain things have already shown up as important (Heidegger, 2012). Heidegger describes this as ‘*thrownness*’, explaining that Dasein (the human kind of being as explained in chapter five) is ‘*thrown*’ into its ‘*there*’ (Heidegger, 2012, p.173). As ‘*thrownness*’ Dasein finds itself already in a certain moral and material, historically conditioned environment: “As something thrown, Dasein has been thrown into existence. It exists as an entity which has to be as it is and as it can be”, (2012, p. 321).

‘*Thrown*’ into the world of birth, women are faced with an array of possibilities or choices which are somehow limited. They therefore choose possibilities of action that are conditioned by their enculturation into the practices of their specific childbearing

community. Thrown into this world women attune themselves, creating their existence in terms of what they see as possible. As *'everyday being-with-one-another'* women are dependent on others and *'they'* (also known as *'das man'*) inconspicuously dominate the way to be (Wrathall, 2005, np).

Heidegger's concept of *'das Man'* alludes to the particular community into which we find ourselves thrown. It is a *"primordial 'publicness' that serves as a shared basis for everyday understandings"* (Bessant, 2010). In our everyday lives we do what *'one'* does according to the norms laid out by the *'anyone'* of which we are a member. Our competence in coping with the world is of a tacit attunement to cultural practices. Heidegger describes our everyday *'being-in-the-world'* as our *'dealings in'* the world arguing that we are so absorbed in the world that we do not consciously interpret or attribute meaning to anything around us, (2012, P. 95). Rather we take for granted and do not question the *'normal'* situatedness of our being:

"We take pleasure as they take pleasure; we read, see, and judge about literature and art as they see and judge; likewise we shrink back from the 'great mass' as they shrink back...Everyone is the other, and no one is himself. The 'they', which supplies the answer to the 'who' of everyday Dasein, is the 'nobody' to whom every Dasein has already surrendered itself in being-among-the-other" (Heidegger, 1962, p. 165-6).

Stephanie, for example, had been born into a family in 21st century Britain, a family whose experience of birth was that of *'it being all out of your hands....you're in there for hours, and everything kind of happens at once and the nurses, or whoever, take over'*. In this world the norm is one where caring involves *'leaping in'* and *'dominating'*; health professionals take up the burden of care and manage women's births for them (Heidegger, 2012, p. 159). Stephanie's attunement to birth was reinforced by the knowledge she encountered in the form of the stories she heard which add emphasise to her understanding of birth as being *'so painful...so awful, you just kind of want to forget about it'*.

Likewise Pamela, born in the 1960s and birthing in the early 1980s gave birth in a world where *'we tended to just accept what we were told and went along with it'*. In this world options for childbirth were limited and women's expectations of the birthing experience were low. Women expected birth to be *'relatively straightforward'* possibly managed with some intervention and ending with them taking home a healthy baby. In Pamela's 'world' birth took place in hospital and *"the attitude was just 'lie down on this bed and have your baby'"*. According to Pamela women complied with procedures and had very little say in what happened to them.

Similarly Isabel, prior to attending antenatal classes, approached the birth of her first baby with a number of deeply entrenched understandings of childbirth; these included birth taking place in a hospital, on a bed, in an *'unnatural'* position, a long and painful labour (meaning she would need an epidural) with care provided throughout by *'experts'* there to *'help and guide her'* and ultimately available should anything *'go wrong'*. Isabel's understandings came from knowledge gained from watching births on the television, her experience as an older sibling visiting her mother in hospital after the births of her sisters and insight gained from the *'traumatic'* stories she had been told about birth.

After attending classes Isabel learned that birth does not need to be something to *'put behind you'* but rather that it could be an experience in itself. Recognising that she wanted the birth to be *'the beginning of something'* and potentially *'the best day of our lives'* is something that Isabel now realised was important to her. At the classes Isabel learned about her body and its capabilities, and the extent to which she could be involved in the decision making relating to her care; *"I feel more empowered and more like I can actually make decisions...I can input what I want into my experience. And there is an experience for me"*. Her perspective of birth changed as she recognised that she could be involved in her birth; in this 'new' world of birth caring involves *'leaping*

ahead' and *'liberating*' and women are empowered to manage their own expectation and experience by accessing information and planning (Heidegger, 2012, p. 159).

At the beginning of our conversation Isabel told me that her views had changed to the extent that she had gone the *'opposite way now'*, away from the idea of a medically managed birth (which she had at the outset of pregnancy) towards a *'completely natural birth'*. Isabel seemed very eager to tell me that she wanted a midwife-led birth (perhaps because she thought that was what I wanted to hear?) and yet her conversation, imbued with an underlying anxiety about being a good patient and a good parent (issues I discuss in depth in the third aletheia chapter), undermined her conviction and suggested that she sought the *'assurance'* of a medically managed birth.

Similarly despite new found understandings (from antenatal classes) Stephanie remained slightly sceptical about her role in the birth as everything she believed prior to the classes was at odds with what she had come to *'know'*. She had obviously discussed what she had *'learned'* with others and still had a concern about the role of the professional in her care; despite being told that choices and decisions would be in her control she told me that *'everybody still says it's not!'* Why should she put faith in what she has heard at the classes if everything she thought she knew and everybody else's opinion is at odds with this? Stephanie struggled with the idea that her experience could indeed be different.

Heidegger believes that people have a natural inclination to conform, because ultimately they want to become accepted in their community. Indeed Dasein exists chiefly in an *'undifferentiated'* state of being that Heidegger calls *'average everydayness'* (Heidegger, 2012, p. 69). Heidegger calls this mode of being *'inauthentic'* arguing that *'everydayness'* and *'averageness'* can *"detract from one's clarity and obscure an authentic way of being"* (Bessant, 2011, p. 4). Heidegger

suggests that in an inauthentic mode people do not feel free to adopt their own unique possibilities and instead adopt the common possibilities they share with others (Heidegger, 2012). Their other option, '*mineness*', recognising their own possibilities which are not shared by others, carries the risk of them feeling alone and possibly ostracized (Heidegger, 2012, p. 312-348).

Perhaps Isabel and Stephanie did not really believe in their ability to experience a different and more natural kind of birth or perhaps they did not have the courage to claim the possibility of being instrumental in their own births? Heidegger tells us that in order to be authentic, people must bring themselves back from the '*anyone*', decide on a '*potentiality-for-being*', and find themselves in terms of their *possibility* (2012, p.313). Blattner (2006) describes this concept as '*ownedness*' maintaining that the phenomenon Heidegger is conceiving is a matter of owning who and how one is. Heidegger discusses the concept of '*resoluteness*' in relation to authenticity, which he describes as the courage it takes to claim one's own possibilities, (2012, p. 312-348).

All the women in the study were attuned to birth in a particular way and that attunement was a consequence of their generation, upbringing, experience and their relationships with others (Hirsch, 1978). For most of the women there was an expectation that childbirth was something natural that everyone should do, and a general consensus that it would hurt, but "*don't worry, you'll forget and you'll come out the other side of it*" (Stephanie). The women were situated in a world of birth which was not of their making but one for which there were a number of norms and conventions. Stephanie described, with some surprise, her belief that knowledge and/or information had '*filtered through*' over the years almost without her realising it.

Until our conversation Stephanie had not really considered how she knew what she did about childbirth; her understandings and expectations were just there in the

background. As she described it 'knowledge' and 'understanding' of birthing is seemingly all around and is passively absorbed into human consciousness by a process akin to osmosis.

7.2 'Horror Stories'

*"I get high on birth stories
the way other people get high over a pint
or watching a good film.
The kinds of stories most people would rather not hear about -
36 hours in labour, haemorrhaged,
had third degree tears, stitched up in catgut.
I long for the importance of it,
as if it's an obstacle course I have to run
before I can call myself a WOMAN".
(Duffy, 1990, p. 85)*

The women birthing in the present day concentrated on the negative stories they had heard. Stephanie spoke about the, '*oh my god it's so painful, it's just so painful*', kind of stories, elaborating with the comment, "*You don't get anyone who says, 'it's brilliant, calm, relaxed'. You just get these horror stories*".

Bonnie described a story told her by her aunt,

"I really wished she hadn't because I was really early on in pregnancy at that point. I'm still quite you know worried by it, but she was saying that her neighbour got gestational diabetes towards the end of the pregnancy and they were going to do a caesarean. And then the consultant said, 'No, we'll leave it'. And then she had a bad episode with her sugar levels, the baby went

completely hyperactive, ended up wrapping his cord around his neck and then dying basically”.

Most of the women seemed accepting of the negative stories; Isabel went as far as to say, *“I have a morbid fascination with them”*. Lucy put it in context suggesting that *“all the different experiences that I’ve heard of will help me to visualise what may happen to me”*, telling me that she wanted to plan for *“the worst cases which I may come up with”*. For Joanna it was important to recognise that she might have a *‘difficult or dangerous birth’*. For Stephanie it seemed another facet of modern life,

“What I found, it’s like you can go and buy something from Amazon, and you’ve got reviews. Some people will put up the good reviews but most of the people who are making the effort to put a review on is because it’s negative”.

Similarly Ruth spoke about listening to her friend’s story,

“She didn’t go into masses of detail but then I think because she had a good birth, you don’t particularly... That’s what I’ve tended to find. I have one friend who had a very traumatic birth experience, and I could probably tell you quite a lot about it in detail; whereas, those who’ve had good birth experiences, you don’t...I don’t get the lowdown as such. It’s just like, “Oh, it’s amazing,” and it is like when you get good or bad customer service. You tell everybody about the bad and not as much about the good”.

The women used consumerist analogies like *‘reviews on Amazon’* and *‘customer service’* to describe the way negative stories are portrayed and in doing so alluded to the fact that in this era birth is somehow constructed as a *‘commodity’*.

The women who birthed in the 1970s-80s similarly reported that negative stories were shared more readily and frequently than positive ones. Emma, for instance, said that she could not remember any specific stories but that *“you always tend to get the horror stories don’t you? Where people tell you things, and you think, ‘oh my goodness”*. Paula gave a specific example about a hospital in her local area, *“it was a really old place that*

had been the former workhouse...and then converted into a hospital. And it was really old and just awful....and people had just said you don't want to be going in there - their experience obviously hadn't been positive, but they didn't really go into detail". Although Paula had not heard any specific 'horror' stories or any details she had heard enough to be 'warned off' going to that particular hospital.

Likewise Carole, who suffered from 'toxaemia' whilst pregnant, said her mother 'terrified' her with stories about people she knew who had had the same problems and whose pregnancies had not been successful. Later in our conversation she shared her view that women were more likely to share their stories if they are 'horrific', going on to say that for some women *"it's a bit like point scoring who has had the worst delivery"*. This idea resonates with my perception, outlined in my personal interview, that childbearing women are often competitive, striving to 'outdo' each other and to tell more dramatic stories than their peers. Equally the notion fits with Heidegger's idea of inauthenticity and the notion of the 'they-self' ('fitting in' with others and 'being-among-one-another') and Rousseau's 'amour propre'; an awareness of oneself relative to others and a need to constantly compare ourselves (favourably) with those others.

7.3 The Media Portrayal of Birth

"Reality TV is realist to the extent that it is fixated upon the ability to represent all elements (no matter how mundane) of its objectified subjects' lives and their erstwhile intimate moments. It purports to represent what really happened in its immediacy. But it is also idealist to the extent that this apparent realism is, in fact, dominated by highly constrained and carefully stipulated formal practices that correspond not so much to real things and events as to various tropes and expectations that we now readily associate with media produced reality." (Gunkel and Taylor, 2014, np)

Without exception the women birthing in the present day talked about media representations of birth and all mentioned watching (or choosing not to watch) a popular

television programme called 'One Born Every Minute' (Channel 4). The women seemed clear that the cases shown were chosen for a reason, for instance Ruth said, *"Obviously, I know they only pick certain stories to go on TV, they've got to make good TV so that's why they do it"*. Similarly Rebecca seemed clear that *"they might have chosen some extreme cases for such things so that people will watch more"*. Isabel told me that *"in 99% of the cases there's a woman who is lying on the bed in agony giving birth...; a lot of them are forceps deliveries, and a lot don't look particularly calm and enjoyable...but it makes good TV I guess"*.

Lucy recognised that certain magazines *"just want to sell their magazine, the more sensationalist it is, the more they sell"*. Similarly Lucy noted that news articles (both on the television and in the papers) *"publicise the bad news all the time. So whenever there is some....something goes wrong, no matterwhether people died or people got infected in the hospital, they just want to publicise it"*.

What the women told me resonates with my perceptions (voiced in my personal interview) that dramatic, scary, frightening or funny stories appear to engage the viewer/listener more readily. My perception is that birth is often portrayed as a theatrical event because if the portrayal was more accurate (in terms of the length and pace of birth) then it would not be as engaging to watch. The messages that people get about birth from the media are tied up in the '*drama of birth*' as Ruth puts it. Certainly the 'stories' shared and the birth environments shown portray birth in a very specific way. Ruth told me that *"what comes to mind is what the room will be like because my only experience of looking at a labour ward is from what I've seen on TV. So to me, you know, pretty much, it is women on their backs, bright lights, medics"*.

Bonnie, a primary school teacher, recognised that the messages portrayed by the media about birth are '*completely unrealistic*'; speaking about young women and young

girls Bonnie was concerned *“that’s the only information they get”*. Apart from the fact that the portrayals might not be realistic the problem with them is that they have the potential to frighten people as Rebecca pointed out: *“I watched one and then decided that’s quite scary, so I don’t watch it anymore....I was like, ‘okay, I shouldn’t really watch that’. I’ll end up scaring myself”*. Interestingly Jean, interviewed in the second phase and birthing in the 1970s, appeared relieved that *“you didn’t see childbirth on the telly”* suggesting that because women did not *“have all these pictures of screaming women and things like this on television.....there wasn’t this kind of, ‘Oh dear, it’s going to be a traumatic experience and things like that”*.

Conversely Meg, who birthed in the 1970s, told me that when she was pregnant she had quite a *‘romantic idea’* about what it was actually like to have a baby and that she felt *“quite bitter and twisted that people hadn’t been more honest about how difficult it could be, you know, to give birth”*. When asked about programmes such as ‘One Born Every Minute’, Meg argued that *“they probably are a more accurate representation than anything I was shown”* but when asked whether the programme had the potential to be frightening said, *“Could they be frightening? It’s hard for me to say, I think my daughter opted not to watch them that might tell you something”*.

In chapter five (section 5.12.2 page 134) discourse as one of the fundamental ontological characteristics of Dasein was introduced; discourse refers to the way in which Dasein expresses the meaningful structure of its world, it is the articulation of intelligibility. Heidegger uses the term *‘Gerede’* (*‘Idle talk’*) to describe the way of speaking within the world of *‘das Man’*. *‘Idle talk’* is *“the form of intelligibility manifest in everyday linguistic communication - average intelligibility”* (Mulhall, 2013, p. 107). According to Griffiths (2009, p. 119) *‘idle talk’* can be described as *‘derivative talk’* whilst Steiner (1989, p. 7) refers to the phenomenon as *‘vacuous high gossip’* suggesting that

people use this way of communicating as a '*pretence*'; a means of appearing '*busy*' and '*well-informed*' in their everyday lives.

The notion of '*idle talk*' is relevant to this thesis as what is shared and heard about birth in everyday conversations and via the popular media makes a difference to what women understand about birth; not only are women '*thrown*' into a particular world of birth they also '*fall*' into the dialogue and speech of that world (much of which may be '*groundless*' and yet appear to be '*authoritative*').

Heidegger explains that when we communicate we talk about something (for instance an 'object') and in that conversation we make claims about that object. He suggests that we do not "*so much understand the entities which are talked about*" but rather that we concentrate on what is claimed about the entity; "*we already are listening only to what is said-in-the-talk as such*" (Heidegger, 1962, p. 212). We accept what is claimed, simply because it is said, and we pass it on, further disseminating the claim. The result, Heidegger tells us, is that "*what is said-in-the-talk as such, spreads in wider circles and takes on an authoritative character. Things are so because one says so*" (1962, p. 212).

The consequence of this is that we lose touch with the entity we were originally discussing and as a result our talk "*becomes aggravated to complete groundlessness*" (Heidegger, 1962, p. 212). Moreover if something is said '*groundlessly*' and gets passed along by further retelling, the telling and sharing becomes a '*closing off*' as opposed to '*an act of disclosing*'. Heidegger explains this further:

"This closing-off is aggravated afresh by the fact that an understanding of what is talked about is supposedly reached in idle talk. Because of this, idle talk discourages any new inquiry and any disputation, and in a peculiar way suppresses them and holds them back" (Heidegger, 1962, p. 213).

Bonnie explained the concept of *'idle talk'* and its relevance to birth beautifully; speaking about the stories that get shared and the media portrayals of birth, she said:

"I think the problem is it's just out there, it's just out there in society. So it's a cultural thing you're battling against. I think that's a lot harder because often, even when you're shown the facts, your culture will overwrite that. You tend to listen to that rather than the facts. I think we're all a bit guilty of that".

If women are satisfied by the *'idle talk'* around them then they may not be motivated to achieve any genuine understanding of birth; rather they may just accept the public way of understanding birth. Heidegger suggests that curiosity goes hand in hand with *'idle talk'*, concerning itself with being just in order to see; curiosity is characterised by restlessness and distracted by new possibilities (as in the information seeking behaviours of the childbearing women). Unfortunately *'idle talk'* and curiosity together, rather than enabling genuine understanding may instead create ambiguity (Heidegger, 1962).

Women may therefore find themselves *"taken in a peculiar direction and....absorbed in the immediate, in fashions, in babble"* (Heidegger, 2002, p. 74). Being caught up in the 'hype' around birth could mean that women understand *"what is said-in-the-talk"* but that what the talk is about is *"understood only approximately and superficially"* (Heidegger, 1962, p. 212). The inference being that women in today's 'world of birth' may be approaching childbirth with an average understanding of the claims about birth (shared amongst women in their conversation) as opposed to a genuine understanding of birth itself and, significantly, that it is likely they have no understanding of this fact. This idea is summed up effectively by Heidegger:

"Yet the obviousness and self-assurance of the average ways in which things have been interpreted, are such that while the particular Dasein drifts along towards an ever-

increasing groundlessness as it floats, the uncanniness of this floating remains hidden from it under their protecting shelter” (Heidegger, 1962, p. 214).

7.4 Societal Expectations

“You know (the Duchess of Cambridge), she’s giving birth within the same year that I am...and she’s going to have it sussed. You know, she won’t have...she’ll be on camera and people will have pics of her within days of her birth looking amazing...I think you worry that...well you’re worried about your partner’s perceptions, ‘my wife’s not like that’, or stuff like that” (Isabel)

A number of the women discussed a ‘pressure’ they felt from society, the media and ‘celebrity culture’ to function or perform, look, behave or feel a certain way both when pregnant and in early motherhood. The insinuation being that women do not always have realistic expectations around their body image, pregnancy, birth and mothering because of the images and messages they are surrounded by, and see and hear in the media. Isabel continued her conversation with me telling me (almost incredulously) that *“I mean I’ve got a friend who...she’s due a month after me. And she’s booked in, for when she goes into labour, to have her false eyelashes done and a fake tan. So she looks good in the pictures!!”*

Similarly Lucy was worried about having a caesarean as she did not want to be left with a scar, saying, *“I don’t want a scar although you may not see it....because my mum showed me her scar after giving birth three times with C-section. And the scar is quite big, quite obvious. And I feel really sorry for my mom. I said ‘Oh, you have already gone through such pain and gone through the whole of pregnancy, and you still have something that’s left on your body which you can never get rid of”*.

Bonnie described feeling ‘let down’ by her body when she was not able to conceive (whilst everyone around her was getting pregnant ‘effortlessly’) telling me she thought

"I don't work properly, what's the matter with me?" Likewise Charlotte was worried because she was not *'maternal'* and felt the potentially she would not bond with her baby. Charlotte was concerned about the responsibility of being a parent but did not feel this was reflected in the discourse surrounding birth, suggesting that the *"sort of rosy picture of family and what it's going to be like"* which is painted by society and the media was not helpful to new mothers.

7.5 'Too Perfect and Wonderful'

For many of the women positive birth stories were an anomaly and *'too perfect and wonderful'* to be believed. Ruth, for instance, who was told positive stories by her yoga teacher, effectively dismissed them as though they were fanciful saying:

"They're all you know, amazingly positive experiences and, you know, there is the odd bit in there that's, you know...there was one with an induction. She sort of described the induction and things but, yeah, I don't know if I fully believe that she hasn't taken out some of the bits and pieces. I'm not sure".

Ruth was used to hearing stories about interventions and about women birthing in a *'traditional'* manner on a bed in *'excruciating pain'*; she clearly thought that the yoga teacher was putting some sort of 'spin' on the stories to make them *'easier on the ear'*. The result, she told me was that the stories were *'a bit wishy-washy'*; the inference being that when engaging with a birth story Rebecca wanted it to grab her attention but more importantly she wanted it to fit within her frame of reference.

Bonnie recalled a positive story:

"She said, 'It's all fine. It was really quick'. You know, in fact she said, 'It was six hours start to finish', she said, you know, 'I was only in the hospital an hour before he was born, so you know, I'd just gone to get my tea and I rang the

midwife' and she said, 'no you better come in. You sound really far along', so she was quite miffed because she was going to have her tea and didn't get to have it and said she went up there and in an hour there he was you know. She said 'I started pushing virtually straightaway as soon as I got to the hospital and he was born and it was all hunky-dory'".

Bonnie went on to tell me that everybody else's story was '*horrendous*' and that this story was the only positive one she had heard and that it had "*less impact on me than the negative ones*". Despite telling me the story Bonnie was expecting that "*there will be something...because people close to me have had caesearans*". Bonnie was not sceptical about the story per se but she was sceptical about the possibility of the story being her experience.

Likewise Stephanie said that she would like to hear more positive stories of birth, as opposed to the '*horror*' stories she has heard countless times. Despite wanting to hear more positive stories Stephanie was dubious when she recalled a positive story, saying that, "*everything was kind of real gushy...and I was like 'yeah, I'm sure it wasn't because it was just...everything was too perfect and wonderful?'*" After hearing countless '*horror*' stories and being exposed to dramatically edited television representations of birth it is hardly surprising that positive stories are not always accepted as '*real life*'; they are at odds with the majority of stories in circulation and with women's perceived understandings of birth (founded in their experience of being-in-the-world of birth). More than that because of Dasein's everydayness and absorption in the world what is extraordinary (the '*horror*' of birth described in a story) is made ordinary through familiarity; the appearance of '*horror*' in a story is accommodated and then made invisible by that accommodation, and other interpretations are effectively '*closed off*' (Heidegger, 1962).

7.6 'Being Economical with the Truth': Protecting or Neglecting?

"It's a slippery slope when you're in the delivery suite, isn't it? If they're on that slippery slope, there's nothing I can do about it and I don't think scare stories help anyone and everybody's birth is so different" (Penny)

The majority of women birthing in the 1970s-80s spoke of their reticence to share their birth stories with their daughters (or other women who they were close to) saying that *'stories are difficult like that'* (Paula); they were happy to discuss the *'bits around birth'* (Paula) and offer platitudes such as *'it's painful but you get over it'* (Sandra) but would not offer much more for fear of *'frightening'* (Penny) women. Sophie for instance told me that *"I think people withhold experiences because they don't want to frighten people and I think I would probably do the same. You know, you actually don't say stitches are horrible and you know, and breastfeeding's awful...my personal view. You don't want to impose that on anyone"*.

Paula said that she had told her daughter the *"bits around what happened, not the actual birth, itself, you know"* adding *"I didn't tell her about the actual birth well because I just didn't"*. Likewise Sandra shared the fact that she had *"never told my daughters the 'nitty-gritty' about birth"* and Marie said *"I think I was probably a bit guarded about what I said in the same way as people perhaps had been guarded with me"*, later in our conversation telling me that she *'regulated'* what she said because she did not want people to feel frightened. Penny said she did not speak about the *"whole horror and dread"* because *"I don't think it helps to be too scared of birth"* explaining that instead she tended to be *"economical with the truth"*.

Seemingly the women made a conscious decision not to share the details of their birth experiences as they did not want to make other women fearful of birth. In not sharing

their stories in any detail the women clearly believed that they were in some way 'protecting' others.

Heidegger discusses fear as a '*mode of state-of-mind*' claiming that it has three structural elements: '*that in the face of which we fear*', '*fearing*' and '*that about which we fear*' (Heidegger, 1962, p. 179). '*That in the face of which we fear*' is something we are faced with, something '*fearsome*' which we believe may put our well-being or safety at risk. '*Fearing*' is our reaction to that something fearsome (we may demonstrate signs of being 'fearful' for instance by avoiding situations or becoming agitated or distressed) and '*that about which we fear*' is ourselves and the impact on us of the something '*fearsome*' (for instance in this situation that birth will 'go wrong' and result in terrible pain and/or adverse consequences).

Heidegger goes onto discuss the notion that one can also '*fear about Others*' which appears to be what the women in this phase were doing. This mode of being however supposes that the 'other' is/or will be fearful which of course may or may not be the case. Heidegger believes that in reality fearing for others is in fact another way of fearing for oneself; the fear that the other (their daughter or daughter-in-law in most cases in this study) may be '*torn away*' from them (Heidegger, 1962, p.183). In this sense it could be seen as a 'selfish' act rather than an altruistic one as it might appear on first sight.

The women birthing in the present day reported engaging with lots of stories, most of which they reported as negative (as discussed earlier) but they also discussed nonverbal behaviours exhibited by other women which gave a suggestion of the nature of birth. Stephanie, for instance, recalled that "*when I was a child and people in my family had babies....I saw them kind of getting up gingerly, and it was all hushed conversations in the corner which gave an impression of how bad it was*". Likewise Bonnie told me "*people don't say 'it's very painful' but there's lots of conversation...of*

raised eyebrows and that sort of thing, so you get the impression it's going to be painful". This suggests that even if women choose not to share their stories in any detail their behaviours may 'betray' their experience of birth.

7.7 Living in a 'Polite Culture': The 'Rules of Sharing'

"People who've had a good experience don't say so much...maybe because they don't want you to think, if you've had a bad birth, that everything was perfect for them and not for you. You might hurt their feelings and you wouldn't do that would you? You wouldn't want to make them feel bad" (Pamela)

A number of the women spoke about the fact that they were loath to share positive stories for fear of making others *'feel bad'*. Mary for instance said that *"we are a polite culture and...we wouldn't want to upset anyone, especially someone you know"*. Likewise Penny talked about being careful about *'pushing the whole breastfeeding thing'*; for her the experience of breastfeeding was *'magical'* and she wanted to promote it but she was conscious that people may have difficulties with feeding and may feel they have failed if they aren't successful. Similarly Penny was mindful that if women need to go back to work to supplement the family income (as was the case with her two nieces) that they may not have the *'luxury'* of breastfeeding and that her discourse may *'alienate people and make them feel bad'*. Interestingly Penny talked about the concept that *'new mothers pretty much feel bad, well, mothers feel bad a lot of the times anyway and...it would be very unfair of me to make them feel worse'* (I discuss this concept further in chapter nine).

For Mary part of this 'politeness' was being *'British'*; she talked about the fact that British people tend to be *'reserved'* and do not tend to promote themselves as easily as people from other cultures might. Mary used the Americans as an example saying that they have: *"a whole American projection that 'I'm wonderful....this absolute positivity about*

who we are and what we are and how capable we are and how wonderful our experience is". For Mary this sits "at odds" with how we (the British are) and she found it rather false suggesting that it is in fact a kind of bravado which hides a fear of telling somebody that you are frightened, or not coping and need support. Aside from the 'Britishness' and its impact on sharing, Mary does not expand on why somebody may not wish to share and celebrate a wholly positive experience. Rather Mary discussed the fact that people 'edit' their lives to suit their audience (much like a storyteller does).

Mary also talked about the importance of the environment and situation as an appropriate one for sharing (either negative or positive stories); this resonates with Charlotte's comments that people do not always consider their surroundings when they share a birth story:

'Some of the things she comes out with like, and she doesn't even do it in a very appropriate place, like I sit next to her at work in a very open office and she'll be like, 'oh, I had a terrible tear, from here to there'. I'm just like, 'um, not really the time and place to have this conversation'. You know we're in an office with men around".

Also significant for many of the women was who they were sharing stories with; Mary talked about hearing a story from one woman and said that she had not "drilled into the detail of the whole thing....she's not a best friend. She's very close. So I think there are respective boundaries on both sides." Later she qualified this saying "the relationship dictates to what depth and detail you have the conversation". Conversely Charlotte spoke about hearing her best friend's story and finding it reassuring because the friend had shared the fact that "she coped with delivery without hardly any pain relief at all...I know she can cope without pain relief. I know that even if she hasn't got a high pain threshold that you can do it".

Interestingly it seems that the '*idle talk*' around birth, the average everyday discourse and understanding, that is shared amongst women is chiefly centred on the medically managed and negative experiences of birth as opposed to the joyous sharing of a positive experience; there appears to very little rhetoric about positive births other than that which sees those stories as spurious. As I argued earlier I think this is because the appearance of negativity in a story is accommodated and then made invisible by that accommodation, and other interpretations are effectively 'closed off' (Heidegger, 1962).

7.8 Chapter Summary

This chapter has established that the phenomenon of engaging with birth stories whilst pregnant exists and that it is worthy of attention. My thinking and writing in and around the participant's stories has revealed: that stories are edited and dramatized by the media (to increase viewing figures), that there is a prevalence of 'horror' stories in circulation and that there appear to be unwritten 'rules' associated with the telling of birth stories.

In the next chapter I consider the aletheia '*It's a generational thing*'; this aletheia looks at the experience of the two cohorts of women in some detail, considering how the two groups understood information in their pregnancies and how this information translated into knowledge and/or meaningful understanding about childbirth. The concepts of historicity and repetition are considered and provide a lens through which the experience of the various women is explored and understood.

CHAPTER 8 - ALETHEIA: *'IT'S A GENERATIONAL THING'*

*"The nighties were in the case in their shop folds
and the soap, not the kind for everyday,
and the thin clothes, for afterwards.
Sister took the case,
she turned her width and bristly neck to face me.
'Pop out of your things and pop into bed.
Brave girls don't cry on my ward.
No husbands here - the only place you're safe from bloody men.'
She laughed a midwife's laugh,
thick with birth jokes, coated with the dirt of centuries".*

(Cooke, 1990, p. 86)

8.0 Introduction to Chapter

The previous chapter considered the aletheia *'Stories are difficult like that'* suggesting that the phenomenon of engaging with birth stories whilst pregnant exists and that at times it can be problematic for women. In this chapter I consider the aletheia *'It's a generational thing'*; this aletheia considers how women from two different generations came to understand what their experience of birth might be based on the stories they engaged with. Embedded in their respective worlds of birth, this chapter explores what mattered to the two cohorts of women when anticipating birth and how what mattered came to matter. The chapter explores the intergenerational sharing of birth experiences

and relies on the concepts of historicity and repetition to inform and clarify the women's recollections.

I start by considering how the two groups of women sought information in order to prepare for birth. I move on to address the perception of the women birthing in the 1970s-80s that birth was something which must take *'its course'* and where women must concentrate their energies on *'coming out the other side'*. I speak about the notion of the 1970s-80s woman as *'a shy nervous girl'*, consider those women who in looking back wanted to do *'better'*, and about a desire by some women in the present day to *'take control'* and *'go the opposite way'*. I discuss the idea of *'nothing being private'* in the modern discourse around birth and I end the chapter by considering the notion of fear and birthing in the two generations of women.

8.1 Preparing for Birth: *'It was all a Bit Shrouded in Mystery'*

Whilst the participants who birthed in the 1970s-80s *'learnt'* about birth from conversations with other women, antenatal classes and books, most did not actively seek out information or seek out stories; perhaps because they did not expect to be offered choices or to be involved in decisions about their care. Certainly it appeared the women had little knowledge and understanding of birthing in their pregnancies. Sandra told me that other than being told by the midwife that *"it will hurt, expect it to hurt"* she had no other knowledge but that instead *"it was all a mystery until you actually gave birth"* and that *"even if I could have had all the information in the world I don't think it would have prepared me for what happened"*. Similarly Sophie explained,

"I think you're told, but it doesn't sink in until you've experienced it. I'm not saying that information was withheld by any means, but it's not until you've experienced it once that you can recognize what's happening to your own body, I think". Likewise Paula said that "I don't think I had any information

really. I didn't feel I had any information. I was just going along with what they were doing".

For Carole, who suffered from 'toxaemia' whilst pregnant '*ignorance was bliss*'; Carole explained that if she had had access to the internet when she was pregnant and had researched some of the complications she would have '*terrified*' herself. Sophie told me that there was "*an element that I didn't really want to know*" primarily it seemed because she was '*squeamish*' and did not want to know about the '*pain*' and the '*things that could go wrong*'. Marie told me that "*information wise I was happy with what I got*"; she said that she was the sort of person who did not want a lot of information and that she would "*take in what I want and put a barrier up to the rest*".

Meg's experience was different; as discussed in the last chapter she told me that she had "*a pretty romantic idea about what it would be like to actually have a baby*" and that afterwards she felt quite '*bitter and twisted*' that people had not been more '*honest*' about birth and given her more accurate information. Meg felt that some things were withheld: "*I don't know...not withheld deliberately, but just it wasn't deemed necessary to share certain bits of information with the mother that was for the professional to deal with not the mothers*". Later in the conversation she told me she felt there was almost a '*conspiracy of silence*' to 'protect' mothers from how difficult it might be. Interestingly she later said that if her daughter had asked her prior to her own pregnancy she (Meg) would have "*tried to pan it (her story) out a little bit and, you know, make it easier*".

Remarkably it seemed the women (on the approach to birth) had no real expectation of being informed; indeed many approached it with limited information feeling that women were '*all the same*', that birth would '*take its course*' and believing that it was '*a natural thing*' (Jean). The women talked about not really having a voice in their care and indicated that they looked to the health care professional for guidance. For these women care was something provided by an 'expert' who made decisions for them

(which they understood as always being in their best interests). As passive recipients of care Paula spoke about *'going along with what they were doing'* and Pamela said that *'we tended to just accept what we were told'* and *'went through the procedures that were suggested'* giving the example that she was *'told to stay in bed and have my baby'*.

Certainly, as discussed in chapter two (pages 33-70), women in this era were birthing at a time where the norm was to birth in a hospital in a 'system' where birth was only considered normal in retrospect and where interventions were almost part of the routine care. In this 'system' pregnant women were treated as hospital 'patients' under the care of an obstetrician and their care was typically focused on the needs of the institution as opposed to the needs of the individual woman. Paula's experiences are a good example of this; she talked about going into labour on New Year's Eve and about being put on a drip to speed up the contractions. At the time Paula had not been aware of the potential for this to happen and observed:

"Because she was born on New Year's Eve and I was thinking is this more about the time of year than actually about me, you know, about the baby. You know -- I did feel like that, but it was more of a process -- I'm not saying it was but that was how it felt at the time the process to get this baby born today rather than staff having to hang on; so I did become quite anxious then".

When asked why she went along with the suggestion Paula told me that 'you' (as in women generally) did not question things then and that because a *'medical professional'* had told her what was going to happen the assumption was *"you need this and that's it"*.

What emerged from the data overall was a strong sense of understanding as acceptance as Marie explained, *"Once it's over and done with, you forget about this, you forget about that"*. Heidegger helps us to understand the passivity of the women explaining how in its *'everydayness'* Dasein is *'disburdened'* by the *'they'*; the *'they'*

make every choice and decision meaning that Dasein assumes a passive role and, in so doing, is disburdened of moral responsibility and autonomy (Heidegger, 1962, p. 165). The ‘they-self’ is a common way of living:

“By thus disburdening it of its being, the ‘they’ accommodates Dasein if Dasein has any tendency to take things easy and make them easy. And because the ‘they’ constantly accommodates the particular Dasein by disburdening it of its being, the ‘they’ retains and enhances stubborn dominion” (Heidegger, 2012, p. 165).

As discussed in the previous chapter people who do not question the ‘they-self’ generally want to conform and ultimately be accepted by others in their community (which in this example is the childbearing community). Choosing not to live in the state of the ‘they-self’, choosing to be individual and make independent decisions, may mean feeling isolated and alone and is perhaps a more ‘difficult’ way of ‘being’ involving responsibility for choices made and ownership of any consequences (a concept I discuss further in the next aletheia chapter pages 219-240).

8.2 Preparing for Birth: Information Seeking and Saturation

“This plethora of information can seduce us into failing to recognise the real problem. We shall not get a genuine knowledge of essences simply by the syncretistic activity of universal comparison and classification. Subjecting the manifold to tabulation does not ensure any actual understanding of what lies before us as thus set in order.” (Heidegger, 2012, p. 77)

Conversely the women birthing in the present day were searching for information on which to base their choices and decisions related to childbearing and as such they pursued many story mediums. There was a sense that they needed to ‘research’ birth much as you might research a new purchase or a new job. Charlotte explained, *“I feel like I have to be informed. Just because I’m like that with everything..... I would never just launch myself into something without reading up on it or researching it first”.*

Charlotte continued telling me, *"I wanted my own information; I didn't want to rely on everyone else telling me"*.

Certainly there was a sense that some of the women were searching for credible and authoritative information because they did not want to rely on the stories of others. On the other hand some of the women felt that women's experiences sometimes proved more fruitful as a source of knowledge than anything a medical practitioner could tell you. Other women could give you a *'detailed view'* about what it was like to go through the experience whereas doctors would be *'very medical'* and any attempt at information giving *"was just a process with the consultant"* (Ruth's comments). Harriet summed up the difficulties saying:

"You'd have an idea about what you could be more or less happy to rely on, you know, what you thought was a credible source of information. But there also seems to be a lot of information out there and I just think how do some women decide?"

The women appeared overloaded with information amassed from a variety of sources some of which they felt was conflicting (Rebecca) and some of which they weren't sure was *'authoritative'* and therefore to be relied on (Mary). Stephanie, for instance, spoke about the fact that the more she read the more confused she got until she felt *"I just really don't know what to know because I just think well, I don't know now"*. Many of the women reached a point where they were no longer open to information. Rebecca said that she *"just let them get on and I manage to pretty much shut my ears, I'm not taking it and I'm not thinking"*. Stephanie was very clear describing how she told her husband,

"I don't want anything more because I've got to the point where I've reached saturation....I'm not buying any books. I'm not getting any in because I've just reached overload that I don't actually know what is going on in my head".

Unfortunately many of the women did not feel that they could rely on the midwife to give them the information they needed when they needed it. Joanna for instance enquired about antenatal classes and was advised that ‘they’ (the midwife and Joanna) would discuss the options for classes at a later appointment. This was too late for Joanna who went on to independently source NCT classes. Joanna said that often issues were “*scheduled for the next conversation*” and that the midwives “*seem to have these ideas of what they’re going to talk about*” at different gestations. Many of the women spoke about the timings of ‘information giving’ suggesting that the ‘authoritative’ information they were seeking (which is of course usually standardised to the ‘generic’ pregnant woman) was delivered at predetermined intervals, coinciding with the gestation of the pregnancy, the anticipated needs of the women and the demands on the maternity service. The result of this was that the women, who had very different needs and agendas (despite being at similar stages of pregnancy) felt that they were not getting the information that they especially wanted or needed; rather they became overloaded with an excess of very generalised and standardised information.

8.3 Preparing for Birth: Acquiring Knowledge in the Virtual Community

“Technology proposes itself as the architect of our intimacies....it is seductive when what it offers meets our human vulnerabilities” (Turkle, 2012, np).

Nearly all the women birthing in the present day relied heavily on the internet as a means of accessing birth stories and as a source of information in preparation for birth. Mary talked about using it “*where I need quick answers on things*” and Joanna suggested that it is a useful tool “*if you’re having an ‘am I allowed to take Rennie’s or not’ moment*”. For some the internet was not merely an information source but was also a place to access social support in the form of online communities. Charlotte explained,

"You can talk about anything on there, like if you're worried about birth or whatever and people have exactly the same sort of questions that I have". Ruth agreed that "its an easy way of having a community without having to put yourself out there".

The sense of community was very valuable for some of the women, particularly those who were new to an area and had no family or friends who they could turn to for support. Ruth explained how isolated she was, *"like, for myself, obviously we moved from south to up here....I don't know anybody here apart from those I work with".* For some the attraction seemed to be that they could be anonymous, *"We're all very open because you don't know who each other are. They have no idea who you are"* (Charlotte). For Charlotte and others it was embarrassing to discuss some things, such as perineal tearing either with the midwife or in an NCT class, particularly if there were men present. Similarly some of the women felt anxious that others would judge them if they discussed concerns such as whether they would bond with their baby. Isabel said, *"It's not something that anybody ever discusses"*. Internet forums were a 'safe' place to discuss these issues.

Despite the value many of the women placed on the 'virtual community' some were quite sceptical about it. Mary got to the hub of the matter stating, *"I mean, you don't know who they are. You don't know whether it's true. It might not be helpful. It might just scare you."* For Mary the internet could be a dangerous place as *'everybody's an expert'*. Rebecca agreed stressing that she was, *"Trying to avoid those like discussion forums as well because people might be just talking about their own experience and it may not reflect the true spectrum of cases."* Considered from Mary's perspective it would seem that the Internet and mediums such as discussion forums are yet another form of the 'idle talk' surrounding pregnancy and birthing as discussed in the previous chapter (section 7.3 pages 183-188).

In his account of technology Heidegger maintains that in the modern world *things* reveal themselves to us ‘technologically’; that is they reveal themselves as resources for our ends. *Things* therefore become not worthy of attention themselves but serve as a means to an end. Heidegger explains that practices in this technological world come to be favoured in terms of their performance, according to some standard of efficiency, and that these standards provide the ultimate criterion for deciding on a course of action (Heidegger, 1962).

Certainly in this study there is a sense that women appropriate the internet and integrate it into their experience of pregnancy and childbirth, using it to help them make choices and decisions. There is almost a sense of them having to use the resource because it is available, as Lucy described, *“that’s why I think, yeah, if the resources are available, why not, you know, go get help”*. When Mary was asked why people accessed the internet for information (even when they knew it wasn’t always reliable) she told me, *“Oh because you can. It’s there. Yeah. I mean it’s an absurd world we live in; you can key in a question and get an answer to anything. You just don’t know whether it’s right”*.

The technological world that Heidegger describes also feeds into the construction of birth as a commodity (as discussed in in chapter 2 section 2.14.4 page 57). For Heidegger man becomes, in the modern age, another resource, something useful when properly ordered and arranged. In relating this understanding to the context of childbirth you reduce a woman’s body to an assemblage of parts, and the woman’s self-vanishes. Moreover a standardised birthing body is ‘shaped’ and all women’s bodies are thereafter expected to conform to the standard, making progress in labour, for instance, as predetermined by the ‘anyone’ of the medical establishment. I discuss these concepts, Heidegger’s understanding of technology and the view of man as a resource, in further detail in the third aletheia chapter (pages 219-240).

8.4 ***'Letting it take its Course and Coming out the Other Side'***

"Before I was born out of my mother generations guided me" (Walt Whitman, 2001)

Although many of the women birthing in the 1970s-80s expressed anxieties about birthing the majority did not appear unduly fearful of birth. Sandra for example said, *"My body was ready and I was thinking 'let's just get on with it and get it over and done with'"*. Similarly Pamela told me that *"I thought okay I'll have the baby and it will be alright"*. Jean said that *"there were no great fears or anything"*. The assumption for these women was that they *would* be able to birth, they felt they *'could do this'* (Pamela) and that birth would be *'hard work'* and undoubtedly *'painful'* but nothing that they could not *'manage'* (Jean). Likewise Marie said that *"I don't ever remember thinking there was going to be a huge crescendo. I just imagined it was going to be a lot of hard work which may be from the classes I had gone to where it was always talked about as.....labour, its hard work"*.

Jean explained that she wasn't overly fearful of the process of labour because she had seen her dogs' birthing and it appeared relatively straightforward *"we'd got dogs and we'd had puppies and things like this. So nothing to it, like shelling peas, you know?"* Jean spoke about the fact that in the majority of cases there *'were no complications'* which she found reassuring. Reflecting on the differences between birthing in the late 1970s and early 1980s and birthing now Jean said that *"you didn't see childbirth on the telly, you know? Didn't have all these pictures of screaming women, and things like this on television"* concluding that *"it puts in people's minds how painful it's going to be"*.

The majority of the women talked of birth as an overwhelmingly managed experience and as little more than a consequence of pregnancy (which was the customary next

step after marriage), and a gateway to motherhood, with Meg telling me that she did not really have any idea what being pregnant or giving birth was like but she figured that *“it was just something somebody did when they got married”* and that she believed *“everything would be fine”*. Likewise Marie said *“I don’t think I ever questioned what it was like....we were going to get a child at the end.”*

Certainly for many of these women a positive experience was measured by everything turning out *‘alright’* and the fact that they were taking home a healthy baby. Paula explains, *“I had two babies and everything was alright, so they were positive experiences for me”*. Sophie was of a similar mind-set saying that *“you go into it thinking all I want really is a healthy baby, I don’t care what really happens in between”*.

8.5 ‘Looking Back as a Mature Woman’

“One would expect people to remember the past and to imagine the future. But in fact, when discoursing or writing about history, they imagine it in terms of their own experience, and when trying to gauge the future they cite supposed analogies from the past: till, by a double process of repetition, they imagine the past and remember the future” (Namier, 1991, p. 431)

Many of the women birthing in the 1970s-80s told me that they had been motivated to take part in the study after their daughters and daughter-in-laws experiences of pregnancy and birthing had caused them to wonder about their own experiences. Emma said that her daughter being pregnant was an important event for her and had made her *“reflect on what happened to me in the past”*. Likewise Marie spoke about the fact that both her daughter and daughter-in-law had recently given birth and that she (Marie) had been intrigued by the sorts of information they were getting and how different it was to the information she remembered.

Interestingly Paula told me she thought it would be interesting to see how care in pregnancy and birth had developed over the years and find out whether it was “*better actually when I had my children than it is now, even with all the different things like birthing plans and all that*”. Paula was interested in this aspect as she felt that her daughter, despite having lots of information and access to care such as ultrasound scans, had very traumatic deliveries where control was taken from her, whereas her experience (with limited information and no expectation of being involved in the management of her care) had been ‘*pretty straightforward*’. Some of the other women had not yet become grandmothers but were interested in contributing as they anticipated that pregnancy and birth were likely to take place in their families in the near future and felt that they were events which they might (and indeed hoped to) have a role in.

As I established earlier the women described, and clearly saw themselves, as passive recipients of care when they birthed, reasoning that the world of birth they experienced was one of deference to the professional with little opportunity for involvement or control in their experiences of birthing. Certainly the women understood their past as a particular way of ‘having been’ and in anticipation of their daughter’s and daughter-in-laws births (in the future) the women drew on their own experiences of birthing (which happened in the larger historical tradition of birthing at that time) to inform the present and reveal the possibilities of birthing for those close to them, whilst at the same time reflecting back on and reinterpreting their own past.

Heidegger’s concepts of historicity and repetition help here; as discussed in chapter five for Heidegger the human way of being is profoundly historical. The past is understood as a way of ‘*having been*’, the present as a ‘*waiting-toward*’ and the future as a ‘*coming-toward*’ (Heidegger, 2012, p. 437). For Dasein the past is always significant and becomes more pertinent according to what it means in relation to

Dasein's future (Prestidge-King, 2006). Heidegger explains how repetition gives the past meaning telling us that it is a *"possibility of existence that has come down to us. Repeating is handing down explicitly - that is to say, going back to the possibilities of the Dasein that has-been-there"* (Heidegger, 2012, p. 437). For Heidegger possibility is more significant than actuality; Dasein acts on and interprets the world on the basis of that possibility (Heidegger, 2012). Schrag (1970) explains the notion of repetition arguing that it *"hands over the past with a meaning or sense"* and clarifying the point that *"without repetition the past would simply be a collection of isolated facts"* (Schrag, 1970, p. 289).

In reaching into their pasts to consider the possibilities for their close female relatives the women recognised that they were birthing in a different world of birth (as discussed earlier) and told me they were different women then. Carole, for instance, said that *"I was very young then, so I did as I was told"*, going on to tell me that *"I probably would have researched far more if I was pregnant now, but then I'm a lot older now"*; Carole sees herself then with the life experience of now and realises that she may have become more informed if she had the benefit of experience at that time. Likewise Meg said that despite being *"a very shy, withdrawn person then"* she would like to believe that if she had been given more information and choice about her situation (she was of small stature and carrying a large baby) she would have been able to be involved in the choices and decision making relating to her care (perhaps by opting for a caesarean).

Meg appreciated however, that she was looking back as a *"mature woman who would be more forceful"* and understood that her younger, less self-assured self may not in fact have acted on any further information had it been given. I wondered on reading the conversation later (but had not thought to ask at the time) whether she imagined that she may have done something different because of the outcome (a traumatic labour leading to a failed forceps and a C-section) and whether if she had found the outcome

more positive she would still imagine her younger self as potentially intervening in the care. Certainly the benefit of hindsight allows us to believe that we could or should have behaved differently.

In reflecting back to her own situation (something which she had put to the back of her mind) Meg was afraid that her own daughter would also have a very traumatic time when birthing; in fact Meg was so concerned that she spoke to her daughter's midwife (she attended the antenatal clinic with her daughter and spoke with the midwife whilst her daughter went out of the room to provide a urine sample). She told me that *"I did explain to the midwife that I'd had this terrible experience and I was very concerned that I didn't want my daughter to go through the same experience and could anything be done, you know, to make sure that it didn't happen to her"*. On being told that there was nothing 'they' (the maternity service) could do and that they would have to wait and see Meg was shaken, *"I thought, well I'm quite surprised, you know, nowadays that still mothers just have to wait and see what happens"*.

Clearly Meg was upset that nothing could potentially be done to 'save' her daughter but also assumedly perturbed as her perception had been that if she had only asked for more information her own experience would have potentially been less traumatic; however from what she was being told her experience may have ended up being the same at that time and potentially even now (had she been birthing in this era). In trying to come to terms with this fact Meg said *"Having said that, they stepped in a lot sooner than they did when I was giving birth to my son, to give her an emergency caesarean, whether that's a good or a bad thing, but certainly she wasn't traumatised like I was"*; it seemed that Meg, by reopening the past and *"translating that which has been into possibilities to be chosen time and time again"* (Schrag, 1970, p. 289), was seeking to understand more clearly both her own experience and that of her daughter.

8.6 'Doing Better'

A number of the women birthing in the 1970s-80s told me that they felt that they could have 'done better' when birthing. Emma said that she "*didn't do so well*" with her second birth and went on to reason that perhaps she had not done enough relaxation classes or wasn't prepared '*in myself*'; Emma said that she knew what the pain would be like and as a consequence did not feel "*in control of it like the first time*". Emma clearly felt she was responsible for not doing 'so well' and in reflecting back was trying to determine why her second experience was not as 'successful' as her first.

Similarly Sophie expressed her view that she could have "*made my experience much, much better*" (speaking of her first birth) and spoke about whether she could or should have relaxed more "*or just been more aware of what was happening*". Sophie attended NCT classes prior to birthing her second baby in an effort, she said, to understand the "*biological - science lesson type stuff*" and in so doing potentially improve her second birthing experience.

Both women seemed to feel responsible for not birthing as well as they would have liked but neither vocalised in any detail what they felt was 'not good enough' (despite being asked about this). Sophie went as far as to say "*if you're being marked on it, you think, oh, you could have done better*" and to confide that she felt guilt, "*yeah, the guilt that I actually didn't do a very good job there*". Their comments suggest that they both had expectations of themselves and their birthing; they expected birth to proceed in a certain way and felt that their behaviour or 'management' could influence this.

8.7 'Taking Control and Going the Opposite Way'

*"Don't touch me:
don't hold me back.
Instead I step from my body's ship
on to the salty stones. Safe,
delivered, triumphant, everything is before me."
(Little, 1990).*

The information seeking behaviour of many of the women birthing in the present day seemed to be related to a need to take control of their experience and, in some cases, ensure that their experience did not follow those of other women they were close to. Lucy having spoken with her own mother about her birth and the births of her siblings was following her mother's advice in seeking out information as a means of preparing herself and putting herself in a more empowering position. She told me *"My mum wasn't happy with her experience and she said it was fortunate she had done some preparation as otherwise my brother may have died; she had to ask for the doctor.....My mum told me to be prepared in situations you may not be able to control."*

For Lucy there seemed to be a need to learn more about her options for birthing as she grew up in a culture where expectations and understandings of birth were different to those she was encountering in the UK. Lucy explained that in her country the '*medical service*' around birth was very different and that *"how people perceive the way that you should give birth is quite different as well"*. After learning about the physiology of birth at antenatal classes Lucy felt comfortable with the prospect of a normal birth something she would not have contemplated in her own country. It seemed extremely important for Lucy to be prepared as what she was experiencing was at odds with what she would have anticipated at home. Maybe Lucy was trying to ensure that her 'story' followed

those that she has heard in the UK as opposed to those in her medicalised country of origin?

The situation was slightly different for Stephanie who had not attended classes primarily with the intention of learning about birth; attending aqua yoga classes was something Stephanie had decided to try in order to find some relief from the pelvic pain she was experiencing in pregnancy. Similarly Stephanie chose to attend NCT classes as a way of making friends and networking as she had recently moved into the area. Significantly, though, the classes changed Stephanie's '*views about birth*'; from imagining that birth was "*all out of my hands*" and that she would be having a medically managed birth, Stephanie recognised that she could be involved in planning the birth, and in considering choices and making decisions arising during her labour and birth. Stephanie also learnt the value of relaxation and the benefits of water for weightlessness and movement and felt reassured that choosing to birth in water would help her to manage the pain and cope with the stresses of labour. After attending classes Stephanie felt a sense of control over the process which she did not have before and saw an opportunity to experience a birth which was '*almost enjoyable*' rather than having an experience akin to those of members of her family.

Likewise Bonnie explained that it was what she found out at the parent education classes which led her to visualise a different kind of birth than that which she had originally anticipated:

"And then the NCT bit on pain relief was really interesting because it sort of changed my mind quite a lot. I was a, "Give me all the drugs." (Laughter) Just give me drugs you know, and I'll be fine. And I think I'm now leaning more towards, "We'll try and do it naturally as far as we can and then we'll see what happens."

Isabel's experience of antenatal classes had been very positive and empowered her, giving her a sense of control which she had not had previously. Going to the classes had helped Isabel appreciate that the labour and birth of her baby could be an '*amazing event*' in her life; something which was potentially life changing and something which she could be involved in and make decisions about. Significantly Isabel realised that '*there is an experience for me*' in the birth of her baby, something which she had not contemplated before. Taking control of her birthing was a new concept for Isabel.

8.8 '*This Generation Nothing's Private to Them*'

"When I was about five, I asked grandma where I came from and she says a stone exploded and then I popped out. (Laughter) And I thought, 'No, doesn't feel kind of right.' And then she would tell me another story, she said that I came out from my mum's armpit (Laughter) because like this very old lady's like in the traditional education. Of course she knows where I came from but she's embarrassed to tell me as a child about the details". (Rebecca)

The women birthing in the 1970s-80s spoke at some length about the fact that birth was a "*pretty private thing to talk about*" (Sandra). Likewise the women birthing in the present day told me that they had not always felt comfortable speaking to their mothers or grandmothers about birth and that their mothers had not necessarily wanted to speak about birth with them. For some it was a cultural issue; Rebecca's, for instance, was of Chinese origin and was born in Hong Kong. Her grandmother was educated in a very traditional manner and did not feel it was appropriate to discuss childbearing with her granddaughter (as evidenced in the example above). Similarly Lucy, also Chinese, expressed a similar view saying that "*they can't really talk about that in the past....it's just a cultural influence. They just found that it is something very private, something quite embarrassing to talk about*". Meg said that she did not remember her mother saying very much about pregnancy and reasoned "*I think it was inappropriate to go into too much detail because, you know, genitals weren't something you referred to in those days*".

For others it was simply not something they talked about; Emma said that she had not really spoken with her mother about birth and that *"the only thing I probably know about when I was born is the fact that I was born on New Year's Day and that my dad was sent out to get a canister of Entonox because they hadn't got anything. He was cycling around trying to find the doctor or something. And that's probably as much as I know"*. Emma did not feel she was in the position to ask her mother about birth saying *"I'm sure it's a generational thing. My mum wouldn't have been as open about things as perhaps I would be with my daughter"*. Sandra told me that when she was pregnant she worked with women who had children but that *"we never discussed what it was like. It was different then to how it is now"*. Sandra felt that it was a *"pretty private thing to talk about"* and that young women 'today' talk about birth more than her own generation or the generation before that saying *"in this generation nothings private to them - nothings off limits, they talk about everything"*.

Despite recognising that young women today *'talk about everything'*, none of the women birthing in the 1970s-80s really expressed an opinion about the notion of sharing everything; rather they just seemed to accept that it happened more now than it had in the past. Sandra however certainly felt that talking was an effective way of learning and that knowledge was *'power'*. Sandra said she thought women needed both positive and negative information about birthing and that by not sharing you would not *'shelter'* people from things that go wrong.

There was certainly awareness among these women that women birthing today have more information at their disposal than they did in their pregnancies but this wasn't always perceived as a good thing. Jean, for instance said that *"it's nice to have some information but I think there's definitely an overload now"*. Likewise Emma clearly felt that there was an awful lot of information to *'get through'* saying of her daughter that *"I mean she can access so much. She's got apps on her phone. She's got an iPad where*

she's got a contraction thing to measure her contractions. She's just got so much, much more than I ever had". Emma spoke about the information '*bombarding you*' but reasoned that younger women were probably okay with it because they were '*used to it*'. However my perception as noted earlier in the section on information seeking and saturation, is that women today may have the skills to access information but do not necessarily have the ability to assess the credibility of the information and/or may feel overwhelmed by the task of navigating their way through the sheer volume of information at their disposal.

8.9 Fear of Birthing

*"Strapped down,
victim in an old comic book,
I have been here before,
this place where pain winces
off the walls
like too bright light.
Bear down a doctor says,
foreman to sweating labourer.
But this work, this forcing of one life from another
Is something that I signed for at a moment when I would have signed for anything".
(Pastan, 1990)*

The women birthing in the present day clearly had anxieties about their impending labours and births; they spoke of birth being '*scary*' and potentially '*difficult or dangerous*' and revealed that they were worried about how they might cope with the pain. For Lucy being scared was about dealing with the uncertainty of birth; having grown up in a culture where the uncertainty was removed by women having scheduled

caesareans Lucy wasn't sure what to expect of a physiological birth. Similarly though she did not want to have a caesarean because "*I've never stayed in hospital before and I don't want a scar*".

Bonnie was worried about the pain telling me that "*I'm rubbish with pain...and I was kind of doubting my own ability to be able to cope*". Bonnie told me that people do not necessarily tell you that it's painful but that "*there's a lot of conversations...of raised eyebrows and that sort of thing so you get the impression it's going to be painful*". Rebecca was also worried about the pain associated with labour and birthing but said she became calmer after she attended antenatal classes and learnt about the various forms of pain relief that could make the birth more manageable.

Speaking of her impending birth Joanna said that it was possible that it would be difficult or dangerous but then she hurried the conversation on saying "*it's a long way off yet!*" Despite telling me that most births are "*handled well and safely and properly*" Joanna referred to birth as being unpredictable and risky. This was a common thread throughout our conversation. There was a strong sense that she was actually very anxious about birthing and that what she knew about birth was making her more anxious rather than helping to prepare her for the experience. Most of the stories she had heard were of what she called '*the worst case scenario*' and reinforced rather than allayed her fears.

Conversely Charlotte's anxieties were based on the responsibility of caring for a newborn and becoming a mother as opposed to the actual birth process. She said "*the actual birth bit, everyone's got to do it, so get on with it*". Charlotte's sentiments are more in keeping with the women birthing in the 1970s-80s than with her own generation. Certainly the older women spoke about having to get on with it and over it (as discussed earlier in the chapter) and in their conversation said more about being curious and

excited rather than frightened. Paula for example said *“I was quite excited really. I think because I’d kept so well I was just excited really to be having the baby. I wasn’t apprehensive”*. Equally Pamela revealed that she wasn’t frightened about labour but that *“I just felt excited and curious and was glad when it finally started to happen”*. Carole said that today she would have been more scared because she would have had more information and this comment was reiterated by Jean who said *“you obviously didn’t have the internet there to search for all these things that can happen and frighten yourself to death”*.

It was significant, of course, that the women birthing in the present day were anticipating birth in the very near future; it would have been somewhat unusual therefore if they had not expressed any worries about what lay ahead. Similarly the women who birthed in the 1970s-80s were recalling how they felt quite some time ago (and with the benefit of hindsight and the knowledge that they had birthed healthy babies). Nonetheless the women birthing today seemed to be more fearful about birth and of course, as discussed in the last chapter, all spoke of the *‘horror stories’* they had heard and the media representations of birth they had been exposed to.

8.10 Chapter Summary

This chapter has explored how two different generations of women prepared for birth within their distinct information landscapes. I argued that for the women birthing in the 1970s-80s understanding of birth was experienced as acceptance of the care offered and provided by care professionals. I also argued that women birthing in the present day were overloaded with information which they amassed in an attempt to fit the role of the informed patient and to demonstrate their competency as mothers. Later in the chapter I examined the intergenerational sharing of birth experiences and the women’s perceptions and recollections of the birthing process.

The concepts of historicity and repetition were used to make sense of the experiences of the various women demonstrating the means by which the women birthing in the 1970-80s 'reopened' their pasts in an attempt to understand their own experiences more clearly and also anticipate the possibilities of birth for their daughters and daughter-in-laws. I ended the chapter by arguing that the women birthing in today's world of birth appeared more fearful of birthing and that the culture of birth as portrayed in stories and popular media may be instrumental in creating and perpetuating this fear.

In the next chapter I consider the aletheia 'Birth in the Twilight of Certainty'; this aletheia considers women's experience of being in '*the system*' of birth on the '*conveyor belt of care*'. I move on to discuss birth as a '*technological feat*', a process framed in risk and neat conceptualisation. I speak of the notion of being a '*good patient*' and a '*good mother*' as presented by the women birthing in the present day, and I end the chapter by considering the existence (or not) of birthing 'know how' in the twenty first century.

CHAPTER 9 - ALETHEIA: ‘BIRTH IN THE TWILIGHT OF CERTAINTY’

“Safety and consumer ideology interpenetrate with the veneration of technology, the institution, and patriarchy in such a way that they become located in the hospital and embodied in the doctor, whose tools and technological expertise become the safe fetal space to be purchased by expectant mothers. Her eyes extended by ultrasound, her hands by the scalpel and laparoscope, her brain linked to databases of the latest clinical research, the cyborg obstetrician seems to guarantee the perfectly predictable product - baby. How can a conscientious pregnant consumer justify buying anything less?” (Wendland, 2007, p. 225).



Figure 3: ‘Special Delivery’ (Miller, 1955)

9.0 Introduction to Chapter

In the last chapter I explored how two different generations of women came to understand what their experience of birth might be and looked at ways in which the

women shared and understood their stories, perceptions and memories of birthing. I addressed the notion of birth as something which must take '*its course*', spoke about the idea of the 1970s-80s woman as '*a shy nervous girl*', and considered the desire of some women in the present day to '*take control*' of their birth experience. I discussed the idea of '*nothing being private*' in the modern discourse around birth and ended the chapter by discussing fear of childbirth, coming to the conclusion that women in the present day appear more fearful of labour and birth than the previous generation. I argued that the culture of birth portrayed in stories and in the media may be instrumental in making women fearful of birthing.

In this chapter I consider the aletheia 'Birth in the Twilight of Certainty'; this aletheia considers women's experience of being in '*the system*' of birth and on the '*conveyor belt of care*'. I move on to discuss birth as a '*technological feat*', a process seemingly stripped of live content and imbued with possibly disastrous consequences for women and birth. I consider the onus on women to be seen as both '*good patients*' and '*good parents*' as shared by participants from the first phase of the study, and discuss the responsibility and pressure this puts on women. I end the chapter by suggesting that despite being overrun with information, women birthing in the twenty first century may in fact be lacking in birthing 'know how'; having little understanding of physiological birth and lacking the belief in their bodies to birth.

9.1 Being *'In the System'* on the *'Conveyor Belt of Care'*

"Happy life with the machines

Scattered around the room

Look what they made

They made it for me

Happy technology

Outside the lions run

Feeding on remains

We'll never leave

Look at us now

So in love with the way we are"

(Deadmau5 'The Veldt' lyrics, 2012)

A number of women discussed the notion of being part of a *'system'* of birth suggesting that they felt like one of the *'processes'* on the *'conveyor belt of care'*. Meg, for instance, told me that *"I just felt like one of those processes..... your job was to produce this baby...it was about getting the baby out"*. Jean said of her first birth *"I seemed to be just pushed from pillar to post on this kind of never ending conveyor belt"*. For Meg being part of the system was a frightening experience as *"nothing was explained"* and she did not feel that the people *'caring'* for her were concerned about her welfare. Likewise Marie said that childbirth was *"a process we were going through...we were going to get a child at the end"*.

For Ruth, however, who was pregnant with a much wanted baby after fertility treatment, birth was merely another *'process'* she had to go through to have her *'dream baby'*. Up until this point Ruth's path to having a baby and becoming a mother had been keenly managed; any sense of uncertainty had been removed from the experience and Ruth

felt *'in control'* of what was happening. Strangely being part of the *'process'* of childbirth similarly reassured her and helped her maintain that feeling of control.

Joanna spoke at some length about her experience of the *'system'* of birth telling me that at the beginning of pregnancy she thought she would be building up a relationship with a midwife but that instead she had seen a different midwife every time. In this sense Joanna found the system rather impersonal. She went on to say that when *'you'* (women) get pregnant there's an assumption that you'll do all the *'routine things'* (like have ultrasound scans, blood tests and screening) even though some of them are *'supposedly optional'*. Joanna remarked:

"It's a bit like being on a conveyor belt and actually if you do nothing it's just going to happen anyway. You turn up and you're in the system and you just sort of potter along, going along to the next appointment when you have to".

For Joanna being in the *'system'* may feel a little impersonal but is ultimately reassuring because *"it's just so routine; you know what you're meant to be doing and you know what you're meant to be finding out and that they will check various things to make sure you're still well"*. Joanna is reassured by the routine nature of the antenatal care; she is part of a system like every other woman and if there was anything to worry about she would need *'special treatment'* rather than routine care. As part of the *'process'* Joanna is conforming to the social norms of care and disburdening herself of the need to make difficult choices and decisions; she says that *"I've probably more or less consented to most things by not 'not consenting'"*.

Joanna it seems is not behaving *'resolutely'* (as Heidegger says Dasein must do in order to behave authentically); by not facing up to the situation in which she finds herself (a situation shared by many of the *'they'* but in this instance uniquely individual to her) she is conforming to some predetermined *'general state of affairs'* and way of being-

towards-birth (Carmen, 2005, p. 291). Further Joanna is not embracing the second component of authenticity; the notion of ‘*anticipation*’ or ‘*forerunning*’ which Carmen explains as “*akin to the famous leap of faith wherein I take up my personal commitments as irreducibly my own, even though they may be irreconcilable or incommensurable with ethical norms applying to everyone, including me*” (Carmen, 2005, p. 291).

In order to behave authentically Joanna must be “*ready, willing, and able to embrace a particular and essentially fragile set of possibilities*” (Carmen, 2005, p. 291). Joanna, it seems, is unable to embrace any sense of ‘fragility’ or possibility relating to her birth; despite her confident demeanour and articulate conversation she is clearly very frightened about birthing. She tells me that women still sometimes die in childbirth, “*not often, but they do*” and that “*a lot of money is handed out in compensation in maternity cases*”. Joanna needs to be reassured by the care that she receives and wants what she perceives to be the ‘certainty’ of routine care within the ‘system’ of birth.

9.2 ‘Birth as a Technological Feat’

“The myth insists that the more we control nature, the better it gets, and that the ultimate control of nature is possible. Believing this myth, we have focussed enormous energy on building machines that we can control in order to control nature, which we ultimately cannot control. But these powerful machines do generate at least the appearance of control.” (Davis-Floyd, 1997, np)

Throughout our conversation Jean, one of the group of women who birthed in the 1970s-80s, said that when she was pregnant she felt birthing was a “*natural thing to do*” explaining that she was a ‘*no-fuss*’ kind of person who did not anticipate complications and was reassured by the fact that “*animals do it all the time*”. Jean told me that her knowledge of primitive civilisations and the work of the American anthropologist Margaret Mead may have helped her reach this understanding. Jean felt

she was well prepared for birth and had no reason to be fearful, saying that *“my best friend had had her baby a couple of weeks before me and she was okay, so you know”*.

Speaking of her daughter and daughter-in-law's experiences of birthing Jean told me she felt their experiences were made more complex by the volume of information available to them and the technology relied on to *‘monitor’* both their wellbeing and that of their babies. Jean spoke of the world of birth now as *‘high tech’* telling me that *“there’s all this technology that surrounds you when you’re pregnant”*. Jean said she understood the need for technology from *“the safety point of view”* (she believed that the technology was designed to keep mothers and babies safe) and yet she is uncomfortable with women being *“attached to all these wires and goodness knows what else and things and it’s, you know, it’s all so closely monitored”*.

Jean is of the view that in the present day, birth rather than being a *“natural occurrence”* which happens in the bosom of your family (as was the case with three out of four of her births) the advent of technology has made it a *“technological feat”*; her language suggests that today to *‘succeed’* in birth women must yield to and exploit the technology surrounding it. Conversely Sandra did not appear to think that birth was now more medicalised than when she birthed telling me of her first birth:

“By the time I got there I was already four centimetres. They had to break my waters to bring it on quicker because the water weren’t breaking. I can remember having the waters broken. I could remember they put like a little clip on her head and I think that was so they could hear her heartbeat. So, I didn’t know that was going to happen and I could remember they put a belt around me which monitored the contractions and I didn’t know that that was going to happen”.

Sandra's own experiences of birthing were medically managed and for her this was clearly the norm; as a result the *‘modern’* landscape of birth does not look very different. However for Paula birthing *‘technology’* such as ultrasound scans and electronic fetal

monitors (part of her daughter's care in pregnancy and labour) have made the landscape of birth more challenging and complex but paradoxically not necessarily improved women's experience, telling me of her daughter:

"She had a horrendous, horrendous time. And when she was actually delivering -- she had to go in for an epidural and she had -- because of all this pain she had with the pelvis and then she had a really bad reaction to the epidural. I mean I wasn't there -- Paul her husband was with her and he actually thought she was going to die because she was out, you know, during that. So yeah, she had a pretty horrendous time".

Paula was shocked that despite all the 'preparation' her daughter had done in the form of information gathering, and despite what she perceived to be 'improvements' in care (such as the introduction of birth plans and routine ultrasound scans) her daughter's experience had been more negative than her own (when the information wasn't as widely available and the technology not as well advanced).

For a lot of the women birthing in the present day there was an expectation that birth would be medically managed; for some this was because they had health issues (Harriet had a heart condition and Mary had had previous major abdominal surgery), for others, as discussed in the first aletheia chapter, it was something they anticipated from the stories they had heard and the representations of birth they had seen (Stephanie and Isabel). And for two women (Lucy and Rebecca) it was a cultural issue (as discussed in the second aletheia chapter).

The experience of being-in-the-world of birth for these women was an experience of being in a world populated by doctors and technology; all in place to safely 'manage' their well-being and their births. Heidegger's concepts of '*facticity*' and '*ruinance*' help us to understand this; Heidegger's view is that the human way of being is incomprehensible in isolation from a grasp of the world in which it 'is'. Dasein exists in an environment in which it is "*tempted, seduced, soothed or estranged*" by the world

around it (Harman, 2007, p. 30). The childbearing woman then can never just 'be' within the world of birth without already being a part of it and potentially being '*spoiled*' by it.

Being '*spoiled*' by the modern technological world is something which gravely concerned Heidegger as he believed that technology held more danger than potential and had the capacity to obscure the meaningful presence of things to human beings (Wrathall, 2013). In his quintessential paper '*The Question Concerning Technology*' Heidegger considers the 'essence' of technology differentiating between 'technology' as an ability to bring things to presence by making them, which he defines as '*instrumental*' technology, and 'technology' as a '*revealing*' (Heidegger, 1954, p. 12). Technology as a '*revealing*' (as discussed in the previous chapter) brings things into '*intelligible availability*'; implying that a person understands something according to their own framework of meaning depending on what they want to make of it or given whatever purpose they have in mind for it (Heidegger, 1954, p.4).

Heidegger's concept of the essence of technology is not an easy one to understand; for Heidegger there have been a number of different worlds each with a unique 'essence' (Wrathall, 2013). Each of these worlds establishes different orders of intelligibility, and in doing so gives the people who live in that world, different understandings of how to manage their lives. Wrathall gives an example describing how "*in the Christian Middle Ages....everything showed up as God's creation, and was defined in terms of its nearness or distance from God's own nature*" (Wrathall, 2013, np).

This example helps to clarify Heidegger's notion of the 'essence' of technology; that in the modern world (with the emergence of modern machine technology) things show up as having the potential to be ordered, to be '*regulated*' and '*secured*', according to the norms of control and efficiency of that world (Heidegger, 1954, p. 16). Similarly in this world people share a way of 'being' with all other 'things' and are therefore prized in

terms of their ability to function as another 'resource'; to be productive and efficient. For Heidegger ultimately the essence of technology is not of human doing and is something which we cannot control but instead is an 'epic' in which humans live:

"Everywhere we remain unfree and chained to technology, whether we passionately affirm or deny it. But we are delivered over to it in the worst possible way when we regard it as something neutral; for this conception of it, to which today we particularly like to do homage, makes us utterly blind to the essence of technology" (Heidegger, 1954, p. 4).

The notion of birth as a '*technological feat*' in which women are tasked with yielding to and exploiting technology is a disturbing one; in this interpretation women's disembodied experience of birth is accepted as normal and mainstream. Certainly, as Heidegger's thinking helps us understand, the move towards a more technologically orientated birth is an epic in which we live and which on the face of it appears relatively neutral (Heidegger, 1954).

The problem with the '*horizon of meaning*' surrounding birth as discussed above, a meaning that supposedly increases the '*orderability*' of birth and utilises calculative thought (orientated towards measurement, certainty and control), is that it sees women as standardised resources with reproductive capacities (Heidegger, 1954). Likewise the adoption of calculative thought in relation to birth (a form of positivist thinking that does not explore meaning but looks for solutions to problems) drives "*an industrial vision of birth that seeks control through fixed time parameters*" (Crowther, Smythe and Spence, 2015, p. 452).

In posing contemplative thought (which considers the human situation in which we find ourselves and seeks to establish meaning and understanding of that situation) Heidegger is looking beyond the human relationship to the world as a productive one; he sees contemplative thought as a way of questioning the being of things and, in so

doing, as a means of engaging with the world in a completely open and sincere way. This kind of thinking is defined by Hixon (1978) as natural and spontaneous, a movement away from reasoning. Heidegger does not suggest that we adopt one mode of thinking over the other rather he argues that we embrace both ways of thinking to truly interpret experience into meaning. Further to be open to meaningful presence Heidegger urges us to remember our finitude (our essence of being human) as we engage with the world and make our interpretations (Heidegger, 2012).

The image below, a mixed media piece by my sister Caroline and reproduced with her consent, was 'birthed' this year twelve years after the traumatic birth of her son. The birth of my nephew was not an experience to be wondered at or a time of sacredness or joy, rather it was something which Caroline forced to the back of her mind, willing herself to 'forget', whilst she concentrated on mothering her son. Twelve years on she is finally coming to terms with what happened and this image is part of her 'recovery', her means of understanding what happened during her son's birth. It is a means of confronting the lived experience of the birth and making it part of her history; something which was denied her at the time as *'the C-section under GA with the 11 lb baby and the PPH'*.

Because of the constraints of this thesis I do not offer a detailed interpretation of Caroline's piece however I do want to bring to the reader's attention the caption in the right hand corner which reads *'my his story'*; in including this I would suggest that Caroline seeks to make the 'history' or factual account of her birth into her own very personal story of birth, a story she can move forward with into the future. Significantly the letters making up the caption are made up of newspaper print; Caroline has used the typeface of the everyday generic story of birth to 'write' her own unique story. This story recognises her triumph as a mother and starts from the moment that she first breastfed her son; this for Caroline was her experience and 'moment' of birth. The

image of the baby (an image created by Adam Fuss in 1992) can be seen rooting for the breast. Significantly the image of the baby is called 'Invocation' suggesting the presence of something other worldly, spiritual or godly.



Figure 4: 'dis chord' (Calonder, 2015)

9.3 'Being a Good Patient and a Good Parent'

"Motherhood, once taken-for-granted and relatively unreflective, has consequently become imbued with the meanings of risk, danger, responsibility and constant reflexivity upon how well one cares for one's children. Mothers are expected to seek out information about the risks to which their children might be exposed and to take steps to manage and minimise these risks. They are now held accountable for many of the ills and misfortunes which affect children that once were considered bad luck or the result of fate". (Lupton, 2011, p. 638)

Women birthing in the present day spoke about the responsibility to behave as a 'good patient' whilst pregnant and birthing, and perform as a 'good parent' both in relation to their developing foetus and to their newborn baby. Stephanie for instance spoke about her previous experiences of attending hospital for operations and the 'expected' behaviour she would conform to; being told where to go, getting changed into a hospital gown and 'allowing' health professionals to do everything for her. Her expectation was that she would do the same in pregnancy saying that the *"professionals will probably tell you - we want you like this"*.

For Isabel being a 'good patient' involves *"hopping up on the bed"*, *"lying still and being good"* and not *"making a fuss"* or being a *"nuisance to anyone"*. Isabel told me that she always wanted to please people and that when she gives birth she will be particularly anxious to please. Being a 'good patient' proved problematic however when Isabel attended the hospital for a glucose tolerance test; Isabel said she *'wanted to do well'* but that it was the hardest two hours of her life as she felt so violently sick. Isabel did not want to *'ruin the test'* which she felt was crucial to being a 'good patient' but also significant in being a 'good parent' as she *"wanted to have the test to make sure that everything was fine"* with the baby.

Certainly childbearing women in the modern world of birth are faced with an endless array of both expert and lay advice about the ways in which they should protect their foetuses and babies from risk and promote their health and wellbeing. This 'pressure' to make the right choices and to fit the profile of the 'perfect mother' is encapsulated by what Isabel describes as the "*massive list of rules about your baby*". Isabel gives examples such as the need to keep doctor's appointments whilst pregnant, the responsibility to get the baby vaccinated, and the necessity to ensure the baby sleeps in the 'correct' position and is covered by the right number of blankets. Isabel was undoubtedly anxious that she fit the requirements of a '*good parent*' telling me that she strove to be what she described as a '*good vessel*' for her baby, by doing everything in her control to '*help the baby*' and '*protect it*'; in this sense she was endeavouring to "*tick all the boxes and get it all perfect*".

Isabel's desire to '*please*' everyone and her responsibility to '*protect*' her baby (from seemingly a potentially dangerous and stressful birth and possibly from her own poor decisions because she is not an 'expert') suggested that she would seek out guidance and care which absolved her from responsibility and instead put others who had the necessary expertise in charge. She told me she felt very '*nurturing*' towards the baby and did not want to put it at risk; "*I've a terrible fear that if I did something to jeopardise the health of my baby, then how would I ever recover from that guilt?*" For Isabel guilt was one of the '*worst feelings you can have*'.

Similarly at antenatal classes Lucy learned she could make decisions about what is "*right for her and her baby*". Doing what is '*right*' is a responsibility and Lucy talked to friends, watched the television and read books to try and get ready for the experience. Lucy believed that knowledge was power and that being informed would alleviate some of her fears about birth, helping her to have the experience that she wanted but

ultimately helping her to make the '*right*' choices and decisions which would have the best possible outcome for her baby.

The concepts of being a 'good patient', making 'informed' and 'correct' choices and fulfilling the role of the 'perfect mother' are fashioned from widespread priorities determined by (but not restricted to) bodies such as the media, government agencies, health professionals, and family and friends and fit with the Foucauldian concept of governmentality; this is the notion that a myriad of different control mechanisms govern our way of life and together form an '*ensemble*' which is tasked with managing the "*welfare of the population, the improvement of its condition, the increase of its wealth, longevity, health, and so on*" (Foucault, 1994, p. 217).

The image of the foetus on the scanner makes the baby 'real' for many women as Ruth found when she went for a four dimensional ultrasound scan which she described as a "*wonderful experience*" during which she could see the baby's characteristics and distinguish that "*it has my nose*". Endowing the foetus with its very own identity through the ultrasound image can be understood as a form of control making the woman more concerned about her own health and wellbeing and about avoiding behaviours which may 'threaten' the baby such as smoking or drinking alcohol.

Similarly the image of the foetus affords it with a sense of autonomy which muddies the presence and significance of the pregnant woman. The image of the foetus in utero reinforces the mechanistic approach to birth (as discussed in chapter 2 section 2.6, pages 41-42) favouring the woman as little more than a container for a precious cargo; the image privileges the idea of pregnancy as a physical event as opposed to seeing it as a significant lived experience for the woman. This idea is captured beautifully by Chagall's '*Pregnant Woman*' painting of 1913 as shown below:



Figure 5: 'Pregnant Woman' (Chagall, 1913)

Heidegger suggests that in being-in-the-world human beings have an awareness of the concepts of responsibility and guilt and he calls this awareness '*conscience*'. According to Foulds (2012, np) conscience is experienced as "*a kind of call that summons you to be responsible for some aspect of your existence*". At home in your 'everydayness', your conscience calls you to your potentially-for-being which is at odds with your place in the world of the 'they'. Feeling '*guilty*' in the Heideggerian sense then is not about being guilty of something but rather is about having a sense of responsibility for something (Heidegger, 2012, p. 325). Understood in this way conscience and guilt are a call to exist authentically, to see past our 'thrownness' and into possibility.

Applying Heidegger's understanding of conscience to two of the examples given above illustrates Lucy's need to act authentically by understanding what was possible and best suited for her and her baby. Isabel, on the other hand, although sensing a need to act authentically was frightened to do so; it seemed Isabel had no belief in herself or her own abilities either to make decisions for her baby or to birth her baby safely without expert guidance and care. She was frightened about not making the right choices and of being seen as a 'bad' mother if she chose unwisely.

9.4 Birthing 'Know How'

As discussed in the previous chapter the women birthing in the 1970s-80s had no real anxieties about their ability to birth; the women accepted that their labours may be long and arduous but were reassured they would get through, reach the 'other side' and go home with their baby. Despite telling me that they had limited information to prepare them for birth the women of this phase expressed a confidence in their ability to birth. Jean for instance told me that she thought at the time *"Right. It's all easy. It's a natural thing. Animals do it all the time."* Likewise Marie said *"I wasn't anxious at all. And both births were very quick and very easy"*. Paula reported a similar experience telling me that *"I was quite excited really. I wasn't -- I think because I'd kept so well I was just excited really to be having the baby. I wasn't apprehensive. I just went to the hospital and, you know, kind of let things take the course"*. On the contrary the women birthing in the twenty first century were generally fearful of birth and did not portray any confidence in their abilities to birth; indeed their extensive information seeking was in part undertaken to prepare for what Joanna termed the *"worst case scenario"*.

Certainly the pregnant women I interviewed were information seeking in order to try and relieve anxiety and deal with what Isabel termed the *'great unknown'* of birth. Harriet, for instance, said *"I think the anxiety comes from not knowing, because it's a major*

experience that I've not had before, just not knowing what's going to happen, which is why it's good to research all the different possibilities."

The women having shared stories, accessed blogs and various forums on the internet and watched media portrayals of birth, were anticipating that birth would be painful, long and arduous and, more significantly, that it would very likely be medically managed and 'controlled' by others. This being the case they did not trust their bodies to birth nor believe that they would be able to manage their experience without some form of analgesia and/or intervention. It was only when they started attending the NCT antenatal classes that the women started to question their presuppositions and understandings of birth and to envisage a different sort of birth.

The women were also concerned that they needed to behave 'appropriately' whilst birthing in order, as discussed earlier, to conform to the 'good patient' ideal. Ruth explained that she did not want to "get out of control" saying that "*Ideally, I don't want to be screaming because that would show that I'm, you know, out of control or whatever and how embarrassing.*" There is a sense that the women wanted to be able to control the experience of birth, as they controlled other aspects of their lives, and that they almost wanted it 'sanitised'; so that they would not have to confront the rawness and unpredictability of the experience. Lucy for example was worried about the uncertainty of birth and hoped that by increasing her knowledge of birthing she could negate this uncertainty. The women wanted reassurances that all would go well and tried to persuade themselves that it would, whilst ultimately believing that it would not. Ruth epitomised this idea when she told me what her ideal birth would look like:

*"It's a reasonably peaceful time, but **realistically, it probably won't be.** And then, you know, we'd go to hospital. **We wouldn't be turned away** and, you know, **we would've gone at the right time**, because **you hear a lot of stories about women going at the wrong time and being turned away** and all that sort of thing. We'd go at the right time. And yeah, **the water pool would be***

***available** for one and I suppose it would just be a straightforward birth whereby...I know there's going to be pain but it's not excruciating and I'm not screaming and the baby's delivered and the **baby is healthy**".*

I have marked in bold type the parts of Ruth's commentary which illustrated her lack of faith in the system of birth but which also highlighted her main concerns, how painful the experience would be because if it was excruciating she would not be able to cope, the fact that she did not want to scream because it would be embarrassing and gives the wrong message to those around her and the outcome of a healthy baby which was her absolute priority. The idea that Ruth might go in at the 'wrong time' is an interesting one; presumably being 'turned away' from Ruth's perspective was indicative that women have no real understanding of their bodies or the process of birth. Instead of recognising that women tend to go to the hospital when they are finding it hard to cope and need support (which is perfectly reasonable and which doesn't necessitate them being at a particular point on the birth trajectory) Ruth imagined that these women have misunderstood their bodies and made a mistake by attending; in this scenario the institution seemingly has the authoritative knowledge about women's bodies and is most suited to make decisions about issues such as time of admission and when it is appropriate to seek support.

Throughout the women's conversations there is a sense that physiological birth is too difficult both from a personal perspective and from an institutional perspective. Bonnie said that she was "*rubbish with pain*" and that she doubted her ability to cope; despite finding out that the pain served a purpose and that she could help manage it by employing various techniques Bonnie was fairly categorical that once she got to the hospital she would resort to asking for "*all the drugs*"; she had no confidence in herself to birth her baby without analgesia.

Likewise Isabel spoke about choosing where to birth saying that although she had a preference for a midwifery-led unit she was not confident enough about the process of birth, her ability to birth and about choosing to birth in a midwifery led setting for the birth of her first baby. Birth, especially a first birth she told me, is unpredictable and Isabel wanted the reassurance of a consultant presence 'in case' she needed an emergency caesarean. On reflection it seems that the default position of the women birthing in the twenty first century, as expressed in our conversations was a deep seated belief that they would not be able to cope with the pain and stressors of labour. Being unable to cope meant they would need to birth in a setting where help was at hand and where they and their babies could be 'rescued' should the situation demand that.

The need for control of the process of birth and anxiety about the physicality of birth awareness that birthing is something instinctive, outside their normal experience and with a 'power' all of its own) was a common thread throughout the conversations. Ruth spoke about her fear that she would behave in a way that was not '*ladylike*' and said she wanted to "*avoid the drama of birth*" and Isabel, as discussed earlier, was worried about screaming and "*letting go*" during birth (especially in a ward situation where it would not be that private) telling me that she understood birth was a '*primitive*' experience but that she found that concept quite challenging. Joanna told me that she would not consider a homebirth because it would undoubtedly be '*messy*' and Bonnie said that her husband on seeing a televised birth had said that birth was '*grim*' and she felt he would have preferred to see a more sanitised version.

The women are used to living in a world of reason, a world where things are explained and understood rationally; they are used to employing their intellect and are not used to surrendering to the physicality of their bodies and experience. It would appear that in seeking to 'understand' birth and to increase their knowledge about the process of birth

women source and utilise information to the nth degree and, in doing so potentially distance themselves from a fully embodied, feeling birth.

Heidegger maintains that Dasein lives in a state of being-towards death and that this being towards death is always there and shapes Dasein's existence. For Heidegger *"an endless life would be unmanageable and careless with no way of deciding what to do or when to do it"*; (Inwood, 2000, p. 44) whereas being open to our own death he believes opens us up to truly being. Most people, however as Heidegger acknowledges, prefer not to think about and face up to their own death as it provokes fear and anxiety (Heidegger, 2012). For Heidegger Dasein can only be truly authentic if it is open towards the prospect of its own death; not facing up to one's own death means living as one of the 'they'. Heidegger supposes that every moment of our lives could be our last and that we should live with this understanding in mind and make choices accordingly (Reedy and Learmonth, 2011).

It seems that the majority of women I spoke with who were birthing in the present day were extremely anxious about their own physicality and vulnerability and as a consequence were not able to behave authentically by making 'real' choices. Rather in not facing up to the potential of their own deaths they sought solace in the comfort and everydayness of the world of birth around them; a world in which technology, intervention and management by the 'they' was the norm rather than a world where they questioned the birth practices around them and embraced the unpredictability and primal qualities of birth. The women experienced their bodies as part of the wider machinery of birth rather than 'letting go' and trusting their bodies to birth and in doing so 'wondering' at their bodies and their capacities to birth safely and powerfully (Frank, 2002, p. 59).

9.5 Chapter Summary

This chapter has explored women's experience of being in '*the system*' of birth and on the '*conveyor belt of care*' both in the 1970s-80s and in the present day. I argued that for some women being ensconced in the system of birth was a positive thing making them feel safe and affording a degree of certainty about birth. I then considered birth as a '*technological feat*', suggesting that birthing in today's childbirth landscape undermines the cultural and spiritual significance of birth and instead normalises the notions of controlling, expediting and ordering birth. I moved on to consider the onus on women to be seen as both '*good patients*' and '*good parents*' and the role of the media, government agencies, health professionals, and family and friends in 'governing' birth and motherhood. Finally I ended the chapter by suggesting that women today are afraid of the unpredictable nature of birth, are uncomfortable with the visceral, physicality of birth and are anxious that if they do not make choices that fit with the accepted norms of birth, then they could make both themselves and their babies vulnerable.

In the next chapter I present the central interpretive findings of the study and advance the fundamental argument of the thesis. I remind the reader of the underlying theoretical and methodological assumptions that guided the study, explore the findings in the context of the existing literature, consider the unique contribution of the thesis to midwifery theory and knowledge, discuss the limitations of the study and review its implications for practice.

CHAPTER 10 - DISCUSSION: SEEING THE BIG PICTURE

“Several (stories) seemed licensed by what medical discourses designate a ‘good outcome’ to elaborate and to embellish the preceding dangers and conflict, with the effect, whether intentional or incidental, of improving the climax, of ensuring relief in the final orderliness of all things.... they delivered order from disorder and pleasure from abandon, transgression, and pain”. (Pollock, 1999, p. 4)

10.0 Introduction to Chapter

This thesis has explored how pregnant women across two generations engaged with stories of birth and how they interpreted and understood birth in the light of those ‘stories’. By utilising a hermeneutic phenomenological approach and by considering the perspectives of two different generations of women I have created in-depth insights into the meanings and lived experience for women of engaging with stories of birth whilst pregnant with and anticipating the birth of their child.

In this chapter I present the central interpretive findings of the study. I start by reminding the reader of the initial objectives of the study and the underlying theoretical and methodological assumptions that guided it. I reiterate the notion of the ‘*modern birth story*’ and share how birth stories were told to me in the context of this study. I explore the findings in the context of the existing literature and consider the unique contribution of the thesis to midwifery knowledge. I consider the implications for practice and discuss the strengths and weaknesses of the study; recognising how the limitations of the study may affect the usability of its findings. I make recommendations for further research and

I close by considering my impact on the research and my experience of the PhD journey.

10.1 Initial Objectives and Underlying Methodological Assumptions

My initial objectives in carrying out this research were to establish the constructs, norms and meanings that underline the birth stories women tell and, to understand how women make sense of the stories they are told. The study was unique in that it considered how women from two different generations came to understand birth in the context of their own experience but also in the milieu of other women's birth stories.

I wanted to find out what it was like to be pregnant and engaging with birth stories in the 'world of birth' and in so doing consider the conditions that construct and shape meaning around birth. Further I wanted to explore the notion of shared understandings around birth and where they might come from. I wanted to learn something about '*women's ways of knowing*' about this significant life event (Belenky et al., 1997), and about the transmission of birth stories from one generation to the next. I was interested in determining whether the information gleaned from stories creates meaningful understanding about birth for women (and determine whether there was any difference in those understandings between the two generations).

My research aim was to describe and consider how engaging with stories of birth influenced expectations and experiences of childbirth for two generations of women. For this purpose, birth stories encompassed personal oral stories as well as media and other representations of contemporary childbirth, all of which had the potential to elicit emotional responses and generate meaning in the interlocutor.

I trusted that a hermeneutic phenomenological framework would help illuminate the feelings and experiences of pregnant women engaging with stories of birth, allowing me to recognise each woman's experience as unique but at the same time enabling me to explore the ultimate essence of the experience. I believed that a hermeneutic phenomenological approach offered a methodology through which the significance of the experience of engaging with birth stories could truly be thought out and grasped as well as a way of positively using my preconceptions in the thinking of the research (Van Manen, 1984).

By successfully utilising the framework; through my conversations with the women, my engagement with the literature, by inviting philosophical and Heideggerian notions in, and by working within the hermeneutic circle, I went through a process of "*insightful invention*" and "*discovery*", as Van Manen describes (1990, p. 79), and reached an appreciation of what it must be like to be a pregnant woman engaging with stories in the 'world of birth'. Further I was able to reveal how birth stories are told in this world, what the 'unspoken rules' of the telling are, and to consider some of the consequences of engaging with the stories; including whether the information gathered generates meaningful knowledge of birth for women.

In the three aletheia chapters I presented interpretations of the phenomenon offering the reader an insight into the phenomenon and a platform from which to consider the phenomenon for themselves; in this chapter I develop my discussion of the three aletheia, building on what I found, determining the meaning of the phenomenon, and showing what my work adds to the body of knowledge.

10.2 The 'Modern Birth Story'

As discussed in chapter one my understanding of the concept of the birth story evolved as the study moved forward. Having previously understood a birth story as an exchange between women used as a means of preparing for the birth experience (by making sense of the experience from the reflections of those who had been there already) and expressed as a '*personal, intimate, analogue thing*' (Alexander, 2011, np), I was forced to question this. I came to appreciate that for women birthing in the 21st century, other sources which depicted birth, such as media images, written stories and novels, television programmes and shared spaces on internet forums, were equally valuable and could therefore be understood as part of the '*modern birth story*'.

The focus of the study, originally pivoting purely on what women hear from one another in the form of a personal oral story, widened to reflect the variety of different story mediums women share and use to prepare for birth and, in doing so, potentially 'construct' their own birth story. I came to understand that from a Heideggerian perspective, the birth story was constructed through 'idle talk' (those taken for granted assumptions of how things are which come into being through language), and took place across a variety of media accessed by women, as well as through face to face conversations.

10.3 Telling the Story

Nearly all the women I interviewed relayed birth stories to me using the narrative 'master frame' defined by Labov and Waletzky in 1967 and described in chapter 3, section 3.2 pages 71-73. For instance 'Lucy' told me the following story which I have slotted into the six stage structure:

1. **Abstract:** *"I heard a story when I was first pregnant...from a friend who gave birth three years ago".* From this introduction I knew Lucy would be telling me a birth story.
2. **Orientation:** *'My friend gave birth in the same hospital that I would be going to. I asked my friend about her experience in that particular hospital because I would be there as well'.* I found out who the story was about, where it took place and its relevance to Lucy.
3. **Complicating action:** *'Suddenly the midwife looked very serious and pressed the emergency buzzer...so basically the heartbeat of the baby dropped'.* This was not supposed to happen and a resolution was needed otherwise the baby would potentially die or be badly brain damaged.
4. **Evaluation:** *'Her case is quite different because it was before her due date and her waters broke at home'.* Whilst telling the story Lucy considered the relevance of the story to her situation. Although pregnant and planning to birth at the same hospital at this stage Lucy rationalised that this would not be her experience.
5. **Resolution:** *'They had to do a C-section immediately'.* The situation had to be managed in order to 'rescue' the baby. Lucy's friend had a caesarean to ensure her baby wasn't compromised any further.
6. **Coda:** *'And that's her story. She was in the operating room and she gave birth and that's it'.* The story was at a close and Lucy came back to the time of telling.

Despite me endeavouring to ask about the experience of engaging with birth stories in different ways, and despite me prompting, interrupting and questioning the participant's recollections, the majority followed a similar format to Lucy suggesting that there is a 'narrative script' in circulation; a script which dictates how a birth story is told. This concurs with Soparkar's 1998 doctoral study (discussed in chapter four, section 4.12 pages 92-95) in which she argued that the stories she heard had a chronological presentation; a beginning, middle and end involving a '*slow beginning*', a '*swell of excitement*', a '*dramatic climax*', a '*denouement*' and, finally, an '*epilogue*'.

Apart from a definitive way of telling a birth story I also learnt, In the course of my interviews, about the norms and practises of birth and mothering being shared and circulated in stories. The following are examples: that most women give birth in hospital on a bed (Stephanie), that birth is a '*process*' which is managed (Ruth), that interventions in childbirth are normal and help to make birth 'safe' (Isabel), that birth is painful but it leads to a baby so it's 'worth it' (Pamela), that a large number of women use analgesia (Stephanie), that most women will scream whilst birthing (Isabel), that at times birth is dramatic (Ruth), that breastfeeding can be 'awful' (Sophie), and that a 'good' birth is one where the outcome is a healthy baby (Penny).

10.4 Central Interpretive Findings

Five central and interrelated interpretive findings (as detailed below) came out of this study:

1. The birth stories heard had a significant role to play in the women's understanding and expectations of birth. The 'norm' as portrayed in the circulated stories was one which perpetuated the 'drama of birth'.

2. The modern 'landscape' of birth (populated with many media representations of birth) created and perpetuated fear of childbirth for many of the women in my study. The stories the women heard were lacking in detail about women's lives, and did not necessarily help them to become 'knowers' and gain wisdom about birthing.
3. The women birthing in the present day were overloaded with information amassed in an attempt to manage their anxieties about birthing as well as to fit the role of the informed patient and demonstrate their competency as mothers.
4. The cultural and spiritual significance of birth was not shared in the 'modern birth story'.
5. Some of the women felt secure in the 'system' of birth as constructed, portrayed and sustained in the stories widely circulated.

In the next part of the chapter I develop each of the findings and relate them to the wider literature.

10.4.1 The Birth Stories Heard Influenced Women's Understandings and Expectations of Birth

"Stories are always told within particular historical, institutional, and interactional context that shape their telling, its meanings and effects. They are told with particular interests, motives, and purposes in mind. Furthermore, stories are constrained by both rules of performance and norms of content".
(Ewick and Silbey, 1995, p.206)

Birth stories are cultural 'productions' that convey various ideologies and belief systems shaping women's expectations and experience of childbirth. Rather than merely

reflecting existing ideas and values, the stories women tell embody the values and belief systems of our society and, in so doing, “colonize consciousness” and “come to constitute and sustain the lifeworld” of birth (Ewick and Silbey, 1995, p. 214). Shain (2009, p. 495) explores this idea in more detail suggesting that “*given the historicity of language, current experiences and their expression are shaped by the past.*” Shain’s argument is that words are historical and as such meanings depend on what came before; likewise they provide a ‘*lens*’ by which we see and experience the world, a lens which governs the way we think and behave in that world. This echoes the thinking of both Heidegger, who suggests that “*whatever and however we may try to think, we think within the sphere of tradition*” (Heidegger, 1961, p. 41), and Gadamer who maintains that our tradition is the means by which we do our thinking. Notably Gadamer argues that tradition, as a means of thinking, is not something we can easily decide to accept or reject (Gadamer, 1970).

These ideas also fit with Holmes (2010, p. 289) notion that we understand and know things based on the all-encompassing cultural ‘*recipe*’ for the world of which we are a part. The ‘*ingredients*’ of this recipe are the prevailing values and beliefs that inform practices and function as a point of comparison as we navigate that world and make choices and decisions. Further Holmes argues that we exist and know within a sociohistorical context within which we:

“Contribute to, modify, and perpetuate cultural ideas and objects at the same time that cultural ideas and objects contribute to, modify, and perpetuate how individuals think, feel, and behave” (Holmes, 2010, p. 293).

My findings suggest that the ‘lifeworld’ of birth being sustained in the modern world is overwhelmingly one of product and process; concentrating on the stages and progression of labour and the birth of a healthy baby as the only significant outcome. The stories are told in a prescriptive way, have a linear sequence, concentrate on

timings, the 'practicalities' of the birthing situation, and tell of birth taking place in a predominately medically managed setting (to minimise 'risk' and ensure the safe delivery of the baby). The stories are primarily '*action*' stories as Soparkar (1998) described as opposed to '*affect*' stories (chapter 4, section 4.12 pages 92-95). The stories, all of which are mediated and reinforced through 'idle talk', are dramatic, telling of near misses and emergency situations where women and babies are 'rescued' and 'saved' by the attending medical team. Significantly the 'idle talk' of birth is not innocuous; what is shared in these birth stories becomes more and more familiar, gaining momentum and authority (despite being potentially groundless in essence).

Firmly ingrained in our culture these stories make what Ruth, one of the participants, called '*the drama of birth*' the norm. As discussed in chapter seven (section 7.5 page 190), as a result of Dasein's everydayness and absorption in the world, what is extraordinary (the '*drama of birth*' described in a story) is made ordinary through familiarity; the appearance of '*drama*' in a story is accommodated and then made invisible by that accommodation, and other interpretations are effectively 'closed off' (Heidegger, 1962).

The circulation of these stories is, in itself, a form of hidden 'authority' within the world of birth with the ability to dominate and oppress; making the medical model of birth the default 'setting' of birth and making women who birth outside the '*drama of birth*' (or who tell a positive story of birthing) feel ostracised. Further women who choose to birth outside the accepted models of care as determined by the shared stories, women who choose to ignore the 'idle talk' in and around birth, may be labelled as difficult patients and/or 'bad mothers' for putting themselves and their unborn babies at unnecessary 'risk'.

I would argue that whilst sharing stories can certainly be a way of learning about birth, the stories being told and widely circulated today, via the '*modern birth story*' are constrained by the 'rules' of sharing, as discussed in chapter seven (section 7.7 pages 193-195), and the accepted norms regarding form and content. Thus birth stories are themselves disciplined by the 'idle talk' of birth and then in their telling and sharing become part of the 'idle talk' and the consensus which itself constrains and determines those very same norms.

The portrayal of birth as a commodity (see chapter 2, section 2.14.4 page 57 and chapter 7, section 7.2 page 181), for instance, and the favouring of negative stories over positive ones have the potential to accentuate childbirth as a medical event which needs to be managed. Viewing childbirth as a medical event places a natural event into '*a pathological illness model*' which undoubtedly has ramifications for the ways in which women experience and make sense of their own birth (Miller, 2000, p. 309). The inference being, that if women expect their birth to be medically managed and their experience to be negative, then it is likely to be so.

Similarly the messages women receive from the stories shared may have a 'disciplining' effect; constraining them to behave compliantly, to follow accepted traditions and practices and 'perform' in a 'ladylike' fashion. According to the feminist literature the medicalisation of childbearing (discussed in chapter 2, pages 40-48) disempowers women during the birthing process causing them to lose agency (Martin, 1989; Oakley, 1980). Equally Zadoroznyj (1999) argues that the natural childbirth model requires control of the woman and her body in the form of disciplining the self (to move or breathe in a certain way for instance) again causing her to lose agency.

Martin (2003, p. 56) adds another perspective to the discussion suggesting that '*internalized technologies of gender*' also have a disciplinary effect on birthing women's

behaviours. Martin (2003) argues that internalized technologies of gender '*produce who we*' are even during primal experiences such as birth. Certainly a number of the women I interviewed who were birthing in 2013 were conscious of behaving '*appropriately*' and spoke about not '*screaming*' (Isabel), following perceived hospital procedures (Stephanie), being '*polite*' (Mary), being a '*good patient*' and not embarrassing themselves by being out of control (Ruth).

I would argue that by engaging with these stories women come to expect birth to be a certain way and this expectation and '*cultural shaping*' is '*internalised*' and played out by individual women (Reiger and Dempsey, 2006, p. 368). Further it is possible that the social construction of birth in these stories may have a direct effect on the physiological processes of childbearing affecting the actual '*doing*' of birth (Bordo, 1993).

If birth is portrayed as something to be feared, as something excruciatingly painful which women will want to ultimately forget, then the very thought of it and the actual '*doing*' of it is likely to promote adverse psychological responses. These responses will then be expressed through the role of oxytocin in the neural pathways in the brain and in hormonal responses through the nervous system affecting the complex physiological processes which need to be in motion to initiate, sustain and progress birth (Uvnas-Moberg, 2003).

10.4.2 The Modern Landscape as Depicted in the Stories Being Shared Created and Perpetuated Fear of Childbirth

In the world of the '*modern*' birth story the stories being told and represented in the popular media are primarily '*horror*' stories. These stories stress the inherent '*dangers*' of birthing and the need for expert and interventionist care. The stories describe, in an almost conformist way, what happened and when, telling of who was there and what

they did; they portray stages and interventions (often used to accelerate birth and/or to dispense with pain) rather than fears and feelings and any sense of what birth means to women. The stories tell of or show birth as managed by the people and institutions around women rather than by the women themselves.

This is reminiscent of the mechanized metaphor of birth (as discussed in chapter two pages 36-44) and as suggested by Davis-Floyd, 2001, p. 56 where the hospital is portrayed as a '*factory*', the woman's body as a '*machine*' and the baby as a '*product*'. Care managed in this way sees women objectified, distances the health professional from the woman, invests power in the health professional rather than the woman and ignores consequences for the maternal-newborn pair (Wendland, 2007).

In this '*vision*' women, who are each unique and in no way 'standardised', are expected to conform to the standard and, amongst other things, make consistent progress in labour, keeping time along with '*the arbitrary clock*' which has dominated maternity care since it was conceived in the 1950s by Friedman (Simonds, 2002, p. 565). If women do not keep to time as dictated by the clock then they are seen as '*deviant*' and as having failed in some way (Simonds, 2002, p. 565). Following the clock and thinking about childbirth in a calculative way does not encapsulate the complexity of birthing or the needs of women and their bodies. Moreover it can be seen as '*unyielding*' and '*without feeling*', something which is not conducive to effective and satisfying care of the childbearing woman (Pierson, 1998, p. 166).

The sharing of 'horror' stories does not give women any understanding of themselves as capable of birthing or of mothering, rather they portray women as somehow lacking and ultimately they frighten women. Told in this way stories do not tell of a transitional life event, of the journey to motherhood and the beginnings of a family; the stories are formulaic and end abruptly with the 'rescue' of the baby. There is no sense of the

personal or individual in the stories; they are generic and could effectively be told by any one of the 'they' of which childbearing women are a part. The stories lack the detail and richness which are needed to describe birth as part of a woman's life and history; as such they are impoverished and do not help women to become 'knowers' and to gain wisdom about birthing.

Rather the stories shared persuade women that birth will be lengthy, painful and disturbing (to the extent that they will want to forget about it and put it behind them). As a result the women become fearful of the duration of labour, the extent of the pain and their ability to cope with it, and become increasingly anxious that they will lose control and that in some way this may compromise the 'outcome'. Again these fears may initiate and sustain adverse psychological responses which in turn may affect the physiological doing of birth.

Cultural causes (such as horror stories) are recognised as a significant cause of fear for childbearing women (Fenwick, Gamble, Nathan, Bayes and Hauck, 2009). According to Melender (2002, p. 102) childbirth fears centre on "*pain, obstetric injury, emergency caesarean section, or dying during childbirth*" but also include anxieties about getting enough support, not being 'allowed' to be involved in decision-making and an inability to physically give birth as well as a fear of losing control in the birthing situation. Lowe (1993) suggests that our world of birth challenges women's belief in their ability to birth. Further Otley (2011, p. 216) argues that "*escalating intervention and operative rates are seen by women as proof that birth is dangerous and frightening*". It is not surprising, therefore, that women birthing today are probably more frightened about the prospect of birthing than the women birthing in the 1970s-80s were.

Certainly the women in my study birthing in today's world of birth expressed more fear of birthing than those birthing in the generation before. The women birthing in the

1970s-80s, unlike women birthing today, had some anxieties about birthing but were not overly fearful. Significantly these women were not continually confronted with dramatic media representations of birth. Indeed when discussing such representations with me most of the women were thankful that these 'resources' had not been available when they were pregnant as they could see that they could induce fear. Jean, for example, told me that *"you didn't see childbirth on the telly, you know? Didn't have kind of all these pictures of screaming women and things like this on television....I think it puts in people's minds how painful it's going to be"*.

Evidence and discussion about a possible relationship between media representations and birthing anxiety is slowly starting to emerge; for instance in their study on media representations of pregnancy and childbirth in the United States, Morris and McInerney (2010, p. 139) maintained that the reality-based birth television shows they analysed made childbirth *"much more dramatic and perilous than they are in reality"* perhaps explaining why *"nearly one-third of women pregnant for the first time who watch these shows reported that they felt more worried about giving birth after watching one of these shows"*. Similarly in her commentary Bak (2004, p. 45) discusses how the popular media present birthing as a *"dramatized caricature"* which *"overwhelmingly both censors the natural ability of women's bodies to birth and distorts the process to reflect birth as a clinical event from which women need to be saved by medical representatives"* (Bak, 2004, p. 65).

A certain amount of fear around an essentially unpredictable process is to be expected. However it is unfair to women if the only stories they hear are those which contain elements of 'horror' and which fill them with fear. Women need to hear stories which tell of the triumphs of birthing, of birth as fulfilling and powerful, a rite of passage on the way to motherhood. In their study on childbirth fear Saisto and Halmesmäki (2003)

suggest that 80% of women will have 'normal' anxieties about birthing whilst 20% will have extreme fear.

Although perceived as a negative feeling fear could instead be seen as a move away from certainty to a space of possibilities (Gammeltoft, 2013) or as a means of educating oneself by "*grasping the world and gaining knowledge*" (Kukkola, 2014, p. 380). Certainly being afraid can be a catalyst for action; we are faced with something fearsome and so we find out as much as we can to help us face it. Fear can therefore be a stimulus to learning helping us acquire new knowledge, plan ahead and change our behaviour as a means of safeguarding ourselves from what it is we fear.

Extreme fear of childbirth however has no redeeming features as it can lead to an array of negative outcomes. These may include antenatal and postnatal depression, sleeplessness, requests for elective caesarean section, higher rates of epidural analgesia, higher rates of emergency caesarean section, poor birth experiences, and feelings of failure after birth (Hall et al, 2009; Waldenstrom, Hildingsson and Ryding, 2006; Laursen, Johansen and Hedegaard, 2009; Melender, 2002). Indeed fear as Kirkham tells us may have a "*corrosive effect upon the confidence, performance and happiness of all involved*", mothers, families and midwives alike (Kirkham, 2011, p. 3).

10.4.3 *The Women Birthing Today Felt Overloaded with Information*

"I'm too deep to sleep

I do my best to decide

The best course of action but inaction subsides

*Distracted by the fractions that direct my own life who's concerned with what's going
on outside?*

Contending for the prize leaves us preoccupied."

(Above Ground Media, Harry Ixer & Buckers the Realist -

'Coke From a Glass Bottle' lyrics, 2014)

The women birthing today took great care to seek out information to prepare themselves for birth; frightened by what they heard in popular stories the women sought knowledge as a means of reducing their anxiety; information seeking for them therefore played a "*protective homeostatic function*" (Maslow, 2013, p. 61). The literature on information concurs with this finding advising that people seek information for two main reasons: as a coping mechanism in the face of a stressful life event and as an adaptive strategy leading to mastery of an unknown (Deutsch, Brooks-Gunn, Fleming, Ruble and Stangor, 1988; Janis, 1971; Lazarus and Folkman, 1984).

As women approach birth and motherhood (especially for the first time) they face a time of great uncertainty and a huge life change and so it is unsurprising that they are avid information seekers. Gammeltoft explains how women '*approach pregnancy as a state of being in whichtheir sense of possibilities is heightened*'; women are more receptive and more interested in the experiences of others as the experience of others may have a bearing on what comes next for them (Gammeltoft, 2013, p. 160).

Certainly the majority of the women I interviewed told me that when they were pregnant they became fascinated by the concept of pregnancy and birth (even if they had had no interest prior to this). Mary, for instance, said ‘*it’s funny you don’t really tune into the reality of pregnancy or birth or parenthood until you’re in it*’; this is not surprising as Heidegger tells us that we participate in and understand the world around us on the basis of ‘*possibility*’ (Heidegger, 1962, p. 63).

Wu Sung et al. (2012, p. 773), in their study of white middle-class women in the United States ‘*The Making of Informed Patients and Ideal Mothers*’, report that information seeking, and more specifically accessing the Internet to source information, allows women to ‘*confirm normalcy*’ and ‘*take control*’ in their childbearing whilst enabling them to “*more fully perform the informed patient role in order to demonstrate their competence as mothers*”. My interpretation is that the women in my study felt a sense of responsibility to themselves, to their babies and to society, to gather enough ‘knowledge’ to fit the role of the informed patient and to demonstrate their competency as mothers.

In the modern world of birth, as described in chapter two, women are likely to feel under pressure to ‘do the right thing’. Women interviewed in the present day spoke of the schedule of appointments they needed to follow and the ‘accepted’ patterns of care, such as routine antenatal screening and ultrasound scanning, which Joanna said that you consented to by “*not, not consenting*”. The women spoke of seeking out information to enable them to make the ‘right’ choices and decisions, to do a ‘good job’ and thereby ensure their baby was not ‘*jeopardised*’ as Isabel put it.

The notion of doing a ‘good job’ whilst birthing is an intriguing one begging the following questions: who defines what a ‘good job’ is and what are the criteria? And who makes an assessment of whether ‘you’ have done a ‘good job’? The idea implies that women

have to 'perform' birth in a certain way and that if they do not they will be judged (either by themselves or by themselves and 'others'). 'Performing' in a certain way implies that there are rules to be followed and a right or wrong way of going about the business of birthing.

Able to access vast amounts of information via various mediums such as the Internet and the television the women in my study birthing in the present were overloaded and saturated with information to the extent that it had a paralysing effect. According to the literature accessing health information is extremely prevalent with internet users. Bernhardt and Felter (2004), for instance, report the internet as one of the fastest growing sources of information about pregnancy and childbirth. Likewise Spink et al (2004) maintain that 'pregnancy/obstetrics' is one of the top five health related enquiries on the internet.

In one study, exploring the use of the Internet as a source of health information amongst participants at an antenatal class, Larsson (2009) reported that 91% of pregnant women had access to the internet and 84% used it frequently as a source of health information. A later web-based survey conducted by Lagan, Sinclair and Kernohan in 2010 found that the Internet *"played a significant part in the respondents' health information and decision making in pregnancy"* (Lagan et al, 2010, p. 114), whilst an earlier study reported that this demographic use the Internet to seek social support from other pregnant women and to research specific problems as my findings suggest (Lagan et al., 2006).

Birthing however is not a knowledge process. As Kirkham states *"no amount of information will clarify the decision making process for women"* (2010, np). There is no 'magic formula' or catalogue of information which will make women feel thoroughly prepared to birth their babies. The women birthing in the 1970s and 80s seemed to

recognise this saying that they did not feel that any amount of information would have prepared them for what was to come. Sandra spoke of birth being a '*mystery*' until you actually gave birth and Pamela said "*however much preparation you have you can't say what something is going to be like if you've not done it before*". The women birthing in the present day though were used to researching other aspects of their lives, felt they would be remiss if they did not research options for birth and appeared to believe they could find out what they needed to know to 'perform' birth effectively.

10.4.4 *The Cultural and Spiritual Significance of Birth Was Not Being Shared in the 'Modern Birth Story'*

As I have already discussed, the stories being told and heard by the pregnant women concentrated on the product and process of birth. In my study there were no stories about physiological, undisturbed birth. Similarly there was no narrative being shared about birth as a joyous, life changing event; birth as 'an experience' where women feel empowered and powerful and as something they instinctively know how to do was not something the women talked about.

Instead the 'idle talk' framing the modern birth story is impersonal, perilous and out of place; portraying an understanding of birth as a drama to be navigated, as something which takes place in an institutional setting with experts at hand and which women will want to forget. This is a worry as learnt understandings about birth being managed by others and being something women want to put behind them may inevitably assist women to construct their own birthing identity and experience which in turn may be a negative one.

I believe, as Crowther describes, that "*something special attunes at birth that makes the occasion different from other daily experiences*" (2014, p. 158). But this something

special was rarely spoken about or shared in the stories of birth. I would argue that these types of stories were not shared because they did not fit the narrative script or approved content as previously described. Further if women did hear positive stories they did not necessarily find them credible in and amongst the accepted rhetoric.

The opportunity for every birth to be understood as a unique lived experience, as something other worldly infused with joy and specialness for the individual woman and her family, rather than merely as a process resulting in the birth of a healthy baby, appears to me significant to all of us. Women and their bodies are not merely resources tasked with producing young; rather each individual woman is physically embodied as a self in a unique world personalised to her own '*lived context*' and each woman has the ability to exercise agency in childbirth as in every other facet of her life (Marcum, 2004, p. 315). The danger of not protecting the 'transcending significance' of birth is that we will be left with nothing more than the '*physical husk*' of ourselves (Kitzinger, 1978, p. 133) and with the majority of women experiencing what Wolf describes as "*ordinary bad births*" (Wolf, 2002, p. 122).

A healthy mother and baby are of course of the upmost importance but it is not remiss of us or voracious of us to want the experience of birth to be something special, something positive to be carried forward into the next stage of our lives. I would argue that in birth we need to protect the notion of enchantment and wonder described by Heidegger as the meaningful presence of things (Heidegger, 1954). It is by thinking in a contemplative way and being open to notions of enchantment and wonder that we can understand childbirth as an event of cultural and spiritual significance, a time of meaningfulness and a time where something '*magical*' is present (Crowther et al, 2015, p. 457).

10.4.5 Women Felt 'Secure' in the 'System' of Birth

A number of the women I interviewed felt 'comfortable' in the 'system' of birth (as constructed, portrayed and sustained in the stories widely circulated). The women were afraid to take responsibility for birthing their own babies; worried about making the 'wrong' decisions, about potentially poor outcomes, about being judged by others and ultimately about being accountable. Birthing as part of the 'system' allowed these women to abdicate responsibility.

Much as Kirkham (2010, np) describes the use of risk assessment as an "*instrument of social control*" I would argue that the 'idle talk' the women heard when preparing for birth was another form of control, limiting the women's choices around birth and limiting the way that they expected to 'perform' birth. 'Thrown' into the modern world of birth the women were similarly thrown into the dialogue of that world and the dialogue spoke of technology, intervention and management. Unable to prepare for the uncertainty of birth many of the women chose instead to accept the birth practices around them; taking what they saw as the more palatable option experiencing themselves and their bodies as part of the wider machinery of birth rather than coping with uncertainty (Frank, 2002).

Part of the women's motivation appeared to be an inability to trust their bodies to birth; reliant on their intellect and on knowledge to help them prepare for most eventualities the women approached birth in the same way expecting to find an 'answer' to the conundrum that is birth. Thomson remarks on the notion of trying to prepare for the uncertainty of birthing arguing it is a '*paradox*' and that any attempts to prepare women for all eventualities are "*superficial and unrealistic*" (Thomson, 2007, p. 373). In a world permeated with technology and bound by calculative thought as Heidegger describes it is perhaps not surprising that women seek out intellectual 'answers' to help them

counter the unpredictability of birth rather than relying on their own bodily knowledge and instinct (Heidegger, 1954).

10.5 A Unique Contribution in the Horizon of Other Voices

Other researchers have considered the birth story as a narrative which is recognisable amongst women who have given birth (Soparkar, 1998); questioned why it is that women tell these stories (Soparkar, 1998); discussed the birth story as a learning and development tool for midwives and their practice (Leamon, 2001); and examined the story as a means by which women gather knowledge and remember their own birth experiences (Weston, 2001). No other published research however, has explicitly and exclusively considered the phenomenon of engaging with birth stories whilst pregnant and, by doing so, revealed how the sharing of such stories shapes and constructs the meaning of birth for the first time pregnant woman. Further no other published research has explicitly identified the premise of the 'modern birth story' or the notion of 'idle talk' in relation to childbirth. My study is therefore unique and in considering how the phenomenon was lived by two different generations of women is similarly inimitable.

Despite no other studies being conducted on this phenomenon a number of studies have a degree of resonance with my study and as such provide what Smythe et al. call "*a hallmark of trustworthiness*" (Smythe et al., 2008, p. 1396). Thomson's 2007 study on traumatic and positive childbirth for example speaks of the technocratic world of birthing and suggests, much like my study, that "*the powerful messages and techniques of machination*" work to unconceal risk whilst simultaneously concealing "*a woman's self-beliefs and inherent knowledge*" (Thomson, 2007, p. 379). Similarly Reiger and Dempsey's 2006 paper on performing birth in a crisis of fear tells of a deterioration in cultural and individual confidence in women's birthing capacity and suggests that "*rather than supporting women to be fully present in their bodies and actively 'birth*

giving', many practices hinder the complex mind/body processes involved" (Reiger and Dempsey, 2006, p. 369).

In her chapter '*The less we do the more we give*' Leap (2010, np) talks about the unpredictable world of childbirth and of the need for the midwife and woman to "*embrace uncertainty together*"; she argues that the midwife must provide mothers with what she terms a '*safety net*'; the midwife must be someone they can turn to and trust in a situation where there are more questions than answers. Similarly Anderson (2010, np) talks about the midwife assisting women to feel "*safe enough to let go*", to enter an altered state of consciousness so that they can abandon psychological control and in doing so embrace physiological control at birth.

Perhaps most significant however is the study carried out by McAra-Couper about the factors shaping the practice of health professionals and the understanding of the public in relation to increasing intervention in childbirth. In McAra-Couper's words the findings from the data chapters "*found that the everyday world and its associated processes of socialisation shape understanding and practice in ways that are leading to increasing intervention in childbirth*" (McAra-Couper, 2007, p. 95). In the findings themes such as '*a right and wrong way to birth*', '*fashion, fads and the media*', '*horror stories informing choice*' and '*the everydayness of technology*' are all reminiscent of my study adding that coveted '*hallmark of trustworthiness*' (Smythe et al., 2008).

10.6 What do the Findings Mean?

The central interpretative findings I have shared in this chapter are very simply the '*impression*' I have gained of the phenomena from my own "*standpoint of time, place, culture and experience*" (Smythe et al, 2008, p. 1396). My impression is what Smythe

et al describe as an “*offering of thinking*” enticing the reader to consider, to question and to reach their own interpretation (2008, p. 1396).

My impression is that the information gleaned from stories of birth did not create meaningful knowledge and understanding about birth for the pregnant women in my study; rather I argue that the information gathered from the modern birth story served to make women fearful of birthing, persuading them that birth is a ‘drama’ to be navigated and forgotten rather than a pivotal life moment and a rite of passage marking the transition to motherhood. This is significant as the birth experience does not end when the baby is born (Simkin, 2006).

Childbirth, as Simkin explains, is a ‘*landmark*’ in a woman’s personal development, a time when a woman:

“Encounters some of life's most intense and demanding sensations and emotions. No other single event encompasses this range of experience: excitement, joy, pain, fear, worry, self-doubt, unpredictability, exposure, and vulnerability, dependency on strangers, and possible physical injury or major surgery” (Simkin, 2006, p.4).

In an effort to truly appreciate the value of my findings I decided to write another ‘*I*’ poem inspired by the work of Gilligan (1982). Throughout this process I have found the concept extremely powerful as a means to unearth meaning and reflect on my own experience.

Everydayness, absorption and the 'idle talk' of birth

I wanted to tell a story
I was interested in meaning and in birth
I thought that storying was significant
I knew everyone had a story to tell
I was excited about understanding and engaging with stories of birth
I wanted to live the experience
I wanted to listen and to learn
I took part in the phenomenological conversation
I started to see how it could be being-in-the-world-of-birth
I acknowledged many story mediums
I called them the modern birth story
I was inspired by storying power
I knew a story could be a spark
I heard about the horror
I heard about the drama
I heard nothing of joy or of physiological birth
I watched as women tried to understand
I felt their need to know
I noticed everyone wanted to share, partake and be part of the story
I recognised the fascination
I saw the energy and risk of sensationalism
I remembered the feeling of fear
I remembered worrying about death
I remembered the questions without answers
I knew about the uncertainty
I knew about the pain
I observed how stories could devastate
I appreciated how stories could transform
I wanted them to value the journey
I saw them race to the end

I thought we have taught them to question
I thought we have said we offer choice
I thought we have told them what and where
I thought but we have not told them how
I wanted them to know their power
I wanted them to believe in their strength
I wanted them to be primal and I wanted them to be proud
I knew women felt there was a right way
I saw them struggle to be good
I watched them try to be compliant, to try and follow the rules
I heard them doubt their own bodies, their own knowledge and strength
I listened as they tried to imagine
I watched as they sought and they sought
I saw how they turned to the experts
I knew they did it to feel certain and be safe
I was saddened by the stories
I heard the same formula again and again and again
I recognised the same narrative script, the long and short of it
I saw women absorbed in the immediate, in fashions and in babble
I knew they were caught up in hype
I saw the extraordinary made ordinary
I saw other interpretations closed off
I watched them float in the shelter of gossip
I watched them bolstered by Heidegger's 'idle talk'
I saw birth was a paradox, a mystery waiting to be solved
I saw that the storying needed to be positive, capable, loud and proud
I saw women needed nurturing and ultimately to be heard
I finally understood women need to believe in birth

10.7 Implications for Practice

10.7.1 Implication One

Stories of positivity need to be shared more freely

Women need to be encouraged to seek out and share positive stories and be told how powerful these stories can be in reinforcing women's capacity to birth. Women must be given the tools to appreciate the potential of birth to be something other than a drama in today's childbearing world. The nature of the 'idle talk' being shared around birth needs to change so that the default story is not 'impersonal, perilous and out of place' as discussed earlier in this chapter (section 10.3.4 page 257).

In her commentary on what makes a good birth Simkin (2006) describes a '*great birth*' as one where some or all of the following characteristics were present:

- The birth experience exceeded woman's expectations
- There were no complications
- The woman felt emotionally safe
- The woman was free from fear and from physical and/or psychological trauma
- The birth was orgasmic
- Care was planned and centred around the woman
- The woman experienced a sense of achievement from her own efforts

Significantly a '*great birth*' has the woman at the centre whereas often a '*good birth*' (from a maternity services perspective) whilst beginning with a mother and baby who are alive and have not suffered any morbidity centres around "*efficiency, adherence to*

policies, convenience, profit, medico-legal safety, adequate staffing, hospital culture, peer pressure, and personal comfort for the staff" (Simkin, 2006, p. 6). As I stated earlier a woman's experience of labour and birth should not be discounted on the basis that she has a healthy baby; her experience is the starting point of her life as a mother and will have a long lasting effect on her life, that of her family and on that of her baby. A woman has the right and I would argue the need to feel fulfilled by her experience of birth.

An understanding that positive stories need to be shared is finally being recognised at the grass roots level within the childbearing community and fostered within organisations such as 'The Positive Birth Movement'; a movement initially spreading positivity about childbirth locally and now doing so on a global level via free groups and social media. The movement was set up as a means of questioning and challenging the accepted socially constructed and oftentimes negative portrayal of birth. The group defines a positive birth as the following:

"A positive birth means a birth in which a woman feels she has freedom of choice, access to accurate information, and that she is in control, powerful and respected. A birth that she approaches, perhaps with some trepidation, but without fear or dread, and that she then goes on to enjoy, and later remember with warmth and pride. A positive birth does not have to be 'natural' or 'drug free' – it simply has to be informed from a place of positivity as opposed to fear" (Positive Birth Movement, 2015).

Even more pertinent to this thesis is an organisation aiming to encourage the telling of real life positive birth stories and in doing so to encourage and nurture confidence in women about their ability to birth. The Positive Birth Stories webpage uses a powerful metaphor to describe the dangers of engaging with negative stories and of living in a world where the mode of being is portrayed in a particular light:

"Imagine you are preparing for the Olympics and your aim is gold. In the daily lead up to the games during conversations and in newspapers you read and

television & films you watch you are exposed to detailed accounts of other athletes losing and dreadful past accidents in your particular race. Your mind starts to fill with these images and fear becomes a regular visitor. Your many consultations with professionals (supposed experts) are filled with the dire consequences of possible problems especially if you don't adhere to their way of competing. You leave their offices feeling powerless and worried. Eventually you stop training deciding to rely solely on their guarantee of assistance. Friends and family only confirm your fears with their own regaling of hideous accounts of the same race. The day comes and you feel extremely stressed and apprehensive about it and your ability. The race begins and the muscles designed to power you, falter because your tension and fear constrict them. Your coach and manager decide its best if they take over for you."
<http://www.positivebirthstories.com/about/>

This metaphor is powerful because it is hugely reminiscent of the context of birth for women today; surrounded by negative stories, images and portrayals of birth none of which are easily avoided and many of which are seemingly reinforced by the professionals who should be encouraging and supporting women and letting them know how powerful and able they are to birth their babies.

Women must be given help and guidance to 'unpack' and understand any negative stories and portrayals rather than letting these stories fill their minds with fear. On a societal level we need to acknowledge that many of the popular portrayals of birth are misguided and that the messages they give about birthing are potentially damaging. Health professionals need to be instrumental in ensuring images, messages, stories and media portrayals reflect birth as a normal physiological life event with the woman at the centre birthing her own baby.

10.7.2 Implication Two

Women need education and support to recognise that birth is an instinctual process rather than a knowledge process

Developing knowledge is dynamic and relies on many and varied sources (Mander, 2001). In midwifery, for instance, knowledge is drawn from empirical science, personal knowing, experience, intuition, embodied knowing and contextual knowing (Siddiqui, 2005; Hunter, 2008). Midwives utilise a combination of these ways of knowing when caring for the childbearing woman; they assimilate objective and subjective knowing as well as knowledge of the contextual experience of birthing (Hunter, 2008).

The concept of 'relationality', women connecting with other women as a source of knowledge and knowing, has been discussed in this thesis (Belenky et al., 1997; McHugh, 2001; Van Manen, 1990). The women I spoke with shared their experience of engaging with (and in the case of the women birthing in the 1970s-80s) telling stories of birth. However despite telling me about various mediums they utilised to try and learn about birth very few of the women I spoke with discussed the concept of embodied knowledge. This is surprising as many women practice embodied knowing when birthing.

By walking around, changing their position, closing their eyes and shutting out the outside world, using water submersion to help with the pain and by distracting themselves with other activities women effectively and intuitively use their bodies (and their understanding of their bodies) to 'manage' their experience. Unfortunately however many women do not appear to trust themselves or their bodily knowing and will look to the 'expert' to tell them how to behave when birthing. Further women, such as Isabel may fear that if they take the lead and birth as their bodies dictate then they will not be behaving as a 'good patient' should and, as a consequence, may be viewed as a 'bad mother'.

Women need to understand their birthing bodies as '*knowing*' bodies as Grosz (1989, p. 72) describes and have faith in their bodies to capably birth. Part of the problem with

having faith in their bodies is that women are not exposed to the physicality of their bodies in the modern childbearing landscape; rather women are confronted with portrayals of birth as a 'sanitised' and technological endeavour. Women need to confront birth as a corporeal and primal experience, one where they embrace their bodies as powerful and mammalian, and where they allow their instincts and intuition to take over from the intellectual and reasoned control they exercise in other parts of their life.

Antenatal education classes need to centre on birth as a visceral and animalistic experience, inviting and helping women to 'let go' and instead go along with birth as it unfolds, trusting their bodies and themselves to live the experience and birth their babies. '*Nonrational power and knowing*', the embodied ways of knowing and experiencing as described by Parratt (2008, p. 42), must be developed and fostered with women in the lead up to their births.

10.7.3 *Implication Three*

Women must be supported to expect the unexpected and to embrace rather than fear the uncertainty of birth

According to Thomson (2007, p. 385) childbirth "*operates on a plane of liminality between life and death. It represents an unknown anxiety provoking situation which is beyond logic and reasoning*". Women need support to confront this characteristic of birth, to accept that an element of anxiety is normal as they approach birth and one which cannot be reasoned away. Women must be supported to experience a birth which is wholly theirs, during which they feel emotionally safe, well supported by those caring for them and where they gain a real sense of achievement.

In order for this to be a realistic goal midwives need to be given the time and space to work with women on a one-to-one basis; getting to know each individual woman will enable the midwife to recognise deep seated (and often negative) beliefs and views about birthing and provide an opportunity to foster self-belief and strength in women helping them recognise that they can birth. The newly instigated ‘*Quality Maternal and Neonatal Care*’ (QMNC) framework developed for the Midwifery Lancet Series will help in this regard as it is based on a definition of midwifery that takes account of skills, attitudes and behaviours. The Series positions midwifery as mattering more than ever and defines the practice of midwifery as follows:

“Skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum throughout pre-pregnancy, pregnancy, birth, post-partum and the early weeks of life. Core characteristics include optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women’s individual circumstances and views, and working in partnership with women to strengthen women’s own capabilities to care for themselves and their families.”

10.7.4 Implication Four

In early pregnancy women need to be signposted to good quality information which they can choose to access when they need it and in a format they are comfortable with

Health professionals should acknowledge that pregnant women will engage with numerous information sources to support their decision making in the childbearing period. Many of these sources are likely to be Internet sources and will not always be accurate and/or comprehensive sources of pregnancy related information. Midwives are ideally placed to develop a dialogue with women about information sources; helping women appreciate the need to critically evaluate information and directing women to credible, evidence-based and understandable pregnancy information. This will help

women to negotiate the infinite and at times superfluous information available and thus empower them to make informed decisions about their care.

10.8 Study Limitations

As with most studies a number of limitations are apparent in this study and may therefore affect the usability of its findings. The first of these is the fact that the participants were all from England in the UK and the birth stories they heard, and in some instances told, were shared within the context of the prevailing maternity system. Whilst the phenomenological descriptions of birth stories outlined in this thesis may be shared by women in other high resource settings with similar models of maternity care and societal and cultural norms, they are unlikely to be replicated in contexts where the models of care and socio-cultural norms are fundamentally different.

The number of participants was relatively small (twenty women) however the sample was in accord with the phenomenological approach where an upper limit of between twelve to twenty participants is deemed appropriate for a PhD study (Smythe, 2011).

The women were recruited from a particular socio-economic demographic (to try and ensure that recruitment would be relatively straightforward). Recruited predominantly from the 'National Childbirth Trust' (NCT) and the 'National Federation of Women's Institutes' (NFWI) most of the women were white Caucasian and were largely from a middle class background; it was likely therefore that these women viewed the world through a lens skewed to their way of thinking and their way of being in the world. It would be interesting to conduct a follow up study with different socio-demographic groups, cultures and contexts.

A final critique of the study may be my 'immersion' in the study; some may assume that my involvement means that the study is not objective and because of that is not scientific. However this kind of research does not pretend to be objective or claim that it is able to determine the real truth of something. Rather this methodology speaks of the commonality of experience and demands a researcher that can bring something to the evolving interpretation and the presentation of the phenomenon. My presuppositions were therefore integral to the study design, its development and the interpretation of the data, culminating in the phenomenological description which makes up this thesis.

10.9 Recommendations for Further Research

In this study I have shown what it is like to be pregnant and engaging with birth stories in the 'world of birth' in England in the UK. In doing so I have demonstrated that an understanding of birth is shaped by the birth stories women tell and listen to. Further research would help to support and add depth to my interpretations. As discussed earlier a study focused on a different socio-economic group of women would help establish whether the experience of women from a less affluent demographic is congruent with that of the women included in my study. Further it would be interesting to conduct a study in a low resource country where assumedly women are not perpetually exposed to popularised images and negative televised portrayals of birth but instead presumably rely on other women's stories and the support of those caring for them (if they are in a setting with carers) as they prepare for birth.

10.10 My Impact on the Research and My Experience of the PhD Journey

"Why do research for which you must deny responsibility for what you have found?" (Steier, 1991, p. 10)

I am absolutely and concretely at the heart of this work. In designing, conducting and writing up this study I have relied on my own experiences of womanhood, pregnancy, birthing, midwifery and storytelling to help me engage with the study, the participants and to take part in the phenomenological conversation. My reflexive writing throughout the thesis serves as an audit trail of my engagement and impact on the research ensuring transparency and increasing the credibility of the study; in this sense I have continuously signposted the reader to what was 'going on' whilst I was researching.

My involvement in the research has, I believe, helped me to better question, listen, think and write (iteratively and within the hermeneutic circle) about the phenomenon of engaging with birth stories. Throughout I have felt excited and challenged both by the developing interpretation and by the PhD 'journey' itself. The journey has been arduous, taxing, exhilarating, creative, 'freeing', frightening, overwhelming and ultimately enriching. I have learnt about my strengths (strong organisational skills, the capacity to work independently and to sustain motivation and momentum, the ability to work to deadlines and good writing skills) and my weaknesses (letting the best be the enemy of the good and the art of procrastination). At the end of this long process I remain invigorated by the ideas which motivated me at the outset and by the notion that women intuitively know how to birth. I see the midwife as a 'port in the storm' of birth, helping women to recognise and use their embodied knowing as they birth.

CHAPTER 11 - CLOSING: THE END OF A JOURNEY

*"I held you in the still lake
of my womb,
a tadpole's eye
floating in the gloom.
I fed you in the river of my blood,
a gasping fish
carried on the flood.
You struggled in the torrent
of my screams
a little lifeboat
on a wave of dreams.
Now I watch you from the island
of my heart
sailing away,
making your own start."*

(Roberts, 1990, p. 193)

11.0 Introduction to the Chapter

Quite appropriately, I feel, this closing chapter starts and ends with poetry; the poem at its beginning typically symbolises the birth of a baby but in this context is used to signify the birth of my thesis (from its inception, creation and interpretation via my thought processes, conversations and writing), out into the midwifery world. Certainly the thesis

has enjoyed a lengthy gestation and has caused both wonder and angst in its formation. In this chapter I finally 'wrap up' my findings and send them out into the world to be read, heard, wondered at and potentially added to.

To do this effectively I synthesise the threads from across the chapters and weave the text into a whole determining the thesis of the thesis. I discuss the significance of what I have found and I end by signposting the reader to a dissemination plan identifying how my contribution can be shared and considered in the childbearing and midwifery world.

11.1 Synthesising the Threads

As I lived with, thought through and worked with the conversations I shared with the participants I started to see and hear the texts speak of the phenomenon of engaging with birth stories whilst pregnant. The phenomenon revealed itself tentatively at first; hidden as it was within the experiences of each individual woman. As I started to consider the data as a whole and invited other voices into the phenomenological conversation commonalities started to appear allowing the phenomenon to move out of the shadows into what Heidegger describes as the '*clearing*' (Heidegger, 1962). In writing the aletheia chapters I articulated the meanings that emerged from my thinking and reading; these meanings formed the threads of the thesis.

The threads of the thesis spoke of stories as problematic for the women in the study, of a prevalence of 'horror' stories and of a scepticism around positive birth stories. Further they spoke of the notion of birth as something '*which must take its course*' and where women must concentrate their energies on '*coming out the other side*'. Finally the threads expressed the idea of birth as a '*technological feat*'; as a process stripped of live content and imbued with potentially disastrous consequences for women.

11.2 The Thesis of the Thesis

Taken as a whole, the threads of this thesis reveal that the information gleaned from birth stories did not in fact create meaningful knowledge and understanding about birth for these pregnant women. Instead of helping women to prepare for birth the stories shared made women fearful of birthing, persuading them that birth was a 'drama' to be navigated and forgotten and an endeavour for which they lacked the necessary knowledge and skills. Seeking 'sanctuary' from the 'drama' of birth many of the women appeared to persuade themselves they would be more 'secure' within the system of birth where accountability rested with the 'experts'.

11.3 Significance of my Findings

My findings suggest that women birthing today (in England in the UK), although able to access a huge array of information about childbirth, are not well prepared for birthing their babies. Rather they are overloaded with information sought in an attempt to prepare for the unexpected, address their anxiety and demonstrate their competency as mothers. Further these women are delimited by the 'idle talk' surrounding birth; which serves to emphasis the hype of birth as opposed to giving them any real understanding of birth and/or creating meaningful knowledge.

My work highlights a need for further research to qualify the relationship between what women see and hear about birth and their expectation and indeed experience of birth. Further it highlights the need for midwives to support women to recognise the instinctual, rather than rational knowing, nature of childbearing and for midwives to support women to use their embodied knowing as they birth. A comprehensive

dissemination plan identifying how my contribution can be shared and considered in the childbearing and midwifery world can be found in Appendix Twelve.

I end with this poem which speaks to me of women's embodied knowledge of birth and the realisation a woman has (when she feels secure and supported to birth by those caring for her) that she always already intuitively knew how to birth her baby.

***“It is like I have always known
what to do. Of course this is how

it feels. The pain, the heat, the profusion
of fluids and fears. The breath, the body,

the hands on my body, your heartbeat
thrums, thrums, thrums. Head, shoulders

fingers, toes, and a voice that makes the
world stop spinning, just for a moment,

to welcome you home. Little impossible being, little baby. I always knew it
would be you”.***

‘40 Weeks’ by Brittney Corrigan (2012)

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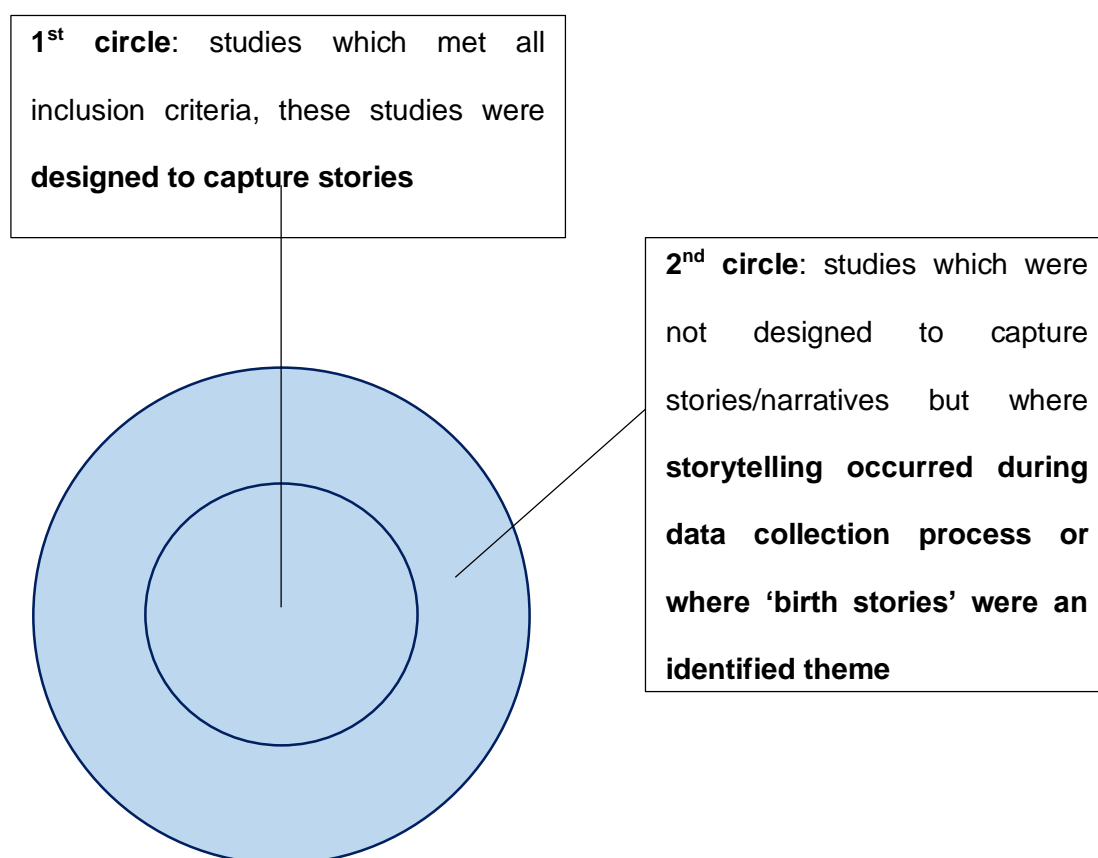
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APPENDIX 1A - DIAGRAMMATIC INTERPRETATION OF INCLUSION PROCESS



APPENDIX 1B - SATISFYING INITIAL INCLUSION CRITERIA

<i>Study Details</i>	<i>Objective Met?</i>	<i>Primary Study?</i>	<i>Qualitative Methodology?</i>	<i>Who's Story?</i>	<i>Study Aim</i>	<i>Country/ Language</i>	<i>Date</i>	<i>Decision</i>
Callister, L. C.; Vega, R. 'Giving Birth: Guatemalan Women's Voices' - <i>JOGNN</i>	Establish the constructs, norms and meanings that underpin the stories women tell of childbirth	Primary	Qualitative – ethnographical approach	Mother's stories	To gain an understanding of the cultural meanings of giving birth for Guatemalan women by focusing on their birth stories	Guatemala, Central America Spanish – translated into English	1998	Include in 1st concentric circle – designed to capture birth stories
Dahlen, H. G.; Barclay, L. M.; Homer, S. E. a. 'Processing the first birth: journeying into motherland' – <i>Journal of Clinical Nursing</i> b. 'Preparing for the First Birth; Mothers' Experiences at Home and in Hospital in Australia' – <i>Journal of Perinatal Education</i> Same study reported in 2 different journals	Establish the constructs, norms and meanings that underpin the stories women tell of childbirth	Primary	Qualitative – grounded theory approach	Mother's stories	To explore first time mothers experiences of birth at home and in hospital in Australia	Sydney, Australia English	2010 and 2008	Include in 2nd concentric circle – study was not designed to capture stories – women compelled to tell their stories as result of being involved in research study

Study Details	Objective Met?	Primary Study?	Qualitative Methodology?	Who's Story?	Study Aim	Country/ Language	Date	Decision
Halldorsdottir, S.; Karlsdottir, S. I. 'Journeying through labour and delivery: perceptions of women who have given birth' - <i>Midwifery</i>	Does not meet objectives	Primary	Qualitative – phenomenological approach	Mother's experiences rather than stories	To explore the essential structure of the lived experience of childbearing as seen from the perspectives of women who have given birth	Akureyri and Reykjavik in Iceland	1996	Excluded Interactive interviews were conducted – birth stories were not sought
Katcher, R.; Callister, L. C. 'Giving Birth: Voices of Chinese Women' – <i>Journal of Holistic Nursing</i>	Does not meet study objectives	Primary	Qualitative – phenomenological approach	Mother's experiences rather than stories	To increase cultural understanding by examining the childbirth experiences of Chinese women	People's Republic of China Chinese translated into English	2003	Excluded Interviews were conducted to examine women's experiences of birth -stories were not sought
Leamon, J. 'Stories about childbirth: learning from the discourses' – <i>unpublished doctoral thesis</i>	Establish the constructs, norms and meanings that underpin the stories women tell of childbirth	Primary	Qualitative – narrative approach	Mother's and 'carer's' stories	To explore the narratives themselves and to consider the educational possibilities of stories within pre and post registered midwifery education	East Anglia, UK English	2001	Include in 1st concentric circle – designed to capture birth stories

Study Details	Objective Met?	Primary Study?	Qualitative Methodology?	Who's Story?	Study Aim	Country/ Language	Date	Decision
Lindgren, H.; Erlandsson, K. 'Women's Experiences of Empowerment in a Planned Home Birth: A Swedish Population-based Study - <i>BIRTH</i>	Establish the constructs, norms and meanings that underpin the stories women tell of childbirth	Primary	Qualitative – approach not specified	Mother's stories	To describe the factors experienced as empowering during a planned home birth	Sweden	2010	Include in 1st concentric circle – designed to capture birth stories
McCallum, C.; dos Reis, A. P. 'Childbirth as Ritual in Brazil: Young Mother's Experiences' - <i>Ethnos</i>	Establish the constructs, norms and meanings that underpin the stories women tell of childbirth	Primary	Qualitative – ethnographical approach – part of a larger research study which used a combination of quantitative and qualitative methods	Mother's narratives	To understand young black mother's experiences of birth in an obstetric centre run by white middle class obstetricians	Savador, Brazil Spanish – translated into English	2005	Include in 1st concentric circle – designed to capture birth stories
Munro, S.; Kornelsen, J.; Hutton, E. 'Decision Making in Patient-Initiated Elective Cesarean Delivery: The Influence of Birth Stories' – <i>Journal of Midwifery & Women's Health</i>	Understand how women make sense of the stories they are told about childbirth	Primary	Qualitative – exploratory approach	Mother's stories	To determine impact of socially circulated birth stories and cultural narratives on attitudes to mode of delivery	British Columbia, Canada English	2008	Include in 1st concentric circle – designed to capture birth stories

Study Details	Objective Met?	Primary Study?	Qualitative Methodology?	Who's Story?	Study Aim	Country/ Language	Date	Decision
Nystedt, A.; Hogberg, U.; Lundman, B. 'Some Swedish women's experiences of prolonged labour' - <i>Midwifery</i>	Does not meet study objectives	Primary	Qualitative – approach not specified	Mother's experiences	To illustrate women's experiences of prolonged labour	Vasternorrland , northern Sweden N/K	2005	Excluded Women who had prolonged deliveries were purposefully sampled – their experiences were sought – they were not asked to tell their story
Rautava, P.; Erkkola, R.; Sillanpaa, M. 'The outcome and experiences of first pregnancy in relation to the mother's childbirth knowledge: The Finnish Family Competence Study' – <i>Journal of Advanced Nursing</i>	Does not meet study objectives	Primary	Quantitative	Mother's experiences	To determine the possible influence of the expectant mother's knowledge of childbirth on the outcome and experience of pregnancy	Province of Turku and Pori, south-western Finland N/K	1991	Excluded Quantitative study
Reese, E.; Hayne, H.; MacDonald, S. 'Looking Back to the Future: Maori and Pakeha Mother-Child Birth Stories' – <i>Child Development</i>	Does not meet study objectives	Primary	Qualitative – approach not specified	Mother's stories	Birth stories were told by mothers to test the role of early memory socialisation	Dunedin, New Zealand English	2008	Excluded Stories used as a mechanism to determine correlations between maternal reminiscing and children's memory

Study Details	Objective Met?	Primary Study?	Qualitative Methodology?	Who's Story?	Study Aim	Country/ Language	Date	Decision
Savage, J. S. 'The Lived Experience of Knowing in Childbirth' – <i>Journal of Perinatal Education</i>	Understand how women make sense of the stories they are told about childbirth	Primary	Qualitative – phenomenological approach	Mother's experiences	To understand the ways first-time mothers learn about birth – how do women impart knowledge with one another on an informal basis?	New Orleans USA English	2006	Include in 2nd concentric circle – study was not designed to capture stories – women described stories as a way of knowing about childbirth – stories were a theme of the study
Smyth, E. 'Safety is an interpretive act: A hermeneutic analysis of care in childbirth' – <i>International Journal of Nursing Studies</i>	Does not meet study objectives	Primary – a re-interpretation of data from an earlier study (1998) that explored the meaning of being safe in childbirth	Qualitative – hermeneutic phenomenological approach	Mother's stories	To explore the interpretive nature of safety through a hermeneutic analysis of women's stories of feeling unsafe	New Zealand English	2010	Excluded Study not originally designed to purely capture stories of birth – agenda 'safety'

<i>Study Details</i>	<i>Objective Met?</i>	<i>Primary Study?</i>	<i>Qualitative Methodology?</i>	<i>Who's Story?</i>	<i>Study Aim</i>	<i>Country/ Language</i>	<i>Date</i>	<i>Decision</i>
Soparkar, A. A. 'The Telling of Childbirth Stories' - <i>unpublished doctoral thesis</i> – Have emailed to try and get copy/access to this	Establish the constructs, norms and meanings that underpin the stories women tell of childbirth	Primary	Qualitative – approach not specified	Mother's stories	To determine whether the telling of childbirth stories exists as a phenomenon of oral narrative that is recognisable among women who have given birth	Massachusetts, USA English	1998	Tentatively include in 1st concentric circle – designed to capture birth stories – waiting for full text

Study Details	Objective Met?	Primary Study?	Qualitative Methodology?	Who's Story?	Study Aim	Country/ Language	Date	Decision
<p>Vandevusse, L.</p> <p>a. 'Personal meanings of control reported by women in their birth stories: a feminist perspective' – <i>unpublished doctoral thesis</i></p> <p>b. 'The Essential Forces of Labor Revisited: 13 Ps Reported in Women's Stories'- <i>American Journal Maternal/Child Nursing</i></p> <p>c. 'Decision Making in Analyses of Women's Birth Stories' – <i>BIRTH</i></p> <p>d. 'The Theater of Birth: Scenes from Women's Scripts' – <i>Journal of Perinatal and Neonatal Nursing</i></p> <p>Same study – reported four times</p>	Does not meet study objectives	Primary	Qualitative – exploratory /descriptive approach & feminist perspective	Mother's stories	<p>a. To explore the shared and personal meanings of control women gave to their experiences of giving birth</p> <p>b. To analyze birth narratives for the 'forces' women reported that exerted control during their labours</p> <p>c. To clarify how decisions were made in labor by analyzing women's birth stories.</p> <p>d. Analogy between theatre and birth to describe birth from a fresh perspective</p>	Mid west USA English	1993, 1999 and 2001	<p>Excluded</p> <p>Study not originally designed to purely capture stories of birth – agenda 'control'</p>

<i>Study Details</i>	<i>Objective Met?</i>	<i>Primary Study?</i>	<i>Qualitative Methodology?</i>	<i>Who's Story?</i>	<i>Study Aim</i>	<i>Country/ Language</i>	<i>Date</i>	<i>Decision</i>
Weston, R. 'The influence of birth stories from friends and family members on primigravida women' – article in <i>MIDIRS reporting on unpublished Master's thesis</i>	To understand how women make sense of the stories they are told about childbirth	Primary	Qualitative – phenomenological approach	Mother's stories	To explore the influence of friends and family members' birth stories on six primigravida women	UK English	2001	Include in 1st concentric circle – designed to capture birth stories

APPENDIX 2 - CONCEPTUAL GRID

Methodology, methods & concepts	Leamon, 2001 <i>Stories about Childbirth: Learning from the Discourses</i>	Soparkar, 1998 <i>The Telling of Childbirth Stories</i>
Emphasis	SHARING	TELLING
Theoretical perspective/ orientation	Not defined	Not defined
Methodology	Narrative	Not defined
Study focus/ aim/question	Exploration of stories about the childbirth process & consideration of how they may inform the learning & development of midwives & their practice	1. Does the telling of childbirth stories exist as a phenomenon of oral narrative that is recognisable among women who have given birth? 2. Why do women tell these stories?
Sample	Women/mothers 5 Women/midwives 8 Women/student midwives 6	10 primiparous women (7-11 months postpartum)
Setting	Hampshire and Suffolk	Home interviews – Massachusetts
Data collection	Study conversations	Participant-ready observation – active listening to stories Followed by semi-structured interviews
Data analysis	Reflection as a mode of questioning, analysing and reviewing Developed a matrix that displayed storyteller's themes for each conversation	Combing, combining, clustering
Concept 1	Hearing voices and attending to relationships - listening & attending - relationship framed by emotion - extenuating circumstances	Stories shared as a ritual – social/anthropological realm – incorporates mother into 'timeless order of motherhood' Comparisons and connections with other women

<i>Methodology, methods & concepts</i>	<i>Leamon, 2001 Stories about Childbirth: Learning from the Discourses</i>	<i>Soparkar, 1998 The Telling of Childbirth Stories</i>
Concept 2	Transitions and boundaries - powerful medical discourse - personal boundaries and transition	Transcending the mundane – the psychological realm – the narration lived Identifying with the new self Reliving the moment to dispel disbelief
Concept 3	Learning from the discourses - resources for exploring reflexive story telling	

Methodology, methods & concepts	Leamon, 2001 Stories about Childbirth: Learning from the Discourses	Soparkar, 1998 The Telling of Childbirth Stories
Story construction	<p>Story sharing can involve the spoken word, written word, pictures, artefacts, sounds and drama</p> <p>Story sharing occurs in a given time and place that can not be recreated – stories have a subjectivity and temporality</p> <p>Story sharing occurs within and across socially and personally constructed boundaries – these inform the context of story sharing</p> <p>The desire to be heard is strong</p> <p>Storyteller may move from private world to public</p> <p>A multi dimensional narrative enquiry space:</p> <ol style="list-style-type: none"> 1. Temporality (process of labour & birth can be marked by temporality of each stage) 2. Personal & social 3. Place <p>(Clandinin & Connelly, 2000)</p> <p>Types of stories:</p> <ul style="list-style-type: none"> • Dramatic • Magical mystery • Collaborative <p>Purpose of sharing –</p> <ul style="list-style-type: none"> • Seeking to make meaning from experiences • Increase personal knowledge • Explore personally constructed boundaries & experience transition • Cathartic release • Process past • Inform future choices 	<p>Similar in structure, organisation & character of presentation – beginning, middle and end</p> <ul style="list-style-type: none"> • Slow beginning • Swell with excitement • Dramatic climax • Denouement • Epilogue <p>Structure self-imposed by teller – need to stick to chronology - ? part of way of processing events</p> <p>Story told is culturally concordant</p> <p>Version told primarily the 'action' story rather than an 'affect' story</p> <p>Tell you what happened and when</p> <p>Already edited in their own minds for different audiences and at request of listener – 'do you want the long or the short version?'</p> <p>Triggered by birth memories – visual, verbal, corporeal & aural/olfactory</p> <p>Purpose of telling –</p> <ul style="list-style-type: none"> • Edification • Entertainment • Stimulation • Rejuvenation <p>Main audience appears to be themselves</p>

Methodology, methods & concepts	Leamon, 2001 Stories about Childbirth: Learning from the Discourses	Soparkar, 1998 The Telling of Childbirth Stories
Process of Narration/Narrative Format	<p>Subjects, players, context</p> <p>Time frame – story sequence not necessarily sequential to events</p> <p>Explores use of narrative forms to 'invite reader in' and invite activity on the part of the reader - shows 'flexibility' of stories by presenting interview data in different formats/genres:</p> <ul style="list-style-type: none"> • Fictionalised • Autobiographical • Spoken play • Letters • Diary • Storytelling with analysis <p>Suggests that storytellers use different 'ploys' to engage reader</p> <ul style="list-style-type: none"> • Wetting the appetite • A clue to the storyline • A taste of the ending 	<ul style="list-style-type: none"> • Long and short of it • It's a matter of time • Chronological presentation • On a moving train • Telling – in more than one voice • The self observed • Characters in the story • The heroine • Hearing – 2 audiences self and others • Between the lines • Birth story 'correctness' • Beyond words – the 'storm'
What insights can be applied to my study?	<p>What I learnt about the birth story as a phenomenon of oral narrative:</p> <ul style="list-style-type: none"> • Why stories were told: as a means of processing the birth experience, making meaning and as a means of potentially preparing for the next birth by informing future choices • Where stories were told: within and at times across social and personal boundaries and within specific and concordant cultural contexts • How stories were told: by capturing the attention of the audience, relaying the story in a particular fashion (not always chronologically but within a 'framework' designed to engage the reader) 	
How can knowledge gained inform my interviews?	<ul style="list-style-type: none"> • Ask participants why they shared/or think others shared their stories • Ask about the situation in which the telling took place • Ask about the narrative structure of the stories • Ask what it felt like to hear birth stories whilst pregnant 	

APPENDIX 3A - MPhil APPROVAL



4th April 2012

Soo Downe & Lesley Kay
School of Health
University of Central Lancashire

Dear Soo & Lesley

Re: BuSH Ethics Committee Application
Unique Reference Number: BuSH 005

The BuSH ethics committee has granted approval of your proposal application 'A critical hermeneutic study considering how other women's birth stories construct and reconstruct the meaning of birth for primigravida women'.

Please note that approval is granted up to the end of project date or for 5 years, whichever is the longer. This is on the assumption that the project does not significantly change, in which case, you should check whether further ethical clearance is required

We shall e-mail you a copy of the end-of-project report form to complete within a month of the anticipated date of project completion you specified on your application form. This should be completed, within 3 months, to complete the ethics governance procedures or, alternatively, an amended end-of-project date forwarded to roffice@uclan.ac.uk quoting your unique reference number.

Yours sincerely

Denise Forshaw
Chair
BuSH Ethics Committee

APPENDIX 3B - PHD APPROVAL



28th January 2014

Soo Downe and Lesley Kay
School of Health
University of Central Lancashire

Dear Soo & Lesley

Re: BuSH Ethics Committee Application
Unique Reference Number: BuSH 005 Amendment

The BuSH ethics committee has granted approval of your proposal application 'How do pregnant women experience stories of birth?'

Please note that approval is granted up to the end of project date or for 5 years, whichever is the longer. This is on the assumption that the project does not significantly change, in which case, you should check whether further ethical clearance is required

We shall e-mail you a copy of the end-of-project report form to complete within a month of the anticipated date of project completion you specified on your application form. This should be completed, within 3 months, to complete the ethics governance procedures or, alternatively, an amended end-of-project date forwarded to roffice@uclan.ac.uk quoting your unique reference number.

Yours sincerely

Tal Simmons
Chair
STEMH Ethics Committee

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

APPENDIX 3C - AMENDMENT APPROVAL



17 November 2014

Soo Down / Lesley Kay
School of Health
University of Central Lancashire

Dear Soo / Lesley

Re: STEMH Ethics Committee Application Unique Reference Number: BuSH 005

The STEMH Ethics Committee has approved your proposed amendment – to includes option of interviewing the participants over the telephone, as face to face - to your application 'How do pregnant women experience stories of birth'.

Yours sincerely

A handwritten signature in black ink, appearing to be 'Paola Dey', with a stylized, cursive-like script.

Paola Dey
Deputy Vice Chair
STEMH Ethics Committee

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

APPENDIX 4A - MPhil PARTICIPANT INFORMATION SHEET (MARCH 2012)



Participant Information Sheet March 2012

Title of Project: A critical hermeneutic study considering how other women's birth stories construct and reconstruct the meaning of birth for primigravida women.

This study is being undertaken by a PhD student as part of a doctorate degree to explore how first time mothers understand and construct meaning around birth. This study aims to consider how women's birth is influenced by their own and others stories and experiences.

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

Why is this research being undertaken?

Women are often eager to speak about their experience of birth and there is a suggestion that 'birth wisdom' passed on in women's stories can have a significant effect on the first time mother. This study aims to explore how first time mothers understand and construct meaning around birth.

It is intended that the findings of this study will help identify how women's birth expectations and experiences are influenced by others, and the results may be used within the development of antenatal information and education for pregnant women.

The findings of this study will be included in the final research degree report; the results may also be presented at conferences and written up for publication purposes.

Who is doing the research?

The research will be undertaken by a PhD research student from the University of Central Lancashire over June to September, 2012.

Why have I been invited to participate?

You have been approached as a potential participant as you are pregnant with your first baby and you are a member of the NCT.

What will I be asked to do?

If you would like to take part in this study, please contact the research student within three weeks on the contact details provided below. You will be asked to take part in an in-depth interview, lasting approximately 45 minutes at a time and location convenient to you (but will not be held within an NHS environment).

During the interview, basic information will be collected on your age, ethnicity and the date around which your baby is due to be born. The interview questions will explore what information you have received about the birth from your family and friends, the media as well as your expectations for your forthcoming birth.

With your permission the interview will be digitally recorded, or if preferred detailed notes will be undertaken.

At the start of the interview, the researcher will answer any questions you may have and provide you with a form to sign indicating that you wish to take part.

Please note that a summary of the key points to emerge from the study can be forwarded to you, and you will have a one month period to provide any comments or feedback.

Who has approved the study?

In order to make sure that the study that is being proposed is ethical the project has been reviewed by the Ethics Committee at the University of Central Lancashire and the National Childbirth Trust (NCT) 'Research and Information Team'.

What benefit is there to taking part in the study?

Whilst there is no direct benefit of participation, involvement in the study will provide you with an opportunity to reflect on your experiences and beliefs about birth which you may find useful. Involvement will also enable greater appreciation of the factors which influence women's understanding and anticipations of the birth experience; appreciation of these contributory factors may help to inform future antenatal preparation and education.

What if I agree to take part and find the experience upsetting?

Some of the questions and information explored may be sensitive, embarrassing or upsetting for some participants. As the researcher is a practising midwife, she has experience of dealing with people in times of stress and distress. However you will have the option to meet with a member of the supervisory team to debrief if necessary and details of a local counselling service will be provided.

Do I have to take part?

No - taking part is voluntary. If you don't want to take part, you do not have to give a reason and no pressure will be put on you to try and change your mind. If you do choose to take part then you will have the right to refuse to answer any questions or withdraw

from the interview situation. You will also have the option of withdrawing your interview data from the study within a time frame of one month post interview.

A decision to withdraw, or a decision not to take part, will not be reported to the NCT and will not affect your health or legal rights.

What will happen to the data?

All data will be kept secure in a lockable filing cabinet, and on password protected files on a computer, and will be destroyed at the end of the project. All transcribed data will be kept for a minimum of 5 years in line with the University's ethical guidelines and will then be destroyed.

Will the data be kept confidential?

All information will be kept confidential. Once all the interviews have been completed, any information linking the interview data with you will be destroyed and the interview data will be coded so that you cannot be identified. The results of the study may be published in a summary report, presented at conferences and published in peer reviewed journals but you will not be identifiable in these publications.

What do I do now?

Please take your time to think about the information on this sheet, and contact a member of the research team if you are not sure about anything. If you wish to take part please contact the researcher either by telephone or email within the next 3 weeks.

What would participating mean for me?

- To take part in an interview at a convenient time and location
- The interview will be digitally recorded and/or detailed notes undertaken (following consent)

What do I do if I have any concerns or issues about this study?

If any complaints, concerns or issues emerge as a result of your engagement with this study, please contact the main supervisor (Professor Soo Downe) in the first instance on the contact details provided below.

Thank you for reading this information sheet and considering taking part in this study.

For further information on the study

Contact the research team:

Researcher: Lesley Kay. Work Phone: 08451965335, Mobile Phone: 07807193627
Email address: Lesley.kay@anglia.ac.uk

Research supervisor: Professor Soo Downe. Work Phone: 01772 893815
Email address: SDowne@uclan.ac.uk

APPENDIX 4B - PHD PARTICIPANT INFORMATION SHEET (JANUARY 2014)



Participant Information Sheet January 2014

Title of Project: How do pregnant women experience stories of birth?

This study is being undertaken by a PhD student as part of a doctorate degree to explore how first time mothers understand and construct meaning around birth.

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

Why is this research being undertaken?

Modern-day women have access to information from a variety of mediums including television programmes, internet sites, forums, blogs, popular literature and newspapers; all of which they can use to ready themselves for their own experience. With so many choices in childbirth and with so many 'voices' offering advice, research suggests that women often struggle to know where to turn for information and support.

In the first phase of this study, first-time pregnant mothers were consulted to explore the information they used in preparing for childbirth.

In this second phase, a more historical context is planned in order to understand the information sources that women in the late 1970s – early 1980s accessed in their pregnancies. It is hoped that lessons can be learned from this study to better inform the provision of information to childbearing women in the modern day context; this is important as in the current information landscape women need guidance on which 'voices' to listen to.

The findings of this study will be included in the final research degree report; the results may also be presented at conferences and written up for publication purposes.

Who is doing the research?

The research will be undertaken by a PhD research student from the University of Central Lancashire over February 2014 – December 2014.

Why have I been invited to participate?

You have been approached as a potential participant as you are a 50-60 year old woman who has birthed and whose children are adults.

It is intended that up to 12 women will be interviewed during this phase of the study. If more women than required come forward, we will advise you accordingly and thank you for your interest in the study.

What will I be asked to do?

You will be asked to take part in an in-depth interview, either face to face or over the telephone (depending on your geographical location). The interview will last approximately 45 minutes and will be conducted at a time and (in the case of face to face interviews) in a location convenient to you.

During the interview, basic information will be collected on your age, ethnicity and the ages of your children. The interview questions will explore what information you received about the birth from your family and friends, the media and health professionals.

With your permission the interview will be digitally recorded, or if preferred detailed notes will be undertaken.

At the start of the interview, the researcher will answer any questions you may have and either ask you to sign a consent form (or if you are being interviewed over the telephone will record consent on your behalf). Giving consent will indicate that you wish to take part. The consent form will be sent to you prior to the interview along with this information sheet.

Please note that a summary of the key points to emerge from the study can be forwarded to you, and you will have a one month period to provide any comments or feedback.

Who has approved the study?

In order to make sure that the study that is being proposed is being undertaken in an ethical manner the project has been reviewed by the BuSH (Built Environment, Sports & Health) Ethics Committee at the University of Central Lancashire.

What benefit is there to taking part in the study?

Whilst there is no direct benefit of participation, involvement in the study will provide you with an opportunity to reflect on your experiences and beliefs about birth which you may find useful. Involvement will also enable greater appreciation of the factors which influence women's understanding and anticipations of the birth experience; appreciation of these factors may help to inform antenatal preparation and education in the future.

What if I agree to take part and find the experience upsetting?

Some of the questions and information explored may be sensitive, embarrassing or upsetting for some participants. As the research student is a practising midwife, she has experience of dealing with people in times of stress and distress. However you will have the option to discuss your experiences with a member of the supervisory team to debrief if necessary and you could also access the 'Cambridge Counselling Service' on 01223 261061 should you need to.

Do I have to take part?

No - it is entirely up to you whether you want to take part or not. If you don't want to take part, you do not have to give a reason and no pressure will be put on you to try and change your mind. If you do choose to take part then you will have the right to refuse to answer any questions or withdraw from the interview at any time. You will also have the option of withdrawing your interview from the study up to one month post interview.

What will happen to the data?

All paper copies of any information (e.g. consent forms) data will be kept secure in a lockable filing cabinet, and the digital recordings and transcript of the interviews will be saved on UCLan password protected computer files. All data will be kept for a minimum of 5 years in line with the University's data protection policy and will then be destroyed.

Will the data be kept confidential?

All information will be kept confidential. Once all the interviews have been completed, any information linking the interview data with you will be destroyed and the interview data will be coded so that you cannot be identified. The results of the study may be published in a summary report, presented at conferences and published in peer reviewed journals but you will not be identifiable in these publications.

What do I do now?

Please take your time to think about the information on this sheet, and contact a member of the research team if you are not sure about anything.

If you would like to take part in this study, please contact the research student within three weeks on the contact details provided.

What would participating mean for me?

- To take part in an interview at a convenient time and location.
- The interview will be digitally recorded and/or detailed notes undertaken (following consent).
- In the case of face to face interviews the researcher will share details of the venue and timing for the interview with another member of the research team (thereby ensuring the researcher's personal safety).

What do I do if I have any concerns or issues about this study?

If any complaints, concerns or issues emerge as a result of your engagement with this study, please contact the project supervisor in the first instance; alternatively you may contact the Dean of School, Dr Nigel Harrison:

Tel. 01772 893700

Email: nharrison@uclan.ac.uk

Thank you for reading this information sheet and considering taking part in this study.

For further information on the study

Contact the research team:

Research Student: Lesley Kay. Tel: 07876 089660

Email address: lkay6@uclan.ac.uk

Research supervisor: Professor Soo Downe. Tel: 01772 893815

Email address: SDowne@uclan.ac.uk

APPENDIX 5A - MPhil CONSENT FORM



CONSENT FORM

Title of Project:

A critical hermeneutic study considering how other women's birth stories construct and reconstruct the meaning of birth for primigravida women

Please insert your initials in the boxes provided to indicate 'YES' to the following statements:

1. I confirm that I have read and understood the participant information sheet (version number 1, dated March 2012) and have had the opportunity to ask questions. ☐
2. I understand that I can withdraw from the study without having to give any reasons. ☐
3. I understand that I have the right to refuse to answer any questions and to withdraw from the interview situation. ☐
4. I understand that I can withdraw my interview data from the study within a time frame of one month post interview. ☐
5. I am aware of, and consent to, the digital recording or hand-written notes being undertaken of my discussion with the researcher. ☐
6. I agree that the results of this study may be published in a summary report, presented at conferences and published in peer reviewed journals. I understand that I will not be identified in these publications. ☐
7. I agree to the researcher sharing details of the venue and timing for the interview with a member of the supervisory team (thereby ensuring the researcher's personal safety). ☐

8. I give my consent to be involved in this research project. ☐

<p>If you would like a copy of the key themes to emerge from this study please indicate how you would prefer to receive a copy of this document, i.e. through email or by post (home or work address) and give your contact details.</p>	<p>I would like to receive a copy of the key themes Yes/No</p> <p>I would like to receive them by Email/Post</p> <p>Contact details:</p>
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<p>Name (PRINT):</p> <p>Signature:</p>	<p>Date:</p>
<p>Name of researcher:</p> <p>Signature:</p>	<p>Date:</p>

APPENDIX 5B - PHD CONSENT FORM



CONSENT FORM

Title of Project: How do pregnant women experience stories of birth?

Please insert your initials in the boxes provided to indicate 'YES' to the following statements. (In the case of telephone interviews please give your verbal consent to each statement and ask the researcher to record it on your behalf).

1. I confirm that I have read and understood the participant information sheet and have had the opportunity to ask questions. ☐
2. I understand that I can withdraw from the study without having to give any reasons. ☐
3. I understand that I have the right to refuse to answer any questions and to withdraw from the interview situation. ☐
4. I understand that I can withdraw my interview data from the study up to one month post interview. ☐
5. I agree to my interview being digitally recorded. ☐
6. I understand that if I wish for a copy of the themes to be sent to me, I will have up to one month to provide feedback. ☐
7. I agree that anonymised quotes from my interview can be used in the PhD report, presentations and any publications produced from this study. ☐

8. I agree to the researcher sharing details of the venue and timing for the interview with a member of the supervisory team (thereby ensuring the researcher's personal safety). ☐

9. I agree to take part in the above study. ☐

Name (PRINT):

Date:

Signature:

Researcher Name (PRINT):

Date:

Signature:

If you would like a copy of the key themes to emerge from this study please indicate how you would prefer to receive a copy of these, i.e. through email or by post and give your contact details:

I would like to receive a copy of the key themes: Yes/No

I would like to receive them by: Email/Post

Contact details:

APPENDIX 6A - NCT RESEARCH

AUTHORISATION LETTER



Alexandra House
Oldham Terrace
London W3 6NH
Pregnancy & Birth Line
0300 330 0772
Breastfeeding Line 0300 330 0771

14 May 2012

To NCT Branches and Members in the UK

The NCT has agreed to support Lesley Kay, a researcher from the University of Central Lancashire (UCLAN) who is carrying out a study on how first time mothers understand and construct meaning around birth.

I have reviewed the research proposal, the participant's information sheet and the ethics committee approval and I am happy to recommend the study to you. If you are able to offer support please do so.

The research involves being interviewed by the researcher on a one-to-one basis at a venue and time chosen by you. It is anticipated that the interview will last approximately 45 minutes. The findings from this research will help identify how women's birth expectations and experiences are influenced by others and the results may be used within the development of antenatal information and education for pregnant women. This is explained further in the participant's information sheet.

PHD research student Lesley Kay would like to recruit NCT members who are pregnant with their first baby. If you are comfortable with this, the researcher may attend an NCT event to hand out notices about their study. Nobody should be made to feel under any pressure to participate as this is entirely voluntary.

The researchers may take out an advertisement, paying the insertion fee, in your branch newsletter or website, subject to the approval of the editor and the terms and conditions that apply. Or you may ask them to write a feature article in exchange for placing a notice about the study.

Do contact me at m_newburn@nct.org.uk, or Lesley.kay@anglia.ac.uk if you have any questions or concerns, or need any further information.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Mary', followed by a period. The signature is fluid and cursive.

Mary Newburn
Head of Research and Information

APPENDIX 6B - STUDENT RESEARCHER REGISTRATION FORM



Name	Lesley Kay
Degree course title	PhD Midwifery
Year of study	Year 2
University	University of Central Lancashire (UCLAN)
Title of research project	A critical hermeneutic inquiry considering how other women's birth stories construct and reconstruct the meaning of birth for primigravida women
Has ethical approval been gained from an appropriate committee for this research?	Yes – written approval from UCLAN BuSH Ethics Committee
What is the purpose of the research?	To determine how primiparous women construct the meaning of childbirth in the milieu of other women's birth stories.
What are the eligibility requirements of participants for your research?	<ul style="list-style-type: none"> • Primiparous women at approximately 16 weeks gestation • Ability to adequately understand verbal explanations and written information in English
Is the study anonymous?	Yes
If you are conducting a survey: N/A	1. Have any of the questions been used in previous research? 2. Are you using any previously validated measures? If so, please give their names and indicate the numbers of the questions they apply to.
Estimated time it takes to complete the survey	Individual interviews likely to take around 45 minutes.

What is the deadline for responding to your survey?	The participants will have up to three weeks to respond to the recruitment message and to contact the researcher.
Your contact details in case possible participants would like to contact you	Mobile: 07807193627 Work number: 01223 695335
NCT membership number or membership application reference number*	1844160
Is there any other information you think is important for us to know?	N/A
Checklist of required attachments:	
Research protocol	<input type="checkbox"/> ✓
Written evidence of ethical approval	<input type="checkbox"/> ✓
Copy of the questionnaire or research questions	<input type="checkbox"/> ✓
Parent information leaflet and/or cover letter	<input type="checkbox"/> ✓
A recruitment message	<input type="checkbox"/> ✓
Approval granted and date (for office use only)	

** In return for our assistance with your research we ask researchers requesting our assistance you to join the NCT. This is a great way for you to support us and get involved in our work. Alternatively, a donation would be very welcome if you prefer. Please visit our website if you would like to join or leave a donation:*

<http://www.nct.org.uk/support-us/>

APPENDIX 7A - MPHIL RECRUITMENT MESSAGE



Request for research participants

Title of Project: A critical hermeneutic study considering how other women's birth stories construct and reconstruct the meaning of birth for primigravida women.

A PhD student at the University of Central Lancashire (UCLAN) is conducting research on how first time mothers understand and construct meaning around birth. It is intended that the findings of this study will help identify how women's birth expectations and experiences are influenced by others, and the results may be used within the development of antenatal information and education for pregnant women.

We would like to talk to women who are in their first pregnancy, and are able to adequately understand verbal explanations and written information in English.

If you agree to take part, this will mean being interviewed by the researcher on a one-to-one basis at a venue and time chosen by you (this excludes the option to be interviewed on NHS premises). It is anticipated that the interview will last approximately 45 minutes.

If you may be interested in taking part in this study, or would like further information, please read the information sheet provided and contact the researcher on the contact details below within the next 3 weeks. The research has been approved by the Ethics Committee at the University of Central Lancashire and the National Childbirth Trust (NCT) 'Research and Information Team'.

Please contact the researcher Lesley Kay via email: Lesley.kay@anglia.ac.uk or telephone number: work: 0845 1965335; mobile: 07807193627

Many thanks

APPENDIX 7B - PHD RECRUITMENT MESSAGE



Request for research participants



Title of Project: How do women experience stories of birth?

A PhD student at the University of Central Lancashire (UCLAN) is conducting research into how mothers understand and construct meaning around birth.

As part of this study we would like to find out what type of information women could access in the late 1970s-early 1980s and see whether any lessons can be learned to better inform the provision of information to childbearing women in the modern day context.

We would therefore like to talk to women who have birthed and whose children are now adults. The women must be between the ages of 50-60 and able to adequately understand verbal explanations and written information in English.

If you agree to take part, this will mean being interviewed by the researcher either face to face or over the telephone. The interview will last approximately 45 minutes and will be conducted at a time and (in the case of face to face interviews) in a location convenient to you.

If you are interested in taking part, please contact Lesley Kay via email: lkay6@uclan.ac.uk or telephone number: 07876 089660

Many thanks

APPENDIX 8A - MPHIL SUGGESTED INTERVIEW SCHEDULE

Suggested Interview Schedule

Title of Project: A critical hermeneutic study considering how other women's birth stories construct and reconstruct the meaning of birth for primigravida women.

Researcher Details:

Name: Lesley Kay

Contact Details: W. 0845 1965335 M. 07807193627

Lesley.kay@anglia.ac.uk

Designation:

1. PhD Student, University of Central Lancashire (UCLAN), Preston
2. Senior Lecturer in Midwifery, Anglia Ruskin University (ARU), Cambridge

Project Supervisor: Professor Soo Downe, UCLAN, Preston

Interview Questions/Prompts:

- Tell me what your mother told you about birth
- Tell me what your friends told you about birth
- Tell me what you have read about birth
- Tell me what you have seen on the television about birth
- Tell me what you think your birth will be like

APPENDIX 8B - PHD SUGGESTED INTERVIEW SCHEDULE

Suggested Interview Schedule

Title of Project: What was the information landscape like for first-time pregnant women in the late 1970s - early 1980s?

Researcher Details:

Name: Lesley Kay

Contact Details: M. 07807193627

Lkay6@uclan.ac.uk

Designation: PhD Student, University of Central Lancashire (UCLAN), Preston

Project Supervisor: Professor Soo Downe, UCLAN, Preston

Interview Questions/Prompts:

- Tell me what your mother told you about birth
- Tell me what your friends told you about birth
- Tell me what you read about birth
- Tell me what you saw on the television about birth
- Tell me what you thought your birth would be like

APPENDIX 9 - STEPHANIE'S CRAFTED STORY

Stephanie - Things that JUMP OUT

- NCT and aqua yoga classes have changed my views about birth
- It's all about relaxation
- If you relax you can control the pain a lot more
- Stories I've heard were all the 'oh my god it's so painful, it's so awful, you just kind of want to forget about it' kind of stories
- The stories you hear, about what seems to happen, make it feel like it's all out of your hands
- You go in, basically you're in there for hours, and everything kind of happens at once and the nurses, or whoever, take over
- The classes have taught me that I can do a lot to make it what I want - I had no idea before that
- All the stories are about how rough it was, how sore and how long it took to recover
- There the only stories you seem to get - you don't get anyone who says 'it's brilliant, calm and relaxed'. You just get these horror stories
- Stories from my family were about things being completely out of their hands - it was all a rush and all major panics and upset
- I was anticipating that, because of the problems with my pelvis, a lot of it would be out of my hands - people in my family said that they might decide it would be easier to do a C-section

- But the classes have made me question that - it's even been suggested that I could have almost 'a kind of semi-enjoyable delivery'
- I thought it would be that it would just happen and I wouldn't get a choice but I now know they can't tell you, it's your decision and you've got to keep it in your control
- Mind you everybody still says it's not!
- Friends have told me you just get through it and you know it's all worth it
- People who have positive stories don't want to kind of go into it
- The people who go into it are the ones who have the horrific stories...its almost kind of cathartic...they have to keep telling it and they have to tell you
- And it's all you know, 'well, we managed to get through it but, you know it was 30 odd hours of absolute hell and you know, I don't quite know how I got through it and the end and everything else'...and you think 'oh god that's what I've got to look forward to'
- When I was a child and people in my family had babies.... I saw them kind of getting up gingerly, and it was all hushed conversations in the corner which gave an impression of how bad it was
- There's also a sense of naivety about it - you fall pregnant, it's all fine and then you have the baby
- After my nephew was born I saw my sister and she was just kind of ashy
- My mum was a midwife and she's got very set ideas
- I grew up with the view that you need to try and do everything for yourself because it's not good to have intervention
- As I say I didn't think it'd be so much kind of choice that it's be very much, well, you do what we say, you breathe when we say and then, kind of we see what happens and decisions get made
- I thought there wouldn't be a lot of choice because it didn't sound like there was with the births that I'd known most about

- It's probably worth saying if things aren't too bad rather than letting everyone just get on with this...yeah it's absolutely terrifying, it's awful, but don't worry, you forget
- That's what you get told, that's the message
- One friend of mine had quite a long labour but she was... all the way through everything, whatever happened, she was always amazingly happy about everything. Everything was kind of real gushy...and I was like 'yeah, I'm sure it wasn't because it was just...everything was perfect and wonderful?'
- The more I read the more conflicting it gets, the more confused I get and the more I just really don't want to know because I just think well , I don't know now
- I've got to the point where I don't want to read anymore because I've reached saturation
- I've reached overload and I don't know what's going on in my head
- I think there's too much out there at the moment
- You can buy something from Amazon, you've got reviews. Some people put up good reviews but most of the people who are making an effort to put a review on is because it's negative
- You don't think about how much of it gets filtered in through the years - there's an expectation that childbirth is something natural that everyone should do. But it's also the fact that the general consensus is it hurts, but don't worry, you'll forget and you'll come out the other side of it
- Even knowing what I did I still thought you get on a bed at the end and just kind of be on a bed and someone kind of coming out through your legs and up in the air and everything
- I think you get that idea from what people say and photos you see straight afterwards
- I've been into hospital many times for operations and normally you go in, you get changed, you get told where to go, they do everything for you now - so when

you're pregnant you think surely they'll do the same thing because you're in a hospital

- Professionals will probably tell you - we want you like this

Crafting Stephanie's Story

Stephanie talks about her understandings of birth and where those understandings have come from. She recalls being a child and remembers women in her family having babies; seeing them with '*ashy*' faces, getting up '*gingerly*' and having '*hushed conversations in the corner*' all gave her an impression of how bad birth was. As she got older Stephanie recalls stories about how '*rough it was*', how '*sore*' women felt afterwards and how '*long*' it took to recover from birth. The stories from Stephanie's family were all about situations being completely outside of their control; about it all being "*a rush and all major panics and upset*". Stephanie tells me that the stories you hear make it feel like "*it's all out of your hands and that you go in, and basically you're in there for hours, and everything kind of happens at once and the nurses, or whoever, take over*".

The stories Stephanie has heard as an adult have mostly been '*horror stories*'; the "*oh my god it's so painful, it's so awful, you just kind of want to forget about it*" kind of stories. Stephanie describes a likely story: "*well, we managed to get through it but, you know it was 30 odd hours of absolute hell and you know, I don't quite know how I got through it in the end*", and her reaction to the story saying "*oh god that's what I've got to look forward to*". Stephanie describes the message of the stories being that "*yeah it's absolutely terrifying, it's awful, but don't worry you forget*".

Stephanie tells me that positive stories rarely get told and that it would *“probably be worth saying if things aren’t too bad”* rather than always perpetuating the ‘horror’ stories which circulate so readily. Stephanie compares telling such stories to writing reviews on something like ‘Amazon’ saying that although some people put up good reviews most of the people who make an effort to put a review on do so because it’s negative. Telling me a positive story Stephanie is quite sceptical because the woman was *“always amazingly happy about everything”*; Stephanie thinks that the story she has heard is unlikely as everything was just too *‘perfect and wonderful’*.

Stephanie says that you do not appreciate how much information about birth *“gets filtered in through the years”*; for instance the expectation that childbirth is something natural that everyone should do and the general consensus that it hurts, but *“don’t worry, you’ll forget and you’ll come out the other side of it”*. Stephanie tells me that her perception had been that *‘you get on a bed’* and that you birth on the bed, something which she thinks probably came from things that people had told her and photographs she had seen of women sitting in bed cradling their new born babies.

Before attending NCT classes and aqua yoga classes Stephanie had no appreciation that she would be able to make choices and decisions and take control over what happens during her baby’s birth. Rather she thought that it would be more like *“you do what we say, you breathe when we say and then, kind of we see what happens and decisions get made”*. Having been into hospital many times Stephanie assumed that her experience would be similar; *“you go in, you get changed, you get told where to go and they do everything for you now”*. Similarly Stephanie thought there would not be a lot of choice because it did not sound like there had been with the births that she’d heard most about.

Stephanie describes attending the NCT classes and aqua yoga classes as having “*changed my views about birth*”. Stephanie has learnt the value of relaxation and the benefits of water for weightlessness and movement and now feels reassured that she can do a lot to make the birth what she wants. She recognises that she can be involved in planning the birth, and in considering choices and making decisions arising during her labour and birth. Stephanie feels a sense of control over the process which she did not have before.

Interpretation

Brief summary:

Stephanie has memories of the women in her family coming home with their new babies. She remembers ‘*hushed*’ conversations in the corner as they explained what their births had been like. In our conversation Stephanie expresses surprise at the amount of ‘information/knowledge’ that has ‘*filtered through*’ to her over the years via stories, experiences and the assumptions she has made. Stephanie has heard a lot of stories about childbirth, the majority of which she describes as ‘*horror stories*’.

From the stories she has heard, and her own experience of hospital stays, Stephanie’s expectations (prior to attending antenatal classes) were that she would birth in a hospital, on a bed, she would have very little say in what happened to her and that ‘*nurses*’ would ‘*take over*’ her birth deciding on what was best for her and her baby. Stephanie anticipated a lot of pain, a lengthy labour (or a managed C-section at the suggestion of the professionals because of ‘*problems*’ in her pelvis) and had been told that she would be glad to get the whole thing over with and that ultimately she would ‘*forget all about it*’.

After attending NCT classes and aqua yoga Stephanie feels better informed and has started to recognise that she can be involved in her care, can make choices and decisions and even question professionals if she sees the need. Stephanie understands that she can be in control of her birth and feels reassured by what she has learnt about her body's capabilities at the aqua yoga class. She remains slightly sceptical however about whether or not professionals can tell you what to do as despite being told *'it's your decision.....everybody still says it's not!'* Despite wanting to hear more positive stories describing birth as *'calm, brilliant and relaxed'* Stephanie appears somewhat sceptical about positive stories telling me about a friend who had *"quite a long labour but she was... all the way through everything, whatever happened, she was always amazingly happy about everything. Everything was kind of real gushy...and I was like 'yeah, I'm sure it wasn't because it was just...everything was too perfect and wonderful?'"*

Moving to interpretation:

Prior to attending antenatal classes Stephanie had some pre-understandings of what birth would be like, describing what she calls the *'general consensus'* of birth as, *"it hurts, but don't worry, you'll forget and you'll come out the other side of it"*. Her first understandings were based on what she had witnessed as a child, heard people talk about as she grew up, what she imagined from pictures and TV programmes, and what she had deduced from stories she had been told. Her perception was also based on her experiences of hospital admissions for surgery; where *"normally you go in, you get changed, you get told where to go, they do everything to you now"*. She imagined that during birth *"surely, they'll do the same thing, you're in a hospital?"* This is a valid deduction to make; Stephanie is used to handing over responsibility for herself and her body when she enters a hospital. She anticipates that the professionals know the

correct course of action to take and believes that they will always act in her best interests. Nothing in her experience to date has led her to question this.

Stephanie describes, with some surprise, her belief that knowledge and/or information has *'filtered through'* over the years almost without her realising it. Until our conversation Stephanie had not really considered how she knew what she did about childbirth; her understandings and expectations were just there in the background. As she describes it 'knowledge' and 'understanding' of birthing is seemingly all around and is passively absorbed into human consciousness by a process akin to osmosis. This fits with the notion of *'received knowledge'* described by Belenky et al (1986) who suggest that listening is a way of knowing and that often what women hear in the words of others is *'concrete'* and that women *'absorb'* and *"store the truths received from others"* (Belenky et al, 1986, 757).

Stephanie's experience of stories is primarily of the *'horror'* type of story; the *"oh my god it's so painful, it's so awful, you just kind of want to forget about it"* kind of stories. Stephanie recognises that a lot of her ideas were based on the stories she had heard saying that the reason she did not anticipate a lot of choice during the process was because it did not sound like there had been with the births that she'd heard most about. Despite wanting to hear more positive stories Stephanie appears sceptical when she recalls a positive story she has heard, telling me that, *"everything was kind of real gushy...and I was like 'yeah, I'm sure it wasn't because it was just...everything was too perfect and wonderful?'"* Again this is unsurprising if stories such as this one are completely at odds with her perceived understandings of birth as something painful, long, arduous and which necessitates you to 'get over it' and 'forget it'.

Stephanie had not attended classes primarily with the intention of learning about birth; attending aqua yoga classes was something Stephanie had decided to try in order to

find some relief from the pelvic pain she was experiencing in pregnancy. Similarly Stephanie chose to attend NCT classes as a way of making friends and networking as she had recently moved into the area. Significantly, though, the classes changed Stephanie's '*views about birth*'; Stephanie has learnt the value of relaxation and the benefits of water for weightlessness and movement and now feels reassured that she can do a lot to make the birth what she wants. Stephanie's experience is a positive one which has led her to question her pre-understandings of birth; if Stephanie had not attended the classes she may have approached her birth with a different attitude and it is worrying to think that many women will not attend classes (either because they do not see the need or perhaps because they cannot afford to do so with NHS classes being so scarce) and that therefore their pre-understandings (and possibly expectations and experience) may be similar to those of Stephanie.

After attending classes Stephanie recognises that she can be involved in planning the birth, and in considering choices and making decisions arising during her labour and birth. Stephanie feels a sense of control over the process which she did not have before. Stephanie has been given a lot of information and told that she can be instrumental in her own birth; she wants to believe this and to experience a birth which is '*almost enjoyable*' rather than having an experience which is akin to those of members of her family. She remains slightly sceptical however as everything she believed prior to the classes is at odds with what she now 'knows'. She has obviously discussed what she has 'learnt' with others and still has a concern about the role of the professional in her care; despite being told that choices and decisions will be in her control she tells me that '*everybody still says it's not!*' Why should she put faith in what she has heard at the classes if everything she thought she knew and everybody else's opinion is at odds with this?

Bringing in other voices and phenomenological notions:

Stephanie's pre-understandings are rooted in her experience of '*being-in-the-world*' of birth; she experiences aspects of this world in relation to other people in that world. In Stephanie's case these people are members of her family and her close friends. In her pregnancy Stephanie finds herself in a world that appears to operate in a certain way and where certain things have already shown up as important (Wrathall, 2013). Heidegger describes this as '*thrownness*', explaining that Dasein is '*thrown*' into its '*there*' (Heidegger, 2012, p.173). As '*thrownness*' Dasein finds itself already in a certain moral and material, historically conditioned environment. "*As something thrown, Dasein has been thrown into existence. It exists as an entity which has to be as it is and as it can be*", (2012, p. 321).

Women are '*thrown*' into the world of birth; once in this world women are faced with an array of possibilities or choices which are somehow limited. Women therefore choose possibilities of action that are conditioned by their enculturation into the practices of their specific childbearing community. Stephanie, for example, has been born into a family in 21st century Britain, a family whose experience of birth is that of "*it being all out of your hands....you're in there for hours, and everything kind of happens at once and the nurses, or whoever, take over*".

Thrown as she is into this world Stephanie attunes herself, creating her existence in terms of what she sees as possible. Stephanie as '*everyday being-with-one-another*' is dependent on others and '*they*' inconspicuously dominate the way to be (Wrathall, 2005, 686). In this world the norm is one where caring involves '*leaping in*' and '*dominating*'; health professionals take up the burden of care and manage women's births for them (Heidegger, 2012, p. 159). Stephanie's attunement to birth is reinforced by the '*received knowledge*' (Belenky et al, 1986, 652) she encounters in the form of

the stories she hears which add emphasise to her understanding of birth as being “so painful...so awful, you just kind of want to forget about it”.

Stephanie would like to hear more positive stories of birth, as opposed to the ‘horror’ stories she describes. Despite wanting to hear more positive stories Stephanie appears dubious when she recalls a positive story she has heard, saying that, “*everything was kind of real gushy...and I was like ‘yeah, I’m sure it wasn’t because it was just...everything was too perfect and wonderful?’*” This is unsurprising as stories such as this one are completely at odds with her perceived understandings of birth as something painful, long, arduous and which necessitates you to ‘*get over it*’ and ‘*forget it*’.

After attending classes Stephanie recognises that she can be involved in planning the birth, and in considering choices and making decisions arising during her labour and birth. Stephanie feels a sense of control over the process which she did not have before. Her perspective has changed and she sees new possibilities of interacting with others; Heidegger describes this type of interaction as ‘*leaping ahead*’ and ‘*liberating*’ (Heidegger, 2012, p. 159). By attending classes and confronting what she thought she knew about birth Stephanie has learnt how to exert control over her experience and in doing so sees the potential to experience a birth which is ‘*almost enjoyable*’ rather than having an experience which is akin to those of members of her family.

Despite her new found understandings Stephanie remains slightly sceptical as everything she believed prior to the classes is at odds with what she now ‘knows’. She has obviously discussed what she has ‘learnt’ with others and still has a concern about the role of the professional in her care; despite being told that choices and decisions will be in her control she tells me that ‘*everybody still says it’s not!*’ Why should she put faith in what she has heard at the classes if everything she thought she knew and

everybody else's opinion is at odds with this? Stephanie struggles with the idea that her experience can indeed be different.

Heidegger believes that people have a natural inclination to conform, because ultimately they want to become accepted in their community. Their other option, '*mineness*', recognising their own possibilities which are not shared by others, carries the risk of them feeling alone and possibly ostracized. Perhaps Stephanie does not really believe in her ability to experience a different kind of birth or maybe she has not got the courage to claim the possibility of being instrumental in her own birth?

APPENDIX 10A - ALETHEIA ONE - MAPPING DOCUMENT

<i>'Stories are difficult like that'</i>			
Emerging meanings	Other voices	Philosophical notions	Transcript
Protecting or neglecting Shrouded in mystery or blissful ignorance Conspiracy of silence Horror stories	<ul style="list-style-type: none"> • <i>'The unsaid in the said and the unspoken in the spoken'</i> • Where language & naming are power, silence is oppression, is violence' (Rich, 1977) • 'After such knowledge what forgiveness?' ('Gerontion', T. S. Eliot, 1920) • <i>'What is this world if full of care, we have no time to stand and stare'</i> (William Henry Davies 'Leisure') • <i>'The world is too much with us; late and soon, Getting and spending, we lay waste our powers: Little we see in Nature that is ours; We have given our hearts away, a sordid boon!'</i> (Wordsworth) 	<ul style="list-style-type: none"> • Thrownness' - women 'thrown' into the world of birth, choose possibilities of action that are conditioned by their enculturation into the practices of their specific childbearing community – consumerist one of first phase • Care - as Dasein's act of expressing anything about itself to itself – our interaction with things in the world - dimensions of 'authentic' and 'inauthentic' existence 	<ul style="list-style-type: none"> • Stephanie - filtering through idea - too perfect stories. Also conformity and being-in-the-world of birth - role of received knowledge • Rebecca - hearing horror stories • Joanna - worst case scenario birth stories • Lucy - preparing for the worst via the 'modern birth story' • Pamela - you hear more about difficult births - you don't tell positive stories because you don't want people to feel bad • Ruth - too perfect idea of stories • Isabel - influence of TV as part of the modern birth story - mother and friend's

<p><i>'Too perfect and wonderful'</i></p> <p>Offering platitudes</p> <p><i>'Avoiding the gory bits'</i></p> <p>Knowledge and information <i>'filtering through'</i></p> <p>Making people feel bad</p> <p>The 'modern birth story'</p> <p>'Media portrayal'</p>	<ul style="list-style-type: none"> • 'Saying is the bridge between the hiddenness of earth and the disclosedness of world' (Palmer, 1976) • Weber and his 'disenchanted world' • Ibsen 'Ghosts' <p><i>"It isn't just what we have inherited from our father and mother that walks in us. It's all kinds of dead ideas and all sorts of old and obsolete beliefs. They are not alive in us; but they remain in us nonetheless, and we can never rid ourselves of them. I have only to take a newspaper and read it, and I see ghosts between the lines. There must be ghosts all over the country. They lie as thick as grains of sand. And we're so horribly afraid of the light".</i></p> <ul style="list-style-type: none"> • Is the discourse of meaning dead? (Robert Harrison) • Ontological power of language • <i>'Concepts, just like individuals, have their history and are no more able than they to resist the dominion of time, but in and through it all they nevertheless harbour a kind of homesickness for the place of their birth'</i> (Kierkegaard) • <i>'First, Language used to express experiences not merely in sentences, but also in words used to name things. Second, there is always a surplus of what is experienced to what is expressed. Finally, according to the usual</i> 	<ul style="list-style-type: none"> • 'Leaping in' and dominating - where one cares for the other by simply taking up that other's burden and doing it for them, e.g. by not providing information leading to women feeling out of control when birth is not as expected/medical professionals 'taking care' of women • 'Leaping ahead' and liberating - 'where the other is helped to take up their own burden by giving them the means to bear that burden on their own' (such as through providing information/birth planning/raising awareness of difficulties that could present). • Lostness in the 'they' • Historicity - of language - current experiences shaped by the past • Idle talk 	<p>stories - traumatic - direct influence on care chosen</p> <ul style="list-style-type: none"> • Emma - horror stories - mass of current information women have to negotiate • Mary - it's an absurd world we live in - modern birth story - editing life experience in portrayals to others - live in a polite culture - don't want to upset anyone we know • Charlotte gravitates to the more positive stories. • Bonnie - more influenced by horror stories - would 'tailor' her own story for others - thinks we get our info from other women - recognises influence of culture - need to override that - message given to children is sanitised • Sandra - I can remember my mum saying it was painful but it was worth it • Paula - 'stories are difficult like that' - I didn't tell her about the actual birth, I just didn't <p>Meg - conspiracy of silence - protect - I was a shy, withdrawn person then - now mature and sees things differently - temporality? Historicity?</p> <ul style="list-style-type: none"> • Penny - <i>It's a slippery slope when you're in the delivery suite, isn't it? If they're on</i>
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<p>'Celebrity culture'</p> <p>'Going the opposite way'</p>	<p><i>conception, only present experience is expressed. Given the historicity of language, current experiences and their expression are shaped by the past. Because of the importance of the origin, current experiences and their expression are affected by and reflect the originary experience of the tradition and its expression'. (Shain 2009)</i></p> <ul style="list-style-type: none"> • Circulation of 'plotted stories' - selves as narratively constructed - <i>'careful the tale you tell, that is the spell' children will listen</i> (Sondheim 'Sunday in the Park with George, 1984) 	<ul style="list-style-type: none"> • Heidegger and language – 3 ontological levels: <ol style="list-style-type: none"> 1. Existential language 2. Language as use 3. Language as something on hand (Powell 2013) 	<p><i>that slippery slope, there's nothing I can do about it and I don't think scare stories help anyone and everybody's birth is so different'</i></p> <p><i>'Being economical with the truth'</i></p> <ul style="list-style-type: none"> • Carole - my mum terrified me - I wouldn't want to worry anyone - it's not fair on people who are pregnant • Marie - I suppose I regulated what I said to people really • Sophie - withholding experiences so as not to scare people - not imposing personal views
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APPENDIX 10B - ALETHEIA TWO - MAPPING DOCUMENT

<i>'It's a generational thing'</i>			
Emerging meanings	Other voices	Philosophical notions	Transcript
<p><i>'It was just done to you'</i></p> <p><i>'In their hands'</i></p> <p><i>'I was a shy nervous girl then'</i></p> <p><i>'Letting it take its course'</i></p> <p>Birthing 'know how'</p>	<ul style="list-style-type: none"> • Understanding as acceptance • Paternalistic care • 'Absence of voice and dependence on external authority for direction' (Belenky et al, 1997) • Self-awareness of the way we live in history (katz, 1982) • 'But when are we?' (Rilke, Sonnets to Orpheus) • Passivity of women - then and now - rendering herself <i>'wholly dependent on an expertise other than her own'</i> Belu 	<ul style="list-style-type: none"> • 'Thrownness' - women 'thrown' into the world of birth, choose possibilities of action that are conditioned by their enculturation into the practices of their specific childbearing community – consumerist one of first phase • 'Being-in-the-world' - Past as understood as a particular way of 'having been' • Historicity • Repetition - a handing over and appropriation – a going back to the possibilities of Dasein that-has-been-there – the inclination of 'forward- 	<ul style="list-style-type: none"> • Stephanie - experience of hospital procedures as an inpatient for operations - putting it behind you. Experience and historicity of family birthing • Isabel - idea of 'good' patient - experience of hospital as a child - putting it behind you • Lucy wants reassurance that she is capable of birthing - 21st century fear around birth • Lucy historicity of her mother's experience • Rebecca - historicity of her mother's experience - wanting care that leaps ahead rather than that which leaps in • Pamela - you just lie down on the bed and have your baby - options limited - care paternalistic - leaping in - expectations low - outcome healthy baby • Isabel - waited for care - doesn't want to take responsibility - conforming - absolving responsibility 'being a good patient and a good parent'

Doing better	<ul style="list-style-type: none"> • Women's ways of knowing - Belenky et al 	looking' Dasein gives the past meaning – the ontological structure	<ul style="list-style-type: none"> • Emma - did not speak with her mother about birth - not the done thing
Taking control	<ul style="list-style-type: none"> • Self-efficacy and confidence - Bandura 	'liberates the past for the future, and it is then that the past gains force and becomes productive' – our past is only really meaningful when interpreted in the light of the future? (Prestidge-King 2006)	<ul style="list-style-type: none"> • Mary - we're in a polite culture
Making choices	<ul style="list-style-type: none"> • 'Catastrophizing' birth • Reliance on expert knowledge 		<ul style="list-style-type: none"> • Sandra - it's a pretty private thing to talk about. I think young girls today talk about it more than we did in our time. My generation were more open than my parents' generation. But this generation nothing's private to them - nothings off limits, they talk about everything
Info seeking & overload	<ul style="list-style-type: none"> • 'Giving birth like a girl' - gender - internalised sense - playing a role in disciplining women 		<ul style="list-style-type: none"> • Paula - I went into the pregnancy thinking I wouldn't have any problems, I didn't even consider it - you didn't really question things then - it was just kind of a medical professional telling you this is going to happen
<i>'It hurts, but don't worry you'll forget and come out the other side of it'</i>	<ul style="list-style-type: none"> • A 'deskilling of the populace takes place when experts manage human experiences' (Weitz, p. 49) • Nihilistic forgetfulness of the essence of our being as women who can birth (Van Manen) (Nietzsche) • Choice and responsibility • 21st Century fear of birthing • Expectation and experience • Waited for care - no responsibility - no expertise - likely to conform to medical model - Kirkham 	<ul style="list-style-type: none"> • Repetition occasions a reopening of the past by translating that which has been into possibilities to be chosen time and time again. Repetition hands over the past as a past with meaning and sense. (Schrage 1970) • Temporality - Dasein is in the present, indebted to the past and orientated towards the future • Authenticity - conscience - guilt • Guilt (Heidegger) - being disburdened by the 'they' 	<ul style="list-style-type: none"> • Meg - you didn't talk about genitals - I was a shy, nervous 21 year old • Carole - <i>'I probably would have researched far more if I was pregnant now, but then I'm a lot older now. I was very young then, so I did what I was told'</i> • Jean - But no, there doesn't all kind of...you know, it was all kind of them telling you what to do. And it wasn't the partnership that it should be which I think it is more now • Marie - it was all a bit shrouded in mystery • Sophie - I think I talked my mum and my Nan and they sort of give you snippets. They don't give you a blow by blow because your memory plays tricks on you - I never felt pressurized, but I don't think that there was ever any choices

APPENDIX 10C - ALETHEIA THREE - MAPPING DOCUMENT

'Birth in the twilight of certainty'			
Emerging meanings	Other voices	Philosophical notions	Transcript
<p>Part of a process: <i>'in the system'</i></p> <p>Birth as a technological feat</p> <p><i>'Worrying about getting the baby out and not the mother's welfare'</i></p> <p>Birthing 'know how'</p>	<ul style="list-style-type: none"> • Tedium of delivery? Infatuated with new technology - saving time - efficiency - Belu • Ascendancy of administration - governance the moving force - Harrison podcast • <i>'Women's disembodied experience of birth becomes the norm'</i> (Belu, 2012) • <i>'The technology was out there and could not be put back in the box'</i> (Belu, 2012) • Reproductive <i>'enframing'</i> (Belu, 2012) • Birth as technological feat - framed in risk and neat conceptualisation • ? stripped of live content • Weber 2004 <i>'we can in principle control everything by means of calculation'</i> • Harraway (1988) situated knowledge 	<ul style="list-style-type: none"> • Authenticity - conformity - the 'they' - 'sleep walking' Keirkegaard • Machination and man as a raw material: man becomes, in the modern age, another resource, something useful when properly ordered and arranged - standardised birthing body is 'shaped' and all women's bodies are thereafter expected to conform to the standard, making progress in labour, for instance, as predetermined by the 'anyone' of the medical establishment. 	<ul style="list-style-type: none"> • Stephanie - experience of hospital procedures as an inpatient for operations - conforming • Isabel - idea of 'good' patient - experience of hospital as a child - conforming • Lucy - thrown into UK world of birth - agency as simultaneously individual but also social - lost in the 'they' of birth • Joanna - lost in the 'they' of birth - finding the system reassuring - care and leaping in - disburdened by the 'they' • Rebecca - thrownness - but leaping ahead not leaping in

	<ul style="list-style-type: none"> • Descartes and the mechanisation of the human body (Treatise of Man) • Understood from the mechanized point of view the 'reduced' body is an abstract, universal thing that is subject to physical and chemical laws and is, as a result, stripped of its lived context, (Marcum, 2004, p. 313) • Marcum (2004) - when a person's body is fragmented into parts and standardised to conform to particular criterion (as deemed appropriate by the medical community), it becomes estranged from the self and from other people. In this situation the person no longer has control over their own body or experience • Wertz & Wertz (1977) - the uterus was described as <i>"a mechanical pump that in particular instances was more or less adequate to expel the fetus"</i> • Martin (1989) - the medical metaphor continues to dominate obstetrics and both <i>"underlies and accounts for our willingness to apply technology to birth and to intervene in the process"</i>. In this analogy the woman's body is the machine and the doctor the technician who 'fixes it'. • Foucault (1988) describes the human body as a <i>'subjected, practiced and docile'</i> body which enters <i>"a machinery of power that explores it, breaks it down and rearranges it"</i>. Foucault maintains that within institutions such as schools, hospitals and prisons, the body's time and space is rigidly controlled and regulated by the various activities of the institution. 	<ul style="list-style-type: none"> • Total disappearance of enchantment and questioning • <i>'We are aware unaware that we are historically determined to relate to nature in a controlling way'</i> • <i>"The consumption of all material, including the raw material man, is determined in a concealed way by the complete emptiness in which beings are suspended. This emptiness has to be filled up by the endless possibility of production, the production of everything. But the emptiness of being can never be filled up by the fullness of beings especially when we don't experience it for what it is, the only way to escape this emptiness is to endlessly order and arrange beings so as to guarantee incessant, aimless activity"</i>. ('The End of Philosophy', 2003, p. 106-107) • Heidegger is concerned about our lack of questioning 	<ul style="list-style-type: none"> • Ruth - managing the process to birth the dream baby - protecting baby at birth - guilt - responsibility • Isabel - guilt idea as well - wanting own experience - authenticity - 'there is an experience for me' • Pamela - limited options - low expectations - part of system - outcome measured on healthy baby • Isabel - waited for care - doesn't want to take responsibility - conforming - absolving responsibility 'being a good patient and a good parent' • Paula - I didn't have any information I was just going along with what they were doing - I had two babies and everything was alright, so they were positive experiences for me • Meg - <i>'I just felt like it was one of those processes, you were just like a piece of meat really, your job was to produce this baby and however much pain</i>
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	<ul style="list-style-type: none"> • R. Kipling 'The Secret of the Machines' <i>'But remember, please, the Law by which we live, We are not built to comprehend a lie, We can neither love nor pity nor forgive. If you make a slip in handling us you die! We are greater than the Peoples or the Kings— Be humble, as you crawl beneath our rods!- Our touch can alter all created things, We are everything on earth—except The Gods!'</i> • <i>'The most exquisite pleasure is domination. Nothing can compare with the feeling. The mental sensations are even better than the physical ones. Knowing you have power has to be the biggest high, the greatest comfort. It is complete security, protection from hurt. When you dominate somebody you're doing him a favour. He prays someone will control him, take his mind off his troubles. You're helping him whilst helping yourself. Even when you get mean he likes it. Sometimes he's angry and he fights back but you can handle it. He always remembers what he needs. You always get what you want', (Holzer, 'Inflammatory Essays' 1979-82)</i> • Does the technologization of birth serve to conceal the central existential questions about being and finitude? (Carnevale 2005) • Human agency as individual but also as social • Waited for care – Kirkham 	<p>regarding our relationship to technology</p> <ul style="list-style-type: none"> • Heidegger seeks to demonstrate that calculation (centred on measurement, manipulation and control) is but one form of thought – he argues for a leap toward contemplative thought – which seeks to uncover the meanings of things • Machines today – many occupy themselves with the manipulation and processing of 'information' – for Heidegger a further refinement of 'das Gestell' (Essence of technology - Buckley 1992) • 'Disburdened' by the 'they' B&T p. 165 • Notion of our 'finitude' - Modern age of technology obscures the meaningful presence of things to human beings – need to remember our 'finitude' – reflection must be kept alive to reengage humans with the world 	<p><i>you might be in, there was no real time for that, you know, it was about getting the baby out, not about the mother's welfare'</i></p> <ul style="list-style-type: none"> • Penny - being sewn up by a 'disrespecting doctor' • Carole - doing what I was told • Jean - conveyor belt in the hospital - no choice or control • Marie - <i>'I don't think I ever questioned exactly what it was like. I think it was just something, we wanted children. It was a process we were going through. We were going to get a child at the end'</i> • Sophie - I don't ever remember having any relationship with a midwife, however short lived. I was just being processed as part of the thorough put of a busy general hospital sort of thing
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APPENDIX 11 - TRANSCRIPT EXEMPLARS

Script	Cohort & Identifier	Exemplar	Themes
Lucy	First CB1	<i>'I believe that other people's stories will give me ideas about my own birth. I am really interested in talking to people who have birthed in the last year or so at the same hospital as me. I feel they will help me understand the 'procedure' of labour'</i>	<i>'Stories are difficult like that'</i>
Joanna	First CB2	<i>'The system is reassuring because it feels so routine'</i>	<i>'Birth in the twilight of certainty'</i>
Rebecca	First CB3	<i>'I had to shut my ears to sensationalist stories'</i>	<i>'Stories are difficult like that'</i>
Ruth	First CB4	<i>'Trying to avoid the drama of birth'</i>	<i>'Birth in the twilight of certainty'</i>
Mary	First CB5	<i>'We are a polite culture and...we wouldn't want to upset anyone, especially someone you know'</i>	<i>'Stories are difficult like that'</i>
Stephanie	First CB6	<i>'I didn't realise how much information and knowledge had filtered through the years'</i>	<i>'Stories are difficult like that'</i>
Isabel	First CB7	<i>'I've a terrible fear that if I did something to jeopardise the health of my baby, then how would I ever recover from that guilt?'</i>	<i>'Birth in the twilight of certainty'</i>

Charlotte	First CB8	<i>'They have very, very different sorts of outlooks in life. And so I gravitate much more towards the lady at work with the positive attitude...otherwise you could just hear stuff from someone like the lady with the big baby and be absolutely terrified'</i>	<i>'Stories are difficult like that'</i>
Bonnie	First CB9	<i>'I've had two stories where they've said about the cord being wrapped around the neck. So I tend to get a bit, Oooohhh...'</i>	<i>'Stories are difficult like that'</i>
Harriet	First CB10	<i>'Some sources are more authoritative like the NHS, the NCT. Some are more personal like friends and family'</i>	<i>'Stories are difficult like that'</i>
Sophie	Second Winchester	<i>'You know that you can talk about experiences that -- and I think people withhold experiences because they don't want to frighten people and I think I would probably do the same. You know, you actually don't say stitches are horrible and you know, and breastfeeding's awful... my personal view. You don't want to -- you don't want to impose that on anyone'</i>	<i>'Stories are difficult like that'</i>
Emma	Second Newmarket	<i>'I'm sure it's a generational thing. My mum wouldn't have been as open about things as perhaps I would be with my daughter'</i>	<i>'It's a generational thing'</i>
Jean	Second Ipswich	<i>'They've made it almost a technological feat having a baby. You know you have to be attached to all these wires and goodness knows what else.'</i>	<i>'It's a generational thing'</i>
Marie	Second Cambridge	<i>'I don't think I ever questioned exactly what it was like. I think it was just something, we wanted children. It was a process we were going through. We were going to get a child at the end'</i>	<i>'Birth in the twilight of certainty'</i>
Carole	Second Yorkshire	<i>'I probably would have researched far more if I was pregnant now, but then I'm a lot older now. I was very young then, so I did what I was told'</i>	<i>'It's a generational thing'</i>

Penny	Second Suffolk	<i>'It's a slippery slope when you're in the delivery suite, isn't it? If they're on that slippery slope, there's nothing I can do about it and I don't think scare stories help anyone and everybody's birth is so different'</i>	<i>'Stories are difficult like that'</i>
Meg	Second North East	<i>'I just felt like it was one of those processes, you were just like a piece of meat really, your job was to produce this baby and however much pain you might be in, there was no real time for that, you know, it was about getting the baby out, not about the mother's welfare'</i>	<i>'Birth in the twilight of certainty'</i>
Paula	Second Teeside	<i>' 'Because I think stories are difficult like that...well you don't want to frighten people, you know, I think the thing is as women...I suppose we're all the same you just think it's going to be okay really, don't you? I went into the pregnancy thinking...not thinking I would have any problems, I didn't even consider it'</i>	<i>'Stories are difficult like that'</i>
Sandra	Second Cleveland	<i>'The midwife said it will hurt, expect it to hurt. Other than that it was a mystery until you actually gave birth'</i>	<i>'It's a generational thing'</i>
Pamela	Second Skipton	<i>'I thought okay I'll have the baby and it will be alright'</i>	<i>'It's a generational thing'</i>

APPENDIX 12 - DISSEMINATION PLAN

1. In Academia:

Publication Plan:

1. 'Reflexivity in the hermeneutic circle' - in this article I intend to reflect on my experience of being interviewed regarding my place in the 'world of birth' and my experience of engaging with birth stories. In the article I will consider whether studying one's own 'story' and experience is an effective means of identifying the biases and assumptions carried by the researcher into a research study.
2. Article detailing findings of MPhil phase.
3. Article detailing findings of PhD phase.
4. Article detailing overall findings of PhD and implications for practice.
5. Reflective piece on PhD journey.

Potential Conference Presentations:

- I intend to submit an abstract to the 'ICM 2017 Midwives Congress' Toronto

2. Clinicians, Service Users and Wider Public Domain:

- Circulation of main themes to participants
- Guest lecture at Anglia Ruskin University: the institution who provided support and funding at earlier stages of PhD
- Web access to summary report
- Information to media contacts
- Use of social media such as 'Facebook' and 'Twitter'
- Written reports to National Childbirth Trust and National Federation of Women's Institutes: the two organisations who assisted me with recruitment
- Circulation of summary report to Lead Midwives for Education at Universities facilitating midwifery education
- Summary findings to Director for Education at Nursing and Midwifery Council
- Written article detailing findings to be forwarded to contact at 'The Practicing Midwife'
- Networking
- Targeted mailings e.g. 'The Wellcome Trust'