A Journey from Science to Art: Valuing the voices of women in the exploration of traumatic childbirth and perinatal mental health.

By

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Abstract

Informed by a feminist perspective, this thesis critically explores the multiple conceptual metanarratives of in childbirth. The research focuses on the lived experiences of traumatic childbirth and perinatal mental health problems from the perspective of Health Visitors and mothers to journey from the dominant, broad medical perspective to the unique, personal emotional understanding. This highlights the knowledge to be gained through listening and learning from the voices of women who are experts by experience in traumatic childbirth and perinatal mental health care.

The research was structured in three phases, a thematic analysis of focus groups with ten Health Visitors; a narrative analysis of mothers with self-defined traumatic birth stories; and a holistic representation of the stories and research experience. Using focus groups with Health Visitors, a thematic analysis constructed an over-arching theme of 'Protecting an uncertain professional identity', encompassing two sub-themes constituted of 'the knowledge narrative' exploring differing types of professional wisdom, and 'Health Visitors role in perinatal mental health care.' In the thematic analysis Health Visitors demonstrate some technical knowledge of PSTD following childbirth, but are under-confident in this knowledge. They outline a juxtaposition between not wanting to take on a role and responsibility in perinatal mental health care, but doing so in practice, creating anxiety. The importance of experiential and relational knowledge underpinning professional artistry is also highlighted.

A narrative analysis of twelve mothers' traumatic childbirth stories utilizes van Gennep's (1960) Rites of Passage theoretical framework to propose a period of acute liminality following traumatic childbirth experiences, with specific strategies and rituals enabling mothers to reintegrate and incorporate these experiences into their maternal self-identity. Secondly, narrative analysis explores the dilemmatic qualities of the traumatic childbirth narratives through the use of contextually-bound 'cervix' repertoires, discursive resources used to negotiate unique and personal experiences within the medical discourses which contextualise contemporary childbirth.

Illuminating and integrating the multiple people and positions invested in this project; the researched, the researcher, and the audience, this thesis concludes with an arts-based, novel representation/presentation of mothers' traumatic childbirth narratives. This provides an alternative, holistic understanding through an emotional capture of the individual traumatic childbirth narratives, creating 'empathetic engagement' and reactive reflections. This demonstrates the unique value of aesthetic, visceral knowledge created through potent, evocative and essentially human connection.

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List of Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
APA	American Psychological Association
BAM	Becoming A Mother
CBT	Cognitive Behavioural Therapy
CETHV	Council for the Education and Training of Health Visitors
CPD	Continuing Professional Development
CSA	Childhood Sexual Abuse
CTG	Cardiotocography
CQC	Care Quality Commission
DH	Department of Health
DRT	Dual Representation Theory
DSM	The Diagnostic and Statistical Manual of Mental Disorders
EMDR	Eye Movement Desensitisation and Reprocessing
EPDS	Edinburgh Postnatal Depression Scale
FG	Focus Group
GAD	Generalised Anxiety Disorder
GP	General Practitioner
HCP	Healthy Child Programme

HEE	Health Education England
HELLP	Hemolysis Elevated Liver enzymes Low Platelet count
HV	Health Visitor
HVPT	Health Visitor Practice Teacher
ICD	International Classification of Diseases
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK.
MRA	Maternal Role Attainment
MW	Midwife
NCT	National Childbirth Trust
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NMC	Nursing and Midwifery Council
NQHV	Newly Qualified Health Visitor
PDEQ	Peritraumatic Dissociative Experiences Questionnaire
PHQ	Patient Health Questionnaire
PIMH	Perinatal and Infant Mental Health
PMHP	Perinatal Mental Health Problem
PND	Post Natal Depression

PTCI	Post Traumatic Cognitions Inventory
PTG	Post Traumatic Growth
PTSD	Post Traumaic Stress Disorder
RGN	Registered General Nurse
RMN	Registered Mental Health Nurse
SAM	Situationally Accessible Memories
SCPHN	Specialist Community Public Health Nurse
TENS	Transcutaneous Electrical Nerve Stimulation
TL	Team Leader
UEA	University of East Anglia
U.K.	United Kingdom
VAM	Verbally Accessible Memories
VLBW	Very Low Birth Weight
WHO	World Health Organisation

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Author's declaration

The candidate has not previously submitted any of the work towards the award of a degree, nor has any of the following material appeared in solely or jointly authored publications.

CHAPTER ONE

Introduction

The context of the thesis

Childbirth is a multidimensional transitional event in a person's life and thus it is experienced physically, socially, psychologically and emotionally. There are multiple discourses and knowledge systems surrounding childbirth. These include two arguably contradictory discourses: the women-centred model, which is linked to the natural childbirth discourse and the androcentric, medical model which has conceptualised childbirth as a risk-laden, medical event. The dominant perspective in the United Kingdom (U.K.) is the medical model, which has superseded the alternative perspective of birth as a social event. These discourses surrounding childbirth in Western societies are echoed in women's experiences (Walsh, 2007; Nettleton, 1996), which arguably sit somewhere in the middle of the conceptual dichotomy between medicalised and natural birth (Walsh, 2010). However, both the biomedical and the 'natural' conceptualisations of childbirth tend to universalise the birthing experience. The tensions created by a lack of congruence in the management of childbirth are reflected in social practices around birth, and are embedded in the narratives of women's childbirth experiences (Brubaker & Dillaway, 2009; Henley-Einion, 2003; Malacrida & Boulton, 2013; Walsh, 2010). This research presented in this thesis acknowledges and considers these competing discourses, whilst refocusing the key consideration away from them (Graham & Oakley, 1981) to explore and consider the woman's subjective experience of traumatic childbirth.

This PhD began as a mixed-methods, clinically focussed PhD exploring the trajectory and experience of PTSD following childbirth. Following an emerging conceptual awareness of trauma and subjective experience and a growing confidence in creative methodologies this PhD became something much different from the original proposal.

This PhD does not take the feminist perspective approach through the hard-line concept of hegemonic masculinity and the challenge to the medicalisation of the female body.

Instead it utilises the feminist perspective as an influence creating a more pragmatic acknowledgment of healthcare as a masculine environment with degrees of gender bias throughout (Verdank, Benschop, Hanneke & Toine, 2009). As the process of exploring the research progressed and moved into more qualitative and creative methodologies the feminist dimensions which foreground the experience of women became increasingly influential.

Through my development as an academic I was able to explore the different perspectives and political statements made through the c research literature through both philosophical and conceptual standpoints and theoretical perspectives. However, I believe that this PhD sits in multiple different areas, from creative methodologies, to practical implementations of some of the findings in medicine and healthcare through my role in educating practitioners. My primary aim from this PhD was to enable to voices of women who have experienced traumatic childbirth to be heard in both academic and medical arenas, for their experiences to be considered and acknowledged within service design and individual care interactions. It was never my intention to draw a hard-line feminist perspective into my PhD, instead it takes a softer feminist perspective in order to provide an open dialogue with all to explore the findings in a way which may be able to support and address the needs of individual women.

Elmir, Schmeid, Wilkes & Jackson (2010) outline the difficulties in defining traumatic childbirth. Indeed, the definition lacks consistency, and the terms childbirth/birth trauma, and traumatic childbirth/birth, amongst others (Greenfield, Jomeen & Glover, 2016) are used interchangeably within the literature. There can be specific or multiple physical, psychological, social and personal elements of the childbirth experience which can be perceived as traumatic, therefore there are difficulties in the systematic assessment of traumatic childbirth (Elmir et al., 2010). The literature tends to be consistent in its

understanding that traumatic childbirth is self-defined, and based on the mother's subjective perception and appraisal of her childbirth experience (Greenfield et al., 2016). Research outlines that clinically, the birth/labour event does not have to be obstetrically indicated as traumatic in terms of possible serious injury, or threat to life, towards either the mother or infant; what is important is how the event is perceived by the mother (or father). There have been some attempts to provide definitions of traumatic childbirth in individual studies, one such definition is provided by Moyzakitis (2004):

> A woman who has suffered distress as a result of injury to her body, or pain or sorrow, which is of such a magnitude that it may lead to a traumatic condition, which can have a prolonged psychological and/or physical effect upon that woman (p.8).

Alternatively, Greenfield et al. (2016) undertook a conceptual analysis and from this the following definition of 'traumatic birth' was constructed:

> The emergence of a baby from its mother in a way that involves events or care that causes deep psychological distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature (p.257).

This thesis chooses not to provide an explicit and set definition of traumatic childbirth, as the freedom for participants to self-define the concept is important when considering the phenomena of traumatic childbirth from the unique perspective of the participant. This thesis concurs with Beck's (2004) title of her paper which aptly describes traumatic childbirth as "in the eye of the beholder".

While childbirth is increasingly safe in Western industrialised countries, despite the global Safe Motherhood Initiative (1987) the inequalities within and between countries are still vast (Stanton, Kwast, Shaver, McCallon & Koblinsky, 2018). It is acknowledged that between 20 to 48 per cent of women worldwide perceive their birth experience as traumatic

(Simpson & Catling, 2016). Post-Traumatic Stress Disorder (PTSD) is a clinical psychiatric diagnosis based on the criterion outlined in the International Classification of Diseases version 11 (ICD-11; WHO, 2018) and the Diagnostic and Statistical Manual of Mental Disorders version 5 (DSM-5; APA, 2013), and highlights the importance of a traumatic etiological agent when diagnosing this disorder. The publication of DSM-IV (APA, 1994) allowed for the traumatic experience to be within usual/normal human experience (National Centre for PTSD, 2013), and subsequently childbirth has since been considered an etiological agent for the development of PTSD (Ayers, Bond, Bertullies & Wijma, 2016; Ayers and Pickering, 2001). Research indicates that approximately 4% of women develop Post-Traumatic Stress Disorder (PTSD) following traumatic childbirth experiences (Yildiz, Ayers & Phillips, 2017). PTSD following childbirth has a range of possible vulnerability and risk factors and the consequences of this illness are multiple for the mother, infant, and the wider family (Elmir et al, 2010; Fenech & Thomson, 2014; Olde, van der Hart, Kleber & van Son, 2006; Parfitt & Ayers, 2009; Parfitt, Pike & Ayers, 2013). Ayers (2017) has highlighted the rise in research interest and the assembling of evidence about traumatic childbirth and PTSD following childbirth over the past twenty years, although research is dominated by Western countries (Simpson & Catling, 2016). This increased attention is mirrored within professional guidance such as National Institute for Health and Care Excellence (NICE; Clinical guideline 192, 2018).

Alongside the consideration of traumatic childbirth and subsequent PTSD, in general there has been a wide-spread increase in focus on Perinatal Mental Health Problems (PMHP) in the U.K. and the inequality that exists between physical and mental health in the perinatal period (Maternal Mental Health Alliance, 2014). This has initiated changes and increased the focus on perinatal mental health in health care provision during this period. In the U.K. one source of health care provision in the perinatal period comes from the Health Visiting service,

a professional public health service which currently focuses on the mandated universal delivery of the Healthy Child Programme in pregnancy and the first five years of life (Department of Health, 2009). The promotion of mental health as an action point and priority for Health Visitors is supported by the Closing the gap: priorities for essential change in mental health document (Department of Health, 2014), and concurs with National Institute for Health and Clinical Excellence guidelines (2018b) which suggest that identification of mental health problems in the family is within the remit of Health Visitors. The National Institute for Health and Clinical Excellence recommends that "All health care professionals should be aware of the signs and symptoms of maternal mental health problems that may be experienced in the weeks and months after the birth" (Recommendation 1.2.24). The maternal mental health pathway guidance document (Department of Health and Social Care, 2012) stated that Health Visiting should contribute "to early maternal mental health detection, intervention, support and referral" (p.6). The identification and management of post-natal depression was previously emphasised in the Heath Visitors' role, but more recently this has been extended to include all perinatal and general psychological disorders occurring in the perinatal period (Jomeen, Glover, Jones, Garg, & Marshall, 2013). This early identification and intervention can produce better outcomes for parents and their families (Public Health England, 2017).

With a move towards 'women-centered' care during the perinatal period, qualitative research has begun to demonstrate the value of women's birth narratives and experiences within the research literature (Carolan, 2006). Utilising the tendency of women to share their perinatal experiences, including childbirth stories, the research literature provides an avenue of exploring the social context of childbirth, what is important to women, and how specific interventions and situations are experienced (Carolan, 2006). Although under-represented in the literature in terms of quantity, women's experiences of childbirth have been explored,

focusing on a range of different factors. Elmir et al. (2010) conducted a meta-ethnographic study on women's perceptions and experiences of traumatic childbirth, the pervasive influence of the experience resonates in the identified themes. There were six themes, which were; 'feeling trapped: the reoccurring nightmare of my childbirth experience', 'a rollercoaster of emotions', 'feeling invisible and out of control', 'to be treated humanely', 'disrupted relationships', and 'strength of purpose: a way to succeed as a mother'. The study highlights both similarities and differences in experience, alongside the implications for policy and/or practice. The combination of this small, but significant literature base cannot be under-estimated as it demonstrates that to improve maternity experiences, and decrease the rates of traumatic childbirth, we must first aim to understand it. Indeed, the creation of this type of research, knowledge, and understanding is of equal importance to the more quantitative, traditional forms of knowledge and understanding.

The feminist perspective has had a consistent focus on women's reproductive interests, and through the women's health movement in the 1970/80s, it has challenged the marginalisation of women's experiences, both professional and personal (Doyal, 1983), in the knowledge base (Sobnosky, 2013). The feminist perspective and associated research methods are key in exploring the experiential understanding of women's professional and personal involvement in traumatic childbirth and perinatal mental health.

The way in which inquiries into health and illness are approached has developed and incorporating the voice of the expert by experience is more common now than it has been historically. However, there is still a tendency to value the scientific, medical, and traditional forms of knowledge more highly than the alternative, 'softer' forms of knowledge and tacit knowing. The development of arts-based research embraces a unique questioning of what constitutes evidence and how this evidence creates knowledge. It provides an alternative

paradigm for research dissemination, and one which explicitly considers the engagement of the audience (Boydell, Gladstone, Volpe, Allemang & Stasiulis, 2012).

> Art and science bear intrinsic similarities in their attempts to illuminate aspects of the human condition. Grounded in exploration, revelation, and representation, art and science work toward advancing human understanding. Although an artificial divide has historically separated our thinking about art and scientific enquiry, a serious investigation regarding the profound relationship between the arts and science is underway." (Leavy, 2015, p.3)

The use of an arts-based method for providing novel representations of some of the mother's traumatic childbirth narrative data enabled the researcher to address some of the limitations of the more formal and traditional methodologies also used in this thesis.

This Thesis

Childbirth is a unique, significant and important event in a woman's life, and is central to the transitional move into motherhood (Winson, 2009), which is assumed to be intrinsically linked to the female identity (Ireland, 1993). Therefore, as Cosslett (1994) suggests: "As a central, life-changing event for many women, childbirth needs to be made visible, written about, from a women's perspective. Too often, the story has been taken away from women . . ." (p.2).

The medicalisation of childbirth is embedded into the social and cultural context of childbirth in the U.K., with a focus on science, power, knowledge, and control (Kitzinger, 2012), and as a result there is an argument that childbirth and maternity care has become depersonalised. Traumatic childbirth is not immune from this depersonalisation, and arguably understanding that traumatic childbirth can result in subsequent Post-Traumatic Stress Disorder (PTSD) has increased the dominance of the medical and scientific perspective on this particular type of childbirth experience. The 'expert' medical, scientific perspective

marginalises the experience of some of the most active participants (usually women) who are intrinsic in understanding traumatic childbirth and associated perinatal health care. Utilizing the post-structuralist feminist perspective this thesis explores traumatic childbirth from the personal perspective of Health Visitors, mothers, the researcher, and ultimately reflects on the reactive reflections of the research audience. The thesis highlights the voices of women and explores their experiences within the perinatal period, valuing the participation of women with lived experiences in research, whilst analysing the data with the broader social and cultural context.

Embarking on and acknowledging the academic and personal journey of the author, this thesis begins by exploring the scientific, medical and theoretical perspective of Post-Traumatic Stress Disorder (PTSD) following childbirth moving on to the alternative and interacting approaches and perspectives of the social, psychological and personal. Replicated in the studies and their presentation, this body of research begins with more mainstream, explicit considerations of traumatic childbirth and methodologies, moving into creative, arts-based and subjective considerations and dissemination of findings.

Chapters two and three critically evaluate the biomedical perspective in framing and understanding traumatic childbirth. This is achieved through the assembly of a critical literature review exploring the medical taxonomy of the psychiatric diagnosis of general Post-Traumatic Stress Disorder (PTSD) (chapter two) and more specifically PTSD following childbirth (chapter three). These chapters critically explore the underpinning theoretical frameworks of PTSD and how these have been applied to PTSD following traumatic childbirth events. In addition, it examines whether PTSD with the determined etiological agent of a traumatic childbirth experience is qualitatively different to alternative traumatic events precipitating PTSD diagnosis. Using a three-dimensional organisational framework

(Slade, 2006) chapter three provides an outline of the possible antecedents, and consequences of PTSD following childbirth.

Becoming a mother is a multi-dimensional, transitional process in a woman's life, with the rise and development of the biomedical perspective the complexity of the involved social processes and transitions are less attended to in the current literature into traumatic childbirth. Chapter four critically explores the contextualisation of women's experiences of childbirth and motherhood within alternative paradigms. Using fictional and personal accounts as examples, this chapter critically evaluates the social perspective in framing and understanding women's construction and re-construction of beliefs (hopes and expectations) about the childbirth experience in response to wider social and cultural norms and ideas. In addition, the transition to motherhood, which involves multiple social and psychological processes, is explored through a critical evaluation of a number of the theoretical accounts of this transition. These include van Gannep's (1960[1909]) 'Rites of Passage', and Rubin's (1967) and Mercer's (2004) 'Maternal Role Attainment (MRA) and 'Becoming a Mother' (BAM) frameworks. This chapter also explores the 'good/ideal' mother discourse, a contemporary, socially constructed and culturally pervasive discourse in the U.K (Miller, 2007). It explores how this discourse is created and maintained, and explores the potential impact on mothers' experiences. However, the biomedical, social, cultural, and even the psychological broad perspectives and theoretical accounts of childbirth present in the literature tend to negate the individual, idiosyncratic, emotionally rich personal experiences of traumatic childbirth, and these unique representations of the experience are currently under-valued both in research and in practice. Theses perspectives are also not experienced in isolation, instead they impact in differing ways on women and their framing and understanding of childbirth. This chapter concludes with a section outlining the lens used in this thesis in researching motherhood and valuing the voices of women. Giving a brief

description of the feminist theoretical positioning it highlights the focus on the individual experiences and the rationale for doing so.

The first study is presented in chapters five (introduction), six (methods) and seven (analysis and discussion) in this thesis, it explores how Health Visitors frame and understand perinatal mental health problems. It is presented first as Health Visitors are more closely associated with the medical and scientific perspective. Health Visitors play a primary and pivotal role within health and social care in the perinatal period, and have a recently extended remit to detect, identify, support, and refer in instances of perinatal mental health problems (Department of Health, 2012; Jomeen et al., 2013) and are positioned well in under-taking this role (Noonan, Galvin, Doody, & Jomeen, 2017). Thus, chapter five, is an introduction and brief literature review, and explores perinatal mental health care provision and the Health Visiting profession by outlining policies, procedures, and research associated with U.K. Health Visitors' roles and responsibilities in relation to caring for families where perinatal mental health problems are a concern.

Chapter six presents the methods used in the gathering and analysis of data for the Health Visitor study (study one). This study involved two focus groups with a combined number of ten female Health Visitors, recruited from a single Trust. The initial primary aim was to explore Health Visitors' knowledge and understanding of PTSD following childbirth. However, due to the reticence of participants to discuss PTSD following childbirth the research question was changed, prior to analysis, to focus more broadly on how Health Visitors frame and understand perinatal mental health problems. Data from this study was analysed using the six-stage analytical framework of thematic analysis outlined by Braun and Clarke (2006).

Linking explicitly with chapters five and six, chapter seven presents the findings of the thematic analysis of focus group data which explored how Health Visitors frame and

understand perinatal mental health problems. The thematic analysis constructed an over-arching theme of a 'Protecting an Uncertain Professional Identity', which evidences areas of incoherence and instability in the professional identity of Health Visitors in this study, especially in relation to their knowledge of, and role in, perinatal mental health care. This finding is supported by the previous literature, outlined in chapter five, which indicates that the professional identity in Health Visiting has been marred, historically and currently, with ambiguity and confusion (Billingham, Morrell & Billingham, 1998; Cowley et al., 2015). The two sub-themes presented as part of the thematic analysis include: 'The role of Health Visitors in perinatal mental health care', which explores the concepts of responsibility, accountability, capability, and risk; and the how these impact on Health Visitor's professional practices and personal reflections. The second sub-theme; 'The Knowledge Narrative' discusses three key forms of knowledge (technical, experiential and relational) identified through the analysis, it also encompasses Health Visitors' perception of their own and others value of these types of knowledge. 'Knowledges' and how these are transacted in practice relating to perinatal mental health problems are discussed in this chapter.

Study two of this thesis explores how mothers frame and understand their traumatic childbirth experiences. Presented in chapter eight, nine and ten, this study demonstrates a movement away from the medical perspectives of childbirth and trauma, instead emphasising the mother's subjective framing, appraisal and understanding of her traumatic childbirth experience. Chapter eight presents the method of the post-natal mothers' study (study two). Twelve mothers who had experienced a self-perceived traumatic childbirth in the previous six-months were recruited through social media. They were interviewed face-to-face about their childbirth expectations, traumatic childbirth experiences, and the impact of these in the post-natal period. This study presents analysis which focused on the mothers' personal narratives of their traumatic childbirth experiences. These were explored using narrative

analysis due to being synonymous with storytelling, its diverse utility, and that it fragments the data less than some of the alternative qualitative analytical methods.

Chapters nine and ten present the narrative analysis of the post-natal mothers' study (study two). Provided in two sections (chapter nine – section one and chapter ten – section two), each describes a key theoretical conceptualisations of traumatic childbirth experiences constructed through the narrative analysis of mother's individual traumatic childbirth stories.

Chapter nine explores traumatic childbirth through van Gannep's (1960) Rite of Passage framework, outlining the experience of the liminal space, and the implicit distinction between the 'creation of a mother' (the physical birth of a baby) and 'entering motherhood' (the psychological and emotional connection with the birth experience and the beginning of the integration of the experience into the motherhood identity). The traumatic childbirth creates a fracture or biographical disruption in the socially constructed 'normative' childbirth narrative, creating an ambiguous, void-like, transitional period of acute liminality. The analysis also explores strategies implemented by women who had experienced a traumatic childbirth, to move out of acute liminality into a period of normative sustained liminality. These included; re-storying, re-telling, and the re-incorporation of medically-based, but socially and culturally embedded rituals associated with childbirth in the U.K. into their personal experiences. These three strategies seem to aid women by giving them the time and space to psychologically and emotionally connect with their new role and identity to 'enter motherhood', and move into a more 'normative' period of sustained liminality – a part of their transition into motherhood.

The second section of narrative analysis is presented in chapter ten and explores the medically-based contextually-bound interpretive repertoires used by women in their traumatic childbirth narratives to combine public understanding and personal experience. This analysis highlights how dominant medical, obstetric discourses have become normalised

aspects of the childbirth experience (Oakley 2016), and thus are utilised by women as common and pervasive discursive devices (Potter, 1996) in their traumatic childbirth narratives. Using obstetric discourses as discursive tools allows mothers to create a validation of their personal experiences, and legitimises the value of their personal experiences, both on an individual, interpersonal level within the narratives, and more broadly within the research arena. The first presentation of this analysis is an exemplar narrative, which demonstrates the explicit and consistent use of tropes situated within the medical, obstetric conceptualisation of childbirth. This represents and demonstrates the dilemmatic qualities of traumatic childbirth narratives in attempting to balance unique and personal experiences within the broad, often conflictual conceptual and contextual discourses surrounding childbirth. Subsequently this section of narrative analysis explores women's use of the cervix as a discursive resource within their narratives of traumatic childbirth experiences. This demonstrates how in their narratives of experience women integrate the dominant medical and social conceptualisations, which are often artificially divided and considered (Schmeid & Lupton, 2001; Oakley, 2016). The discussion explores how women manage the tensions and divisions surrounding reproductive labour, and how they incorporate the dominant biomedical conceptualisation of childbirth into their narratives in an attempt to reclaim some of the knowledge, power and control over their bodies and childbirth experiences which traditionally have been situated with the biomedical perspective. In turn, the influence of this management on their traumatic childbirth experiences is discussed in relation to the positive and negatives implications for the individual woman.

In a unique challenge to more traditional forms of knowledge creation and research dissemination, chapter eleven uses arts-based research methods to provide an alternative paradigm. It presents novel representations of the traumatic childbirth narratives with associated reflective commentaries. It has been created as a result of my reflections during

the research processes and analysis involved in the post-natal mothers' study (study two) exploring traumatic childbirth experience from the perspective of the mother. These reflections stemmed from my concern that the more traditional forms of qualitative research analysis were fracturing and diluting aspects of the data, and therefore this gave rise to a need to present and disseminate all the 'data' from this study in a different form. This 'form' of presentation needed to be able to represent the data in shorter, contextually whole, subjective, emotional accounts whilst retaining the original participants' words. Enabling a demonstration of the incredible value and impact of the voices and narratives of those with lived experience.

I was (and still am) moved by the traumatic childbirth narratives throughout the research process and I felt that aspects of the unique context, subjectivity, and emotionality of the individual accounts has become somewhat diluted during the research processes. Drawing on parallel ideas to those used by critical health psychology in action research, and embracing the interactive nature of the data construction, between myself as a researcher, and the participant as an expert by experience, I decided to combine science and art to create unique and novel representations of the data. These novel representations consider all the study 'data' in the creation and presentation of each unique contextualised narrative, with an emphasis on the emotional experiences. This in turn, allows the audience 'empathetic entry' into the lived experience of another, creating an additional layer of understanding and knowledge about traumatic childbirth, that has traditionally been given little weight in the research and practice arenas.

Signifying the researcher's personal embracement and comfort with qualitative methodologies, and reflective of the feminist perspective, chapter eleven draws on arts-based methods (poetry) to represent the narrative data in subjective, entire and emotive forms for each of the mothers who participated in this study. Embracing the voices of the mothers, my

own reflective reactions, and a consideration of the audience's reactive reflections, novel representations of each mother's traumatic childbirth narratives creates a unique emotional capture of the individual experiences. Poetic representations were chosen for their heuristic value in exemplifying the whole subjective and emotional elements of each of the traumatic childbirth narratives. It is an accessible and evocative form of data dissemination, which retains the value of the mother's words. The poetic form within arts-based research has been used previously (Ohlen, 2003), however the intricacies of the method of creating the poems and the associated reflective commentaries are unique to this thesis.

Chapter eleven presents a rational, reflective account, and the analytical procedure associated with the novel poetic representations of the traumatic childbirth narratives. Following this, each narrative is represented individually, with three accompanied by reflective commentaries which each discuss one of the three unique contributions of this arts-based method of representing research data. These are the entirety, the subjectivity, and the emotionality of the traumatic childbirth narratives.

Chapter twelve provides a short discussion for each of the studies presented in this thesis, highlighting the implications for practice, policy and future research. It then brings together all of the information presented throughout the thesis to provide an overall discussion and conclusion. In summary, the research reported in this thesis qualitatively explores traumatic childbirth from the personal perspective of both Health Visitors and mothers. This provides a counter-balance to the dominant medicalisation discourse of childbirth, the de-personalization of maternity healthcare (Kitzinger, 2012), and the under-representation of women in research. Exploring personal, individual accounts from both professionals (Health Visitors) involved in traumatic childbirth and mothers who have experienced it, this thesis provides an demonstrative example that when exploring traumatic childbirth, it is impossible to dichotomize many of the prevailing perspectives and discourses

associated with childbirth and mental health (as outlined in chapters one, two and three). From a feminist perspective it critically examines the biopsychosocial landscape of the research and demonstrates how women's professional and private experiences of traumatic childbirth and perinatal mental health problems integrate the artificially created dimensions (Oakley, 2016; Schmeid & Lupton, 2001) between public medical and social factors associated with childbirth. This relates to the findings from this thesis, which suggest this enmeshment of perspectives is replicated when considering scientific, objective, medically-based traditional knowledge, and the subjective, holistic individual experiential understanding and knowledge of traumatic childbirth. Final conclusions propose that there is need for parity of esteem between these two types of understanding and knowledge in relation to traumatic childbirth, as each perspective brings a unique view, and a layered understanding of traumatic childbirth is critical.

The findings from this thesis are useful for consideration in health-care practice, specifically in relation to perinatal mental health-based training for Health Visitors, and deepening the knowledge of the uniqueness of experience for mothers who experience a traumatic childbirth. Although a limitation of the findings from the post-natal mothers' study is that all of the participants were white, educated women in long-term relationships, although generalisability is not a primary aim of qualitative research, this understanding does limit the extrapolation of findings. The poetic representations have utility in multiple areas, but most applicable is in health-care education when exploring the 'expert by experience' perspective. The findings have been used within teaching sessions for undergraduate midwifery students, however the impact and utility of this needs further investigation.

Main aim and associated objectives

1) Aim: To critically evaluate the biomedical perspective in framing and understanding traumatic childbirth.
   Objective: To assemble a critical literature review of the medical taxonomy, the scientific theoretical underpinnings, and the empirical research surrounding PTSD following childbirth.
2) Aim: To critically evaluate and contextualise women's experiences of childbirth within the alternative (to the biomedical) perspectives of childbirth.
   Objective: To assemble a critical literature review which contextualises women's experiences of childbirth within alternative perspectives.
3) Aim: To utilise feminist, qualitative research methods which allows for the exploration of women's experiences of traumatic childbirth and perinatal mental health problems.
   Objective: To carefully select appropriate research methods which decrease the power imbalances and provide avenues to explore the value of women's voices in research.
4) Aim: To explore the policies, practices and research outlining U.K. Health Visitors' (HVs) roles and responsibilities in caring for families with perinatal mental health problems.
   Objective: To assemble an overview of the literature on 1) maternal mental health care provision in the U.K., 2) the history and associated principles and policies associated with the Health Visiting profession, and 3) examine Health Visitors' (HVs) roles and responsibilities in perinatal mental health.

5) Aim: To explore how Health Visitors (HVs) frame and understand their professional roles and responsibilities in perinatal mental health, with a focus on PTSD following childbirth.

   Objective: To collect Health Visitors (HVs) accounts of perinatal mental health problems, and undertake a thematic analysis to represent Health Visitors' professional experiences of perinatal mental health problems.

6) Aim: To explore how mothers frame and understand traumatic childbirth experiences.

   Objectives: To use semi-structured interviews with women who have experienced a self-perceived traumatic childbirth to generate individual, rich accounts of their experiences. To undertake a narrative analysis to represent women's framing and understanding of their unique, lived experience of traumatic childbirth.

7) Aim: To disseminate the traumatic childbirth narrative using a creative, arts-based method to capture the aspects of the data which became fractured and/or diluted with the use of more traditional, qualitative methods.

   Objective: To design and utilise a method of creating poetic representations of narratives in a way in which the entirety, subjectivity and emotionality of accounts are retained.

CHAPTER TWO

General Literature Review

Post Traumatic Stress Disorder (PTSD): Conceptualisation and Diagnosis

This chapter aims to critically explore the medical, psychiatric diagnosis of Post-Traumatic Stress Disorder (PTSD) and the associated theories. This is achieved through the assembly of a critical literature review exploring the medical taxonomy of the psychiatric diagnosis of PTSD, and how this is underpinned by a number of theoretical frameworks. The phenomenology of PTSD has historically been explained by a range of theories, and more recently three broad, multi-representational frameworks are suggested as the most comprehensive theoretical accounts. These are: Dual Representation Theory (Brewin, Dalgeish & Joseph, 1996), Emotional Processing Theory (Foa & Riggs, 1993; Foa & Rothbaum, 1998), and Ehlers and Clark's (2000) Cognitive Model of Post-Traumatic Stress Disorder (PTSD). All three of these trauma-centric theories explore human cognition and memory, focusing specifically on the differences between trauma-based and normative autobiographical memories.

A medical diagnosis of PTSD can be constructive and valuable in that it provides a biocentric model of causality, a universal and organised understanding of associated symptomology, and thus outlines medical, evidenced-based treatment interventions. This in turn, allows for an exploration of a theoretical basis for the development of the disorder following a traumatic incident/s. However, the dominance of the scientific, medical approach to psychiatry is not without issue. Trauma can have multiple biological, psychological, and social consequences and through the creation of a criterion-based scientifically and medically dominated organisational, universal framework the complexities of the experience and impact on an individual becomes reduced to a broad, symptom focussed disorder, based on theoretical, scientific assumptions. The medical perspective not only draws the focus away from the experience of the individual, but it also does not account for, or acknowledge, those who have been traumatised, but have not received a diagnosis of PTSD, either through a lack of assessment or because their symptomology does not meet the fixed criterion of the DSM-5

(APA, 2013) or ICD-11 (WHO, 2018). In medical terminology we might call this population sub-symptomatic. Through the categorisation and reductionism of the diagnostic criteria of PTSD, and the proposal of cognitive, scientific theoretical framework to provide phenomenological explanation, the unique, personal experiences of individuals are minimised.

Post Traumatic Stress Disorder (PTSD): The diagnosis.

This section provides an overview of what Post-Traumatic Stress Disorder (PTSD) is, as informed by the Diagnostic and Statistical Manual of Mental Disorders version 5 (DSM-V; APA, 2013). The International Classification of Diseases (ICD) also provides diagnostic criteria for PTSD, which are similar to the DSM, but less detailed. The ICD-11 (WHO, 2018) has recently been released for use by member states and other stakeholders, however it is still under translation and review. For further information and a description of PTSD see 'The ICD-11 Classification of Mental and Behavioural Disorders', section 6B40 Post Traumatic Stress Disorder (WHO, 2019).

Post-traumatic Stress Disorder (PTSD) was first included in the Diagnostic and Statistical Manual of Mental Disorders in 1980 (DSM-III; APA, 1980). This version stated that the etiological agent needed to be an experience outside of normal/usual human experience. The current DSM-5 (APA, 2013) provides the following criteria for a diagnosis of PTSD:

Table 2.1: Criteria imported from DSM-5 (2013) for a diagnosis of Post-Traumatic Stress Disorder (PTSD) (DSM-5; APA, 2013).

Criterion	
Criterion A.	Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1) Directly experiencing the traumatic event(s). 2) Witnessing, in person, the event(s) as it occurred to others. 3) Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental. 4) Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse.
Criterion B	Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred: 1) Recurrent, involuntary, and intrusive memories of the traumatic event(s). 2) Recurrent distressing dreams in which the content and/or effect of the dream are related to the traumatic event(s). 3) Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were reoccurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) 4) Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s). 5) Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
Criterion C	Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, evidenced by one or both of the following: 1) Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s). 2) Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Criterion D	Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: 1) Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs). 2) Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g. "I am bad", "No one can be trusted", "The world is completely dangerous", "My whole nervous system is permanently ruined".) 3) Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others. 4) Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame). 5) Markedly diminished interest or participation in significant activities. 6) Feelings of detachment or estrangement from others. 7) Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings)
Criterion E	Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: 1) Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects, 2) Reckless or self-destructive behaviour. 3) Hyper-vigilance. 4) Exaggerated startle response. 5) Problems with concentration. 6) Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
Criterion F	Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
Criterion G	The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Criterion H	The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

The publication of DSM-V (APA, 2013) revealed changes in the criterion for PTSD, including the addition of two sub-types: preschool (under the age of 6 years), and dissociative (the experience of depersonalization or derealisation). The disorder moved from the anxiety

category to a new distinct category named Trauma and Stress Related Disorders, and the experiences of dysphoria (a state of unhappiness and unease - symptom D_4), anhedonia (an inability to feel or express pleasure - symptom D_7) (National Centre for PTSD, 2013), and distorted blame (Friedman, 2013) were highlighted. PTSD can be acute, chronic (lasting more than six months), or present in 'delayed expression' forms (symptoms manifest more than six months after the trauma) (DSM-V; APA, 2013). Eighty percent of clients with PTSD also present with co-morbid psychological disorders (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995; Brady, 1997). In the U.K. it is estimated that 1 in 3 people who experience a traumatic event will develop PTSD (NHS, 2013).

There has been some debate surrounding the concept of subthreshold PTSD (Cukor, Wyka, Jayasinghe & Difede, 2010), which also draws attention to the idea of medicalisation and raises the question: by having a mental health disorder called PTSD, is the human reaction to trauma pathologised? Conversely, by creating a set of discrete diagnostic criterion for a diagnosis of a mental health disorder, which then informs the choice and prescription of treatment, are a number of people with subthreshold PTSD being marginalised and precluded from recognition and treatment?

Historically feminist criticisms of the PTSD diagnostic criterions focused on the 'outside of normal/usual human experience' requirement, as this excluded events which primarily impacted on women (Brown, 2001). In an examination of psychic trauma Brown (2001) discussed the complex feminist proposals of a difference between male, public trauma, such as war, and the personal, often secret traumas, such as rape and domestic violence, often experienced by women, and whether these latter experiences could be appraised as 'outside of normal human experience'. A further criticism of this formulaic-type diagnostic criteria is that it does not account for the differences in symptom presentation and intensity experienced by people with PTSD. In addition, although the criteria for diagnosis

draws on aspects of experiencing thoughts and beliefs around blame and responsibility, it does not explore or recognise some of the interpersonal and social realities of trauma and mental health. Therefore, concentrating on a medical diagnosis in relation to the consequences of trauma creates a focus on a limited aspect of the impactful post-trauma experience.

Post-Traumatic Stress Disorder (PTSD): Theoretical accounts

A coherent and useful theory of PTSD needs to explain the phenomenology, symptoms and associated features, and the course of reactions to trauma. It also needs to explain the efficacy of associated or already developed treatment approaches (Cahill & Foa, 2007), for example; Cognitive Therapy, Cognitive Behavioural Therapy (CBT), Exposure Therapy, and Eye Movement Desensitisation and Reprocessing (EMDR) (Spector & Read, 1999).

Early theories of PTSD include: Conditioning theories (e.g. Keane, Zimering & Caddell, 1985; Kilpatrick & Veronen, 1985; Barlow, 1988) which use classical and instrumental conditioning concepts to explain acquisition of fear and anxiety. Schema theories, such as the stress response theory (Horowitz, 1976, 1986), and the theory of shattered assumptions (Janoff-Bulman, 1992) draw upon "the concept of schemas, that is, core assumptions and beliefs that guide the perception and interpretation of incoming information" (Cahill & Foa, 2007, p. 59). The main premise of schema theories is that a discrepancy exists between prior core assumptions/beliefs, and incoming trauma information (Brewin & Holmes, 2003). Through assimilation (processing external information so it 'fits' with internal knowledge) and accommodation (changing internal knowledge to accommodate external information) (Piaget, 1971) modification of existing schemas occurs. 'Information-processing' theories of PTSD concentrate on the event and the idiosyncratic representation of

the event within memory. They draw upon perspectives which concentrate on physiological reactions, as demonstrated in the evolutionary perspective of trauma (Chemtob et al., 1988) and the creation of a persistent physiological state of arousal and fear activation which "violates formerly held basic concepts of safety" (Brewin & Holmes, 2003, p. 349). The Fear Network Approach is another example (Foa, Steketee & Rothbaum, 1989).

In summary early theories can be placed in three distinct categories: conditioning theories where fear and anxiety is created and maintained through learned associations and avoidance; social-cognitive theories where trauma information needs reconciliation with previous beliefs/assumptions; and information-processing theories where encoding, storage and recall of the trauma event are disrupted, and have consequences for responses to trauma associated stimuli (Brewin & Holmes, 2003). These early theories have not been discredited, and they have provided an excellent basis for, and stimulation of, further more detailed and rigorous research into the area of PTSD. Due to the tendency of these older theoretical frameworks to focus on the processing of trauma related information, they tended to lack the ability to explain some of the more specific symptoms of PTSD for example flashbacks and disorganized memories of the trauma event (Brewin & Holmes, 2003).

Dual Representation Theory (DRT) of Post-Traumatic Stress Disorder (PTSD).

The Dual Representation Theory (DRT) of PTSD (Brewin, Dalgleish & Joseph, 1996) combines social-cognitive and information-processing perspectives. It is a broad theoretical framework, including normative and pathological responses to trauma. The theory proposes a dual memory system (see figure 1.1) involving two sets of qualitatively different memories, which work at the same time, however at times one or the other may take priority in memory integration and retrieval. These are Verbally Accessible Memories (VAM), which, as Brewin and Holmes (2003) outline:

> Contain information that the individual has attended to before, during, and after the traumatic event, and that received sufficient conscious processing to be transferred to a long-term memory store in a form that can later be deliberately retrieved (p.356).

And Situationally Accessible Memories (SAM), again outlined by Brewin and Holmes (2003) as:

> Information that has been obtained from far more extensive, lower level perceptual processing of the traumatic scene, such as sight and sounds (also the person's bodily responses to the trauma) that were too briefly apprehended to receive much conscious attention (p. 357).

This theory addresses how and where memories related to trauma are processed and stored, and the consequences of this for both normative responses to trauma and PTSD symptomology (Brewin et al., 1996). This model displayed below (figure 2.1) demonstrates how trauma is processed within memory and the possible outcomes.

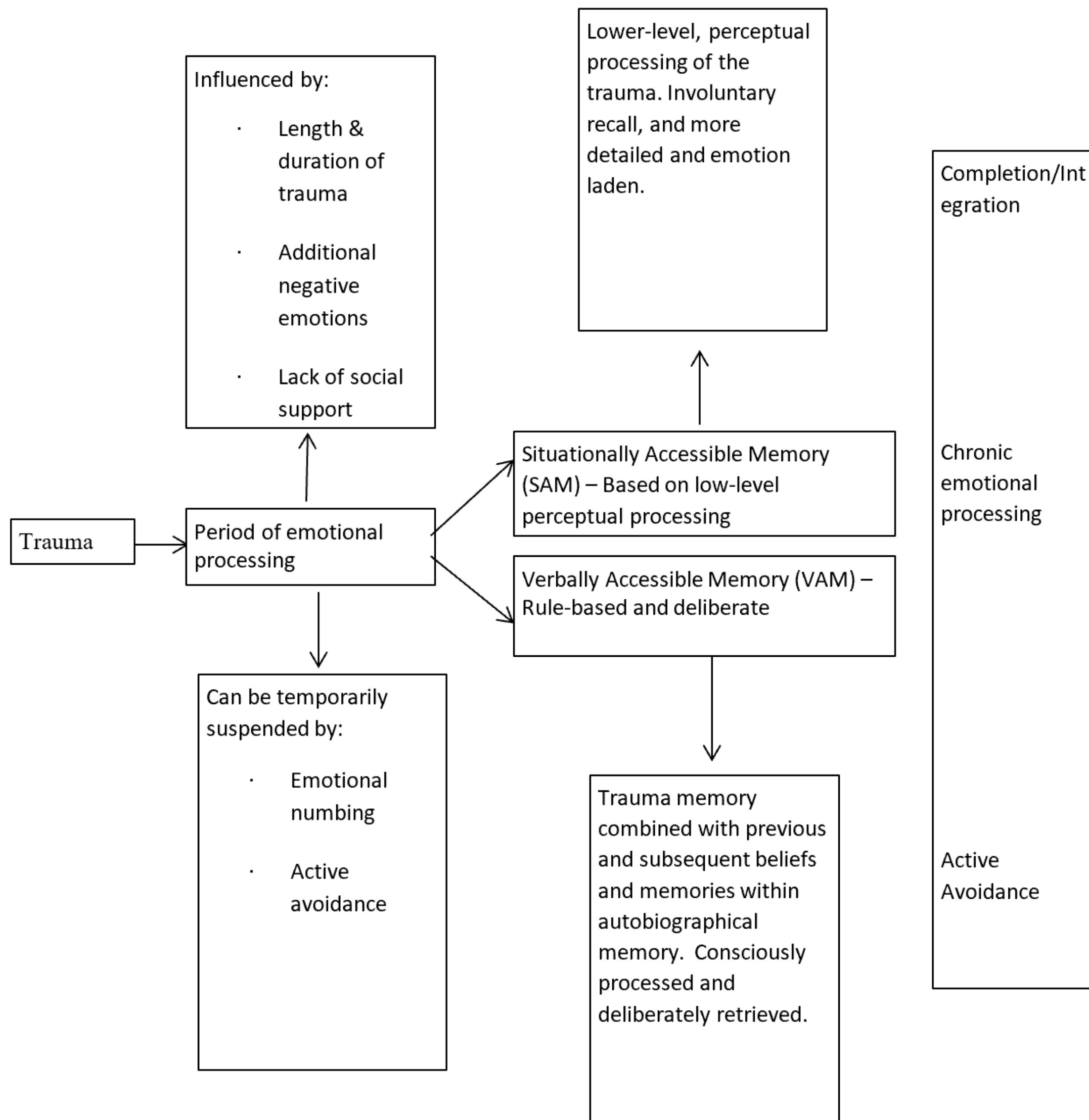


Figure 2.1: A model portraying emotional processing following a trauma, as described by the Dual Representation Theory (DRT) of Post-Traumatic Stress Disorder (PTSD) (Brewin et al., 1996).

The link between emotions and memory within DRT explain findings that clients with PTSD present with differing trauma memory forms (Brewin, 2001). These can be detailed, vivid account of specific aspects of the trauma – “flashbulb” memories (an example of SAM), but memories can also present as general fragmented, disorganized narratives of the

trauma (an example of VAM). The influence of hormones in emotion and memory supports DRT as there are two consequences of heightened stress: 1) substantial impairment which can be linked to people having gaps in their memories of the trauma event and, 2) increasing memory for central stimuli, whilst decreasing peripheral stimuli (Christianson, 1992), which accounts for the symptoms of 'flashbacks'. Different memory systems explain PTSD symptoms of difficulties in intentional, comprehensive and ordered narratives of the event, and unintentional intrusions or flashbacks, which often contain sensory and very specific details of the traumatic event. Indeed, research by Hellawell and Brewin (2002) explains that 'flashbacks' are believed to only be automatically and not deliberately accessed, and they also contain more visuospatial information and involve perceptual processing which needs little conscious processing; therefore they are more detailed and based on central rather than peripheral stimuli.

Empirical research evidence suggests that heightened stress impacts on hormones (Woodson, Macintosh, Flashner, & Diamond, 2003), which in turn affects hippocampus-learning causing fragmented conscious memories. DRT proposes two distinct neuronal pathways (LeDoux, 2003): 1) through the hippocampus, which is inhibited by heightened emotion – the verbally accessible memory system (VAM). 2) Directly through the amygdala, this initiates immediate reactions not influenced by emotion – the neuronal pathway for situationally accessible memories (SAM). A revision to DRT was made by Brewin, Gregory, Lipton and Burgess (2010) through situating DRT within a 'neurobiological model of normal memory and imagery' (Byrne, Becker & Burgess, 2007). The model examines enhanced involuntary visual intrusions which occur in many psychological disorders, not just PTSD. The basic premise is that for involuntarily accessed SAMs there are distinct neuronal pathways involved (subcortical structures and areas associated with perception i.e. visual cortex and thalamus) in comparison to the deliberately

retrieved conscious experiences contained in VAMs, which involve prefrontal areas of the brain and medial temporal lobe structures, such as the hippocampus. These distinct neuroanatomical pathways provide neurobiological evidence of a dual memory system.

Dual Representation Theory (Brewin et al., 1996) describes three potential endpoints of emotional processing (see figure 2.1) (Brewin et al., 1996). The first and ideal outcome is 'completion/integration'. Trauma memories are fully processed and integrated into memory through repetition and understanding of the event, evidenced by the cessation of overwhelming emotions, and an ability to tolerate SAMs in consciousness. A period of profound readjustment, encompassing the concept of Post-Traumatic Growth (PTG) (Park & Helgeson, 2006) may also occur. The second endpoint is chronic emotional processing, occurring due to the trauma information and prior knowledge being so distinct sufficient integration cannot occur, or there is a lack of cognitive capacity to integrate trauma-related information (Brewin & Holmes, 2003; Brewin et al., 1996). It results in chronic PTSD, and the probability of co-morbid disorders. The third endpoint is 'premature inhibition of processing' – the surface remission of PTSD symptoms due to both active and automatic avoidance of trauma-related SAMs and VAMs, whereby the majority of symptoms are seemingly extinguished, however it causes the reoccurrence or delayed onset of PTSD symptoms (Andrews, Brewin, Philpott & Stewart, 2007).

In summary PTSD occurs as a result of a failure of both VAM and SAM systems. High levels of stress and arousal during the trauma event can interfere with normal processing and thus cause poor VAM representations. This prohibits the integration of the trauma event and pre-existing knowledge which is required for a 'normal' trauma response (Brewin, 2001). Failure of the SAM system occurs when a lot of the trauma information is represented only in this system. Thus information is then unavailable for integration with

previous knowledge and information, and is also likely to be reactivated involuntarily by trauma-related cues (Brewin, 2001).

Brewin et al. (1996) suggest that ‘chronic emotional processing’, and ‘premature inhibition of processing’ occurs due to the distinct nature of trauma information and prior knowledge deterring sufficient integration. Or internal and external issues that prevent the processing of trauma knowledge. These are; competing demands, additional secondary emotions, nobody to confide in/unwillingness to confide, age, or on-going trauma. The recovery process has two goals; “(1) altering negative secondary emotions resulting from unhelpful appraisals of the trauma and the person’s reactions during and afterward, and (2) preventing the automatic activation of SAM memories of the trauma” (Cahill & Foa, 2007, p.69). Although theoretically these goals lend themselves to both cognitive restructuring and exposure therapy, dual representation theory does not specify a framework for a single therapeutic intervention for the treatment of PTSD, unlike alternative contemporary theories of PTSD. Instead it advocates two therapeutic focuses; addressing automatic retrieval and flashbacks, and correcting verbal reasoning and negative appraisals, and that these may be most effectively treated using differing therapeutic techniques (Brewin & Holmes, 2003).

Emotional Processing Theory of Post-Traumatic Stress Disorder (PTSD).

Emotional processing theory (Foa et al. 1998; Foa & Riggs, 1993; Foa & Rothbaum, 1998) of PTSD is a comprehensive and explanatory theory, linked with prolonged exposure therapy which is an effective treatment option for PTSD (Powers, Halpern, Ferenschak, Gillihan & Foa, 2010). Highlighting the emotional processing of trauma (Foa, Hembree & Rothbaum, 2007) there are two aspects to this theory. The first draws on Lang’s (1977, 1979) bio-informational theory of a network of fear structures within memory; “The elements of such a structure are viewed as cognitive representations of the stimulus characteristic of

the fear situation, the individual's responses in it, and aspects of meaning for the individual" (Foa & Kozak, 1986, p.20). Fear responses are caused by activation of the fear network through environmental stimuli. Indeed, "Foa and Rothbaum (1998) proposed that the fear structure of PTSD includes excessive stimulus and response elements as well as pathological meaning elements" (Rauch & Foa, 2006, p.61). The second aspect concentrates on cognitive elements, and is outlined by Brewin & Holmes (2003) review paper. Emotional processing theory postulates a predisposing risk factor of rigidity of views pre-trauma (either positive or negative), involving rigid ideas about the self and the world. These are either contradicted or confirmed by traumatic event information. Pre-trauma views interact with negative appraisals of the trauma event, and behaviours and symptoms elicited by this event. This interactive combination of views and appraisals combine to create and maintain symptoms of PTSD (Brewin & Holmes, 2003).

Emotional processing theory informs prolonged exposure therapy in the treatment of PTSD (Rauch & Foa, 2006). This intervention involves the activation of fear memories, so corrective information can be provided for integration, thus modifying original fear memories. This intervention allows for a reduction in physiological reactions and changes in the subjective meanings associated with the trauma (Foa et al., 1989). Repeated exposures produce both automatic and strategic effects (Brewin & Holmes, 2003), including, habituation of fear, viewing the trauma as an isolated incident, self-mastery and courage, prevention of avoidance of memories, incorporation of safety information, creating a more integrated and less fragmented memory of the event, and rejection of "previous negative evaluations" (Brewin & Holmes, 2003, p.353). It requires extensive exposure to create emotional engagement (Hembree et al., 2003), this is created through psycho-education and imagined or in-vivo exposure to the trauma (Hembree et al, 2003). Within therapy, barriers to treatment include; under and over-engagement, avoidance of fear activation, over-

activation of fear structures preventing emotional engagement, and lack of habituation (see Rauch & Foa, 2006). Overall there is substantial evidence of the efficacy of exposure therapies in the treatment of PTSD (Foa, Keane & Friedman, 2000). Prolonged exposure therapy has been demonstrated as producing faster and more effective outcomes in reducing PTSD symptoms than Eye-Movement Desensitisation and Reprocessing therapy (EMDR; for more information see Shapiro, 1989) and relaxation training (Taylor et al., 2003). In addition, Paunovic and Ost (2001) demonstrated little, if any difference in the efficacy of exposure therapy in comparison to trauma-focused CBT (which has the largest empirical database of all PTSD treatments; NICE guideline NG 116, 2018). There does however seem to be a clinician reluctance to using exposure therapy in practice. Feeny, Hembree and Zoellner (2003) argue that this is due to unsubstantiated myths surrounding its clinical use and there are no more ‘barriers’ to this treatment than any other psychological therapies.

Ehlers and Clark’s (2000) Cognitive Model of Post-Traumatic Stress Disorder (PTSD).

One of the most comprehensive, empirically supported, and treatment specific theories of Post-Traumatic Stress Disorder (PTSD) is Ehlers and Clark’s (2000) cognitive model. Based on a model of persistence, it suggests that PTSD is caused when an individual processes the trauma in a way that leads to the perception of threat (either external or internal) as being current. The model explains the main clinical symptoms of PTSD, and provides a theoretical basis and framework for using Cognitive-Behavioural Therapy (CBT) in the treatment of PTSD (Brewin & Holmes, 2003). The two main mechanisms of this theory are (1) individual differences in both negative appraisals of the trauma and/or its sequelae, and (2) the storage of the trauma memory within autobiographical memory (Ehlers & Clark, 2000). Maintenance of mechanisms through maladaptive behavioural and cognitive processing strategies causes a circular process of PTSD symptom persistence. Both

theoretical mechanisms, and the associated behavioural and cognitive processing strategies need to be addressed and modified (Brewin & Holmes, 2003). This is realised in various therapeutic interventions within the paradigm of CBT (Ehlers & Clark, 2000).

Strong negative appraisals include; negative ideas about the event (i.e. overgeneralisation of danger), and negative appraisals about the ramifications of the trauma (i.e. the interpretation of symptoms, others' reactions, and consequences for the self) (Brewin & Holmes, 2003). These in turn influence emotional responses, including; fear, anger, sadness, shame, and guilt (Ehlers & Clark, 2000). Appraisals are influenced by both cognitive processing during the trauma, and prior experiences and beliefs (Brewin & Holmes, 2003). Ehlers and Clark (2003) provide four cognitive processes occurring during trauma which may negatively impact on appraisals, and thus PTSD symptoms. These are; (1) dissociation, (2) a lack of cognitive capacity so memories are encoded at a "default 'true' value", (3) a lack of conceptual memory processing and mental defeat, and (4) a loss of autonomy, which "refers to the victim's perception that she gave up in her own mind and was completely defeated" (Elhers, Clark, Dunmore, Jaycox, Meadows & Foa, 1998, p.461).

Clinical PTSD involves contradictory presentations of trauma memory. Intentional recall of trauma memories often includes substantial gaps, amnesia and fragmentation (Gray & Lombardo, 2001). In contrast, involuntary recall (flashbacks) triggered by internal or external cues (Ehlers, Hackmann & Michael, 2004) involves highly sensory "here and now" re-experiencing of the trauma (Ehlers & Clark, 2003). Ehlers and Clark (2003) and Brewin et al., (1996) suggest that these are caused by the autobiographical memory system having two retrieval routes. Although similar to VAM and SAM conceptualisations presented within the DRT of PTSD, this model specifically examines the retrieval of memories, whereas DRT examines both storage and retrieval of memory. Normal memory processing inhibits unintentional recall and enhances route 1, as portrayed in figure 2.2.

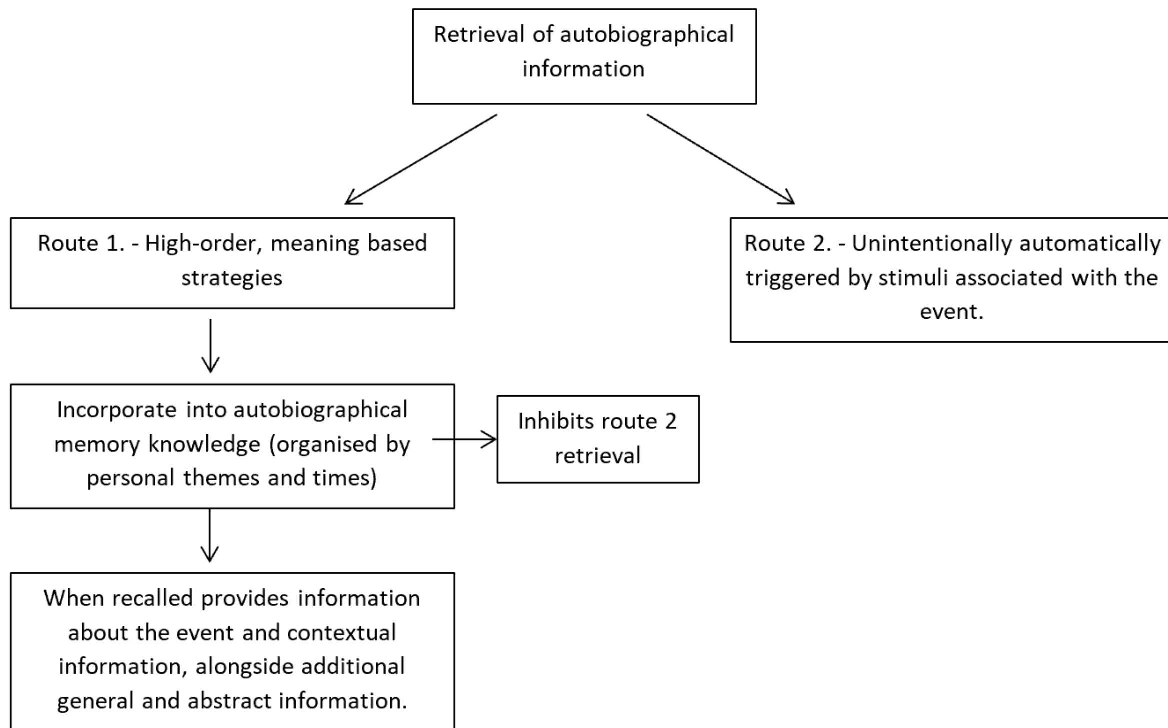


Figure 2.2: Two processing routes for retrieval of autobiographical memories as explained in Ehlers and Clark's (2003) cognitive model of PTSD (Ehlers & Clark, 2000; Ehlers, Heckmann & Michael, 2004; Brewin & Holmes, 2003).

Ehlers and Clark (2003) suggest that the poor elaboration and integration of trauma memories into autobiographical memory causes incoherence. Subsequently individuals with PTSD have problematic intentional recall, and have a lack of previous general and abstracted information to 'make sense' of the event. In addition, encoding of traumatic memories is subjected to stronger than usual perceptual priming, stimulus-response (S-R) and stimulus-stimulus (S-S) associative learning (Brewin & Holmes, 2003). The increasing association between, and heightened observation of cues, causing unintentional recall. Unintentional recall can precipitate both concrete trauma memories, and "affect without recollection" (activation of emotional responses without the awareness of trauma linkage) (Ehlers,

Hackmann & Michael, 2004). This explains the lack of coherent trauma memory, and unintentional intrusive memories (Ehlers et al., 2004)

The reciprocal relationship between trauma memory and appraisals (Ehlers & Clark, 2003) are outlined in figure 2.3. Negative appraisals of the trauma, and the perception of current threat, is maintained through selective attention to memories which adhere to negative appraisals, thus new contradictory evidence is not realised.

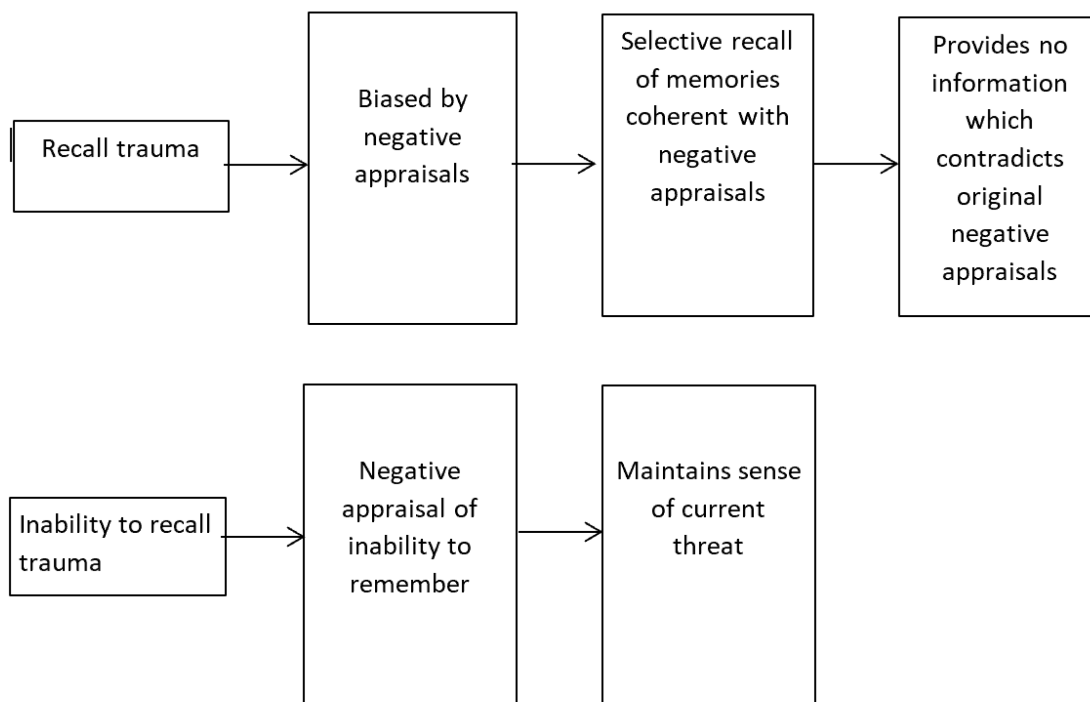


Figure 2.3. Model showing the reciprocal relationship between the nature of trauma memory and negative trauma appraisals as outlined in Ehlers and Clark's (2000) cognitive model of PTSD.

The model presented in figure 2.3 shows how negative appraisals are present with or without the ability to intentionally recall the trauma event. It also shows how negative appraisals of the trauma and/or its sequelae are maintained through selective recall of memories which adhere to the current negative appraisals.

Individuals with PTSD attempt to control the perception of current threat and symptoms of PTSD through maladaptive behaviour and cognitive processing. These strategies actually maintain PTSD symptoms by preventing the change of negative appraisals of the trauma and/or its sequelae, and preventing changes in the nature of trauma memories (Ehlers & Clark, 2000). Examples include, thought suppression, safety behaviours (i.e. cognitive avoidance (Moulds, Kandris, Williams & Lang, 2008)), rumination, dissociation, avoidance, selective attention to threat, and use of alcohol and/or illicit substances (Ehlers & Clark, 2003). Thought suppression maintains symptoms of PTSD and is when a person attempts to stop thinking about a specific stimuli or emotion, and by doing so a paradoxical effect of thinking more about stimuli or emotion occurs (Wegner, Schneider, Carter & White, 1987).

Ehlers and Clark's (2000) model of PTSD provides a comprehensive theoretical framework for Cognitive Behavioural Therapy (CBT). The therapy aims to address both negative appraisals of the trauma and/or its sequelae and the storage of trauma memories, as well as changing maladaptive behavioural and cognitive processing strategies. Problematic appraisals and re-experiencing are decreased through imagery and reliving techniques aimed at reconstructing and elaborating the trauma memory - a process of updating and contextualizing the event. Ehlers et al. (2004) describe this process:

> (1)Identify the moments during the trauma that create the greatest distress and sense of "newness" during recall ("hotspots") through imaginable reliving (or writing a narrative) and discussion of intrusive memories, (2) identify information that updates the impression the patient had at the time either by identifying the course, circumstances, and outcome of the trauma or by cognitive restructuring, and (3) actively incorporate the updating information into the hotspots using verbal and imagery techniques (p.143).

Alongside this, clients are taught awareness of perceptual trigger cues for intrusive memories, and how to discriminate between 'then' and 'now'. This is often achieved through in-vivo exposure (Ehlers et al., 2004). Maintenance of symptoms through maladaptive behaviours and cognitive processing strategies for example, thought suppression, are addressed through psycho-education. In combination these therapeutic techniques have been shown in Randomized Control Trials (RCT) to be extremely effective in the treatment of PTSD in both adults (Ehlers, Clark, Hackmann, McManus & Fennell, 2005) and children (Smith et al., 2007).

Evaluation of theories of Post-Traumatic Stress Disorder (PTSD)

Theories of PTSD have evolved from uni-representational to multi-representational frameworks, creating additive explanatory power. This evaluation concentrates on the three most applicable and commonly referred to trauma-centric theories (Dalgleish, 2004) of PTSD; Dual Representation Theory of PTSD (Brewin et al., 1998), Emotional processing Theory (Foa & Riggs, 1993; Foa & Rothbaum, 1998), and Ehlers and Clark's (2000) Cognitive Theory of PTSD. All concur with the concept that trauma memories differ from normative autobiographical memories (Ehlers et al., 2004), and that failures in elaboration and integration of trauma event memories have consequences for symptoms of PTSD, although the explanations of why this process is critical differ between theories (Brewin & Holmes, 2003). All three theories explain the core clinical characteristics, symptoms and time course of PTSD with varying levels of detail. They agree that the distinctive symptoms of PTSD are re-experiencing and avoidance of trauma-event related stimuli, thus allowing for explanations for discrimination and co-morbidity with other psychological disorders (Dalgleish, 2004).

Emotional Processing Theory (Foa & Riggs, 1993; Foa & Rothbaum, 1998) is based on habituation of fear providing an explanation of both normative and pathological responses to trauma. It incorporates knowledge concerning schemas and network representations, although, unlike the Dual Representation Theory (Brewin et al., 1996) and Ehlers and Clark's (2000) Cognitive Theory of PTSD, it does not provide information regarding mental representations of referential meaning (Dalgleish, 2004). It does however offer information about the interactions between memory structures and schemas, which the other two theories do not explicitly address (Dalgleish, 2004). Emotional Processing Theory (Foa & Riggs, 1993; Foa & Rothbaum, 1998) is the theoretical framework for exposure therapy; a manualized psychotherapeutic intervention for PTSD (Foa, Rothbaum, Riggs & Murdock, 1991), which is well documented as a highly effective treatment, with good long-term outcomes for patients (Powers et al. (2010). The theory emphasizes fear network modification and treatment non-response explanations, as such, theoretical details such as the mechanisms of memory change, for example whether trauma memories are changed or blocked through the incorporation of new information during therapy (Brewin & Holmes, 2003), are not elucidated.

Ehlers and Clark's model of PTSD is probably the most comprehensive and extensively empirically supported theory. It was developed as a framework for Cognitive Therapy and Cognitive Behavioural Therapy (Ehlers & Clark, 2000) and empirically evidenced as effective treatments for PTSD (Ehlers et al., 2005). Describing a two-layer system of memory, it highlights the influence of negative appraisals of the trauma thus incorporating referential meaning. However, aspects of this theory are difficult to empirically test, for example elucidating the cognitive mechanisms of data-driven versus conceptual data processing (Brewin & Holmes, 2003), and therefore parts of the theory cannot yet be grounded in empirical research evidence.

The Dual Representation Theory (DRT) of PTSD (Brewin et al., 1996) has explanatory value and presents novel ideas about the time course of PTSD i.e. premature inhibition of emotional processing (Dalgleish, 2004). It combines social-cognitive and information processing assumptions and draws on neuro-psychological literature to propose a multi-representational theory, based on the notion of two separate memory systems (VAM and SAM). Although it provides information concerning referential meaning, it fails to explicitly address the interactions between components of representation. For example, it does not explicitly address how interactions between the SAM and the VAM memory systems occur (Dalgleish, 2004). It incorporates network theory and cognitive processing, but does not include schema knowledge or many pre-trauma risk factors (Dalgleish, 2004). Alongside this, it does not fully explain the occurrence of, or mechanisms involved in, dissociation or emotional numbing, which are pertinent symptoms related to PTSD (Brewin & Holmes, 2003). Although this theory, unlike the previous two, is not a framework for one particular treatment intervention, it is able to inform treatment approaches and generate novel hypotheses regarding empirically validated current treatment options (Brewin & Holmes, 2003).

The three core theories of PTSD are comprehensive and have added explanatory value to the PTSD knowledge base; in turn they all inform practise, research and clinical applications. The theoretical basis of treatment options i.e. cognitive therapy, cognitive behavioural therapy and exposure therapy, seem to be fairly comprehensive, although newer techniques, such as Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 1995), are currently lacking in terms of theoretical grounding (Spector & Read, 1999). However due to their multi-representational nature current theories have heightened complexity. Although at the present time the complexity is justified, through the progression and testing of theories it is likely that complexity will increase (Dalgleish, 2003). If theories

become more focused on the details of involved mechanisms it is likely that clinicians will be less likely to incorporate them into the application of treatment, due to their complexity (Dalgleish, 2003). There is however progress to be made specifically in the descriptions and theoretical foundations that outline the interactions between previously demonstrated components of mechanisms, and it is this area which would most likely be of interest to scientists and pure theorists (Dalgleish, 2003).

CHAPTER THREE

General Literature Review

Post-Traumatic Stress Disorder (PTSD) Following Childbirth: Conceptualisations and Associated Research

Prior to the conceptualisation of Post-Traumatic Stress Disorder (PTSD) as a mental health disorder, similar symptomologies were attributed to the consequences of war/combat trauma with the terms 'shell shock', 'war strain' (Smith & Pear, 1917), and Freud's term 'war neurosis' (Ferenczi, Abraham, Simmel, Jones & Freud, 1921). This precluded most women, as in that period they were unlikely to experience war/combat directly. However, as Herman (1997) states interpersonal trauma needs to be highlighted, as more women experience PTSD as a consequence of traumatic events which occur in an everyday setting, than people experience in more unusual settings, such as war and combat.

Historically, Post-Traumatic Stress Disorder has been associated with unusual, unexpected and negative events, such as rape, war-based combat, terrorist attacks and natural disasters. These events are understood both objectively and subjectively as possible traumatic experiences. Indeed, until relatively recent changes in criterion of both the Diagnostic and Statistical Manual for Mental Disorders (DSM) and the International Classification of Diseases (ICD), childbirth, because of its normative occurrence, was unable to be considered as an etiological agent for a diagnosis of PTSD. With these changes to the criteria of the etiological agent, diagnosis, treatment and research has begun to focus on the phenomena of PTSD following a traumatic childbirth. Furthermore, with the publication of DSM-5 (APA, 2013), Ayers, Wright and Thornton (2018) have developed a childbirth trauma specific measurement scale called the City Birth Trauma Scale based on DSM-5 (APA, 2013) criteria for Post-Traumatic Stress Disorder (Ayers, Wright & Thornton, 2018).

This chapter critically explores the research literature into Post-Traumatic Stress Disorder (PTSD) following childbirth. It examines whether PTSD with the determined etiological agent of a traumatic childbirth experience is qualitatively different to alternative traumatic events precipitating a PTSD diagnosis, and the application of theoretical frameworks to the phenomena. Furthermore, this chapter examines some of the antecedents

associated with PTSD following childbirth. Utilising a three-dimensional organisational framework, initially proposed by Slade (2006), a range of the predisposing (pre-pregnancy and/or antenatal), precipitating (labour and birth), and maintaining (post-natal) factors are described, alongside possible consequences of PTSD following childbirth as identified through the empirical research literature.

Post-Traumatic Stress Disorder Following Childbirth

Changes to criterion A in the publication of Diagnostic and Statistical Manual of Mental Disorders DSM-IV (APA, 1994) allowed the traumatic experience (the etiological agent) to be within usual/normal human experience (National Centre for PTSD, 2013), therefore childbirth has since been considered an event for the development of PTSD. (National Centre for PTSD, 2013). There are further implications for PTSD following childbirth with the changes in criterion from DSM-IV (APA, 1994) to DSM-V (APA, 2013). Although traumatic birth can still be considered as an etiological agent for PTSD development, questions are raised about whether infant death during or just after birth can be. Ayers (2013) suggests that assessments should be made for both PTSD and complicated grief reactions in these situations. There is also the consideration of the need for updated or new measurement tools with four, rather than three main symptom clusters.

The research literature also demonstrates that childbirth can be an etiological agent for the development of PTSD in the perinatal period (Ayers & Pickering, 2001, Ayers, 2004; Olde et al., 2006). Indeed, approximately one third of women appraise their birth experience as traumatic, and 10% have severe traumatic stress responses postpartum (Ayers, 2004). Acute PTSD following childbirth (present up to six months following the trauma) has a prevalence rate of between 1-6% (Ayers & Pickering, 2001; Creedy, Shocher & Horsfall, 2000), with estimated rates rising to 15.7% in at-risk groups (Grekin and O’Hara, 2014).

When exploring rates of chronic PTSD following childbirth prevalence drops to around 1.5% at 6 months postpartum (Ayers & Pickering, 2001; Wijma, Soderquist & Wijma, 1997). These rates are dependent on measures used, and are in the majority based on self-report questionnaires not diagnostic interviews. Reported rates increase for specific sub-populations, for example, women who experience premature or stillbirth (Ayers et al., 2008).

There is not enough research evidence to make any firm conclusions concerning whether PTSD following childbirth is the same as PTSD following alternative traumatic events (Ayers at al., 2008). A critical caveat, outlined in the introduction of this thesis, is that birth does not have to be objectively traumatic for the development of PTSD; rather it is dependent on the women's perception of the childbirth experience. In most instances the birth is not clinically 'life-threatening', Ayers at al. (2008) states that in the U.K. only 0.1% of births are classified as life-threatening to the mother (Baskett & Sternadel, 1998), and 0.86% as life-threatening to the infant (Confidential Enquiry into Maternal and Child Health, 2006). However, a higher percentage of women report PTSD following childbirth than experience objectively life-threatening birth experiences (see previous paragraph for statistical breakdown). In addition, not all women who experience objective threat to their own or the infant's life develop PTSD following childbirth. Therefore, it is the subjective perception of the event which is a critical component in the perception of a childbirth experience as traumatic and the subsequent development of PTSD following childbirth (Ayers et al., 2008).

When examining whether PTSD following childbirth is different from PTSD following alternative trauma events in terms of diagnostic criterion, it is important to use clear terminology, for example, are there idiosyncratic features, or idiosyncratic symptoms, of PTSD following childbirth? PTSD following childbirth is comparable to general PTSD symptomology; however, some features seem more pronounced/common in PTSD following

childbirth (Bailham & Joseph, 2003). These include; sexual avoidance (Bailham & Joseph, 2003), tokophobia (Bailham & Joseph, 2003), and attachment and parenting problems (Ballard et al., 1995). However evidence suggests that these symptoms are also present in PTSD caused by alternative trauma, for example sexual abuse can lead to tokophobia (Lukasse, Vangenm Oian & Schei, 2010), and sexual avoidance (Noll, Tickett & Putnam, 2003), and combat trauma has been related to parenting problems (Jordan, Marmar, Fairbank, Schlenger, Kulka, Hough & Weiss, 1992). Therefore, the tentative hypothesis that PTSD and PTSD following childbirth are not qualitatively different is proposed, however certain symptoms, such as those mentioned previously, are more likely to be present in cases of PTSD following childbirth than in cases of PTSD with an alternative etiological agent.

The phenomenology of PTSD following childbirth has distinctive features in comparison to general PTSD. Childbirth by essence is, for the majority, a voluntary process, and deemed by society to be a desired (for most), positive event (Ayers et al., 2008). It is also relatively predictable: birth is the endpoint of pregnancy. However, the form the birthing process takes is not necessarily predictable, and is subject to sudden change, and the development of PTSD following childbirth may be contributed to by the loss of the expected or desired birth trajectory (Ayers et al., 2008). Alongside this, the birth process, and postpartum period create huge physiological changes and neuro-hormonal shifts within women (Ayers et al., 2008). Alternative traumatic events, for example; rape, explosions, and earthquakes, are not positive, predictable events entered into voluntarily, nor are physiological and hormonal changes in the victim often a feature. It may be suggested that combat experiences are voluntary, and somewhat predictable, as often soldiers voluntarily enter a war zone, which predicts combat experiences, but no alternative trauma event has all the previously mentioned elements. It may be concluded that the symptoms of PTSD

following childbirth and general PTSD are comparable, however the phenomenology of PTSD following childbirth differs from general PTSD.

The medicalised and technocratic framework of psychiatric disorders in relation to PTSD following childbirth further medicalises childbirth (see chapter four for more information about the medicalisation of childbirth) and the postpartum period, thus, creating a narrow focus on the symptoms and treatment of the medical psychiatric diagnosis of PTSD as a consequence of traumatic childbirth. This negates the role of social and cultural factors, and the unique, individual experiences, which usually do not fit neatly into diagnostic classifications (Marecek, 2002).

Antecedents of PTSD following childbirth.

There are numerous factors which have been identified as having an association with symptoms of PTSD following Childbirth. Slade (2006) outlined potential predictors within an organizational framework using a two-dimensional matrix. This matrix separates factors into predisposing (pre-pregnancy and/or antenatal) and precipitating (during labour and birth) dimensions; there is a third dimension proposed of maintaining factors (post-natal), which at the time of writing had insufficient evidence to be included in the matrix by Slade (2006). This section utilises this three-dimensional matrix to organise research evidence on potential antecedents for PTSD following childbirth (see figure 3.2), but acknowledges that there is a complex interplay between pre-pregnancy, anti-natal vulnerability and intrapartum and post-partum risk factors (Ayers, Bond, Bertullies & Wijma, 2016).

Table 3.2: Three-dimensional matrix of antecedents of PTSD following childbirth as determined through research

Predisposing factors	• General and pregnancy related demographics - Age - Relationship status - Social economic status - Unplanned pregnancy - Parity • Previous psychopathology and trauma - Sexual abuse - PTSD - Other psychopathologies • Attachment and personality - Trait anxiety - Neuroticism - Avoidant attachment style • Social support • Expectations of birth
Precipitating factors	• Obstetric variables - Mode of delivery - Obstetric emergency - Maternal and neonatal complication (HELLP syndrome/haemorrhage/stillbirth/preterm birth) • Labour pain • Control • Peri-traumatic dissociation • Social support - Partner support - Professional support • Expectation and experience incongruence
Maintaining factors	• Social support • Within-couple mental health • Co-morbid disorders - Anxiety - Depression - Insomnia

Predisposing (prenatal and antenatal) factors. ***General and pregnancy-related demographics***. The associations between demographic (Social Economic Status (SES), age, ethnicity and educational level) and PTSD following childbirth have inconsistent findings within the literature (Anderson, Mel Vaer, Videbech, Lament & Joergenson, 2012). Age of mother (Vossbeck, Elebusch, Freisfeld & Ehring, 2014) and relationship status in targeted (at-risk) samples, demonstrated small effect sizes in a meta-analysis, but was not significant in community samples (Grekin & O'Hara, 2014). A qualitative systematic review found low socio-economic status (SES), unplanned pregnancy and parity were some of the lowest rated factors (Anderson et al., 2012). Other studies have suggested that nulliparity is a predisposing factor in the development of PTSD (Ayers, Harris, Sawyer, Parfitt & Ford, 2009), but other studies do not find a significant association (i.e. Cohen, Ansara, Schei, Stuckless & Stewart, 2004). Although, as stated, findings across studies are inconsistent in relation to the associations between general and pregnancy-related demographic variables and PTSD following childbirth, a number of these variables may moderate relationships between other predisposing and precipitating antecedents and PTSD following childbirth.

Previous psychopathology. Childbirth can only physically be experienced by women and thus PTSD with childbirth as an etiological agent is most likely to occur in women, however witnessing a traumatic birth can have an impact on fathers (White, 2007), although a quantitative study found that in a sample of nearly 200 men, none reported symptoms of full PTSD, and only 12% reported some symptoms (Bradley, Slade & Leviston, 2010). The World Health Organisation (2015) state that gender is a significant predisposing risk factor in the development of PTSD, with women being the 'largest single group' affected by PTSD mainly due to exposure to sexual violence. The literature suggests correlations and relationships between previous trauma experiences, pre-existing PTSD and PTSD following childbirth (van Heumen, Hollander, van Pampus, van Dillen & Stramrood, 2018). Research

into the relationships between previous traumatic experiences and PTSD following childbirth has tended to focus on sexual abuse (e.g. Ayers, Harris, Sawyer, Parfitt & Ford, 2009), most specifically childhood sexual abuse (CSA) (Lev-Wiesel, Daphna-Takoah & Hallack, 2009). A prospective study of incidence and risk factors of PTSD following childbirth carried out by Verreault, Da Costa, Marchand, Ireland, Banack, Dritsa & Khalife (2012) used multivariate logistical regression and demonstrated that a history of sexual trauma is the strongest predictor for the development of PTSD following childbirth. Qualitative research (Reynolds, 1997) and published case studies (Rose, 1992) suggest that for some women there are similarities between rape experiences and subsequent birth experiences. Halvorsen, Nerum, Oian and Sorlie (2013) carried out interviews with women who had experienced serious sexual assaults prior to childbirth and found that women described both a 'reactivation of the rape' during labour and 're-traumatization after birth'. It is likely that specific elements of the birth experience, such as, physical exposure and intimate examinations can, in some cases, reactivate memories of past sexual assaults, thus causing re-traumatization. The concept of re-traumatization also provides evidence of the link between pre-existing PTSD and PTSD following childbirth. Further research has demonstrated that experiencing PTSD following childbirth is a predisposing factor to re-experiencing the disorder following subsequent labours (Skari, Skreden, Malt, Dalholt, Ostenson, Egeland & Emblem, 2002). The relationship between previous trauma experiences and PTSD following childbirth allows for the identification of women at risk of PTSD following childbirth (Lev-Wiesel et al., 2009).

Other pre-existing psychopathologies (and a family history of psychopathology) have also been demonstrated as possible antecedents in the development of both general PTSD and PTSD following childbirth (Carzoncka & Slade, 2000; Maggoioini, Margola & Filippi, 2006; Olde, van der Hart, Kleber & van Son, 2006). A meta-analysis demonstrated that a 'history

of psychological distress' and 'pregnancy psychopathology', specifically symptoms of anxiety, depression and PTSD were associated with post-partum PTSD symptoms (medium effect sizes of between .30 and .49) (Grekin & O'Hara, 2014). The associations between pre-existing PTSD and previous experiences of trauma, specifically sexual abuse may be useful in clinical practise when assessing predisposing factors related to the experience of post-partum PTSD. However theoretically it is difficult to distinguish whether women who have experienced previous traumas and/or pre-existing PTSD can be diagnosed with PTSD with childbirth as the determined etiological agent. It may be that the course of pre-existing PTSD is exacerbated by childbirth, through reminders of previous traumas (i.e. sexual assault) and therefore may not be truly represented as PTSD following childbirth. In addition, recent research by Goutaudier, Bertoli, Sejourne and Chabrol (2018) explore pre-traumatic stress as part of the etiology of PTSD following childbirth. They suggest that fear of labour pain, which is in turn associated with the broader concepts of fear of childbirth and tokophobia may elicit a traumatic continuum in traumatic reactions associated with childbirth.

Attachment and personality. Personality factors have been studied in relation to PTSD, although there are limited and somewhat contradictory empirical findings. Indeed associations between trait anxiety (Czarnocka and Slade, 2000), neuroticism (Lyons, 1998) and PTSD following childbirth, and following miscarriage or stillbirth (Engelhard, van den Hout & Schouten, 2006) have been found, however Soderquist, Wijma, Thorbert and Wijma (2009) demonstrated that high trait anxiety is associated with postpartum depression, but not post-traumatic stress symptoms. The role of attachment styles and mental health are consistent, however the investigation of these processes in relation to PTSD following childbirth is underdeveloped. Ayers, Jessop, Pike, Parfitt and Ford's (2014) prospective study results suggest that avoidant attachment style alongside other variables are significantly associated with PTSD following childbirth, however further regression analysis demonstrated

that the relationship between operative delivery and PTSD following childbirth is moderated by avoidant attachment style.

Social support. Social support can be defined as: "A transactional communicative process, including verbal and/or nonverbal communication that aims to improve an individual's feelings of coping, competence, belonging and/or esteem." (Mattson & Hall, 2011, p.184). Although there are discrepancies within the literature about the number and types of social support, five types are described by Schaefer, Coyne and Lazarus (1981): emotional, esteem, network, information and tangible support. The levels of social support can also be divided into two aspects; actual (the objective or actual social support provided) and perceived (the perception or belief of availability of support). All of these 'types' of social support can in some ways be related to the needs of women before, during and after childbirth, and in the context of childbirth the perception, of social support, is of more importance (Zamani, Ziaie, Lakeh & Leiki (2019). In the current literature examining associations between social support and PTSD following childbirth there are three core social support aspects which are concentrated on, these are; partner, professional and informational support. It is proposed that emotional, tangible and maybe esteem support would be sought from partners and professionals, whereas informational support needs would mainly be sought from professionals. Throughout, research has concentrated on the perceived social support rather than the actual/received support, this is probably for two reasons; 1) perceived social support is more likely to impact upon or buffer against psychological distress (Wills & Shinar, 2000), and 2) measuring actual or received social support before, during and after pregnancy is difficult.

In terms of levels of social support before birth and the association with PTSD following childbirth the evidence is limited. Soet et al (2003) found that low levels of social support pre-event were related to experiencing the birth as traumatic. Prospective studies

have examined social support during pregnancy and found that it was not a predictor of Post-Traumatic Stress at one month postpartum (Soderqiuest et al., 2009).

Precipitating (Intrapartum) Factors. ***Obstetric variables.*** This section encompasses a number of often over-lapping factors associated with objective obstetric events during labour, including mode of delivery (i.e. vaginal birth, instrumental (forceps, kiwi etc) vaginal birth, and caesarean section) obstetric emergencies (i.e. emergency caesarean section, shoulder dystocia, cord prolapse), maternal complications (HELLP syndrome – H (hemolysis), EL (elevated liver enzymes), LP (low platelet count); a life threatening pregnancy condition, pre-eclampsia, haemorrhage), and neonatal complications (prematurity, admission to Neonatal Intensive Care Unit; NICU). A national survey of women's experiences of maternity care in England found that mode of birth is associated with a woman's well-being (physical and psychological) in the postpartum period (Rowlands & Redshaw, 2012). Anderson et al. (2012) systematic review of qualitative studies identified obstetrical emergencies as a risk factor for PTSD following childbirth, however within the paper they report that results are often conflicting when considering the association between both emergency caesarean sections and instrumental vaginal deliveries, and PTSD following childbirth (Anderson et al., 2012). Assisted vaginal deliveries, especially forceps-assisted deliveries (Rowlands & Redshaw, 2012), and unplanned caesarean sections (Rydling, Wijma & Wijma, 1997) have been identified through quantitative studies as increasing the risk of symptoms of PTSD following childbirth. In summary, obstetrical emergencies, and as a result, mode of delivery, can be associated with an increased risk of the development of PTSD following childbirth, however caution must be taken when addressing these findings in clinical applications. It has been consistently stated that PTSD following childbirth does not only develop in response to

objectively obstetrically traumatic events, rather the mother's subjective perception of the labour is the critical factor (Ayers et al., 2008).

Maternal and neonatal complications in the perinatal period may affect the development of PTSD symptoms following childbirth. A systematic review conducted by Futura, Sandal & Bick (2012) attempted to examine the relationship between severe maternal morbidity and PTSD following childbirth, however due to a mix of differing measures and complications often not being adequately described, the study findings were limited and not very specific. Maternal complications covered in the examined studies included pre-eclampsia, HELLP syndrome (there is some evidence of these complications being linked with PTSD symptoms (Futura et al., 2012; van Pampus, Wolf, Weijmar, Schultz, Neeleman & Aarnoudse, 2004)), haemorrhage and infection among others. The main conclusion was that women who experienced maternal morbidity (not severe maternal morbidity) and/or preterm birth had a higher prevalence of PTSD following childbirth. However, results were inconsistent and there may be mediating relationships with other variables (i.e. condition of the neonate). PTSD can occur following a stillbirth (loss of a baby after 24 weeks gestation), indeed a third of women showed clinically significant Post-Traumatic stress symptoms following a stillbirth (Grevensteen et al., 2013), which increases to approximately 70% in women who also have high neuroticism and low educational levels (Engelhard et al., 2006). During subsequent pregnancies a past stillbirth experience is a major stressor for PTSD following childbirth (Turton, Hughes, Evans & Fairman, 2001). However, when examining PTSD following a stillbirth it is important that clinicians distinguish between PTSD and persistent complex bereavement disorder (Ford, 2013). Preterm birth has also been identified as a possible risk factor for the development of PTSD following childbirth. Holditch-Davis, Bartlett, Blickman & Miles, 2003) carried out semi-structured interviews with women after discharge, analysis of interviews identified all women as having at least one symptom of

PTSD. Further quantitative research found that at 2-3 years after birth mothers who had had a Very Low Birth Weight (VLBW) infant had higher levels of PTSD in comparison to women who had an infant born at term (Ahlund, Clarke, Hill & Thalange, 2009). Difficulties arise when examining the relationship between preterm birth and PTSD following childbirth, as although the birth of a preterm infant is likely to be more objectively traumatic for the mother, there is also the consideration that the experience of having an infant admitted to the Neonatal Intensive Care Unit (NICU) may also be a potential stressor. Thus, differentiating between whether PTSD has developed as a direct result of the birth, or of experiences in NICU, or indeed a combination of both experiences is extremely difficult.

Labour pain. Undoubtedly for the vast majority labour is extremely painful, but unlike the context of most other forms of experienced pain, labour pain is conceptualised not as a 'pathological process', but a 'basic human process' (Bergh, Johansson, Bratt, Ekstrom & Martensson, 2015). This under-values women's experience of pain, minimising both the physical and psychological experiences of labour pain. This may be impacted upon by a number of factors (i.e. professional emotional and informational support, mode of delivery, and the availability and efficacy of pain relief during labour), and may also affect other factors (i.e. appraisal of the birth experience). Soet, Brack and Dilorio (2003) found that pain during the first stage of labour was among nineteen significant variables associated with the perception of the birth experience as traumatic. In a qualitative study with twenty women who described their birth as traumatic Allen (1998) suggests that the experience of pain and ineffective pain relief were related to a lack of control, which was identified as a central theme. This suggests that there is a complex combination of factors involved, and conflicting results when examining the relationship between experienced labour pain and PTSD following childbirth. Indeed, Stramrood, Paarlberg, Veld, Berger, Vingerhoets, Schultz & Pampus (2011) and Soet et al., (2003) found that high pain intensity was related to PTSD

symptoms, however Soderquist et al. (2002) did not. Alternative studies suggest that pain is related to levels of distress during labour (Czarnocka & Slade, 2000; Lyons, 1998), or is partially mediated by overall birth experience (Garthus-Niegel, Knoph, von Soest, Nielsen & Eberhard-Gran, 2014). Furthermore, pain during labour may only be influential in the development of postpartum psychological distress when women interpret pain in a catastrophic way (Garthus-Niegel, 2014). Although research results are mixed in their findings the experience of pain during labour is an important consideration, but instead of examining direct relationships between perceptions of pain and PTSD following childbirth, research should focus on the role labour pain plays in respect to other variables, such as overall birth experience, high distress, control and the difference between expectations and experiences. The measurement of pain during labour also needs to be addressed in the literature, and studies need to explicitly state whether they were attempting to measure an individual's appraisal or the intensity of pain. Also, as labour is often a long process future research could attempt to examine the pain through the process, for example in first stage, second and third stage labour, and also differentiate between affective and sensory pain (Garthus-Niegel, 2014).

Control. Levels of perceived control and feelings of powerlessness during labour and delivery have been examined both in relation to a woman's perception of her birth as traumatic, and also PTSD symptoms. Level of perceived control (O'Donovan et al., 2014) and feelings of powerlessness (Soet et al., 2003) during labour can distinguish women who perceive their birth to have been traumatic from those who do not. However, perception of control was not a variable that could distinguish between the development and non-development of PTSD following childbirth (O'Donovan et al., 2014). Whereas other studies suggest that the perception of low control during labour and birth are related to PTSD symptoms (Czarnocka & Slade, 2000), but a meta-analysis shows small effect sizes (Grekin

& O'Hara, 2014). A systematic review states that in the development of PTSD following childbirth the most important factors are 'subjective distress in labour' and obstetrical emergencies'. Both factors involve a woman's perception of control during birth, hypothetically due to the nature of obstetrical emergencies it is likely that women would not be in control of the occurring events. In terms of subjective distress in labour, a feeling of loss of control was directly referred to within the context of distress, and thus was related to PTSD following childbirth more directly. In conclusion it may be suggested that feelings of a lack of control and powerlessness are associated with the perception of birth as traumatic and the development of PTSD following childbirth.

Peritraumatic dissociation. Wing Lun (2008) provide the following definition of peritraumatic dissociation:

> Peritraumatic dissociation refers to a number of acute dissociative responses that occur at the time of the trauma (Marmar, Weiss & Metzler, 1998). Marmar et al. describe these responses as including an altered sense of time, with time being experienced as slowed down or rapidly accelerated; experiences of depersonalization; profound feelings of unreality that the event is occurring or that the individual is the victim of the event; out-of-body experiences; confusion and disorientation; altered body image or feelings of disconnection from one's body; tunnel vision; altered pain perception; and other experiences reflecting immediate dissociative responses to trauma (p.297).

In a meta-analysis peritraumatic dissociation was the strongest predictor of subsequent PTSD (Ozer, Best, Lipsey & Weiss, 2003), and three case studies presented by Moleman, van der Hart and van der Kolk (1992) report perinatal dissociative responses during childbirth, with the development PTSD in two out of three cases. Quantitative research has demonstrated that peritraumatic dissociation during pregnancy loss is strongly related to both acute and chronic

PTSD (Engelhard, van den Hout, Kindt, Arntz & Scouten, 2003). The role of peritraumatic dissociation and the development of PTSD following childbirth is further highlighted in research which proposes a 'perinatal dissociative pathway' to PTSD following childbirth (van Son, Verkerk, van der Hart, Komproe & Pop, 2005). This study suggests that high pain and intrusiveness of delivery is associated with high levels of perinatal dissociation as measured using the Peritraumatic Dissociative Experiences Questionnaire (PDEQ; Marmar, Weiss & Metzler, 1997). A more in-depth longitudinal study measured both perinatal psychoform and somatoform dissociation, with heightened levels of both forms of dissociation associated with higher levels of PTSD symptoms. Although limited the literature base thus far suggests that in concordance with the general PTSD literature, peritraumatic dissociation is also a significant precipitating antecedent of PTSD following childbirth.

Social support. As outlined on page 69 social support can be divided in to differing aspects, however a lack of general social support during and/or after a traumatic event has been identified as a risk factor for the development of PTSD (Brewin, Andrews & Valentine, 2000). The influence of social support during birth investigated in the current literature has in some studies been divided into partner support, professional emotional support and professional informational support. These division of types and support resources are helpful when applying findings to clinical situations. Partner support during labour refers to support from a birthing partner, although in the majority this tends to be the infant's father and mother's romantic partner, this is not necessarily true in all birth situations. A birthing partner can also be, for example, the woman's mother, alternative partner, friend or doula (Simkin, 2018). The absence of a birthing partner during labour (Czarnocka & Slade, 2000), or the perception of a less supportive birthing partner has been associated with PTSD symptoms following childbirth (Cigoli, Gilli & Saita, 2006; Czarnocka & Slade, 2000). Perceived inadequate support from professionals during labour is also associated with PTSD

symptoms, however there is evidence that moderating variables may be involved in this association (Cigoli et al., 2006; Dikmen-Yildez, Ayers & Phillips, 2017). The concept of inadequate informational support during birth is related to birth trauma (Soet et al., 2003). Van Son et al. (2005) demonstrated that informational support from medical personnel during birth was associated with perinatal dissociation, but not PTSD symptoms following childbirth. Also, a 'deception' between expected/desired and actual support from medical professional was not related to PTSD symptoms unless women also had high trait anxiety. Overall support (both partner and professional) during birth does correlate, but is not a predictor of PTSD following childbirth (Ayers et al., 2014). It is probable that there are a number of moderator and mediator variables that influence the relationship between social support and PTSD following childbirth. It is also likely that the perception of, rather than the actual social support, is the most influential factor when examining childbirth, as levels of satisfaction with social support is likely to impact upon the perception and experience of childbirth.

Maintaining (post-natal) factors

There is a paucity of research into the maintaining or postnatal factors for PTSD following childbirth. These factors are described as those which either increase or reduce the symptomology over time. However, Ayers (2004) suggests some maintaining factors which may be influential, including coping strategies, increased stress, low support and complex emotions.

Social support. The association between social support and PTSD symptoms following childbirth is still evident postpartum (Grekin & O'Hara, 2014). A high level of social support postpartum has been identified as a protective factor against PTSD symptom development (Lemola, Stadlmayr & Grob, 2007; Verreault et al., 2012), and low levels or

dissatisfaction with social support is associated with PTSD following childbirth (Garthus-Niegel et al., 2015). However, when other factors were controlled the association is no longer significant (Garthus-Niegel et al., 2015), and satisfaction with support was not a significant predictor of PSTD following childbirth in a hierarchical regression analysis (Iles, Slade & Spiby, 2011). Partner support is highlighted in the literature, but the evidence is inconsistent, with Iles et al. (2011) suggesting that a woman's perception of support from a partner is associated with symptoms of PTSD, however Garthus-Niegel et al. (2015) found that relationship satisfaction, which would encompass support, does not predict PTSD symptoms following childbirth.

Within-couple mental health. The roles of relationships and social support as maintaining factors for PTSD following childbirth can be further examined in the context of within-couple mental health. Health concordance within couples has been examined in relation to a number of health issues. Meyler, Stimpson and Peek (2007) conducted a systematic review into health concordance in couples and suggest that there is a significant concordance of depression and well-being within couples, alongside this but with a less substantial evidence base they also suggested a concordance of grief and PTSD within couples. This phenomena has been explained by a number of theories including; assortative mating, shared resource hypothesis, social control and mood convergence or affective contagion. This last theory is specifically linked to mental health and proposes that emotions between couples are linked and may therefore play a role in the concordance of psychopathological symptoms (Meyler et al., 2007). Evans, McHugh, Hopwood and Watt (2003) demonstrated that if one member of a couple had PTSD as a result of combat experiences, the other member also experienced some symptoms of PTSD, this is known as Secondary Traumatic Stress (STS). The evidence for within couple concordance of PTSD following childbirth is limited, but an association has been identified (Iles et al., 2011).

Indeed, when partners display acute trauma symptoms in the postpartum period this has been found to be related to a women's symptoms of Post-Traumatic Stress (PTS) at 6 weeks and 3 months postpartum (Iles et al., 2011). It is suggested that within couple concordance in PTSD following childbirth may be higher as it is highly probable that both members of the couple were exposed to the traumatic event, in conjunction with the confirmed knowledge that symptoms of PTSD can have detrimental implications on close relationships.

Co-morbid disorders. PTSD is often comorbid with a number of psychopathologies, for example, substance abuse, phobias and depression (Steel, Dunlavy, Stillman & Pape, 2011). PTSD following childbirth can be comorbid with depression (Howard, Molyneuax, Dennis, Rochat, Stein & Milgram, 2014) and high trait anxiety (Iles et al., 2011). However, whether comorbid depression and/or anxiety can be described as a maintaining factor, or are better described as concurrent disorders which need separate consideration requires further investigation. Research demonstrates that experiencing complex emotions, such as guilt and blaming oneself (Czarnocka & Slade, 2000), has been associated with postnatal distress (Coates, Ayers & de Visser, 2014) which concurs with research in the general PTSD arena that complex emotions can be associated with PTSD development and maintenance (Ayers, 2014). Insomnia as a result of hyperarousal can be a symptom of PTSD, and experience of sleep disturbance can impact on the severity of PTSD symptoms (Belleville, Guay & Marchand, 2009). Interestingly in a study examining the maintaining factors of posttraumatic stress symptoms insomnia was the only significant association (Garthus-Niegel et al., 2015).

The literature examining maintaining factors in relation to PTSD following childbirth is sparse, however the aforementioned factors have been associated with PTSD following childbirth in the postpartum period, and other possible factors include high levels of stress and poor coping (Garthus-Niegel et al., 2015). It is probable that maintaining factors impact upon the cognitive processing of the traumatic childbirth post-event, and understanding

which factors influence this process can help inform the care of women with PTSD following childbirth (Garthus-Niegel et al., 2015). Thus, it is important that maintaining factors are examined separately from onset (predisposing and precipitating) factors.

The consequences of developing PTSD following childbirth are multiple and affect not only the mother, but also the infant, the wider family, and potentially wider social networks and activities. Research has demonstrated detrimental consequences in a number of areas including the ability to cope and levels of stress (Ayers, Bond, Bertuilles & Wijma, 2016), within the psychosocial domains of trusting others and fundamental changes in the way the women view the world. Physiologically and psychologically PTSD following childbirth can impact on intimate sexual relations and future childbearing (Poote & Mckenzie-McHarg, 2015; Stramrood & Slade, 2017).

The focus on the development of psychopathology which has arisen as a consequence of the ability to demonstrate that PTSD can be diagnosed following traumatic childbirth experiences has both positive and negative implications. For a sub-set of women who experience traumatic childbirth and are diagnosed with PTSD (and therefore can access treatment), between 1-6% of women (Ayers & Pickering, 2006), the ‘diagnosis’ can be useful. For those who have experienced a traumatic childbirth but do not meet the diagnostic criteria for a diagnosis of PTSD, but still experience a significant personal and social impact, the intense focus on the ‘disorder’ rather than the experiences is concerning, as it is likely these women represent a ‘hidden’ population. Ayers (2004) suggests that a third of women experience their births as traumatic, and 10% have a severe traumatic stress response. This thesis therefore focuses on ‘traumatic childbirth’ rather than PTSD following childbirth; the lack of focus on diagnosis allows for a broader exploration of experiences in a more holistic manner.

Theories of PTSD following childbirth

If, as most clinicians and researchers now agree, PTSD following childbirth is comparable to general PTSD, then it follows that current psychological theories of general PTSD should also be applicable to PTSD following childbirth. However, the literature examining PTSD following childbirth currently lacks a solid theoretical basis (Ford, Ayers, & Bradley, 2010; Ayers, Joseph, McKenzie-McHarg, Slade & Wijma, 2008).

Only one article has been found which directly applies a detailed and evidenced model of general PTSD to examine the predictive value of the model in PTSD following childbirth. Ford et al. (2010) investigated the predictive value of Ehlers and Clark's (2000) cognitive model of PTSD in the perinatal population, and whether adding social support to the model would increase the variance explained (Ford et al., 2010). This model of persistent PTSD is based on the idea that threat is perceived as current (Ehlers & Clark, 2000). It suggests that the characteristics of the trauma event, prior beliefs, experiences and the ability to cope influence negative appraisals of the trauma event and its sequelae. It is these negative cognitive appraisals which cause PTSD symptoms (Ehlers & Clark, 2000). Using a repeated-measure longitudinal design Ford et al. (2010) measured trauma history, dysfunctional attitudes and self-efficacy prenatally (36 weeks), and then at 3 weeks post birth they used the Intrapartum Intervention Score (Clement, Wilson & Sikorski, 1999) to determine characteristics of the trauma event, alongside post-traumatic cognitions, social support, and PTSD symptoms. PTSD symptoms were measured again at 3 months postpartum. Results suggest that at 3 weeks postpartum, prior beliefs and abilities to cope were fully mediated by negative cognitive appraisals (as measured using the Post-Traumatic Cognitions Inventory; (PTCI); Foa, Ehlers, Clark, Tolin & Orsillo, 1999), which in turn explained 23% of the variance in PTSD symptoms, with medium effect sizes. However, inclusion of social support into the model only increased the explained variance by 2%. At 3 months postpartum the

cognitive model explained only 9% of variance, but when social support (which was partially mediated by negative appraisals) was added to the model, a total of 16% of variance was explained (Ford et al., 2010).

Ehlers and Clark's (2000) cognitive model of PTSD provides a good model with predictive power for PTSD following childbirth, but it is more applicable for earlier symptoms - initial/acute stress reactions. At later time points the addition of social support enhances the model substantially in the perinatal population (Ford et al., 2010). A caveat of Ford et al.'s (2010) study is that partial PTSD/PTSD symptoms, rather than only full/diagnosable PTSD, were measured due low prevalence rates. It may be that using a large population of women with full/diagnosable PTSD may generate different results (Ford et al., 2010). However due to the low prevalence rates of diagnosed PTSD following childbirth (acute rates of between 2.8% and 5.6%, dropping to 1.5% in chronic cases; see chapter three) this would be difficult. Interestingly in the Ford et al. (2010) study, trauma history (prior experiences) and the characteristics of the trauma event did not predict either appraisals or PTSD symptoms. This is in contrast with evidence that previous trauma, for example, prior sexual abuse, is a risk factor for PTSD following childbirth (Lev-Wiesel et al., 2009; Wijma, Soerquist, & Wijma, 1997). In terms of characteristics of the trauma event there are conflicting ideas. Indeed, it is the woman's perception, rather than the clinical characteristics of the birth that are influential in the development of PTSD following childbirth (Bailham & Joseph, 2003). Ford et al. (2010) measured the trauma event characteristics using the intrapartum intervention scale (Clement, Wilson, & Sikorski, 1999), which creates a weighted estimation of self-reported clinical intervention during birth. It may be argued that measuring a woman's perception of the event, rather than clinical characteristics would generate different results. Alternatively, there is evidence that mode of delivery is a risk factor for PTSD following childbirth (Ryding et al., 1998), thus it may be proposed that the

characteristics of the birth/trauma event should have had a significant effect on negative appraisals, and thus PTSD symptoms. However, this may only occur if the characteristics of the birth are different from what was expected or hoped for prior to or during pregnancy.

Alternative theoretical models of PTSD applied in the childbirth population include Gamble and Creedy's (2009) model of postpartum counselling which is an intervention focused theoretical model developed specifically for use in PTSD following childbirth. It does not explicitly address the mechanisms involved in the development of PTSD following childbirth. Instead it amalgamates Cognitive Behaviour Therapy (CBT) and exposure therapy treatment approaches, in combination with increasing social support (Gamble & Creedy, 2009), creating a person-centered prevention and intervention treatment package for traumatic birth experiences, including those diagnosed with Acute Stress Disorder (ASD) and PTSD symptoms. It draws on concepts presented in a number of general PTSD theories, although mostly it does not explicitly place concepts within a particular theoretical framework. Cognitive models of general PTSD outline the idea of 'making sense' of the event, and the creating of coherent, rather than fragmented narratives of the trauma event/s within treatment (Brewin & Holmes, 2003). This is done within the counselling model by creating exposure through the construction of a verbal birth narrative during counselling sessions and through imagined exposure opportunities after counselling (Gamble & Creedy, 2009). The model also draws on schema models of PTSD (Cahill & Foa, 2007), and information-processing theories, (Horowitz, 1979) addressing the need for prior knowledge to become congruent with trauma knowledge. The model suggests this should occur through a process of integration, assimilation and accommodation (Piaget, 1971) of trauma knowledge into previous schemas and beliefs. Maladaptive behaviour and cognitive strategies are addressed through a process of cognitive restructuring (Ehlers & Clark, 2000; Gamble & Creedy, 2009).

Gamble and Creedy (2009), unlike alternative models of general PTSD, add a second layer of explanation by incorporating the idea of growth through adversity. Drawing on organismic valuing processes theory (Joseph & Linley, 2005) it proposes that positive accommodation (rather than negative accommodation) of trauma event information can increase psychological well-being (Joseph & Linley, 2005). Joseph and Linley's (2005) theory is similar to the more general theory of post-traumatic growth, which is conceptualized by Tedeschi and Calhoun (2009) as:

> The experience of positive change that occurs as a result of the struggle with highly challenging life crises. It is manifested in a variety of ways, including an increased appreciation for life in general, more meaningful interpersonal relationships, an increased sense of personal strength, changed priorities, and a richer existential and spiritual life (p.1).

The theoretical basis of PTSD following childbirth is limited; however, there do seem to be potential benefits to applying theories of general PTSD to the childbirth population. The research into PTSD following childbirth has examined predisposing, precipitating and maintaining factors (Slade, 2006). However the literature base is limited and sometimes contradictory and despite making the theoretical linking of contemporary theories of PTSD and PTSD following childbirth knowledge difficult, it is possible. All the three contemporary theories propose that prior beliefs and experiences impact on the integration into memory, and appraisal of, trauma event/s. Each theory places a differing weight of importance and highlight differing mechanisms in the role of prior beliefs and experiences, but all concur that the concept has a central role in the development and maintenance of PTSD.

The role of prior beliefs and experiences within the development of PTSD following childbirth may be explained by Dual Representation Theory (Brewin, Dalgleish & Joseph, 1996) and Ehlers and Clark's (2000) cognitive model through the influence of prior

expectations (not necessarily experience) of birth. For example, women may have idealized views (Choi, Henshaw, Baker & Tree, 2005) and expect the experience to be positive and rewarding (Lavender, Walkinshaw & Walton, 1999). When these positive prior expectations are not met by the event, PTSD symptoms may occur in the postpartum period. There is limited research investigating this, however Maggioni, Margola, and Filippi (2006) found no direct relationship between pre-birth expectations and PTSD following childbirth, furthermore high expectations were not related to negative outcomes, but low expectations were (Green, Coupland, & Kitzinger, 1990). Emotional processing theory (Foa & Riggs, 1993; Foa & Rothbaum, 1998) provides additional explanatory power, as it takes into account both negative and positive prior expectations within their concept of rigidity of views. These views are likely to be heavily influenced by societal and other women's subjective experiences of childbirth, indeed Savage (2001) suggest that other women's birth stories are a "way of knowing and learning about the values and beliefs surrounding childbirth must be incorporated and accounted for as a vital educational process" (p. 6). However other women's birth stories may not necessarily be positive, and through the influence of negative birth stories, negative expectations prior to giving birth may also occur for some women - they may dread the event, for primigravida mothers especially who may be influenced by their contemporaries. Fisher, Hauck and Fenwich (2006) qualitatively investigated how social context impacted women's fears of childbirth. One theme to arise was the concept of 'horror stories', with a participant describing the impact of these during pregnancy; "well I think the biggest thing is being a first time mum, a lot of people choose to be brutally honest about childbirth and they tell you all the horror stories, the ones you don't want to hear" (Fisher et al., 2006, p.69). These 'horror stories' may cause women to expect their birth to be 'traumatic', painful, and create an 'I'll never cope' attitude. If these women go on to experience birth as expected from the 'horror stories' they have been influenced by, negative

beliefs generated from prior expectations would be confirmed. In conclusion, prior beliefs, experiences and expectations whether positive or negative have the ability (although dependent on the actual birth experience) to hypothetically impact on PTSD symptomology following childbirth.

The role of cognitive processing style (Dunmore, Clark & Ehlers, 2001) during birth, and the appraisal of the birth sequelae can impact on the development of PTSD following childbirth. An example of a cognitive processing style associated with PTSD is mental defeat (Ehlers & Clark, 2000), and an appraisal example is the interpretation of continuing threat postnatally (Ayers, 2007). Ayers (2007) carried out qualitative research examining thoughts and emotions during a traumatic birth comparing a matched sample of women with and without PTSD symptoms. Results suggested that women with PTSD symptoms experienced more negative thoughts and emotions during birth, including mental defeat, and postnatally they reported more negative memories.

Ehlers and Clark's (2000) cognitive model and DRT (Brewin, Dalgleish & Joseph, 1996) both outline memory mechanisms that may explain the development, and symptoms, of PTSD. Although the concept of alternative (Brewin et al., 1996), or poorly elaborated memories (Ehlers & Clark, 2000) can be applied to the disorder of PTSD following childbirth, and would explain symptoms of fragmented conscious memories and 'flashbacks', there may be additional features specific to childbirth that need consideration. For example, during childbirth often strong analgesics are administered, additionally women experience huge hormonal changes. The biochemical status of women includes both endogenous (hormones i.e. oxytocin) and exogenous (i.e. analgesic use) factors which are idiosyncratic features of childbirth which may impact on memory systems distorting recall of the labour event (Niven & Murphy-Black, 2000).

The concept of peritraumatic dissociation is an element of PTSD development that is alluded to, but often not fully addressed within the general PTSD theory literature. Ozer et al., (2003) propose that peritraumatic dissociation is a major precipitating factor in general PTSD. Olde, van der Hart, Kleber, van Son, Wijnen and Pop (2005) found that psychoform perinatal dissociation predicts PTSD following childbirth, but is partially mediated by emotional reactions. Further research into peritraumatic psychological processing characteristics, (Ozer et al., 2003), both protective and maladaptive, utilised during childbirth (Slade, 2006) should be examined within a theoretical framework.

Currently PTSD following childbirth is considered as comparable to PTSD following alternative events by researchers and clinicians; however, it has additional idiosyncratic features (Bailham & Joseph, 2003). These need consideration when applying general theories of PTSD to the childbirth population and adjustments may be needed to explain and incorporate these features. One is the potential distribution and impact of distress when a woman suffers from PTSD following childbirth. The exceptional and irregular nature of the perinatal period affects relationships with close family members, and specifically the new born infant. The consideration of the potentially detrimental impact on relationships is critical in protecting the psychological, emotional, and physical needs of the infant and close family members. Alongside this the incorporation of risk/precipitating factors specific to this population is important, for example the role of social support (Ford et al., 2010; Czarnocka & Slade, 2003; Bailham & Joseph, 2003; Olde et al., 2006; Lyons, 1998), and social and personal expectations of birth in general seem particularly pertinent.

Conclusion

PTSD following childbirth is comparable to PTSD following alternative events, but may have some idiosyncratic features. On this basis contemporary psychological theories

can be applied to PTSD following childbirth, however much more research is needed. This research should focus on two aspects: the first is to test the hypothesis that the theories are able to successfully account for the phenomenology of PTSD following childbirth and the second is to identify any possible additional features specific to PTSD following childbirth and investigate whether these can be accounted for by current theories of general PTSD. If they cannot account for additional features it may be that theories specific to PTSD following childbirth need to be developed and empirically tested. In addition, the efficacy of treatment interventions, for which theories provide a framework, needs to be further empirically researched with a population of women experiencing PTSD following childbirth.

Research into childbirth in general needs to explore the experience of traumatic childbirth, with or without a diagnosis of PTSD, as there will be a sub-set of women who are experiencing the serious and negative implications of a traumatic childbirth, but who are not captured by the research which focuses only on those who are diagnosed with PTSD. In addition, the concept of traumatic childbirth needs to be considered within the psychological, social and cultural context of the event to explore how this context is framed and understood.

CHAPTER FOUR

General Literature Review

Contextualising women's experiences of childbirth within alternative perspectives

Historically in Western cultures childbirth was viewed as a social process, and in many other cultures this view is currently retained. Kitzinger (2012), a social anthropologist, outlines childbirth as a social process:

> Birth reinforces bonds between women and their community and, through them, their families. Birth is women's business, takes place in women's space, and is choreographed by women. They are powerful agents of social cohesion. Birth is a social act and is still in many cultures in southern and eastern countries today, although medical management is fast taking over. (p.301)

With the rise and development of the medicalisation of childbirth, women's experiences have become dominated by the medical perspective. The consideration of medicalisation is an integral aspect of feminist focus, in exploring how medicalisation impacts on women. The orthodox critiques of medicalisation present medicine as a patriarchal institution dominated by technology and logico-positivism, in which the 'experts' (often doctors) have authoritative and 'expert' knowledge which is used to guard against risk. This discourse of risk, expert narratives, and focus on logico-positivist knowledge helps to maintain control over women's health, illness, and reproduction. Perhaps one of the most obvious and discussed implementations of medicalisation is in terms of childbirth. As a 'natural', physiologically normative process, which historically was once considered a primarily social, domestic event (Cahill, 2001), the encroachment of technology, industrialisation and medicalisation on childbirth is clear with the medical model now dominating childbirth in the Western world. Medicalisation maintains its power through the extrapolation of the risk paradigm as a central component, and focus is maintained on the surveillance, regulation, and management of childbirth to manage this inherently risk-laden event (Henley-Einion, 2003). This in turn promotes the use of obstetric medicine and reproductive technology, both of which are primarily based on male-stream knowledge and

scientific understanding, thus creating and promoting the expert narrative and authoritative knowledge which is associated with power and control.

> The modern environment of birth is the institution – the hospital, with its own set of rules, standards of behaviour, language and technology. Risk and risk management are rapidly becoming the dominant discourses within the obstetric domains of this institution. In order to function within such a system, the woman and her partner must comply with and conform to the rules and standards, and their childbearing experience is likely to become redefined for them in terms of risk, risk reduction and risk management (Henley-Einion, 2003, p.188).

The medical model of risk management shapes the birth experience, and this is even more so for women who experience traumatic birth. "Between 20% and 48% of women around the world are reporting their birth experiences as traumatic" (Simpson & Catling, 2016, p.203-204), in the United Kingdom (U.K.) research suggests similar figures, with 34% women reporting traumatic birthing experiences (Soet, Brack & Dilorio, 2003). For a number of these women, between 1.5% and 5.6%, increasing for high-risk groups, implications include subsequent Post-Traumatic Stress Disorder (PTSD) symptoms and/or diagnosis (Ayers & Ford, 2012; Grekin & O'Hara, 2014). There are multiple contributing factors associated with women's perceptions of their birth as traumatic, as well as multiple negative consequences, for both the mother, family, and society (Ayers & Ford, 2012).

Unlike the medical psychiatric diagnosis of PTSD, which has specific criteria outlined in the diagnostic manuals, traumatic childbirth is difficult to define and assess (Elmir, Schmeid, Wilkes & Jackson, 2016: Greenfield, Jomeen & Glover, 2016). This is due not only to its subjective nature, but also because of differing conceptualizations.

Historically, there was a move from the reductionist biomedical model of health and illness, to Grinker coining the term 'biopsychosocial' in the 1950s, and then Engel (1977)

applying this model to medicine in the 1980s (Ghaemi, 2009). The two conceptualizations of 'birth trauma' reflect these two models of health and illness. The medical or biomedical model conceptualizes 'birth trauma' based on the physicality of the injury and/or harm to the mother or infant during birth. Thus, focusing on the disease, rather than the whole person. This is comparable to the diagnosis of PTSD, where the focus is on psychiatric symptoms of a diagnosable disorder, rather on the subjective experience of the individual. When exploring the phenomena of traumatic childbirth, the biopsychosocial model is more readily accepted, as Beck's (2004) paper aptly describes birth trauma as being 'in the eye of the beholder'; the mother's perception of her birth as traumatic. This perception may or may not be representative, or due to, any physical or objective traumatic injury or event during childbirth.

The biomedical model has been explored in chapters two and three in reference to both the psychiatric diagnosis of PTSD and associated theories, and how this is now understood as a possible medical diagnosis following childbirth experiences. The majority of research into Post-Traumatic Stress Disorder (PTSD) following Childbirth has focused on the antecedents of the disorder, in an attempt to understand and reduce the associated factors to reduce incidents of traumatic childbirth and thus PTSD following childbirth. In addition, the difference between objective, bodily birth trauma explored in the obstetric research literature, and the subjective perception of psychological traumatic childbirth is examined. Whilst this wealth of knowledge generated through the diagnostic manuals, theoretical accounts and empirical research findings, is important, the dominance of the positivist tradition and medical perspective underplays the legitimacy of the women's subjective expert experience, and marginalises the accounts of individuals.

The biopsychosocial model is more extensive, integrating biological, psychological, social, and cultural factors of health and illness (Suls & Rothman, 2004), and considers the whole person rather than just the disease (Smith, 2002). It is this biopsychosocial model

which may best explore the psychological and subjective phenomena of psychological traumatic childbirth. Saxbe (2017) suggests that the biopsychosocial model is not utilized enough in research into childbirth and makes a case for future inclusion and enhancement of this model:

> Biopsychosocial research on childbirth can extend knowledge of pain, stress, social support, and many other phenomena into a realm with powerful implications for lifelong health (p.84).

Although there are criticisms of how the biopsychosocial model is utilized with critical health psychology suggesting that it essentially remains a biomedical perspective, and there is largely a lack of integration of the components (Chamberlain & Murray, 2009).

Childbirth remains a complex social process and transition, and it is important that the social paradigm is considered as it explores the entirety of the childbirth experience and not just the immediate, medical and physical event. In the exploration of the social context of childbirth this chapter critically examines the dichotomy between the technocratic, medical perspective of birth and the 'natural' childbirth movement. It aims to critically evaluate the social perspective in framing and understanding women's childbirth hopes and expectations prior to their childbirth experiences, using fictional and personal accounts as examples. This is achieved through an exploration of why and how childbirth expectations and hopes are created and how these two related, but independent beliefs are constructed and reconstructed in response to wider social and cultural norms and ideas. Exploration of how hopes and expectations of childbirth are influenced draws on the multiple sources of information utilized by women (and men) when they are developing and shaping their understandings of the possibilities of the childbirth experience. These information sources demonstrate the combination of the biomedical, social, and cultural factors which influence individuals framing and understanding their hypothetical childbirth experiences.

Secondly this chapter examines the transition to motherhood exploring the social and psychological processes occurring through this period. Theoretical accounts of the transition to motherhood, including van Gennep's (1960 [1909]) 'Rites of Passage' model and Rubin's (1967) and Mercer's (2004) 'Maternal Role Attainment (MRA) and 'Becoming a Mother' (BAM) frameworks, are critically examined. Part of the transition to motherhood is the incorporation of a maternal identity into the sense of self, and this transformation of self-identity includes losses and gains. This chapter also explores the cultural representations of motherhood, and how, in the U.K. motherhood is often culturally framed as a natural, instinctive and enjoyable role and identity, which links into the cultural concept of a 'good mother' and mothering orientations (Miller, 2007; Raphael-Leff, 2015). This chapter concludes with a section on the feminist perspective and associated research methods utilised in highlighting the perspective of the woman and her unique experiences when researching motherhood.

Childbirth as a Medical or 'Natural' Event

The social perspective has become somewhat synonymous with the 'natural' childbirth rhetorical viewpoint. The medical discourse situates childbirth within a biomedical/technocratic model, conceptualising a process with inherent risks which requires medical management (van Teijlingen, 2005). In high-income countries this medicalisation of childbirth (Henley-Einion, 2003) acknowledges that "interventions to address the known risks associated with pregnancy and birth have been largely successful and have resulted in very low levels of maternal and neonatal mortality" (Shaw et al., 2016, p. 2282). The medicalised approach is also associated with a rise in unnecessary interventions and increasing medico-legal issues (Johanson, Newburn, & Macfarlane 2002). In contrast the 'natural' childbirth discourse has an inherently vague framework, but in its purest form it

outrightly rejects that medical model, aiming to return childbirth to a natural, instinctive and intervention-free social event (Mansfield, 2008). With the knowledge that "the term 'natural' is often taken as a proxy for 'good'" (Conrad, 2007, p.91), both Mansfield (2008) and Kitzinger (2012) outline how 'natural' and traditional social conceptualisations of childbirth have a tendency to romanticise the childbirth experience.

Although the social perspective and 'natural' childbirth discourses have issues, the conceptualisation of childbirth as an entirely medical event does not allow for the consideration of the entirety of experience. Since the 1970s for feminist writers such as Oakley (1980) the dominance of the technocratic medical model of childbirth reflected the patriarchal and androcentric vision, establishing control over, and disempowering women's subjective experiences of health, pregnancy and childbirth. These subjective experiences, by their very nature, encompass and acknowledge the shared social aspect of childbirth (Kitzinger, 2012). The dominant discourses surrounding childbirth in Western societies are echoed in women's experiences (Walsh, 2007; Nettleton, 1995;1996), which sits somewhere in the middle of the conceptual dichotomy between medicalised and natural birth (Walsh, 2010). Therefore, instead of conceptualising childbirth as an entirely medical event, also exploring the concept of childbirth as a social, transitional life event is also important (Walsh & Newburn, 2002). This, in addition, allows for the consideration of the social aspects of health care, highlighting and legitimizing 'softer', but equally important, aspects of health care provision, for example, the creation of relationships and more holistic forms of support (Oakley, Rajan, & Grant, 1990; Oakley, Hickey, & Rajan, 1996).

It is important to acknowledge the shared social experience of childbirth, alongside the dominance of the medical model and the biological, natural perspectives by understanding the relationship between nature and science – the biosocial approach (Jordan, 1993 in Mansfield, 2008) in understanding traumatic childbirth. A balance between these

perspectives is required to reduce the levels of perceived traumatic childbirth experiences. Linking to the previous chapter exploring the antecedents of PTSD following childbirth, the importance of the social experience is demonstrated because social support has been identified as a risk factor in the development of PTSD. More specifically it is associated with PTSD following childbirth symptoms (Czarnocka & Slade, 2000), and also encompasses professional support (Cigoli, Gilli & Saita, 2006).

Childbirth Expectations and Hopes

Differing factors involved with the social perspective of childbirth have been investigated through research over a number of years. The impact of society and culture on mothers' (and fathers') childbirth hopes and expectations prior to the event is one area of consideration.

An expectation is "1) the act or state of expecting or the state of being expected, 2) something looked forward to, whether feared or hoped for" (Free Dictionary, 2019). Although taken from a dictionary the second part of this quote lends itself to the childbirth literature, for what could be more 'feared and hoped for', than the event of childbirth. For the majority of mothers and fathers the months preceding the birth of their baby is a time of preparation. Included in this preparation is the consideration of the birthing process, this will involve thinking about their expectations and hopes for this life changing event. Indeed, previous to, and during pregnancy, women will continuously develop and evaluate multiple expectations about the birth experience (Gupton, 1991). By building expectations of childbirth women are able to create a psychological representation of what they anticipate happening during their childbirth experience. This continuous, and not necessarily conscious, reflexive process can be adaptive as "forming expectations for major life events can help one prepare mentally and physically for the experience" (Martin, Bulmer, & Pettker, 2013, p.103). However there can be a 'gap' between what is expected and what is actually

experienced during childbirth (Lally, Murtagh, Macphail, & Thomson, 2008), and this can cause difficulties in the post-partum period.

Childbirth expectations are multi-faceted and include both positive and negative possibilities concerning a range of obstetric, social and personal characteristics and attributes. The considered elements may include; obstetric events, pain levels, expectations of self, including control, and emotional responses, expectations of other, including professionals and birth partners, and expectations of the context of the birth. Expectations are built and augmented throughout a person's lifetime, changing in response to incoming information, with the greatest adaptions to expectations probably occurring during pregnancy as the prospect of childbirth becomes more imminent.

Childbirth hopes are idealized-based in comparison to expectations. In this instance 'childbirth hopes' refer to what a woman would ultimately desire or wish for her birth experience. It may be that in some instances expectations and hopes of childbirth are identical, however there may be vast divergences and an inconsistency between what is expected and what is hoped for from childbirth. The distinction between birth expectations and birth hopes "is not trivial, in that expectations are commonly based on knowledge of what is available, whereas preferences concern an individual's wishes" (Hodnett, 2002; Melender, 2006). For example, a woman may expect childbirth to be extremely painful and to feel out of control, but may hope to not feel too much pain or too out of control. Again, a woman may have a pre-planned caesarean, so what she expects from childbirth is a caesarean section, but what she hopes or wishes for is a home water birth. These two are examples of a divergence between expectations and hopes, however there may be cases where there is little or no inconsistency between what is expected and what is hoped for. For example, a woman may wish for a hospital birth with an epidural but no further interventions, and this may also be what she expects to happen during her labour.

Fictional and personal account examples of childbirth expectations from literary sources are provided below, the first is a more contemporary account from an autobiography authored by a modern-day popstar – Myleene Klass (2009), and the second is taken from the novel 'Surfacing' by Margaret Atwood (1972):

> But I was certain about how I wanted the labour to go I wanted it to be just me and Gary. I didn't want him down the business end and I wanted an epidural (p.214).

> This time I will do it by myself, squatting, on old newspapers in a corner alone; or on leaves, dry leaves a heap of them, that's cleaner. The baby will slip out easily as an egg.

Whilst the biological and physiological process of birthing a baby has not changed, the external aspects and the woman's experience of the event have changed dramatically over the years. Childbirth expectations are products of wider cultural and societal norms. Indeed as medical technology has progressed (Fenwick, Hauck, Downie, & Butt, 2005) and societal views of birth have adapted and changed (Cassidy, 2007), so too have people's expectations of childbirth (Green, Coupland, & Kitzinger, 1998). Although there is a general shift through the years, expectations are by their very nature specific to the individual and can differ greatly between women. This is likely to be a result of mothers' differing demographics, experiences and whether they identifies with the medical model or the natural model of childbirth (Fenwick et al., 2005). Slade, MacPherson, Hume, & Maresh, 1993) suggest that women can hold multiple expectations of birth, and that both positive and negative dimensions of expectations can co-exist independently.

How women's and men's expectations of childbirth are influenced is an important consideration. Throughout history the sources of information used by people when forming and adapting their expectations of childbirth have changed to reflect the social and cultural norms of any given period (Cassidy, 2007). Birth expectations and hopes are created through multiple sources, with each source holding more or less weight and credibility as time progresses. Presently there are multiple sources of information concerning childbirth, and it is likely that women's and men's expectations are built and revised in response to the information available to them.

There are four main sources of information for women regarding what to expect during childbirth; authoritative knowledge (Lothian, 2008), 'the women's network', the written word, and childbirth preparation classes (Nolan, 1997). Authoritative knowledge refers to an inner wisdom that women as the experts of themselves possess within, allowing for some expectations of what may occur during childbirth (Lothian, 2008). 'The women's network' is probably the most pervasive and lasting source of information which is used by women to create birth expectations (Nolan, 1997). It refers to the sharing of information about childbirth between females; mothers, other family members, friends and associates. This shared knowledge and shared experience can be viewed in everyday life when the topic of birth is raised in conversation, almost every woman who has experienced childbirth has a view, an experience, or an anecdote to relate to others. The sharing of childbirth information and experience by written word has become increasingly popular as society has developed and changed, and the notion of tight-knit communities are becoming rarer. The need and popularity of accessible written knowledge began in Victorian times and can be attributed to the publication of an encyclopaedia for domestic-life titled 'Enquire within about everything' (Anon., 1856 as cited by Nolan, 1997). In the absence of a substantial 'women's network' women have turned to books, and more recently internet sites, to learn about childbirth and

what they should expect from this experience. This is evidenced by the thousands of books published about what to expect during pregnancy and labour, and the multitude of internet sites dealing specifically with this subject. Information about birth can also be gained from specific educational classes, there are two types of classes; those usually run by professionals, for example midwives, these are often called antenatal or childbirth preparation classes, and focus on factual information and advice. In the U.K. these classes are usually run by the National Health Service (NHS, 2019) and are often aimed only at primiparas. The second type of childbirth preparation class are those run by voluntary organisations; in the U.K. this tends to be National Childbirth Trust (NCT, 2019), but these are becoming more diverse.

Figure 4.4 outlines the potential sources of information concerning childbirth. Qualitative research has investigated, from the viewpoint of the mother, potential informal or anecdotal sources (i.e. other mothers) and formal or authoritative souces (i.e. antenatal classes) sources of information (Fenwick et al., 2005; Martin et al., 2013). In a national U.S. survey titled 'Listening to Mothers II', Declercq, Sakala, Corry, and Applebaum (2007) state that women perceive books (33%) as the most important source of childbirth information, followed by friends and family (19%), doctors/midwives (18%), the internet (16%) and following these, antenatal classes (10%). Indeed, as previously suggested, as technological advances are made, the sources and ease of access to information regarding childbirth grow, and it is probable that in the next few decades reliance upon books will be replaced with the internet.

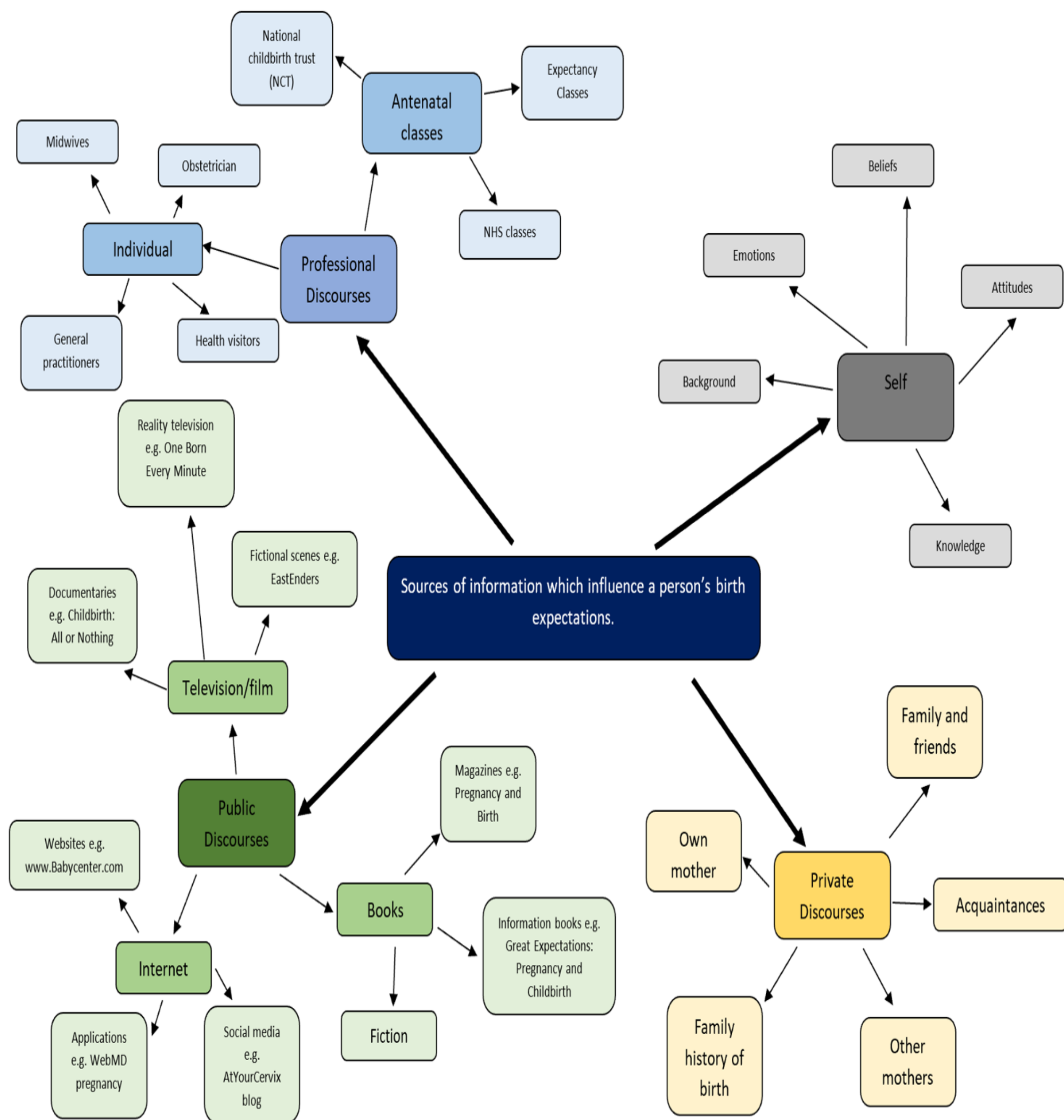


Figure 4.4: Potential sources of information about childbirth which many influence people's expectations.

The role of fathers in childbirth has changed dramatically over the past century. From the 1970s onwards a shift occurred, from the societal view that fathers did not have a place in the delivery room, to now expecting fathers not only to be present, but also to be actively involved (King, 2015). Therefore it is also important to acknowledge and examine fathers' expectations of childbirth. Hallgreen, Kihlgren, Forslin, & Norberg (1999) suggest the idea of 'vital involvement' of fathers in childbirth; this relates to the idea that pregnancy, childbirth and the post-partum period can be experienced as a couple with both members being involved, and although opportunities and experiences of involvement can differ there is shared understanding that fathers' involvement is as important as mothers'. Fathers will of course experience childbirth differently to mothers, and will therefore experience different challenges (Schytt & Bergström, 2014). Fathers will have expectations placed upon them, to, for example, participate in, and support their partner during the labour process (Fenwick, Bayes, & Johansson, 2012), and they will also have their own expectations of childbirth.

A qualitative study by Fenwick et al (2012) with twelve fathers suggests that men tend to develop their expectations of childbirth as the pregnancy progresses. Initially the men claimed that they did not have any expectations; indeed, they did not know what to expect. However, expectations were built and developed as the pregnancy progressed, with fully-formed expectations usually present by the third trimester. Fathers suggested that their expectations were created in response to incoming information from books, television etc. (Fenwick et al., 2012), which are similar to informational sources suggested by mothers (see figure 4.4) (Ayers & Pickering, 2005; Gibbins & Thomson, 2001; Martin et al., 2013). In addition, fathers also stated that their own expectations were heavily influenced by those of their partners. As fathers experience childbirth differently to mothers, there were subtle differences in the way in which factors of expectations were described, for example, watching their partner in pain, but the actual topics were very similar to those of mothers, for

example, expectations of support, pain, pain relief and the hope for a healthy baby and an uncomplicated delivery (Fenwick et al., 2012). Quantitative research suggests that there are no differences in the childbirth expectations of mothers and fathers, this is based on a sample of 200 Taiwanese couples (Kao, Gau, Wu, Kuo, & Lee, 2004). But the father's age may impact upon how positive or negative his expectations are, for example from a sample of 777 first time fathers Schytt & Bergström (2014) found that older fathers were more concerned about the labour process and had more negative feelings, including fear, involved in their expectations of the birth.

Theoretical Accounts of the Transition to Motherhood

The social perspective of childbirth considers the childbirth event and associated perinatal experiences as a transitional life event. This influential psychosocial developmental event involves a movement from a known to a relatively unknown reality (Mercer, 2004) and requires a substantial complex and multidimensional psychosocial adjustment (Winson, 2009). There are a number of theoretical frameworks which have attempted to account for this, including van Gennep's (1960) Rites of Passage model, and Rubin's (1967) theory of 'Maternal Role Attainment' (MRA) and Mercer's (2004) continuing development of this theory, eventually replacing the original term with 'Becoming A Mother' (BAM) to acknowledge the continuous development of maternal identity through a lifetime.

Van Gennep's (1960) 'The Rites of Passage' framework.

The seminal work of anthropologist van Gennep (1960 [1909]) describes 'The Rites of Passage'; a theoretical framework which explores life transitions and is built on the observation of universal applications of explicit 'rituals' within cultures. These 'rituals' are used to signify social and cultural transitional life events in which people move from one stage or 'position' to another. This framework has been applied to numerous life events,

from career transitions (Mayrhofer & Iellatchitch, 2005) to illness (Martin-McDonald & Biernoff, 2002). Van Gennep (1960) outlines a three-part framework for the transition through stages, which is demonstrated below in figure 4.5.

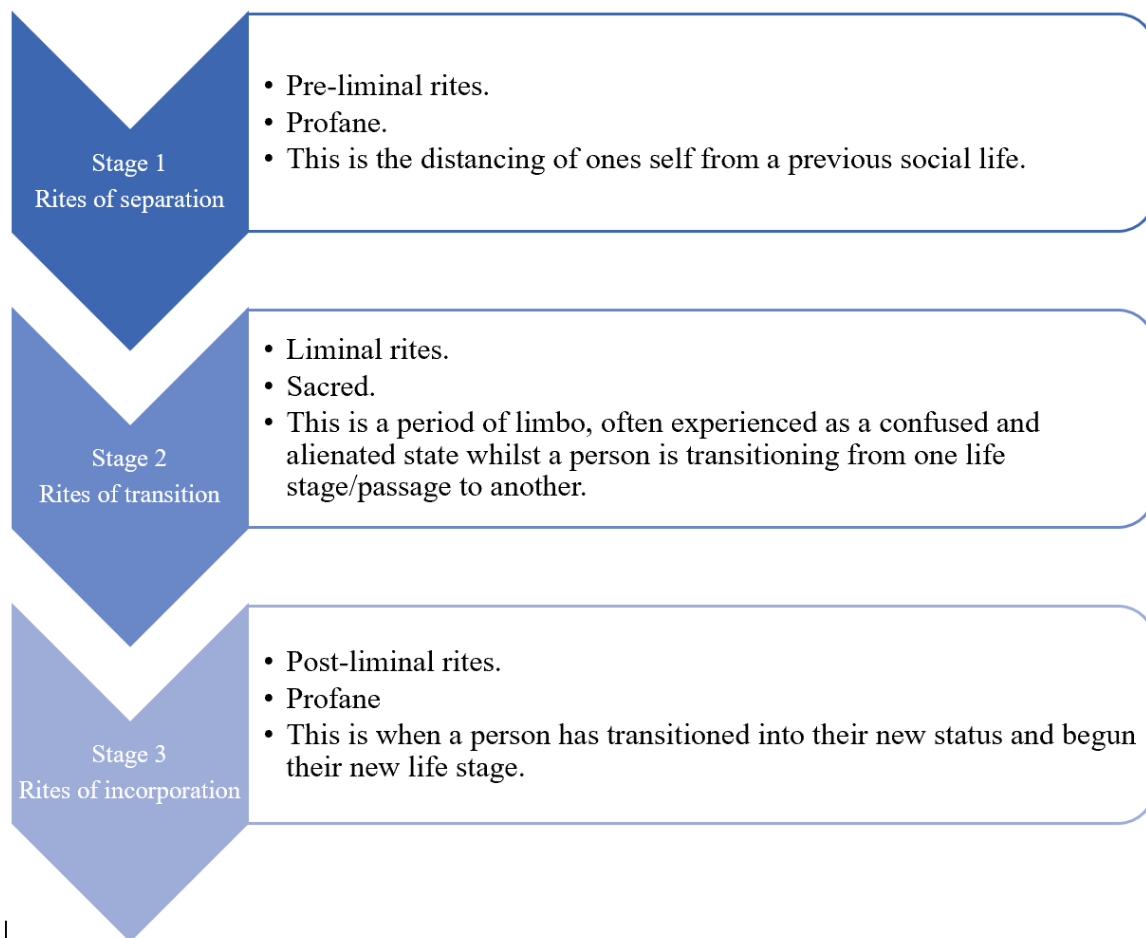


Figure 4.5: The tripartite structure of the Rites of Passage as described by van Gennep (1960 [1909]).

Van Gennep's 'Rites of Passage' are explained here using the example of the maternal transition into motherhood. The initial rites of separation involve a move to distance oneself from the previous social role/status: this occurs during pregnancy, with both the woman and society beginning to recognise her as different. The rites of transition stage;

an ambiguous transitional period of liminality or marginality, is viewed in different ways by different cultures with regard to pregnancy and childbirth (Winson, 2009). Turner (1967) describes this as an 'in-between period', when applied to pregnancy and childbirth, it is when a woman is between two social statuses, she is not a single individual, and she is not yet a mother (Winson, 2009). From this stage a person in transition moves into the 'rites of incorporation', which signals a coherent move into a new life stage or 'position' with a new social role/status. In terms of the transition to motherhood, this is the point at which both the mother and society recognise the person as a mother, with an understanding of the new identity and responsibilities (Winson, 2009). Van Gennep's (1960) 'Rites of Passage' model is simple, but explanatory and maps onto the transitional and developmental experience of pregnancy and childbirth coherently. It has been used by a number of researchers exploring childbirth as it draws attention to the social context and provides a framework for understanding a range of childbirth and perinatal experiences (Cote-Arsenault, Brody, & Dombeck, 2009).

Rubin's (1967) Theory of 'Maternal Role Attainment' (MRA) and Mercer's (2004) theory of 'Becoming A Mother' (BAM).

Reva Rubin (1967) undertook a piece of longitudinal, qualitative research and the findings from this study, alongside the influences of developmental and role theories, informed her creation of the theory of 'Maternal Role Attainment' (MRA) (Meighan, 2018). This account of the transition to motherhood focuses on cognitive and social processes (Rogan, Shmied, Barclay, Everitt & Wyllie, 1997), which result in the outcomes of a mother 'binding-in' with her infant (a broader conceptualisation similar to attachment), and the achievement of, and comfort with, a maternal role identity (Meighan, 2018). Meighan (2018) defines maternal role attainment, including a direct quotation from Mercer (1981):

> Maternal role attainment is an interactional and developmental process occurring over time in which the mother becomes attached to her infant, acquires competence in the caretaking tasks involved in the role, and expresses pleasure and gratification in the role (Mercer, 1986b). "The movement to the personal state in which the mother experiences a sense of harmony, confidence, and competence in how she performs the role is the end point of maternal role attainment – maternal identity." (Mercer, 1981, p.74). (p.434).

Rubin (1967) outlines three topics involved in the achievement of maternal role identity. These are; the 'taking-in' process, the self-system, and operations. The 'taking-in' process refers to how a woman understands 'becoming a mother'. The self-system refers to the mother's self-image, body image and ideal image, these aspects of image are linked to self-esteem and the ability to undertake the maternal role (Winson, 2009). Operations refer to five active processes which mothers transition through, beginning with a more superficial identity towards a deeper, internal identity achievement (Rubin, 1967). These operations are depicted in figure 4.6 below:

Figure 4.6: The five operations outlined by Rubin (1967), which are involved in the transition to achieving a maternal identity.

Mimicry is the term used for describing a mother's attempts to seek information and her observation of other mothers. Role-play describes a mother's attempts to have ago at playing the part of the mother, either through trying out pushchairs, or playing the part with others' children. These two stages were later combined and re-named 'replication' (Rubin, 1984). 'Fantasy' describes a woman's fantasies about becoming a mother, and introjection-projection-rejection is when a woman explores the information she has acquired, incorporating aspects which are appropriate for her, and rejecting those which are not. This operation was also later renamed as 'dedifferentiation' (Rubin, 1984). The final operation is

the grief work which is when a woman grieves for aspects of her identity which she has to relinquish as they do not fit with the new maternal role identity. The process concludes with a new role identity (Mercer, 2010).

Ramona Mercer, a student of Reva Rubin's, continued to develop the theory of 'Maternal Role Attainment', which incorporated developmental and role theories, including Thorton and Nardi's (1975) theory of role acquisition. This is demonstrated below in table 4.3 which outlines the four stages involved in maternal role attainment which women sequentially progress through in order to achieve their maternal identity.

Table 4.3: A representation of the four-stage process outlined by Rubin (1967) and developed by Mercer (1991) in the development of maternal role identity (Meighan, 2018).

Rubin and Mercer's stages of maternal role identity achievement (have been re-named and re-defined over time)	**Description of the stage**	**Time period for each stage**
Commitment and preparation	A period of psychological adjustment and preparation in readiness to take on the maternal role.	Pregnancy
Acquaintance, learning, and physical restoration	Assuming the role guided by social systems and information from others.	2 weeks post-partum
Approaching normalisation	A period in which the mother develops her own unique way of mothering.	2 weeks to 4 months post-partum
Integration of the maternal identity	Signifies the achievement of the maternal identity and the joy of motherhood.	4 months post-partum

A mother's progression through the four stages is influenced by a multitude of factors, including maternal and infant characteristics and experiences, as well as multiple environmental influences. Mercer (1991) draws on Bronfenbrenner's (1986) interacting levels of nested environments; microsystem, mesosystem, and macrosystem. These broadly map onto the intimate environment (the family unit), which in turn is embedded in a community, and this is embedded into a society with laws and cultural consistencies (Mercer, 2006).

In 2004 Mercer retired the term ‘Maternal Role Attainment’ replacing it with ‘Becoming A Mother’ (BAM), reflecting the development of research which demonstrates that there is a process of continuous evolvement of motherhood throughout a lifetime, and thus a theory with an end point goal of role attainment does not reflect this continuity of process (Meighan, 2018). In addition, Mercer (2004) demonstrated that with each childbearing event women proceed through a transition which incorporates substantial psychosocial work.

> A new personality dimension is incorporated into a woman’s self-system with the birth of each subsequent child, with no transference of a maternal identity from one child to another. Each childbearing experience is different, just as the woman’s life space and self-system are different. The uniqueness of each child, and of the mother at that particular point in her life, require systematic, extensive maternal work in getting to know and incorporate each child into herself and family systems (Mercer, 2004, p.227)

The theories of the transition to motherhood tend to over-simplify and reduce the experiences of the mother during this period. Rubin and Mercer’s theoretical frameworks have been widely criticised for being baby-centred, rather than woman-centred, reducing their applicability to the midwifery profession (for which they were created). They also create yet another, alongside the medical model, expert discourse. This expert discourse pathologizes women when they do not conform to, or achieve the required outcome and can disempower the people and diminish the experiences it seeks to explain.

Parratt and Fahy (2011) present a lengthy feminist critique of the theory on the transition to motherhood. They argue that the theoretical framework of ‘Maternal Role Attainment’ (Rubin, 1967) and ‘Becoming a Mother’ (Mercer 2004) create a singular, prescriptive, functional pathway through the transitional period, which is the same for all.

This meta-narrative of the logico-empirical approach over-simplifies the process, reducing the understanding of the diversity and complexity of experience. Focusing on the similarities in experience during the transition to motherhood does not allow for the consideration of the complex embodied lived experience of the individual, and the exceptions to the general, normative trajectory (Parratt & Fahy, 2011).

Parratt and Fahy (2011) also criticise the humanist philosophy of which the transition to motherhood is an expression, commenting on how these theoretical frameworks essentialise the woman, reducing her to her role in caring for the baby, rather than exploring and considering her personal experiences. This demonstrates the need to explore childbirth and the transition to motherhood from an alternative perspective, namely the post-structuralist feminist perspective, as this allows the embodied, complex, lived experience, including the subtleties and exceptions to be embraced within the research arena.

The 'Good Mother' Discourse

There exists a contemporary socially constructed and culturally pervasive discourse of the 'good mother' and 'ideal motherhood' in the U.K. The universalistic and essentialist 'good mother' script is created through the negotiation of dominant discourses, and provides unrealistic assumptions and expectations which are embedded into the discourses surrounding motherhood (Miller, 2007). The stereotypical 'good mother' incorporates the concept that women have biological abilities, this concept describes motherhood as 'natural' and 'instinctual' (Cosslett, 1994), and resonates with multiple aspects of motherhood, including bonding, breastfeeding, and giving birth, to name but a few. The other strand is that women incorporate and accept the medicalisation of motherhood, through their adherence to the 'expert' medical view. These common and pervasive biomedical discourses create expectations of motherhood for women, and through 'achieving' aspects of motherhood

'naturally', 'instinctively', and as prescribed by medical experts, women become framed as 'good mothers'.

This universal and essentialist view of what constitutes a 'good mother' does not allow for any diversity in the conceptualisation, it also does not recognise or explore the experiences of women who do not feel that they 'achieve' the status of 'good mother'. The power of these pervasive discourses can have a significant impact on how women frame and understand their experiences of motherhood. As is explained by Miller (2007):

> Women continue to come to motherhood with unrealistic expectation, the unrealistic expectations are embedded and reinforced through the strands of discourse that in powerful ways shape thinking about motherhood (Bobel, 2002; Hays, 1996; Oakley, 1979; Rich, 1977) (p.339-340).

In comparison, Raphael-Leff (2010) explores motherhood from a psychoanalytical perspective exploring the de-subjectification of motherhood which negates the experiences of mothers. She also highlights how 'failures' associated with the 'good mother' discourse can produce maternal guilt, anxiety, and self-blame, and through the pathologizing of women's responses to motherhood society can create a 'demonization of mothers'. Raphael-Leff (2010) outlines orientations of mothering based on distinct philosophies, thus exploring an alternative view of motherhood. This view begins to dismiss the universal, idealised perspective of motherhood, arguing that it does not represent the normative diversity of experience (Raphael-Leff, 2010; 2015). This diversity of experiences and healthy ambivalence outlined by Raphael-Leff (2010), alongside paediatrician and psychoanalyst Winnicott's (1971) description of the 'good enough mother', allows some degree of flexibility, and promotes a move away from the discourse of a 'good' or 'ideal' mother.

Conclusion

Childbirth is still a social and psychological event, but with attention focused on the biomedical model, there is little explicit recognition and embedding of this perspective in the research into traumatic childbirth and subsequent PTSD. The testable and concrete aspects of the role of social relationships and wider social systems are explored in the literature, and research demonstrates the importance of social support in preventing PTSD following childbirth, and the impact of interpersonal relations, especially with health care professionals, during childbirth experiences as an influencing factor in the perception of childbirth as traumatic (Simpson & Catling, 2016). The research and theoretical accounts which represent the social perspective are not without their limitations and criticisms, however the consideration of this perspective helps to challenge the implicit idea that the medical model is the best model (Kitzinger, 2012). The tensions created by a lack of congruence in the management of childbirth are reflected in social practices and processes around birth, and embedded in the narratives of women's childbirth experiences (Brubaker & Dillaway, 2009; Henley-Einion, 2003; Makacrida & Boulton, 2013; Walsh, 2010).

Childbirth is a 'pivotal and paradoxical life event' (Prinds et al., 2014), with associated multidimensional and complex processes. Chapters two, three and four demonstrate the need to consider the entirety of the childbirth experience and associated period, not just the clinical event of physiologically giving birth, as there is substantial psychosocial work which occurs prior to and after the actual childbirth event. This whole experience perspective allows the consideration not only of the individual journey, but also the social and cultural context in which the journey occurs. Both the biomedical and the 'natural' childbirth conceptualisations of childbirth, alongside the theoretical frameworks of the transition to motherhood, tend to universalise the birthing experience. They also tend to position their understandings as expertise, thus disempowering and devaluing the woman and

her experiences. This thesis refocuses the key consideration away from the competing ideologies of the medical model or the social perspective towards the woman's subjective experience of birth. Framed within the feminist perspective and utilising associated research methodologies this thesis highlights the rich, valuable, and diverse nature of traumatic childbirth experiences.

Researching motherhood and valuing the voices of women

From first wave feminism in the late nineteenth and early twentieth centuries, which focused on gaining political equality, through to second wave feminism in the 1960/70s, exploring personal inequality, and the rise of the third wave of feminism in the mid 1980s, the questioning and challenging of inequality and oppression has been the focus of feminism. Although key areas of interest have developed and changed, there has been a consistent interest in women's reproductive and sexual matters throughout the history of feminism, which is directly related to health and illness.

The women's health movement beginning in the 1970/80s explores the broad spectrum of health and illness for women and spans multiple disciplines. This movement examined and challenged the entrenched sexism in the dominant biomedical, technology-orientated health-care systems (Sherwin, 1998). It did this both in terms of women as users of health care, but also of women as workers in health care (Doyal, 1983). Driven by a passion to move away from medicine, androcentrism and the associated oppression (Tuana, 2006), and the objectification of women as 'human tools', the movement explored the politics of knowledge, including the 'epistemology of ignorance' (Tuana, 2006). Through reducing oppression and developing and championing women's embodied health knowledge, the women's health movement sought to explore what we know, who knows it, and also what do we not know and why do we not know it?

Activists from the women's health movement used their own and others experiences as evidence for a need for change (Sobnosky, 2013), this drove forward the embedding of women's experiences into the knowledge base. Indeed, the Feminist Health Care Ethics Research network have highlighted how the medically-dominant perspective of health perpetuated oppression through the de-valuing of non-medical contributions to knowledge (Sherwin, 1998), of which experiential knowledge is one. However, the second wave of feminism has been criticised for essentialising womanhood, and being dominated by predominantly white, middle-class experiences. The third wave of feminism has tried to move away from these criticisms, and one way in which they do this is through the use of intersectionality theory (Carastathis, 2014). This aims to incorporate different groups, whilst recognising differences between those groups, and acknowledging the social and cultural context, thus moving away from the previous homogenisation of womanhood. The issue then is that with the creation of 'different' categories or groups of women, it is still expected that these will have common or normative experiences and interests, once again falling into the trap of essentializing women's experiences (Carastathis, 2014). Post-modernist feminism arose from the post-modern and post-structuralist era, proposing to examine the flaws of modernist feminism (Zalewski, 2000). Part of this feminist perspective focuses on an opposition to essentialism (Flax, 1990) and sweeping meta-narratives (Zalewski, 2000), instead exploring the difference and complexity of constructed meaning and subjectivity (Zalewski, 2000).

This thesis focuses on childbirth, and perinatal mental health, as an individual, subjective experience, thus highlighting the uniqueness of experience. Although as is demonstrated throughout the literature review chapters childbirth is a physiological, psychological, social, and cultural phenomena, how these contexts are experienced is different for each individual. Therefore, women's individual, subjective experiences and

understandings are presented as forms of valid and important knowledge. In order to gain this experiential understanding of women's subjective experiences of traumatic childbirth and associated perinatal mental health problems this thesis draws on qualitative methods to gather data. Although the feminist perspective incorporates a range of research methods, qualitative methods tend to be favoured. Westmarland (2001) suggests that this is because some feminists propose that quantitative methods are associated with positivist science and thus masculinity, which is at the cost of the inclusivity of women (Oakley, 1974). Although hesitant to enter such a debate, this thesis uses qualitative methods as they allow for subjective knowledge, and reduce the potential oppression of women in research through the consideration of equality between the researcher and the researched (Oakley, 1974; Westmarland, 2001).

CHAPTER FIVE

Literature Review for Study One: The Health Visitor Study

Exploring Perinatal Mental Health Care Provision and the Health Visiting Profession

Chapter five is presented as an introduction and orientation to the study exploring how Health Visitors frame and understand Perinatal Mental Health Problems (PMHP). This is the first of two studies presented within this thesis. As outlined in the introduction this study initially aimed to explore Health Visitors' (HVs) knowledge and understanding of PTSD following childbirth. However, due to the participants' hesitancy at answering questions directly associated with this initial research question, the scope was extended, before analysis of the data, to encompass perinatal mental health problems (PMHP) more broadly.

The aim of this chapter is to explore the policies, practices and research associated with U.K. Health Visitors' (HVs) roles and responsibilities in caring for families with PMHPs. This achieved through an exploration of maternal mental health care provision, the history of Health Visiting as a profession, and the principles and service specifications associated with this public health focussed role. This chapter then combines these two areas to examine the research literature base of HV's roles and responsibilities in PMHP. This includes sections on the detection and management of PMHP and associated barriers and facilitators, with a focus on the role of intuitive skills and building HV-family relationships and how these are used by HVs in the detection and management of PMHP.

The choice to focus on HVs rather than any other professionals involved in the perinatal period primarily occurred due to a paucity of research exploring Health Visitors' understanding of traumatic childbirth and subsequent PTSD, whereas there is some research exploring the role and experiences of midwives (for an example see Cunen, McNeill, & Murray, 2014), who are the other principle primary health care provider in the perinatal period. In addition, the impact and the consequences of traumatic childbirth and associated PMHP present in the post-partum period, which is when the HV input is most substantial. Indeed, the DSM-5 (APA, 2013) for a diagnosis of PTSD requires the symptoms to have

been present for at least one month (see table 2.1), which would go beyond the usual post-partum care of midwifery (see figure 5.7). HVs' remit has also broadened to encompass the identification of a range of PMHPs (Jomeen et al., 2013) rather than just focusing on post-natal depression. Finally, the approaches to care between midwives and HVs differ, in that HVs tend to work in a more holistic manner due to their broader and relatively fluid roles and responsibilities within health.

This chapter begins with a brief exploration of why perinatal mental health is important, and the multiple and pervasive detrimental consequences associated with mental ill health in this specific period. It outlines the healthcare provision in the perinatal period and how this differs from other time points in a person's life. Following this the chapter focuses on the profession of Health Visiting. A description of the Health Visiting profession is presented with the associated historical context, including an outline of the development of the role. This, alongside an overview of the principles of Health Visiting, demonstrate the continuous developments and contentions associated with the role and identity of the HV which have occurred in response to the changing social, economic and political climate.

Focusing specifically on the role and responsibilities of the Health Visiting profession in addressing PMHP this chapter explores the following three areas. The detection of PMHP by HVs, the possible barriers and facilitators which impact on this in practice, and the possibility of HV implemented psychologically-informed interventions. Finally, a conclusion is provided highlighting the need for research into how HVs manage and understand their involvement in traumatic childbirth and perinatal mental health problems.

Maternal Mental Health Care Provision

Perinatal mental health is a serious public health issue (Centre for Mental Health and London School of Economics, 2014), with undiagnosed and/or untreated issues having

multiple, far-reaching consequences, including; suffering that could be avoided, adverse impacts on children and families, serious injury or death, and economic costs (Jomeen et al., 2013; Martin, 2012; Maternal Mental Health: Everyone's business campaign, 2014). Furthermore, a U.K. National Inquiry suggests that whilst heart disease is the leading cause of death during pregnancy and in the first 6 weeks post-partum, suicide is still the leading cause of maternal death over a year, with 1 in 9 women who die in the perinatal period dying due to suicide (Kalifeh, Hunt, Appleby, & Howard, 2016; MBRRACE-UK, 2017 – Mothers and babies: reducing Risk through Audits and Confidential Enquiries across the U.K.). Although rare, mental health difficulties are also often prominent in cases of maternal filicide (Bourget, Grace, & Whitehurst, 2007). The impact of maternal mental health difficulties on the infant and/or child can be multiple and long lasting, and includes less optimal foetal and neonatal outcomes, such as premature delivery and low-birth weight (Stein et al., 2014), and negative developmental and psychological consequences, such as internalizing disorders (depression) and externalizing disorders (Attention Deficit Hyperactivity Disorder; ADHD) (Stein et al., 2014). In terms of the wider family unit, research has indicated that maternal mental health difficulties can have negative implications for fathers, for example Goodman (2004) suggests that maternal depression is the strongest predictor of paternal depression.

Previously, health care provision in the perinatal period was primarily concerned with the physiological health of the mother and foetus/newborn. Although, with an estimated 10 - 20% of women experiencing a mental health disorder in this period (Public Health England, 2017), there is a growing inclusion of assessment of psychological well-being (see figure 5.7), and identification and treatment of psychological distress and psychiatric disorders (National Institute for Clinical Excellence, 2018). Primarily, psychological health assessments in the antenatal period focus on previous (preconception) and current severe mental illnesses, and/or a history of perinatal mental illness in the family (NICE, 2018), whilst the postnatal period also

includes postpartum disorders, such as, affective disorders (i.e. post-natal depression), and postpartum/puerperal psychosis (NICE, 2018). There is an increased risk of the development and reoccurrence of serious mental illness during the perinatal period (Royal College of Psychiatrists; CR197, 2015). Indeed, “the rate of referral to Psychiatric Services is also increased following childbirth and has been estimated to be at least five times greater than in non-childbearing women” (Oates, 2003, p.221).

The provision of health care in the perinatal period is distinct from the prevailing care provided throughout an individual’s lifetime. The perinatal period provides an opportunity for regular and focused general and perinatal health care for both the mother and infant. Women have universal, regular points of contact with a number of primary health care providers (Oates, 2003; Royal College of Psychiatrists; CR197, 2015), including (but not limited to) midwives, General Practitioners (GP), and Health Visitors in the U.K.. Due to the frequent and prescribed nature of women's contact with primary health care services in the perinatal period, midwives and health visitors are well positioned for early detection and intervention for those at risk of, or suffering from, perinatal mental illness (Agapidaki et al., 2014; Alderdice, McNeill, & Lynn, 2012; Jomeen et al., 2013; Oates, 2003).

In a normative situation Health Visitors and midwives are the primary health care providers with the most regular and routine points of contact, as demonstrated in figure 5.7.

	ANTENATAL* Please note that NICE guidelines relate to subsections of the work described only.							POSTNATAL	
When	**Booking in (8-12 weeks)**		**16-28 Weeks**		**32-36 weeks**		BIRTH	**Birth visit to 10-14 days**	
Who	Midwife	Health visitor	Midwife	Midwife/Health visitor	Midwife	Midwife/Health visitor		Midwife	Midwife/Health visitor
Where	Home, Health Centre, Children's Centre (CC), GP Surgery – (dependant on family need and local provision)							Obstetric/Midwifery unit/ Home/Children's Centre	Home
Action Proposals you may wish to consider developing	Antenatal screening. There is a need to address the consent issues of the mother and father for further notification. There needs to be recognition that the midwife is responsible for the mother, unborn child and father during the antenatal period and is responsible for ensuring all appropriate services are in place. Midwifery team to notify health visiting team of pregnancy, and Family Nurse Partnership if appropriate. Notification to include assessment of need, including needs of the father, and referrals to other agencies and action plan. This should be a particular consideration for women and fathers with complex social factors (NICE 110). 12 weeks health needs assessment.	Health visitor/health visiting team to inform midwife of named health visitor for every woman.	Ongoing review of action plan. Midwife to communicate any change in the pregnancy status and/or changes in risk to the family or child to the named health visitor/health visiting team. Health promotion review. Midwifery team to notify health visitor within one working day of any significant changes to maternal or child wellbeing, for example, miscarriage, still birth, congenital abnormality, serious illnesses and admission to NICU.	Possible further health needs assessment, including father's needs. Where a woman or father is identified as vulnerable the midwife and named health visitor should work collaboratively to assess the needs of the woman and it is recommended that they consider a joint meeting with the family (NICE 110). Information exchange between health visitor and midwife. Early identification of need.	Birth plan, including father's needs and place of birth. Shared with health visitor. Postnatal care choices and needs. Midwifery team to notify health visitor within one working day of any significant changes to maternal or child wellbeing, for example, miscarriage, still birth, congenital abnormality, serious illnesses and admission to NICU.	Health visitor universal contact. Supported emotional transition to parenthood in vulnerable groups. Offer of a holistic assessment of unborn child and family risk and resilience factors, using a strengths-based partnership approach to support transition to parenthood, if appropriate (the timing of this is variable between trusts but should be completed pre-birth). Women with identified vulnerability to be considered for a joint antenatal meeting. All women with identified vulnerability (e.g. maternal mental health, learning disability, fetal developmental issues, obstetric issues, domestic violence etc.) or need to have received an 'individualised postnatal care plan' prepared in conjunction with midwife and health visitor (NICE 37).		Midwife to update the health visitor on the health and social status of both mother and baby. Midwife to explain to all women the purpose of the parent-held personal child health record and how it will be used by midwife and health visitor (NICE 37). Day 5-7 midwife to complete appropriate sections of the parent-held personal child health record to facilitate handover to the health visitor. Midwifery team to notify health visitor within one working day of any significant changes to maternal or child wellbeing, for example, still birth, congenital abnormality, serious illnesses and admission to NICU.	Child and family needs assessment, including father's needs. It is recommended that by day 14 all women, particularly those with identified vulnerability or need, have received a joint handover/contact visit with their midwife and health visitor; it is recommended that this be a home visit. At discharge of vulnerable women and women who require midwifery input after day 14, the midwife and health visitor to have completed and recorded a verbal handover in addition to a written handover (NICE 37).
HCP Key Messages and Actions	• Promoting the health and emotional wellbeing of the mother. • Promoting positive mental health of the mother. • Promoting Healthy Start for all women. • Preparing families for transition to parenthood. • Promoting breastfeeding and the support available. • Promoting the importance of the involvement of the father. • Promoting the neurological development of child, the negative impact of stress and the importance of attachment. • The Healthy Child Programme also promotes good liaison between midwife and health visitor to benefit early intervention.		• Promoting the health and emotional wellbeing of the mother. • Promoting positive mental health of the mother. • Providing information on local Children's Centre services and consent to contact. • Providing smoking cessation support. • Promoting breastfeeding and the support available. • Providing information on screening and immunisations, child development, maternal nutrition e.g. folic acid and other dietary or lifestyle advice as required. • Preparing families for transition to parenthood. • Promoting the importance of the involvement of the father.		• Promoting the health and emotional wellbeing of the mother. • Promoting positive mental health of the mother. • Preparing families for transition to parenthood. • Promoting the importance of parent and baby mental health/attachment. • Providing safe infant feeding information. • Promoting breastfeeding and the support available. • Signposting parents to Parent Education. • Promoting the importance of the involvement of the father. • Delivering the Pregnancy, Birth and Beyond programme in partnership.			• Providing safe infant feeding information. • Promoting breastfeeding and the support available. • Observing and promoting the importance of parent and baby mental health/attachment. • Promoting attuned, sensitive parenting that supports the baby's early development and positive mental health. • Assessing maternal mental health. • Promoting the importance of father/partner involvement. • Supporting mothers with postnatal exercise. • Promoting home safety. • Promoting steps to take to prevent Sudden Infant Death Syndrome (SIDS). • Providing information on smoking cessation, development and growth. • Providing information on, and registration with, local Children's Centres. • Delivering the Preparation for Birth and Beyond programme in partnership.	
Your Community	Targeted to meet the identified needs of the community. Your community has a range of services including some Sure Start services and the services families and communities provide for themselves. Health visitors and midwives work together to develop and promote community based support for expectant and new parents, such as transition to parenthood groups and activities that meet the needs of local families.								
Universal Services	Universal services are for all families. Health visitors deliver the Healthy Child Programme to ensure a healthy start for children and families, for example immunisations, health and development checks, support for parents and access to a range of community services/resources.								
Universal Plus	Targeted according to assessed or expressed need, universal plus gives a rapid response from the health visiting team when families need specific expert help, for example with postnatal depression, a sleepless baby or answering any concerns about parenting.								
Universal Partnership Plus	Targeted according to identified need, universal partnership plus provides ongoing support from the team plus a range of local services working together with families to deal with more complex issues over a period of time. These include services from Sure Start Children's Centres, other community services including charities and, where appropriate, the Family Nurse Partnership.								

SAFEGUARDING

Figure 5.7: Outline of the Health Child Programme delivered by midwives and health visitors in the perinatal period (Public Health England and Department of Health, n.d., p.3).

In the pregnancy and post-partum period midwives and Health Visitors work together to provide joined-up care, and both will have professional experience of traumatic childbirth. Midwives are likely to be the primary health care professional present at the traumatic childbirth event, and will have some time-limited input in the post-partum period. However, when exploring the experiences of traumatic childbirth this thesis considers the experiences of the HV. This is due to their role in identifying, managing and sign-posting to additional services any woman who identifies as having experienced a traumatic childbirth and subsequent PMHP. As a community public health nurse, the HV focuses on enhancing health through a proactive and universal service (Institute of Health Visiting, 2019). Working under the remit of the Healthy Child Programme (Department of Health, 2009), in a holistic manner the Health Visitor is able to assess and address multiple needs from the antenatal period to when the child begins school (see figure 5.8), thus taking into account the possible lengthy psychological impact of traumatic childbirth experiences.

Research has explored the role of midwifery in traumatic childbirth and subsequent PTSD (for example see Patterson, Martin, & Karatzias, 2018), and the impact of involvement in traumatic childbirth events and the subsequent development of secondary traumatic stress in midwives (Schroder et al., 2016; Sheen, Spiby, & Slade, 2015). Whereas, the research into Health Visitors and traumatic childbirth is limited. However, their remit has been extended beyond a focus on Post-Natal Depression (PND), with an expectation that they should be able to identify of a range of PMHP across the perinatal period (Jomeen et al., 2013), and maternal mental health is now considered a high impact area within perinatal care (see figure 5.8). Whilst the research into the related experiences of Health Visitors has begun, the research is yet to specifically explore HVs identification of traumatic childbirth experiences and subsequent PTSD following childbirth.

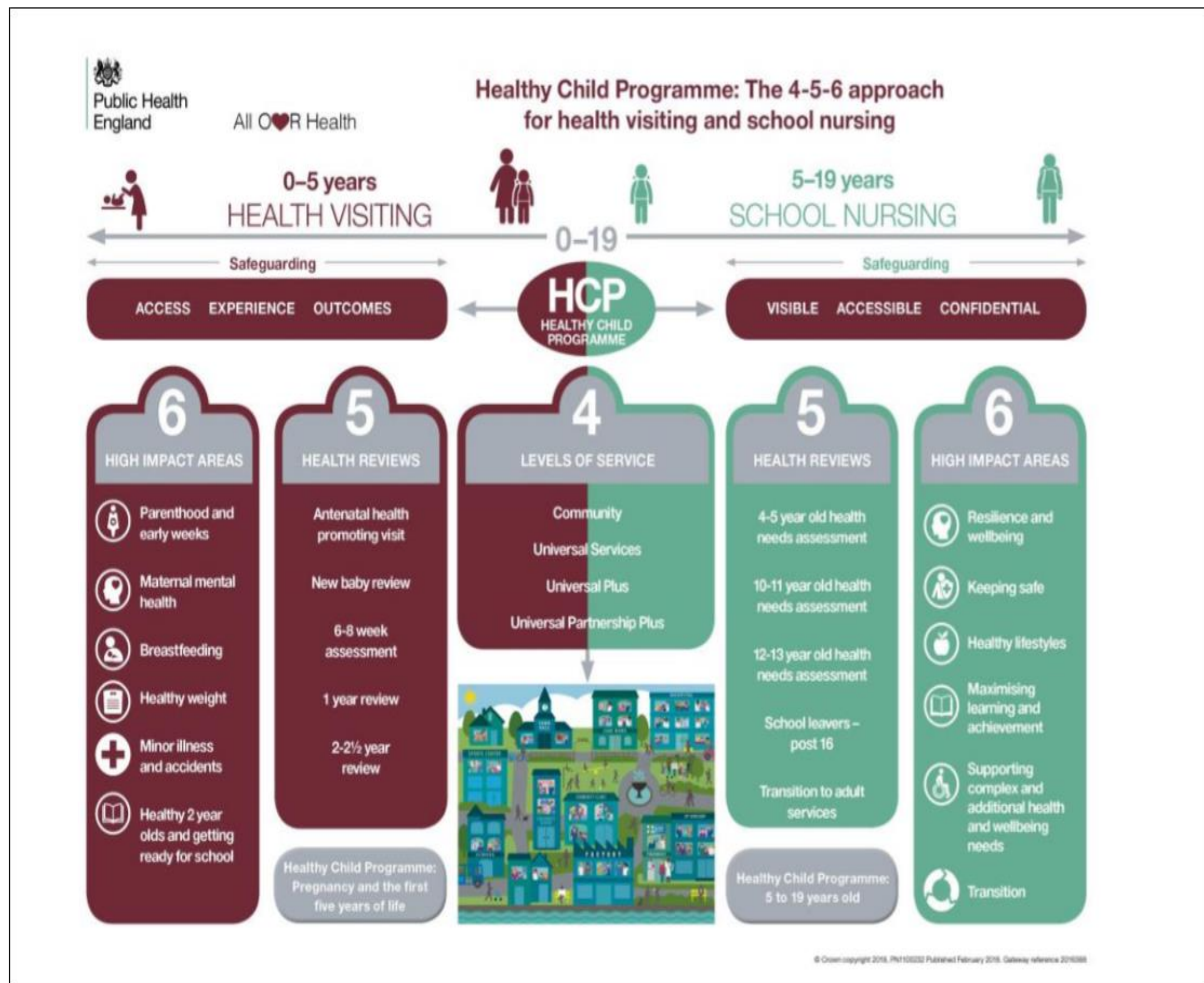


Figure 5.8: The 4-5-6 approach for Health Visiting and School Nursing (Public Health England, 2018, p.14)

The History of Health Visiting

Health Visitors (HVs) have a variety of titles, in Europe they are usually known as public health nurses, and in Australia ‘maternal, child and family health nurses’. In the U.K. they are commonly known as Health Visitors, although their full title is Specialist Community Public Health Nurse (SCPHN). They are qualified nurses or midwives with additional postgraduate training, and are registered and regulated by the Nursing and Midwifery Council (NMC) (Sayer, Barriball, Bliss, Bakhshi, & While, 2016).

The beginning of Health Visiting can be traced back nearly 150 years to the early 19th century (Billingham, Morrell, & Billingham, 1996). The public health movement introduced the concept of HVs or Lady Sanitary Workers, in response to the prevalence of unsanitary, squalid, cramped living conditions, and high infant mortality rates in the U.K. (Adams, 2012; Billingham et al., 1996). By the early 1920s a shift occurred from concentration on the environment to the family, thus creating a distinction between sanitary inspectors and health visitors (Billingham et al., 1996). In 1956, with the publication of the Jameson working party report on Health Visitors (Department of Health, 1956), the remit of the Health Visiting service was expanded. HVs were expected to provide care to; all children, families, the chronically ill, and the elderly, adhering to the quote 'from cradle to grave' (Adams, 2012). In the past 15 years the role of the HV has reverted back to the original specification of provision of public health care to families with pre-school children as it was recognized that the previously described diversity and breadth of the Health Visitor role was reducing the quality of interventions, especially for families with young children (Adams, 2012).

The Principles of Health Visiting

In 1974 the responsibility for health visiting moved from the local authority to the NHS, although in 2015 this decision was reversed and the commissioning of Health Visiting services was transferred from NHS England back to local authorities (Public Health England, 2018). As with all health-based services there are continuous changes in the targeting of specific areas of concern, usually in response to political, economic, socio-cultural and environmental influences. Thus, the augmentation of strategies and policies will reflect in the changing roles and responsibilities of work forces as they shift to meet these demands. This can be seen throughout the sections on health visiting, as the social and economic climate changed, so did the remit of the HV.

In 1977 four contemporary principles of health visiting were outlined by the Council for the Education and Training of Heath Visitors (CETHV, 1977). These principles were further reaffirmed and re-established by Cowley & Frost (2006), and in essence remain the same to the present day (Robotham and Frost (2005). The Institute for Health Visiting (2019) outline the four process statements, which are more generally known as the principles of Health Visiting:

- The search for health needs.
- The stimulation of an awareness of health needs.
- To influence policies affecting health.
- To facilitate health enhancing activities.

Cowley et al. (2015) define Health Visitors as:

> Health Visitors are the professional group charged with supporting early child development, by delivering a universal service designed to promote the healthy development of pre-school children, whilst improving public health and reducing health inequalities. (p.467)

Health visiting continues to work in two areas, with individual, family and child centered work (Malone, 2000), and a public health community work-population approach (Billingham et al., 1996) which concentrates on the social context of 'parenting' (Malone, 2000). Furthermore, with changes in public health priorities, health visiting has moved from focusing on sanitation, to the antecedents of chronic diseases, which includes mental health (see figure 5.8) (Adams, 2012).

It is clear from the history of Health Visiting that there have often been contentions in what constitutes the Health Visiting role and identity, and although the role has changed and developed in response to social, economic, political and ideological changes (Billingham et

al., 1996), the identification of the role is still to the present day marred by confusion and this is evidenced in the quotations below.

> The role and scope of the health visitor has never been clear and numerous policy documents have failed to clarify the position. The role has remained confusing to their colleagues, the public and, sometimes, even to the profession itself (Billingham et al., 1996, p.391).

> Health visiting is a 'contested' profession and field of practice, which is to say that, whilst there is broad agreement about the phenomenon, there are continuing debates about its nature, form and purpose, and which terminology is most appropriate in describing it" (Cowley et al., 2015, p.30).

Although the role specifications and meta-narratives about Health Visiting may be lacking, it has endured through the years and remains a key public service (Peckover, 2013), meeting central policy objectives, such as early intervention, public health, and child protection (Peckover, 2013).

Current Health Visiting Service Specifications

From 2015 the commissioning of the health visiting service was transferred back to local authorities from NHS England, in line with other key services, such as the 5-19 children's services (Public Health England, 2018). The aim of the transfer was to, "support service sustainability, build on and support continuing service transformation and integration; and complete a process of joint national and local development work so that local authorities are well placed to get maximum benefit for local people" (Department of Health, 2015, p.1). Currently the role of the Health Visitor is to provide a progressive universal and targeted package of care to the families of children aged 0 and 5 years. The National Health Visiting

Programme (HVP; 2011-15) (Department of Health, 2011) is delivered by the Department of Health (DH; system lead), NHS England (NHS E), Public Health England (PHE) and Health Education England (HEE). HVs are the lead providers of the Healthy Child Programme for 0-5 years (Department of Health, 2009). The Health Visitor Programme (2011-15) and the Health Visitor Implementation Plan: Call to action (Department of Health, 2011), aimed to increase the number of practicing Health Visitors and transform and rejuvenate the health visiting service (Department of Health, 2011). The transformed and rejuvenated service aimed to fulfill the four key aims of the Health Visitor Programme (see figure 5.9) which were to:

1) Improve access to services.
2) Improve the experience of children and families.
3) Improve health and well-being outcomes for under-fives.
4) Reduce health inequalities.

The specification includes a four level (Community, Universal, Universal Plus, Universal Partnership Plus, see figure 5.9) Health Visiting service, and highlights key high impact areas, including maternal mental health (NHS England, 2014).

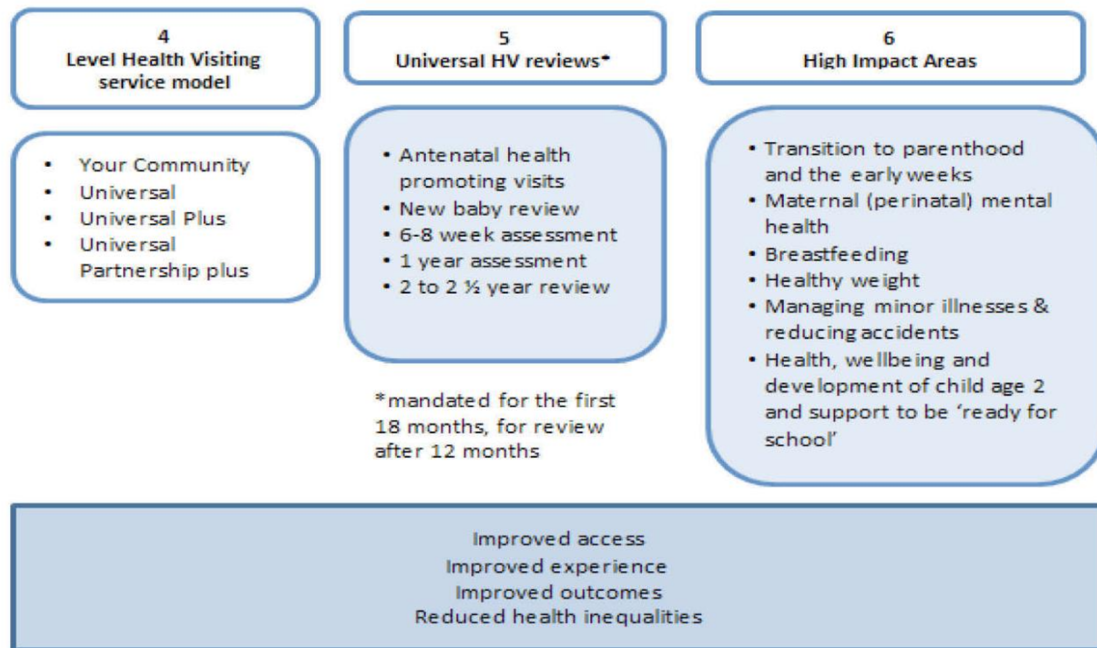


Figure 5.9: National Health Visiting Service Specification 2014-15 (NHS England, 2014).

More recently the 4-5-6 approach for Health Visiting (Public Health England, 2018) has been implemented (see figure 5.8), with the associated early years high impact areas outlined in six key documents published by the Department of Health and Social Care and Public Health England (2018a,b,c,d,e,f) (PHE publications gateway number 2018582). The six areas are:

- Transition to parenthood
- Maternal mental health
- Breastfeeding
- Healthy weight, healthy nutrition
- Managing minor illness and reducing accidents
- Health, well-being and development of the child aged two

The role and responsibilities of the HV in maternal mental health

The maternal mental health pathway guidance document (Department of Health, 2012) stated that health visiting should contribute “to early maternal mental health detection, intervention, support and referral” (p.6). In addition, Specialist Health Visitors in Perinatal and Infant Mental Health (PIMH) were introduced to help facilitate more specialist training and also provide consultation to their immediate colleagues (Health Education England, 2016). This early identification and intervention can produce better outcomes for parents and their families (Department of Health, 2012).

Detection of perinatal mental health problems (PMHP). HVs and other primary care professionals in the perinatal period are well placed to assess and identify perinatal mental health problems (Jomeen, et al., 2013). However, historically, the focus has been on the identification and management of postnatal depression (PND) (Jomeen et al., 2013). Research demonstrates that HVs do assess for PND and post-natal anxiety regularly in practice, and are clinically trained to use screening tools, such as the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987) or Whooley questions (Whooley, Avins, Miranda, & Browner, 1997) as a starting point for conversations about mental well-being (Noonan, Galvin, Doody, & Jomeen, 2016). The National Institute for Health and Care Excellence (NICE, 2018) support the use of these tools, with the Whooley questionnaire (Whooley et al., 1997) described as a primary assessment tool, and the EPDS (Cox et al., 1987), Patient Health Questionnaire - 9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001), and/or GAD-2 (Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007) as identification and assessment screening tools.

Although the mental health pathway documentation (Department of Health, 2012) focuses on clinical assessment and skills, in practice health visiting assessments require a range of both clinical and softer skills and knowledge. In a case study of health visiting assessment

Appleton and Cowley (2008, p.237) identified seven assessment principles outlined in figure 5.10 below.

Figure 5.10: Health Visiting Assessment: Essential Principles.

This demonstrates the need for both clinical and softer skills, as the assessment process is both complex and multifactorial, incorporating professional judgements as well as more formal guidelines. Softer skills such as intuitive skills have been identified in qualitative studies as key in identifying and assessing perinatal mental health issues (Chew-Graham et al., 2008; Jomeen et al., 2013; Noonan et al., 2016). When discussing perinatal mental health detection, HVs have described their intuitive abilities using a number of differing terms, including ‘senses’, and ‘silent’ and ‘intuitive’ knowledge (Jomeen et al., 2013; Noonan et al., 2017). These skills help HVs to identify when “something was not right” (Jomeen et al., 2013, p.482), however there are limitations to these skills/knowledges in that HVs suggested that they do not necessarily help in the identification of specific mental health conditions (Jomeen et al., 2013).

In addition, the relationship between HVs and the families they support is pivotal in facilitating the use of their intuitive and clinical skills, as demonstrated in research into the identification of PND (Brown & Bacigalupo, 2006; Chew-Graham et al., 2008; Jomeen et al., 2013; Noonan et al., 2016). HVs suggest that the creation of a good HV-parent relationship offers opportunities for meaningful engagement and builds rapport, which in turn builds trust. This trusting, non-judgmental and meaningful relationship allows the family to be open about their emotions and feelings (Noonan et al., 2016), and therefore aids the identification and detection of un-met mental health needs in the perinatal period.

Barriers and facilitators in the identification of Perinatal Mental Health Problems (PMHP). The literature suggests a number of barriers and facilitators in identifying PMHPs. The first, and most commented on, concerns the creation of a trusting relationship between HV and parent. HVs and parents value this relationship as it is pivotal in creating rapport, and provides continuity of care (Cowley et al., 2015). It allows for an individual and holistic approach to PMHP detection, by allowing for 'meaningful' visits, either in the home or clinic (Noonan et al., 2016). HVs feel that the main barrier is a lack of working time for investment in the valued HV-parent relationship (Noonan et al., 2016). These trusting relationships are often utilized in the detection of PMHP, one way this is evidenced is by the facilitation of help-seeking by parents (Dennis & Chung-Lee, 2006).

The reluctance to proactively help-seek by parents is also viewed as a barrier to identification. This reluctance occurs for many reasons (Dennis & Chung-Lee, 2006), including cultural diversities (Baldwin & Griffiths, 2009), mental health stigma (Agapidaki et al., 2014; Brown and Bacigalupo, 2006; Chew-Graham et al., 2009) , and parental concerns about child protection agencies (Agapidaki et al., 2014; Brown and Bacigalupo, 2006; Noonan et al., 2016). Alongside this parental reluctance to help-seek, there is also the notion that HVs can be reluctant to identify PMHP (Noonan et al., 2016), for a number of reasons.

HVs often describe a lack of available or adequate referral pathways and services to refer parents on to (Noonan et al., 2016), and on occasion in European countries they mention a lack of collaborative working with mental health services, unless the situation is particularly serious (Borglin, Hentzel, & Bohman, 2015). These reasons have an impact on HVs, as it creates additional responsibilities for them in an area where they describe reduced confidence and a lack of formal qualifications to adequately deal with PMHP (Noonan et al., 2016). HVs suggest that PMHP training, robust interventions and good referral pathways are all ways to facilitate the detection of PMHP (Noonan et al., 2016).

Interventions for Perinatal Mental Health Problems (PMHP). There is some research into non-mental health specialist-led interventions in the perinatal period, like those that could be implemented by HVs. For example Morrell et al. (2009) conducted a pragmatic cluster randomized trial offering 8 one-hour HV run cognitive-behavioural approach or person centered approach sessions with postnatal women with depression. Although the equivalence paradox was adhered to in the findings, overall the long-term clinical effectiveness of the interventions was good, and demonstrates that with the right training HVs are able to provide psychologically informed care packages in practice.

As is demonstrated in the literature outlined above HVs are expected to be involved in the detection, and occasionally the treatment, of perinatal mental health conditions, however the literature has focused, in the majority, on the detection, management, and treatment of postnatal depression (PND). There are ongoing changes in the expectations of HVs' role in relation to wider perinatal mental health conditions:

> HVs have historically had a remit to identify and manage PND, but not the broader spectrum of psychological disorder. They are now being asked to extend their knowledge beyond the remit of PND and understand and recognise psychological and

mental health problems throughout the perinatal period and across the spectrum from mild to severe (Jomeen et al., 2013, p.480).

Conclusion

The examination of the literature has identified what HVs think about their role in PND, both in terms of identification and treatment. Research is beginning to emerge concerning the application of current knowledge to a wider spectrum of perinatal mental health disorders (Jomeen et al., 2013; Noonan et al., 2016), and a number of facilitators and barriers to HVs' involvement in the care of families where PMHPs are a concern have been identified. It is now paramount that research into health visiting and perinatal mental health considers each individual perinatal mental health disorder. This will allow for the idiosyncratic aspects of each disorder to be recognised and understood, and will also highlight areas which need to be focused on in HV training, thus increasing the effectiveness of HVs identification and management of all perinatal mental health conditions.

CHAPTER SIX

Study One: The Health Visitor Study

Method

The first study presented in this thesis explores how Health Visitors frame and understand their role in perinatal mental health care. Two focus groups with a combined number of ten Health Visitors (HV) were run, with the primary aim of exploring Health Visitors' knowledge, understanding and experiences of Post-Traumatic Stress Disorder (PTSD) following childbirth. Due to the reticence of participants to discuss PTSD following childbirth, the focus groups more broadly explored perinatal mental health problems. Thus, focus groups collected rich, detailed data of the lived experience of perinatal mental health care from the perspective of the Health Visitor as a key professional present during the perinatal period.

The data was analysed using thematic analysis; a qualitative research method which aims to analyse patterns of meaning within the data (Braun & Clarke, 2006). Originally developed to explore more implicit and tacit concepts (Merton, 1975), thematic analysis allows a deeper consideration of the data than, for example, content analysis, by allowing for subtle and complex analytical interpretations (Joffe, 2012). As a flexible approach which can be utilized within multiple epistemological approaches it has no singular framework (Braun & Clarke, 2006), and can explore both the manifest and latent content of the data, as is done in this thesis. It explores the "most salient constellations of meaning present in the dataset" (Joff, 2012, p.210).

This chapter presents the method of data collection and the method of analysis used in the Health Visitor study, outlining both practical and theoretical considerations. Initially it outlines the justification for the method of data collection, it then describes the recruitment procedures, the demographic information of participants, the data collection procedure and information about the ethical approval. This chapter then provides a justification for using thematic analysis to explore the data gathered in this study, and details the analytical

procedures which were followed, and the associated considerations of the confirmability of findings.

Method

This qualitative study was carried out in a Community Health and Care NHS Trust in England which covered both rural and urban communities.

Justification of method of data collection.

Focus groups were chosen as they are a well-established, credible method of collecting qualitative data (Shenton, 2004), and have been used previously in the health research arena, including with HVs (Jomeen et al., 2013; Wilson et al., 2008). Focus groups allowed for the rapid collection of data from multiple participants, reducing the time cost for participating, which was an important consideration as focus groups were carried out in working hours.

There is relatively little known about HVs' knowledge and understanding of PTSD following childbirth. Using focus groups allowed for a degree of flexibility, addressing unanticipated issues, and facilitating full, rich accounts within context. Although deviations from the topic of discussion are more likely to occur in a group situation than, for example, one-to-one interviews, it was felt that the interactions between participants would prompt further discussions and generate avenues of interest. Indeed, interactions between participants tend to highlight challenges and differing perspectives, as well as stimulating discussion and producing collective consensus on some issues (Kitzinger, 1994).

The status of the researcher, who was independent both from the Trust and the Health Visiting profession had a number of benefits including: 1) It allowed for an alternative perspective, which may be less likely to be influenced by the norms and values of the health

visiting profession; 2) Participants may have felt more able to talk freely due to the lack of senior management or 'expert' presence; 3) Clarification of specific procedures and protocols by participants for the benefit of the researcher, allowed the common discourses and understanding of HV to be drawn out through the research process; 4) It aided the positioning of participants as experts in their own experiences and profession, changing the power differentials between researcher and researched, and enabled participants to explore areas that they felt were important rather than constantly seeking guidance from the researcher.

Although having an independent researcher may have created relative freedom for participants to explore their views without the influence of senior managers within the Trust, the make-up of the groups may have had some influence over discussions. In focus groups there is usually a common characteristic of members, in this study, all members of the groups were registered HVs. The desire was for representation from HVS with differing roles and responsibilities to explore diverse views and experiences, but it was noted that the variation in job titles and length of time as a HV (see participants section for more detail) may have impacted on the power balance within the group, thus impacting on discussions (Marshall & Rossman, 2006). Focus groups facilitated the exploration of the explicit social interaction between participants during data collection (Traynor, 2015), which was important as this study aimed to explore both HVs collective knowledge and understanding of PTSD following childbirth, as well as any differences. In addition, the 'strength of collective reactions' (for example; murmurs of agreement/disagreement) from participants (Kitzinger, 1994) to points raised gave the researcher a further depth of understanding which would not have been possible through alternative data collection methods.

Recruitment.

A senior manager within the Trust acted as a gate-keeper sending out recruitment requests. Recruitment was achieved through two sources; an information email (appendix A) sent out to all student HV and HV employed by the Trust, and an advertisement in the HV staff news e-bulletin, with a further prompt email one month after the original advert. The information contained a brief outline of the study and asked for participants interested in taking part in a focus group on the topic of maternal mental health to contact the principal investigator directly.

The research supervisors, researcher and senior contacts within the Trust agreed that by revealing the specifics of the focus groups a self-selecting bias may occur, or participants may be primed. For the research data to be 'truthful' to HV current knowledge and understanding of PTSD following childbirth, the stance of "truthful but vague" (Taylor & Bogdan, 1984, p.25) was taken. Participants were told, during recruitment, that the study was exploring maternal mental health, but not specifically PTSD following childbirth. Although there is still a possible bias using the current recruitment and sampling strategy, this method was employed to protect against self-selecting bias, whilst maintaining participation as voluntary. Two focus groups were arranged and HVs who had registered their interest were given the option of attending either group.

Participants.

Two focus groups were run on different days in the same location. Both focus groups had five participants. All participants were female, with a mixture of part-time and full-time HV from a diverse range of localities within the Trust (including both rural and inner-city teams). The length of time that participants had been qualified as HV ranged from 3 months to 30 years. Participants indicated a mix of previous nursing qualifications which included;

paediatric, neonatal, learning disabilities, mental health and general nursing, and midwifery. In focus group 1, participants included Newly Qualified Heath Visitors (NQHV), a team leader (TL), and HVs. In focus group 2, participants included HVs and a practice teacher. The only group not represented in either focus group was student HVs. All the demographic information for each Health Visitor is presented in tables 6.4 and 6.5.

Table 6.4.

Focus group 1. Participant demographic information

Participant	**Current job title**	**Rural/city location**	**Length of time as a HV**	**Previous nursing occupation**
1	NQHV	City	3 months	NICU nurse
2	TL	City	14 years	RGN
3	HV	Rural	30 years	RGN/MW
4	HV	City	10 years	RMN
5	NQHV	Rural	1 year	Paediatric nurse

Note: HVPT; Health Visitor Practice Teacher, NQHV; Newly Qualified Health Visitor, TL; Team leader, HV; Health Visitor, RGN; Registered General nurse, RMN; Registered Mental Health Nurse, NICU nurse; Neonatal Intensive Care Unit Nurse, MW; Midwife.

Table 6.5.

Focus group 2. Participant demographic information

Participant	Current job title	Rural/city location	Length of time as a HV	Previous nursing occupation
1	HV	City	10 years	RGN
2	HV	City	5 years	RGN
3	HV	No location provided	15 months	RMN
4	HV	Rural	15 months	Learning disabilities nurse
5	HVPT	Rural	25 years	Paediatric nurse

Note: HVPT; Health Visitor Practice Teacher, NQHV; Newly Qualified Health Visitor, TL; Team leader, HV; Health Visitor, RGN; Registered General nurse, RMN; Registered Mental Health Nurse, NICU nurse; Neonatal Intensive Care Unit Nurse, MW; Midwife.

Data Collection

Focus groups were run in December 2014 in a central doctors' surgery meeting room. Each session lasted approximately 90 minutes. On arrival participants were given an information sheet (appendix B) informing them that the focus group would explore PTSD following childbirth. Participants were asked to complete a consent form (appendix C) and demographic questionnaire, detailing their gender, job title, location of current post, employment status, length of time as a HV, and previous nursing occupation (appendix D), and at the end of participation HVs were given a debrief sheet (appendix E). The focus groups were split into two 45 minutes sessions, with a short break in between. The first session concentrated on the questions outlined below in figure 6.11. The second session asked HVs to use post-it notes to write down factors they associated with traumatic childbirth and then these were discussed in the second half of the focus groups. This data from the second half of the two groups has not been explored within this thesis.

The data generated through the post-it notes method for exploring HVs ideas about factors which might be associated with PTSD following childbirth is not included in this thesis. There are two reasons for this. Firstly, the data from the initial focus group session was so rich and detailed that it felt better to focus on, and do this justice within the thesis, rather than attempting to explore everything in less detail. From a methodological perspective the data from the post-it notes lacked detail and did not generate the in-depth discussion expected, this may be due to the timing of presentation – in the second half of focus groups with busy health professionals who and other commitments to attend to. It may also have been a product of their hesitancy in answering questions specifically about PTSD following childbirth, which is explored later in this thesis. So, although not directly explored, it has provided some reflective utility both in thinking about the data as a whole and the

methodological limitations of the strategies used within the focus groups. Indeed, positioned as a methodological learning exercise it would be adapted if used again in the future, both in timing and in thinking about whether it is an appropriate method for specific participants.

Both focus groups used identical flexible questions guides (see figure 6.11) to aid the exploration of areas pertaining to HVs knowledge and understanding of PTSD following childbirth, these included; level of knowledge and understanding, sources of knowledge, and perceived required knowledge and understanding. The question guide included open questions in order to elicit free responses and discussion between group members, and more focused questions, which were only used for prompting if the need arose. Both focus groups were audio-recorded using two Dictaphones and were both transcribed verbatim and anonymised.

Examples of some of the questions used in the semi-structured focus groups.

- How do you think a woman might present if she had symptoms of PTSD following childbirth?
- If you were aware of a client presenting with what you believed might be symptoms of PTSD following childbirth, what questions would you ask in order to investigate further?
- Do you think that you, as health visitors, could tell the difference between PND and PTSD following childbirth?
- How do you know about PTSD following childbirth? What has informed your knowledge on this topic?
- Have you seen clients with either symptoms of PTSD following childbirth, or a diagnosis of PTSD following childbirth, in your practice?
- How confident do you feel about managing the symptoms of PTSD following childbirth in practice?
- What would you do if you had a client who was displaying symptoms of PTSD following childbirth?

Figure 6.11. Semi-structured focus group flexible question guide.

Ethical approval.

This study was approved by the University of East Anglia (UEA) School of Psychology ethics committee and was granted ethical approval by the Trust involved.

Thematic Analysis

This thesis used an interpretative, inductive approach to thematic analysis, exploring both the manifest and latent content of the focus group data. It used the six-stage analytical framework outlined by Braun and Clarke (2006) to explore the collective framing and understanding of perinatal mental health problems by Health Visitors (HVs) - a group of professionals working within perinatal healthcare.

Justification of analytical choices.

There is little known about HVs knowledge and understanding of PTSD following childbirth, and how this is reflected in their practice, and thus qualitative analysis was appropriate. It allows for the subjective construction of what constitutes knowledge, and in this study, the personal reflections on the value of knowledge and understanding of perinatal mental health problems within the context of the Health Visiting profession. Thematic analysis allowed for the construction of a comprehensive representation of the collective ideas and experiences expressed in the focus groups. The use of a method which could explore patterns (themes) across an entire dataset, allowed for the consideration of not only the group representation of experiences, but also individual differences, which was important in this study.

Although the content of the focus group discussions was an unknown entity, there was the awareness that HVs would be used to group discussions and talking in detail due to their job roles. Therefore, it was expected that the data collection was likely to generate rich, detailed and lengthy accounts. Thematic analysis was chosen to capture the detailed and

nuanced complexity of the unknown data, which may be missed by other analysis techniques, such as content analysis (Braun & Clarke, 2006; Vaismoradi, Turunen & Bandas, 2013). In addition, thematic analysis is a relatively accessible and transparent form of qualitative analysis, with systematic procedures (Braun & Clarke, 2006; Joffe, 2012). This was important as it was felt that the professionals involved in the research needed to be able to understand the analytical processes and be provided with explicit examples of how the analysis was derived from the data.

Grounded theory (Glaser & Strauss, 1967) was considered and rejected for two core reasons. Firstly, it tends to focus on theory generation (Strauss & Corbin, 1997), and this study did not aim to generate theory, rather it aimed to collect rich, detailed data of the lived experience of perinatal mental health care from the perspective of the Health Visitor as a professional, and the implications in practice. Secondly, the continual and repeated data collection required for Grounded Theory to refine emerging theory (Lingard, Albert & Levinson, 2008) was impractical for research carried out with professionals, in work time and an applied setting.

In conclusion, Thematic Analysis was the chosen analytical method in this study, as it is commonly used in nursing research (Vaismoradi et al., 2013), and allows for a rich, detailed description and interpretations of the data gathered through a systematic and iterative process. Therefore, it could provide insight into how HVs frame and understand their role in perinatal mental health. Conducted from a feminist position, analysis was inductive in nature, drawing on the semantic/explicit and implicit levels of meaning for theme identification (Braun & Clark, 2006). This approach allowed the focus of the analysis to remain on the experiences, meaning and perceived reality of the participants, allowing coding to be data, rather than theory driven.

Analytical process.

Analysis of the data broadly followed the 6-steps of thematic analysis described by Braun and Clark (2006) and demonstrated in figure 6.12. These were: 1) Data familiarisation (transcribing, reading and re-reading the data), 2) Initial code generation (systematic coding and collating of all data which was of interest), 3) The search for themes (further collation of codes into themes), 4) Review of the generated themes (level 1 checks that themes work with codes and extracts of data, and level 2 checks with the entire data set), 5) Continued analysis to refine themes (including the creation of names and definitions for each theme, and the production of the overall coherent analysis), 6) report production (extract selection in response to the research questions and previous literature, and production of the research report) (Braun & Clark, 2006).

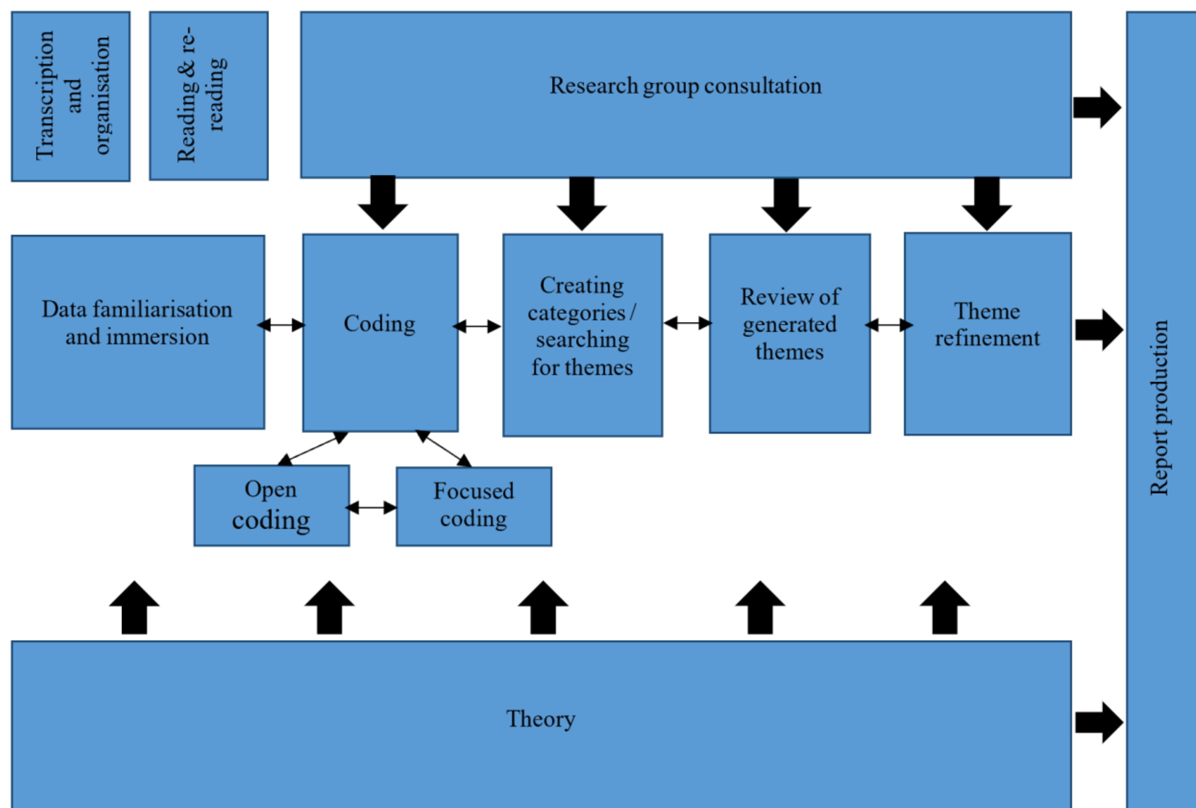


Figure 6.12: Diagrammatic representation of the analytical procedure of the thematic analysis.

The researcher who facilitated the focus groups, both transcribed and analysed the data, this helped to provide an understanding of the context of the focus groups, and the shared experience provided further insight into the data (Marshall & Rossman, 2006). The initial stages of data analysis included organising, transcribing (checked by another researcher for accuracy) and thorough reading and re-reading of both focus group transcripts. These processes allowed for immersion in and familiarisation with the data, enabling the researcher to "comprehend its meaning in its entirety" (Bradley, Curry & Devers, 2007, p.1761).

Initial opening coding was used to explore the breadth and depth of the data; it was utilized as a safety mechanism against missing any unexpected or unusual findings that may not have seemed to be linked to the research question. The primary research question was: 'To explore how Health Visitors (HVs) frame and understand their professional roles and responsibilities in perinatal mental health, with a focus on PTSD following childbirth.' This was kept in mind during initial coding, aspects of the data which seemed interesting, but their initial relevance to the research aim was questionable, were still coded. This open coding proved to be especially important in this study, when, as described previously, the focus of the topic explored shifted during both of the focus group's discussions, from an initial attempt by the researcher to generate discussion based on PTSD following childbirth. The phenomena discussed became broader, encompassing perinatal mental health in general and the professional identity of Health Visitors.

Focused coding which was directed at the newly formed research aim was then employed. These processes of coding the data were achieved through close readings of the transcripts in order to identify sections of texts which conveyed experience and concepts. The link between these codes and overall sub-themes and themes were captured in tables with

quotations and the explanations and explorations examined and discussed by the research team.

Table 6.6.

Example table exert demonstrating links between coding and themes with associated explanation, exploration and evidence as used during thematic analysis.

Theme	Explanation	Initial Codes	Exploration	Evidence
Sources of knowledge	This theme examines where HVs acquire their knowledge of PTSD following childbirth. \overall HVs were quite evasive of questioning and when asked to comment on specific symptoms found this quite difficult. This links into the idea that they are somewhat defensive of their professional capabilities – product of protecting the self in front of external agencies (myself as a researcher) and colleagues (of various levels).	Non-specialist/professional knowledge Less desirable knowledge	Need to explore whether people are more accepting of their limitations depending on their professional role/status i.e. NQHV/Manager.	"I suppose from general knowledge rather than professional knowledge about PTSD you can start to think actually it may be more than just depression . . . so I think rightly or wrongly probably my knowledge comes from outside of health actually."

Individual codes were assigned a meaningful, data-driven conceptual code label, which aimed to capture the richness of the data. Sub-themes (categories) were identified through an iterative process after initial coding, and in conjunction with more focused coding. Boyatzis' (1998) concept of themes as cited in Bradley, Curry and Devers (2007) was used and is described as:

> Recurrent unifying concepts or statements (Boyatzis, 1998) about the subject of inquiry. Themes are fundamental concepts (Ryan & Bernard, 2003) that characterize specific experiences of individual participants by the more general insights that are apparent from the whole of the data (p.1760).

Once the various coding strategies outlined above had been completed, the researcher grouped these to construct sub-themes and themes. Due to the substantial number of codes, a large white board, with each individual code written on post-it notes was used to provide the researcher with a visual and interactive means to work with the entirety of the analysis at once. Once the themes and sub-themes had been identified, an over-arching theme was constructed from this conceptualisation of the phenomena being explored. This iterative process continued in discussion with two other senior researchers (and supervisors) involved in the project, and with a continuous review mechanism which checked the sub-theme, themes and over-arching themes against the data and coding. The over-arching theme, themes, and sub-themes were then named and defined, again in consultation with the research team.

Throughout, the analytical process was iterative and reflexive, with lengthy discussions and team explorations of the data, coding, and construction of themes. Any disagreements were handled by researchers taking time to reflect on ideas, and re-visiting the data.

Confirmability of findings.

Qualitative research aims to demonstrate trustworthiness through credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985; Madill, Jordan, & Shirley, 2000; Graneheim & Lundman, 2004; Vaismoradi et al., 2013; Shenton, 2004). In this study these four aspects of trustworthiness have been demonstrated in a number of ways. Credibility refers to the congruence between findings and reality (Merriam, 1998), and dependability is a version of reliability, in that it seeks to suggest how likely it is that findings would be similar if the study was repeated (Shenton, 2004). These have been demonstrated in this study through a number of strategies, including: 1) a varied sample of Health Visitors, thus analysed data includes contributions from a variety of perspectives; 2) an in-depth explanation of the coding/theme generation process has been provided; 3) discussion between three independent researchers allowed for agreement over the representativeness of quotations and agreement on both codes and themes. This latter strategy was implemented as a form of triangulation with multiple people being involved in the analysis to increase the trustworthiness of findings.

Confirmability is the ability to demonstrate that the findings are driven by the data and not by the researcher's own agenda (Shenton, 2004). This has been addressed by a clear diagrammatic representation (see figure 6.12) and written explanation of the analysis, and the researcher's position as an external person not involved directly with the Health Visiting profession or the Trust involved in the research. Transferability is the ability to transfer the findings of one study across various populations (Graneheim & Lundman, 2004). In this study transferability both within the studied Trust, and between Trusts within England is of interest. This methodology section gives a clear description of the context of the data collection, and the characteristics of participants, therefore the reader is able to make a

judgement on whether findings can be transferred to another situation (Graneheim & Lundman, 2004).

CHAPTER SEVEN

Study One: The Health Visitor Study

Analysis and Discussion

This chapter presents the analysis and discussion of the qualitative study exploring how Health Visitors (HVs) frame and understand perinatal mental health problems (PMHP). Data from two focus groups, with a total of ten HVs, was analysed through thematic analysis to fulfil the aim of exploring HVs' knowledge and understanding of Post-Traumatic Stress Disorder (PTSD) following childbirth. The conversational strategies employed by HVs as they grappled with the issues raised in the groups generated data which not only addressed the concerns about PTSD and childbirth but contextualised their professional positions. This chapter therefore explores all collected data and presents the core themes of 'The role of the HV in perinatal mental health care' and 'The knowledge narrative', which are brought together through an over-arching theme of 'Protecting a confused professional identity.'

The core theme, 'the role of the HV in perinatal mental health care', explores how HVs frame and understand their professional role in perinatal mental health care. HVs feel that they are often expected to work outside their self-perceived professional boundaries, which impacts on their individual practice responsibilities, accountability, and capabilities. This theme explores HVs considerations of the risks associated with perinatal mental health care and the inadequacies of secondary services. The analysis demonstrated that HVs have high levels of both professional and personal anxieties when addressing perinatal mental health in their practice. A diagrammatic representation of this theme is presented in figure 7.13. This theme directly links to the concept of professional identity, and how HVs have difficulties in conceptualizing their professional identity and therefore the boundaries of the role.

The second core theme; 'the knowledge narrative' explores the forms of knowledge possessed by HVs. These are constructed into the sub-themes of; technical knowledge in relation to PTSD following childbirth, experiential knowledge, and relational knowledge. It examines the emphasis or value placed on each of the three knowledge forms, both by HVs

themselves, and their perceptions of ‘others’ (senior colleagues and other allied health professionals). Although separated in the analysis, in the form of three distinct sub-themes, the boundaries between different types of health visiting knowledge are often blurred. In summary it is proposed that all three knowledge forms are valuable and are inter-related, working in complex combination in the identification of PMHP.

Finally, this chapter presents the over-arching theme of ‘Protecting an uncertain professional identity’ and how this brings together previous literature and the two core themes constructed through the thematic analysis in this study. The data demonstrates in various ways that HVs in this study lack a coherent and stable professional identity, especially within the context of their knowledge of, and role in, perinatal mental health care. This is supported by a limited, but consistent literature base which indicates that professional identity in Health Visiting has been marred over time, and to this present day, with ambiguity and confusion (Billingham et al., 1996; Hunt, 1972a,b)

The Role of Health Visitors in Perinatal Mental Health Care

During focus group discussions HVs explicitly demarcated themselves away from a role in perinatal mental health care, conversely, they also outlined practice experiences in which they took on a primary role within the care of families where perinatal mental health problems (PMHP) were a concern. This section explores HVs perception that they are not ‘experts’ in mental health, however due to external and internal factors they do ‘carry’ or ‘hold’ families with PMHP. This juxtaposition in what HVs feel their role should incorporate and what is expected from them in practice, plus HVs understandings and conceptualisations of the risks and responsibilities involved in caring for families with PMHP creates high levels of both professional and personal fear and anxiety for HVs. The construction of the theme of ‘The role of HV in perinatal mental health care’ is represented in figure 7.13.

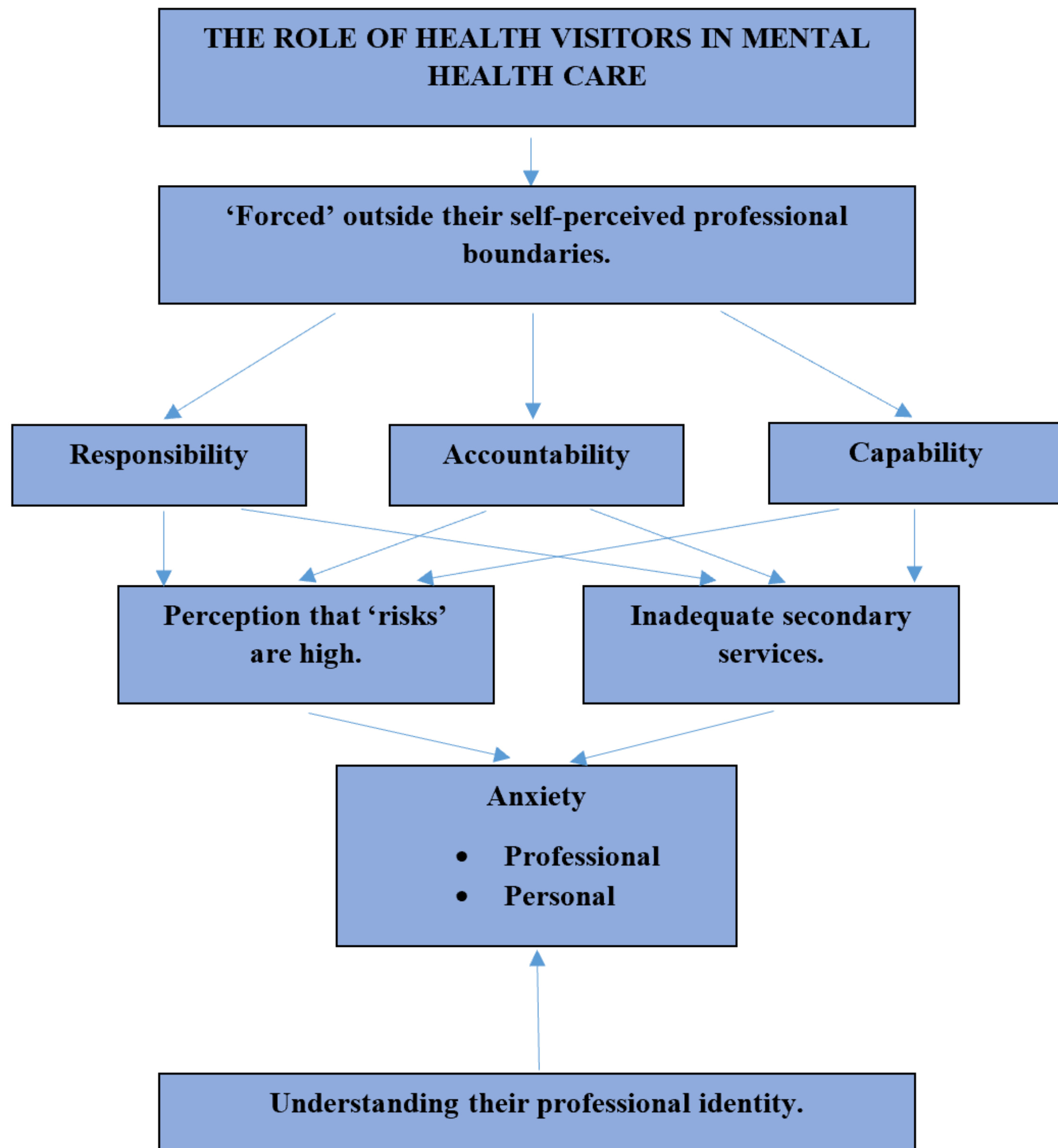


Figure 7.13: A diagrammatic representation of the theme – 'Role of the Health Visitor in Mental Health Care'

There seem to be multiple and often conflicting ideas about the role of health visiting in perinatal mental health care. Stakeholders invested in these judgments include: secondary services (e.g. mental health services), other primary services (e.g. General Practitioners), managers, clients and HVs themselves. As arguably the primary health care provider in the

postnatal period, and with an emphasis on health promotion, prevention and early intervention for health needs in general, HVs are perfectly positioned to identify and support parents with mental health difficulties (Jomeen et al., 2013; Noonan et al., 2017). However, in the focus groups HVs often demarcated themselves away from the idea that parental mental health care came under their remit, indeed one participant continually referred to being *'not experts' (Jane: FG2: p.19)* in mental health.

Risk management and responsibility are inherent in boundaries within health care; these boundaries outline which profession has responsibility for which aspects of client care, and is therefore accountable. Throughout the focus groups HVs constructed arguments against their profession taking on the responsibility, and therefore risk, of families with parents with PMHP. One of these arguments concerned their lack of specialist knowledge and skill in PMHP.

> *"And with something like this it is so important that women get the right specialist support, and they don't just get a health visitor who has done half a day's training." (Jane: FG 2: p.19)*

HVs felt other more specialised secondary services were better placed to take on the core perinatal mental health care provision, implying that specialist services would have the knowledge and expertise to provide 'better', more 'specialised', 'expert' care.

> *". . . you need to be able to pass them on to the appropriate services and that's where it is lacking." (Sasha: FG 1: p.33).*

Overall analysis constructs that HVs have a poor opinion of the availability and adequacy of perinatal mental health services, based on both their individual and collective professional experiences, giving multiple experiential examples. They talk about having an assumption that services will be available if the need is present, but that actually in practice

services are lacking or inadequate. In turn, this leaves HVs feeling responsible for parents with PMHP, something which the quote below demonstrates they are not comfortable with.

> *"Jane: And I think that is what we struggle with generally with mental health. Health visitors are left holding a lot of women with mental health difficulties and we are not experts in it. Some will be because obviously some will be mental health trained before they were health visitors. I wasn't so I have never felt that I am an expert and I've sometimes felt quite uncomfortable actually holding things whilst we . . .*
>
> *Celia: Yeah definitely.*
>
> *Jane: Whilst we are waiting for mental health services to kick in. And it always seems that the threshold is quite high before that will happen.*
>
> *Celia: And time scales as . . .*
>
> *Jane: Time scales are long." (FG2: p.19-20).*

Participants talked about a lack of confidence in referral routes for families in need, and this caused feelings of isolation and burden in terms of accessing mental health care provision for their families.

> *"I have always driven away thinking actually I hope I can get some help with this and very often it is no. Actually because it doesn't meet the threshold so for me when there when there's any kind of acute mental health issue I don't think I have probably ever felt totally confident because I'm never that confident that we've got a sound referral route for that next tier of support that mothers need and I, I just feel quite strongly." (Jane: FG 2: p.22-23)*

The lacking or inadequate specialised mental health services create feelings of isolation and a lack of choice for HVs. On occasion HVs discussed their perceptions of being the 'only' service available, *"so we haven't got many places to go these women have got us . . ." (Jane:*

FG 2: p.23). This goes some way to explaining the juxtaposition in HVs statements of not being responsible for PMHP, but in practice taking on this responsibility.

A fine line between the power, autonomy and responsibility of their professional role, and their personal feelings of powerlessness when they cannot offer mothers what they as HVs deem to be the 'right' type of care creates a form of moral dilemma for HVs in this study. In a profession which allows autonomy, as Health Visiting does, there are always moral dilemmas, and in order to ease the anxiety created by autonomy, people usually attempt to pass on the responsibility to others. Robinson and Cottrell (2005) explore issues involved in changing professional practice within multi-disciplinary and multi-agency working. HVs perceive a lack of multi-agency working practices with mental health services, due to deficient services and pathways, and consequently this leaves HVs 'holding' families in which PMHP was a concern.

> *"I feel confident in identifying it and supporting her, and I would say normally cause looking with the view to actually get, acting as sort of the middle person. You know getting them to see the GP, getting them to see. But this is what I was saying right at the beginning, where you can sometimes end up holding them – which is not appropriate. Cause you haven't got that level of expertise, you need to be able to pass them on to appropriate services and that's where it's lacking . . . And so, I can see why some people would say 'ahhh - don't like PND', and actually hide it in their care of the women, because it's almost like 'I don't know what to do with them? There is nowhere I can pass them on to once we've got to that stage." (Sasha: FG 1: p.32-33).*

In this context 'holding' refers to situations in which HVs are providing the primary support to a family, without the involvement of more specialist health professionals e.g. a mental health practitioner. The concept of 'holding' is a type of support often talked about within

Health Visiting. It relates to Donald Winnicott's (1960) theory of a 'good enough' mother, part of this theory describes the idea of a 'holding environment' and a 'sense of being held', the provision of both physical and emotional care by a mother to her infant. In the case of the HV-family relationship, it is when the HV 'holds' the mother and/or family by providing emotional care and demonstrates an empathy towards the experiences of the family. Stern (2006) outlines the concept of enabling the parents to feel contained and 'held' through the emotional support provided by the HV, theoretically the parents continue to have the capacity to provide their infant/child with a 'holding environment', limiting the impact of parental emotional distress on the child.

During the focus groups, HVs were quite adamant in their perception that they are 'forced' into caring for families where PMHP were a concern, for reasons outlined previously. HVs talked about different 'types' of care (assessment and holding) that they deliver to families with PMHP. 'Assessment' referred to clinical knowledge and judgements in identifying whether there is evidence for concerns, and evaluating the risks associated with any such concern. This links into the second theme constructed during analysis; the knowledge narrative, which is presented later in this chapter and discusses the multiple different knowledges possessed by HVs and how these are used in combination in practice to identify PMHP.

Individual roles and professional boundaries in inter-professional practice are often created through the cultivation and maintenance of 'unique knowledge systems' (MacNaughton, Chreim & Bourgeault, 2013). HVs discursively demarcate their boundary parameters in regards to their role in perinatal mental health care, however the conversations indicate that in practice these boundaries are often blurred. There are micro-level influences on professional role boundaries, an example of this is demonstrated in the quotation below,

with a HV being asked to make an individual risk assessment for secondary mental health services, a request which she deemed to be outside of her professional role and responsibility.

> *"I was cross that this particular referral that I made that she that they wouldn't accept it umm they said if it was like they could only accept it over 72 hours they wouldn't get to the person for 72 hours umm if I wanted it within 4 hours it could only be a GP that could do the referral. And umm I said I can't make that call that that's not what my area, I can't make that call whether this woman can wait for 72 hours . . . don't know how can we judge whether this woman is a risk to herself other than that until she does it . . . " (Felicity: FG1).*

This attempt by another profession to 'force' HVs to work outside their perceived boundaries of capability, responsibility and accountability creates both personal and professional anxieties for individuals. Nancarrow & Borthwick (2005) draw on Freidson's (1988) social organisation approach when exploring the negotiation of professional boundaries. They explored the concept of vertical substitution, which is a move across traditional disciplinary professional boundaries. In the instance presented here, due to situational factors (limited perinatal mental health provision within the study locality), professional boundaries are becoming blurred, as one profession (secondary mental health services) are attempting to delegate their specialised role knowledge and skills onto another profession (Health Visiting) where training is not equivalent, and their professional roles and identities are dissimilar. By utilizing the perception of professional boundaries HVs are able, at least discursively, to protect themselves from taking on the responsibility, and thus liability for any possible consequences of undertaking risk assessments in PMHP.

This raises the question as to why HVs continue to take the burden of responsibility and risk? HVs talk openly about their need to do what they feel is morally right, and when

'left' with families in need it is their responsibility to hold those women until services are available.

> *"We are not an emergency service but when at you're sitting in an office and you get a phone call from a dad who is in floods of tears and who is saying I can't cope any longer with my wife she is saying she hates the baby I don't know what to do ummm what do you do? Do you say oh dear never mind you know I'm sure you are going to be getting better and go and make an appointment to see the GP or do you respond and actually think safeguarding is that baby in jeopardy there . . . Is that family you know about to sort of is he about to put his hands around her neck cause you know he can't cope is he about to have a sudden nervous breakdown he's the one that has been carrying that family for a while cause she is in total disarray umm my, my response was I'm coming out to see you and I went out to see them but first of all I made I rang up the GP and warned him I might be contacting him to come and do a crisis visit you know in order to be able to get the ball rolling cause I didn't know what I was going to meet when I got out there. So and I am glad I did that and I wouldn't change that but I got told well you are not an emergency service so why did you go out there and it was like because there was a need and because I am a human being and because I've got empathy (laughs). . .Cause actually I was the only one around at that time." (Sasha: FG 1: p. 25-27)*

They discuss feeling unable to leave women without some form of support and care, however in juxtaposition these situations can cause tremendous personal and professional anxieties. These are demonstrated by HVs throughout previous quotations, with references to feeling uncomfortable and drawing on worst case scenarios to demonstrate the scale of the responsibility and risk they are 'holding', therefore justifying their discomfort and anxiety.

"And I think that is what we struggle with generally with mental health . . . I have never felt that I am an expert and I've sometimes felt quite uncomfortable actually holding things . . . (Jane: FG 2: p19-20)

Maternal mental health has recently been high on the research agenda (Maternal Mental Health Alliance, 2014), added to this is an increase in media coverage of maternal mental health (McGowan, Sinclair & Owens, 2007) and in particular maternal suicide and infanticide. The data suggests that HVs in these groups were very aware of the responsibilities and risks associated with working with parents who have PMHP, and at times these risks cause significant anxiety for HVs. On more than one occasion HVs mentioned maternal suicide, and this was used to highlight and explain their reticence at being placed in a position of core responsibility for perinatal mental health care. The quotation below directly refers to a specific case within the study locality of maternal filicide and maternal suicide.

"Should I have done something more? Could I have done something more? Would I? And what if, what if, what if they do jump off the nearest carpark. You know then there will be an investigation and you know you are the ones that are going to be wrapped and said – 'Well what did you do? What could you have done better?" (Sasha: FG 1: p.36).

The relationship between HVs anxiety and their focus on risk is complex, and although in this instance anxiety is not described in pathological terms Beck's (1976) cognitive model of anxiety can be utilized to explain the perceptions of danger involved in caring for families with mental health needs. Cognitive errors which increase a sense of danger, and therefore fear and anxiety, are: "a) overestimating the probability (risk) of a dangerous event, and b) overestimating the severity (threat) of a feared event" (Tripp, Tan & Milne, 1995, p.37). These cognitive errors are identified in this data through a) multiple

references to poor outcomes for families with mental health needs, and b) the severity of the examples provided by HVs in relation to the catastrophic risks which can, occasionally, occur during caring for families with PMHP. Furthermore, indirect influences, such as media portrayals of maternal mental health (McGowan, Sinclair, & Owens, 2007) and the current research focus on the topic (Maternal Mental Health Alliance, 2014), may have further amplified the possible risks and consequences in this area. The focus on risk, and the consequential professional and personal anxiety is not without a basis. The literature demonstrates the wide-ranging impact of maternal mental health and the serious possible consequences, for both mother and infant (outlined in chapter five). However, the estimated statistics of numbers of women suffering from mental ill health during the perinatal period in the study locality are comparable to national estimates (see table 7.6).

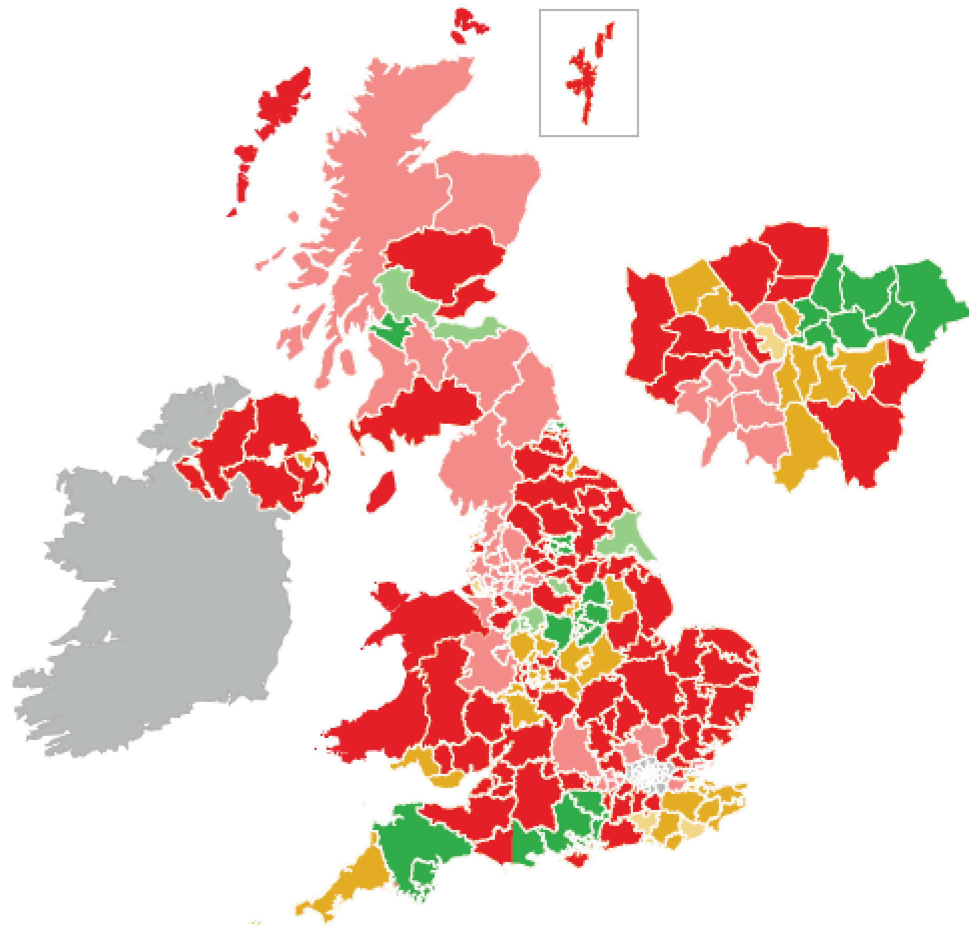
Table 7.7: Estimates of perinatal mental health conditions applied to the Norfolk population. (Norfolk County Council, 2006)

Condition	Lower est.	Upper est.	Estimated number in Norfolk	
Postpartum Psychosis	0.2%		20	
Chronic serious mental illness	0.2%		20	
Severe depressive illness	3%		265	
Mild to moderate depressive illness and anxiety states	10%	15%	875	1,310
Post-traumatic stress disorder	3%		265	
Adjustment disorders and distress	15%	30%	1,310	2,620

Table 1: Estimates of perinatal mental health conditions applied to the Norfolk Population. Source: Public Health England, Child and Maternity Health Intelligence Network[7]

It is important to note that when the data was collected there was no specialist perinatal mental health provision in this area, and mental health services in the locality were rated as ‘inadequate’ by the Care Quality Commission (CQC). The Maternal Mental Health Alliance: Everyone’s Business campaign created a map of the levels of specialist community and

inpatient perinatal mental health services across the UK, and this is presented in figure 7.14 below.



LEVEL	COLOUR	CRITERIA
5		Specialised perinatal community team that meets Perinatal Quality Network Standards Type 1 http://www.rcpsych.ac.uk/pdf/Perinatal%20Community%20Standards%201st%20edition.pdf
4		Specialised perinatal community team that meets Joint Commissioning Panel criteria http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf
3		Perinatal community service operating throughout working hours with at least a specialist perinatal psychiatrist with dedicated time AND specialist perinatal mental health nurse with dedicated time, with access to a perinatal psychiatrist throughout working hours
2		Specialist perinatal psychiatrist AND specialist perinatal nurse with dedicated time
1		Specialist perinatal psychiatrist or specialist perinatal nurse with dedicated time only
0		No provision
Disclaimer Levels of provision in this map have been assessed using the best information available to us from local experts but have not been independently verified. Please contact info@everyonesbusiness.org.uk if you suspect any inaccuracy or know of recent developments that may alter the level of provision level in any area listed here.		

Figure 7.14: Pictorial representation of specialist perinatal mental health service provision across the U.K. (Maternal Mental Health Alliance: Everyone's Business, 2014).

Summary: The Role of Health Visitors in Perinatal Mental Health Care

In summary HVs feel uncomfortable being placed in a primary care role for families with PMHP. They continuously refer to 'not being experts' in mental health, and how they should not be expected to provide mental health interventions and support as this is not part of their role as HVs. There are many challenges associated with working with mothers/fathers who have PMHP, analysis has constructed and explored one of the most prominent professional challenges - how HVs frame the responsibility and risks associated with these families.

When discussing what their role should entail, HVs outline multiple, sometimes conflicting demands made on the health visiting profession from a variety of sources, including colleagues, managers, families and other agencies, such as secondary mental health services. Due to HVs perception that there are inadequate mental health services, they often feel the burden of responsibility for perinatal mental health care, which they believe should not be theirs. This study is not making suggestions about where the ultimate responsibility for perinatal mental health care should lie, but policies suggest that collaborations between services should be the prominent ideology (Barbour et al, 2002). However previous research (Barbour et al., 2002) and data from this study highlights that 'organisational tribalism' (Dalley, 1989) still remains in frontline services and can be a significant barrier in the inter-professional working practices required when addressing PMHP.

The role of the HV in perinatal mental health care raises the question: What should HV be doing in terms of perinatal mental health care? This is represented in a conflictual discourse between HVs verbally demarcating themselves away from perinatal mental health provision by using terms, such as*, 'we are not experts' (Jane: FG 2: p. 19), 'urghhh don't like mental health' (Sasha: FG 1: p.33)* and *'that's not my area [mental health assessment]' (Sasha: FG1: p.35),* and external pressures (such as the lack of secondary services) and an

innate need to provide care (which seems to be an inherent need in nursing professions and is evidenced in this study's data) 'forcing' them into taking on this role in practice. The conflictual discourse raises anxieties within HVs in two ways. The first is that as health professionals HVs are unable to fully transact their values within their professional role, instead they feel 'forced' into caring when they feel this is inappropriate. In addition, their provision of care through 'holding' or 'carrying' causes HVs to experience significant professional and personal anxiety due the perceptions of risk and the associated responsibility and accountability of perinatal mental health care.

The 'Knowledge Narrative'

The core theme – 'Knowledge Narrative' (figure 7.19) explores the three key forms of knowledge identified by Health Visitors (HVs) in this study, outlining the emphasis and value placed on each knowledge type, both by HVs, and their perceptions of others' (senior colleagues and other allied health care professionals) understandings. The three key areas of knowledge (and skills) are: technical, experiential, and relational. These three discrete knowledge categories exist within current academic literature, although often with differing terms being used to describe very similar phenomena, and this is commented on within each of sub-theme sections. The multiple terms and descriptions are partly due to an incomplete general understanding of knowledge typologies, and partly due to the complexity of professional knowledge (Appleton & Cowley, 2008). Although separated in the analysis in the form of three distinct sub-themes, the boundaries between different types of health visiting knowledge are in practice blurred and inter-related. Each knowledge form holds value, often complimenting each other, and therefore all three are required for competent practice.

‘Technical Knowledge’ (figure 7.15) explores HVs basic, literature-congruent technical knowledge of PTSD following childbirth. As previously outlined HVs were hesitant in addressing this specific area, conveying a lack of confidence in their knowledge of PTSD following childbirth, which then created a sense of anxiety. Thus, HVs utilized a number of strategies during focus groups to deflect the discussions away from this topic area, and indeed, the exploration of alternative knowledge forms was one of these strategies. This was an attempt to protect their professional identity, professionalism, and perceptions of professional power for which technical knowledge is a source. Therefore, the sub-theme ‘Technical Knowledge’ examines the original research question, which was to explore HV knowledge and understanding of PTSD following childbirth. This section examines HVs technical knowledge of PTSD symptoms, the acquisition and legitimacy of their knowledge sources, and the identification of PTSD following childbirth in practice.

Experiential and relational knowledge are knowledge categories that can be described under the umbrella term of tacit or implicit knowledge. Kothari et al. (2012) explains that many view explicit and tacit knowledge as a dichotomy, whereas others (i.e. Polanyi, 1966) describe knowledge as a continuum. In this instance they are described as different, but complementary. Tacit or implicit knowledge is a multidimensional, practice-related type of ‘know-how’ knowledge (Kothari et al., 2012). In Kothari et al. (2012) Polyanyi (1966) describes it as “we can know more than we can tell” (p.4), which is comparable to intuition; ‘a feeling’, and thus difficult to verbalise and evidence. ‘Intuitive awareness’ within health visiting has been recognised in research exploring the identification of child protection needs by HV (Ling & Luker, 2000).

Experiential knowledge (figure 7.17) explored the concept of the HV ‘sense’ – a way of knowing that arises from intuitive abilities. HVs suggested that experiential knowledge is continuously revised through experiential learning, and thus there are differences in expertise

in this area of knowledge between individual HVs. HVs acknowledge that their experiential knowledge is key in recognising need (in this study the talk was around the search for perinatal mental health needs), and autonomous practice. Within the concept of autonomous practice HVs voiced their frustrations with perceived limitations (demonstrated in figure 7.17) placed upon their abilities to work autonomously and intuitively. Overall this sub-theme demonstrates that experiential knowledge (the HV 'sense' and intuitive abilities) is core to what participants call their 'professional artistry', which relates to HVs professional identity. Using the term 'professional artistry' allows HVs to assign credibility to a concept which is often acquired without conscious reasoning and learning, and is difficult to evidence.

The sub-theme 'relational knowledge' (see figure 7.18) focuses on the importance of the HV – parent relationship. Relational knowledge is key in building relationships and rapport with families, this in turn aids the implementation of other forms of knowledge (especially experiential knowledge), and collaborative working *with* families. HVs discussed relationship formation through re-visiting families as a core component in building rapport, and thus identifying difficulties. However, some service level guidelines (demonstrated in figure 7.18) can impact on HVs ability to use their relational knowledge in relationship and rapport formation, which then impacts on the use of experiential knowledge and application of technical knowledge. Depending on an individual's confidence and experience HVs manage and negotiate service level guidelines to limit their impact on their professional autonomy.

Technical Knowledge.

Focus groups began with open questions aimed at eliciting participants' technical knowledge and understanding of PTSD following childbirth, and the sources (for example basic training, Continuing Professional Development (CPD), etc.) of that knowledge. From this the sub-theme of 'technical knowledge' was constructed (see figure 7.15)

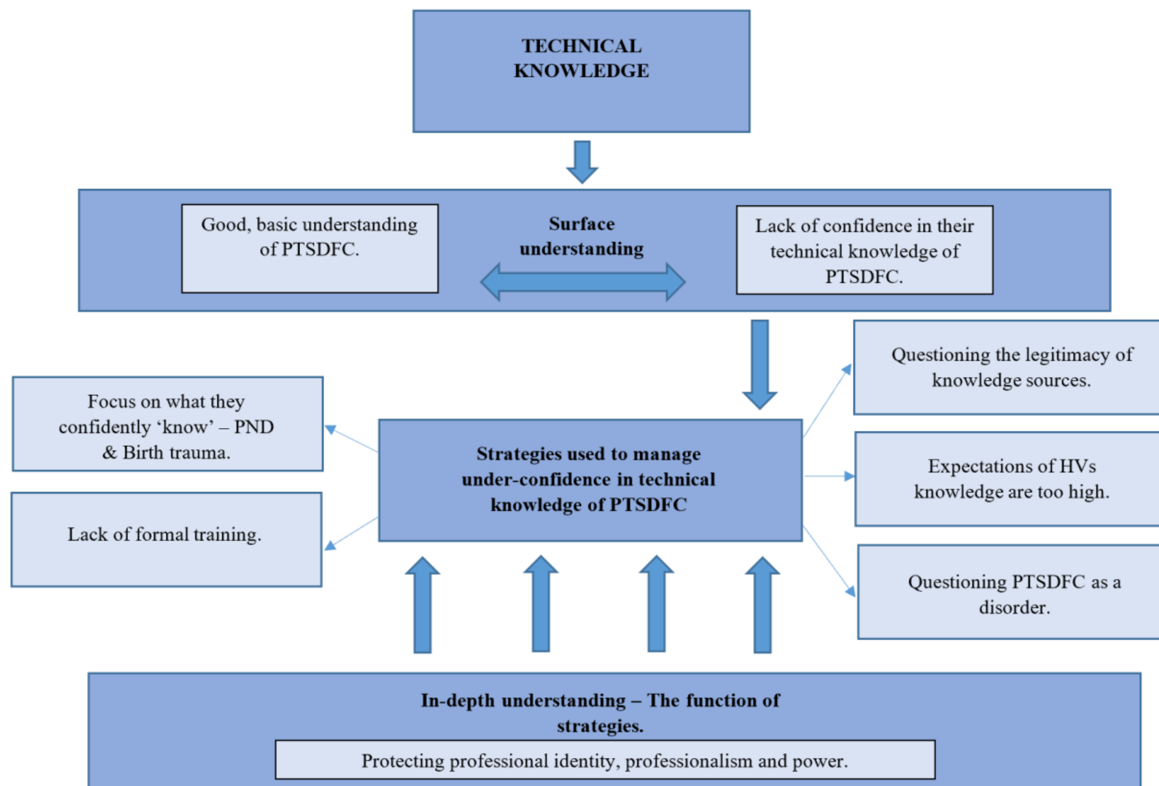


Figure 7.15: A diagrammatic representation of the construction of the sub-theme of 'technical knowledge'.

Technical knowledge is a form of rational, professional knowledge, sometimes described as 'empirics' (Carper, 1978), or 'propositional knowledge' (Erault, 1994; Appleton & Cowley, 2006). It is concrete and systematic, and is traditionally prescriptively learnt, and enables a demarcation, through a discrete skill-set, of the professional (in whichever capacity) from the

lay public. Due to its empirical, explicit base, technical or professional knowledge is the easiest form of knowledge to evidence and articulate.

During focus groups initial questions were met with a hesitancy from HVs, they seemed unwilling, unsure, or unable to answer such direct questions.

"Researcher: Post Traumatic Stress Disorder following childbirth can you tell me as a group what, what you know about that disorder? . . .

Jane: Hmmmmmm (laughter).

Researcher: Do you know what it is?

Jane: I don't, I don't know a lot about it if I am honest . . ." (FG 2: p.3)

Indeed, one participant could not remember the name of the disorder, and also presented difficulties in distinguishing PSTD following childbirth from Post-Natal Depression (PND).

Anita: Also, I think it's quite difficult to know the difference between . . . ummmm

Researcher: PTSD?

Anita: Oh yeah! And postnatal depression. (FG 2: p.6)

Although this initial hesitancy could be attributed to nervousness in the research setting, HVs are very used to group discussions, and they talked willingly throughout the session about other subjects. This stilted section of conversation was due to HVs self-perception that they had very limited specific, technical knowledge of PTSD following childbirth. Participants conveyed that they felt *'ill-informed'*. For some this meant that they felt they 'only' had a basic level of technical knowledge, but one Newly Qualified HV (NQHV) felt she had no technical knowledge in PTSD following childbirth due to a lack of experiential learning.

"Laura: With individual families, with all their different things, can sometimes, there is a lot of going back to colleagues and asking, or researching yourself and things like that.

Researcher: Mmmmmmmm.

Donna: Yeah.

Sylvia: There's the sort of thing that you can only learn with experience.

Laura: yeah it is" (FG 1: p.18).

Although technical knowledge is usually learnt through basic training, for practitioners it can also be gained through job experience (experiential learning) and/or Continuing Professional Development (CPD). This may help to explain this seemingly juxtaposed statement of a lack of technical knowledge due to a lack of experiential learning. Overall technical knowledge can be conceptualised in practice as a foundation upon which other more experiential knowledge builds.

Knowledge of symptoms of PTSD following childbirth. When asked directly about their knowledge of symptoms of PTSD following childbirth (see table 2.1 in chapter two for the symptoms of PTSD as outlined in the DSM-5 [APA, 2013]) there seemed to be a difference between the two groups. The demographic differences between the groups can be seen in chapter five, but the most notable difference is that focus group 1 they had a Registered Mental Health Nurse (RMN) with recent practice experience.

"No, and I feel more comfortable with PTSD kind of as a you know as an illness and what causes that. Then in training I did come across some people who had maybe not, you know, but definitely had some elements of traumatic birth and dads as well as mums actually that had had some, you know, and that went on to impact on their relationship and sort of sex life and different things as well. So, I did some reading about it then. Umm, and yeah, sort of PTSD in general, I feel relatively, I mean not ever so confident with, but you know I feel like I've got some knowledge on, you know, sort of signs and symptoms and things, but that might have come from cause I was a mental health nurse before I became a health visitor so I guess some of that training is transferable" (Donna: FG 1: p.15).

The talk in group 1 was confident and listed some general symptoms of PTSD, and used terminology associated with the disorder e.g. preoccupation, flashbacks, anxiety, and commented on some of the potential impacts, for example; *"impact on relationships and sort of sex life" (Donna: FG 1: p.15)*. In contrast, group 2 reacted with silence, and when prompted, they tended to talk more generally about anxiety, although again they mentioned some PTSD specific symptomology.

> *"Umm, I would recognise things like anxiety, generalised anxiety, but also particular acute anxiety episodes, kind of flashback type umm feelings and thoughts, disturbed sleep, umm disturbed sleep patterns for reasons other than the baby. You know waking up feeling anxious in the middle of the night. So, I would say general anxiety types symptoms umm. . . But, but, I would say anxiety more, you know, than we would expect, and it would be kind of punctuated by episodes of quite acute panic attack type episodes" (Jane: FG 2: p.5).*

Although one focus group was less able to identify the symptoms of PTSD following childbirth, both groups made some interesting and literature-congruent considerations surrounding what constitutes a traumatic birth. There was talk about the need to consider individual perceptions of birth, and how there may be differences between what a professional and mother may consider to be a traumatic birth experience.

> *"It goes down to your perception if they, if you said – 'oh how was the birth?' And they went, oh it was, I mean, I have had women who say it was wonderful. It was wonderful I had an epidural. And you know me, as an ex-midwife, it's oh you had an epidural, you had to go through that . . . I think again it's down to the perception for them." (Sasha: FG 1: p.11).*

They differentiated between physical and emotional trauma, and between objective and subjective trauma. At all times the HVs were considering the views of the individual parent,

including the father, in what constitutes a traumatic birth, identifying that there is no immunity from the experience.

> *"Jane: I think it is interesting to sort of think about what, what is a traumatic birth experience anyway because it's different between people I don't think we can assume that's it's just the really difficult births.*
>
> *Celia: Yes.*
>
> *Jane: That may lead to PTSD anyway.*
>
> *Celia: Yeah.*
>
> *Jane: Because you know some people will react quite negatively to what is perceived as a fairly normal straightforward birth because it depends on their. . .*
>
> *Celia: Absolutely.*
>
> *Jane: Their . . .*
>
> *Celia: Yeah.*
>
> *Jane: Their capacity to cope with that and also it depends on what's happened previously like you say . . .*
>
> *Celia: Yes.*
>
> *Jane: It's not always a, a outwardly a very traumatic birth but some of those women will still be quite traumatized by it. (FG 2)*

As demonstrated in the above extract HVs considered literature congruent factors (Slade, 2006) (see chapter three for more detail), aside from the birth experience, which may be influential in a parent's appraisal of the birth as traumatic. These included; an individual's capacity to cope, previous experiences, and in focus group 1, a lack of family and social support.

Knowledge acquisition and legitimacy. Participants talked in detail about the sources of acquisition of their current knowledge of PTSD following childbirth. HVs

suggested they had not received any formal, technical training of either general or childbirth related PTSD, within their role as a HV.

> *"I don't recall having any specific training on post-traumatic stress."*
>
> *(Jane: FG 2: p. 13)*

This was punctuated by the caveat that they could not *"possibly learn everything you might face" (Sylvia: FG 1: p.18).* Professional status is largely dependent on understanding and knowing the answers to questions, and in the majority of disciplines 'not knowing' is viewed negatively (Crossman & Doshi, 2014). Therefore, the justification used in the above quotation is interpreted through analysis as a defensive strategy to enable HVs to manage their self-perceived lack of knowledge of PTSD following childbirth.

When exploring the sources of knowledge further, HVs suggested that any knowledge they did possess had been accumulated through a variety of both informal and formal sources. These included: previous roles, the relayed experiences of clients, as well as general mental health knowledge, the collective health visiting team knowledge, and general lay knowledge. Some participants seemed to question the legitimacy of their own particular sources of knowledge of PTSD following childbirth, especially when these sources could be judged as informal, or unconnected to the health arena. The self-perceived source-illegitimacy is one reason for HVs lack of confidence in their technical knowledge of PTSD following childbirth.

> *"Jane: I think there is a lot more kind of generally in the media about post-traumatic stress . . . but knowing what we know generally, I suppose from general knowledge rather than professional knowledge about PTSD, you can start to think - actually this is more than just depression? Maybe, actually, there's the traumatic stress aspect to it. So, I think rightly or wrongly probably my knowledge comes from outside health*

actually, it's not specific training we have had . . . That's probably not a good thing to say but (laughter) . . . But I am being honest that's probably where I've got it from. Celia: yeah I think that's right . . . it's in conversations with other professionals . . . case scenarios and how people are presenting . . . it is just slow experience talking to women about their experience helps you gain that insight." (FG 2: p.13-14).

The apparent questioning of the legitimacy of information sources adheres to the idea of an 'expert discourse' which is prevalent in health care. With the rise of the evidence-based focus in the 1990s, medicine and nursing tend to favour a technical rational approach (Schon, 1983). Indeed, the Department of Health currently takes a positivist approach, with empirical demonstration of knowledge being key in nursing. This is illustrated by the adherence by practitioners to evidence-based guidance and advice produced by the National Institute for Health and Care Excellence (NICE, 2019). HVs situated themselves within an 'expert discourse', by arguing that admission of gaining knowledge outside of more formal evidence-based arenas is *"probably not a good thing" (Jane: FG 2: p.13)*, which concurs with a reduction in the value of this knowledge. However, these ideas were based on the context of discussion, and were sometimes contested within the focus groups. The idea of placing a quantitative importance 'value' on differing types of knowledge demonstrates that HVs conform to the idea of a hierarchy of knowledge which is represented in figure 7.16.

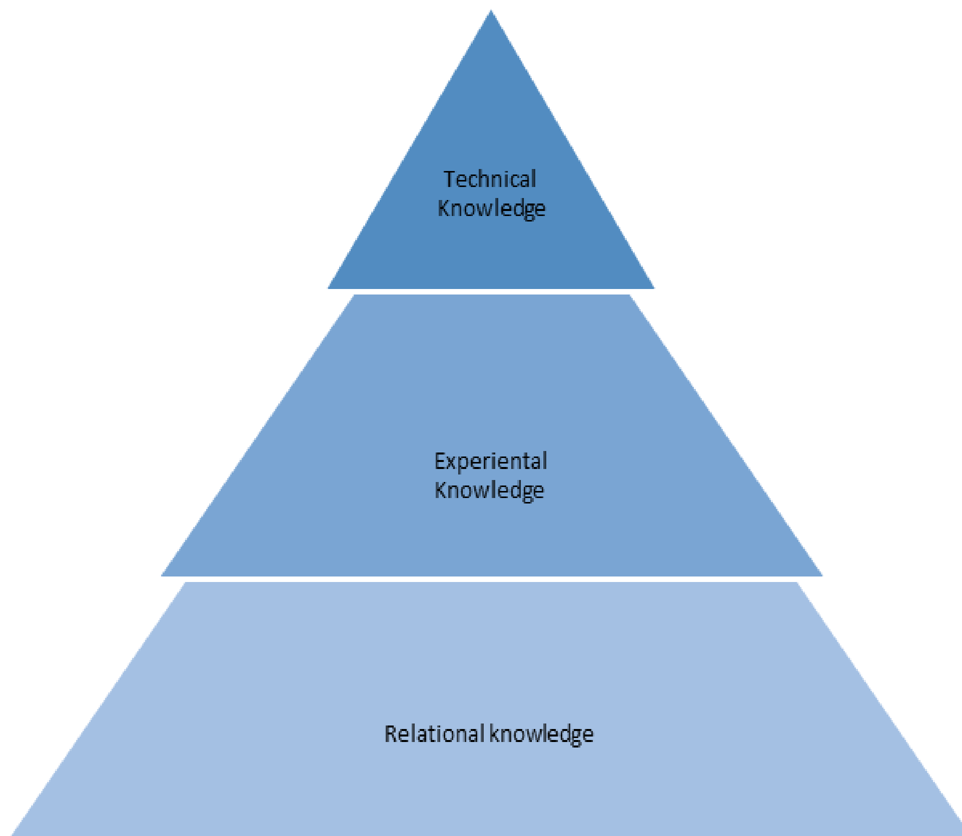


Figure 7.16: A diagrammatic representation of a hierarchy of knowledge, with technical knowledge being the most valued form of knowledge within the health arena.

Knowledge, identity and power are inter-woven concepts, which impact upon one another in the professional world. Examining professionals within the wider social contexts, Foucault (1980) suggests that knowledge is not objective or neutral, instead it is bound together with power, and that power is exercised rather than possessed. Indeed, power is created through knowledge and interactions between people, which in turn allows professionals to maintain their professional status and powerful position. In this study, by the admission of 'not knowing' the answers to some of the more specific questions posed during focus groups, HVs risk their professional status. This, alongside the understanding that HVs

are relatively low in the professional hierarchy (in comparison to GPs, consultants, and managers), amplified the threat to their limited status and power, thus stimulating defensive strategies.

One strategy implemented by HVs was to move the discussions away from PTSD following childbirth, instead discussing phenomena that they were more confident in their technical knowledge of. This is demonstrated through HVs talking more broadly about traumatic childbirth and alternative perinatal mental health problems, namely Post-Natal Depression (PND), and occasionally linking traumatic childbirth with the development of PND.

"Sylvia: I think historically probably, well probably still does a lot, post-traumatic stress probably gets swept in under the post-natal depression.

Laura: Mmmmmmm.

Sylvia: Umbrella. Do you think, I think?

Sasha: Yeah. I, I don't think it is." (FG 1: p.19)

Thus, HVs conflated PTSD following childbirth and PND, questioning the distinction between the two disorders and whether PTSD following childbirth comes under the 'umbrella' of PND. HVs receive training on PND, whereas usually they do not receive any training on PTSD following childbirth, which is evidenced with data from this study, and personal communications with HV educators (Personal Communication, 2016). Therefore, HVs are more comfortable with their technical knowledge of PND, as they have some formal training on this specific disorder, and discussing this demonstrates they do possess professional technical knowledge of maternal mental illness. This overt knowledge demonstration was important as it allowed HVs to protect their professional integrity by being knowledgeable, a notion that has already been discussed.

Within focus groups HVs outlined conflicts between their own expectations and 'others' expectations of what professional technical knowledge they should possess as HVs.

> *"I think it would be quite useful to have some information on kind of like interventions as well. Ummm, because sometimes it really worries me that health visitors are sometimes given training and expected to become an expert in mental health or an expert in something else. We have so much training at the moment, and it's almost like health visitors are bombarded with so many assessments, we've actually got to focus on what we're good at." (Jane: FG 2: p.18).*

A fundamental principle of health visiting is 'the search for health needs' (Council for the Education and Training of Health Visitors (CETHV), 1977), which could be interpreted as including the identification of mental health needs, but not specifically mental health disorders. This outlines the subtle, but important distinction between identifying a perinatal mental health problem or need, rather than having the knowledge to 'diagnose' or suggest which disorder a person may be experiencing. In relation to this, rather than being defensive of a lack of technical knowledge, HVs were attempting to protect their professional role boundaries and responsibilities from becoming blurred with more specialised mental health care professional. This concept is explored in more detail in the theme 'The role of the HV in mental health care'.

However, historically PND has been the focus, and under the remit of the HV, and it is the main perinatal mental health disorder HVs would deal with, both in term of identification and intervention (i.e. listening visits/HV therapeutic interventions). In recent times there has been a societal and policy level shift towards a concentration on all perinatal mental health. It is now expected that HVs should be aware of, and be able to identify, most perinatal and general mental health disorders (Jomeen et al., 2013). In terms of PTSD, HVs in the locality where the study was conducted are not explicitly or formally trained in the

identification of PTSD following childbirth either within their initial qualifying training, or in further Continuing Professional Development (CPD) (Personal Communication, 2016). However, the NICE (2018b) guidelines suggest that HVs should be able to identify mental health problems, which would include PTSD following childbirth. The conflicts between policy guidance, training provision, and HVs understanding of their role work to increase HVs anxieties around perinatal mental health, and their understanding and conceptualisation of their professional identity and roles.

Identifying PTSD following childbirth in practice. In terms of practice there was an uncertainty around whether individuals and/or HVs in general would be able to identify PTSD following childbirth within their current practice.

> *"I think it's one of those disorders that health visitors might recognise some of the symptoms and guess that that might be what it is . . . when I was clinical, I don't recall women being diagnosed with that as a condition formally." (Jane: FG 2: p.3-4)*

The above quotation reflects the consensus position of participants that they may be able to informally identify the disorder through 'guess work', but that identification would be dependent on the individual HVs knowledge. This highlights the lack of uniformity in Health Visiting knowledge and approaches in practice, which is echoed in the quotation below.

> *"And depending on your background and what strengths you've got, not saying that, that is anyone's fault, but to pick up everything" (Laura: FG 1: p.17)*

These self-perceived differences between HVs in their quantity and quality of technical PTSD following childbirth knowledge is attributed, not only to the lack of formal training in PSTD, but also to the broad HV recruitment strategies in England (Health Education England, 2019), whereby any nurse or midwife can apply to become a HV. HVs can previously have been either: adult, paediatric, leaning disability, mental health nurses, or midwives, and these professions all differ in terms of technical knowledge. It has been

demonstrated by Donna in group 1, a qualified, Registered Mental Health Nurse (RMN) (see quotation on page 166), that certainly in the first few years of being qualified, an individual HV may have more knowledge in certain areas depending on their transferable technical knowledge and skills from their previous nursing roles. Furthermore, there were very few HVs who stated that they had had a client with a formal diagnosis of PTSD following childbirth, indeed many had never heard of it in clinical practice (see previous quotation). Whether this is due to HVs lack of formal training and thus confidence in their knowledge of PTSD, or due to the low rates of diagnosis of PTSD following childbirth is beyond the findings of this study. However, the lack of visibility of potential cases of PTSD following childbirth in practice was used by HVs as a reason for a lack of knowledge about and ability to identify PTSD following childbirth.

Summary: 'technical knowledge' sub-theme.

HVs do have some technical knowledge of PTSD following childbirth, and make literature congruent considerations. However, they lack confidence in their personal and collective group technical knowledge of this specific disorder. HVs are public health nurses working within the NHS for which evidenced-based, empirically demonstrable practice is key, and claims of exclusive technical knowledge is the basis for professional knowledge (Edwards, 2011). A self-perceived lack of technical knowledge from formal health-related sources, in the specific diagnosis of PTSD following childbirth causes an uneasiness in participants, and impacts on their professional identity. In this study HVs attempted to protect their professional identity through several defensive strategies including; stating they have limited formal training, thus relying on more informal sources of knowledge, and by demonstrating in-depth technical knowledge of other (PND) perinatal mental health disorders. In addition, they also explore the concept of 'expertise' in mental health, outlining that they feel they should not be expected to 'experts', instead delegating this role to other

health care professionals. This occurs even though there are policy and practice documents which outline a shift in the expectations and remit of HVs, outlining that HVs should be able to identify a range of perinatal mental health disorders (Jomeen, et al., 2013) beyond the historic focus on PND. This movement in the role expectations and associated knowledge illuminates the uncertainty in the professional identity of HVs.

Experiential knowledge.

Based on reflective learning (Dewey, 1938), experiential knowledge is a continuous process of forming and re-forming ideas through experience exposure (Kolb, 1984). Originally introduced by Borkman (1976), the term has been subjected to multiple definitions and conceptualisations (Blume, 2017). In the current study experiential knowledge has been conceptualized using Carper's (1978) taxonomy of knowledge, by combining experience-based, personal knowledge, a confidence in one's practice and a self-awareness; and aesthetics, highlighting intuition as a way of knowing (Power, 2015). The construction of this sub-theme is presented in figure 7.17.

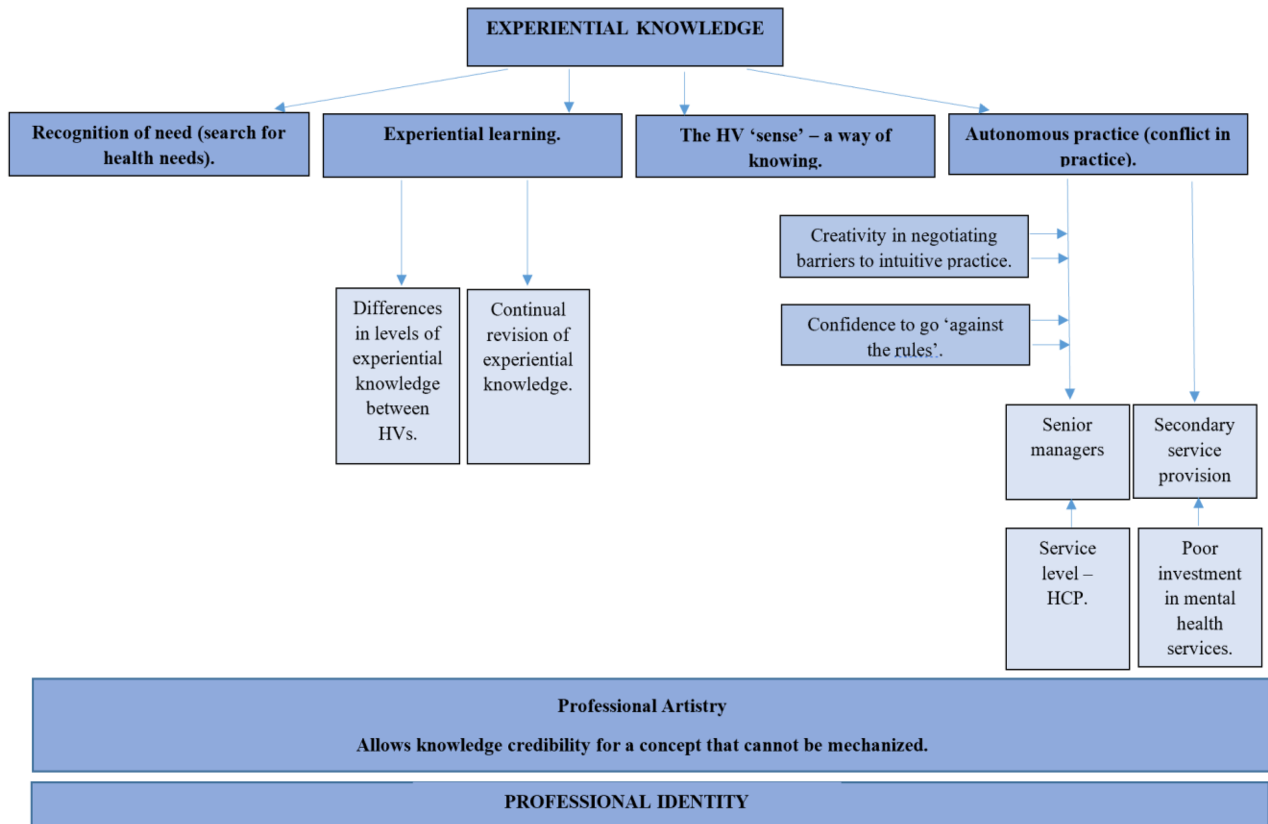


Figure 7.17: A diagrammatic representation of the sub-theme 'Experiential Knowledge'.

Core components of health visiting are the identification of health needs and subsequent support and sign-posting to services (CETHV, 1977). Focus group discussions included the recognition of need, both in terms of parents who have experienced a traumatic birth, and more generally for mothers who experience perinatal mental health problems. Within discussions the importance of the health visiting 'sense' was raised. Participants talked about 'a feeling' that something is 'not right', picking up on 'cues' from the woman, and personal intuition.

"I think again that is something that comes with experience you do learn to pick up that there is more to it and a mum is very unlikely to just say with a questionnaire for example the EPDS they are very matter of fact questions and the way that you do it

they are not going to go oh well actually and start telling you everything you need to be able to pick up that there is more going on. I think a lot of it is intuition and the relationship you have with that mum if you've got a good relationship it is going to be easier for them to open up to you more and for you to pick up that something is not right with them. (Natasha: FG2: p.27)

This suggests that the identification of psychological difficulties in clients often stemmed from their experiential, implicit or tacit knowledge - a 'way of knowing', rather than concrete, technical knowledge. 'Experiential knowledge' is a combination of previous experiences, which impact on HVs implicit, intuitive abilities, and intra and inter-personal skills, which facilitate the recognition of need. HVs outline intuition as key in the identification of PMHP, as they suggest that women can find it difficult to disclose their feelings, the differences in the presentation of distress, and how help-seeking is often implemented implicitly by families.

"I think people can be quite, I think they can be either over, over-whelming full of emotion and that's really evident or they can be quite shut down so, ehhh, and quite difficult to, to read because they are quite shut . . ." (Loren: FG1: p.9)

"So uh I had a woman I saw last year and it wasn't until I, I, I went to see, she requested a developmental review of her little one, so little one was about nine months and ah this has happened before when someone has requested a development review. That you go and they are clearly not ok. And umm you can overlook that if you're, you could over-look it. So you have to pick up the cues you're not at that stage looking for an emotional problem with the mum are you so umm err and in fact that's just remembering now that's definitely happened to me twice ehhh when people have called to make the excuse for you to go and they haven't been able to say

anything about it until that point and even then they find it quite difficult to, to, to talk to you about it." (Loren: FG1: p.7)

Indeed, by using their intuitive abilities HVs are able to identify un-disclosed, and/or un-met PMHP needs within a family. Limitations to intuitive working were described, for example HVs felt they could rely on these abilities to identify a difficulty, but when exploring what the difficulty was, and how best to support it, HVs would utilise more concrete knowledge and objective plans. The quotation below shows how HVs combine their different types of knowledge to provide individualised care to the families they support.

"First and foremost I guess I just offer those opportunities to talk about it, ummmm, and explore other, kind of, networks that she's got to kind of talk about it. And whether she needs referrals into other services, ummm, cause again it's kind of you, you're kind of always thinking: Is it this? Is it that? Cause we, we can't diagnose those, those, those things for the mum. So, it's kind of working out what is the best avenue of support really, and who the best person she can get that from." (Celia: FG 2: p. 32).

HVs describe how their intuitive abilities are continuously developed through experiential learning; a process of adaption and refinement. Discussions about Newly Qualified Health Visitors' (NQHV) lack of intuitive abilities, due to a lack of experience and/or trust in their own intuition further cements this idea of continual experiential learning:

"I think particularly now we have got a lot of new very, very young, newly qualified health visitors and I can think of two or three of them who confronted with that would just be rabbit in the headlights. Absolutely, because they just have, they just haven't got the maturity or experience just to connect with a woman when she is in that in that in that place." (Felicity: FG.1: p. 20-21)

Intuitive abilities develop through the NQHV primary year in practice, with the support of their peers and preceptors, as well as through experience. HVs like other nursing professionals adhere to the Preceptorship Framework for newly registered nurses, midwives, and allied health professionals (Department of Health, 2010). This framework provides a supportive partnership between a preceptor and a newly registered practitioner to create:

> A period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behavior and continue on their journey of life-long learning (Department of Health, 2010, p.11).

The idea of learning through experience or practice is not new, by talking about NQHV two different, but related concepts concerning knowledge acquisition through practice are highlighted. The first relates to a NQHVs need to experience a range of practice experiences in order to develop and expand their reflexive skills and experiential knowledge, helping the NQHV to "move from the novice reflecting on action to the expert reflecting in action" (Power, 2015, p.655). Thus, instead of reflecting on their practice after the event, for example when driving away from a home visit, as a novice may do, HVs through practice experience, learn to reflect on their practice in action by using their previous experiences and intuition (Schön, 1983 Power, 2015), creating a professional and competent expert.

> *"I think you are right, we are all nurses, we have been doing this for a long time, and there is that element of experience. And you are intuitive, well most of the time, but, but again to go back to the newly qualified ones, who haven't maybe gained that over the years, it's perhaps helped them. When I have a student, I will say 'it's not the answer that's important, it's the interpretation of that. And when you tick a box saying – oh can you tell me more about that? You know so you are exploring what the answer*

is.' Ummm, and I have known students tick the box, you know see the answer, and move on, and not explore what it actually means." (Felicity: FG2: p.27).

The second concerns the need to continuously revise and update intuitive practice in relation to any new incoming information.

"Yeah, umm, some of our training is fairly minimal. You know it's like the kind of question in the EPDS, about have you thought of harming yourself? What a loaded question! What a loaded question . . . And, only I don't care, I think however experienced you are, unless you've really got a mental health background, that's a very difficult question to respond to. I've got used to answering it over the years, but again, just little tit bits of information from those with more specialist knowledge about how to ask it actually" (Jane: FG2: p.23-24).

However, unlike technical knowledge, which due to its much more prescriptive nature, is updated through, for example, Continuing Professional Development (CPD), intuitive practice development is more individualistic. Indeed Power (2015) concurs with the ideas presented here in that intuitive practice is "a cyclic learning process with ongoing reinforcement from expert knowledge, recognition and reflection to inform future practice" (p.654).

Experiential knowledge as a form of professional artistry. HVs experiential knowledge, their 'way of knowing', of which intuition is part, is important in practice, and conceptually in the formation and definition of the HV professional identity. One participant epitomises this by saying:

"We are losing our professional artistry umm and that's what makes us good isn't it." *(Loren: FG1: p.23)*

The term 'professional artistry' poses a juxtaposition between two separate concepts. The notion of a professional is connected with words, such as 'skilled', 'competent', and 'special training' (Oxford Learner's Dictionaries, 2019), often recognized by formal training and

accreditation, which allows for professional identification in the health arena and is easily understood and evidenced. Whereas conceptually 'artistry' conveys a creative skill (Collins Dictionary, 2019), a usually natural, not necessarily taught ability, which is fluid and open to interpretation. Artistic skills can be linked to the concept of experiential knowledge, for example intuitive abilities are usually gained through experience and are not easily identified. The term 'professional artistry' gives some credibility to HVs personal intuitive and interpersonal skills, their experiential knowledge. It allows HVs to practice in an individualistic and personal way, whilst maintaining the protection and identification under the umbrella of a collective profession. However, in practice HVs work within the health care arena, which is dominated, like childbirth, by the medical perspective. Valuing technology and logico-positivist knowledge which is possessed by professional 'experts', the lack of a clear evidence-base, or training to develop 'professional artistry' and experiential knowledge has implications for the professional identity of HVs. Indeed, the reductionist biomedical model of health and illness underplays the legitimacy and value of experiential knowledge in professional practice, and thus it is unlikely that this renaming and redefinition of such a fluid, holistic knowledge base is going to increase the professional status of the HV.

The constraints of the biomedical, evidence-based model on HVs use of their experiential knowledge is clear within the focus group discussions. Needing to practice within the confines of the Healthy Child Programme (HCP; Department of Health, 2009), which outlines the execution of the progressive universal service provided during the early years (0-5years) by HVs is one example of a limitation.

> *"Loren: . . . At point 1 there is a huge waiting list, although I guess they would push it up if it was a tiny baby. Umm, so we haven't got that many places to go, these women have got us, and our managers only want us to do eight visits. And umm, and I'm really worried about what you said. About, I , I mean we have got the confidence to maybe*

stand our ground . . . It came up on the training I was giving last week, and there were ten newly qualified health visitors on the training. And they were saying the same sorts of things – 'we are told we can only do this and we can only do that'. And they are not supposed to do another visit after the new birth until 8 weeks. And they really didn't have the confidence to umm, to be able to say, 'I'm not going to do that', and errrr, it does worry me.

Sylvia: I think that is difficult, and I think that it is going to become increasingly difficult. I think it is something that is really going to take some unpicking and looking at, because the drive is around meeting the Health Child Programme." (FG1: p.20-21).

This quotation outlines multiple considerations in using intuition in practice, not only the time and visits needed to 'check' out intuitive 'hunches', but also the need for adequate referral pathways (explored in more detail in 'The role of the HV in perinatal mental health care' theme), and the support of senior colleagues. In addition, internal struggles are recognised, as some HVs (especially NQHVs) lack the confidence to against the rigid 'rules', even when it feels like it is in the best interests of both client and professional.

"At least you have your experience to draw, doing it for so many years. I sometimes feel, cause I'm a bit like, that, that's my way to go back and check and make sure, and I feel that person, you know, and then I need to. And then I start doubting myself. And I question am I encouraging this relationship, cause you're really, you know, as confident in your experience if you haven't been doing it for that long." (Laura: FG1: p.23-24).

More experienced HVs used some of the policies and procedures outlined previously to their advantage. For example, they occasionally used safeguarding procedures to negotiate additional opportunities to re-visit families, as is demonstrated in the quotation below.

"And it leads back to what you were saying about justifying why you are doing it [re-visiting], and in my head I was thinking I'll just use safe-guarding. I mean there was that point anyway, but I'll just, if they start going on too much about 'you shouldn't have gone out there, duh, duh, duh'. I will keep saying 'safe guarding, safe guarding'." (Sasha: FG1: p.27).

Summary: Experiential Knowledge.

All HVs, in both focus groups, placed an emphasis on experiential knowledge, which includes intuitive skills, as central to their practice. This knowledge was identified as key in enabling the identification of PMHP. HVs suggested that the rigidity of the HCP (Department of Health, 2009), management protocols, lack of secondary services and internal confidence struggles have limited their abilities to use their professional artistry as part of their autonomous practice, and therefore feel unable to provide the level of individual and context-specific care they wish.

"And is probably going to become a lot more difficult in the way we are being asked to work around the healthy child programme and much targeted visits that doesn't give the flexibility that I think we previously had" (Sylvia: FG1: p.21)

The in-depth and continual referral to experiential knowledge and intuitive abilities, and the description of these under the heading 'professional artistry' highlights the need to consider the range of differing types of knowledge and skills possessed by HVs and utilized in the identification of PMHP.

Relational knowledge.

Relational knowledge may also, like experiential knowledge, be described as 'personal' knowledge (Rolfe, 1998), although there are subtle differences. Relational knowledge concerns a person's knowledge of the self, the other and the interactions between

people. In a nursing capacity it is the ability to interact with, and 'know' clients, as well as encompassing a person's ability to collaborate inter-professionally (Edwards, 2010). This is a key feature of Health Visiting with HVs having daily contact with a multitude of other professionals, for example, general practitioners, social workers, midwives, nursery nurses and teachers. The construction of this sub-theme is presented in figure 7.18.

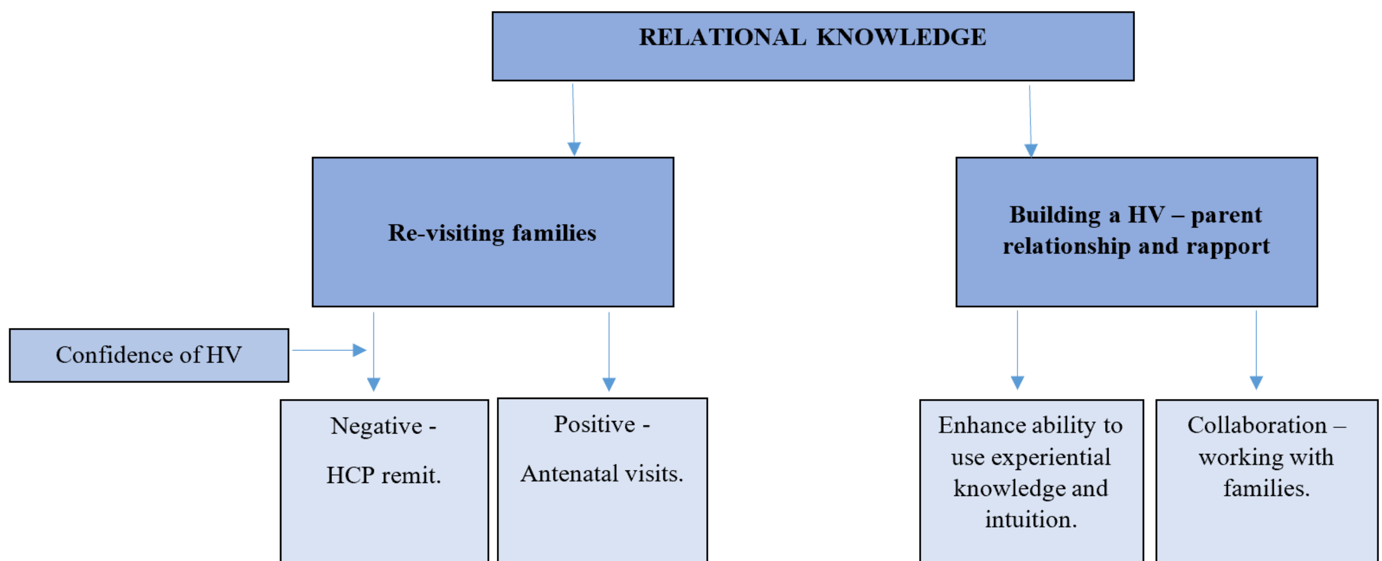


Figure 7.18: A diagrammatic representation of the sub-theme 'Relational Knowledge'.

The Health Visitor-parent relationship. The core aspect of relational knowledge which has been constructed through analysis concerns the parent-health visitor relationship. Building a rapport and relationship with families is a well-established function of the health visiting profession (King, 2016), and the importance of this fundamental relationship cannot be under-estimated, as it both enables and mediates working practices (De La Cuesta, 1994).

"A lot of it is the basic people thing, getting to know someone they are going to open up, which is a lot of trust things is the most important thing." (Laura: FG1: p.19).

HVs identified building relationships with families as a core factor within practice, especially in relation to implementing experiential knowledge and intuitive abilities, and thus recognising PMHP needs. The development of a measured and accepting relationship between HV and client is pivotal in creating a safe arena for open and honest conversations.

"... they are not going to go oh well actually and start telling you everything. You need to be able to pick up there is more going on. I think a lot of it is intuition and the relationship you have with that mum, if you've got a good relationship it is going to be easier for them to open up to you more and for you to pick up that something is not right with them." (Natasha: FG 2: p.27).

A good trusting working parent-health visitor relationship enhances engagement (Bidmead & Cowley, 2005) and allows the HV to work *with* a client in a collaborative and co-productive manner, facilitating the identification of both needs and risks. Chalmers (1990) sums up the importance of 'the relationship', when she states that it is needed "for the complete work of the health visitor" (p.181).

Barriers and facilitators in relationship formation. HVs explored the time and effort required to create rapport and relationships with families, and that this was often achieved through re-visiting. This need for time and effort in building and maintaining professional practitioner-client relationships is often negated with the health visiting literature (De La Cuesta, 1994).

"But you want to just build up that rapport though and sometimes you, I, I'm always felt that you do need to see someone you can't make that judgement just like that and they are not going to open up straight away, but if you feel something there, and sorry it's true there always has been I've never felt there isn't but . . ."(Laura: FG1: p.25)

HVs made two references to current practice protocols; the implementation of antenatal visits (Department of Health, 2009; Public Health England, 2017), and the discouragement of multiple visits outside the Healthy Child Programme (HCP; Department of Health, 2009) remit. Participants suggested that the newly implemented antenatal visits were useful in identifying issues postnatally, because a rapport had already been created.

> *"Sometimes if you have already seen them on the antenatal visits so you have some sense of, of, of the person beforehand and that does help a bit especially if you build up a bit of a rapport. It does take a bit, some people they don't say anything and it's you sort of have to go back and you just get the sense and eventually they do trust a bit and . . ." (Laura: FG1: p.9)*

However, in a similar frame to the one outlined in the sub-theme 'experiential knowledge' it was HVs' perception that senior staff discouraged such working practices (unless there were quantifiable grounds, such as safeguarding concerns), due to the adherence to the Healthy Child Programme (HCP; Department of Health, 2009) remit. Demonstrating again, that in certain contexts the dominance of evidenced-based, medicalised policies restricts HVs' autonomous practice and implementation of their relational knowledge in practice.

> *I am really worried about that cause the message is definitely out there that you are in that you can only offer your eight visits post-natally for people with whatever it is they are presenting with. And there is no, well, the message is that that we shouldn't be offering more than that." (Loren: FG 1: p21)*

Summary: Relational knowledge.

There is a conflict between what HVs perceive to be 'best practice' and what clinical protocols and guidelines, such as the HCP (Department of Health, 2009) outline. However, this research concurs with previous research findings from Cowley et al. (2015) which suggest:

> Parent-health visitor relationships (Bidmead, 2013; Chalmers and Luker, 1991; DeLa Cuesta, 1994a) are mentioned in much of the research as a key mechanism or way of working, being considered especially important in enabling uptake by families who sometimes find services hard to access" (p.474).

HVs practice is relationship-based (Peckover, 2013) and "relational work, with those who need it most, cannot be done quickly" (Edwards, 2011, p.95). However, there are significant pressures placed on HVs from a range of sources which reduce the time available for creating these trusting, fundamental relationships with the families in their case load.

Overall summary: Knowledge Narrative.

In summary the analysis demonstrates that all forms of knowledge and associated skills are important in practice, and they are utilized in complex combinations to help the identification of PMHP by HVs. However, when focusing on the specific diagnosis of PTSD following childbirth HVs in this study were under-confident in their technical knowledge of this disorder. During analysis it became clear that HVs do have a basic understanding of PTSD following childbirth, but that levels can differ between individuals based on experience and previous training. Furthermore, on occasions HVs conflate PND and PTSD, which could have implications for the family.

HVs acknowledge the needs for professional technical knowledge in both implicit and explicit ways. Claims of exclusive technical knowledge is the basis of professional knowledge (Edwards, 2011), and the potential lack or under-confidence of this impacts on the professional identity of the HV. To guard against this impact on their professional knowledge HVs in this study outline the value and legitimacy of alternative, tacit forms of knowledge; experiential and relational. The concept that Health Visiting should combine scientific, factual knowledge (technical knowledge) and art and practical knowledge (experiential and relational knowledge)

is not new (Goding & Cain, 1999; Twinn, 1991). However, in general less emphasis and value is given to the 'softer', more tacit forms of knowledge, HVs in this study try to mechanise these concepts to fit in with the medicalized, evidence-based forum of healthcare. They do this by assigning the term 'professional artistry' to the knowledge and skills they possess which are not easily evidenced. This term 'professional artistry' has been highlighted by others within the nursing literature (for example Conway, 1994), and although it is a complex and difficult to define concept, this research concludes that it is essential in the search for health needs, a core principle of the Health Visiting profession.

'Protecting an Uncertain Professional Identity'

Through the thematic analysis an over-arching theme of 'Protecting an uncertain professional identity' was constructed, bringing together the two main themes described above; the 'knowledge narrative' and 'the role of the HV in perinatal mental health care'. The construction of the overall analysis is presented in figure 7.19.

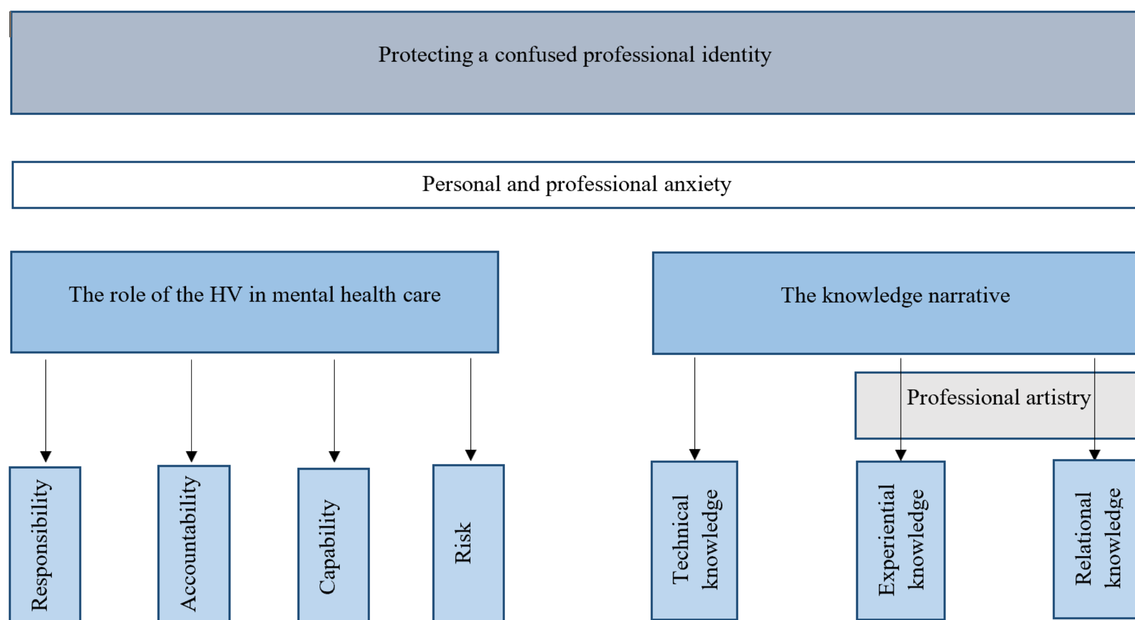


Figure 7.19: A diagrammatic representation of the overall construction of themes.

HVs present an understanding of the importance of specific technical knowledge in defining themselves as health care professionals, and become defensive when they perceive themselves as unable to demonstrate this in the specific area of PTSD following childbirth. This provoked the implementation of a range of defensive strategies by HVs, including demarcating themselves away from a role (and therefore need for knowledge) in PMHP more generally, and also highlighting the other, more tacit, less objectively evidenced forms of knowledge they possess as professionals. Both of the themes demonstrate the juxtapositions and conflicts which are present within the Health Visiting profession, the analysis constructs these as arising due to an uncertain professional identity. For example, HVs seem to struggle to delineate the boundaries of their profession, in comparison to others, verbally they achieve this, but in practice the picture is very different. Indeed, data from this study suggests that HVs take a significant role with families with PMHP, and this has professional and personal implications for the HV. These anxieties arise due to HVs' uncertainty over their positioning, knowledge and skills within PMHP; their uncertain professional identity, in combination with the significant risk associated with this type of work.

In comparison, in the 'knowledge narrative' the analysis demonstrates that HVs have multiple knowledges and skills and that a combination of these are vital in the identification of PMHP. However, the tacit, 'softer' types of knowledge; experiential and relational are difficult to evidence, and are perceived as having less value in the medically dominant healthcare arena. To manage and deliver all the aspects of their professional principles HVs need to have some knowledge of many areas within health and social care. However, this means that their roles often cross many traditional professional boundaries, for example, they can give health advice and prescribe some medication (Nuttell, 2013), crossing into the traditional boundaries of medicine, and they have a pivotal role in safe-guarding (NICE,

2014), so also crossing into the social worker domain. In this study, whilst discussing whether HVs should or should not have a role within perinatal mental health care, one participant stated that she did not want HVs to be viewed as a ‘jack of all trades’ (a little knowledge in many areas), because:

> *I just think that we’ve got to be really careful that health visitors end up being a bit of a jack of all trades. And with something like this it is so important that women get the right specialist support and they don’t just get a health visitor who has done half a day’s training (Jane: FG 2: p.19).*

HVs are part of the wider health system, and thus expected to use their skills in partnership and multi-agency working to deliver services to children and families (Department of Health, 2009). As discussed above HVs struggled to define and own their own professional identity, demonstrated in this study by their inability to clearly define their role boundaries and responsibilities within perinatal mental health. This, alongside their outlines of multiple knowledges, and the previous literature (Hunt, 1972a; 1972b; Baldwin, 20) indicates there is an argument that a HV is expected to be a ‘jack of all trades’. As a front-line service they are expected to encompass the wide-ranging domain of public health. The cross-boundary and diverse roles in Health Visiting, may explain some of the historical claims in the literature (outlined in chapter five) regarding the ambiguity of the professional identity of the HV as diversity of tasks/role within a profession can often cause professional identity confusion (Mackey, 2007).

Perinatal mental health care is a relatively recent formally identified area of Health Visiting practice, which will have redefined the role of the HV. The hesitancy of HVs in this study to verbally acknowledge and believe in their role in mental health care, plus their objections to being viewed as a ‘jack of all trades’, suggest that they are uncomfortable with

incorporating another aspect of working, which crosses yet another traditional professional boundary of mental health, into their professional identity. HVs in this study also made continual references to the inherent responsibility and risks associated with perinatal mental ill health, demonstrating an explicit awareness, and an associated anxiety and fear, of incorporating mental health into their practice. This in turn could have worrying consequences, with some HVs suggesting that they may not address perinatal mental health in practice due to their discomfort, potentially 'missing' families in need.

CHAPTER EIGHT

Study Two: The Post-Natal Mothers Study

Method

Methodology for study two: A narrative analysis of how women frame and understand their childbirth experiences.

This chapter presents the research methods used in the collection and analysis of the data for study two in this thesis which aimed to explore how women frame and understand their traumatic childbirth experiences. The study explored the experience of traumatic birth, alongside the role of birth expectations and the mother's perception of the impact of a traumatic birth on herself, her infant and wider family. This chapter begins by detailing the recruitment procedures and the demographic details of the mothers who volunteered to take part in this study. It then provides twelve 'participant profiles', these give a brief synopsis of each of the mothers' demographic information, the medical details of the labours, and a brief introduction to her family, including the baby. These 'participant profiles' provide the reader with an understanding of the general and medical context in which the childbirth event occurred. This allows the narrative analysis (presented in chapters nine and ten) and the novel representations of the traumatic childbirth stories (presented in chapter eleven) to be understood alongside additional, more quantitative details that were available to the researcher.

The data collection procedure, which focused on a one-to-one interview, is described in detail, and includes some considerations of interviewing mothers with young infants, and also interviewing women about traumatic experiences and the ethical considerations around this. Interviews were used for many reasons, and these are detailed in this chapter, however the primary reason was that narratives are usually best captured through this method, and in this study they had "the potential to validate the knowledge of 'ordinary' people, especially 'ordinary' women who are liable to be omitted from many research projects" (Fraser, 2004, p.184). A conversational interview style was adopted, however the narrative analysis presented as part of this thesis draws data from a specific question. This question asked

women to think back to their childbirth experiences and to talk the interviewer through the traumatic childbirth experience from beginning to end, exploring the events that happened, the people who were present and her own feelings and emotions during the birth experience. It is the lengthy, rich narratives provided in response to these questions which are used during the narrative analysis (presented in chapters nine and ten) and the novel representations (presented in chapter eleven). The justification for using narrative analysis is provided, alongside a brief description of this type of methodology and how it was implemented in this study.

Recruitment and Inclusion criteria

Participants needed to consider themselves as having experienced a traumatic birth in the preceding six-month period. Women were recruited on-line from a Facebook page for mothers within an East of England area, permission from the administrators of groups was requested before advertisements were placed on-line (appendix F). This recruitment method has been successfully utilized previously, by the researcher and others (Richiardi, Pivetta & Merletti, 2012; Walsh & Bagge, in prep.). The on-line face-book page is a facilitated by local mothers for local mothers, it is described as a forum for discussions around pregnancy, childbirth and early childhood. It was a good form of recruitment for this study as it has a relatively large number of women (at the time of advertising it had 3924 members).

Participants

Participants were a self-selected cohort of twelve women who had given birth to a live baby within the preceding 6 months and considered themselves to have experienced a traumatic birth. A definition of a traumatic birth was not provided in the study advert, so it was very much based on the woman’s own perception of her experiences.

All women, apart from one, identified themselves as white British, the age of participants ranged from 23 to 35 years (mean = 29.5 years), and all had, and lived with their partners, just over half of the women were married. The length of relationships ranged from 3 to 12 years (mean = 5.96 years). All women had either A-levels or undergraduate degrees, and all apart from one were in employment. None of the women revealed a physical disability, and only one woman stated that she had previously experienced a mental health condition (anxiety).

Two women had previous pregnancies, all resulting in live births. All pregnancies were singular, and there were 3 male and 9 female infants, they ranged in age from 3 weeks to 6 months (mean = 4.16 months). All the infants were born at term (mean gestation at birth = 40.61) and had no physical issues at the time of interview.

All women had given birth in hospital, although two had initially planned a home birth, one had been transferred into hospital during labour, the other changed her mind before labour commenced. The length of time women were in-patients ranged from 1 to 13 days (mean = 4.3 days).

Participant profiles

These twelve participant profiles are provided to give a brief synopsis of the mothers' demographic information, the medical details of the childbirth events and a brief introduction to the families of each mother. These offer the reader an understanding of the general and medical context of the childbirth event, allowing the narrative analysis and the novel representations of traumatic childbirth experiences to be understood within the quantitative contextual details available to the researcher. All the information was provided by women in response to a self-report questionnaire, women were able to clarify details with the researcher

if they did not know the medical terminology associated with their experiences during pregnancy, labour and the post-partum period.

Amelia and baby Lauren (4 months old). Amelia is a 33-year old British woman, living with her husband and two children, aged two years and 4 months. She works in finance and banking and has no physical or mental health issues. Amelia gave birth to baby Lauren at 38 weeks gestation in a hospital delivery suite. Lauren weighed 6lb 8oz at birth, has no physical problems and is fully breastfed. Amelia experienced a vaginal birth with a spinal anaesthetic and gas and air used as pain relief. Monitoring included a continuous cardiotocography (CTG) and foetal scalp electrode and complications were periods of bradycardia and a perineal tear which was sutured in the birthing room. Amelia spent three days in hospital.

Suzie and baby Eva (11 weeks old). Suzie is a 30-year old British woman living with her husband and baby. She works in the public sector and has no physical or mental health issues. Suzie gave birth to baby Eva at 40 weeks gestation in a hospital delivery suite. Eva weighed 9lb 12oz at birth, had no physical problems and was breastfed for two days. Monitoring during labour included a constant CTG, a foetal scalp electrode, and two blood tests for foetal distress. Suzie experienced an emergency caesarean section, with a spinal anaesthetic, she also had and intra-partum haemorrhage and an infection following the birth. Eva had periods of bradycardia in utero, was an undiagnosed breech, and meconium was present in the waters at delivery. Eva was admitted to NICU for jaundice and antibiotic treatment. Suzie and Eva spent 12 days in hospital.

Cassie and baby Vanessa (six months). Cassie is a 28-year old European woman living with her partner and baby. She works as a health care professional and has no current physical or mental health issues. Vanessa weighed 9lb 1oz at birth, has no current physical

issues and is breastfed. Vanessa was born at 42+2 gestation in a hospital delivery suite, monitoring included constant CTG, and pain relief included gas and air and water. Cassie had a vaginal birth with shoulder dystocia and perineal tear which was sutured in the birthing room. Vanessa was born with meconium in the waters, required resuscitation by the paediatric team, and was admitted to NICU. Cassie was in hospital for 4 days.

Ruth and baby Elijah (4 months). Ruth is a 24-year old British woman living with her husband and two children, aged two and a half and 4 months. She works in the public sector and has no physical or mental health issues. Elijah was born at 40+1 weeks gestation, weighing 10lbs and has no current physical problems. Monitoring during labour included a CTG electrode. Ruth experienced a vaginal delivery, artificial rupture of membranes, an episiotomy, and forceps assistance. She had a spinal anaesthetic and gas and air for pain relief. Ruth had both an intra-partum and post-partum haemorrhage, infant bradycardia and required stitches to a perineal tear which was carried out in theatre. Ruth spent 2 days in hospital.

Lorna and baby Felicity (6 months). Lorna is a 29-year old British woman living with her husband and baby. She has degree level qualifications and works as an administrator. She has no physical or mental health issues. Felicity was born at 40+2 weeks gestation, weighing 8lb 10oz and has no current physical problems. Monitoring during labour included CTG. Lorna had experienced a spontaneous rupture of membranes, an induction by pessary, followed by an emergency caesarean section in a hospital delivery suite. She had paracetamol and a spinal anaesthetic for pain relief. There was a deceleration in baby's heartbeat during labour, and Felicity needed antibiotics after delivery. Lorna and Felicity spent seven nights in hospital.

Julie and Ted (five months). Julie is a 35-year old British woman living with her husband and baby. She has A-level qualifications, works with children, and has no physical

or mental health issues. Ted was born at 43 weeks gestation, weighing 7lbs 2 oz, and has no current physical problems. Julie wanted a home birth, but delivered in the hospital delivery suite theatre. When in hospital monitoring included a constant CTG. Julie experienced an emergency caesarean section and used water, a TENS machine, hypno-birthing, paracetamol, and a spinal anaesthetic as pain relief. Complications in labour included a deceleration in baby's heartbeat, and intra-partum haemorrhage and meconium in the waters. Following delivery, the baby required resuscitation by the paediatric team, antibiotics and admission to the Neonatal Intensive Care Unit (NICU). Julie and Ted spent five days in hospital.

Cindy and Elsa (3 weeks). Cindy is a 29-year old British woman living with her partner and baby. She has A level qualifications and works in customer service. She has no physical or mental health issues. Elsa was born at 40+12 weeks gestation, weighing 8lb 3oz and has no physical issues. Cindy gave birth in a hospital delivery suite and experienced a spontaneous rupture of membranes and an emergency caesarean section. She used water, pethidine, gas and air, and a spinal anaesthetic as pain relief, and experienced monitoring including; sonic aid, intermittent CTG and a foetal scalp electrode. Complications during labour included a deceleration in baby's heartbeat, and both intra-partum and post-partum haemorrhage. Cindy and Elsa spent three days in hospital.

Melody and baby Ruby (3 months). Melody is a 28-year old British woman living with her partner of two years. She has A-level qualifications and works in recruitment. She has no physical or mental health issues. Ruby was born at 41+4 weeks gestation, weighing 8lb 4oz and has no physical issues. Melody gave birth in a hospital delivery suite and experienced a spontaneous rupture of membranes and attempted to have a water birth. Due to a deceleration in the baby's heartbeat, melody had an emergency caesarean section. Melody use gas and air, TENS machine, paracetamol, codeine, pethidine and a spinal anaesthetic for pain relief, and experienced monitoring via sonic aid, constant CTG, and foetal scalp

electrode. Ruby was born with meconium in the waters and required resuscitation by a midwife. Melody and Ruby spent 2 days in hospital.

Lyndsay and Ralph (4 and a half months). Lyndsay is a 24-year old British woman, who lives with her partner of nine years (married for two years) and children. She has A-level equivalent qualification and is currently a stay at home mother. She has three children under the age of five years. She has no physical or mental health issues. Ralph was born at 40+4 weeks gestation, weighing 10lb 4oz and has no physical issues. Lyndsay gave birth in a hospital delivery suite, she delivered vaginally after experiencing an artificial rupture of membranes. Lyndsay had no pain relief and was monitored using a sonic aid. During labour Lyndsay experienced a shoulder dystocia and ralph was born with meconium in the waters. Lyndsay and Ralph spent two days in hospital.

Rosie and Lola (6 months). Rosie is a 34-year old British woman, who lives with her partner of six years and baby. She has a degree qualification and currently works in customer relations. She has no physical or mental health issues. Lola was born at 39 weeks gestation, weighing 8lb 6oz and has no physical issues. Rosie gave birth in a hospital delivery suite, she had a vaginal, forceps delivery with stitches to a perineal tear in theatre. Rosie used paracetamol and a TENS machines, and had a spinal anaesthetic as pain relief. During labour Rosie had constant CTG monitoring and experienced a deceleration in baby's heartbeat. Rosie and Lola spent one night in hospital.

Lillian and Helena (4 months). Lillian is a 28-year old British woman, who lives with her husband of five years and baby. She has a degree qualification and currently works in customer relations. She has no physical issues. Helena was born at 42 weeks gestation, weighing 9lb and has no physical issues. Lillian gave birth in a hospital delivery suite, she experienced an induction by pessary, drip and an artificial rupture of membranes, with a ventouse delivery and stitches to a perineal tear in the birthing room. Lillian had a spinal

anaesthetic as pain relief and experienced monitoring via; sonic aid, intermittent and constant CTG. There were decelerations in baby's heartbeat and Lillian experienced a post-partum haemorrhage. Lillian and Helena spent six nights in hospital.

Cheryl and Eleanor (3 months). Cheryl is a 33-year old British woman, who lives with her partner of three years and baby. She has A-level qualifications and currently works in administration. She has no physical or mental health issues. Eleanor was born at 42+1 weeks gestation, weighing 9lb 2oz and has no physical issues. Cheryl gave birth in a hospital delivery suite, she experienced an induction by drip and an artificial rupture of membranes, and delivered vaginally with subsequent stitches to a perineal tear in the birthing room. Cheryl had paracetamol, a TENS machines and a spinal anaesthetic as pain relief and experienced monitoring via constant CTG and foetal scalp electrode. There were indications of foetal distress and meconium in the waters. Cheryl and Eleanor spent four days in hospital.

Self-report questionnaire data

Due to the small number of women who took part in this study, the usual quantitative analysis was unable to be completed using the data from the three self-report questionnaires. However, the data has been explored and indicates that on measures of anxiety and depression (HADS), none of the women (n = 12) scored above the clinical cut off score of 8 for psychological symptoms of depression. On the measure of psychological symptoms of anxiety two women scored within the moderate range and one woman scored within the mild range. All other women (n = 9) scored below the clinical cut off score for anxiety. Exploration of the data from the perinatal posttraumatic stress disorder scale (Callahan & Borja, 2008), three women scored above the clinical cut off of 19, two of these women had also scored moderately for anxiety using the HADS questionnaire.

Interestingly, when exploring the measure of general PTSD a number of women did not complete the questionnaire as they verbally indicated that they had not experienced one of the identified stressful or traumatic life events (n = 4). Only two of the completed general PTSD measures detailed childbirth as a trauma, and one of these was completed on the basis of a different traumatic experience. All other completed general PTSD measures (n = 6) provided details of alternative traumatic events experienced by the women in this study.

The findings from the quantitative data, alongside the qualitative analysis raises some interesting and pertinent points for consideration. Based on the quantitative data from the measures of anxiety, depression and perinatal specific PTSD psychological symptoms, it is unlikely that the majority of the women interviewed as part of this study would be identified as in need of further support if only self-report measures were implemented. The combined findings from this study also indicate that although women may present as sub-threshold in terms of symptom's they are likely to still be in need of support, and this is important to be mindful of in practice. The findings from the general PTSD measure highlights two points for consideration. The first is how women understand and conceptualise their traumatic childbirth experiences, as although these women had self-identified as having experienced a traumatic childbirth, and they were being interviewed about this specific experience, most women did not identify their childbirth experience as a trauma on the self-report questionnaire. This is suggestive of a propensity by women to minimise the trauma associated with childbirth in comparison to alternative traumas such as sexual assault and life-threatening illness. The second point relates to measures, although utilising small numbers, the data suggests that it is important to utilise specific perinatal posttraumatic stress disorder self-report measures rather than generic measures when exploring PTSD following childbirth.

Data Collection

This qualitative study was primarily conducted as an exploratory analysis of women's childbirth expectations, traumatic labour, effect of labour on the individual, and experiences of post-trauma/childbirth support. Interviews rather than focus groups or written accounts allowed for a personal intimate conversational experience which could not be created in a group environment. It allowed for disclosures to be made and intimate experiences to be shared in a comfortable, non-judgemental environment, without the pressures of time or concern about the impact of topics on others. Due to the topic nature and the presence of an infant the researcher was concerned from an ethical perspective about incidents in which a participant may be deemed to be a risk to themselves or others. Interviews rather than focus groups or written accounts would have allowed the researcher to act in accordance with a pre-agreed protocol for managing any concerns should the need have arisen. The researcher was also mindful that all participants had an infant under the age of six months and creating the space and time to provide a full written account of their experiences would for some have been difficult. Alongside this are considerations about literary abilities with the emphasis placed on attempting to not exclude mothers through the data collection methods where possible.

Women were interviewed either in their homes or on the university campus, whichever was logistically easier or more comfortable for them. It was felt that participants needed to be given the option of having their baby present for the interview. Only one woman chose not to have her baby present, however the infant was in the house being cared for by his grandparents. This: 1) reduced the need for childcare, 2) respected differing feeding practices and 3) allowing the positive result of the birth to be kept in mind. There were however difficulties with having infants and on occasion older siblings present for the interview. They included practical difficulties, for example; keeping children entertained

over quite a long period, and being able to record the interviews effectively with what on occasion was quite a lot of background noise. There were additional considerations in terms of the emotional reactions from mothers and the effect that these may have on the children present. Fortunately, in most interviews this was not an issue, however the researcher was continuously monitoring the situation to assess the mother and baby for any distress. For those interviewed on campus a specially designed room was used, which was both quiet and 'baby friendly'. Two women decided to be interviewed on campus, the rest were interviewed at home and these interviews did not seem to differ from those conducted in a home-setting. Women were free to have their partner present for the interview. From an ethical standpoint this allowed women the option of additional support during the interview. However, the presence of another, especially somebody who was likely to have been present during the birth experience would have changed the audience during the interview. This had the potential to alter the women's narrative due to the co-construction rather than individual construction of the story. These issues are not pertinent as only one woman had her partner present in the house, but they were not in the room during the interview.

A printed information sheet (which had already been emailed to interested participants) was provided (appendix G) and any questions or concerns addressed. A consent form (appendix H) was signed to ensure that participants were fully informed. High street vouchers were given as a thank-you for taking part in the research. These were given at the beginning of the research process so no woman felt that she had to continue with the interview and allowed for withdrawal from the study without being penalised. Women completed a general and obstetric demographic questionnaire (appendix I) before the interview. Post-interview they were asked to complete self-report measures of; general PTSD, using the Posttraumatic Stress Diagnostic Scale (PDS; Foa, Cashman, Jaycox & Perry, 1997), anxiety and depression, using the Hospital Anxiety and Depression Scale (HADS;

Zigmond & Snaith, 1983), and a measure of perinatal specific PTSD symptoms using the Perinatal Post-Traumatic Stress Disorder Questionnaire (Callahan & Borja, 2008).

Semi-structured interviews allowed for a degree of flexibility to be sensitive to the individualised birth experience, with questions adapted and generated for differing situations (see appendix L for an outlined of the interview procedure and questions). Initially women were asked to reflect on their expectations of labour whilst pregnant. Questions included both objective events; e.g., pain relief and location of birth, and also more subjective expectations; e.g., thoughts about how others would respond to them during labour, and how they expected to respond, feel and cope during labour. A personal narrative of the birth experience was then sought, this was facilitated by requesting that the women talk the researcher through her labour experience in as much detail as possible. The following question was used to elicit the traumatic childbirth story:

> I would now like you to think back to your actual labour experience, from beginning to end. I would like you to talk me through your birth, telling me about events that happened, the people who supported you and your feelings and emotions during that time. I would like to know about the bits that you found especially difficult, however if there are aspects of the labour that you find too difficult to discuss please say so and we can move on? Please take as much time as you need and give as much detail as you feel comfortable.

Women spoke for extended periods, offering full, rich accounts of their birth experiences. I tried not to interrupt with questions/clarification, and instead noted points to discuss when the women had finished her birth story. Gentle prompts were occasionally given to encourage the women to continue, these included both verbal and non-verbal cues (i.e. nodding head, smiles). Women reconstructed and emplotted their birth experiences into lengthy and rich

narrative accounts of their lived experiences, embedded within the social, historical and cultural contexts.

The researcher was mindful of the experience of 'telling a story' and therefore attempted to avoid interruption. This allowed participants to locate their own beginning and end to their experience (Riessman, 2013) and offered a "mode of interviewing that reflect and respect participants' ways of organizing meaning in their lives" (Riessman, 2013, p.169). In conclusion participants were asked to reflect on if, and how, their experiences had impacted upon their relationships with; their child, partner and close friends and family, and/or how the birth had affected them emotionally or physically. Finally, they were asked about accessing support in relation to their traumatic birth, in terms of ease, experience, type, and benefits of possible avenues of support. Drawing on their own traumatic birth participants were asked how they would advise another mother who had been through a similar experience.

Post-interview, participants were asked how they felt in general and about the interview, and whether they wished to continue by completing the questionnaires, outlined previously. Finally, a de-brief sheet (appendix K) containing a study rationale, contact details of the research team and sources of support (appendix J) was provided. It was verbally reiterated that if participants had any concerns about their own physical or psychological well-being or that of their baby, then they should contact their general practitioner or health visitor.

Creating a space in which women are comfortable in sharing their discrete, personal narratives of a transitional life event, or arguably a life disrupting event has its own challenges. The concept of boundaries in qualitative research is not new, however it requires specific, detailed consideration when under-taking health-related research on a sensitive topic (Dickenson-Swift, James, Kippen, & Liamputtong, 2006). The development of rapport with the women in this study was important as the aim was to collect rich data. "Many researchers

undertake some level of self-disclosure to encourage participant disclosure" (Dickenson-Swift et al., 2006, p.856). As a woman with young children the researcher was ideally placed to imply a common understanding and knowledge of childbirth and parenthood. Although during interviews the researcher did make some disclosures these were not outside the common discussions one would have with any mother regardless of the relationship. The issue of 'blurring boundaries' was avoided through the maintenance of professional boundaries i.e. not displaying one's own emotional reactions to distressing events.

The researcher was continuously mindful that the interview process may cause distress and reiterated throughout that the process was entirely voluntary. This, alongside sensitive questioning aimed to create a comfortable and trustworthy environment for women to share events that could cause both distress and embarrassment. The process of childbirth is a very intimate and personal experience, building trust and rapport can allow a woman to express both the physical and emotional elements of her birth experience without hindrance.

Birth 'stories' are consistently used to create both a feeling of collective union between childbearing women, and as a form of lay education: "Sharing birth stories becomes more long-lasting as wisdom is passed from "one who knows" to those "who need to know."" (Walker, 1984; Bruner, 1990, cited in Savage, 2001, p.3). Utilizing the everyday phenomenon of the want to share and the need to know about childbirth, this research creates the space for women 'who know' to inform the research which 'needs to know' about the idiographic perceptions of birth expectations and traumatic birth experiences. Using direct accounts from mothers the research adheres to the concept of 'women-centred' care which places the emphasis and value on the woman's experience (Carolan, 2006). Through qualitative research, we as researchers are providing a platform from which women's stories and experiences can be illuminated within research and thus inform future policy and practice.

The credibility, validity and trustworthiness of birth stories as research data may be questioned, however it is suggested providing a 'faithful description' by using women's words verbatim as examples, explicit and clear explanations of analyses and having categories verified by other researchers, addresses most concerns (Carolan, 2006). Although birth "stories might be viewed as a secondary and colloquial form of data, the literature suggests that birth stories actually offer a powerful, rich source of data and this finding can be extrapolated to midwifery research" (Carolan, 2006, p.67). Indeed, although concerns are raised within the literature about 'birth stories' as research data it is argued that the benefits of providing women with a 'voice', and the value of this type of data far outweighs concerns about the credibility and validity of this form of data.

Facilitating the transfer of 'birth stories' from women who have experienced a traumatic birth to the researcher has multiple ethical concerns which have been addressed in another section (see 'Ethical considerations' section below). However, there are also possible benefits not only for the researcher in terms of data collection, but also for the woman. By talking about their birth women may feel that their experiences are being validated (Brook & Barnes, 2001). For women who have perceived their labour as traumatic the interview process may have provided a 'therapeutic pay-off' (Dickenson-Swift et al., 2006), indeed a number of participants alluded to this post interview. Qualitative research which uses depth interviews is suggested as being "parallel to a therapeutic encounter" (Birch & Miller, 2000), with the process allowing for space to reflect and make sense of experiences and ultimately creating a new understanding. This concept also relates to the use of de-briefing services for women who have had a traumatic labour. Although the evidence of the use of post-trauma de-briefing is complex, contradictory and not without criticism, Boyce and Condon (2000) suggest that there is a value in creating the opportunity to talk about labour experiences.

Although women may perceive the research interview as a therapeutic exercise it does raise concerns. The researcher is just that – a researcher and not a counsellor or therapist. Although similar skill sets are required, for example, empathy and listening skills (Corey, Corey & Callanan, 2003), researchers are not trained to therapeutically deal with issues that may arise (Dickenson-Swift et al., 2006). Ultimately in this study the therapeutic entity of the interviews was reportedly beneficial to the women, as previous research has also demonstrated (Birch & Miller, 2010), however on reflection the issue of responsibility placed on the researcher needed to be negotiated within the execution of data collection and analysis.

Ethical considerations

A key consideration in facilitating trauma-related research is the concept of re-traumatisation. Here the concern lies with recounting the traumatic event in considerable depth, which may have the potential to be traumatising in itself for the women. However, "trauma researchers argue that equating the recounting of traumatic experience with re-traumatization is a mischaracterization of the phenomena" (Legerski & Bunnell, 2010, p. 431). Instead, the concerns mainly lay with causing significant expected or unexpected emotional distress and feelings of regret in participating (Legerski & Bunnell, 2010; Newman, Risch & Kassam-Adams, 2006). However, research demonstrates that there is a low level of risk, for both expected and unexpected significant emotional distress (Newman et al., 2006), and when significant distress does occur it tends to dissipate relatively quickly (Legerski & Bunnell, 2010). Participants usually do not report any regret due to taking part in trauma-related research, instead many report both personal and societal level benefits (Legerski & Bunnell, 2010; Newman et al., 2006).

Qualitative research interviews can be inherently therapeutic, as they offer participants the opportunity to talk about and share their experiences. One participant in the

current study highlighted the ‘helpful’, arguably therapeutic value of the research interview process for herself:

> *“Talk it properly out with somebody. I don’t know if it would have helped me at the time. But I think if I it did now, like I just have - I think it will help now.” (Lyndsay).*

Conducting research into sensitive topics has the potential to cause distress to both participants and the researcher. Strategies can be utilized to increase comfort, and increase the richness of any accounts provided (Elmir et al., 2011). Pivotal in the collection of interview data on sensitive topics is the development of rapport (Karnieli-Miller, Strier, & Pessach, 2009) and trust between the researcher and participant (Elmir et al., 2011). Dickerson-Swift, James, Kippen, & Liamputtong (2007) suggests that this is best achieved through the two-way process of giving and receiving information. In this study I engaged in appropriate self-disclosure, indicating that I had children of my own and thus had the shared experience of childbirth, but not traumatic childbirth, and of general motherhood. This reciprocity in information exchange not only created rapport and a more relaxed atmosphere, but it also aided the reductions of the power differentials between myself and the mother (Karnieli-Miller et al., 2009). I attempted to guard against blurred boundaries and ‘therapeutic misconceptions’ by indicating my background in academia, however there were points in which mothers seemed to confuse professional boundaries by asking me for medical advice or experiences, this was addressed by the reiteration of my professional status as an academic and not a health care professional.

The interview environment was also an important consideration (Elmir et al., 2011), all mothers were able to choose the location of their interview and all opted for private environments. The birth narrative was collected in the middle of the interview, as this allowed mothers adequate time to become familiar with the interview format and allowed a supportive and relaxed interviewing technique to be established before more sensitive areas

were broached for discussion. It also allowed some time to recover from providing accounts of the traumatic birth experience whilst I was still present.

Exit strategies were considered prior to the interview. Leaving the women emotionally calm and without distress was especially important due to their positions as mothers with young babies (and children). I utilized re-framing strategies towards the end of the interviews to re-frame any potentially distressing or negative experiences. An example of this occurred in the interview of Lyndsay. She became visibly distressed when talking about the absence of her partner during her birth. To re-frame this conversation I steered the discussion towards the positive relationship the mother had with her partner, creating a visible change in the emotional state of the woman. At the end of all interviews, I spent some time talking about everyday subjects in order to leave every mother in a calm, non-distressed state.

Whilst questions were open-ended and mothers were given the space and time to answer how they wished to, long silences were generally avoided, unless they were deemed to be appropriate, so as not to cause unnecessary discomfort and/or anxiety. Although literature supports the concept of compassionate or therapeutic silence (Bassett Bingley & Brearley, 2017), this was in essence a research interview, and although (as discussed previously) there are elements of the research interview which mimic a therapeutic exchange, the possibility of provoking anxiety was too high and so guarded against in this context.

An additional concern arose around inducement of payment for participation. Paying participants' money to take part in trauma-related research seemed morally dubious, and so a decision was made to give mothers shopping vouchers as a token thank-you rather than as payment for participation. The amount given was commensurate with the amount which would have been paid under the wage-payment model of participant payment (Dickert &

Grady, 1999). Vouchers were given before the data collection began to guard against any 'undue inducement' (Dicket & Grady, 1999).

This study was approved by the School of Psychology Research Ethics Committee at the University of East Anglia on 8/5/14, reference number: 13-14-43.

Narrative Analysis

Justification for the analytical procedure.

Since the 'narrative turn' in the 1980's, as a challenge to the positivist and realist approaches, interest in narrative accounts and analysis has been developed as a methodological approach for interpreting storied data, usually in case-centred research. In combination with a shift in attention on to individual experiences, and in particular the feminist exploration of the diversity of women's experiences (Sherwin, 1998), the exploration of narratives has grown within research. In narrative analysis extended narrative accounts are explored in their entirety, maintaining coherence and context, rather than fragmenting the data as is usual in other category-centred methodological approaches (Riessman, 2008), such as thematic analysis (Braun & Clarke, 2006) and grounded theory (Glaser & Strauss, 1967). Narrative analysis examines "how knowledge is constructed through the everyday word through an ordinary communicative act – storytelling" (Riessman, 2008, p.13-14). Incorporating a number of ideas from other forms of research inquiry and traditions, narrative analysis has diverse utility and is executed in many different forms. Unlike other research methods, such as thematic analysis (Braun & Clarke, 2006), narrative analysis does not have a particular framework for use in research practice. Instead researchers are required to explore their research aims and data to implement this method in the way which is most appropriate of their research and data (Riessman, 2008).

Storytelling is synonymous with ‘narratives’ and is a normative, natural and universal phenomena (Riessman, 2008). This study draws on people’s ‘narrative impulse’ to storify experiences, and the value of childbirth narratives has begun to be recognised within the research literature, and concurs with the women centered ethos of current maternity and perinatal health care (Carolan, 2006). The elicitation of childbirth ‘stories’ within this research validates women’s experiences and understanding, whilst utilizing their tendency to share and discuss their perinatal experiences, especially childbirth (Carolan, 2006). In addition, the memories of childbirth tend to be accurate and long-lasting (Simkin, 1992). This is utilized during this research as an avenue for exploring how women frame and understand their traumatic childbirth experiences. The creation of narratives as data through interviews lends itself to the use of narrative analysis as the research method for exploring the data, the detailed reasonings are outlined below.

Informed by a feminist perspective a key aspect of this study was to focus on, and value, the voices (and narratives) of mothers who had experienced a traumatic childbirth. Exploring multiple women’s narratives of this experience through narrative analysis allows for the examination and interpretation not only of the idiosyncratic nature of childbirth stories, but also the shared experiences, highlighting the use and analysis of individual narratives as a form of valued knowledge production (Cotterill & Letherby, 1993; Riessman, 1990). The use, and analysis of ‘narratives’ has been pivotal in countering the dominance of patriarchy in research, by allowing the “individual ‘private’ experiences” to be located in the “larger ‘public’ domain” (Crossley, 2000, p.114). This idea of private experience is especially present when examining childbirth, as the intricacies of the experience are inherently private, personal and intimate, both socially and physically. Due to this, and the medicalisation and presumed universality of childbirth, the more holistic explorations of individual experiences tend to be negated in the research literature, this is something which is

not historically unusual, especially in the male-dominated arena of health and illness (Sherwin, 1999; Tuana, 2006). Utilizing the social constructivist approach, this narrative analysis is less concerned with 'truth', and instead focuses on the subjective construction of experience through the creation of stories. This in combination with feminist ideals has "the potential to validate the knowledge of 'ordinary' people, especially 'ordinary' women who are liable to be omitted from many research projects" (Fraser, 2004, p.184).

Riessman (2008) outlines the construction of narratives as:

> . . . transforming a lived experience into language and constructing a story about it is not straightforward, but invariably mediated and regulated by controlling vocabularies. Narratives are composed for particular audiences at moments in history, and they draw on taken-for-granted discourses and values circulating in a particular culture (p.3).

As demonstrated by the above quotation, utilizing narrative analysis to explore these constructions allows for the consideration of the interconnection of the self, and the socio-cultural historical climate of childbirth, and the exploration of women's experiences as valued knowledge sources. This is analysed not only through the structural construction of the narratives, and the exploration of events and associated emotions, but also through language and linguistic practices present within the narratives. Utilizing a social constructivist approach this narrative analysis borrows from discourse analysis, demonstrating the flexibility and encompassing nature of narrative analysis to create individual frameworks which are the most appropriate forms of analysis for the data under investigation (see page 217 for more specific details of the framework formation for this study). In this study the narrative analysis explores how language and linguistic practices are used within the narratives to construct and make sense of the traumatic childbirth experience (Potter & Wetherall, 1987).

Again, as outlined in the quotation above provided by Riessman (2008), narratives are constructed for particular audiences and thus are essentially co-constructed with the researcher, acknowledging not only the role of the researcher, but also questioning the role or presence of an 'expert'. In this research mothers were asked a broad research question aimed at placing the power and control over the creation of the narratives back into the hands of the mother, rather than the researcher. This was explicitly demonstrated though the purposeful attempt to minimise asking multiple questions, giving unsolicited comments, or asking for clarification through the narratives, instead the researcher waited until the mother came to the natural end of her narrative and then asked for further clarification if necessary. The idea of negating the 'expert' role in terms of the researcher also considered how this had the potential to mirror the role of expert medical professionals during the actual experience and any connotations related to power and control which may be present for the women being interviewed. Narratives tend to have a temporal order, however the above described strategy, created a freedom for mothers to construct this in their own unique form. This tendency for people to episodically organise their ideas into consequential and contingent patterns is advantageous when examining childbirth experiences, which by their very essence encompass temporal, flexibly sequential processes within the boundary of an event. Thus, this creation of episodic accounts within the larger narrative is explored in context within narrative analysis.

In addition to temporality, change and transition is a pivotal aspect of childbirth, and more specifically traumatic childbirth, with its connection to illness. In general childbirth is understood, from multiple perspectives as a transitional life event, and how this transitional journey is framed and understood is most appropriately analysed through narrative analysis. This is due to the enabling of a focus on how the journey through transition is framed and assembled in each individual case, and with comparisons across cases. In addition, the

exploration of traumatic childbirth experiences adds an additional layer for consideration, which is that of trauma and of the conceptualisation of the event as, or similar to, an ‘illness’. Narrative analysis is a well-used method in the exploration of health and illness (Murray, 1999), and trauma, and often combines the two (for examples see Stevens & Doerr, 2010, a narrative analysis of the trauma of the diagnosis of HIV infection, and Papthomas & Lavallee, 2011, narrative constructions of anorexia and abuse), and narrative analysis has also previously been used to explore traumatic childbirth (Beck, 2006). Narrative analysis as a method allows for the exploration of the context and the sequences of events when a biographical disruption occurs, in that illness or trauma can disrupt the assumptions or expectations; what was ‘supposed’ to happen during a person’s life or a specific event. Traumatic childbirth experiences disrupt the assumed or expected childbirth event, causing a change, sometimes small, sometimes large, in the person’s expected trajectory of childbirth. Narrative analysis allows the examination of the story around the disruption exploring how it is managed and understood.

How the analytical process for this research was formed.

Narrative Analysis is a qualitative research approach and a basic definition can frame this as the examination of how people construct and share stories about experience so that experiences are understandable within specific sociocultural and historical contexts (Riessman 1993). The ‘narrative turn’ arose in psychology during the 1980s as the qualitative inquiry of lived experience based upon a relativist ontology and a social constructionist epistemology responded to the dominance of positivist approaches (Sarbin 1986; Bruner 1986; Polkinghome 1988; Gergen and Gergen, 1988). This narrative perspective recognised that stories do not capture a world ‘out there’ but represent an interpreted account. As techniques for data gathering and analysis developed a range of interpretive Narrative data was formed of diaries, letters and images with interviews being a primary form of data

gathering with life-history and episodic interviews focusing upon unfolding life events (Stephens 2011). McAdam's (1993) developed life history approaches, while Labov (1972) focused on narrative structure and temporality, Bruner (1990) determined how narratives functioned to create the self, memory and emotion. As well as imposing a chronological order on events, and creating meaning Elliot, (2005) recognised a third fundamental aspects of narrative, that they are performed for an audience and are therefore social. Narrative analysis has been utilised to comprehend traumatic experiences and disruptive life events especially within the health context (Crossley 2000; Murray 2000). The analytic framework drew upon this tradition recognising that the research questions would drive the analysis and that the data was co-created by participants telling their stories within a specific interview context.

The narrative framework (as demonstrated through the table on page 225 and appendix N) was formed as initially narratives were identified in the interview transcripts so narrative episodes which could be framed with a beginning, middle and end were loosely defined by their emplotment (Polkinghome 1995). Within these episodes terms and meaning were interpreted by paying attention to narrative tone (McAdams 1993). Narrative tropes were coded such as how 'causes' of events were positioned, how characters were described in terms of agency and passivity. This coding was developed so that the way in which stories were assembled could be considered in terms of narrative themes which could be theoretically developed. This broad eclectic approach to narrative enabled meaning to be developed so that challenging and chaotic events were managed into systematic themes which situated the women's experiences (appendix N).

The analytical process

Initially the researcher re-read the transcripts and listened to each of the audio-recordings of each interview. Focusing on the narrative of the traumatic childbirth event, all the information included in the response was highlighted. Information which was taken into

account included not only the lengthy narrative provided in response to the question, but also if the mother referred back to something she had said previously in the interview this was highlighted, and if after the mother's narrative the researcher asked for clarification of any details these were also included. These were not merged into the single narrative, instead they were kept separate so as not to disturb the unique, sequential construction created by the mother.

Throughout narratives people tend to organize experiences into episodes, and thus the method used in this thesis involved the researcher working through the traumatic childbirth story, separating it into sections which represented the small embedded stories. There was not any data left out of the analysis, as one story moved straight on to the next. These 'smaller' stories varied in length from a couple of sentences to many pages of text. Each story was identified by a 'beginning' or was due to the natural end of the previous story, and each one had an identified complicating action and some form of resolution. The two smaller episodes/stories taken from Ruth's narrative are provided below to demonstrate the difference in the length of these individual episodes of experience.

BEGINNING *So, I was pushing from about, what's it about half nine. I was pushing for about two and a half hours with him, and because I was getting tired and his heart rate was decelerating, she was checking me constantly, to see if I was pushing properly. She was happy that I was pushing properly, umm she just felt like he was getting a, like swelling, on his head. From where he was sitting because he was just slightly off a bit, I think, because of being back to back his head was just not in a brilliant position. She got the doctors in to come and check and then in the end because of having my section before, cause I thought I'd still get my vaginal delivery like I wanted. But then, then they did a spinal and then I went in, and within five minutes of being in there once they'd managed to put the spinal in, obviously I was still pushing and it was really uncomfortable. I was like holding*

myself off the bed while they were putting it in, and they still wanted me to sit still! Once I'd gone in and they told me to push almost straight away and he was out, and his head was out and his body was out within a minute, think it was a minute anyway, straight away. END/BEGINNING *And then obviously they passed him, they put him on my chest, so I had him skin to skin, which was perfect, which is that I didn't get with Eddie at all, and Eddie didn't breathe immediately, so that was all nice, because I got to have him . . .* END

In the first of these two episodes of experience, the beginning of the story is clearly demarked by the use of the word 'so', which indicate to the listener/reader that there is a movement or shift onto another experience. For each of the small stories the analysis table presented in table 8.7 was completed, the information was generated in consideration of what had come before in the entire narrative, but focused on the information in the smaller episode/story.

An example of the table completed for each of the episodes identified within the larger narratives is provided in table 8.7.

Table 8.8: An example of the table used I the narrative analysis to identify and explore smaller episodes/stories within the traumatic childbirth accounts.

Section	**Abstract**	**Orientation**	**Central section theme**	**Self-positioning emotions**	**Language**	**Complicating action**	**Central narrative tone**	**Resolution**

Each section covered the following information form the episodes:

- Section: The lines numbers which encompass the episode under consideration.
- Abstract: A brief synopsis of the episode.

- Orientation: Information about how the mother positioned herself within the episode.
- Central section theme: The overall theme of the episode.
- Self-positioning emotions: The emotions involved in the episode and how they related to the mother's positioning of herself.
- Language: A detailed exploration of the language used within the episode
- Complicating action: The crux of the episode, what was the main or complicating action.
- Central narrative tone: The overall tone of the episode, sometimes this was quite simple, sometimes the tone changed within the episode and this was documented.
- Resolution: The resolution to the episode, which often involved the resolution of the complicating action.

One of these tables, with a section for each episode were completed for each of the twelve narratives. Alongside this more focused work on the episodes, throughout the process of table completion the researcher kept notes of areas of interest, reoccurring and idiosyncratic aspects of the narratives. These combined processes were the basis of the two narrative analysis findings chapters presented in this thesis (chapters nine and ten).

CHAPTER NINE

Study Two: The Post-Natal Mothers Study

Narrative Analysis and Discussion: Section One

Using van Gennep's (1960) 'Rites of Passage' Framework in Understanding Women's Traumatic Childbirth Experiences

> ***"I didn't, I don't know, she was just out! And that it was over! . . . And then I am in hospital, I can barely move, and I've got this baby that keeps crying."***

Becoming a mother is a complex, multidimensional transitional rite of passage in a woman's life. This section of narrative analysis highlights an (often implicit) distinction between the physical birth of a baby in the 'creation of a mother' and the psychological and emotional birth of a baby as experienced by a woman – the acknowledgement and feeling of 'entering motherhood'. There is a period or void described in all of the traumatic childbirth narratives – the liminal period, between the physical birth of the baby and the mother's recognition, acceptance, and feeling of 'entering motherhood'.

The seminal work of anthropologist van Gennep (1960 [1909]) describes 'The Rites of Passage'; a theoretical framework built on the observation of universal applications of explicit 'rituals' within culture. These 'rituals' are used to signify social and cultural transitional life events in which people move from one stage or 'position' to another. Van Gennep (1960) outlines a three-part framework for the transition through stages as demonstrated in a repeat of figure 4.6.

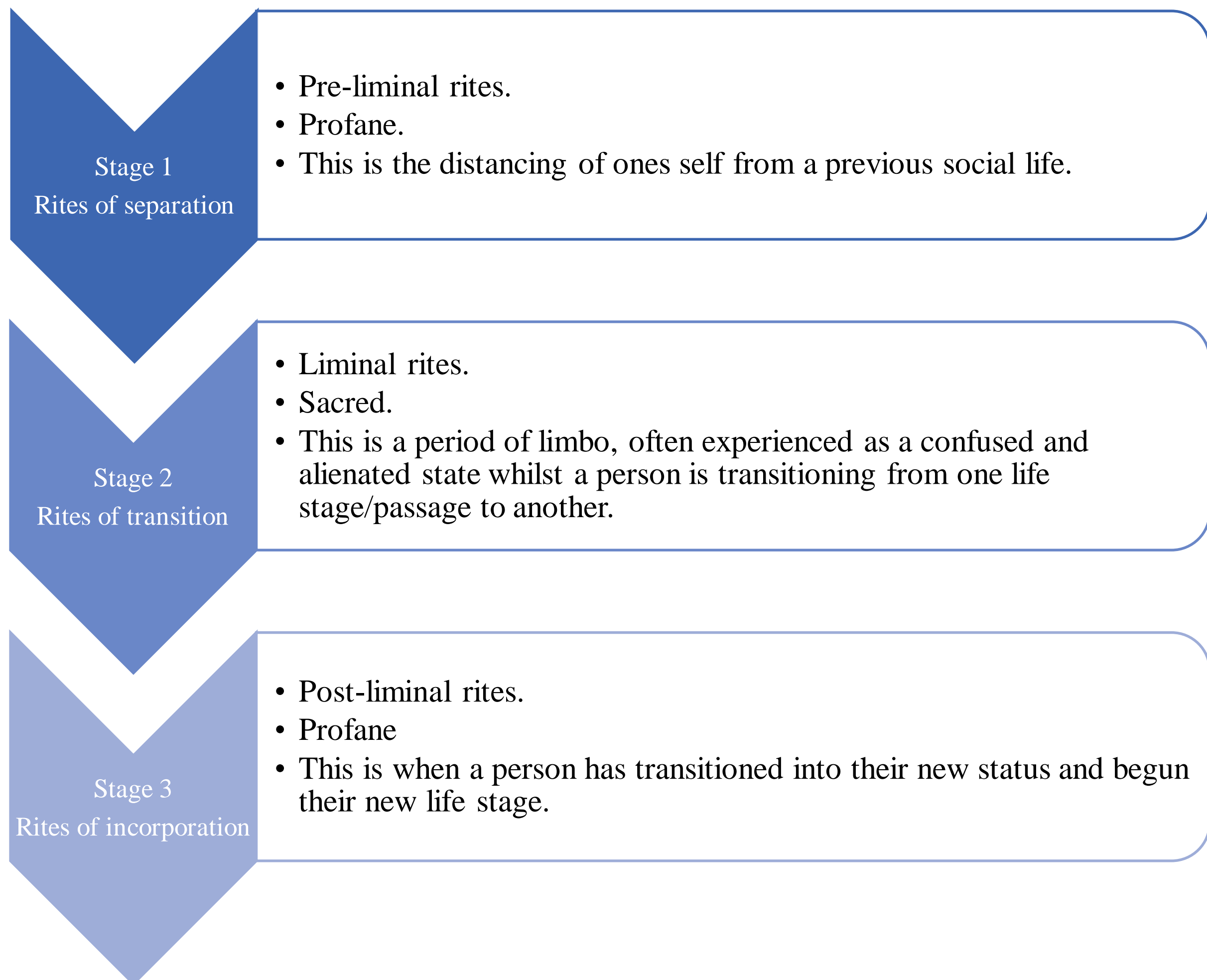


Figure 4.6: The tripartite structure of the Rites of Passage as described by van Gennep (1960 [1909]).

The rites of separation signify a move to distance oneself from one social role/status, moving into the rites of transition, an ambiguous transitional period of liminality, and then into the rites of incorporation; the incorporation of a new life stage or 'position' with a new social role/status.

Anthropologist Victor Turner (1967) focuses on the middle ambiguous liminal stage in his study 'Betwixt and Between: the liminal period on Rites of Passage'. Drawing on Durkheimian sociology, a distinction is drawn between the profane, mundane, external events of the rites of separation and the rites of incorporation, and the 'sacred' (out of the ordinary)

magico-religious experiences occurring in the liminal period (rites of transition). Demonstrative of the complexities of the internal world, "the "sacred" denotes extraordinary moments or experiences that escape ordinary classification and that can be referred to by texts only in an indirect way" (Giesen, 2006, p.328).

Van Gennep's (1960) theoretical framework and Turner's (1967) further exploration of the liminal period are drawn upon in this section to offer explanations of the experiences of women during, and just after, their traumatic childbirth experience. Using the concept of liminality to create a framework for understanding this voided, sacred period of time between mothers physically birthing their babies, and the individual emotional and psychological recognition of themselves as a mother.

The concept of liminality has been applied to normative life events (van Gennep, 1960) and non-normative events, such as illness. Research studies in this area tend to explore life/biographical disruption caused by chronic, life-limiting or life-threatening illnesses and the experience of periods of liminality (e.g. Trusson, Pilnick, & Roy, 2016). Traumatic childbirth bridges both normative life events (childbirth) and non-normative illness narratives (trauma). Indeed, when conceptualising and applying liminality to specific experiences or events consideration of the subject, space and time is needed. Also of importance is the scale or degree to which the period of liminality is experienced (Thomassen, 2009). Blows, Bird, Seymour, and Cox (2012) make a distinction between acute and sustained liminality, describing a phase of acute liminality in their paper exploring the experience of cancer survivorship. They describe it as follows; "Acute liminality begins at diagnosis and is characterised by disorientation, loss of control and uncertainty" (p.2159), whereas sustained liminality is described as "an adaptive, enduring phase characterised by a search for meaning and challenge to identity" (p.2159).

In this study acute liminality often begins at the physical birth of the baby. It is characterised by a focus on the self rather than the infant, of uncertainty, concern, loss of control, and a lack of positive emotions and feelings. Due to the acute nature of the liminal period for these women, they often report events which resonate as sacred, almost ethereal incidents.

> *"They told me 'we are going to take her to intensive care', so uh, they quickly allow me to give a kiss – I will remember that kiss forever." (Cassie).*

Rites of Separation - Normative social expectations of pregnancy, birth and motherhood

Part of the transition into motherhood includes changes to the woman's self-identity. These developments start to occur prior to and/or during pregnancy, and fit into the pre-liminal rites/rites of separation period (see figure 4.6 and 8.20). Women begin to separate from their previous identity and roles, and start to adapt to their new roles and responsibilities by incorporating these into their new self-identity as a mother. Women in this study describe how they often built a picture of themselves as mothers during pregnancy and in preparation for their childbirth experiences, a period of individual identity construction. This was often based on substantial and relatively fixed ideas of how they would be as a mother, which linked with their hopes and expectations of their childbirth experience. An example of these in-depth hopes and expectations comes from Kirsty as she describes her birth plan:

> *"It was very detailed, and I had basically as little intervention as possible. Ummmmm. It was a prescribed birth plan that I'd used from hypno-birthing and I just adjusted it to my requirement. And it was, it's hands free as much as possibly could be in terms of intervention, and less was needed. So, you know there was no injections for the baby, things like that, to begin with. I didn't want an injection to*

remove the placenta, I wanted it totally natural, unless my birth has been compromised in any way" (Julie).

This excerpt demonstrates that mothers in this study constructed their own, unique 'normal' expected childbirth narratives during pregnancy. Thus, there are childbirth specific aspects involved in women's conceptualisations of their self-identity as a mother. This process of negotiation and adaptation is part of women's psychological preparation in transitioning from one social status/role into that of a mother.

Rites of Transition – The biographical disruption/fracture caused by traumatic experiences during childbirth and the post-partum.

A fracture or disruption in the 'normal' expected childbirth narratives women hold in mind whilst pregnant, and build the beginnings of their motherhood self-identity upon, is caused by the experience of a traumatic childbirth. This biographical disruption is similar to those described in the literature on health and illness and Rites of Passage (e.g. Ussher & Perz, 2018). The disruption undermines assumptions about one's life course expectations and impacts on self-identity through a 'critical situation', which in this instance is the traumatic childbirth experience. Melody reflects after her traumatic birth on what the event could have meant for her life course and self-identity in a worst-case scenario as she questions what could have happened. The traumatic childbirth experience, although ending for Melody with a healthy baby, highlights to her other possible pregnancy outcomes, such as stillbirth.

"And I wanted a girl, but we didn't find out, and I'd convinced myself we were having a boy, just so I wouldn't get upset, but, ummm not upset, but you know, you know, not . . . I think that first week I just kept looking at her thinking how close really were you of not being here. What would I have done? If I suppose, you kind of think, of the

what ifs, and what would I have done if I'd gone through the whole pregnancy, and umm you know, she wouldn't have been here." (Melody).

For some women there were multiple biographical disruptions or fractures (Reeve, Lloyd-Williamsn, Payne & Dowrick, 2010) to contend with during the birth and post-partum period. For example, Kirsty describes not only her traumatic childbirth, but also multiple traumas in the post-partum period, including not being able to breastfeed her baby. This was something which earlier in her narrative she expressed as an important part of becoming a mother, and in this quotation, she demonstrates that providing breastmilk for her baby as part of her expected motherhood experience.

"We, uh, managed a week in this blissful sort of breastfeeding heaven I suppose, where I thought it was working. And he was weighed a week later and he'd lost a pound in weight. And I had this massive surge, I felt so sick and traumatised (begins to cry) that I gave up instantly on the spot. So I thought I couldn't, he'd been suffering even more than he already did, he'd had a traumatic birth and I was failing to feed him . . . So, I went at it like a good'un, with two hourly feeding for twenty-four hours a day, and I managed to get his weight coming back up again. But it was like a double trauma (crying), it was at that point that I really felt like I had failed, because I hadn't picked up on the fact that he was wasting away in front of my eyes, and I still struggle with the prospect of him not having food, and not providing for him. I need to know that he is physically cared for, if you know what I mean?" (Julie).

For some women in this study their unexpected and traumatic childbirth experiences destroyed their childbirth plans, disrupting and undermining their expectations and desires. In turn this rocked their emerging and fragile self-identity as a mother, prompting questioning of their new identity, and a disconnection from their role as a new mother. The excerpt below from Melody demonstrates this period of unsettledness after the traumatic birth, she

describes not feeling how she imagined she would, instead experiencing a numbness and disconnection from the birth experience and the mother role.

"I think once she was first born all I felt was a bit numb, I think, I don't know if that was the drugs that had been inside me for so long, or you know? I felt a little bit like, I don't know, if I should feel more excited than I am, I'm not depressed, I'm not down but should I feel really excited? And then I think as soon as I'd ummm, kind of had my, the, the, errr, the sort of next evening. Also, this was, would have been, sort of, on the, ummmm, the evening of the Sunday morning, early hours Monday night after the visitors had gone, and you know you have to sort of go to bed time, like you know, sort of 1, 1 o'clock. I think I just thought this is it now, we've got our baby girl now, she's coming home tomorrow, we're going home tomorrow, so I think for that day I was just in shock of what had happened, and it seemed so traumatic, you not trau, so dramatic. And so, you know, just so not what I was expecting or what I was hoping for that I just kind of almost had to get my head around it. So that was the initial thought, and then as soon as I had a word with myself, and thought 'Oh my God' we're, we're going home now, we've got our baby girl." (Melody).

Rites of Incorporation – Reconstructing and renegotiating self-identity and life course expectations through the integration and incorporation of the traumatic childbirth experience.

Towards the end of her narrative Melody describes a period of reconciliation:

"I had a miscarriage two months previously . . . I think that brought back that whole experience so that first week, it was just trying just to sort of work out what had happened really." (Melody).

Indeed, mothers attempt to reconcile their traumatic childbirth experiences with their previously held 'normative' expected childbirth and motherhood fragile biographies which have begun to shape their new self-identity. They have to work to reconstruct and redefine their sense of self-identity as a mother to incorporate and make sense of their traumatic childbirth experiences into their new identity, this is represented in figure 8.21. Although as suggested by Mercer (2006) an individual's maternal identity is continually evolving through the life course, the experience of a traumatic childbirth may be one of the first significant experiences to impact on a newly formed and fragile maternal identity. This analysis explores three strategies women implement in an attempt to reintegrate and incorporate their previous expectations and their current experiences to create a coherent and stable maternal self-identity and re-shape their life course expectations. The three strategies are; re-storying, re-telling, and reintegrating rituals.

Re-storying.

Kralik, Visenten and van Loon (2006) state that "people who have experienced profound disruption often have a diminished sense of identity. Thus, re-storying their biography has been integral to healing during the transition period" (p.326). For many of the women re-storying included locating, acknowledging and highlighting the positive consequences of their traumatic birth experiences, aiding the healing process. For example, Suzie describes how due to her being critically ill in the immediate post-partum period she was unable to care for her baby, therefore her baby was cared for by multiple professionals and family members. She now attributes her baby's ease with strangers as a positive for her.

> *"Ummmm, and because she was passed round from midwife to midwife in the first days of her life she's absolutely fine sitting with stranger. Whereas some babies you know that you can't they're attached to the mother and no one else can hold them and that's really hard on the mother." (Suzie)*

Re-telling.

Mothers also reported engaging in multiple re-tellings of their traumatic birth experiences. Re-telling is a process of talking through, or in some instances writing down, the traumatic birth story multiple times, usually to different individuals. This clarified their memories of the events, aided their emotional processing, and somewhat de-sensitised them to the traumatic birth experiences.

> *What has happened, obviously the people, the person who was my community midwife was extremely helpful. Umm because every time she was coming, uh she was trying to give me an extra time, just to speak again and again. Uh and this helped me a lot, speaking with people about this and keeping umm uh yeah, keeping tell the same after last. So, I could go through and be stronger and stronger and accept, maybe help me accept what had happened and it happened to me ok, laugh, and, and just accept, cause at the beginning I didn't probably. Didn't want to, to accept this, and I was crying and saying you know, I wanted to do differently and I hope I accept it because I'm not sure if I accept it or not, because the fact that I, I dream to have to give to give birth another way, I don't know if these are the kind of not acceptable or something else. I'm not a bit experienced in these things, so I cannot tell, but I hope I accept, I'm accepting. So umm speaking with her has been really, really helpful and umm also with my other colleagues, because they were really they are, but friends, and coming and giving me and see Vanessa, and they want to know, and, and speaking was always I was feeling much better after I speak and that was also having this interview. I wanted to it was a kind of check every time. . . umm so every time was better and better and better. (Cassie).*

Alongside this, mothers worked hard during interviews to achieve chronologically sound narratives, although some were more successful than others in this endeavour. The

Rites of Passage framework as outlined by van Gennep (1960) would suggest that mothers should progress through the three liminal stages in a linear and uni-directional manner in the transition to motherhood, this is not what occurs for women in this study. Instead, their transition into motherhood is non-linear and multi-dimensional, with stages blurring into one another (this is discussed in more detail in the next section: Acute liminality – a qualitatively deeper liminal experience as a result of traumatic childbirth experiences). Therefore, mothers utilize time chronology to create a sequence of experiences and actions, which is the nature of story-telling (Ricoeur, 1991), to create coherence and impose order. The significant resources and effort mothers in this study invested into creating their chronological birth narratives is demonstrated by their questioning of themselves, and their linking of salient and more subjacent events, and time.

> *How it should be I think, I think I'd gone into labour probably about two in the morning? And it was probably about twelve hours, just under, probably ten actually? He was born, what time were you born? (looking at the baby). Twelve o'clock, so yeah, about ten hours, yeah about ten hours, which was nice. But it was always going quite nicely, and I had the urge to push a little bit earlier that they'd usually like you to, but she said I was fully dilated, and she was happy for me to push. So, I was pushing from about, what's it about half nine, I was pushing for about two and a half hours with him, and because I was getting tired, and his heart rate was decelerating she was checking me constantly to see if I was pushing properly. . . Once I'd gone in they told me to push almost straight away and her was out, and his head was out, and his body was out within a minute, think it was a minute anyway, straight away (Ruth).*

Using the biomedical stages and events, such as their waters breaking, or cervical dilation, women used fixture points to locate their narrative in time imposing not only a coherence and sense of order on their traumatic childbirth experiences, but also an attempt at

reconciliation between two often conflictual personal perspectives of childbirth. By using their understanding, and expectations of, normative birth experiences, woman demonstrate their attempts at reconciling their previous birth expectations and their traumatic birth experiences. Most women began the exploration, remembering and locating of birth experiences in the immediate post-partum period to begin the process of creating a coherent narrative, thus beginning to impose some control and boundaries over their experiences

> *Ah I was trying to remember what had happened, and the order things had happened, cause it was all, at that point it was all a bit of a blur. Umm, I think from sort of lunch time onwards when umm when everything was happening then. Yeah it was just all, all a bit of a blur, and then I think it's the contrast, as well of going to, umm, to having all those people on you, sort of working on you to everybody duh de duh de duh. Umm, and then suddenly into a ward, ward at, at night time. Umm where it's just sort of, other than screaming babies and beeping it's, there's nobody there so my head was just, just racing really. I tried to think about what had gone on. (Rosie)*

The length of time it took, through personal reflection and/or re-telling, to create a comfortable level of control over their emotional reactions to the traumatic experience, deviated from woman to woman.

Threading their narratives through technocratic events and generic, temporal time orientates both the self and the audience to the socially constructed norms and expectations of birth. The deviations (traumatic events) from these artificially imposed birth trajectories highlights the unexpected nature of birth trauma for women, through re-telling their birth narratives chronologically, on multiple occasions, women are able to create their own idiosyncratic, but coherently represented version of their experience, with the product of increasing a sense of control and ownership over the birth experience.

Reincorporating Rituals.

Within periods of liminality, rituals are more than just demonstrations of social order as suggested by Durkheim (1967) (Thomassen, 2009). Created through socio-cultural values rituals are used to help an individual create a sense of order and predictability (Parratt, 2008), in a liminal period which is characterised by disorder and unpredictability. Although post-partum rituals are not common in Western societies (Cox, 2009), mothers in this study worked hard to create or maintain opportunities to adhere to often quite small, but in their own way symbolic rituals, regardless of, and often in spite of, their traumatic childbirth experiences. An example of this is holding the baby for the first time, often occurring as a period of skin-to-skin contact between mother and baby.

Skin-to-skin contact has developed into a ritual during childbirth. It has become expected and promoted in Western cultures and in non-traumatic births it usually occurs in the moments after birth, with the 'ideal' situation being that the baby is delivered straight onto the mother's uncovered chest/tummy. This ritual is a historically relatively recent development originating in scientific research and policy guidelines (NICE guideline CG190, 2017; Dabrowski, 2007). Research findings suggest that skin-to-skin contact benefits breastfeeding and the physiological stability of the infant (Moore, Anderson, Bergman & Dowswell, 2014), and there is some evidence of a reduction in depressive symptomology and physiological stress in the mother (Bigelow, Power, MacLellan-Peters, Alex & McDonald, 2012). This ritual has become part of the birth experience (Dabrowski, 2007) and is embedded into social and cultural expectations of the post-partum period in Western society. This momentous moment has become amplified, and for the women interviewed the importance of the ritual of meeting their infant for the first time and skin-to-skin contact is significant in the experience of entering motherhood. This is demonstrated by every, bar one,

mothers need to maintain or create this 'moment' regardless of the traumas experienced or the time passed.

The quotation below details Suzie's drive to acknowledge her adherence to the ritual of skin-to-skin contact in the post-partum period even whilst still physically poorly due to her traumatic childbirth experience.

"She was in the same room as me, and they just kept laying her on me, so that I could, like, have some skin-to-skin, even though I was half unconscious." (Suzie).

For most of the mothers in this study, due to the traumatic experiences during birth they were unable to either meet their baby or have skin-to-skin contact immediately, however they created the opportunity in some form when they were able to. Below Rosie describes holding her infant for the first time and the positive impact that it had on her after her traumatic birth.

"But I, I couldn't have actually held her because I was shaking so much so that was sort of heart-breaking cause she was there, but I wasn't physically capable of giving her a cuddle. Ummm I think I wound, winding myself up at that point, because I was trying really hard to calm down, like take deep breaths, deep breaths, but my body wasn't doing what I wanted it to, just shivering, ummmm. So, I think I was getting just more upset, because I just wanted to hold her, umm and then we finally got through into, umm back into the room we were in originally. Umm back in there I had sort of calmed down enough that I was then able to give her a cuddle. That – That's the happy moment there." (Rosie).

In comparison for those mothers in this study who did not manage to fulfil the ritual of skin-to-skin contact, they still talk about those missed 'momentous moments' using language associated with intense distress, such as "*guilt*" and "*heart-breaking*", thus an awareness of the emotional and psychological consequences of not achieving childbirth associated rituals is evident in the exert below from Cindy.

"They pulled her out . . . it all started to go a bit odd . . . Jordy over there with the baby . . . normally I thought they'd put her on me and I'll see her and that'd be fine, no I didn't, I didn't see her at all. . . It was awful because I didn't get any time with her, do you know what I mean? It was like Jordy had all that, he was sitting holding her, crying, pretending it was happiness, but apparently, he was terrified. Chatting to her, I, I don't know I felt I sort if missed out really cause I hadn't had this nice time holding the baby and doing whatever. . . But it definitely affected my bonding, you know they say when you have a baby, or whatever, you feel an instant rush of love and that. And I didn't get that for a few days. I didn't I don't know she was just out! And that it was over! . . . And then I am in hospital, I can barely move, and I've got this baby that keeps crying." (Cindy).

Parratt (2008) suggests "an example of a socially sanctioned path through liminality is when women enter pregnancy and give birth under the auspice of institutionalised childbirth practices" (p.41). These practices include rituals, such as skin-to-skin contact, these work for women by providing reference points to guide them through the period of liminality that all women experience during the transition into parenthood. Reference points developed, often through the medicalisation of childbirth, to create a sense of order and predictability for women. These reference points are evident throughout the traumatic childbirth narratives with mothers situating themselves and events not only in time, but also in cervical dilation.

"So I think ah must be baby must be comin' cause I'm getting all pressure down below and she was like if you've got pressure push through it if you need to push through it so you know we're sort of trying and she was like oh we'll probably have the baby by two in the morning. Excellent so that goes on for a while. And she's like oh I'm not really sorta seeing any progress I'd better check you get out of the pool and I'll check you. Four centimetres (laughs) at which point again I go mad . . . so I

sorta started losing the plot at this point cause I thought I can't do this for another hours and hours and hours and hours when we are only four centimetres. So then she got the gas and air out cause I hadn't had anything up till that point . . . Then eventually I woke up and it was day light and I was eight centimetres and I was like wahoo I'm eight centimetres now it will be alright I'm eight centimetres and I had previously ordered an epidural but I said I will hold off on the epidural cause I'm eight centimetres and maybe I can just do this." (Cindy)

These more current medically based, but socially and culturally embedded rituals have replaced out-dated scientific and social rituals around birth. Although women in this study all gave birth in hospital under the medical, risk adverse model of childbirth, their experiences were traumatic and not what they expected or predictable. Therefore, a biological disruption was created in the pathway through the usual period of liminality in the transition to motherhood. Reclaiming post-partum rituals and ceremonies, after a period of biological disruption (Kralik et al., 2006) enabled most women in this study to begin to move beyond acute liminality, to a phase of sustained liminality (explored further in the following section), with the proposed next stage being the reintegration (post-liminal) stage of establishing a new role and identity. The rituals of skin to skin contact and other reference points, such as cervical dilation, encourage the individual to connect the experience of birthing a baby and the thoughts and feelings surrounding that. It is the connecting of experience and, thoughts, feelings and emotions which begins to dissipate acute liminality and encourages a move through the Rite of Passages.

Acute liminality – a qualitatively deeper liminal experience as a result of traumatic childbirth experiences.

The Rite of Passage to motherhood for women in this study, who had all experienced a traumatic birth, involved a period of acute liminality which tended to begin as the physical birth of the baby happened. Acute liminality for women following a traumatic childbirth is defined as a period of overwhelming feelings of uncertainty, a lack of control, and an almost panicked concentration on the self. It is an almost void-like, sometimes ethereal existence, where the person is neither 'not a mother' or 'a mother'. Women in the period of acute liminality are caught between two antonymous identities, physically their bodies have 'created a mother', but emotionally they have not yet 'entered motherhood'.

A normative Rite of Passage to motherhood may involve a linear transition from separation, to sustained liminality, to incorporation (see figure 8.20).

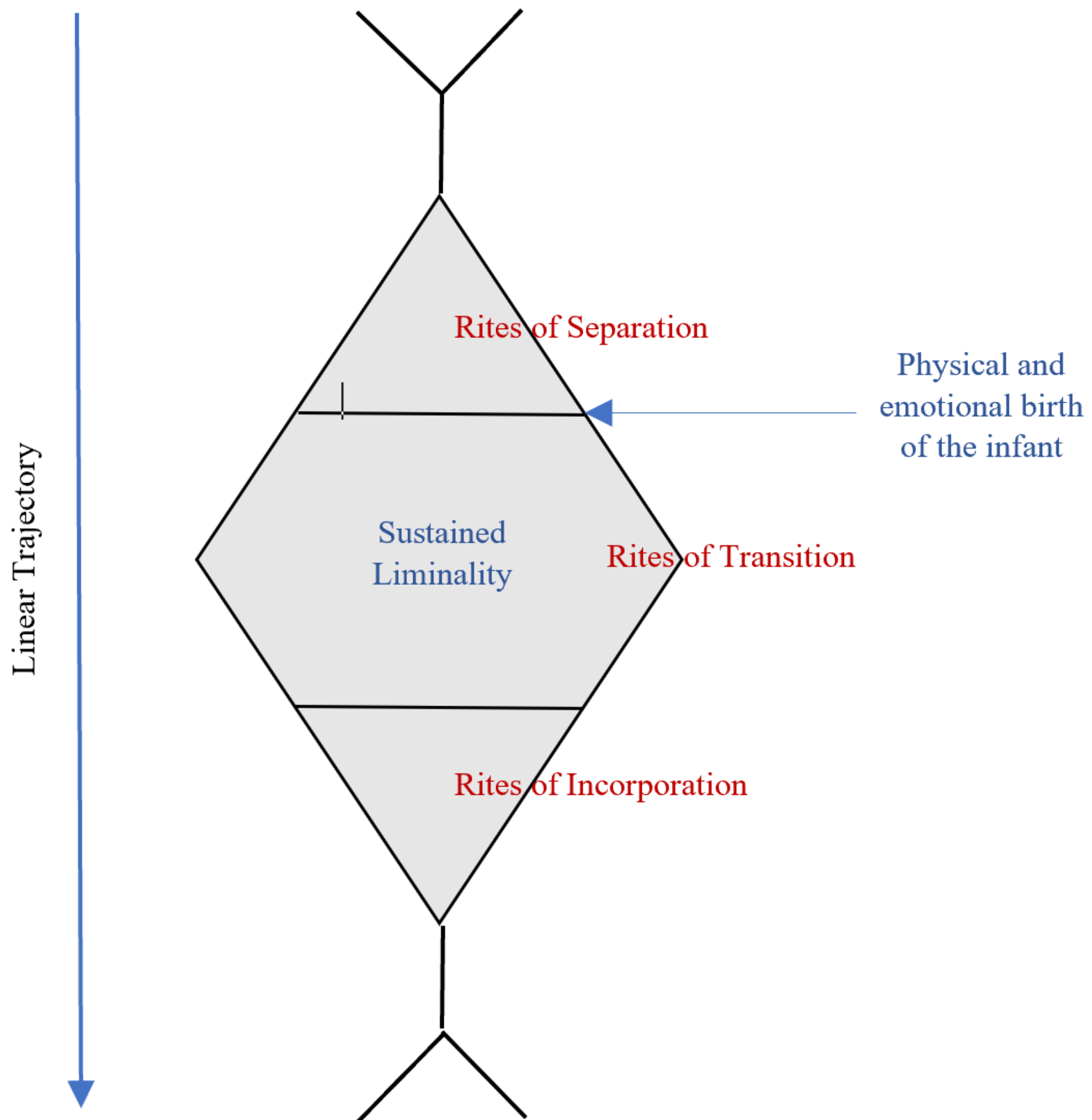


Figure 8.20: The transitional trajectory from non-mother to mother following a normative birth experience utilizing van Gennep's (1960 [1909]) theoretical framework of a Rite of Passage.

This study's narrative analysis proposes that for women who have a traumatic childbirth this transitional process to motherhood is not linear, and instead it is conceptualised as a multi-dimensional life event (Johnston-Robledo & Barnack, 2004). Therefore, rather than a relatively smooth transition into a sustained liminal period, following a traumatic birth,

women contend with a deeper, more acute liminal period, before moving into sustained liminality (see figure 8.21). For some women this trajectory is not straightforward, and they move back and forth between acute and sustained liminality, a number of times. This is often due to further traumatic experiences which once again gave rise to feelings of unpredictability, a lack of control, and a loss of ownership and emotional connection with the maternal role and identity.

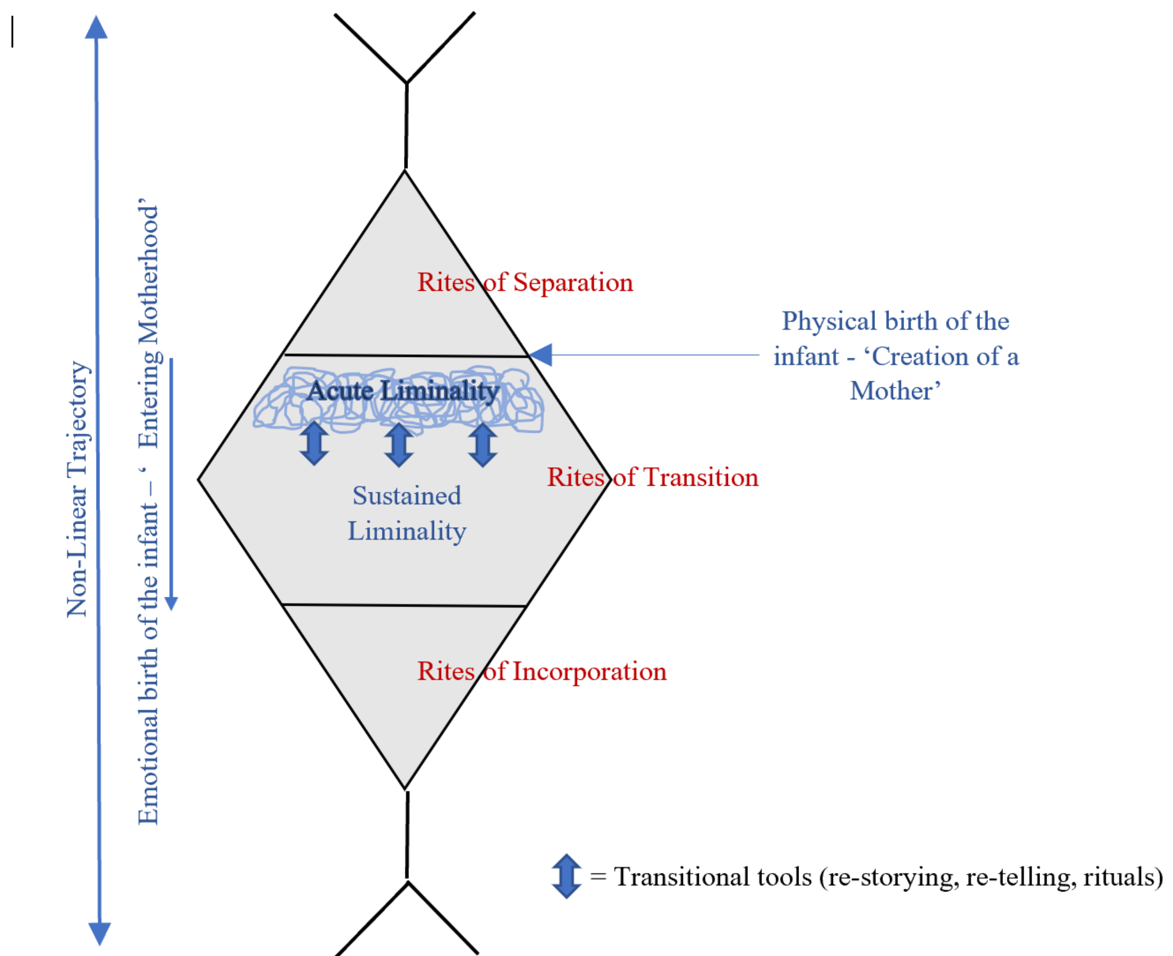


Figure 8.21: The transitional non-linear, multi-dimensional trajectory from the creation of a mother to entering motherhood utilizing van Gennep’s (1960 [1909]) theoretical framework of the Rites of Passage.

In addition, the move between the Rites of Separation and the Rites of Transition (the liminal phase) was not sequential for mothers in this study, instead, the two stages bled into one another. Mothers demonstrated significant mental effortful focus post-birth in beginning to create a coherent birth narrative, once this had begun mothers' understanding and acceptance of the occurrence of the traumatic childbirth started. As the negative emotional reactions and experiences slowly dissipated, mothers were more able to allocate the mental time and space to re-visit the Rites of Separation stage to renegotiate and adapt their fragile new identity as a mother to incorporate their understanding and acceptance of their traumatic birth experiences. This demonstrates not only the non-linear trajectory through the stages of the Rites of Passage to motherhood following a traumatic birth experience, but also the continual evolution of maternal identity (Mercer, 2004). This study explores one of the first evolutions in maternal identity with women working to amalgamate their previously formed fragile new identity as a mother created during pregnancy, and their very real experiences of traumatic childbirth.

Women in this study begin the creation of a new identity as a mother in the Rites of Separation stage of transition, part of which is the creation of a wished for, or expected childbirth experience, influenced by the social and cultural context, and is based on their ideas of themselves as mothers, and what is important to them in their new role. All of the women experienced a traumatic birth, which is at odds with wished for or expected birth experiences, thus this catapulted women into an unexpected period of acute liminality. Whilst in this stage of transition women in this study described their lack of emotional connection with their role as a new mother, this may have occurred due to the traumatic birth experience causing an inability for the mother to connect with, or transact their needs and desires as a mother, either physically or emotionally. As previously described, a mother is created through the physical birthing of an infant, but it seems to take some time for women

to emotionally 'enter motherhood' following a traumatic birth – it is this void like period, between two identities that constitutes the 'acute liminal phase'.

The 'acute liminal phase' is managed by mothers over varying periods of temporal time through a variety of implicit and explicit strategies in an attempt to impose a sense of order and predictability. This then allows the women to emotionally connect with their new maternal role and identity, thus enabling each individual to 'enter motherhood'. These strategies include: 1) Re-storying; the mother's re-framing of the traumatic experience to create positive outcomes. 2) Re-telling; 'telling' the birth trauma story multiple times to create a coherent, chronological, controlled and predictable narrative. 3) Opportunity for, and adherence to, childbirth rituals; women reclaim control and predictability by creating their own opportunities to take part in rituals associated with childbirth in their culture. In this study the focus is on the ritual of meeting the baby for the first time and skin-to-skin contact. Each of these strategies work to rebuild the biography following the fractures, which in these traumatic birth narratives are caused mainly by the trauma experiences. Re-storying, chronological re-telling and childbirth rituals increase the individual's feelings of control and predictability around the traumatic childbirth event, this in turn allows women the time and space to emotionally connect with their new role and identity as a mother and to 'enter motherhood'.

Conclusion

Côté-Arsenault, Brody and Dombeck (2009) suggest that "viewing pregnancy and birth as a liminal phase provides a valuable framework for understanding normative and non-normative pregnancy experiences" (p.69), this study concurs and extends and adapts the framework for understanding non-normative, traumatic childbirth experiences. It describes a void-like space which exists between the 'creation of a mother' – the physical birth of an

infant, and ‘entering motherhood’ – the emotional birth of an infant, and that this void-like space involves an acute liminal period. The acute phase seems particularly present for women who have had a traumatic childbirth, and need to understand and process not only the birth of their infant, but also an unexpected, traumatic experience/s. The narrative analysis highlights the experience for women in the acute liminal phase by proposing a period of more overt and deeply felt liminality following a traumatic childbirth. It explores strategies mothers use to manage the often over-whelming negative feelings of uncertainty, lack of control, and unpredictability, during this acute liminal phase. This study proposes that the transition through the ‘Rites of Passage’ during the perinatal period is not linear, and that how women negotiate and manage their pathway through the transition to motherhood is individualistic due to the multi-dimensional and unpredictable nature of traumatic childbirth.

This study focuses on the acute liminal stage during the ‘Rites of Passage’ in the transitional phase of pregnancy and childbirth. However, it would be interesting to explore the incorporation/post-liminal stage in more depth in future studies, to investigate how women experience this stage after a traumatic childbirth. In addition, the experiences of other actors in the birthing room need to be explored, for example the father. Throughout the interviews there were a multitude of mentions of the father, and the role he played in the birth experience, which seemed heavily entwined with the mother’s report of her experience. Often women reported re-telling their traumatic birth stories to their partner, or considering their partners experiences and memories when re-storying the birth narrative, evidently partners played an important role not only in the birth, but also during the acute and sustained liminal phases. This raises the question about how women manage these strategies if they do not have a birthing partner, or is the experience different if there is a qualitatively different person present in the role of birth partner, for example a mother, friend, or doula? Furthermore, research has suggested that although men to not experience the physicality of

traumatic childbirth, they can and do have negative emotional reactions and consequences to witnessing a traumatic childbirth (White, 2013). Exploring how they manage and negotiate through the transition to fatherhood following a traumatic childbirth could also provide novel research evidence.

As suggested by Reed, Barnes and Rowe (2016) how women experience labour does not necessarily 'fit' with, or align to the biomedical stages of childbirth. This study demonstrates that when a woman experiences a traumatic childbirth there is a disparity between the physicality of 'creating a mother' through the birthing of an infant (the biomedical view), and 'entering motherhood' on an emotional level (the individuals emotional experience). Although this study provides a framework, drawn from the work of van Gennep (1960) and Turner (1960) on the Rites of Passage, this study does not impose stages which occur at the same point for every woman, nor does it suggest that the transitional experience is linear or uni-dimensional. Instead it offers a way of thinking about individual experience, allowing a more flexible, accepting, holistic, and woman-centred perspective on the impact of a traumatic birth experience on 'entering motherhood'.

CHAPTER TEN
Study Two: The Post-Natal Mothers Study

Narrative Analysis and Discussion: Section Two

Interpretative Repertoires used in Traumatic Childbirth Narratives

"I was still only seven centimetres and my cervix was beginning to toughen."

The late 1950's signalled a revolution in care during childbirth, locating the event within the medical realms; hospital based and obstetric interventions became commonplace (Oakley, 2016). This, in conjunction with a lack of consideration for women's experience (Rossi, 1977), caused scientific medical obstetric knowledge to dominate conceptualisations and considerations of reproductive labour in both practice and research. With these happenings a conventional separation between social and medical factors occurred, however, currently such a parsimonious explanation negates the complexities of how these two factors exist in combination within women's private and public experiences of reproductive labour (Oakley, 2016). Indeed, women's narratives of experience tend to integrate these artificially created divisions (Schmeid & Lupton, 2001; Oakley, 2016). A renegotiation of 'normal' childbirth has occurred with the developments in obstetric medical techniques for monitoring and intervention during pregnancy and childbirth, further blurring the boundaries between medical and social factors associated with childbirth, with certain obstetric processes and procedures becoming integral, normalised aspects of the childbirth experience (Oakley, 2016).

Using an analytical frame of critical discourse analysis following a post-structuralist epistemology (Wetherell, 1998) this chapter explores the contextually bound available interpretative repertoires used by women as discursive tools in their traumatic childbirth narratives.

> "The term interpretative repertoire is an attempt to capture the 'doxic' (Bathes, 1977) nature of discourse. An interpretative repertoire is a culturally familiar and habitual line of argument comprised of recognisable themes, common places and tropes (doxa)

> (Potter & Wetherell, 1987; Wetherell & Potter, 1988; 1992; Wetherell et al., 1987)" (Wetherell, 1998, p.408).

The growth and dominance of the medicalisation of childbirth is highlighted in the previous paragraph, and women in this study utilise these common and pervasive discursive devices (Potter, 1996) to create a mutually understood narrative – an interpretive practice (Holsein & Gubrium, 2000) which allows a construction of reality within the specific context of childbirth.

> Stories are assembled artfully using discursive resources, or anchors, that are available to the storyteller. The practical use of discourse, however, is not something conveyed in a narrative vacuum. Rather, it is based on the interpretive wants and needs of the teller and what is available to convey meaning. (Foley & Faircloth, 2003, p.168-169).

Using medical obstetric discourses as discursive tools allows women in this study to negotiate the division between their own private, intimate experiences of childbirth and the medically orientated public discourses. In addition, with both the historical and current dominance of the medical obstetric understanding of childbirth, the use of similar language and shared repertoires (Potter & Wetherell, 1987) allows women to validate their narratives, and legitimise the value of their personal experiences, both on an individual, interpersonal level within the narratives, and more broadly within the research arena. This adherence to, and acceptance of, medical obstetric knowledge in understanding reproductive labour occurs in other interested parties. For example, Foley and Faircloth (2003) present a qualitative study in which they suggest midwives use medicine as a discursive resource to legitimise their profession. Rather than directly reject and dismiss the medicalisation of childbirth, it so deeply enmeshed into the complex overall conceptualisation of childbirth across perspectives, interested parties align themselves with the dominant medical understandings to validate and legitimise their own experiences.

The analysis is presented in two forms, the first is an exemplar – Cassie, who explicitly and consistently utilized a range of tropes situated within the medical obstetric interpretative repertoire throughout her traumatic childbirth narrative. The analysis demonstrates the way in which the use of a variety of medically based discursive tools allows Cassie to locate her personal birth experiences in relation to the medical public understanding of policies and procedures which dictate control and risk aversion during childbirth. Although this narrative favoured, due to the dominance of the medical conceptualisation of childbirth, the medically based discourse, as a health care professional and a new mother, Cassie's narrative demonstrates her attempts to balance her experiences within the broad, often conflictual contextual, conceptual discourses within childbirth; the medical, social, and personal. This highlights the complex dilemmatic qualities of her traumatic childbirth narrative. The second form of analysis presentation focuses on a particular discursive tool – the cervix. This is used by all, bar one woman, in this study. The use of the cervix as a discursive tool echoes the wider conceptual discourses of childbirth, but it also allows women to explore ideological dilemmas (Billig et al., 1988) enabling them to talk about and make sense of their traumatic childbirth experiences, both for themselves and their audience.

The medical, obstetric repertoire; the combination of public understandings and personal experiences: "So I speak like a . . ."

Cassie and her birth of baby Vanessa demonstrate the use of the medical obstetric interpretative repertoire, through a variety of tropes. Cassie was a healthcare professional (HCP) within the reproductive field and a new first-time mother (at the time of interview). The narrative she provides continually refers to her medical understanding of childbirth and the impact of this on her birth experience. Although novel, in that she arguably has more of an understanding of obstetric, medical knowledge than other women in this study, the

narrative highlights how using medical obstetrics as a discursive tool situates the private, intimate, idiosyncratic experience within the public discourses surrounding childbirth. This narrative analysis explores both the positive and negative impact medical understanding can have on the individual childbirth experience.

From the beginning of the interview Cassie demonstrates the conflictual social and medical factors involved in childbirth narratives as she asks the interviewer, from which perspective she should provide her narrative – 'the healthcare professional' or 'the mother'.

> *"I don't know, how you know about that, so I speak like an [HCP], so I try to speak like, I don't know a, ummm [mum]." (Cassie, p.1, lines 18-19)*

The dilemmatic quality of her attempts of situating her perspective within the narrative continues throughout the interview.

> *"I really wanted to go to Vanessa I say can I do it later I knew I when you're you know working as a [HCP] it's such, it's such different I was a woman completely like normal." (Cassie, p.49, lines 1264-1266)*

Early in the interview Cassie outlines a very clear and thought-out desired childbirth experience.

> *"I really wanted a home birth" (Cassie, p.2, line 47)*

When this ideal experience became untenable during pregnancy, she amends her expectations to combine her own ideal and the requirement for a hospital birth. The concept of intrapersonal and interpersonal renegotiation or negotiation is common throughout her narrative, demonstrating a complex balance between personal desires, social expectations and 'required', prescribed medical interventions throughout the pregnancy and childbirth experience.

> *"I hoped to go to midwifery led birthing unit and try to have the most natural labour I could there . . . but this was my hope – most natural birth, vaginal birth, and with,*

with try not having pain relief, umm and obviously that the baby was fine, and we could go home quickly, that was my hope." (Cassie, p.3, lines 55-62).

This statement of 'hoped for' childbirth experience allows an understanding of Cassie's focus on medical monitoring and interventions in her narrative. It contextualises why the possibility of intervention and deviation from what is considered 'normative' created such distress for Cassie. The medical boundaries of normative progression or lack of progression are evident from the beginning of the narrative, starting with the commencement of labour.

"I really wanted spontaneous labour as I said, so I'd been to the community midwife to have lots of membrane sweeps, that is vaginal examination that can help. They can help you, they help you stimulate induction in the most natural way. They just touch the close cervix, so I had been doing this. But nothing was happening – my stress was really high . . . I had, uh, the labour wasn't coming, and I knew, I knew that ummm, more I was wanting. The induction was coming and I really didn't want an induction of labour (Cassie. p.12, lines 295-303)

The understanding of 'risk' from a medical perspective is evident in this quotation, with the use of induction when labour does not begin within the required gestation period. However, also present is the concept of 'risk' from a psychological, experiential construct. The concern and 'stress' created through her understanding of possible obstetric 'risks', negated, for her, unwanted, medical management of reproductive labour, causes a psychological impact, and thus an additional layer of personal and social 'risk'. The focus on medical 'risk' and induction of labour in both the quotations presented here allows Cassie to explore her own unique emotional reactions to her understanding of these medically-prescribed processes. Her desperation due to a lack of control and authority over her body is palpable in the following quotation. It also highlights the positional roles of the actors during

birth, linguistic choices made by Cassie clearly situate the healthcare professional, in this quotation the midwife, as being in control of the final decisions about induction of labour.

> *"I ask her to give me twenty-four hours more . . . induction at 14 days overdue, she booked me 15 days . . . I knew the risks . . . at 14 days overdue I could go still to the midwifery led birthing unit, if my labour was starting that day spontaneously, so I just wanted the last days, the last day, the last hours." (Cassie, p.12, lines 305-307)*

This building of suspense, and desperation for a desired childbirth experience at the start of her narrative provides contextual information for the beginning of her labour experience, as she does begin to experience contractions on day 14 plus.

> *"After 15, 20 minutes the contraction they were every seven minutes" (p.14, lines 350-351)*

The use of timings in relation to contractions (every seven minutes) quantifies the experience, creating a shared understanding of where Cassie is within the childbirth event. On admission to hospital this is combined with the shared knowledge of cervical dilation. After nine hours in labour Cassie is re-examined:

> *"I was exactly the same, I knew I was exactly three centimetres, not changing umm or anything. The waters, the waters were still there and the contractions were the same. I was a bit sad, I knew it, but I was a bit sad but not yet negative because I still had three hours to go! (Cassie, p.18, lines 443-446)*

As time passes Cassie describes an increase in negative emotion commensurable with the lack of progression in either contractions or cervical dilation.

> *"I didn't have any hope that I was changing, I knew nothing had happened." (Cassie, p.20, lines 494 - 495)*

However, a rapid change in emotion description occurs with Cassie's membranes spontaneously rupturing.

"My waters went on their own, I was so happy, so happy, I was yes! Yes!" (Cassie, p.21, lines 527-528)

These constant changes in emotions and appraisals of the events in relation to the physiological happenings during reproductive labour provides the evidence of a need to consider both the physical and psychological, and how they amalgamate experientially for the women during childbirth.

Cassie's second stage of labour was objectively and subjectively lengthy, and involved a shoulder dystocia. She presents a continuous awareness of a lack of progress and the 'risk' of intervention should she take too long in pushing her baby out.

"I didn't feel like anything was happening so I was asking Ellie 'is something changing', because I don't understand I think I am pushing hard, but I don't feel like anything is happening and Ellie told me I know you are pushing fine I can see you are pushing in the right place hard enough I well I can see you're pushing well. And I see a little bit of difference every time but that wasn't enough for me laughs so umm at some point she obviously she cannot let me push forever so at some point I had another examination and head was lower but not, not, not as I was pushing I was its impossible she's not coming it's like why and I was like Ellie we know that am I pushing fine I was keeping asking if I was pushing alright because I was like come on you know how long am I taking to push Vanessa out it's impossible so so at some point because after 2 hours you need to do something you need to understand obviously the doctors will be involved and we need to make a plan because you can't push for umm after 2 hours there needs to be a plan anyway umm so the 2 hours were closing in and the head wasn't there wasn't, they couldn't see yet." (Cassie, p.30, lines 753-768)

Cassie's narrative juggles between presenting the obstetric, physical events and her emotional and psychological experiences, the use of a medically-based interpretative repertoire allows for a common understanding, with an additional level of personal, intimate experience within context.

> *"the head came and with the head came the meconium, very dark fresh meconium, that is the worst you can have umm. there are different grade of meconium so the dark, that is kinda of very fresh poo, basically baby that means probably you can have a lot of risk . . . I remember because at that point I had to push, well I was happy to push it was the last one, and I thought yes - this is the last one, so I took a deep breath and I pushed really hard . . . Umm at that point uh well I know what is happening. Well the, there was, no, well the first thing was said, I look at Eloise, and I say, 'Eloise take her out', because still at that point she hasn't done much, much things to take her out. She let, push the lady, umm, so I was like 'I can't, it's me I cannot push', I thought I cannot push stronger I say – 'take her out, you take her, cause I can't do it'. It was like that, but umm she was doing already and she wasn't coming. So Carla, there was a look at Carla and said it's not coming, so, umm uh err Carla err pulled the emergency bell. They use this, I know, I knew it maybe another lady didn't know, but what you know, it's scare. Anyway, but I knew that there was shoulder dystocia. . . . you don't have much time there are 7 minutes, umm, you know it's there it can take a baby alive . . . panicking I was thinking that's the end all my labour finished with Vanessa who is not fine (crying), after all of this, umm that was really, really scary." (Cassie, p. 36-40, lines 926-1021).*

The following quotation demonstrates the all-encompassing impact of the medicalisation of childbirth on Cassie's experience and throughout her construction of her narrative.

"I need to take the placenta out, we need to check, and we need to do this you know that, and I say I know but I don't want, I don't want, I don't want to do it. Honestly I don't want to do it, I decline anyone to touch me, but I was in a horrible, I was, I think people can see that I was shocked probably but obviously they cannot, cannot allow to go to I say ok. Ok I then I start to be a bit reasonable again, so I say ok I know I cannot go to theatre but let me take the placenta out myself, you should when you got the injection someone should take the placenta out and you cannot wait too long, ehh and the time was going fast because she was taken after 15 minutes, and umm, and umm, within an hour the placenta should be out. And at that time it was at least past half an hour because there was the change of the shift, so they had to explain something at least the main thing, uh and umm, and was a bit and also because people did knew me they were more talkative with me like, you know I don't know, but I again that time was going very fast and I knew I need an hour to do this bloody placenta." (Cassie, p.44, lines 1126-1140)

Using Cassie's traumatic childbirth narrative demonstrates the use of multiple medical, obstetric discursive tools throughout the entirety of the narrative. The use of these discursive tools echoes the contextual, conceptual medicalised discourse bound up in the understanding of childbirth in the U.K. Cassie's traumatic childbirth narrative highlights that as a result of the focus on risk aversion, a central aspect of the medicalisation of childbirth, an additional creation of psychological 'risks' occurs and this is captured here in the underlying essence of conflict in control, choice and power during the childbirth experience.

The cervix as a discursive tool; ideological dilemmas in traumatic childbirth narratives: *"my cervix"*

The cervix is the lower area of the uterus, joining it to the vagina. The two anatomical figures below demonstrate the structure and the location (figure 8.22) of the cervix.

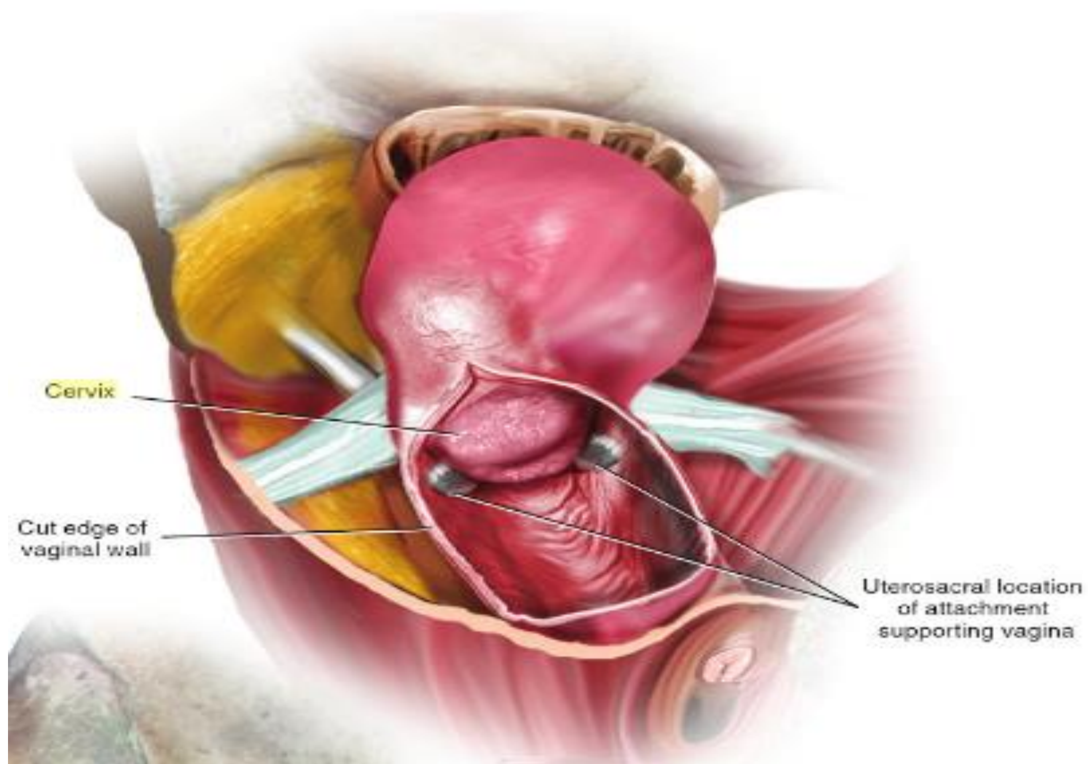


Figure 8.22: An anatomical picture of the structure of the cervix. (Baggish & Karram, 2016)

Women have little awareness of, or give little thought to, their cervix (Howson, 2001). However, an awareness of the cervix (cervical consciousness) occurs through two main medical visualisation techniques. These are; the preventative screening of women using cervical cytology to examine cervical cells for abnormalities (Public Health England, 2015), and internal vaginal examinations of the status of cervical dilation during labour. The status of the cervix during labour is often guided by the Friedman curve (Friedman, 1955); a

sigmoid curve used in labour management to interpret the progression of labour through stages based on cervical dilation and labour duration. Figure 8.23 demonstrates the concept of normal cervical dilation during labour occurring at approximately one centimetre per hour in the active labour stage.

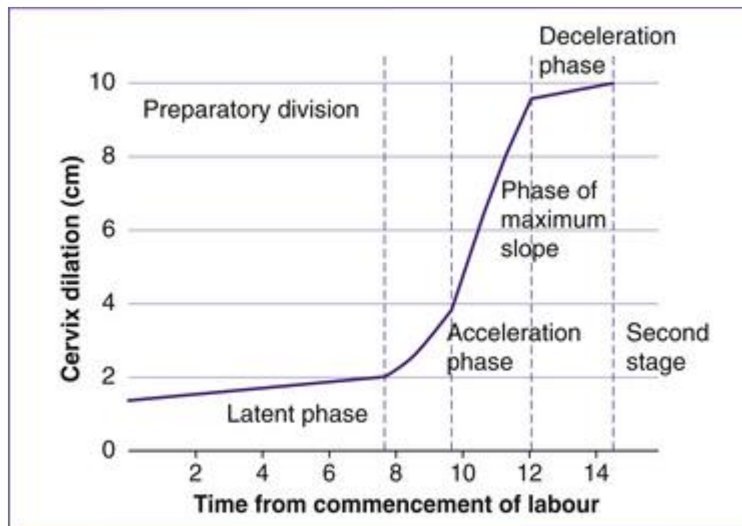


Figure 8.23: An example of Friedman's curve (1955).

Both of the medical visualisation techniques used to 'view' and assess the cervix create a form of privileged knowledge. The medical understanding of the cervix is both created, and accessed by health care professionals. In an attempt to combat this 'knowledge privilege' the 1970's radical feminist self-help health movement promoted and encouraged cervical self-examination to empower women through self-generated knowledge of one's body (Tuana, 2006). Although cervical self-examination did not become wide-spread, either for the purpose of individual knowledge or for the detection of abnormalities, it has had a lasting impact in promoting a new ethics of healthcare by encouraging women to become consumers through the knowledge and understanding of health (Murphy, 2004). Signalling a

change in the social construction of people receiving health care, the social consumer movement (Allsop, Jones & Baggott, 2004) pushes a cultural change with the promotion of experience as valid expertise, challenging and augmenting the power differentials between health care professionals' and patients/consumers.

Currently, in the U.K., the cervix is usually examined/inspected by health care professionals' using visualisation techniques (cervical screening and manual vaginal examinations), the sharing of knowledge generated through these processes tend to equip women with intimate knowledge of their own cervix. Knowledge sharing can occur either through computer/television screens which are now common-place in examination rooms throughout cervical cytology procedures, or in the verbal sharing of 'privileged knowledge' by the health care professional on completion of the vaginal examination used to assess the status of the cervix and its dilation during labour. It is the access to, and sharing of, this information in the traumatic birth interviews which will be focussed on in this section of analysis.

Most of the women interviewed talked about their cervix and cervical dilation as part of their traumatic childbirth narratives. Although women's knowledge about the cervix may be generated through biomedicine (Howson, 1998; 2001), data from this study suggests that when discussing childbirth women often use the knowledge they are given about their cervical dilation during childbirth in a number of both positive and negative ways. They also use the repertoire of cervical dilation and associated changes as a discursive tool to describe progression during labour.

Labour progression can be interpreted through a clinical gaze on cervical dilation and the use of the Friedman curve for interpretation of the visualisation. The transformation of the cervix during labour from closed to ten centimetres dilated is primarily defined and explained through biomedical discourses. Therefore, the gaining of 'privilege knowledge' of the cervix

during labour is thought to be the job of the midwife or obstetrician, below is an extract from Lorna explaining who examined her and the status of her cervical dilation at that point of labour. It demonstrates not only that this information/knowledge is accessed only by professionals during labour, but also that during labour a rare occurrence of cervical consciousness arises for women.

"Ummmmm, and she examined me, and I was four centimetres." (Lorna, p.11, line 129)

"By the time I got into the hospital I was three centimetres." (Cheryl, p.8, line 189)

The inclusion of information about cervical dilation during the traumatic childbirth narratives demonstrates how biomedical concepts and discourses have become embedded into the cultural construction of childbirth. In addition, the use of medical-based language (four centimetres: three centimetres) suggests that the cervix and cervical dilation are not just medical, physiological transformations, but that this information also has personal (I was four centimetres; I was three centimetres) and social meaning.

"I think it triggered something, cause I was, by the time I got into the hospital, I was three centimetres, that Sunday morning." (Cheryl, p.7, lines 188-189)

"then I went to the toilet, oh and I had started having contractions by that point, ummm but not, not too bad they were kind of like period pain, like bad period pains but not too bad. Umm, and then I went to the toilet and the pessary came out so I went and told someone, this was at like 3 o'clock in the morning. So, before they put another one back in, they examined me and they thought that I might be enough to have my waters broken so they didn't put another one in." (Lillian, p.9, lines 176-181)

This is similar to the talk presented by women in this study about 'due-dates' and being 'over-due'. The entrenchment of medical, scientific knowledge into the social

construction of childbirth impacts on women's expectations and experiences of when childbirth should occur, and how it should proceed. When the expected progression points do not occur, the women describe having significant negative emotional reactions during labour which remain within reflections on the childbirth events. The following quotation demonstrates the relatively extreme fluctuations of feelings due to being 'over-due' and the expectations of birth not being met. Lillian describes the disappointment of being 'over-due', then the excitement and anticipation of having the medical knowledge of gestation times, her cervical status and medical procedures which gave her the information that the birth of her baby was imminent. When, following medical intervention (induction pessary) labour does not occur immediately the disappointment she describes is tangible.

> *"Ummmmm, well I went over-due by, I was getting to forty weeks and nothing was happening. Ummm, so I saw the midwife and she did a membrane sweep, and I had a little bit of a show, and I was kind of think, ahhhh, ohhhh, it's the start of something. Ummmmm. And then I had another sweep at the end of the week, ummm, and I was, I think I was about 2cm dilated, so I felt that was a good sign and everything was going to happen. And I was, just, ummmm, errrr, I don't know if it was excitement, I was kind of, a bit, kind of anticipation I suppose that is excitement. I was just kind of waiting for everything to happen, ummmm, but nothing happened after the second membrane sweep, so I was booked in for an induction at fourteen days over. Uh, ummmm, and every night till my induction I didn't sleep very well, and every time I went to bed I thought – this is going to be the night I wake up and I, I think those two weeks, from forty weeks till I had her were the longest weeks of my life. It just seemed to drag on and that waiting for something to happen, and for it not to happen, I'd never felt so much disappointment (laughs). . . and when I woke up in the morning and thought well that's another, that's another night where nothing has happened.*

Umm I was just disappointed and frustrated, so umm we, I went into hospital. When I was 14 days went in about 1, 1 o'clock and they put in a pessary. Ummm and then I think we walked around a bit, ummm with the pessary nothing was happening, ummm, didn't feel anything so umm Jordy had to go home. And I, that, well I just said that was the longest two weeks of my life, that was the longest night of my life! Because I was, umm, I was just, I was just lying in bed crying. I felt so alone, cause I thought when I went in that was going to be it things were going to happen, and I was going to have her, and the fact that Jordy had to go home and nothing happened. I just, I wasn't expecting that, and I was just so desperate by that point to have her, that another night of that disappointment." (Lillian, p.8-9, lines 47-171)

The most conspicuous use of information about cervical dilation by women during their traumatic childbirth narratives was in attempting to create a linear and coherent prose by using the progression in cervical dilation to mimic passing of time, or acknowledgement of progress and movement through the childbirth experience. Much like narratives about alternative significant events use chronological time to create a temporal structure (Ricoeur, 2002), during childbirth narratives women often described being unaware of the passing time in any meaningful, shared sense. Instead they used information about cervical dilation to hang their experiences into a coherent narrative.

"Errmmmmm, and this is where it gets really sketchy cause I don't, from when that switched over to when I actually went into labour. How long that times was, ummm I just remember days and nights came and went. And I just don't know how long it was that I was labouring for. I was on the TENS machines for the majority for the first part of my labour. I think I got to seven centimetres just on a TENS machine . . . Anyhow ummm I laboured for hours and hours and hours, that didn't work. My midwife put me to bed, that didn't work, I tried various different tactics, and he just

wasn't budging. She examined me again, this is hours later, and I was still only seven centimetres." (Julie, p.7-8, lines 161-189).

Julie describes a lack of awareness of, and importance attributed to, time during labour. Instead she uses her knowledge of her cervical dilation to demonstrate and share her experience with the researcher of a lack of progress. It is cervical dilation (and progress) which is important during childbirth, rather than the passing of time. The quotation also indicates a growing frustration at the lack of progress, despite trying *"various tactics"*.

Indeed, the internalisation of medical discourses associated with childbirth shapes women's understanding and experience during labour and these can have multiple ramifications for her appraisal of her childbirth experience. This analysis allows the exploration of what examining the cervix and the passing on of the knowledge of cervical dilation can do *to* women, but also what it can do *for* women. As a result, some of the cultural constructions of, and medically-based social meaning associated with the cervix become apparent.

For most women knowing the dilation of their cervix was described as important both during their childbirth experience, and in recounting the experience to the researcher. During the births, the sharing of medically gained knowledge about dilation allowed women some sense of equality between themselves and the medical professionals looking after them. Although it did not occur often, when this knowledge was not shared women tended to talk about the people caring for them in a more negative manner.

"I had this really grumpy midwife, who was sort of German, and a bit tough. And she was the one who refused to check me or do anything, cause she was there's no point in, there's no point in checking, cause I'll know when you are ready, I was like, yeah, but I would like to know, you know, cause you want, you want your goal, don't you?" (Cindy, p.8, 175-180)

There is a corpus of literature exploring the lack of bodily control (e.g. Lupton, 1998) and situational control (Chadwick & Foster, 2014) women have during reproductive labour. This multi-layered paucity of power and control for women is partially created due to the health care professional's privileged access to, and knowledge of, the female body. The quotation above demonstrates the importance of knowledge sharing, with an understanding of cervical dilation being beneficial to the mother as well as the health care professional. For Cindy, knowing her cervical dilation would have allowed her some feeling of control, and enabled her to locate herself within the whole childbirth experience by understanding how far she was from her "goal" – birthing her baby.

The progression to certain cervical dilation points provided labouring women with a sense of achievement and/or pride in their bodies for progressing during labour. Demonstrating and vocalising their cervical dilation and lack of intervention and/or pain relief creates a representation of an able and strong mother. Often these memories were embedded through mini celebratory narratives within the larger traumatic childbirth narrative. Women often drew attention to these aspects of their accounts, highlighting positive felt emotion, making the incidents feel important and treasured.

> *"I'm thinking I'll be happy with six, and they checked me and I was six! So, I had a big grin on my face by then. It was the only thing that made me smile throughout the whole thing to be fair." (Lyndsay, p.5, 91-92)*

One woman describes not only the celebratory aspect at being at a certain point of cervical dilation, but also how the provision of knowledge about her cervical status, of being seven to eight centimetres dilated renewed her belief in her own abilities to continue to manage her contraction without intervention and birth her baby. This demonstrates that the sharing of medically-based knowledge of cervical dilation during childbirth can help to empower women and enhance the positive experience.

"Unbelievably she examined me, I was 7 to 8, I couldn't believe it. She couldn't believe it because my contractions didn't change much, they were every five. I wasn't having much hope, I was like I know I'm not changing. I need an epidural. So . . . I was so happy, you cannot believe me, you know like okay I don't need the induction, I don't need anything." (Cassie, p.25, lines 639-643).

This analysis also highlights some negative implications of the sharing of knowledge about the status of a woman's cervical dilation. For example, when the cervical dilation status deviated from the expected, medically normative trajectory of progression, or was not in alignment with their qualitative experiences of time and pain, women reported significant psychological distress and upset, and also described instances of despondency and becoming disheartened when given cervical dilation information.

"I tried various tactics and he just wasn't budging, she examined me again this is hours later and I was still only seven centimetres and my cervix was beginning to toughen. So, things were not looking like they were moving along like they should be . . . So, I laboured in that position for what was an hour or two and I did not progress. So, it was at this point that I decided that I wasn't feeling right, that this, I just had this gut feeling that things weren't going to plan. I was getting exhausted and I was nowhere near, the end was nowhere in sight put it that way. Seven centimetres still a long way to go, ummm and I wasn't progressing so I decided at that point I was going to give up, because things weren't working." (Julie, p.8-9, lines 187-207)

"I'm in the pool and I'm getting loads of pressure and stuff. This was the early hours of Sunday morning now. So, I think ah must be baby, must be cumin, cause I'm getting all pressure down below and she was like if you've got pressure push through it if you need to push through it. So, you know we're sort of trying and she was like oh we'll probably have the baby by two ion the morning. Excellent so that goes on for

a little while. And she's like oh I'm not really seeing any progress I'd better check you get out of the pool and I'll check you. Four centimetres (laughs) at which point I go mad . . . so I sorta started losing the plot at this point cause I thought I can't do this for another hours and hours and hours and hours when we are only four centimetres." (Cindy, p.8, lines 191-205)

The traumatic childbirth narratives provide evidence that some professional seems to be aware of the possible occurrence of negative implications when the cervical dilation status is interpreted as lower than then woman may expect. Cindy describes a midwife's refusal to conduct a vaginal examination and thus acquire information about the status of the cervix, due to the possible negative implications for the labouring woman.

"Ummmmmm, but there was one of the midwives that was a bit weird and refused to check like how dilated and stuff I was, which I thought was a bit strange. Cause she was like there's no point me checking it's only going to upset ya." (Cindy, p.5, lines 104-107).

The traumatic childbirth narratives presented by women in this study demonstrate that women are aware of, and attempt to manage differing sides of the rhetorical conflicts involved within the context of childbirth. Indeed, these ideological dilemmas (Billig et al., 1988) are demonstrated through their contradictory narratives about the cervix; women present both positive and negative accounts of their cervical dilation understanding. These in turn impact on their ownership of their cervix. The dilemmatic quality of women's ownership of their cervix is a complex strategy employed to manage both a lack of control over this intimate part of their bodies, removing the self (and thus responsibility) from the equation when cervical dilation is not progressing as expected. This management strategy provides a form of psychological protection from the negative emotional consequences of the lack of control. In contrast, when cervical dilation is appraised in a positive way, women

take ownership of their cervix, embracing this often abstract, precluded piece of anatomy into their self-concept and bodily understanding during childbirth.

The 1980's saw multiple social changes thus creating a second generation of theoretical applications of the medicalisation concept (Christiaens & van Teijlingen, 2009). One of these changes was healthcare recipients becoming active participants (Coulter, 2011), largely as a product of an increase in access to medical information and knowledge (Christiaens & van Teijlingen, 2009). In terms of obstetric knowledge and understanding it has allowed women to become more actively involved in their perinatal care, and may signify the beginnings of a reduction in the power and knowledge differentials between professionals and women. The empowerment related benefits to an increase in understanding and knowledge of medical and physiological events during childbirth is demonstrated in the analysis presented previously on the positive implications of professionals sharing their knowledge of a woman's cervical dilation during labour.

In contrast, the medicalisation of childbirth, reconceptualises birth from a social event/process to a medical process (Henley-Einion, 2009). The medical model is concerned with regulating and controlling women's bodies whilst in labour, with a main aim of a safe delivery of the baby. A product of medicalisation is the creation of a 'normal' birth based on scientific, observable and often physiologically sequential events that occur during labour (Henley-Einion, 2009). With this understanding medical professionals are able to identify when childbirth moves beyond these carefully bounded parameters into abnormal territory in need of intervention to reduce risk. This understanding of a dichotomy between what is considered 'normal', and what occurrences indicate a need for intervention have become embedded into women's expectations and thus experiences of childbirth.

Whilst obstetric medical surveillance in the form of examining the cervix during labour, and interventions such as induction when the gestation period lasts longer than is

defined as normal, are presented as necessary medical procedures to reduce risk, they can also have significant negative psychological effects on the woman. This links to the concept of iatrogenesis (Illich, 1976) (illness or injury occurring due to medical care), in that the medical management of childbirth, for example vaginal examinations, induction of labour, and a focus on physical presentation to 'diagnose' the commencement of labour, can create the iatrogenic artefacts of increased maternal stress, and negative feelings and emotions, which in turn can have long term psychological consequences. The concept of a 'right-way' to birth a baby has become embedded into social discourses surrounding childbirth in the U.K., medical conceptualisations of childbirth dictate when and how a woman should birth her baby and dismisses the qualitative, psychological experience. The idea of medicalisation being a 'master narrative/discourse' (Walsh, 2010), of valuing technology over nature – 'technocratic birth' (Davis-Floyd, 1992) negates the alternative women-orientated philosophy. It is proposed that a significant effort is needed to understand the potential impact of a focus on the 'pathological potential' (Conrad, 2005) on women during and after childbirth, alongside an appreciation of the qualitative, psychological expectations, experiences and effects of childbirth for women.

Conclusion

In conclusion, there is an ever-present conflictual relationship between science and the medicalisation of childbirth, the idea of birth as a social event and the personal, intimate and emotional experiences during childbirth. The core discourses; medical and social, are so closely enmeshed that separation is not the issue, neither is casting doubt on one for the benefit of the other. Instead, parity of esteem in terms of consideration and attention is needed. At present the biomedical model of childbirth dominates all discourses, and women have entered the scientific arena with their knowledge of, and access to, medical knowledge

and technologies associated with childbirth. Indeed, even those who verbally reject the medicalisation of childbirth do so because of their knowledge of what it entails.

> *"Ummm I had an extended latent phase of labour, I was massively overdue as well I ignored the NHS. I had, I had, he was, he was due the 17th umm, the original date they need to be was the 11th but I I had him on the 31st of December. So that was incredible delayed and I was very over-due, umm and I was just waiting until it natural happened, because my thoughts were - he will come out when he is ready. Umm so I had an extended latent phase which is where the I the baby just kept niggling at labour, but, so it wasn't established labour, but for about three days on and off he was coming and going coming and going. (Julie, p.6, lines 143-151).*

Part of this knowledge acquisition is about reclaiming some of the power, knowledge and control over their bodies and birth experiences – knowing what the professionals know. For some women in this when presented with knowledge which is aligned with their expectations of a 'normal' birth trajectory focussed on progression in a timely manner, they are able to use this for their own benefit. For example, understanding their cervical dilation status can motivate them to continue on their desired birth trajectory, for others, it can be a milestone, an achievement, a celebration in an otherwise difficult and traumatic event. However, with benefits, also come difficulties, the pressure to 'achieve' spontaneous labour, spontaneous rupture of membranes, adhere to the normative process of cervical dilation, can put enormous psychological pressure on women to 'achieve' the medically conceptualised 'normal' birth. When their bodies, which during childbirth are often out of their conscious control, do not adhere to the normative biomedical view of childbirth it can have a significant negative impact on their childbirth experience. One strategy employed by women in an attempt to manage these difficulties, is through their dilemmatic thinking concerning whether they take or reject ownership of their cervix at certain points in the narratives.

The ideological dilemmas outlined above are echoed in the traumatic childbirth narratives, women in this study play out conflicts and contradictions in their dilemmatic talk about cervical dilation and the associated ownership of the organ. They work to negotiate the tensions and manage differing sides of wider contextual, conceptual discourses surrounding reproductive labour. This dilemmatic thinking and talk enable women to think about and process the traumatic childbirth experience, indeed engaging with, thinking about, and talking through the experience can for some women allow them to make sense of specific aspects of the birth, and/or the experience as a whole. Something which a number of women commented on during or after the interviews in this study.

> *"What has happened? Obviously, the people, the person who was my community midwife was extremely helpful, umm, because every time she was coming uh, she was trying to give me an extra time just to speak again and again. Uh, and this helped me a lot speaking with people about this, and keeping, keeping, umm, uh, yeah, keeping tell the same story, uh helped me a lot. I could see every time I was speaking, I was crying in the point after last, so I could go through and be always stronger and stronger and accept, maybe help me accept, what had happened, and it happened to me. Ok, laugh and, and, just accept, cause at the beginning I didn't probably. Didn't want to accept this, and I was crying and saying you know I wanted to do differently, and I hope I accept it, because I'm not sure if I accept it or not, because the fact that I, I dream to have to give to give birth another way. I don't know if these are the kind of not acceptable or something else, I'm not a bit experienced in these things so I cannot tell, but I hope I accept, I'm accepting. So, um speaking with her has been really, really, helpful and um also with my other colleagues because they were really they are, but friends and coming and giving me and see Vanessa, and they wanted to know and, and, speaking was always, I was feeling much better after I speak, and that*

was also having this interview I wanted to it was a kind of check every time." (Cassie, p. 66, lines 1709-1725).

"Lyndsay: Talk to somebody. Talk it properly out with somebody. I don't know if it would have helped me at the time. But I think if I it did now, like I just have I think it will help now. . .

Researcher: Yeah. Ok. Ok obviously, obviously you have spoken to me today and you have spoken in a lot of detail which I am really grateful for. How's that made you feel? I mean obviously you got quite upset.

Lyndsay: Better now actually." (Lyndsay, p.27, lines 519-537)

CHAPTER ELEVEN

Poetic Representations

Poetic Representations of Traumatic Childbirth Narratives

"It's Still Getting To Me!"

The title of this chapter, a quotation from a mother who had experienced a self-perceived traumatic childbirth and participated in this research, encapsulates the emotional and contextual understandings of the data from the narrative analysis of women's traumatic childbirth accounts. Mothers who took part in this study all shared the unique ways in which their traumatic childbirth experiences had impacted on themselves and their families, at the point of the interview all of the mothers spoke about how their experiences were "still getting to me", emphasising the lasting and pervasive influence of traumatic childbirth experiences on the individual. In addition, I have adopted this phrase to also encapsulate my experiences of studying, in depth, the experiences of traumatic childbirth. I myself have two children, fortunately both my childbirth experiences were not traumatic, however the memories and emotions associated with the life-changing experience of childbirth will remain with me. This PhD has further cemented this lasting nature of childbirth experiences in memory and the analysis has allowed me to reflect upon others' understanding of their own unique experiences. By valuing and highlighting aesthetic knowing (Carper, 1978), with a move beyond traditional understandings, this thesis has provided me with the ability to explore my personal emotional interactions during the research processes. In turn, allowing a unique 'empathetic entry' into traumatic childbirth experiences, and it this emotional understanding which is "still getting to me" years after the initial interviews.

The development of arts-based research embraces a unique questioning of what constitutes evidence and how this evidence creates knowledge. It provides an alternative paradigm for research dissemination, and one which explicitly considers the engagement of the audience (Boydell, Gladstone, Volpe, Allemang & Stasiulis, 2012).

> Art and science bear intrinsic similarities in their attempts to illuminate aspects of the human condition. Grounded in exploration, revelation, and representation, art and science work toward advancing human understanding. Although an artificial divide has historically separated thinking about art and scientific enquiry, a serious investigation regarding the profound relationship between the arts and science is underway (Leavy, 2015, p.3).

Arts-based research is a unique and alternative paradigm to more traditional forms of evidence, knowledge and research dissemination. This chapter was created as a result of my reflections during the research process involved in the study presented in chapters eight, nine, and ten; a narrative analysis of traumatic childbirth experiences. Those reflections presented a methodological dilemma, in that I felt that the narrative analysis was diluting some of the context, subjectivity and emotionality of the individual accounts of traumatic childbirth. Therefore, a unique and novel representation of each account needed to be able to represent these aspects whilst retaining the original words of the mother. This could only be achieved through a combination of art and science, with a full and explicit embracement of the interaction between myself as a mother and researcher, the participants as experts in the experience, and a consideration of the audience's reflective reactions.

This chapter presents poems to represent the traumatic birth narratives in shorter, but contextually whole, subjective, emotional accounts, whilst retaining the original participants' words, demonstrating the incredible value of the voices and narratives of those with lived experience. The use of poetry broadens the accessibility of the knowledge and insights gained through this research by creating a powerful platform to increase understanding and awareness of the lived experience of traumatic childbirth for academic, professional and lay audiences. Three of the poetic representations are accompanied by reflective commentaries

which acknowledges that traumatic childbirth experiences and the construction of narrative exist within a broader social and cultural context.

This chapter explores psychological, perceived experiences of traumatic childbirth from the viewpoint of the mother, validating personal, subjective experiences as sources of knowledge. Research has explored the subjective experience of women, and acknowledges the often conflictual and multiple social, historical and cultural discourses surrounding childbirth. The poetic representations build on previous findings offering an analysis rooted in feminist critical health psychology as it explores complex data, whilst acknowledging the data as a product of the context in which it was generated.

Initially this chapter presents a rational, reflective account, and the analytical procedure associated with the novel representations of the traumatic childbirth narratives. Following this, each narrative is represented in poetic form individually. Three poetic representations are accompanied by reflective commentaries which each discuss one of the three unique contributions of this arts-based method of representing research data. These are the entirety, the subjectivity, and the emotionality of the traumatic childbirth narratives.

Rationale

Reflection during the narrative analysis of the interviews gave rise to both an obligation and compulsion to provide a whole, contextualised account of each birth narrative. This ‘account’ needed to be able to convey the emotionality involved in the interviews to engage the reader on a deeper, more emotional level, just as I was during the interview process, and subsequent transcription and analysis. It is through my development as a narrative inquirer that I understood and fully recognised, acknowledged and embraced the interactive relationship; between myself as a researcher and the women participating in this research (Pinnegar & Daynes, 2007). It was the knowledge and understanding I gained

through being able to be a part of this relationship and empathise with the women and their narratives which lead me to explore how this may be replicated for a wider audience.

> Greater depth of understanding through an emotional connection with the data may be best presented through a merging of art and science in the form of poetic representations. This provides audiences with the opportunity to engage with and empathetically understand the, usually private, emotional experiences of . . . research participants (Clarke, Febbraro, Hatzipantelis & Nelson, 2005, p.914).

Versions of poetic representation, analysis and reflections have been used in nursing and social science research previously (Ohlen, 2003) often exploring illness and suffering (Chugani, 2016; Clarke et al., 2005; Furman, 2004). Poetic representations, based on the concept of found poems, was chosen for its heuristic value in exemplifying the whole, emotional narrative of each of the twelve birth narratives in an accessible and evocative format, whilst retaining the value of the mother's spoken words. Poetry is a unique and considered art form, the value of which is described by Furman (2004) below:

> Firstly, poetry is especially effective at conveying strong emotion. Operating on the level of image, the poem resounds in the mind . . . An evocative and vivid image can linger in the mind long after words have been read. Unlike photographic images, images conjured by the mind triggered by the written word may be attributable as much to the receiver as to the source. The images inspired by a poem engage the reader in a creative relationship that moves beyond passivity to co-creation. (p.163).

Reflexive account

This data arose from multiple rich, extended birth stories collected for the narrative study presented in chapters eight, nine, and ten. I felt as a researcher I somehow needed to provide a concise representation of this data through a whole, contextualised account for each

woman. The data used in creating the poetic representations included the qualitative interviews, quantitative questionnaires (details of these are presented in chapter eight), and my research insights during data collection and analysis. Plus, the knowledge that all of the birth stories ended with the birth of a live baby, all of whom at the time of interview had no lasting physical consequences of their traumatic entries to the world. These babies were present emotionally (and sometimes physically) throughout all the interviews. In addition to the interview, there is quantitative demographic data about the women and their families, the birth and their babies. The field notes created about my recollections and reflections about the interview were continuously updated and added to throughout the transcriptions and analytical procedures – my involvement in the study.

Indeed, it is my acknowledgement and acceptance of my involvement and participation in the study that has elicited this attempt to analyse the data in a poetic form. During the interviews I was somewhat taken aback, at my own emotional reactions to the stories being told. It was this reaction that I felt taught me the most, it is what made me stop and think about how we understand the 'lived experience' of traumatic birth, and what knowledge we are able to gain from listening to the words of someone who has experienced it. I wanted the audience to have their own unique affective reaction and experience of the data, I wanted to be able to "bring the reader as close as possible to the original researcher/participant experience" (Grbich, 2013, p.130). Through discussions with my supervisor I told him of my frustration and concern that there was something missing, throughout the narrative analysis we were not quite capturing the essence of the whole experience and the associated emotions. Through these discussions he introduced me to the concept of poetic representation, reflective commentaries, and found poems.

I was hesitant and nervous about using this technique within my PhD, believing it to be too creative, too personal, and not scientific and defendable. But it felt like it may be able

to meet a previously unmet need of mine, as a researcher. I needed, somehow, to combine all of the data, in an accessible form, which would engage at an emotional level the audience, just as I was engaged at an emotional level during the interviews. To present the whole contextualised story in one place, whilst emphasising the emotional experience of the participants is challenging. As previously described, I felt that at times, through the transcription and analytical processes of narrative analysis some of the experiences and emotionality involved in these birth stories became diluted. Words and emotions seemed to occasionally become lost in translation.

I wanted the audience to have a further layer of understanding, a depth that is arguably, only achieved when a person is able to emotionally connect with the data. It is this emotional connection that provides an in-depth, personal understanding of the 'lived experience' of another. I also wanted to provide a testament to the bravery and openness the women interviewed for this study afforded me as a researcher. Throughout the data collection all of the participants gave so much of themselves to the process in re-telling their experiences in their own words to a researcher. They allowed me a unique insight into their deeply personal and emotional experiences, and therefore it is important to me to keep the essence and the emotionality of their stories in a contextual whole account.

This data analysis is not about generalisability or objectivity, rather it is the opposite. It is about providing an extra layer, a deeper layer of understanding. It is about accepting that as a person qualitatively studying another person's personal experience, I was unable to remain continuously objective. I was and am still, emotionally moved by the interviews, and at the very basic level me purely being present whilst the birth stories were told involves me in the data. Although through various qualitative data methods I am able to explore common themes and experiences across the birth narratives, as whole accounts these stories, as with every story, are unique. It is this combination of the researcher and participant in creating the

data, and the acknowledgement of uniqueness of stories that we can allow ourselves as researchers to explore the data from an emotional level, both through 'empathetic entry' into the experiences of another, but also through our acknowledgement of our own affective experiences when engaging with the material presented.

Analytical procedure

This study aimed to present a found poetic representation of each birth narrative. To present using the mother's own words each evocative birth story as completely and within context as possible, whilst retaining and valuing the associated emotionality. The data analysis techniques used generally adhere to the poetic analysis method outlined by Glesne (1997). Some differences occurred as poetic analysis of this data in this study was executed in conjunction with narrative analysis (findings for this are presented in chapters nine and ten).

Initially data was individually re-explored one participant at a time. The data set (see reflexive section for content of the data set) for each participant was combined through the initial data analysis process of re-reading of field notes, quantitative data, and re-engagement with interviews through listening to the audio files. Whilst listening to the audio files of interviews specific attention was placed on the tone of the interview, incidents of emphasis placed on certain words or phrases, and evidence of emotions, for example laughter and tears, and more subtle hints at an emotional connection, for example sarcasm and hesitating. A Word document of the entire interview was then subjected to word removal. All interviewer talk was removed, alongside repetition and excess words. The judgement on excess words and repetition was made by the primary researcher. All compelling, salient sections, significant moments and words were highlighted and separated from the rest of the text, whilst being mindful of assumptions. The judgements were made based on all of the

information (interview text, notes from re-engagement with audio files, field notes and contextual information, for example the quantitative demographic data).

The poetic representations captured the essence of the whole narrative, rather than compartmentalizing through coding. This essence was recorded in a single phrase for each birth narrative, which are the found titles of the poetic representations. Separated sections were kept in the order as presented by the participant. However, due to the length and detail of the interview data mimicking the prosody of the original interview in the poetic representation was not possible. Words were placed into a poetic format only using words and phrases from the original birth narrative – creating a found poetic representation. This demonstrated the value that this research places on the original words of mothers, if not the 'natural voice'. Choice of language gives an insight into how mothers frame and describe their traumatic birth experiences. Words and phrases were used sensitively in an attempt to retain their original meaning and emphasis, whilst still maintaining a coherent story. Poem creation was iterative, with continual refinement and re-organisation, until an evocative, coherent poetic representation was achieved. A second researcher checked each poetic representation for accuracy of meaning, coherence, and understanding. A diagrammatic representation of the process in creating the poetic representations is provided in figure 11.24 below.

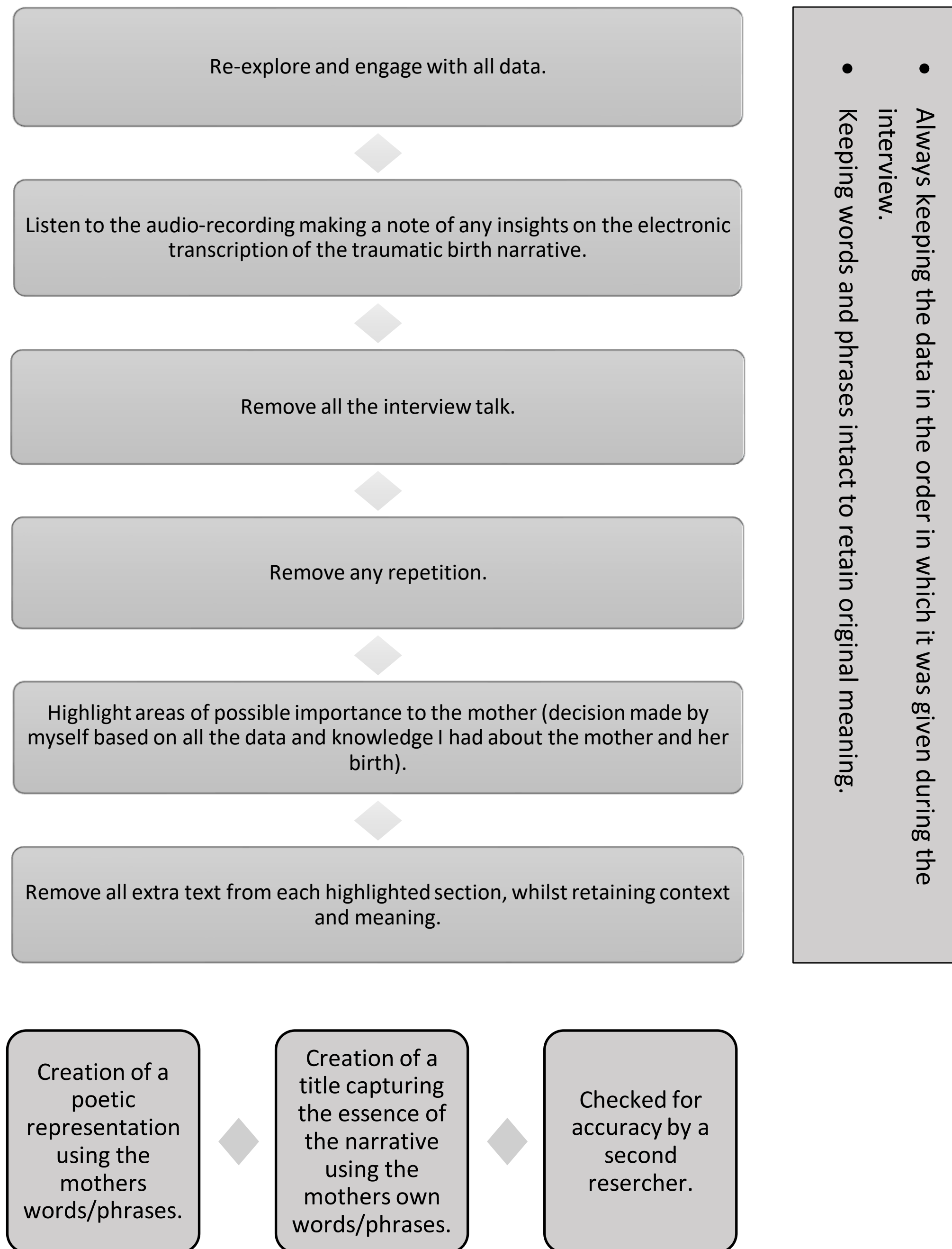


Figure 11.24: Diagram representing the process of the construction of the poetic representations of the traumatic childbirth narratives.

Each of the twelve birth narratives were transformed in to poetic representations, nine of these are presented in the poem section of this chapter. Three poetic representations were explored further due to their representativeness in the three key areas that the poems were

created to demonstrate. The three areas are; the entirety, the subjectivity, and the emotionality, of the traumatic childbirth narratives and poetic representations.

Poetic Representations

Poetic representation of Amelia (baby Lauren)

'I knew what to expect . . .'

I had gestational diabetes,
I had it with my first,
I knew what to expect.

I went in at 9 o'clock,
On a Wednesday morning,
To be induced.

"If I do the examination, break your waters, then go for a walk"

I bounced on the ball,
Just chatting, a few tightenings,
Nothing major, it didn't hurt.

They decided,
To put me on the hormone drip,
And the contractions started.

I had the monitor on,
My mum and husband got crib out,
To have a game.

After two contractions,
I saw the monitor go flat,
I knew there was something wrong.

I knew there was something wrong,
It felt like forever,
I got a bit upset.

All these people came rushing in,
I didn't know
What's going to happen?

"Don't worry, it's just your baby's heart has stopped, we need to get her out."

They just need to get baby out.

People leaning over me,
They ripped my earrings out,
My rings off my fingers,
I was darted to theatre,
Bashed into a wall.
I was panicky,

I was scared,
Also numb,
I was in shock.
It was all a bit of a blur.
I didn't want a c-section,
But I was more worried about the baby – I would have done anything!

They picked up a heartbeat.

"We can slow down a bit. If you want, we can go ahead and do a c-section or you can go back and try again?"

I kinda didn't know what to do,
I didn't want a section,
But I'm here,
She would be out and safe,
But a normal delivery,
Better for both of us.

We decided to try again.
The doctors check the heart rate.

It's burning,
The baby's coming,
Half an hour of pushing,
She was delivered.

She was fine . . . amazing . . . perfectly fine.

Poetic representation of Cassie (baby Vanessa)

'I dream about another labour'

I have told this story many times to help myself after the birth.

I really wanted spontaneous labour, nothing was happening, stress was really high.
I knew induction was coming.
I just wanted the last days, the last hours.
I was a bit sad that it wasn't happening to me.

I went to bed and one contraction - a good contraction
I was really happy, excited - I really want this pain.
Fighting a bit with the time, I was exactly three centimeters.
Unbelievable, 7 to 8, I couldn't believe it, so happy you cannot believe
I don't need anything, I didn't even have paracetamol or anything at all.
It was a short time but it, it was precious, I felt really good, I was 7
to 8.

I wanted to push, sometimes I was doing because it's impossible not to your body is doing it.
A deceleration, I wanted to push much more.
Every examination really painful.
Fully dilated.
Pushing, pushing, pushing.
After 2 hours,
doctors involved
make a plan.
I'm happy
I cannot push harder than this.
I cannot do it anymore

At that moment I felt most the pain, so bad, I knew I could push more, but I don't, I am going to break my bones. I can't push more, I am going to break. You need to do it, there is no other way, Vanessa needs to come from there.
I, I, I, could feel like the bones were opening, it was impossible that she could pass from there. I didn't share that pain, you can do this. I felt this stretching perineum. Horrible, horrible, horrible, horrible, but I didn't have much choice. I needs to finish. I was really scared.

I don't care anymore. I want her out. Whatever happens. An end.

Guilty, the fear, I am going to break, the head, the tear, the feeling of your body tearing, very dark fresh meconium - the worst.

I was so happy and relieved - one contraction and Vanessa is going to come, this is the last one so I took a deep breath and I pushed. I, I hold my legs from the, the back and tried to push harder, I couldn't feel anything moving so I push harder, I push, I push harder, she wasn't coming.
I say "take her out, I cannot push stronger, you take her cause I can't do it!"
Shoulder dystocia, I was scared, but concentrating, don't have much time

- 7 minutes to try and release things.
I panicked totally, she's going to die, she's going to be damaged. I screamed.

I don't even, I don't remember, I don't, it's the only thing I don't remember, I don't remember, but, but, I don't remember . . . I was panicking . . . I was thinking that's the end. My labour finished with Vanessa not fine. After all of this.

A hand inside. I was just screaming, extreme pain, broke, it's done, the bones
Push, push, push.
Body out.
"No Vanessa! No Vanessa!".
Not crying, white, not breathing
I don't care, I just want her to be fine - alive.
I was crying, time was passing.
Why she not crying?
Why she not crying?
Why she not crying?
Why she not breathing.
Nothing.
They allow me to give a kiss.
I will remember that kiss forever.

Destroyed.

Didn't care, nobody is going to touch me. I am going to take the placenta out myself. I don't care, I feel too much. I was crazy in that moment. I thought I was, I was completely open. This bloody placenta. Nobody is going to touch me.

Sometimes I dream about another labour and she comes nicely, I had been scared she was going to die. Afterwards was so horrible, every day, every moment, I was thinking about that and crying, I couldn't stop crying, crying, crying, crying and uh I didn't know what to do, don't think about that . . . but it was inevitable. People were saying try not to worry, but I can't, I can't stop.

Poetic representation of Ruth (baby Elijah)

'Disappointed . . . but it's not my fault'

Woke up in the night, went up to hospital because I'd had a caesarean.
I was in established labour, seven centimetres.
It was nice, how it should be I think.
I was pushing, pushing, pushing, pushing . . .
theatres, forceps.
Which was brilliant, I'd still get my wanted vaginal delivery.
Out within a minute, straight away.
I had skin to skin, which was perfect, really lovely.

I was lying there, they tilted the bed up,
I was bleeding, torn, stitching me up
fourth degree, I didn't really know what that was.
A blood transfusion, torn a lot of muscle.
Afterwards thinking - 'is it my fault I tore, I didn't do it carefully enough?'
Even less mobile than when I had my caesarean section.
It had torn into my bowel.
I didn't want to look at it, see what the tear had done, how awful it was.

Just nobody expects it to happen.
The whole situation made me feel a little bit down, disappointed.

Poetic representation of Lorna (baby Felicity)

'My expectations were broken'

A reduction in movement,
I'd had that a couple of times,
But my blood pressure was quite high.
A show, the midwife had
Palpated my tummy
Really firm, the firmest I had ever felt,
jigged it all around
A bit too much.

Started something off
Oh God, Oh God, Oh God!
On my own up the hospital
Waters broke in the canteen.
On my own.

I basically had 48 hours to get
Myself into labour

The first night was a bit scary
People going into labour,
On their own,
Alarms going off,
Rushing her out.
Oh my God it's going to be one of us next.

Obviously at this point I always
Imagined I'd still be at home
Jude would still be there.

Contractions
Quite strong
Wasn't expecting them
I just felt on my own.
Absolutely on my own.
No-body else was wandering around the ward with me at 3 o'clock in the morning!

Awful
I just want Jude
couldn't cope with the pain
I was texting Jude
'get in the car, this is horrible, come and help me'.

When he turned up – I could share the pain.
I can cope.

I can't, I can't, I can't do it

freaking out
an epidural
I was like a different person
All chilled out.

Waiting for the consultants,
sure it will all be fine.
Senior consultant came round,
Going round in circles – drip, no drip,
Within literally a minute I was in surgery.
It didn't actually panic me
Then, oh my god, weird
Shouldn't be awake when someone is operating

I don't remember her being born
Not thinking she was out baby
Back on delivery suite.
I had some toast.
My expectations were broken –
still didn't really think she'd arrived.
That was the birth.

Poetic representation of Cindy (baby Elsa)

'Thing'

I had a sweep, I was ten days late.
I woke up, with what I thought were contractions.
I lost my bloody show thing,
Disgusting like an alien coming out of you.
So we drove to delivery and I'm one centimetre, she sent us home.
I suddenly felt this strange gush thing.
Called the hospital again, they showed us to a room.
They kept checking me, I took ages.
I was suddenly panicking, I was shouting,
It's kind of like an out of body experience.
I was mental, screaming, clinging to James.
It was horrible.
Then I got in the pool. That was fun, really good.
I'm getting all pressure down below, push, push.
Check – four centimetres, I go mad.
It's her fault, because she hadn't checked me.
I sorta started losing the plot, can't do this
For hours and hours and hours and hours.
I woke up, it was daylight, I was eight centimetres – wahoo!
It went on and on and on and on and on and on and on – nothing!
The lovely doctor came; I really liked the doctor,
Strange position, on the wonk, big old horrible placenta in the way,
Heartbeat funny – a bit odd.
Let's have a caesarean that will be fine, I can't push this thing out.
All quite exciting, it's nearly over.
Cutting me, can't feel anything, pulled her out.
Then it all started going a bit odd.
Everyone needs to stay calm; I'm losing loads and loads and loads of blood.
I'm in pain, feels like tugging, they're quite violent.
I'm screaming in pain, the anaesthetist pumps something into me – I enjoy that!
Fifty minutes and then they said, "Oh it's fine".
I went to recovery, got to see her.
I felt like a bit of a failure.
But it's over now.

Poetic representation for Melody (baby Ruby)

“It’s the most natural thing in the world to give birth”

My due date sort of coming and going, the longest days that I’ve ever experienced, anxious that I had waited for so long, but nothing was happening. A struggle because I like to be in control. I was at home, I sort of felt contractions, I wasn’t sure, just a ouch moment? I was bouncing on the ball and put the TENS machine on. After a couple of hours, I was in a lot of pain, rang up the midwife led suite, they said have paracetamol, a bath, an hour later - “oh I really need to come in, it’s so painful”. They wouldn’t let me in. The third time I screamed down the phone, exaggerating it, I wanted it to be recognised. They said to come in. I didn’t want to go in cause I was too scared to not be as far gone, and for them to send me home. They let me come into the hospital. I was only 1 centimetre. I broke down, I was in such a state, hyper-ventilating, I can’t come home and go back again. Stay in but on the ward.

Then I was four centimetres, so they let me go into the birthing pool, had a sigh of relief, felt the need to push, they wouldn’t let me, my waters broke. She was back to back, is meant to be more painful, so as soon as they said that I was relieved to know that it’s not me being weak, there is a reason the pain is so intense. Meconium - she was obviously distressed. To delivery suite. I again broke down. I was devastated, my birthing plan - a water birth, was lost then. I had the epidural, I was still having gas and air, a drip, the head test. Right we need to get her out now, her heart rate dropped, a C-section. I don’t want to have get her out now it’s not looking good at all. It was my worst fear, I just wanted the natural birth. They took her out quite quickly another upsetting thing is they didn’t give her to me straight away, she wasn’t breathing, had to be resuscitated. But then I did have her and we went through to the recovery. David had to go home

That’s the point when I was like oh I’ve got a baby now, what do I kind of do about this?
Pleased, in shock, confused.
A girl next to me kept tutting and huffing and puffing as Ruby was crying. I felt I couldn’t look after her.
When the midwife came round I said I just have to go home I just can’t stay here any longer.

Poetic representation for Rosie (baby Lola)

'All a bit of a blur.'

Ten days over, I'm just willing it to happen.
I didn't know what it was going to be like.
Delivery suite said have a bath, paracetamol, and get some sleep.
Ridiculous thing to say – a little miffed at that.
Bouncing on the ball, TENS machine on, bleeding heavily.
Ring delivery suite just for advice.
Come in, worried about the bleeding.
Timings out of the window, but felt like forever.
Eight centimeters dilated, more attention all of a sudden.
Monitors and managing contractions
Midwife was lovely, very funny.
Had to break the waters, not pleasant,
Seeing the big metal thing, didn't fancy that much!
Epidural was amazing, calm lull.
Threw up all over the midwife, bless her.
Legs in stirrups, pushing for an eternity.
Mentally prepared for forceps.
No, no, no a c-section now,
A full, general anaesthetic.
Count down from ten . . .
Ok I am going to wake and see my baby.
The room faded, a bit cloudy.
Everybody around me shouting "push"!
Absolutely bonkers!
Recovery room, I was shaking so much,
Heart breaking cause I wasn't capable of a cuddle.
I was trying to calm myself,
Like deep breaths, deep breaths.
I was then able to give her a cuddle.
That's the happy moment there.
It was lovely having a little girl – obviously.
My head was trying to process everything.
I need my home, I need my house.
I got really upset, my first wee didn't meet their criteria.
So I cheated and topped up with water.
A few mls over, in case they got suspicious
My making a break from the hospital!

Poetic representation of Lillian (baby Helena)

"Like you know on one born every minute - that moment"

Anticipation, excitement, waiting for everything to happen
Those two weeks from forty weeks till I had her were the longest weeks of my life.
I'd never felt so much disappointment!
I was at 14 days they put in a pessary and walked.
That was the longest night of my life.
I was just lying in bed, crying, alone, so desperate,
I was just really upset lying there I just thought no one cares.
I was like I can't do another day of this, I really can't.
Then they said we can break your waters and take you to delivery.
I was definitely having contractions.
In my memory it was fine and then absolutely awful.
Unbearable, I panicked, got scared.
Four centimetres, a long time yet.
It was just heart-breaking, I was beside myself.
Once it had gone in ahhh, the relief, it felt just lovely.

I, I, had to have it, didn't feel like a choice.
I can't really remember that much.
After hours and hours and hours they examined
We can start pushing – "oh my god you are my favourite person in the world".
I was so excited.
Push here, push here I didn't understand how, what or where I was pushing?
I was annoying them, disappointing them.
I wasn't doing it right.
It gets very, very blurry, I'm hesitating.
I could feel her coming out, coming down.
She was there for ages nothing happening.
I don't know what I'm doing?
They decided – "right we are going to get this baby out!"
A ventouse, a kiwi delivery, I don't remember.
Wanting it to be over. I don't remember.
They pulled her out.
Oh God the pain.
Straight onto my chest.
Utter relief, just relief.

Everyone started panicking.
I was losing loads of blood.
They started stitching, I felt every single stitch.
Then that was kind of over.
Several hours after I went to the toilet.
I looked down.
What the hell is going on?
What is that?
I knew I had an infection.
Stitches all split.

I am to have an operation to be repaired.
Still painful, bleeding, the journey of having a baby is still going.
I’m kind of happy, getting on well, I feel down, sad, it’s not over yet.

Poetic representation of Cheryl (baby Eleanor)

"I had to consent"

Eleanor was two weeks late in the end
They let me go naturally, I wanted a natural sort of birth
I was only I must have only been four five centimeters, a lot of pain, over to delivery.
The room with a pool – lovely what I wanted.

Things weren't progressing as they'd hoped.
I was quite happily going along.
They decided to rupture my waters.
She pooed.
They had to hook us up.
I didn't have any choice, they just did it.
Obviously, I had to consent,
You don't feel you have much choice.
They tried to put the epidural in me
I remember rocking backwards and forwards
The whole team into the room
Try it once more
It was just like horrendous, it was just horrible.
They finally got the needle in – it was amazing.
If your no more than seven centimeters, we'll take you for a caesarean.
Luckily I was eight centimeters, fully dilated, pushed her out.
It was amazing at the end.

Poetic representations and reflective commentaries

The poetic representations were created in response to my own reflective reactions during the research and analysis processes, the poems were created in an attempt to capture aspects of the data which I felt has become diluted or fractured during the analytical processes. The following three poems are exemplars of how the poetic representations fulfil my needs as a researcher by each demonstrating one of the three unique contributions these poetic representations provide. These are; the entirety, the subjectivity, and the emotionality of the traumatic childbirth narratives. Each poem is presented and then followed with a reflective commentary which discusses the unique contributions within the wider discourses surrounding childbirth.

The entirety of the traumatic childbirth narrative

Poetic representation of the birth experience of Suzie

'I coped with it, so do not feel sorry for me'

Morning sickness, worked through it,
Midwife check-ups fine, normal, right
yeah enjoyed pregnancy.
Labour Tuesday Wednesday contractions
coming and going.

Contractions really strong
decided to break my waters
a little poo in her waters, breech
blood through her head.
An epidural, had to wait four hours!
They put a hole in my spinal cord
so I could still feel a lot!

Emergency c-section.
Could feel a lot
refused to let them knock me out
I could feel them sewing me up.
I just coped with it
Went to recovery.

A temperature
Violently vomiting bile
Black green bile
Stomach swelling.
They started testing
Everything
That was coming out of me.
Emergency theatre
Exploratory surgery
Fluid in my tummy,
Bad fluid.
A tube coming out of my stomach
a catheter
Epidural had gone wrong
Headache
Neck ache.

They were pumping every, single, anti-biotic, they could think of, through me.

Laid completely flat
Couldn't eat
Eight days
Bowels stopped working

Semi-conscious
Cannulas in both arms
Veins collapsing,
Fed through a drip,
Septic levels
300 and something.

They let all come in to help look after Eva.
They did the blood patch
then I was awake!
I could sit up, stand up, shower
Amazing
Just like heaven.
Back to the ward
The member of staff was horrible
I had a breakdown – bitch.

I lost three stone in a week
Which is good
I should write to a celebratory magazine
This is the way you lose weight
Get a mystery infection
Nearly die!

Reflective commentary

The poetic representation of the birth experience of Suzie demonstrates the fullness of accounts - the entirety of the birth narrative. This, alongside the use of humour, allows Suzie to construct a protective shield around her traumatic experiences. The structure of both the narrative and the poetic representation demonstrates a narrative arc, following 'standard' narrative models with an onset, a climax and a resolution (Farley & Widmann, 2001), thus creating the illusion of an entire account as a defence against questioning. In addition, from reflecting upon the interview it felt as though Suzie was 'sticking to her story' - a pre-defined, crafted and practiced 'patter', that could be told and re-told. The narrative process is eased by this modelled recitation negating the need to think about and thus emotionally engage with the material she presents.

In an essay about the experience of incest disclosure Ford and Crabtree (2002) discuss the concept of "fucked-up tellings", a term they use to describe the re-telling of stories of incest experiences for the 'wrong reasons'. This type of 're-telling' is used to scare away or shock the listener which feels akin to the interview process and narrative provided by Suzie. In the climactic section the poetic representation mimics Suzie's use of lengthy, complicated and relatively incomprehensible (to the lay-person) traumatic events and obstetric complications. With the relentless nature of her medical jargon-heavy descriptions, and her lack of emotional connection to the obstetric events, Suzie's 'telling' is both shocking and somehow scary, mainly due to the pretence of a cool, detached recollection of the birth trauma. Ford and Crabtree (2002) describes people presenting a 'too tough to care' pretence and a lack of self-reflection during "fucked-up tellings" (Ford & Crabtree, 2002), which again is echoed in Suzie's 'telling' of her birth narrative and is demonstrated in the section below:

"I could feel them sewing me up.

I just coped with it,

Went to recovery"

Whilst it is not assumed that Suzie chose to provide her birth story for the 'wrong reasons', it did feel as though she used some of the strategies similar to those described by Ford and Crabtree (2002). In a similar way to incest survivors, providing a "fucked-up telling" was part of her attempt to create and maintain control, and guard against any sense of intimacy between herself and the interviewer, allowing Suzie to protect herself, and maybe the interviewer too, as the 'too tough to care' stance, and lack of intimacy almost negates the interviewers want/need to care and emotionally connect – reflected in the title of the poem 'I coped with it, so do not feel sorry for me'.

Humour and sarcasm are used by Suzie in a number of forms, and offer further protective mechanisms, using humour as a communicative tool is both functional and strategic, however individuals differ in their usage of humour as a 'coping mechanism' (Graham, Papa, & Brooks, 1992). The three most influential theories exploring humour are the superiority, incongruity, and relief/arousal or psychoanalytic theories. Although separate, La Fave, Haddad and Maesen (1976) suggest a combination of all three is possible, and in applying to this poetic representation it seems applicable.

The superiority theory suggests that people use humour to increase and fuel their feelings of superiority by laughing at others misfortune, mistakes, suffering, defects or failings, thus sourcing pleasure from viewing the other as inferior and the self as superior (Monro, 1988). Suzie sarcastically refers to 'other' new-mother-focused stereotypical worries – losing the baby weight, demonstrating that her worries about the traumatic medical events experienced are superior to other mothers' 'menial' worries. She also presents seemingly flippant responses to obstetric emergencies and traumas: *"Septic levels 300 and something",* placing herself in a position of superiority, and therefore power, over the events

of the birth trauma. Both of these usages of flippant comments create an 'I am better than' (other mothers and the trauma) narrative, which works to present Suzie as superior, strong and 'ok', therefore protecting the self and others from engaging more deeply with any feelings or emotions associated with the birth trauma.

The incongruity theory of humour suggests that humour arises due to the perception of an incongruity between humour and the topic of discussion, demonstrated by Suzie combining joking/laughter and trauma. For example, laughter at concerns over losing baby weight and the traumatic account of possible post-partum maternal death in the resolution. These incongruous statements create humour and therefore distract from the resolution (ending) which is the realisation that Suzie did indeed nearly die due to childbirth complications.

Thirdly relief/arousal or psychoanalytical theories of humour (Graham, Papa, & Brooks, 1992; Martin, 1998) focus on the unconscious drivers of humour use in releasing the repressed hostile or obscene impulses. Arising through Freudian psychoanalytical theory it is proposed humour is a coping mechanism allowing for the brief expression of unconscious (often aggressive or sexual) repressed impulses by the individual in a socially accepted form (Graham, Papa, & Brooks, 1992). Suzie's use of humour creates an altered, on the surface more light-hearted perspective of the consequences of the birth trauma, thus transforming a negative, abnormal situation into one, which on the surface seems to be positive, normalising the consequences back into the socially acceptable and comfortable post-natal topics of discussion such as losing 'baby weight' following childbirth. There are slips in this facade when Suzie's anger and distress appears in her reference to a nursing staff member as a 'bitch'.

Although the use of humour by Suzie feels slightly uncomfortable, and occasions distasteful and dismissive of the experiences of birth trauma, the additional demographic data

collected as part of this study indicates that she is a frontline emergency services professional. Experimental research has demonstrated the role of humour in reducing the possible negative responses to, and impact of, stressful life events and psychological distress (Fritz, Russe, & Dillion, 2017). The condensing of Suzie's interview into the poetic form emphasised the use of 'gallows humour', an ironic or satirical style of humour involving frightening, serious, painful, desperate situations and subjects (Watson, 2011). It is often associated with medical and emergency services personnel who use it as a coping mechanism during traumatic and/or stressful events (Christopher, 2015; Kuhlman, 1988; Maxwell, 2003; Orbrdlik, 1942; Watson, 2011).

In constructing the poem used as an example of the entirety of accounts, the presenting sarcasm and humour became interpreted as protective mechanisms. The account created a sense of shock, dismissal of suffering, and hesitancy in engaging in more empathetic reactions in the interviewer. It felt like a "fucked-up telling", which was utilized to maintain control, guard against intimacy with the interviewer, and an attempt to upset any social power or relational dynamics that were present. There were very few glimpses of Suzie's physical ("*I could feel them sewing me up"*) and emotional *("I just coped with it")* reactions, as the emergent poem describes the obstetric events and medical complications, again keeping the focus of the narrative clear and negates emotional connection.

The subjectivity of the traumatic birth narrative

Poetic representation of the birth experience of Lyndsay

'A non-event for everyone but me'

Started getting some pains, died off, started up again
- A non-event.
Woke with very painful contractions
- Out of the blue.
Delivery said "come in", 6 centimetres
- I remember that!

The only thing
that made me smile
throughout the whole thing.

Started pushing, everything ok, head out
- The big red button.
Everybody came in

My husband
pushed away
from me

Shaky. Didn't want to continue
- Obviously had to.

Everybody around my bed I didn't know
- Quite horrible.
I'm not brilliant with new people.
Let alone when you're in such,
In such a vulnerable position.

My husband
pushed away
from me

Upset me . . . still does.
Sorry.
He didn't cut the cord
Upset me more.

He's really good at
getting my mind off things
Having his hand
there for me
to hold
Getting me through it.
They

pushed
him
away

I couldn't get to him.

A couple of hours later it was all forgotten
Everybody was ok.
I mean, four and a half, nearly five months later
It's still getting to me.

I had nightmares
baby blues but a bit worse,
didn't want to think about it
I don't know if I would talk to anybody else
About the whole thing
Like I just have

I think it will help now.

Reflective commentary

Lyndsay's poem adheres to the standard narrative model (Farley & Widmann, 2001), however, she utilizes additional discursive tactics to set-up the context of the events: *"The only thing that made me smile throughout the whole thing."* The simple sentence creates a sense of foreboding of an account devoid of positive emotion; a frame of reference which resonates the awfulness of the experience throughout the remainder of the poem. In addition, drawing attention to a singular positive moment/emotion – one *"smile",* does more than just orientate the audience, it also challenges some of the current broad, societal level lay conceptualisations of childbirth, through the rejection of general social ideologies surrounding Western childbirth experiences as a time of joy and happiness.

The climactic section of this poetic representation focuses on the *"pushing away"* of the birthing partner, in Lyndsay's case – her husband, by professionals during labour. It is widely acknowledged and understood that 'birth partners' are to be encouraged and celebrated (NICE, 2007; The Royal College of Midwives 2012), and that support from birthing partners tends to increase coping and happiness during birth experiences (Hodnett,

Gates, Hofmeyr, Sokala, & Weston, 2011). Lyndsay highlights the pivotal role and valuable support that her husband could have offered her during birth:

"He's really good at

getting my mind off things

Having his hand

There for me

To hold

Getting me through it."

For Lyndsay it was the removal of access to, and support of, her birth partner which was the traumatic incident during her labour experience. She talks about being *"alone", "upset"* and in a *"vulnerable position",* emphasising feelings of disempowerment and distress, due the removal of her husband. The literature discusses the idea of the female body being vulnerable during birth (Chadwick & Foster, 2014), but for Lyndsay it was more than just her body, it was also a psychological and emotional vulnerability. Lyndsay conveys what mattered to her during the birth through repetition of phrases; *"my husband was pushed away from me"*, and *"they pushed him away"*. This repetition of the trauma event is a literary and communicative rhetorical device emphasises the event making it memorable. This drives home the importance to Lyndsay of narrating her subjective version of the causes and consequences of her traumatic birth experience, enabling her to re-claim some power and control over the re-telling, if not the actual event.

The construction of the poem highlights Lyndsay's use of relatively controlled language to describe experiences, eliciting the idea of her being a passive, powerless recipient of the birth experience with events being out of her control:

"Everybody came in

My husband

pushed away

from me"

This continues even when she describes the detrimental and long-lasting impact on her:

"I mean, four and a half, nearly five months later

It's still getting to me."

The submissive language *"obviously I had to"* used in describing her birth experience again demonstrates the absence of control and autonomy. The climax of the narrative/poem does not indicate that any consideration or appreciation was given to Lyndsay's perspective of the events, eliciting feelings of isolation, aloneness, and a dismissal of her needs and experiences. This is at odds with the prevailing service philosophy of women-centred maternity care in the U.K. (Deery & Kirkham, 2006), instead reflecting the concentration on medical and technocratic discourses prevalent in Western society.

Creating poetic representations of birth narratives involves the consideration of all data which was critical in this account. Lyndsay's birth questionnaire details a shoulder dystocia which provides an insight into 'missing' information in the birth narrative. Instead, the poem focuses almost entirely on her husband *"being pushed away"* and his absence. Shoulder dystocia is described as an unpreventable obstetric, an "obstetric nightmare" (Gherman, 2002), evoking 'terror' and 'fear' (Gherman et al., 2006). Thus, through Lyndsay's lack of acknowledgement of this obstetric trauma, she conveys her own subjective experience, rather than the usually dominant medical obstetric trauma.

Understated in form, language, pace and complexity this poetic representation subtly strips bare the experience of birth trauma. Lyndsay works to re-claim some of the power she lost during the event by ignoring, or pushing aside (akin to her husband being pushed away) all the 'other' often medically orientated or socially expected aspects of childbirth.

Concentrating entirely on her own subjective perception of events she causes the obstetric events to become invisible, silencing the perceptions of others, mimicking her own experiences during the traumatic childbirth.

Lyndsay gives a very specific performance during her narrative; a raw, authentic account based entirely on her own subjective recollection and perception of events. By doing this Lyndsay works to reclaim the power and autonomy which were absent during her birthing experiences, instead of surrendering to the obstetric, medical discourses and socially constructed ideologies surrounding childbirth.

The emotionality of the traumatic birth narrative

Poetic representation of the birth experience of Julie

'I had put myself somewhere I don't know where it was I went.'

But the point is, I don't remember much
sketchy as to what I actually remember, as to what actually happened.
Massively overdue I ignored the NHS
An extended latent phase
Three days on and off
I was already all over the place.
Labour did start
Called my private midwife
Didn't want to be examined found it very, very painful so I found that hard.
I remember the days and nights
came and went.
Pacing the floors, walks, hypno-birthing, TENS.
I got to seven centimetres
back to back
I laboured for hours and hours and hours
That didn't work.
My cervix was beginning to toughen
I was tired.
The pool, gas and air – brilliant.
Don't like being out of control but that took me to another place.
This gut feeling
Things weren't going to plan
The end was nowhere in sight
wasn't progressing.
I decided to give up.
Things weren't working
Called an ambulance, went in, c-section didn't want that cascade of intervention
Ready for surgery, seemed to take forever
couldn't understand why people were so relaxed?
I wanted to scream
get me in there - hurry up!
They went to
Remove him
covered from head to toe in meconium
No cry
very, very silent.
I was under a towel
hiding.
I knew
Things were not right
In my gut.
I was under a sheet.
I put myself
somewhere

I don't know where it was I went?
I just thought positive thoughts wished him well just had to trust him to be ok.
He wasn't breathing - Apgar score zero.
A very quick recovery
my worry
has he been starved of oxygen?
In a state of anxiety, thinking
They'll sort baby out
am I going to live?
I didn't have Freddie the first night
My partner disappeared
I was sitting for hours
waiting
for people to turn up
Listening
to others visitors
me on my own.
That was hard.
Abandoned
Very painful.
I used that time to recover.
He arrived at 3am
he was born to me
for the first time.
Acutely aware I had twenty-four hours to make up for,
to make up for him sitting in a box without that skin to skin,
I would not put him down, I didn't like people holding him.
It's completely altered my way to parent.
I feel like I am constantly playing catch up
for the potential damage
Robbed
Scarred.
A week in this blissful, sort of breastfeeding heaven
It was working, he was weighed lost a pound in weight.
A massive surge
So sick
Traumatized,
He'd been suffering even more,
a traumatic birth and
I was
Failing
To feed him.
Anxiety even to this day.
Distresses me greatly
to hear him cry.
I'm brain damaging him
I literally see
Synapses dying
In front of me.

Reflective Commentary

Harnessing Julie's varied discursive tactics and language forms allows a unique insight into the emotional experience of birth trauma. The poetic representation begins with talk about not remembering, conveying a vagueness of the event memory: *"I don't remember much"* and *"Sketchy"*. This pre-narrative of missing details or 'not remembering' contradicts Julie's provision of an often-intricate narrative, incorporating multi-dimensional information and reflection. This raises questions about the reasoning behind the declaration of 'not remembering'. It reveals an uncertainty and hesitancy in providing a unique, subjective birth story and the entailing emotional experiences, which may or may not go against what *"actually happened"*. This hesitancy and questioning of the value of her subjective experiences reflects the societal level conflictual discourses surrounding childbirth and childbirth knowledge, with lesser value placed on women's 'lived experience' in comparison to biomedical 'factual' accounts (what *"actually happen[s]")* of childbirth. The dominant and patriarchal biomedical ideology holds the greatest weight and power in society, with the excerpts demonstrating Julie's implicit awareness of these ideologies. In turn continuing the oppression and invisibility of gynocentric science and women's voices in favour of an androcentric model of knowledge and science (Hunter, 2006).

However, when describing the beginning of her birth experience and what she was expecting, she openly rejects the medicalisation of childbirth – *"I ignored the NHS"*, instead discussing 'choosing' and embracing the more 'natural birth' ideology – *"going for walks", "HypnoBirthing"*, and *"TENS"*. The poem highlights Julie sharing her prepared for and expected birth, and demonstrates a conflict between embracing and practicing a 'natural', women-focused birth, and the rejection of the medical model of childbirth, and the dominant, powerful risk-laden paradigm surrounding childbirth in Western cultures (Hunter, 2006).

The consideration of language in understanding the emotionality of birth trauma is important as Kitzinger (2012) suggests; "The language of birth is never value-free. It reveals how we think about birth. But more than this, it shapes the way we think about it, too. Language both mirrors and defines experience" (p.84). The poetic representation includes Julie's experience of labouring "*naturally",* she uses a variety of language to describe both her positive – *"brilliant", "took me to another place",* negative – *"all over the place", "hard",* and ambiguous – *"gut feeling",* emotional experiences. All these words/phrases are easily recognised and are part of everyday vocabularies and link to the 'Emotionology Principle' (Harre, 2009) – they have shared social and cultural meanings (Aranguren, 2016). Therefore, Julie's initial emotional experiences are easily literally and emotionally expressed and understood, allowing for the interactive process of communication to occur.

A transitional point in the poetic representation occurs after Julie re-engages with the biomedical model of childbirth by *"giving up"* her 'natural' home birth expectations. Providing a rationale for "*giving up*", for example *"My cervix was beginning to toughen, I was tired"* and "*The end was nowhere in sight, wasn't progressing"* alludes to a feeling of a maintenance of considered control over the situation, rather than - *"I decided to give up, things weren't working".* Furthermore, as she is transferred into hospital she seems to continue to maintain this control over the situation as she demonstrates a clear and direct continued rational reasoning and control over the birth despite the change in context and favoured birth ideology.

As the birth becomes imminent, the poem signifies a change in tone and how the emotional experiences are expressed and described by Julie. Due to its extraordinary nature the emotional experience of a traumatic childbirth is difficult to both explain and understand. Instead of using words literally, Julie creates a pictorial representation using imagistic language, combining her emotional recollections within the context of the event. Although in

isolation each phrase is ambiguous, within context it creates more than a cognitive response to the conveyed information – *"Things were not right in my gut. I was under a sheet."*

By drawing images with words, Julie satisfies the combined need to share and know. This creative communication style captures the depth of the emotional experience, something for which literal language seems unable to grasp. It is akin to the phrase 'I can only imagine', which is often used when a speaker is describing something exceptional. In this instance Julie has no other comparable, shared emotional experience, so instead of a literal description of the emotional experience, she has to draw on the human imagination to communicate, conjuring a pictorial representation of the traumatic experience as a communicative aid.

In the latter parts of the poetic representation the descriptions of Julie's birth trauma and post-partum experiences suggest a contradiction between what she expected or desired her birth to be like and her actual perception of the experience on reflection. A pre-supposed, itinerary of events is introduced in the initial section of the poetic representation, however these were not transacted during the birth. It is this transgression from the expected itinerary that seems to begin Julie's perception of her birth as traumatic. Following these initial traumas, Julie describes the impact on herself *"Robbed, Scarred",* this language entices emotions associated with loss (loss of her expected, desired birth experience), and of constant reminders of the traumatic birth (scars). Julie also talks about the possible physical and emotional harm to her infant as a result of the traumatic birth, which compounds and continues her own negative emotional experience, emphasising the lasting nature of the emotional impact of traumatic childbirth.

The '*loss*' or '*failure*' in '*achieving*' her ideal birth (a home water birth with private midwife), is an example of an internalised idealised birth, used as a demonstration of the 'type' of mother Julie wishes to become. Wolf (2007) describes these standards internalised by women, but created through historical, cultural and social discourses, as "total

motherhood", also known as "intensive mothering" (Hays, 2006) and "the new momism" (Douglas & Michaels, 2004, in Wolf, 2007). This concept places mothers in the position of experts who are expected to foresee and prevent anything which may negatively impact on their child/ren's development. When Julie is unable to 'achieve' what she understands to be the 'best' birth and infant feeding methods (natural birth and breastfed baby), she perceives herself to have 'failed'. Whereas some of us may suggest that the female body is often out of the women's control, there is the notion that women should exert control over their bodies, and that the female body during pregnancy and childbirth is within 'rationalist control' (Lupton, 1999). Julie attempts to maintain responsibility for, and control over, her body throughout birth, as this control dissipates, so does her control over her feelings and emotions.

The abrogation of her desired birth experience, not only impacted on Julie's perception of her birth experience as traumatic, but also on her perception of possible harm caused to her baby. She talks about a need to *"make up*" for her baby's early, post-partum experiences, such as being separated from his mother, and a lack of skin to skin contact:

> *"Acutely aware, I had twenty-four hours to make up for, to make up for him sitting in a box".*

Beck and Watson's (2008) qualitative study into the impact of birth trauma on breastfeeding acknowledges the concept of reparation by the mother to the baby following birth trauma, through the identified theme of "making up for an awful arrival: atonement to the baby." Initially this occurred for Julie, *"A week in this sort of breastfeeding heaven"*, suggesting a move away from the distress of the birth trauma to a concentration on an almost ethereal experience of breastfeeding. However, the subsequent realisation of the baby's weight loss created a secondary traumatising experience for Julie, reigniting and further compounding the initial birth trauma, *"a traumatic birth and I was failing to feed him"*. This

distressing experience of further post-partum traumatisation, associated with feeding practices, is documented in Beck and Watson's (2008) study with a theme called "dangerous mix: birth trauma and insufficient milk supply."

The ideas described above highlight the global 'bad/failing mother' discourse, which includes negative emotions of self-assessment, such as maternal guilt and shame. These emotions are often and almost universally associated with motherhood (Liss, Schiffin & Rizzo, 2013), regardless of the age of the child (Seagram & Daniluk, 2008). Initial feelings of guilt and shame during motherhood are most readily associated with feeding practices (Taylor & Wallace, 2011), but can also be attributed to the societal and cultural creation of an idealized 'natural' (intervention free) birth (Frost, Pope, Liebling & Murphy, 2006), amplifying the dichotomy between 'natural' and 'medicalised' childbirth (Brubaker & Dillaway, 2009). This suggests 'bad/failing motherhood' discourse begins even before the baby is born by creating the concept of an ideal way to birth and mother. This is reflected not only in the social constructions, but also in political and economic discourses.

Throughout, Julie subtly questions the value of her own 'lived experience' of childbirth trauma in a society in which medical knowledge and expertise dominate. The poetic representation is awash with contradictions and contentions which Julie grapples with before, during and after her birth experiences. This demonstrates the impact of the broad, over-arching discourses and ideologies on the emotional experience of the individual. One of the most emotionally captivating parts of the poetic representation is the demonstration of the guilt and shame that is part of motherhood. Whilst in everyday conversation this concept is addressed in a light-hearted and joking form, Julie exposes the under-lying negative impact these connotations can have from the moment a woman becomes a mother.

Conclusion

This poetic exploration explores a way of managing and extending qualitative analysis providing space for reflection, and feelings of completeness for the research process. Researching women's traumatic birth experiences incorporates the psychological and emotional experiences of hearing accounts which move beyond physical, medical trauma. In adopting a feminist perspective, the poetic representations focus on the mother's holistic reconstruction of individual traumatic childbirth experience – 'in the eye of the beholder' (Beck, 2004). Foregrounding the women's accounts evades medical discourses, and natural childbirth rhetoric. Moving away from the creation of an objective reality and universal experience in childbirth (Leap, 2009) it highlights and embraces the complexity and individuality of authentic, diverse accounts of birth trauma, placing the woman experiencing birth trauma in the position of 'expert'.

This chapter blurs traditional boundaries merging science and art in the form of the three poetic representations with subsequent reflection. The creation of poetic representations captures the accounts of birth trauma from those who experience it, using their own words. Going beyond more traditional forms of qualitative analysis it celebrates the individuality and diversity of traumatic birth experiences. Using poetic representations to represent the entire, subjective, emotional narratives allows researchers to feel as though justice has been done in empathetically understanding and conveying the traumatic birth stories imparted by women during this research. This portrays of lived experience, representing women's voices and the researcher's feelings. It offers a unique insight not only into the rich, subjective, emotional experiences of the traumatic birth experiences of three women, but also into the emotional decision-making processes which occur during the research process for the researcher.

The primary aim of the poetic representations was to replicate a version of emotional interaction between the data and the audience, similar to that experienced by the researcher during the interview process. Poetry facilitates 'empathetic entry' into the experiences of another, and through empathetic engagement with the data the audience create their own personal and unique emotional reactions. These experiences combined create a rich, in-depth knowledge of the 'lived experience' of traumatic childbirth.

The poetic representations provide alternative ways of knowing, including aesthetic knowing (Carper, 1978), demonstrating the parts of the whole without losing sight of the whole account. They also allow the audience to move beyond a theoretical understanding, towards an awareness and sensitivity to meanings within lived experiences (Ohlen, 2003). It is the concept of subjective lived experience which is highlighted, with the emphasis placed on the unique experiences of childbirth of each individual, and the knowledge there is to be gained through listening and learning from those who directly experience a traumatic childbirth.

CHAPTER TWELVE

OVERALL DISCUSSION AND CONCLUSION

This thesis has critically examined the multiple perspectives and conceptual discourses involved in childbirth, and acknowledged and explored how these discourses are represented within women's framing of traumatic childbirth and more broadly perinatal mental health problems. Through a coherent journey from the biomedical perspective of childbirth and trauma, to the experience of women, both professionally and personally, this thesis allows for a shift in focus from the dominant medical perspective onto the individual and idiosyncratic experiences of women.

Discussion

This thesis has critically examined the multiple perspectives and conceptual discourses involved in childbirth, and acknowledged and explored how these discourses are represented within women's framing of traumatic childbirth and more broadly perinatal mental health problems. Through a coherent journey from the biomedical perspective of childbirth and trauma, to the experience of women, both personally and professionally, this thesis allows a shift in focus from the dominant medical perspective onto the individual and idiosyncratic experiences of women.

The primary aim of this thesis was to enable the voices of women who experience traumatic childbirth, either personally or in a professional capacity, to be heard in both medical and academic arenas. Taking a softer feminist perspective to provide an open dialogue with all to explore the findings in a way which may be able to support and address the needs of individual women. The poetic representations provide a creative methodology for enabling this to happen. These are poetic representations are believed to be the first disseminations of traumatic childbirth narratives in this unique form. They were created in response to my reflections during the research process. This harnessing and use of the researcher's emotional reactions demonstrates the requirement and benefits of reflection

during qualitative research. It also draws attention to often unconsidered actors in the research process – the audience, and the type of knowledge being presented. Indeed, through reflection I felt as though the narrative analysis, whilst informative and interesting, had diluted raw aspects of women's unique narratives. These aspects were the entirety and context of the account, the subjectivity, and the emotionality – the hearing of the individual voice and experience. In an attempt to capture these for the audience an alternative paradigm was needed for the dissemination of this research. Drawing on creative, arts-based methods the creation of found poems was decided upon, thus also allowing for a move beyond traditional understandings.

The poetic representations provide 'empathic entry' into the lived experiences of traumatic childbirth experiences creating a unique form of evidence which promotes emotional understanding and knowledge. This thesis has explored multiple discourses surrounding childbirth. Within these the validity and dominance of differing types of knowledge is implicitly explored, from the dominance of 'scientific', biomedical 'expert' knowledge occurring through the medicalisation of childbirth, to evidence and knowledge created through shared, social and cultural discourses surrounding childbirth. These universal, often competing demands have a unique impact on women's individual experiences of motherhood and childbirth by exerting control over, and often dismissing the personal, often private, emotional, subjective experiences of traumatic childbirth. The use of poetic representations in the dissemination of some of the data gathered as apart of this thesis provides an alternative paradigm of evidence on the promotion of emotional, tacit understanding and knowledge, through the 'empathetic entry' into the subjective, lived experience of traumatic childbirth. Thus, empowering and valuing women's experiences within research.

Poetic representations as a valid form of research dissemination.

Sanelowski and Leeman (2012) explore the usability of qualitative health research findings, proposing that although qualitative research is ‘integral to evidence-based practice’, currently the presentation of health-based research can cause difficulties in the translation into practice. Whilst there is agreement that more traditional forms of qualitative research reporting need to be actively disseminated through clear and usable presentations of findings, and that it is able to convey the emotional aspects of data, this should not be used to promote the dismissal, or invalidate the use of, arts-based research. Both forms of research finding dissemination can sit in harmony, meeting the homogeneous needs of research dissemination in distinct forms, and enabling the promotion and demonstration of alternative strands of interest, and types of knowledge.

Arguing strongly against some of the sweeping statements made in Sanelowski and Leeman’s paper (2012) this thesis demonstrates that arts-based research can be used by people who do not have an artistic or poetry-based background; they do not have to be poets or playwrights (the author of this thesis does not have an artistic background and the use of the method in teaching of midwives, outlined previously, further cements this). Indeed, the removal of such a requirement allows the focus to be more explicitly maintained on the data, rather than the creation of ‘stylistically correct’ poetry.

The lack of requirement of interpretation, and the concept that arts-based research conducted by artists has “no obligation to improve the public health and well-being” (Sanelowski and Leeman, 2012, p.1406) is actively defended in this thesis through the production of the narrative analysis and the reflective commentaries alongside the poetic representations. This again demonstrates that these methods are not singular, and instead can be used in conjunction to meet multiple requirements of both research integrity and dissemination. The main drive in constructing the poetic representations was to provide an

alternative form of knowledge to aid the dissemination of these research findings in order to actively promote audience reflection to improve health and well-being in practice. The application of arts-based research to traumatic childbirth is vital, these experiences are self-perceived, and without the entire, subjective and emotional evidence and knowledge, these experiences could be unrecognised both in research and in practice due the variability in the unique experience and the inability to construct a singular, objective definition of what constitutes a traumatic childbirth.

Indeed, the quotation from Sandelowski and Leeman (2012) provided below is limited, and does not embrace the movement forward in attempting to capture the emotionality and uniqueness within the broad understanding of human experience, which is the very basis of feminist qualitative health research.

> We do not address here non-traditional arts-based forms of dissemination such as poems, novels, short-stories, ethnographic and research-based theatre, and other modes of dramatizing or performing data (Keen & Todres, 2006. 2007). These modes of dissemination require an arts and humanities, as opposed to science, skill set and aesthetic sensibility. Few health-sciences journal venues will accept such alternative forms of presenting qualitative research (p.1405).

The use of creativity in teaching is limited in some of the more scientific disciplines, such as health sciences and psychology. The feedback from the presentation of the poetic representations has thus far demonstrated that they meet a need in research dissemination which cannot be fully met through more traditional methods, demonstrating the transformative potential of the poetic methods used here and thus dependability (Treharne & Riggs, 2014). The use of arts-based methods enhances alternative forms of knowledge and reflection, which are especially important in the medical and caring professions. With a growing interest in, and value of, the voice of the ‘expert by experience’, poetic

representations may be one way of bridging the gap between traditional research dissemination and the more informal 'giving of experience' by experts in certain experiences. However, the impact of this type of creative representation has not been fully explored. Future research could focus on evaluating the impact of this type of dissemination, exploring the impact, not only generally, but also for differing audiences, for example health care students. It could also explore the utility of using the methods described in this thesis for creating poetic representations for a variety of different topics and within teaching sessions. Reflective writing and active reflection on practice can be quite a passive process when people first start to engage with this type of learning, however the method is a focused and structured way of allowing students and potentially professionals to reflect on their shared, but idiosyncratic experiences.

'Giving' or 'facilitating' voice

There are some considerations for discussions when claiming to 'give voice' to, and re-represent emotional experiences through research dissemination. An aspect of the feminist perspective promotes the 'finding' of women's voices, and "empowering people to be heard who might otherwise stay silent" (Bogdan & Biklen, 1998, p.204), and this thesis promotes this consideration and representation of women's voices, and thus experiences in research and practice. However, does the taking of 'voices' and 'words', and my own re-representation of narratives as 'powerful' researcher, with unique access to literature and knowledge reinforce the oppression of women; by claiming to 'give voice' do I implicitly suggest that these voices are mine to give? These types of reflexive considerations and discussions occurred throughout the research process and continued into the writing of the thesis. Throughout, I acknowledge my own position and this highlights the transparent quality of the research processes and product thus establishing confirmability as detailed in

Treharne and Riggs (2014) table based on Guba and Lincoln's five quality concepts in qualitative research.

If I was wanting knowledge about a particular phenomenon, I would always rather seek this knowledge from someone with lived experience, perhaps this is intrinsic to my nature as a qualitative researcher, perhaps this is apparent across researchers. However, this is asking a lot from the person with lived experience, especially if the information needs to be disseminated to lots of people. It also assumes that women want to, and are able to, talk about their experiences in-depth, multiple times, and often in the presence of many people. Some people cannot, and some people do not want to do this, but they still want their experiences to be heard, understood and used to create knowledge and understanding. For those who do want to share their experiences, these poetic representations do not propose to represent just the women's experiences, they clearly incorporate my own judgments and perspectives into the poetic representations. They enable the essentially human emotional connections and empathetic entry into the lived experience of another to be provided within and outside the academic and professional arenas without the requirement of often intensive personal effort on behalf of the person with lived experience. I view myself as a researcher as a tool or bridge in taking the lived experience and transporting it into the academic arena in a novel and emotional captivating form, so rather than using the term 'giving voice', instead as Ashby (2011) does, the term 'facilitating voice' may be more appropriate.

By 'facilitating voices' of women we as qualitative researchers are able to explore both the individual and combined experience of women who have experienced a traumatic childbirth. This combined viewpoint, with idiosyncratic features, is explored throughout the narrative analysis by utilising van Gannep's (1960 [1909]) Rites of Passage theoretical framework in understanding women's traumatic childbirth narratives. As is demonstrated in the literature review chapters in this thesis the focus of the biomedical literature around birth

trauma tends to be on the childbirth event and the medical, objective and physical traumas occurring during this period. When exploring the psychological consequences of traumatic childbirth, this tends to examine the period of time occurring some weeks, or months after the traumatic event, as this is when PTSD following childbirth can be diagnosed using diagnostic manuals (DSM-5; APA, 2013). Alongside this, is the understanding that the most dominant discourses surrounding childbirth; the biomedical, cultural, social, and the psychological often universalise the transition in to motherhood, artificially dividing 'stages', often into quite lengthy periods of time (see chapter four for examples). This focus on the childbirth event, the psychological impact in the weeks after the event, and the broad, universalisation of processes occurring through this transitional and multidimensional life-event highlights the 'missing' pieces, which is the individual, idiosyncratic psychological experiences occurring in the immediate post-partum period, just after the physical birth of the baby. This narrative analysis explores this gap in our understanding of how women comprehend their traumatic childbirth, especially within this immediate post-partum period. It explores the early emergence in maternal identity with women working to amalgamate their previously formed fragile new identity as a mother created during pregnancy, and their experiences of traumatic childbirth.

Transition and trauma

Van Gennep's (1960 [1090]) 'Rites of Passgae' model is simple but explanatory and maps onto the transitional and developmental experience of pregnancy and childbirth coherently. It has been used by a number of researchers exploring childbirth as it draws attention to the social context, and provides a framework for understanding a range of childbirth and perinatal experiences (Cote-Arsenault, Brody & Dombeck, 2009). This analysis demonstrates that women in this study had 'normalised' expected and hoped for childbirth narratives created within the 'Rites of Separation' stage, and these represent the

beginnings of a fragile new maternal self-identity. The traumatic childbirth experience causes a fracture or disruption in the 'normal' expected childbirth narratives which are held in mind whilst pregnant. Focusing on the central stage of the framework; 'Rites of Transition', the analysis explores this biographical fracture and the period of acute liminality experienced by women during, and just after, their traumatic childbirth experience. Acute liminality allows for a conceptualisation of this voided, sacred period of time, which is characterised by feelings of disorder, and emotional disconnection with both the infant and their identity as a mother. This acute liminal period signifies a 'gap'/'space' between women physically birthing their babies; 'the creation of a mother', and the individual emotional and psychological recognition of themselves as a mother; 'entering motherhood'. Through multiple strategies mothers put substantial psychosocial effort into their maternal self-identity. The strategies constructed through analysis included: Re-storying; the acknowledgement and demonstration of positive aspects or consequences of the traumatic childbirth experience. Re-telling; engaging in multiple re-tellings of their experiences. Reincorporating rituals; an adherence to rituals expected during childbirth experiences in the Western world, even if these occurred later than they normally would. All these strategies allowed women to exert some control over their traumatic childbirth experiences, allowing for the creation of coherence, order and ownership, thus reducing the feelings of disorder, unpredictability and lack of emotional connection present during the acute liminal period. It is these experiences which present an embodiment of, and connection with, the traumatic childbirth experience and maternal self-identity, moving women from acute into sustained liminality.

Although this study provides a framework, drawn from the work of van Gennep (1960) and Turner (1960) on the Rites of Passage, this study does not impose stages which occur at the same time point for every woman, nor does it suggest that the transitional

experience is linear or uni-dimensional. Drawing on research into the scale or degree of experienced liminality (Thomassen, 2009), and the experiences of liminal periods during illness, this analysis demonstrates that women who experience a self-perceived traumatic childbirth are likely to experience a more profound and acute liminality, before moving into a stage of normative sustained liminality. It also presents the concept of strategies used by women to manage the biographical fractures created through trauma, not only demonstrating the impact of 'normative' or 'normal' childbirth discourses on women's hope and expectations, but also the increased psychosocial work required to integrate and incorporated non-normative or traumatic childbirth experiences into the maternal self-identity. Indeed, rituals around childbirth are perceived as uncommon (Cox, 2009), with a lack of research in this area. However, this study demonstrates rituals are discernible and play an important role in creating order and predictability (Parratt, 2008) in the transition to motherhood, and these are worthy of further research to explore the functionality of different rituals in the transition to motherhood.

This section of narrative analysis offers a way of thinking about individual experience, allowing a more flexible, accepting, holistic, and women-centred perspective of how women 'enter motherhood', and highlights a difference between the universally understood physical, medical and objective 'creation of a mother' and the subjective, individual, emotional and psychological acknowledgement of 'entering motherhood'.

Women in this study may or may not experience liminality in the same way as women without a traumatic childbirth experience. Firm conclusions cannot be drawn directly from the analysis in this study as there is no comparison group of women, which is not unusual for qualitative research. An interrogation of the broader literature suggests that exploring both normative and non-normative pregnancy and childbirth experiences as a liminal phase is valuable (Cote-Arsenault, Brody, & Dombeck, 2009). Generally, the exploration of

childbirth with the ‘Rites of Passage’ theoretical framework concurs with the findings of this study in that the ‘stages’ do not link directly to biological, physically defined stages of labour and is multidimensional (Cote-Arsenault, Brody, Dombeck, 2009). There are two potential differences between the liminal experience of women who have self-perceived traumatic childbirth experience in comparison to those who do not. These are the experience of acute liminality and a distinction between this and sustained liminality (Blow, Bird, Seymour & Cox, 2012). It may be that for women who experience a self-perceived traumatic childbirth the potential rituals surrounding childbirth in Western society become amplified in importance. This would also increase our interest in the cultural differences surrounding childbirth as a ‘Rite of Passage’ and in cultures which have more overt and recognised childbirth rituals (Mccallum & dos Reis, 2007) do these become utilised by women who experience a traumatic childbirth? Future research could provide a comparison group of women who do perceive their birth experience to have been traumatic. Using the same questions and processes of this research, focussed narrative analysis could explore whether acute liminality is also evident in this comparison group, or whether this is potentially a phenomenon only experienced by women with a self-perceived traumatic childbirth.

Traumatic childbirth can have multiple and pervasive emotional and psychological implications on women’s transition to motherhood. Understanding some of the strategies, such as re-storying and re-telling, used by mothers to integrate their childbirth experiences into their maternal self-identity is important. Healthcare professionals present during the post-partum and post-natal periods could assist women by continuing to listen to, and encourage mothers to talk about their traumatic childbirth experiences. Indeed the Health Visitor study specifies that this is a core skill and role which is within, and potentially pivotal to the remit of the Health Visitor. In exploring the immediate post-partum period healthcare professionals could help to facilitate the execution of rituals, such as skin to skin contact.

Acknowledging not only the physical and emotional benefits for mother and infant, but also the social and psychological need for rituals as a form of creating order and predictability, and assisting the transition into sustained liminality.

Current favoured and taught theoretical frameworks for understanding the transition to motherhood tend to universalise the experience into a staged and time-specified, process-like experience. These frameworks do not completely account for differences in experience in terms of perception of trauma, and they do not allow for the full exploration and understanding of the individual, subjective experience. However, with some adaptation, due to its simple, but explanatory power, van Gennep's (1960) 'Rites of Passage' general model of life transitions allows for further depth of understanding and flexibility in application.

In future research it would be interesting to examine the use of rituals during pregnancy, childbirth and the post-partum period in Western societies to explore how women feel about engaging in such rituals, and the functions of these both for individual women and for society. Some potential rituals, include; how women think about their placenta and what it represents, first photos and what they capture/mean, social displays through social media – announcing pregnancy and birth, bringing baby home are just some potentially ritualistic events in the post-partum period. Thinking about how these are managed when the birth experience is not as expected and includes trauma is especially relevant given the findings form this thesis about the importance of rituals for women with traumatic childbirth experiences.

Medicalisation and privilege

The narrative analysis also explored how women use interpretative repertoires, with a specific focus on how the 'cervix' is used by women within their traumatic childbirth narratives. As this concept, along with others, were developed through the analytical process supervisory sessions allowed other academic researchers (three supervisors) to explore and

'audit' the emerging data through presentation of data and the associated concepts the dependability of findings can be assured. Enabling research supervisors who were more distant from the data collection and analysis to assess how the concept was developed and reflect on the arguments proposed provides further reassurance of the dependable quality of the concepts.

There are multiple conceptualisations and discourses surrounding childbirth in Western society. This thesis explored how women integrate artificially created divisions between medical and social factors (Schmeid & Lupton, 2001; Oakley, 2016) in their public and personal representations of their childbirth experiences (Oakley, 2016). This is demonstrated by women's use of contextually bound, available interpretative discourses as narrative tools within their traumatic childbirth stories, creating a blurring of boundaries, with obstetric procedures and processes becoming integral and normalised aspects of the social discourses of the childbirth experience (Oakley, 2016).

Women utilised the discursive practice of using shared language and repertoires (Potter & Wetherall, 1987) to produce mutually understood narratives. With the dominance of the medicalisation of childbirth, women used associated interpretative repertoires to allow for their intimate and personal experiences to be recognised and understood within the broader, more universal medically-orientated public discourse. The combining of the idiosyncratic and the universal experiences of childbirth highlighted the dilemmas created through the conflictual and pervasive discourses surrounding childbirth, and how women manage these in their narratives.

During childbirth women experience cervical consciousness, and use the cervix as a discursive tool. Biomedical concepts and discourses have become embedded into the cultural construction of childbirth, and this is demonstrated through women's use of cervical dilation to create linear and coherent prose. The focus on the bodily change and progression during

childbirth is apparent as this use of cervical dilation replaces the usual and normative use of temporal time present in narratives of other phenomena. The cervical consciousness draws attention to the 'privileged' access to knowledge by health care professionals during childbirth as they are the ones who are able to access knowledge about the status of the cervix. The talk about cervical dilation indicates a reclaiming of medical knowledge and intimate understandings of the female body by women, in turn balancing the power differentials, thus questioning and proposing a need to promote a re-conceptualisation of the current view of healthcare professionals as 'experts' and women as passive recipients of care.

Cervical dilation during childbirth is generally presented as factual, biomedical knowledge (Howson ,1998; 2001), however this narrative analysis demonstrates the important personal and social meanings attached to medical, objective bodily functions and how this plays a complex part in women's appraisal of the childbirth experience. There are ideological dilemmas within the traumatic childbirth narratives and one of these is represented by women's talk about cervical dilation as they explore what their knowledge of their cervical status does *to* them, whilst also acknowledging what is does *for* them. Women outline multiple positive and negative implications due to their understanding of the medically prescribed processes which outline a 'normal' childbirth journey, for which cervical dilation is central. This in turn can impact on their perception of childbirth as traumatic.

The qualitative, psychological experiences of women during childbirth are important, and the recognition of these can impact on how childbirth expectations and experiences are managed during the perinatal period. As women become more able to access in-depth medical information and knowledge, their interest in and use of, associated interpretative repertoires is likely to increase. Health care professionals need to understand the importance of sharing their 'privileged' knowledge about cervical dilation with women, as this will help

to situate women as active participants (Coulter, 2011) in the childbirth experience. There also needs to be an additional acknowledgement that cervical dilation (although primarily used as an objective form of indicating progression during labour) is embedded into women's knowledge, understanding and appraisal of her progression during labour and can have multiple social and psychological implications. Practice guidelines should indicate that sharing knowledge about cervical dilation with women should be common practice, but that we need to fully understand how this appraised and used by women during childbirth.

Future research could further explore how women frame and understand other parts of their body during pregnancy and childbirth. The body during this unique time period is exposed to rapid physical changes. It is also viewed in a qualitatively different manner, with alternative personal and social meanings attached. Thus, how do women, and especially differing populations of women, with differing potential experiences, manage and understand these physical and conceptual changes to her body.

The professional perspective

This thesis took a triangulated approach with study one exploring how Health Visitors frame and understand perinatal mental health problems as professionals. This moves forward the literature into both Health Visiting as a profession, and how perinatal mental health is addressed in primary care. The identification of perinatal mental health problems by Health Visitors has been examined by Jomeen et al. (2013) and Noonan et al. (2017) in response to the widening remit of Health Visitors in identifying and understanding a range of perinatal mental health disorders.

Health Visitors in this study took what felt like a defensive position away from discussion around PTSD following childbirth instead broadening the topics to cover professional identity and types of knowledge in relation to perinatal mental health. This links

into the valuing of women's voices in research and the depth and richness of data and analysis created through a focus on what is important to the individual and in this case the profession. It also highlights the multiple demands placed on individual professions surrounding mental health and the personal and professional anxieties that this can create. In forming recommendations, we need to be mindful of what we are asking and how we implement support for professionals.

Throughout the thematic analysis the experiential knowledge or the Health Visitor 'sense' – a way of knowing which arises from intuitive abilities was highlighted. Health Visitors outlined experiential knowledge as key in recognising mental health needs, and autonomous practice. They felt that their experiential knowledge is core to what participants called 'professional artistry', a term used to create credibility for a central concept of Health Visitors' professional identity which cannot be mechanised. In addition, relational knowledge was outlined by participants as key in building relationships and rapport with families, in turn aiding the use of experiential knowledge and skills, and collaborative working with families.

These latter two types of knowledge; experiential and relational, are key components of Health Visitors' professional identity. During focus groups Health Visitors identified multiple barriers and limitations placed upon them constraining their abilities to transact their experiential and relational knowledge and skills in practice, which were similar to those found in previous research (Noonan et al., 2017). Although artificially separated through analysis, the boundaries between the different types of Health Visiting knowledge are blurred, and each type of knowledge is valuable, in practice they complement each other, and therefore all three are required for competent practice in relation to perinatal mental health problems.

Health Visiting as a profession sits in an area of confused or 'contested' (Cowley et al, 2015) practice and this is explored in the theme of 'Protecting an uncertain professional identity' in this thesis. However, Health Visitors present themselves as more holistic, flexible practitioners and the recognition of the differing types of knowledge held by health care professionals is pivotal when exploring traumatic childbirth from both the mother's and the Health Visitor's perspectives. Indeed, many of the women who took part in this research would not have been identified as having experienced a traumatic childbirth through quantitative measures and objective, medical viewpoints, and therefore have the potential to be excluded from any support available and reduces the validation of their experiences. They may however be identified and aided by the experiential and relational knowledge – Health Visitor's professional artistry in practice. The findings suggest that we should enhance and support Health Visitors professional artistry, allowing them to work autonomously and flexibly as they are perfectly positioned to listen to women who may perceive their childbirth experiences as traumatic. Health Visitors should be enabled to work in a trauma-informed, person-centred way, their strength lies in being able to combine the multiple discourses surrounding childbirth whilst maintaining a focus on the individual woman and her family in practice.

As previously mentioned, we cannot ignore the potential impact on the individual Health Visitor and profession in working in a more holistic way. Health Visitors regularly eluded to a lack of recognition of the time and space needed to transact their professional artistry in practice. The triangulation of the data from women who have experienced traumatic childbirths and Health Visitors unique positioning in recognising and supporting these women, further highlight that there is potentially an unmet need and/or unrecognised practices which have the potential to have a significant beneficial impact on women whose needs may not be identified through more formal, objective avenues.

In addition, Health Visitors spoke of their concerns around 'holding' women when they perceive this to be not in the best interests of the woman and her family. They talked at length about their anxieties about not being able to access timely and adequate mental health support for the families they care for. This generates the recommendation that there needs to be clear referral pathways to timely and adequate additional support for women who experience a traumatic childbirth and associated mental health difficulties. Working as a whole system with trusted assessments, trauma-informed, person-centred working practices would be of significant benefit for women who may struggle to manage their traumatic childbirth experiences. Alongside this, joined up and respectful working practices would help to reduce Health Visitors anxieties around exploring and identifying maternal mental illness in practice.

The triangulation of data from women who experience traumatic childbirth and health Visitors experiences of maternal mental health care add credibility to both the findings presented in this thesis, and also the recommendations which have arisen. Both the quantitative measures used during interviews and the emotional, subjective and context of traumatic childbirth experiences captured in the poetic representations and narrative analysis demonstrate that traumatic childbirth can have a significant psychological and social impact on women who may be classified a sub-threshold for a medical diagnosis of PTSD following childbirth. Health Visitors highlight their lack of technical knowledge of specific maternal mental health disorders, but counter this with an in-depth description and recognition of the value of their professional artistry, by moving away from the medical model we can create a credible positioning of unmet or unrecognised need and how this can be met or recognised by Health Visitors in practice.

There have been considerable developments in the provision of perinatal mental health services within the study locality since data collection. Exploring the impact of this on

Health Visitors' confidence in and perception of the adequacy of secondary mental health services would be beneficial. This leads to the novel and unique opportunity to explore how the introduction of more specialised perinatal mental health services impacts on Health Visitors' perception of their role in perinatal mental health care, and whether they feel they are still required to work outside of their self-perceived professional boundaries by 'holding' or 'carrying' families where mental ill health is a concern.

Authenticity – The use of poetic representations in health-based teaching

A key strength of the research presented in this thesis is authenticity (Treharne & Riggs, 2014). The poetic representations and the methods used in their creation have been presented at both birth trauma and qualitative methods conferences, the presentations have ignited conversations around the representation of those with lived experience at conferences and how the poems enable people to think about concepts from an alternative viewpoint. The use of poetic representations and the methods detailed in this thesis have the potential to transform how we as researchers facilitate the voices of those with lived experience, both within the medical arena and others. An interesting example of the transferability of the methods used in creating the poetic representations was the introduction of the poems and the method in a teaching-based scenario with first-year midwifery students. Although not a common occurrence, the use of arts-based interventions has been used in medical education previously, and a literature review of this has been published by Perry, Maffulli, Wilson and Morrissey (2011). The method designed for, and used in, this thesis was adapted for use in a teaching-based scenario. My aim for the session was to allow students to learn interactively about the construction of poetic representations, and also give them the opportunity to reflect on their own experiences of childbirth as a student midwife. In addition, two of the poetic representations were read to the students, and then they were asked for their reflections.

An interactive teaching session. I designed the teaching session to help student midwives to understand the method used to create poetic representations in this thesis and give them the opportunity to engage with this novel form of research dissemination. It also allowed the students some time for personal and group reflections of a pivotal experiences as a student midwife, exploring both the shared and individual nature of human experience.

I asked students to work in groups (depending on placement experience). They were asked to write, on a large sheet of paper, words or short phrases which captured aspects of their thoughts, feelings, emotions, and experiences about their first childbirth experience as a student midwife. For those who had not yet had this experience they were asked to think about the anticipation and expectations of knowing they were soon going to have this experience. Some of the groups were hesitant in the beginning, providing quite concrete, broad phrases and words, such as hospital and scrubs etc. With some encouragement to reflect on how they felt about the experience, they began to create subjective, contextual and emotion-based words and phrases. This prompted some unique time to share and reflect on their experiences in the first months of their degree.

Following the generation of 'data', the students were asked to use these words, to create found poetic representations of their group's experiences. Again, with some initial hesitation, the groups pieced together their words and phrases to create unique, emotionally salient reflective poetic representations of either waiting for, or experiencing, their first childbirth experience as a student midwife. One of the poems is provided below, the rest can be viewed in appendix M.

It was a bit of a blur,

I can't talk the language,

Everything was fine and then suddenly.

Your stomach drops out of you,

Useless, intrusive.

I was trying to disappear,

Out of my depth.

Miraculous, relief, reassured, new life.

Proud of myself and the woman,

Pure, joyous, girl-power!

The language barrier didn't matter,

Everyone was so happy,

Dad's trying to hold back the tears.

Honoured.

Each group read aloud their poems, allowing for some further reflection and sharing of experience between the cohort. It also provided me, as an 'outsider' of the midwifery profession to have some tacit understanding of the importance of the emotionally charged event of the 'first childbirth' experience for these midwives.

The method I used to create the found poetic representations of traumatic childbirth experiences was explained to the students, and some of the reasoning behind the creation of the poems, and then I read two of the poems created as part of this thesis. After both had been read aloud, the group and myself spent some time in reflective discussion about the poems, which was a valuable learning process, both for the students and myself.

It was a well-attended session, with all students taking an active role. Many of the groups seemed proud of their poems and discussed how they had provided them with some time to share and reflect on their experiences. In terms of the poetic representations of traumatic childbirth experiences, the students had varied responses, some talked about their

own birth experiences and those that they had witnessed, and some talked of feeling angry with one of the poems, others expressed sadness and concern, interestingly nearly all comments had an emotional element. They also discussed the emotional impact of the traumatic childbirth on the mother, and the individual differences between the poems, and how this might impact on their practice. All of these comments demonstrate the possible utility of using arts-based research in the education of health care professionals, as they provide a unique opportunity for emotional reflection and connection to the personal, uniqueness of trauma experiences during childbirth. The impact and effectiveness of the interactive teaching session or exposure to the poetic representations constructed for this thesis was not objectively evaluated, this is proposed as a need for examination in future research. However, some months after the teaching session, a student from the cohort emailed me asking to use one of the poetic representations in a reflective piece of work, writing:

> *"I think highly of your approach to your research and how you represented your data. In fact, it's one of the only pieces of research I've been able to remember since I started the degree, which speak volumes" (Personal Communication, 2019).*

The use of the poetic representations in teaching health care professionals provides an 'alternative voice' in healthcare and highlight the value and authenticity of personal, lived experience. It is the unique, subjective and emotionally-captivating form of the poetic representations which promotes and enables reflective reactions. This can help professionals to focus on the individual experience in clinical practice, which links in with the midwifery model of woman-centred care (Leap, 2009). They have the potential to create novel teaching-based sessions, with their holistic approach poems aid the construction of an empathy with experience and draw attention to the health service user perspective, thus impacting on health care professional attitudes and clinical practices. This is especially

important in traumatic childbirth practice and research dissemination, as often the event of childbirth is socially presented as a happy and joyous occasion (Winson, 2009), and as has been demonstrated throughout this thesis often women self-perceive their trauma, when objectively the birth is deemed as 'normal'.

Reflection on my positioning as a researcher

In parallel to the analytical findings and discussions presented in the body of this thesis, which emphasise the unique value of women's voices in exploring the individual experience within research. The adoption of the feminist perspective and the use of associated methodologies; thematic analysis, narrative analysis, and poetic representations as a form of novel dissemination, had progressive implications for myself as a researcher. The journey from a more structured traditional data analysis method, to a less formalised, but still traditional methodology, to a novel and unique dissemination of the data is a manifestation of my growth, development, and confidence as a researcher. It signifies an embracement of committing to a position as a qualitative researcher, in an environment which, at times, has been perceived as dismissive of this position as legitimate, valid, or desirable.

Conclusion

Childbirth and perinatal mental health, which includes PTSD following childbirth is dominated by the medical perspective. Traumatic childbirth is a qualitatively different phenomena, in that it has been conceptualised in multiple ways in differing domains, for example, medically objective, bodily trauma in obstetrics, and the identification of diagnostic criteria of PTSD following childbirth in determining and categorising the psychological impact under the umbrella of perinatal mental health. However, key to the conceptualisation of 'traumatic childbirth' is that it is self-perceived, and thus has unlimited definitions, which

are uniquely constructed by individuals. The dominance of the biomedical perspective, and the use of broad, universal, theoretical models within alternative perspectives, limits the recognition of the intricate and idiosyncratic experiences and understandings of traumatic childbirth as it over-shadows and curtails the exploration of individual experience.

The multiple perspectives surrounding childbirth are artificially divided, and previous research indicates that when exploring women's experiences of childbirth these perspectives become integrated (Schmeid & Lupton, 2001; Oakley, 2016). This thesis demonstrates that this integration and embedding of perspectives is evident in women's personal narratives of traumatic childbirth, and in professional Health Visitor's framing and understanding of their professional identity, in terms of their role in, and knowledge associated with, perinatal mental health.

Through the exploration of women's voices and experiences, and the acknowledgement of the complexity of the contextual interactions of multiple perspectives, this thesis raises questions about the definition, validity, and utility of the differing types of knowledge and evidence drawn upon in both research and practice into traumatic childbirth and perinatal mental health. There exists a juxtaposition between what one might expect from Health Visitors and mothers in how they frame and understand their experiences. Drawing a very basic summary and distinction, one might expect Health Visitors as health-care professionals, within the medical arena, to align themselves with the medical model. In comparison, one might expect mother's personal experiences to align with an alternative social and psychological position. However, this thesis indicates that women present a more blended, complex positioning in terms of their involvement in perinatal mental health and traumatic childbirth. Thus, highlighting a requirement for the recognition of the complex, experiential and context-based framings and understandings of Health Visitors and mothers in relation to traumatic childbirth and perinatal mental health. This is demonstrated through

the implicit and explicit investigations and demonstrations of knowledge and evidence by women in this thesis.

In brief, Health Visitors acknowledge their position as medical professionals within the dominant medical perspective, and implicitly indicate a requirement to align themselves to this model, through their anxieties about a lack of technical knowledge of PTSD following childbirth. They also draw upon the discourse of 'expertise' which prevails within the biomedical model, however they strongly demarcate themselves away from this 'expert' role in perinatal mental health care. In addition, Health Visitors also questioned the dominance of the biomedical perspective by outlining the validity and utility of alternative forms of knowledge (experiential and relational) when managing perinatal mental health difficulties in practice. Thus, the analysis exposes a move away from the dominant biomedical model, instead promoting a more holistic, 'alternative' conceptualisation of knowledge and evidence in Health Visitors framing and understanding of perinatal mental health.

When examining mothers' narratives of traumatic childbirth experiences, the juxtaposition between the professional and the personal framings and understandings becomes clear. Women interviewed as part of this thesis attempted to authenticate their private and personal experiences of traumatic childbirth by using language associated with the biomedical perspective. This alignment to, and embedding of, the dominant biomedical perspective into narratives allows personal, private experiences to be understood, and considered as valid and useful forms of knowledge and evidence. These strategies acknowledge the dominance of the biomedical perspective, but also highlight the move to unite the individual experiences of differing roles and experiences in traumatic childbirth and perinatal mental health. This will hopefully begin to decrease the power and dominance of the biomedical perspective, as the 'alternative' roles and forms of knowledge utilised by Health Visitors is validated and acknowledged. And as the recognition of women's

experiences as valid and useful forms of knowledge and evidence increases, the dominance of 'scientific', objective knowledge and the associated implications of power differentials, which have historical been present in research and practice will begin to become more balanced.

The embracement and definition of women's voices as valid and useful forms of knowledge and evidence is epitomized in the presentation of unique, poetic representations of mothers' individual childbirth narratives within this thesis. These poems allow for the consideration of the often silenced and discounted emotional element of traumatic childbirth and the unique knowledge that can be gained from the dissemination of research in this form.

This thesis has explored and demonstrated that tangible components of traumatic childbirth and perinatal mental health experiences dominate, often at the expense of more emotional elements and experiences. It does not propose a dismissal of alternative perspectives, instead it demonstrates the ability to execute, and the value of, this type of research, knowledge, and dissemination through the embodiment of more holistic, tacit understandings. Drawing on Riessman's (2002) definition of the utility of narratives; "narratives of illness can provide a corrective to biomedicine's objectification of the body, and instead, embody a human subject with agency and voice" (p.4). This thesis provides a corrective, through the demonstration that women's professional and personal voices in exploring experiences of traumatic childbirth and perinatal mental health are sources of valid and important knowledge and evidence which have utility across many domains. It proposes that each perspective or discourse should be held as commensurate, and the boundaries between them are artificially created. Thus, in furthering the research into understanding traumatic childbirth and perinatal mental health, all perspective should be valued and utilised, and the integration of these in both personal (Schmeid & Lupton, 2007; Oakley, 2016) and professional experiences should be acknowledged.

In summary, there is immense value and knowledge to be gained through facilitating the voices of women who experience traumatic childbirth either professionally or personally. Voices and experiences should be acknowledged of equal importance to other more traditional knowledge forms, both within and outside of academic arenas. We need to continue and enhance our abilities to listen and learn directly from those with lived experience, and importantly we must recognise and embrace this knowledge in order to make meaningful, sustained and positive changes.

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Appendices

Appendix A: Health Visitor Study: Invitation to participate in research

An invitation to take part in research

This is a letter to invite you, as a Health Visitor, to take part in some research being carried out by a doctoral student from the School of Psychology at the University of East Anglia. This study aims to explore health visitors' knowledge and understanding of postnatal maternal mental health. It is interested in the views of practising Health Visitors and trainee health visitors and therefore we are asking if you would be willing to take part in a focus group on the topic of postnatal maternal mental health. It is not important if you do not feel that this is your specific area of expertise, these focus groups are open to all Health Visitors and trainee Health Visitors in Norfolk, we would value and be grateful for the input from everybody.

Attached to this email is a document titled 'Information sheet' this will give you more detailed information about the study and what your participation would involve.

If you have any questions or would like to take part in the research please contact the Primary Investigator Miss Sophie Bagge: s.bagge@uea.ac.uk

Thank you for your time.
Kind Regards
Sophie Bagge

PGR Student
School of Psychology
University of East Anglia
Norwich

Appendix B: Health Visitor Study: Research information sheet

School of Psychology

Information Sheet

Health Visitors' knowledge and understanding of postnatal maternal mental health

Thank you for your interest in this study. Before you decide whether to take part, please read the following information carefully (this sheet is for you to keep). You may ask me any questions if you would like more information.

What is this research looking at?

This research study aims to explore health visitors' understanding and knowledge of postnatal maternal mental health. It will address where your knowledge in this area has come from, and how it informs your clinical practice. It will also examine your views on detection of postnatal mental illness and if you believe this could be improved. It is not a 'test' of your knowledge.

Do I have to take part?

It is up to you to decide to join the study. We will describe the study and go through this information sheet at the beginning of the focus group. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time either before or during the focus group, without giving a reason. Once the focus group has finished you will have twenty four hours to contact the researcher (using the contact details below) to withdraw your data. Due to the complex nature of focus group data if you were to withdraw part way through a group or after a group only your spoken words would be removed, if for example you asked a question and another participant responded, your spoken question would be removed but not the others' response to the question. Withdrawing at any point from the study would not affect you in any way.

What will happen if I agree to take part?

If you agree to take part in this research you will be asked to attend a focus group, which will be arranged at a time and location to suit the majority of participants. The focus group will last between 2 to 3 hours, with a break for refreshments in the middle. The group will consist of between 4 to 8 qualified or trainee health visitors, the primary researcher and a research assistant. All conversations that take place within the focus group will be audio-recorded, and then later transcribed. A research assistant will also take written notes on the content of the group discussions; this is purely to aid accurate transcription of the audio-recording. The time will be split into two hour-long sessions. The first will be a broad and exploratory examination of your thoughts about postnatal maternal mental health. The second session will focus on specific areas of perinatal experience and mental health. More details will be given on your arrival at the focus group. Discussions will take place in response to broad, open-ended questions given to you by the researcher. It may also be that you are asked to reflect on a short, written case study. It is important that you understand that this research is not intended as a test of your knowledge and understanding in this area, we are keen to know your thoughts and opinions. The information you provide is confidential within the group and the research team. Any details of professional experiences or clients will be kept confidential within the group setting and within the research team. Any details of cases given will also be kept confidential and be anonymised. All names of participants and identifying information will be anonymised at the point of transcription, and all audio-recordings and written notes will be securely destroyed after transcription.

Are there any problems with taking part?

The disadvantage for you as a participant is that this study needs you to give quite a large proportion of your working day for the research process; however, a break and refreshments will be provided within the three hours. Due to the nature of focus groups it will be necessary for mobile phones to be placed on silent, although we understand that emergencies happen and that it may be necessary for you to leave the session to answer a call.

Will it help me if I take part?

Although the study may not directly help you, it may raise areas of professional interest that you may wish to explore further at a later time. The dissemination of research findings may help to inform future training opportunities and practice, and will be beneficial for this programme of research.

How will you store the information that I give you?

All information which you provide during the study will be stored in accordance with the 1998 Data Protection Act and kept strictly confidential. The chief investigator will be the custodian of the anonymous research data. All data will be kept for 5 years, and will then be securely disposed of. Before transcription all audio-recordings will be kept either in a locked filing cabinet in a locked office or on a password protected computer. Any paper copies of consent forms involving participant details will be kept in a locked filing cabinet in a locked office, and will not be stored with the focus group data. Therefore nobody outside the research team and the focus group will be able to link what you say with your name.

How will the data be used?

The data from this study will be analysed and written up as part of a PhD thesis. It may be presented at conferences and in academic journals. A synopsis of research findings may be shared with the trust that you work for, however all data will be anonymised, and therefore individuals that take part will not be able to be identified. All data presented will be done so in its anonymised form, and so you will never be identified. We may use quotations from things you have said, but we will always use a pseudonym, and remove any identifying data.

What happens if I agree to take part, but change my mind later?

If you change your mind about taking part in a focus group please email the researcher to let her know. You will be free to leave the focus group at any time, if you leave you will have twenty-four hours to email the researcher and request that your data is removed from the study. Once the group has finished you will have twenty-four hours to email the researcher and request that your data is removed. However due to the complex nature of focus group data only the words you have spoken will be removed and any comments, questions and answers given by other

participants in response to something you may say will be retained for use in the study. This means that you can withdraw as participant at any point before or during the focus group, and you can withdraw anything you say during the focus group within twenty four hours of its completion by contacting the researcher via the contact details given below.

How do I know that this research is safe for me to take part in?

All research in the University is looked at by an independent group of people, called a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This research was approved by the Psychology Research Ethics Committee at the University of East Anglia on [date]. This research project has also been approved by NHS Research and Development ethics on {date}.

You are under no obligation to agree to take part in this research.

If you do agree you can **withdraw at any time without giving a reason.**

Contact details:

Primary Researcher: Miss Sophie R Bagge – s.bagge@uea.ac.uk

Supervisor: Dr Judi Walsh – judi.walsh@uea.ac.uk

School of Psychology

Lawrence Stenhouse Building

University of East Anglia

Norwich Research Park

Norwich

NR4 7TJ

Do also contact us if you have any worries or concerns about this research.

School of Psychology Ethics Committee:

ethics.psychology@uea.ac.uk; Phone 01603 597146

Head of School Professor Kenny Coventry:

k.coventry@uea.ac.uk; Phone 01603 597145

Appendix C: Health Visitor Study: Research consent form

School of Psychology

Consent Form

Health Visitors' knowledge and understanding of postnatal maternal mental health

Name of Researcher: Miss Sophie Bagge

Please initial all boxes

1. I have read and understand the information sheet 'Health Visitors' knowledge and understanding of postnatal maternal mental health' and have had the opportunity to questions and have had these answered satisfactorily. ☐

2. My participation is voluntary and I know that I am free to withdraw at any time, without giving any reason and without it affecting me at all ☐

3. I know that no personal information (such as my name) will be shared outside of the research team or published in the final report(s) from this research ☐

4. I agree to my input in the focus group being audio-recorded, and I understand that at the point of transcription my input will be anonymised using a pseudonym. ☐

5. I understand that a short synopsis of the research may be presented to the Trust that I work for, although this may include quotations they will be anonymous, and I will not be identified as a participant. ☐

6. I agree to take part in the above study ☐

Participant's signature…………………………………………….Date……………………….....

Appendix D: Health Visitor Study: Research Questionnaire

Health Visitors' knowledge and understanding of postnatal maternal mental health

The following are demographic questions, they are asking about you and your job role. They will be used to assess how diverse the sample is for the study in which you are taking part. All the information you give is confidential. If you do not wish to answer a question please just leave it blank and move onto the next one.

Thank you.

Please provide your name:

………………………………………………………………………………………………

What is your gender?

………………………………………………………………………………………………

What is your current job title?

………………………………………………………………………………………………

What is the location of your current job?

………………………………………………………………………………………………

Are you employed full time or part time?

………………………………………………………………………………………………

How many years have you been a health visitor?

………………………………………………………………………………………………

What was your previous nursing occupation (i.e. general nurse/mental health nurse etc)?

………………………………………………………………………………………………

Appendix E: Health Visitor Study: Reseach debrief sheet

Debrief

Health Visitors' knowledge and understanding of postnatal maternal mental health

Thank you for participating in this study. Your time and efforts are much appreciated.

The purpose of this study was to explore what health visitors understand by the term Post-Traumatic Stress Disorder following childbirth. Its first aim was to explore where your knowledge of this area of postnatal mental illness came from and any self-identified gaps in your knowledge. It also aimed to understand how this is reflected in your practice. The second aim of the study was to get your views as health visitors on the relationship between a woman's expectations of birth, her actual experiences during birth and Post-Traumatic Stress Disorder following childbirth.

There were no specific predictions for this study; it was intended as an exploratory research study.

The reason why we did not tell you that we were going to specifically discuss Post-Traumatic Stress Disorder following childbirth is that we wanted to get a true reflection of your current thoughts in this area, without the influence of any research into the topic you may have undertaken in preparation for the focus group. This was not intended as a test of your knowledge and we hope it did not feel this way. What we wanted was for your views as primary health care providers in the perinatal period to have a voice within the academic research in this area.

If you have any questions regarding this study please feel free to ask or contact the researcher or supervisor of this study now, or at a later date.

If this research has brought up issues that you would like to discuss about your own mental health, please see your GP in the first instance. If this research has brought up issues of a professional nature, please discuss with your line manager.

If you are interested in the topic and would like to do some further reading here are the details of an International network for perinatal PTSD research, and also some general academic research papers.

http://blogs.city.ac.uk/birthptsd/tag/childbirth/

Ayers, S. & Pickering, A. D. (2001). DO women get posttraumatic stress disorder as a result of childbirth? A prospective study of incidence. Birth, 28 (2), 111-118.

Beck, C. T. (2004). Post-traumatic stress disorder due to childbirth: The aftermath. Nursing Research, 53 (4), 216-224.

Czarnocka, J. & Slade, P. (2000). Prevalence and predictors of post-traumatic stress symptoms following childbirth. British Journal of Clinical Psychology, 39 (1), 35-51.

If you would like to receive a report of the main findings of the study (or a summary of the findings) when it is completed please contact the researcher, however individual feedback on your results cannot be given.

- Researcher: Miss Sophie R Bagge (s.bagge@uea.ac.uk)
- Supervisors: Dr Judi Walsh (judi.walsh@uea.ac.uk), Dr Laura Biggart (l.biggart@uea.ac.uk) and Dr Laura Jobson (l.jobson@uea.ac.uk).

Do also contact us if you have any worries or concerns about this research.

School of Psychology Ethics Committee:

ethics.psychology@uea.ac.uk; Phone 01603 597146

Head of School Professor Kenny Coventry:

k.coventry@uea.ac.uk; Phone 01603 597145

Thank you again for your participation.

Appendix F: Post-Natal Mothers' Study: Request to advertise the study

Letter of request to advertise

Dear Sir/madam,

I am writing to request permission to advertise a study I am currently carrying out on your webpage/face-book page (delete as appropriate). The study is part of my PhD studies at the University of East Anglia and aims to explore the expectations of childbirth, the experience of traumatic birth, and the subsequent impact of a traumatic childbirth. The information for this study will be collected via interviews with women who have experienced a traumatic birth. All participants who attend an interview will be given a £15 voucher for their time. I would be very grateful if you would allow me to periodically advertise my study on your web page/face-book page using the attached advertisement. If you are happy for this to happen please email me to confirm this in writing.

Thank you for considering my request.

Kind Regards

Miss Sophie Bagge
PGR Student
School of Psychology

Appendix G: Post-Natal Mothers' Study: Research participant information sheet

The influence of birth expectations on traumatic birth experiences and the consequences in the post-natal period.

Participant Information Sheet

Thank you for your interest in this study. Before you decide whether to take part, please read the following information carefully (this sheet is for you to keep). You may ask me any questions via email if you would like more information.

What is this research looking at?

This research aims to examine the experiences, thoughts and feelings of women who have experienced a traumatic childbirth. Specifically, it aims to explore what you expected and hoped for your birth during pregnancy, which aspects of your birth were traumatic, and if you think your childbirth experience has influenced your relationship with your baby and your own well-being. It also aims to explore what help and support you have accessed (if any) following your traumatic childbirth, and your thoughts about the support you received.

Do I have to take part?

It is up to you to decide to join the study. If you have any questions about the research and/or your participation please email the researcher using the contact details given at the end of this sheet. We will describe the study and go through this information sheet again before you complete any questionnaires or take part in the interview. If you agree to take part, we will organise a time and place convenient for you for the interview to take place. This may be in your own home, at the university, or in a place that is comfortable for you. At the beginning of the interview you will be asked to sign a consent form saying that you understand what is involved and that you have had the chance to ask any questions. You are free to withdraw (not take part) at any time before or during the interview, without giving a reason. Following the interview, you will have up to a week to withdraw your interview data from the study by contacting the researcher. This would not affect you in any way.

What will happen if I agree to take part?

If you agree to take part the interview will be set up at a time and place that is convenient for you. It is fine for your baby to be present for the interview and the interview can be stopped if you need to attend to your baby. At the beginning of the interview the researcher will go through this sheet with you to make sure you understand all the points. You will be asked to sign a consent form to confirm that you understand what is involved in taking part in the research, your rights as a research participant, and that you are willing to take part. Once this has been completed you will be asked to fill in a number of short paper questionnaires. There are no wrong or right answers to the questionnaires and if you do not want to answer any of the questions you can leave them blank. The interview will involve the researcher asking you some general questions about the expectations and hopes you had about childbirth during your pregnancy. It will also ask you to describe your childbirth experience, and whether and how (if at all) you feel this may have influenced your relationship with your baby and your well-being since your baby was born. The researcher will also ask you about what help and support (if any) you have had since the birth of your baby, and how you experienced this. The interview process will be audio-recorded using a Dictaphone. Following the interview, you will be asked to complete a few more paper questionnaires. The whole research process will take between one and two hours.

Are there any problems with taking part?

This research is examining an experience that you have had that was distressing at the time, and may still cause you some distress when thinking about it or talking about it. It is important that you consider the effect talking about your experiences may have on you. It is ok to get upset about experiences that we have found distressing and traumatic, however if you feel this would have a significant impact on your well-being following the interview think carefully about whether you want to take part in this study. If you decide to take part and then during the interview you become very upset, or you do not wish to continue, you are free to stop the process at any time. If the researcher is able to see that you are becoming distressed and/or upset she will periodically ask you if you wish to stop the interview. Also if the interview process early. Everyone will still receive vouchers, and everyone will be given a list of possible sources of support.

Will it help me if I take part?

Taking part in this research will not directly help you, it is not a counselling session, but a research interview. It will also provide women who have experienced a traumatic birth a 'voice' within research and hopefully benefit the knowledge in this area. You will be asked to complete some questionnaires once the interview has finished. These questionnaires measure symptoms of mental health difficulties, they do NOT diagnose mental health issues, they simply give an indication of whether you experience certain symptoms. If you feel that your mental health has been affected by your experience, please go to your GP or relevant health professional.

How will the interview be recorded?

The interview will be recorded using two Dictaphones which will be placed on a surface between the researcher and participant. They will be switched on as the interview starts and switched off as soon as the interview is finished. Although to begin with it can feel strange to know you are being recorded most people usually soon forget the Dictaphone is there and can talk normally. The spoken words that are recorded will then be transcribed (written), anonymised, and the recording securely disposed of.

How will I receive my vouchers?

As a thank you for taking part in the interview you will be given a £15 love to shop voucher by the researcher. start Even if you stop the interview, or do not wish to answer certain questions you will still receive your voucher.

How will you store the information that I give you?

All information which you provide during the study will be stored in accordance with the 1998 Data Protection Act and kept strictly confidential. The chief investigator will be the custodian of the anonymous research data. Any identifiable data will be stored separately in a password protected file and will be securely disposed within 5 years. All anonymized results will be stored indefinitely in order to comply with open practice standards. Any electronic data will be kept on a password protected computer. Paper information will be kept in a locked filing cabinet in a locked office. The transcripts of the interviews will be kept separately to any information that may identify you as a participant. Only the research team will have access to audio-recordings and identifiable information.

Although, as this information sheets states, the things that you discuss during the interview will remain confidential there are a number of situations that may occur that would need the researcher to break your confidentiality. Confidentiality would be

breached if at any time you indicated that you were at risk of harm to yourself or to somebody else. If this was to occur you would be told that your confidentiality would be breached, unless that by doing so would increase the risk of harm to yourself or another person.

How will the data be used?

The data from this study will be used in a PhD thesis and may be presented at conferences and written up in peer reviewed academic journals. However, the data is presented, it will always be provided in an anonymous form so you will not be able to be identified. Although direct quotations may be used these will be presented with a pseudonym (made up name) to protect your identity. All data collected through the questionnaires will be presented in its group form (this means that all responses would be grouped together, so we may write 'five women had an epidural, and two women used gas and air for pain relief', so you would not be identified).

What happens if I agree to take part, but change my mind later?

If you agree to take part in an interview and you change your mind before the interview happens, all you need to do is email the researcher and let her know you no longer want to be in the study. If you decide at the beginning or during the interview that you do not wish to continue you are free to stop and withdraw from the study at any point. Once the interview has taken part if you would like to withdraw what you have said during the interview you can do this up to one week after the interview has taken place. At no point will you be expected to give an explanation about why you have wanted to withdraw from the study and this will not affect you in any way.

How do I know that this research is safe for me to take part in?

All research in the University is looked at by an independent group of people, called a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This research was approved by the Psychology Research Ethics Committee at the University of East Anglia on 8th May 2014.

What to expect from the interview?

Due to the nature of this research we believe that it is very important that all participants understand what is going to happen during the interview and understand the topics to be discussed. If you do not wish to answer any questions you can just ask the researcher to move on to the next question. We are providing a statement of what is to be discussed so you are not worried about what we may ask, and so you are fully informed about the content and process of the interview.

During the interview we will ask you to think back to when you were pregnant and tell us about any expectations or hopes you had regarding labour. We will ask you to tell us about your labour experience, and the influence it may have had on you and your family. We will also ask you about any support that you have received since you traumatic experience and ask you how you feel about that support.

Although, as this information sheets states, the things that you discuss during the interview will remain confidential there are a number of situations that may occur that would need the researcher to break your confidentiality. Confidentiality would be breached if at any time you indicated that you were at risk of harm to yourself or to somebody else. The researcher would be duty bound to inform relevant professionals that you have indicated a risk of harm to yourself or another person. If this was to occur you would be told that your confidentiality would be breached, unless that by doing so would increase the risk of harm to yourself or another person.

1) You are under no obligation to agree to take part in this research.
2) If you do agree you can withdraw at any time without giving a reason.

Contact details:

Primary researcher: Miss Sophie Bagge s.bagge@uea.ac.uk

Supervisor: Dr Judi Walsh judi.walsh@uea.ac.uk

Do also contact us if you have any worries or concerns about this research.

School of Psychology Ethics Committee:

ethics.psychology@uea.ac.uk; Phone 01603 597146

Head of School Professor Kenny Coventry:

k.coventry@uea.ac.uk; Phone 01603 597145

Appendix H: Post-Natal Mothers' Study: Research consent form

The influence of birth expectations on traumatic birth experiences, and the consequences in the post-natal period.

Name of Researcher: Miss Sophie R Bagge

1) I have read and understood the information sheet 'The influence of birth expectations on traumatic birth experiences, and the consequences in the post-natal period', and have had the opportunity to ask questions and have had these answered satisfactorily.

☐

2) My participation is voluntary and I know that I am free to withdraw at any time during the interview, or within one week after the interview, without giving any reason and without it affecting me at all.

☐

3) I know that no personal information (such as my name) will be shared outside of the research team or published in the final report(s) from this research.

☐

4) I agree for the interview that I am about to take part in to be audio-recorded.

☐

5) I understand that the audio-recording will be securely disposed of once transcription has occurred. I understand that the transcript will not have any information in it that could identify me.

☐

6) I understand that if I say anything which indicates that I am at risk of harm to myself or others the researcher will be duty bound to inform the relevant professional. I will be told if this is going to happen unless telling me substantially increases the risk to myself or others.

☐

7) I agree to take part in the above study

Participant's signature…………………………………………… Date……………………

Researcher Contact details:

Primary researcher: Miss Sophie Bagge s.bagge@uea.ac.uk

Supervisor: Dr Judi Walsh judi.walsh@uea.ac.uk

Do also contact us if you have any worries or concerns about this research.

School of Psychology Ethics Committee:

ethics.psychology@uea.ac.uk; Phone 01603 597146

Head of School Professor Kenny Coventry:

k.coventry@uea.ac.uk; Phone 01603 597145

Appendix I: Post-Natal Mothers' Study: Research Questionnaire

The influence of birth expectations on traumatic birth experiences, and the consequences in the post-natal period.

Participant Number

Date and time of interview

Demographic Questionnaire

Section 1 – This section is about you. Please fill in the questions to the best of your ability if there are any questions that do not apply to you please write N/A. If there are any questions that you do not feel comfortable answering please leave them blank.

Please state your name

....

How old are you?

....

What is your ethnicity?

....

What is your postcode?

....

Do you have a partner, if yes, are they male or female?

....

How long have you been in your current relationship?

....

If you do have a partner do they live with you?

....

If you do have a partner, are you married, and if so how long have you been married?

....

Is the partner you have described above the father of your baby?

....

If you have a job, what is your job title (even if you are currently on maternity leave)?

....

What is your highest academic qualification?

....

How many children do you have?

....

What age are your children?

....

Have you ever had a mental health condition, if so were you diagnosed by a health professional, and what was the diagnosis?

………

Do you currently have a mental health condition? If so what is the diagnosis?

………

Do you have any physical disabilities, and if so what are these?

………

Section 2 – This section is about your baby. Please fill in the questions to the best of your ability if there are any questions that do not apply to you please write N/A. If there are any questions that you do not feel comfortable answering please leave them blank.

What sex is your baby?

………

What was your due date? (Estimated from your antenatal scans)

………

What is your baby's birth date?

………

How old is your baby?

………

How much did your baby weigh at birth?

………

Does your baby have any physical problems?

………

Did you breastfeed your baby, and if you did how long for?

………

Section 3 – This section is about your labour. Please fill in the questions to the best of your ability if there are any questions that do not apply to you please write N/A. If there are any questions that you do not feel comfortable answering please leave them blank.

At how many weeks gestation did you give birth?

………

How long did you stay in hospital (if you gave birth in hospital)?

………

Where did you give birth? (Please circle)

Home

Birthing centre/Midwifery-led birthing unit

Hospital delivery suite

Other, please give details.

....

....

What sort of delivery did you have? (Please circle all that apply)

Emergency caesarean

Planned caesarean

General anaesthetic

Spinal anaesthetic

Vaginal birth

Water birth

Induction by pessary

Induction using a drip

Artificial rupture of membranes (midwife/doctor broke your waters)

Spontaneous rupture of membranes (waters broke spontaneously)

Forceps delivery

Episiotomy

Ventouse (Kiwi/suction cup) delivery

Stiches to a perineal tear in theatre

Stitches to a perineal tear in the birthing room

Other, please give details.

....

....

What sort of pain relief did you have (even if you feel it did not work) during your labour? (Please circle all that apply).

Spinal anaesthetic (epidural)

Pethidine

Chloral hydrate (sleeping medicine)

Codeine

Paracetamol

Water

TENS machine

Reflexology/alternative medicines

Hypnobirthing

No pain relief

Other, please give details.

....

....

What monitoring did you have during your labour? (Please circle all that apply).

Sonic aid (hand held monitor of babies heart beat)
Constant CTG (monitoring via two straps around your tummy)
Intermittent CTG (occasional monitoring via two straps around your tummy)
Foetal scalp electrode (clip on baby's head)
No foetal monitoring
Other, please give details.

....

....

Did you have any complications during or just after labour? If so what were they? (Please circle all that apply).

Post-partum haemorrhage (substantial blood loss after birth)
Antenatal haemorrhage (substantial blood loss prior to birth)
Intra-partum haemorrhage (substantial blood loss during birth)
Placenta Previa (low lying placenta)
Placental abruption
Pre-eclampsia
Shoulder dystocia
Deceleration in baby's heart beat
Foetal distress/complications
Undiagnosed breech
Other, please give details.

....

....

Where there any complications with your baby during or following labour? (Please circle all that apply).

Bradycardia (deceleration in baby's heart beat lasting more than a minute and not returning to base line).
Resuscitation by a midwife
Resuscitation by the paediatric team.
Meconium in the water.
Low blood sugars.
Low cord gases.
Baby needed antibiotics.
Baby was admitted to NICU.
Congenital abnormalities.
Baby was premature.

Thank you for completing this questionnaire. Please return it to the researcher.

Appendix J: Post-Natal Mothers' Study: Research sources of support sheet

Sources of support

Sometimes people taking part in research projects are interested in finding out more information about dealing with emotional difficulties, either for themselves or their friends. Below are some sources of support if you are interested.

We have provided a list of possible sources of support which are available to you. In all instances you can always discuss any concerns you have about your birth, your mental health, your infant, your relationships with family members, and any additional support you may need with:

- **Your GP**
- **Your Health Visitor (If you do not know who your health visitor is contact your local Sure Start centre and they will be able to assist you).**
- **Your midwife (If your birth was very recent it may be that you still have a midwife).**
- **A counsellor.**
- **Your family and friends.**

Parenting Information and Support

There are various on-line sources of support and information on parenting, here are links to a few:

http://www.netmums.com/
http://www.netmums.com/coffeehouse/advice-support-40/mental-health-support-642/
http://familylives.org.uk/

Mental Health Information and Support

There are various on-line sources of support and information about mental health issues, here are links to a few of them:

General Mind website: http://www.mind.org.uk/
General Mind helpline: 03001233393 (open 9am to 6pm)
Information on postnatal depression:http://www.mind.org.uk/information-support/types-of-mental-health-problems/postnatal-depression/
Information on Post-Traumatic Stress Disorder (PTSD) :
http://www.mind.org.uk/information-support/types-of-mental-health-problems/post-traumatic-stress-disorder-(ptsd)/
Saneline: 08457678000 (open 6pm to 11pm)
Samaritans: 08457909090 (open 24 hours)

Traumatic Birth Experiences Information and Support

http://www.birthtraumaassociation.org.uk/
email: support@birthtraumaassociation.org.uk
post: The Birth Trauma Association
PO Box 671
Ipswich
IP1 9AT

Appendix K: Post-Natal Mothers' Study: Research debrief sheet

Debrief

The influence of birth expectations on traumatic birth experiences, and the consequences in the post-natal period

Thank you for participating in this study. Your time and efforts are much appreciated.

This study is interested in mothers' views of traumatic birth. The aim of this study was to examine how expectations and hopes for labour influence the actual experience of birth. It also aims to examine how a traumatic birth might influence mothers' well-being and relationships following birth, and the support that women access following a traumatic birth experience.

If you have any questions regarding this study please feel free to ask or contact the researcher or supervisor of this study now, or at a later date. If you wish to withdraw your data please contact the researcher within one week via email s.bagge@uea.ac.uk

If you would like to receive a report of the main findings of the study (or a summary of the findings) when it is completed please contact the researcher, however individual feedback on your contribution cannot be given.

Researcher: Miss Sophie Bagge (s.bagge@uea.ac.uk)
Supervisor: Dr. Judi Walsh (judi.walsh@uea.ac.uk)

Do also contact us if you have any worries or concerns about this research.
School of Psychology Ethics Committee:
ethics.psychology@uea.ac.uk; Phone 01603 597146
Head of School Professor Kenny Coventry:
k.coventry@uea.ac.uk; Phone 01603 597145

Thank you again for your participation.

Appendix L: Post-Natal Mothers' Study: Interview schedule information

- Introductions between researcher and participant.
- The information sheet will be re-issued and the researcher will talk the participant through the information sheet answering any questions the participant may have. The participant will be asked verbally if she is still willing to continue with the interview and if she is happy that she fully understands the study and the process of the interview.
- The researcher will then give the participant the consent form and ask them to read through each statement and initial in the boxes beside each statement. Again the researcher will answer any questions the participant has. The researcher will also verbally explain why and how confidentiality will be breeched if the participant gives any information regarding a risk to themselves or another person. Once the participant is confident they understand what they are consenting to, and the researcher is confident that the participant has the ability to give informed consent and has understood all the details of both the information sheet and the consent form, the participant will be asked to sign at the consent form and the researcher will counter-sign the form.
- The researcher will give the participant the demographic questionnaire to complete, again explaining that they are free to leave any questions that they do not want to answer. The participant will complete this without the involvement of the researcher.
- The interview will then begin (this is when the audio-recorder will be switched on). The following questions will be asked in order, and various prompts have been provided. However, as these interviews are semi-structured it may be that the wording of questions will change slightly, and that additional prompts may be given. However, the discussion will stay on the topic of each question. Throughout the interview the researcher will ask the participant if they are ok to continue, if the participant becomes upset or distressed at any point the researcher will ask if they are ok to continue, or if they wish to move onto a different question. The researcher will also use her professional judgement and if she feels like the topics being discussed she will bring the interview to a close early. The well-being of the participant will be the top priority of the interview process at all times.
- Question 1.

  I would like you to think back to when you were pregnant with your baby, and tell me what you expected your birth to be like?

  Prompts

  Did you have a birth plan? What did you imagine would happen during labour?

  How did you think you were going to feel during labour? What emotions did you think you would feel during labour?

  What were your expectations of pain?

  How did you imagine you would cope during your labour?

How did you think your partner would act/respond to labour? And how did you think he would support you? (Obviously omitted if the woman does not have a partner).
How did you think the professionals involved in your care during labour would behave, and support you?
Was there a difference between what you were hoping to happen during your labour and what you expected to happen during labour?

- Question 2.

I would now like you to think back to your actual labour experience, from beginning to end. I would like you to talk me through your birth, telling me about events that happened, the people who supported you and your feelings and emotions during that time. I would like to know about the bits that you found especially difficult, however if there are aspects of the labour that you find too difficult to discuss please say so and we can move on?
Prompts
How/when did your labour start?
When did you go to hospital?
Who was with you during labour?
Who did you feel was supporting you during labour?
How did you feel at the beginning/towards the end/when pushing/when you were taken to theatre etc. (this question will depend on mode of delivery and on interventions).

- Question 3.

Do you think your experiences during your labour have affected your relationship/bond with your baby?
How did you feel about your baby when he/she was first born?
How do you fell about your baby now?

- Question 4.

What affect do you think your labour experiences have had on you; emotionally, socially (relationships), adjustment to parenthood, physically?
Prompts

Do you think that you labour experiences have affected any of your relationships with close friends, family, partners, older children, the infant?

Do you think that your labour experiences have impacted on how you have adjusted to parenthood for this baby?

Has your labour experience affected you physically?

How has you labour experiences made you feel, straight after the birth up until now, and has there been changes in your feelings?

Do you think that your labour experiences have affected your mental health, i.e. made you feel depressed, anxious?

Have you had any emotional experiences since birth that you did not experience before your labour?

- Question 5.

If you have had any difficulties since your birth have you accessed or attempted to access any support (this could be from family/friends/professionals) how did you experience this?

Prompts

Have you talked to anybody about your birth experiences?

Have you needed support to deal with/understand your feelings surrounding the birth?

Have you talked to any professionals about your experience or your feelings and emotions since labour?

Tell me about your experiences of your midwife after your labour?

Tell me about your experience of your health visitor?

- Final Question

If you were advising another mother who had experienced a traumatic birth what advice would you give (in terms of how she may feel afterwards and what help and support she could access and how she might experience this support).

Is there anything else you would like to tell me about your experience of your labour and since then?

Do you have any questions for me or anything you would like to add?

- This will be the end of the interview and the audio-recording device will be turned off at this point.
- Participants will then be asked how they are feeling about the interview, and if they are feeling ok to continue with the final piece of the study. If they are then they will be given the questionnaire pack to complete.
- The participant will be asked to fill in the questionnaires, with the explanation that if there are any question they do not wish to answer then they can leave them blank and move on to the next one.
- The researcher will have a brief look through the questionnaires, and will think back to answers given in the interview. If the researcher feels that the participant has indicated either during the interview or in the questionnaires that they possibly have mental health difficulties the researcher will suggest to the participant that she contacts her GP or health visitor for more help and support. All participants will be given a de-brief form which will reiterate the study aims and provide various sources of support for traumatic birth experiences, mental health difficulties in general, and perinatal difficulties.
- The participant will be thanked for her time and given her vouchers for taking part in the study.

Appendix M: Midwifery teaching: Poems

Poem One

Birth hungry, I want that
Woman! I'm lucky to have a good
Mentor . . . But
Am I a nuisance?
I'm out of my depth, in the way,
Don't know what to say.
Adrenaline. What the hell is happening?
Eyes on the prize, I can't stop looking.
I'm scared to take a break, I might miss
It.
Amazed. Wow! Happy.
I want to cry, holding back the tears.
I'm lucky to have a good mentor.
Tea and toast?

Poem 2 - Fish out of water

A massive life changing event,
I want to play a part,
But I don't want to over-step the mark.
Worried I'll get too emotionally involved
In such a beautiful moment,
I'm ready to support
How can part of our training,
Be so amazing?
How will I compare?
In scenes of trauma,
So nervous,
Like a fish out of water.
Not everything is peachy
Mine was quite tense
Overwhelming, numb and full of suspense
Went from one thing to another
I froze. I was shocked, I didn't want to be
In the way
I was apart of this event.
My first birth was lovely. I couldn't have asked for anything better.
Emotional, privileged, I have actually
Just seen a little child being born.
The support of partners and family, makes
Your heart melt.
Clam, blessed, heart-warming
I could not stop smiling.
I'm an eager beaver to witness my first birth
I'm a keen bean to be part of a life changing
Event
However, I feel scared and under-prepared.
A little anxious, but I'm feeling ambitious.
Desperate to witness one like all the other ones.
I don't want to be in the way when she's feeling a bit dazed.
Overall, I think it is going to be a ball!

Poem three

We feel so ready, but are we ready?

The mothers go off to delivery and leave us behind.

When is it going to be our turn?

We are the wannabes; we missed all the opportunities.

Frustrated, curious, in anticipation of what's

On the other side

But when we finally make it. We have achieved

Our dream

We will feel proud, honoured, keen, overwhelmed

Of all we have seen.

Also aware of the privilege, the responsibility

Amazed and accomplished

Will we feel out of our depth? Sick? Nervous?

We will share a special moment

A milestone

When we win our ticket to the other side.

Poem four

It was a bit of a blur,

I can't talk the language,

Everything was fine and then suddenly.

Your stomach drops out of you,

Useless, intrusive.

I was trying to disappear,

Out of my depth.

Miraculous, relief, reassured, new life.

Proud of myself and the woman,

Pure, joyous, girl-power!

The language barrier didn't matter,

Everyone was so happy,

Dad's trying to hold back the tears.

Honoured.

Appendix N: Example table used for narrative analysis

Section	Abstract	Orientation	Central section theme	Self-positioning emotions	Language	Complicating action	Central narrative tone	Resolution
Lines 75-81	The start of labour/contractions – comparison to previous labour experiences = first experience of naturally occurring labour.	'I believe' – from what she remembers this is what she 'believes' happened, shaping the narrative very much as her own version of events (which others may disagree with?)	Her first experience of naturally occurring labour, comparison to other labours, but brushes it off as a 'non-event'. Initial natural niggles – important because of the difference between this and other experiences.	All very calm. Although this was a new to her experience she seems to take it in her stride by continuing with daily/every day tasks (making tea/collecting the children from school).	Although this was a novel experience for her she somewhat dismisses it as the contractions fade 'died off' 'non-event'.	Contractions 'die down' and become 'nothing' – false start?	Relaxed and clam, with a hint of disappointment (?)	Goes to bed – does not seem to give it any more thought (no anticipation/excitement).
Lines 81 - 98	From initial contractions to the imminent	The labour came on quickly which shocked her – all very quick	Conveying the absolute basics,	Seems quite light-hearted (seems like	1) Constant comparisons to her	Emergency buzzer is pressed once the baby's head is born	Reads like the events were almost part of an	Anticipation – no clue as to why the emergency buzzer had been pressed

	birth of the baby.	(somewhat accounts for the lack of detail and description – and the sudden jump from nothing to everything).	chronological (time situated0 account of the labour (and contractions).	a surface account) throughout – talks about positive experiences (although the mention of happiness seems bittersweet as she adds 'It was the only thing that made me smile throughout the whole thing'). No connection to her personal, individual emotions and feelings when the 'big red button' was pressed – combines everyone's	previous births ('very different to the girls' 'which was really different as well, because I had my waters broken with both the girls') – what function does this play for her? Keep reminding the reader that although she has experience two other	(shoulder dystocia).	everyday occurrence – no real changes in tone or pace.	and interestingly no real feel of emergency or panic from her or anyone else is described (says everyone was scared, but the feel of the narrative does not adhere to this).

				feelings (scared) – to hide her own?	labours this was complet ely new to her? 2) 'Then they decided to press the big red button; which scared the hhhheee the heebie jeebies out of everyon e' – comes complet ely out of the blue (like the beginnin g of labour) also very odd use			

					of informal, colloquial language to describe an exceptional event. Seems to almost make light of what was happening (a protective mechanism?)			
Extra 198 – 235 When asked more questions that are specific								

– talked about being in a panic – but finds it difficult to talk about what happened or how she felt.								
Lines 98 - 118	Baby's delivery, describes her husband being 'pushed' away from her.	Talks about not wanting to continue with the labour, feels like this also applies to her continuing with the narrative (very quickly ends her story) just as she details the trauma – both obstetric and her own perception of the traumatic incidents – 2 different events.	The distance between her and her husband in the critical minutes of the birth of the baby – her husband's lack of involvement with the final (but most critical)	Clearly distressed at the memory of her husband being pushed away and not being able to cut the cord – does not give much away in terms of verbalising her emotions	Very limited detail and description of events, feels like she is unable to verbalise what exactly happened and how it made her feel (still too painful/raw?) Talks about 'it' being 'traumatic', but two types of trauma here = obstetric = shoulder dystocia, and	The absence of her husband's presence/involvement in the final (critical) minutes of the birth. Lost and alone – without somebody to hold and certain her both physically and emotionally.	Continued and compounded distress – almost like a child which is lost/abandoned – guttural, primitive distress arising from a lack of physical and emotional holding/support.	Juxtaposition between 'Really upset me . . . and it still does now, sorry' and 'but you know a couple of hours later it was forgotten and everybody was ok' = brushing it off/creating a positive ending? (Does not feel like this). For everyone else it was forgotten and everyone else was ok (but she is still not ok – again isolation).

			aspect of the birth.	and feelings – talks about being upset, but her visual distress is more than just upset and this is five months after the event – feels very raw.	distance from husband = personal trauma.			
Extra 178 - 196	The pushing away of her husband. Talks about her relationship with her husband and the role he (should/usually) plays in supporting her.	Seems to struggle to explain why her husband's physical and emotional presence was so important to her – uncertainty/struggle.	The relationship (and attachment) between her and her husband offers both distraction and support (psychological and physical safety) at times of distress.	Seems almost destroyed (?)/distraught (still) at the thought of her husband's absence during the birth – talks about needing her husband to 'get me through it', she did physically 'get	Talk about the function of her husband's presence and support as pivotal in her 'managing' the distressing situation (relates it to other situations). Move from crying when she thinks about his absence to laughter when talk is about the positives of the relationship	Thinking about what her husband could have offered had he been able to be physically and emotionally close to her during the birth. Think about adult attachment relationship – lack of physical and emotional proximity to her attachment figure in a period of distress (attachment		Narrative is augmented by the audience to bring the topic to a positive conclusion – further demonstrates the intensity, pivotal nature, importance of this relationship. So by talking about the positives relationship she shares with her husband (thinking about him and the relationship positively) allows her to feel better

				through it', but psychologically it seems as though she has not yet 'got through it'.	between the two of them (felt security).	system activation) = distress due to separation = no felt security (psychological and physical safety) ("separation distress is a normative response to an impending loss of a major source of security" p.5 Shaver, Attach. Bonds in romantic relationships).		(calms/abates the attachment system activation) – allows her to feel more secure?

Reflections

The hardest interview in terms of the mother's emotional response. Although it was obstetrically a traumatic birth (shoulder dystocia) there is very little description/emotion attached to this aspect of the birth. Instead, for her it was about not having her husband within touching distance when she was distressed. Although again there is very little textual description of how this affected her, her obvious distress and seemingly inability to describe/put into words her experience is actually, at points, more powerful than those interviews that went at great lengths to explain. The lack of demonstration/sharing of her experience and her attempts to actively ignore/avoid talk about the birth further compounds the readers/audiences acknowledgement that this birth was hugely traumatic and distressing and still (nearly five months later) impacts on her emotional well-being.

Summary

- There is a huge lack of detail in this narrative – it makes it feel like we as the audience only get a glimpse at how awful the situation was for her and still is.
- Very rushed, quick narrative – almost as if she does not really want to do it (take part/talk) – later she talks about it probably being a positive experience.
- Talks about end goals – healthy baby, healthy mum – this is not the reality in traumatic birth – the outcome is often neither here nor there – THINK.