CHOICE IN CHILDBIRTH: PSYCHOLOGY, EXPERIENCES AND UNDERSTANDING

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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DEDICATION

This thesis is dedicated to my dad, David Toal
and my daughter Eve Jomeen

In Loving Memory

Abstract

Current policy (DoH 2004a), in response to critiques of the biomedical model of pregnancy, advocates choice and control for women within maternity care and promotes women as active childbirth consumers and decision-makers. This model equates choice to increased quality of experience, in the recognition that pregnancy and childbirth are both a physical and psychological experience. However to date the assumed psychological benefit of offering women choice remains unproven. The aim of this thesis is to explore women's psychology and experiences of pregnancy, and early motherhood, within the context of choice in contemporary maternity care. This will be achieved by assessing the impact of women's pregnancy and childbirth management choices on psychological well-being in the antenatal and postnatal periods and examining the ways in which women perceive and relate their experiences of pregnancy and childbirth and early motherhood in the context of their choice.

This thesis argues that understanding of women's maternity experiences necessitates a need to go beyond traditional accounts. Whilst it is important to assess how women respond emotionally to pregnancy, childbirth and new motherhood, there is further a need to comprehend the meanings and understandings that women attach to their maternity experience. Hence, in an attempt to address its own critique, this study adopts a mixed methodology design and uses both a prospective cohort research design and a narrative approach within a single study. In doing so, it addresses the conflict inherent in the use of traditionally opposing methodological stances and argues for a pragmatic approach which aims to understand women's psychology and experiences through a multi-dimensional and integrated frame.

Results revealed that no one care option revealed psychological benefit. The statistically significant differences observed occurred over time and exposed largely corresponding profiles across the groups. The mixed method approach promoted a powerful and illuminating interpretation of the concept of choice in maternity care. Women's narratives revealed the strong and powerful role that maternity influences and discourses play in constructing idealised identities, for women, across their maternity experience. These influences underpin and inform how women represent their psychological status and both facilitate and/or constrain maternity choices.

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Jomeen, J. (2004). The importance of assessing psychological status during pregnancy, childbirth and the postnatal period as a multidimensional construct: A literature review. *Clinical Effectiveness in Nursing, 8*, 143-155.

Jomeen, J., & Martin, C.R. (2005). Confirmation of an occluded anxiety component within the Edinburgh Postnatal Depression Scale (EPDS) during early pregnancy. *Journal of Reproductive and Infant Psychology, 23*(2), 143-154.

Jomeen, J., & Martin, C.R. (2005). The Factor Structure of the Cambridge Worry Scale in Early Pregnancy. *Journal of Prenatal and Perinatal Psychology and Health, 20*(1), 25-48.

Jomeen, J., & Martin, C.R. (2005). A psychometric evaluation of form C of the Multi-dimensional Health Locus of Control (MHLC-C) Scale during early pregnancy. Psychology, Health & Medicine, 10(2), 202-214.

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Jomeen, J., & Martin, C.R. (2006). Self-esteem and mental health during early pregnancy. *Clinical Effectiveness in Nursing, in press (corrected proof)*

Jomeen, J., & Martin, C.R. Assessment and relationship of sleep quality to depression in early pregnancy. *Journal of Reproductive and Infant Psychology, in press.*

ABBREVIATIONS

ANCOVA:	Analysis of Covariance
ANOVA	Analysis of Variance
ASDA	American Association of Sleep Disorders
BC	Birth Centre
BDI	Beck's Depression Inventory
CFA	Confirmatory Factor Analysis
CFSEI	Culture Free Self-Esteem Inventory
CI	Confidence Interval
CLC	Consultant Led Care
CV	Covariate
CWS	Cambridge Worry Scale
df	Degrees of Freedom
DoH	Department of Health
DV	Dependant Variable
EFA	Exploratory Factor Analysis
EPDS	Edinburgh Postnatal Depression Scale
GHQ	General Health Questionnaire
GLM	General Linear Model
GP	General Practitioner
HADS	Hospital Anxiety and Depression Scale
IV	Independent Variable
LOC	Locus of Control
LREC	Local Research Ethics Committee
MHLC	Multi-dimensional Health Locus of Control
MLC	Midwifery Led Care
NICE	National Institute of Clinical Excellence
NSF	National Service Framework
PEFA	Posteriori Exploratory Factor Analysis
PSQI	Pittsburgh Sleep Quality Index
SD	Standard Deviation
SE	Standard Error
SIGN	Scottish Intercollegiate Guidelines Network
SPSS	Statistical Package for the Social Sciences
UK	United Kingdom
WHO	World Health Organisation

Preface

The aim of this thesis is to explore women's psychology and experiences of pregnancy, and early motherhood, within the context of choice in contemporary maternity care.

Current policy (DoH 2004a) advocates choice and control for women within maternity care and promotes women as active childbirth consumers and decision-makers. This model equates choice to increased quality of experience, in the recognition that pregnancy and childbirth are both a physical and psychological experience. This is a response to the critique of the traditional biomedical model of pregnancy, which prioritises the physical aspects of pregnancy and advocates monitoring and surveillance to ensure fetal well-being. However, the concept of choice contained within such policies can be questioned. For example, the assumption of a sharp distinction between the physiological and the psychological is not so straightforward and the ongoing tension between these two stances may leave women caught in the middle as both consumers and recipients of care. Further, choice is a desire but also a rational act, intimate connections between reason and rationality require a weighing up of risks and benefits and an ordering of preferences based on their utility (Allingham 2002). Choice within such a frame would seem less straightforward than policy assumes. It appears to require women to balance their desire for a fulfilling birth experience with reasoned and rational decisions about their experience as a whole. Outcomes during pregnancy and birth are uncertain, so choice may not involve merely desire but also a gamble.

Policy makers in responding to public critiques of the biomedical model, have led us to believe that choice and control is always both desired and possible for women accessing maternity care (Hunt & Symonds 1995). However, as recently as 2003, a House of Commons Health Committee report on maternity services was still questioning maternity choice as '*an illusion*' and urging the Department of Health to ensure women received genuine and informed choice. Moreover, the improvement in psychological outcomes that might have been expected as a result of offering choices in maternity care, has failed to transpire (Renfrew, Green & Spiby 2003). Despite the official focus upon woman-centred childbirth and a move to encourage women to make decisions about their care in both physical and social terms, there remains a lack of substantive and consistent evidence with regard to expected psychological benefit or the 'reality of choice' for women making choices for the management of childbirth. Indeed, the model of choice presupposes that pregnant women are a homogeneous category, which remains ignorant of the multi-

dimensional nature of women's experiences of childbirth. Pregnant women's voices remain somewhat silent in the debates surrounding choice. To inform the discussions and practices about choice, exploration of their multi-dimensional 'reality' is therefore required.

Thus, that is one of the objectives of this study. It will investigate the impact of choice of care type on women's psychological outcomes, but also will consider how those dimensions of psychological well-being can be understood through and related to women's subjective maternity experiences. Motivated by previous work, which had considered women's psychological outcomes with regard to an alternative clinical management type, it seemed that there were psychological consequences in offering women alternatives to traditional management (Martin and Jomeen 2004). However, the lack of substantive evidence that choice in maternity care results in positive psychological outcomes clearly required a more lucid account. This failure to identify positive psychological outcomes with regard to maternity care choices could be a consequence of several factors. One possible explanation could be that psychological health, as assessed in maternity research, has traditionally been defined in narrow terms often focussing on only one or two psychological domains, such as anxiety and depression. A further possible reason is that it is a result of the established preoccupation, within maternity care, with postnatal depression often to the detriment of the consideration of psychological well-being in pregnancy. A more temporal consideration of psychological health as both multi-dimensional and inter-relational seemed warranted and is addressed by the research design in this study. Maternal psychological states, such as depression, do not exist in isolation but as part of a woman's overall 'biopsychosocial' experience. Hence, the interplay of other aspects such as worry, control, self-esteem, quality of life and sleep are equally relevant in assessing, understanding and representing women's psychology across their maternity experience.

The utility of psychometric measures is in their claim to successfully identify associations, trends and patterns of behaviour between and within groups. A perennial problem for psychology is that this can only take place, within the terms that the measures themselves lay down. In generating accounts of women's psychological health it must be acknowledged that they are also a cultural product. Therefore, in producing a theory of psychological health in pregnancy and childbirth, this research argues that, whilst assessing relevant psychological outcomes is undoubtedly of value and clinical significance, using a quantitative approach in isolation to study maternal psychological well-being is both inadequate and inappropriate.

Informed by feminist perspectives, an underpinning premise of this research was to acknowledge, utilise and counter the critique that using psychometric measures would continue to situate women's experience within the bio-medical cause and effect frame. Thus, it was incongruous to present a theory of the impact of choice of care on women's maternity experience based purely on constructed psychological concepts, which present a discourse through a predominantly male lens. In order to promote women's voice, another key principle of the research, understanding how they made sense of their experience was also crucial. Research contributing to the choice debate requires consideration of choice as an event in women's lives and not merely a concept. It should be explicitly expressed that this research recognises pregnancy and birth as surrounded by complex social processes. Developing an understanding of women's maternity experiences necessitates a need to go beyond the traditional biological, psychological and often superficial social accounts that characterise the maternity literature. It is important to assess how women respond emotionally to pregnancy and how policies such as choice impact on psychological health. However, there is a further need to comprehend the meanings and understanding that women attach to the emotional experiences of being pregnant, giving birth and adapting to life after the birth of their babies.

Having a baby does not exist in a biological vacuum, but within a social, historical and political context, which inevitably must shape and influence how women experience both the physical and psychological aspects of pregnancy and birth. The research discussed in this thesis is based on the belief that the social world in which the women are living, is powerfully constructed by human beliefs and attitudes about roles and identities, which in turn shape practices, behaviours and in the case of this particular research, choices and psychological health. Thus in the context of this study, women's realities are regarded as multi-dimensional. The social experiences of these women can be best understood through subjective interpretation and mental constructions; this is not to claim that their experiences or the psychological profiles they display through the more objective measures employed in this research are imaginary. However, the beliefs that underpin this research accord with those of Gatrell (2005), that there are multiple realities and that individuals understand their social constructed reality through lived experience and competing human perceptions of the truth (if such a thing exists), constructed out of what people recognise as facts.

Historically, healthcare research has been dominated by quantitative methods, which have aimed to make associations between interventions and clinical outcomes. Qualitative research, whilst an experiencing a growing profile within the discipline, has generally

continued to be afforded a lower status in the healthcare research hierarchy. The conflict between the two is inherent, firmly entrenched and extensively debated. This thesis acknowledges and critiques that debate and makes the case for a pragmatic methodological approach, which promotes a voice for women within the research. Hence, this thesis is a health sciences study utilising a mixed methodology design. To address the following research questions:

1. ***Does choice of maternity care impact on antenatal and postnatal psychological outcomes?***

2. ***What are women's subjective experiences of pregnancy, childbirth and early motherhood and the policy of choice within contemporary maternity care?***

3. ***How do the context of women's pregnancy, childbirth and early motherhood experience relate to the quantitative dimensions of psychological well-being?***

It is interdisciplinary on two levels. Firstly, in its application of both a quantative research design and a narrative approach within a single study and secondly, whilst not claiming to be a psychology or sociology PhD, in how it draws from the disciplines of psychology and sociology. In adopting this methodological approach it attempts to understand women's experiences through a multi-dimensional and integrated frame in order to address the above questions. It aims to accord women's social and psychological truths a voice, agency and respect and will demonstrate that women's maternity experiences, practices and choices are influenced by cultural and social discourses and practices, as well as wider society's and experts attitudes to their behaviour.

As already stated, this research is significantly influenced by feminist theory, but also theoretically driven by the literature on the psychology and sociology of childbirth, both the institution and ideologies of motherhood and the discourses surrounding maternity care. This thesis is presented in four sections. Section A consists of chapters one and two. Chapter one provides a comprehensive literature review on psychological domains relevant to maternity, the policy context of choice and an overview of the discourses surrounding pregnancy, birth and the postnatal period. This leads to a clear statement of the research questions to be addressed and the aims and objectives of the study. Chapter two offers the rationale and justification for the methodological approaches employed in

the study. It explores the theoretical debate surrounding methodological eclecticism and argues its own case for a pragmatic methodological approach and the use of conceptual triangulation. In addition it presents background to the study in terms of study site, care provision at that site, ethical issues and study design due to the relevance of these to both aspects of the study. Section B presents the quantitative phase of the study in chapters, three and four. Chapter three outlines the method employed and chapter four presents and summarises the impact of choice of care on the defined psychological outcomes. Section C presents the qualitative phase of the study in chapters five, six and seven. Chapter five presents the method and reflexively outlines the development of the analytical framework, for the qualitative data exploration and interpretation, which is unique to this study and based on a synthesis of narrative and semiotic (Greimas 1983; 1982) models. Chapters six and seven utilise the analytical model developed to explore the influences and discourses revealed in women's antenatal and postnatal narratives and the resultant multiple identities created for women, within the context of maternity choices. Section D is the concluding section of this thesis. Chapter eight offers a discussion that integrates both sets of findings, demonstrates their fusion and mutual value and considers the utility of its claims with reference to both psychological health and choice. Chapter nine offers some methodological thoughts and challenges, includes an acknowledgement of the limitations of the study and presents a reflexive account, in order to promote confidence in the conclusions drawn in the final chapter. Chapter ten summarises the overall conclusions of the study, with regard to choice, interwoven with some recommendations for maternity service delivery and practice as well as some future research recommendations.

Section A
Background

The following section provides the background for this thesis. Chapter 1 will present and justify the literature reviewed for the purposes of this thesis. That review then leads to a clear statement of the research aims, objectives and the research questions to be addressed. Chapter 2 proceeds to discuss the methodological stance taken in order to best address the research questions posed. It provides a rationale and creates a strong case for the use of a mixed methods based on a pragmatic approach, which aims to prioritise women's voices within the research. In doing so, however, it acknowledges, counters and critiques the debates around methodological eclecticism and complementarity. It considers the use of triangulation as a methodological strategy and presents and justifies the model of conceptual triangulation, which is used in the research described in this thesis. Lastly, background information pertinent to both aspects of the study will be discussed in a combined manner in this section to avoid repetition of information in later chapters.

Chapter 1: Literature Review

Introduction

This thesis, in essence, aims to explore women's psychology and experiences of pregnancy and early motherhood within the context of choice within contemporary maternity care.

This chapter begins by presenting evidence depicting the potential psychological challenge of pregnancy, childbirth and adaptation to motherhood. The major focus of the following literature review on the psychological aspects of pregnancy and childbirth is to enable and inform the first phase of the research study outlined in this thesis, which is quantitative in nature. The aim of this phase of the study is to assess the impact of choices for maternity care on psychological health outcomes across the maternity spectrum. Hence, it was necessary to ascertain the psychological domains pertinent to the study for several reasons. Firstly, to develop knowledge of the existing concepts of maternal psychological health within the academic literature. Secondly, to ensure that the research would be clinically relevant. Thirdly, to identify the measures associated with the relevant psychological domains and facilitate the development of a questionnaire booklet, as a quantitative research instrument.

Whilst the following chapter presents literature that concentrates on psychological domains relevant to pregnancy, because of the reasons stated above, it is also one of the aims of this thesis to understand and demonstrate psychological health as a multi-dimensional concept. Concordant with that belief the following chapter provides an overview of the political, social and cultural discourses in which women's maternity experiences occur. This represents the belief that such discourses are integral to a multi-dimensional perspective of women's psychology and maternity experience. Firstly, an overview of such literature provides contextual background with regard to the concept of choice, which underpins the study as a whole. Secondly it sets the scene for the second phase of this research. This phase is qualitative in nature and aims to explore the impact of choice on women as pregnancy and childbirth consumers, acknowledging women's psychological experience during this time as a subjective experience.

The chapter will conclude by presenting the aims and of objectives of the study, which will lead to a statement of the research questions addressed in this thesis.

Background

The belief that emotions, behaviour and the physical and social environment of the pregnant woman may influence the development of the fetus is widely held and cross cultural whether based on scientific fact or merely mythical (Paarlberg, Vingerhoets, Passchier et al. 1995). Within western societies the scientific and medicalised focus has been predominantly on factors from the physical environment that influence fetal development, such as smoking, drug and alcohol abuse and the avoidance of potentially harmful foods. Increasing attention in particular over the last decade has addressed the role of psychological stressors as determinants of obstetric problems (Crandon 1979; Lou, Hansen, Nordertoft et al. 1994; Nimby, Lundberg, Sveger et al. 1999; Chung, Lau, Yip et al. 2001; Weisberg & Paquette 2002), and more recently studies have addressed the long term impact of anxiety during pregnancy on children beyond childbirth and infancy (O'Connor, Heron Golding et al. 2002; Mulder, Robles de Medina, Huizink et al. 2001). These studies tend to consider the effects of stressors on the pregnant woman in relation to impact on the pregnancy, the developing fetus or the child. Outcome measures such as birth outcome, apgar scores (a global index of immediate neonatal well-being following birth) and physical and cognitive developments of the child are both routinely available and easily utilised. This has largely to date, however, failed to recognise the mother herself and the maternal effects of psychological stress are less frequently studied.

Pregnancy is acknowledged as a transition period in a woman's life, associated with heightened levels of emotion and anxiety and the rhetoric around maternity care now recognises and promotes the importance of psychological as well as physical well-being of mother and baby during pregnancy, labour and birth (Weaver 2000). It is acknowledged that care should play an integral part in enabling women to make the social and emotional adaptations necessary for successful postnatal functioning both as a woman and a mother (Weaver 2000). Other research literature reinforces the claim that events and experiences during pregnancy are significant in the emotional adjustment that women make to motherhood. Prenatal anxiety and depression have been identified and reaffirmed (Beck 1996; 2001) as two of the strongest predictors of postnatal depression. Psychosocial risk factors during the antenatal period may in addition herald adverse postnatal family outcomes (Wilson, Reid, Midmer et al. 1996). Studies have suggested that social support during pregnancy and post-partum (Okano, Nagata, Hasegawa et al. 1998; Holden 1996) may have a protective effect against postnatal depression. Effective antenatal support by health care professionals facilitates early contact with psychiatric services and reduction in severity of depression (Okano Nagata, Hasegawa et al. 1998). Other studies however have not been able to identify a significant reduction in postnatal depression following interventions

antenatally (Brugha, Wheatley, Taub et al. 2000). Hence, further investigation of the role of care givers in maintaining or improving women's psychological well-being in pregnancy appears warranted.

Despite the number of studies considering antenatal events and the relationship with outcomes and postnatal depression, psychological dimensions of care with regard to pregnancy itself are not well documented in the literature. A study undertaken by the author of this thesis (Martin and Jomeen 2004), indicated that offering women an alternative clinical management type can indeed impact on the psychological status of pregnant women, with some suggestion that this psychological change could be enduring. Little other empirical data supports the assumed link between maternity decisions and psychological outcomes. Maternity decisions can be complex, but there is insufficient research evidence to help understand the decision-making process. A limited number of non-UK studies have considered women's experiences of birthplace choice (Cunningham 2003; Schneider 2002) and perceptions of risk in childbirth (Gupton, Heaman & Cheung 2000) and some researchers have explored the demography of why women choose midwife-led or doctor-led deliveries (Coyle, Huack, Percival et al. 2001; Galotti, Pierce, Reimer et al. 2000). Several UK studies have considered maternal satisfaction with maternity care choices (Spurgeon, Hicks & Barwell 2001; Hundley, Penney, Fitzmaurice et al. 2002) and clinical outcomes (Petrou, Kupek, Vause et al. 2003; Hundley, Cruickshank, Lang et al. 1994). Other studies have considered women's views of care options (Lavender 2003; Walker 2000; Walker, Hall & Thomas 1995), the concept of real choice for home birth (Hagelskamp, Scammell, Gray et al. 2003) and issues of personal control (Green & Baston 2003; Green, Coupland & Kitzinger 1990). Whether choice and decision-making does impact on psychological health clearly merits further investigation. The paucity of evidence in this area may be a result of the lack of consideration and investigation of psychological well-being as an inter-relational, multidimensional concept, which this study aims to address.

Anxiety and Depression in Pregnancy

Depression during pregnancy has been relatively under represented in the literature compared with the attention paid to postnatal depression. Evidence however suggests that antenatal depression is a health problem as prevalent as postnatal depression (Rubertsson, Waldenstrom & Wickberg 2003), with clinical implications for the expectant mother and infant (Glover 1997, Molfese, Bricker, Manion et al. 1987). Studies have identified rates of antenatal depression to be at least as high as the rates of postnatal depression (Evans, Heron, Francomb et al. 2001; Green 1998; Green & Murray 1994). In addition it has been suggested that the severity and nature of depressed mood does not differ before and after childbirth

(Evans, Heron, Francomb et al. 2001). Animal experiments have convincingly demonstrated that prenatal maternal stress affects pregnancy outcome and results in early programming of brain functions resulting in life long effects (Weinstock 1997; Schneider & Coe 1993). Recent studies have found antenatal depression to be associated with deleterious effects on both the newborn infant and the developing child. A Finnish study following children of depressed mothers up to school age, found that maternal depressive symptomology at any time, but particularly antenatally was a risk factor for a child's well-being (Louma, Tamminen, Kaukonen et al. 2001). Retrospective studies have related childhood problems to psychological stress during pregnancy and discovered delayed motor development, cognitive and behavioural disorders. Huizink and colleagues performed assessment of maternal stress and anxiety during pregnancy and found them to be associated with low psychomotor scores and poor adaptation to the new environment (Huizink, Robles de Medina, Mulder et al. 2002; 2003). The strongest effect on infant development and behaviour were found for pregnancy specific anxieties. A study by Van den Bergh (1992) followed mothers and infants from pregnancy through to nine years and found more fetal and neonatal bodily activity in those babies of highly anxious women. These children continued to exhibit negative behavioural characteristics up to nine years. The Avon Longitudinal Study of Parents and Children (ALSPAC: O' Connor, Heron, Golding et al. 2002), suggests that antenatal stress and anxiety has a programming effect on the fetus that lasts until at least middle childhood, and may well persist into adulthood. They identified strong and statistically significant links between antenatal anxiety and children's behavioural and emotional problems. Associations were found for a range of disturbances in children and for both boys and girls. The effects were maintained when antenatal, obstetric and socio-demographic risks were controlled for together with a measure of anxiety and depression in the postnatal period. Further, the association of elevated levels of anxiety in late pregnancy and behavioural/emotional problems in both boys and girls persisted even when controlling for the effects of multiple postnatal reports of anxiety. The conclusion of this study being that antenatal prediction is not mediated by a link between antenatal or postnatal anxiety and depression but as in animal models is due to a direct causal mechanism (O'Connor, Heron, Golding et al. 2002). This concurs with earlier studies, which established postnatal depression as predicted by levels of anxiety and depression during pregnancy (Tamaki, Murata & Okano 1997; Bridge, Little, Hayworth et al. 1985).

A relationship between depression during pregnancy and adverse clinical outcomes in pregnancy have been demonstrated, depression during late pregnancy being associated with a significant increase in the use of epidural analgesia, caesarean section, instrumental deliveries and increased rates of admission for the neonate to intensive care (Chung, Yau,

Lip et al. 2001). In women expressing anxiety as measured by a self-report measure the incidence of obstetric complications was statistically significant when compared to those women not expressing anxiety (Crandon 1979). Subsequent studies have considered the effects of pregnancy specific anxieties on pregnancy outcomes and have linked an increased risk of spontaneous abortion to a recent life event (Neugebauer, Kline, Stein et al. 1996). Studies have also demonstrated associations between the developments of structural malformations of the fetus in the context of increased psychosocial problems (Nimby, Lundberg, Sveger et al. 1999). Depression and anxiety and some stress experienced in the first trimester have been associated with an increased risk of developing pre-eclampsia in later pregnancy and increased risk of preterm delivery has been linked consistently with stressful experiences during pregnancy (Paarlberg, Vingerhoets, Passchier et al. 1995). High levels of anxiety and depression have also been demonstrated to result in reduced birth weight and smaller head circumference, the effect of prenatal stress being of the same magnitude as the effect of smoking (Lou, Hansen, Nordentoft et al. 1994).

The experience of depression in the antenatal period is often associated with the symptoms of anxiety. The question whether anxiety and depressive orders are clearly separate entities continues to be a controversial issue (Gorman 1997). Clark and Watson (1991) introduced the idea that anxiety and depression each have distinct features but also share a common dimension, called general distress or negative affect. This co-morbid relationship between anxiety and depression in pregnant women has been demonstrated (Da Costa, Larouche, Drista et al. 2000; Demyttenaere, Lenaerts, Nijs et al. 1995).

The negative impact of depression during pregnancy on the long term mental health of the mother and the quality of the relationship between the mother and child can be profound and enduring (Stocky & Lynch 2000). Antenatal anxiety and depression have been identified as significant predictors of postnatal depression (Beck 2001), with other associations being demonstrated between prenatal depression and schizophrenia (Jones, Rantakallio, Hartikainen et al. 1998). The treatment of depression during pregnancy by pharmacological methods is contentious due to risks of teratogenic effects (Hostetter Stowe, Strader et al. 2000). A recent update from the Commission on Human Medicine (2005) recommended caution with use of the antidepressant drug Paroxetine (Seroxat), following the recommendations of two epidemiological studies that linked use of the drug in the first trimester to birth defects. Such recommendations would only seem to strengthen the case for alternative interventions. Accruing evidence suggests that early psychosocial interventions can significantly reduce levels of anxiety and depression during pregnancy (Bullock, Wells Duff et al. 1995). Unlike postnatal depression which has been the focus of a multitude of

research studies, especially with regard to cause and effect, the psychosocial factors associated with antenatal depression are less well studied, although the value of such studies is now acknowledged. Factors consistently associated with antenatal emotional disturbance include, lack of control over the environment, psychiatric history, inadequate social support, poor marital adjustment and stressful life events. Results regarding age, parity and socioeconomic variables have been inconsistent (Bernazzani, Saucier David et al. 1997). More recent findings suggest lack of support as the factor most strongly associated with antenatal depression, stressful life events within the last year, age and unwanted pregnancy were also significant risk factors for primiparous women, whilst single status was a risk factor for multiparous women (Rubertsson, Waldenstrom & Wickberg 2003). A study of depressed mood during the transition to parenthood cites the causes of depression to be complex and changing (Matthey, Barnett & Ungerer 2000); consequently women at risk are rarely recognised during pregnancy or at delivery (Nielson Forman, Videbech, et al. 2000). Antenatal depression affects not only the pregnant woman but may have consequences for the whole family, suggesting strong reasons for the identification of those women with increased anxiety and exhibiting early symptoms of depression. The separate examination of factors related to the postnatal onset of depression compared to postnatal depression with an antenatal onset also warrants further attention. The factors related to postnatal depressive symptomology which is a continuation of the antenatal state may be different from depressive symptomology that begins in the postnatal period. The nature of antenatal anxiety and depression needs to be considered in the context of optimal care options that facilitate identification and intervention for antenatal depression.

Worry in Pregnancy

The significance of anxiety in pregnancy has already been discussed, but literature over recent years has begun to distinguish the constructs of anxiety and worry. Following the identification of worry as an important diagnostic criterion for generalised anxiety disorder (Barlow 1988), it has been argued that certain aspects of worry are related to psychological health outcomes (Boehnke, Schwartz, Stromberg et al. 1998). Measures of worry in the general population have been reported, which measure either the degree of worry or the measurement of worries content (Tallis, Eynsenck & Matthews 1991). The literature with regard to worry in pregnancy is scant but it is now a construct recognised to be of importance for pregnant women, with worry being strongly correlated with trait anxiety (Statham, Green, & Kafetsios 1997).

With particular regard to worry in pregnancy, concerns frequently expressed by pregnant women are about the health of their baby, delivery and their own physical appearance

(Glazer 1980; Light & Fenster 1974). Studies have identified women's worries as u-shaped with a decrease in mid-pregnancy (Green, Kafetsios, Statham et al. 2003; Ohman, Grunewald & Waldenstrom 2003), consistent with the characteristic u-shaped curve for mood during pregnancy first described by Lubin, Gardner & Roth (1975).

New technologies in pregnancy aiming to detect fetal abnormalities in pregnancy may increasingly affect women's anxieties. Studies have shown an increase as well as a decrease in anxieties dependant on various factors such as point of time anxiety was measured, women's own estimate of fetal risk and the quality of the information (Green 1990a). A Swedish study considered the effect of screening by early ultrasound compared to routine screening on women's worries. Results concurred with other studies that major worries in pregnancy were about the baby's health, closely followed by worry about the approaching birth (Ohman, Grunewald & Waldenstrom 2003).

A range of experiential, attitudinal, personality and mood factors have been found to be related to baby worry (Statham, Green, & Kafetsios 1997). Further evidence suggests specific areas of pregnant women's concerns correlate with anxiety but still have unique predictive value (Glazer 1980) for psychological health outcomes. Recent evidence has also demonstrated discrimination between non-pathological worry and anxiety in the pregnant population (Stober & Muijs 2001); this would suggest that worry has a certain content and is worthy of an independent assessment in pregnant women, in order to ascertain its associations with clinical and psychological outcomes regardless of anxiety.

Postnatal Depression

Cultural images of the birth of a baby in western society present it as an event of joy and celebration amongst women and their families. Approximately 13% (O' Hara & Swain 1996) of all childbearing women will experience an episode of minor or major depression, termed as postnatal depression. The significance of depression at this time lies in the potential negative consequences on women and their families. Apart from inflicting distress on the mother, postnatal depression undermines the marital relationship, impairs emotional and cognitive development of the infant (Hay & Kumar 1995; Murray, Cooper & Stein 1991), particularly when associated with other risk factors such as poverty (Murray & Cooper 1997a) and may even lead to infanticide and maternal suicide. The Confidential Enquiry into Maternal Deaths 2000-2002 (Royal College of Obstetricians and Gynaecologists 2004) recorded deaths from psychiatric causes as the leading cause of maternal mortality overall, citing most as a result of suicide. Although it should be noted that a significant number of the deaths attributed to psychiatric causes were from self

administered recreational drugs and other physical causes attributable to psychiatric disorder, postnatal depression is now a recognised public health issue (Cox & Holden 2003). Postnatal depression is mediated through impaired maternal-infant interactions and negative perceptions of infant behaviour, rendering infants and children particularly vulnerable. In comparison with well mothers, mothers with post-partum depression report significantly higher rates of problems with infant feeding, crying and sleeping as well as relationship problems with their infant (Seeley, Murray & Cooper 1996). The cognitive, emotional, social and behavioural development of the child may be affected both in the short and long term (Murray & Cooper 1997b; Cooper & Murray 1997; Ballard, Davies, Cullen et al. 1994). Longer term negative influences of a mother's postnatal depression in the first year of life on infant's language skills, social and emotional development and intelligence quotients particularly in boys have been demonstrated (Scottish Intercollegiate Guidelines Network: SIGN 2002).

A small body of evidence points to an association between a mother's depression and the subsequent report of depression in her partner, with fathers more likely to suffer from depression and general health problems if their partners are diagnosed with postnatal depression (Ballard, Davies, Cullen et al. 1994). "*This is significant in the context of the detrimental effects of depressed partners may have on each other and the consequences for the infant*" (SIGN 2002 p.1)

Whilst the prevalence of postnatal depression does not differ from prevalence amongst women of childbearing age in the general population, the inception rate for depression does seem to be raised in the first three months post-partum; according to Cooper & Murray (1998) the risk is three-fold in those early months. Postnatal depression is not a specific discrete disorder, fundamentally different from depression occurring at other times and use of the term does not indicate that such depression always develops after delivery or is necessarily caused by the specific stress of childbirth (Cox & Holden 2003). Depressive symptomology, however, may be of greater severity than depression experienced at other times in women's lives, as a result of the psychological and social demands of infant care (O'Hara, Zekoski, Philipps et al. 1990). Furthermore if undetected or mismanaged, an episode of major postnatal depression may result in chronic or recurrent depression (Philips & O'Hara 1991). Women who have suffered postnatal depression are twice as likely to experience future episodes of depression over a five-year period (Cooper and Murray 1995). Left untreated one third and one tenth of mothers continue to be depressed by the end of the first and second postnatal years respectively (Oates 1995). This hidden maternal morbidity has well documented public health consequences. Moreover the socio-cultural connotations

which are normally associated with new motherhood render the symptoms of depression hardly recognisable to the new mother. Psychological state is rather interpreted in moral terms and so symptoms are minimised (Righetti-Veltema, Conne-Perreard, Bosquet et al. 1998).

There is little evidence to support a biological basis to postnatal depression. Postnatal depression sits within the spectrum of postnatal mood disorders, which range in severity from postnatal blues, a short-term episode characterised by tearfulness, sad mood and emotional lability, to postnatal psychosis. Psychosis, although affecting less than 1% of mothers (Evins & Theofrastous 1997), is an incapacitating disorder that usually requires hospitalisation (Gotlib, Whiffen, Wallace et al. 1991). Henshaw (2000) has confirmed the findings of an earlier study (Cooper & Murray 1995) that severe 'postnatal blues' are a powerful predictor of postnatal depression. However as Green (1998) suggests a woman in the postnatal period will experience a spectrum of emotions ranging from euphoria to misery, yet may not be clinically depressed and many women will recover from postnatal blues with no long term detriment to their psychological health.

Recent reviews of aetiological factors for postnatal depression stress the significance of complex interactions of social factors for example the quality of the marital relationship (Whiffen 1988; Kumar & Robson 1984; Cox, Connor & Kendall 1982) and social support (Lloyd & Hawe 2003; Gotlib, Whiffen, Wallace et al. 1991; Campbell & Cohn 1991). Individual factors such as personality type and cognitive style are also cited in the literature and some authors describe a state of psychological vulnerability (Kumar & Robson 1984; Watson, Elliott, Rugg et al. 1984). Depressed mood during pregnancy has also been linked in several studies to subsequent postnatal depression (Righetti-Veltema, Conne-Perreard, Bosquet et al. 1998; Tamaki, Murata & Okano 1997; Green 1990b; Cox. Connor & Kendall 1982), however a recent study by Evans, Heron, Francomb et al. (2001) found that depression scores were higher at 32 weeks of pregnancy than at 8 weeks postnatal. History of depression in a meta-analysis by Beck (1996) was found to have a small effect size when determining its relationship with postnatal depression. Generally research in this area fails to reach consensus. A more recent meta-analysis by Beck (2001) identified thirteen significant predictors of postnatal depression utilising a total sample of 84 studies. The results of this meta-analysis confirmed the results of Beck's (1996) findings, which identified nine predictors of postnatal depression and in addition revealed four new significant predictors including low self-esteem, single marital status, low socio-economic status and unplanned/unwanted pregnancy. The total of thirteen predictors is summarised in Table 1. This replicated meta-analysis also confirmed the findings of O'Hara & Swain (1996) who

reported the strongest predictors of postnatal depression were past history of psychopathology, psychiatric disturbance during pregnancy, poor marital relationship, low social support and stressful life events. The demographic variables of marital and socio-economic status may begin to tentatively sketch out a profile of vulnerable women at risk of postnatal depression. These women may experience a number of stressors related to their demographic status that are exacerbated after childbirth and are deleterious in their transition to motherhood.

Table 1: Postnatal Depression Risk Predictors (Source: Beck 2001)

Predictor of Postnatal Depression	**Effect Size**	**Number of Studies Included**	**(r =)**
Prenatal Depression	Medium	21	.44 to .45
Self-esteem	Medium	6	.45 to .47
Childcare Stress	Medium	7	.46
Prenatal Anxiety	Moderate	4	.41 to .45
Life Stress	Moderate	16	.38 to .40
Social Support	Moderate	27	.36 to .41
Marital Relationship	Moderate	14	.36 to .39
History of Depression	Moderate	11	.38 to .39
Infant Temperament	Moderate	10	.33 to .34
Maternity Blues	Moderate	5	.25 to .31
Marital Status	Small	3	.21 to .25
Socio-Economic Status	Small	8	.19 to .22
Unplanned/Unwanted Pregnancy	Small	6	.19 to .22

This meta-analysis permits the systematic synthesis and integration of results from multiple individual studies, which focus on the same research question. However it cannot help to understand the complex interrelationships between the predictors and their direct or indirect impact on the development of postnatal depression. The significant correlation of the variables with postnatal depression does not imply that they are causative factors, serving more as a checklist to identify those women at risk.

Screening for Postnatal Depression

The morbidity of clinical depression is often prolonged by delays in diagnosis, especially in the case of postnatal depression, where feelings of guilt or failure may be intense (SIGN 2002). In view of the consequences of postnatal depression, early detection, effective treatment and adequate management would seem imperative. Screening for postnatal depression by health visitors is now common practice within the United Kingdom and good evidence supports the use of screening in the postnatal period.

Screening to detect postnatal depression in the antenatal period has been based around the identification of known risk factors (Lopez-Nahas 2001). The Edinburgh Postnatal Depression Scale (EPDS) is the most commonly used screening tool and has been validated in several studies as a suitable screening instrument for antenatal depression as well as postnatal depression but not as an antenatal predictor of postnatal depression. Guidelines on antenatal care by the National Institute for Clinical Excellence (NICE 2003) suggest that there is no evidence to support routine screening in the antenatal period to accurately classify woman 'at risk' of developing postnatal depression. This is supported by a systematic review (Austin & Lumley 2003) which concluded that no screening instruments met the criteria for routine application in the antenatal period. Other factors linked with the development of postnatal depression have been cited as traumatic birth experience (Ayers & Pickering 2001), poor physical maternal health after birth (Brown & Lumley 2000), and obstetric complications (Sutter, Glatigny-Dallay, Minisini et al. 2002) although other studies did not find such associations (Forman, Videbech, Hedegaard et al. 2000; Warner, Appleby Whitton et al. 1996). Clearly antenatal screening cannot include intrapartum and postnatal findings and as such will always be limited.

Choice and Control in Pregnancy and Childbirth

The dominant medical philosophy of management of women in pregnancy is that pregnancy is a condition that can only be considered normal in retrospect and in labour is primarily focussed on the efficient and safe removal of the fetus from the mother (Rothman, 1996). Traditionally issues surrounding women's personal control and choice have, until recently, been viewed as of secondary concern. The labouring woman's perspective is often not acknowledged during childbirth by the clinical staff determining her care (Beaton, 1990). Improving the experience of childbirth for women was nationally prioritised by the previous Conservative government through the Changing Childbirth (DoH 1993) policy document, the central tenets of that document being choice, control and continuity. This rhetoric continues in the agenda of the current labour government. At the launch of the maternity

sub-committee final report into choice in maternity services, Julia Drown MP, chair of the sub-committee said:

> *"This report reflects our disappointment that extensive reforms to government policy on maternity services ten years ago, have not resulted in a greater degree of choice and control for women and their families"* (quoted in Bonar 2003 p4)

In September 2003 a national consultation launched by Sir Nigel Crisp, then Chief Executive of the Department of Health (DoH 2003), on the themes of choice, involvement and flexibility, identified maternity services as the focus of one of the consultation groups. The report of this group (House of Commons Health Committee on Maternity Services 2003), although suggesting that women reported an overall increase in the extent to which they feel involved in decision-making and in control of what staff were doing to them, concluded that the prevailing philosophy and underpinning assumptions of Changing Childbirth (DoH 1993) needed revisiting. The National Service Framework maternity standards (NSF:DoH 2004a) present a clear opportunity to recast maternity services to further increase control for women. Evidence seems to suggest that the constructs of choice and control are intimately connected for women with regard to pregnancy and their childbirth experience. The opportunity for greater choice over care allows more involvement with decision-making and impacts on a woman's feelings of control. In a study by Walker (2000) women choosing delivery in a midwife led unit formulated a very clear idea about the type of experience they wanted for the birth of their baby and loss of choice was found to be an important reason for feelings of loss of control. Green, Coupland & Kitzinger (1990) conducted a large study examining the psychological effects of childbirth on mothers and found that the perception of feeling in control was reliably and consistently related to positive psychological outcomes. Recent studies have concurred with these findings. Lavender, Walkinshaw and Walton (1999) revealed control to be amongst the themes contributing to women's views of a positive birth experience. A study by Schneider (2002) using a qualitative framework found that control emerged as an important issue even in the first trimester. Studies have identified that women seem to judge most situations by the degree of control they feel they can maintain (Davies-Floyd 1992). Maushart (1997) however, suggests that it is the illusion of control over their bodies that is important to women and Green & Baston (2003) propose that women are more concerned about negotiated levels of control and that any surrender of control is voluntary. Women themselves are not always clear what they mean by control, control can relate to many aspects of pregnancy such as behaviour, decisions related to her pregnancy, control during labour and delivery or control over the course and direction of her pregnancy. Women may demonstrate awareness of the changes that are happening in pregnancy, and feel conflict as a

result of the difference between their self-perception of being in control and discomfort as a result of those things 'just happening to their bodies' (Schneider 2002). This may leave women feeling loss of control reinforced by their inability to relieve the physical symptoms of pregnancy.

Personal perceived control has been found to be an important determinant of women's satisfaction with their birth experience (Slade, MacPherson, Hume et al. 1993). Personal control has been found to be dependant upon pregnant women having options that allowed choice, adequate information and involvement in the decision-making process. It is suggested that a midwife is the professional best placed to provide access to adequate information (Oakley 1993), and so women receiving midwifery led care might be expected to demonstrate greater levels of personal control. A study of women with negative memories of their first birth having a subsequent home birth, found that women felt able to exercise control over their subsequent deliveries due to the role of the caregiver, who enabled them to overcome personal characteristics including low self-esteem and obedience to authority (Milan 2003). Other studies conducted using qualitative research methodologies have also highlighted loss of personal autonomy and control as a key theme for women during labour and childbirth (DiMatteo, Khan & Berry 1993). Eakins (1986), focusing on women who conceptualised childbirth as non-medical, found that they rejected the institutionalised hospital system in favour of attaining personal control; participants in postnatal interviews, cited feeling in control as their most preferred aspect of the experience of labour and birth. Cunningham (1993) found women choosing birth centre and home births nominated the desire to have an active birth with control. In contrast to this a recent study by Martin and Jomeen (2004), when investigating home versus hospital management of women with a prelabour rupture of membranes, found women in the hospital group displayed higher internal locus of control (LOC) scores than those in the home group at the onset of labour or prior to induction of labour. This suggests that those women in the hospital group actually felt more in control of events governing their health at that time. An interpretation of these results may be afforded by the narratives of some women involved in the study, suggesting that the safety of their baby was paramount and although they expressed feelings of personal control of their pregnancy at that time, they were unable to know or control the status of their babies (Jomeen 2002). This adds to the argument that the conceptualisation of control in pregnancy and childbirth is more complex than some of the literature has previously assumed.

More recent studies have implicated the domain of personal control, in particular low levels of perceived personal control, as being related to experience of post-traumatic stress

symptoms following childbirth (Czarnocka and Slade, 2000). Indeed developing care interventions that enhance perception of control has been suggested as a possible intervention to reduce the possibility of post-traumatic stress symptoms post-partum (Czarnocka and Slade, 2000). Using a quantitative experimental paradigm, Scott-Palmer and Skevington (1981) found that women with an internal locus of control (LOC) orientation (women who felt more in control of events governing their health), had significantly shorter labours compared to women with an external LOC orientation (women who felt their health was governed either by chance or powerful others). Tinsley and colleagues (1993) found that perceptions of personal control were associated with compliance to pre-natal health regimes, which in turn were related strongly to actual birth outcomes. This suggests that control during pregnancy and birth has far reaching implications beyond those of satisfaction with care or experience.

The mother to be's perceived uniqueness of the experience of labour and childbirth has also been identified to influence LOC orientation. Lowe (2000) found that high levels of fear and apprehension regarding a forthcoming confinement were significantly associated with high levels of 'chance' and 'powerful others' health LOC. There thus appears to be accumulating compelling evidence that perceived control represents an important psychological construct interfacing with the psychobiological process of the woman's childbirth experience. It is apparent that the impact of care type may well have a direct and significant impact on women's feelings of personal control, which is then related to emotional disturbance throughout pregnancy (Bernazzani, Saucier, David et al. 1997) and following childbirth (Laizner and Jeans, 1990). Green & Baston (2003) support this assumption, demonstrating that control was related to how women perceived they were treated and consideration from caregivers was significantly and positively related to feelings of control.

It is now acknowledged that childbirth represents a major transition in a woman's life and serves as a 'rite of passage' into the social institution of motherhood. Birthing is both a physical and psychological challenge and the manner in which a woman experiences birth is likely to affect her adjustment to motherhood (Dimatteo & Khan 1997). Care options that attend to not just a pregnant woman's physical health but also to her psychological well-being by involving her in decision-making and negotiating control seem imperative. It remains unclear to what extent loss of control is linked with anxiety and the interaction between the two variables warrants further investigation, alongside an evaluation of options of care and their impact on feelings of control for pregnant women.

Quality of Life in Pregnancy

Recent studies have documented that physical functioning as measured by a standard quality of life measure decreases during normal pregnancy (Ochet, Carey & Adam 1999, Heuston & Kasik-Miller 1998). For example, more than 70 % of pregnant women experience nausea and vomiting and 28% report that symptoms cause them to change their usual activities (O'Brien & Naber 1992). In their study O'Brien & Naber (1992) found nausea and vomiting to have substantial lifestyle limitation on pregnant women, causing them to report changes in family, social and occupational functioning as a result. These findings have been confirmed by other studies (Attard, Kohli, Coleman et al 2002; O'Brien & Zhou 1995), however a Canadian study examining quality of life issues primarily with reference to nausea and vomiting in the antenatal period found women also identified several other areas of impairment. The identified areas included physical symptoms/aggravating factors; fatigue; emotions and limitations which are more related to general pregnancy than to nausea and vomiting specifically (Magee, Chandra, Mazzotta et al .2002). Clearly factors related to pregnancy that impact on daily life other than nausea and vomiting are important to pregnant women. Indeed, poor physical functioning has also been significantly associated with clinical outcomes. Women with reduced physical functioning in the third trimester of pregnancy had an increased risk of preterm labour (Haas, Meneses & McCormick 1999).

Kelly, Russo, & Katon (2001) found that physical symptoms are amplified in pregnancy by the existence of depression and anxiety. Indeed, studies in primary and secondary care settings have found that unexplained medical symptoms are associated with psychopathology (Simon, Von Korff, Piccinelli et al. 1999; Russo, Katon, Sullivan et al. 1994). Further, anxiety and depression amongst patients with a known medical disease are associated with an amplification of the disease specific and non-specific symptoms (Dwight, Kowdley, Russo et al. 2000).

Clearly physical symptoms are common in pregnancy and predominantly associated with the normal physiological changes that occur. However, the elevated incidence of somatic complaints may be more than just a normative response to pregnancy and rather be associated with psychological disturbance, seemingly warranting further investigation. Weisberg & Paquette (2002) comment that many of the physiological symptoms associated with pregnancy closely resemble anxiety symptoms and so may be construed as 'normal'. This may also be true in reverse, and the amplification of somatic symptoms may contribute to the existence of anxiety and depression. Any future assessment of quality of life in pregnancy should be complemented with measures of anxiety and depression, which exclude somatic symptoms, in order to establish whether the constructs of anxiety and depression

and quality of life are inter-related.

Abundant evidence demonstrates a strong association between depression and decrements in self-reported functional status or quality of life (Simon 2003) and also that effective treatment helped to restore function. Using data from the Medical Outcome Study (1992), studies reported that outpatients with depressive disorders experienced functional impairment and decreased well-being comparable to or greater than that of people with chronic medical conditions (Hays, Wells, Sherbourne et al. 1995; Wells, Stewart, Hays et al. 1989). Other trials have demonstrated that improving depression leads to significant improvements in quality of life (Coulehan, Schulberg, Block et al. 1997). Only a few studies to date have considered these relationships in pregnant and postnatal women. A study which considered the role of quality of life and its relation to postnatal depressive symptomology, found antenatal family quality of life, and postnatal family quality of life to be significant predictors along with other risk factors to postnatal depression (Martinez-Schallmoser 1992). An inverse relationship has also been demonstrated with elevated levels of depressive symptomatology strongly correlated with lowered health-related functioning and perceived well-being in pregnant women (McKee, Cunningham, Jankowski et al. 2001).

Women experience a broad spectrum of physical as well as emotional problems following childbirth; some of these are persistent and have an impact on the woman's quality of life. Quality of life in the postnatal period has recently become the focus of several studies. A study considering the degree of perineal trauma and its impact on the postnatal woman's daily life found that women with an episiotomy had a longer period of disruption to their daily life including sleeplessness, difficulty bathing and resuming normal daily activities (Okubo, Mitsuhashi & Saito 2000). Symon, MacDonald & Ruta (2002) found quality of life in the postnatal period to be a complex and personal area affected by many different aspects of health and well-being.

Pregnancy and childbirth are associated with intense physical changes and often a great deal of emotional upheaval, with the ability to perform usual roles affected (Attard, Kohli, Coleman et al. 2002). Even in an uneventful pregnancy women have subtle changes that may detract from their quality of life (Heuston & Kasik-Miller 1998). It seems apparent that quality of life may have a significant role to play in the psychological well-being of pregnant and postnatal women, with a possible suggestion that recognition and validation by caregivers of the need for pregnant women to make changes in lifestyle will contribute to improved quality of life and less risk of psychological sequale. However evidence regarding outcomes related to quality of life and maternity experience remains scant and merits further

investigation before any clear associations can be made between quality of life issues and pregnant and postnatal women's psychological well-being.

Self-Esteem and Pregnancy

Self-esteem is a key feature in a person's perception of their own self-worth. Low self-esteem is a vulnerability factor for depressive symptoms (Hall, Kotch, Browne et al. 1996). An inverse relationship between self-esteem and depressive symptoms has been demonstrated in a number of studies (Miller, Kreitman, Ingham et al. 1989; DeLongis, Folkman & Lazarus 1988; Ingham, Kreitman, Miller et al. 1987). Whilst findings from other studies suggest that self-esteem mediates the relationship between stress and depressive symptoms. In the presence of a life crisis, low self-esteem was associated with a twofold increase in the risk of depression among women over a one year period (Brown, Andrews, Harris et al. 1986).

Self-esteem remains a personal resource less well studied than others in the field of pregnancy. Kobasa (1987) argued that self-esteem may be a critical resource for women, because many life contexts challenge women's sense of self-evaluation. Higher self-esteem may directly limit depression by enhancing a positive sense of self throughout life circumstances. It might also buffer stress, in that those with high self-esteem are able to resist translating stress to negative self-evaluation because they can see beyond the particular circumstance being faced (Cohen & Edwards 1989). Based on research in the 1990's, self-esteem has emerged not only as a new, significant predictor of postnatal depression but as one of the strongest predictors.

Alfonzo & Arizmendi (1986) also found self-esteem to be negatively associated with depression during the postnatal period. A more recent study (Fontaine & Jones 1997) assessing the associations of both optimism and self-esteem with depressive symptoms in pregnancy, found self-esteem to be the only independent predictor of lower levels of depressive symptoms in the postnatal period. This suggests that self-esteem may be a contributing factor to susceptibility to depression both antenatally and postnatally. Mothers who have high self-esteem may well be able to withstand the stressors of early motherhood (McVeigh & Smith 2000) that may impact on this sense of self-worth and contribute to the incidence of postnatal depression. Sichel & Driscoll (1999 in Beck 2001) postulate in their model of women's mental health that the postnatal period

> *'is a fragile time for the self-esteem of the most ablest of women and is made much worse by the occurrence of depression'* (Beck 2001 p198).

A lack of intimacy, negative interactions and a lack of support in close relationships has also been shown to have an adverse effect on self-esteem (Miller Kreitman, Ingham et al. 1989). The potential interplay here is that lack of support is also identified as a predictor of antenatal and postnatal depression, as discussed earlier. Further studies have also identified the importance of support, support received and closeness to partner as significant predictors of self-esteem and subsequent postnatal depression (Logsdon & Usui 2001). Low self-esteem and lack of attendance at antenatal classes have also been correlated (Wilson, Reid, Midmer et al. 1996). The identification of low self-esteem may enable the development of individual support plans to enhance self-esteem and assist mothers in assuming baby care responsibilities, this may be able to be provided by the focus of the care received. An illustration of this is provided by Waldenstrom & Nilsson (1993) in a randomised trial comparing women's satisfaction with care in a hospital birth centre with standard obstetric care. Women in this study expressed raised self-esteem due to the antenatal care they received, alongside greater satisfaction with care. Further research considering care options for pregnant women and impact on psychological aspects of pregnancy and childbirth including self-esteem appears warranted.

Several studies have considered the associations between fear of childbirth and self-esteem. Fear of childbirth affects almost 20% of pregnant women (Saisto, Salmela-Aro, Nurmi et al. 2001) and may be manifested as nightmares, physical complaints and difficulties in performing daily tasks (Saisto & Halmesmaki 2003). Fear of childbirth is the reason for up to 22% of caesarean sections in Finland, Sweden and the United Kingdom (Saisto & Halmesmaki 2003). Studies results seem to concur that fear of childbirth is not an isolated problem but associated with a woman's personal characteristics including low self-esteem. This may lead to a catalogue of effects in that women with fear of childbirth are less likely to have a normal delivery, often requesting a caesarean section (Ryding 1993; Ryding 1991) and that in turn affects self-esteem following delivery and into the postnatal period. Indeed fear of childbirth has been linked to symptoms of traumatic stress (Soderquist, Wijma & Wijma 2002). A study by Fisher, Astbury & Smith (1997) found women who had spontaneous vaginal deliveries were most likely to experience a marked improvement in mood and an elevation in self-esteem in postnatal period. In contrast those women who had caesarean sections were significantly more likely to experience deterioration in mood and diminution in self-esteem. Research has indicated that women with low self-esteem had significantly higher odds of delivering a preterm baby (Jesse, Seaver & Wallace 2003), concurring with a study suggesting that women with stronger personal resources inclusive of self-esteem are more likely to deliver at term (Edwards, Cole, Oyemade et al. 1994). High self-esteem has also been associated with women having higher birth weight babies

(Killingsworth-Rini, Dunkel-Schetter, Wadwha et al. 1999), these women were also found to have lower stress, more likely to be married and have a higher income and education. Interplay of these factors may well act on self-esteem in the postnatal period and affect the transition to motherhood.

Studies have indicated that body image satisfaction is related to self-esteem in pregnancy with women who exercised responding more favourable to changes in their bodies (Boscaglia, Skouteris & Wertheim 2003) and display higher self-esteem and lower physical discomfort scores (Wallace, Boyer, Dan et al. 1986). The limitation of these studies is that the direction of the relationship is unclear; it may be because women have higher self-esteem that they exercise, rather than the exercise causing an increase in self-esteem. However in the general population body dissatisfaction has been found to exhibit a negative relationship to both self concept and self-esteem in women (Webster & Tiggemann 2003) and in a population of college students (Mable, Balance & Galgan 1986). With regard to pregnant women in the postnatal period Jenkin & Tiggemann (1997) found women were heavier four weeks after having their baby than they were prior to becoming pregnant and were less satisfied with their postnatal shape, with actual postnatal weight being an important predictor of psychological well-being following birth including a negative association with self-esteem. Weight gain is an integral part of pregnancy which women are unable to control. It seems possible that acceptance and adjustment to weight gain in pregnancy is linked with self-esteem and strategies and care options that can influence and increase women's self-esteem will help to improve psychological well-being in pregnancy and the postnatal period.

It seems apparent that self-esteem is significant in women's psychological well-being during pregnancy and in the transition to motherhood. It is however a factor which has been neglected in the literature with regard to pregnancy, both in terms of self-esteem as a main effect or as an interaction effect between self-esteem and other dimensions of psychological well-being. This is surprising given the evidence for associations between self-esteem and the development of depression in women (Priel & Besser 1999) and its link to postnatal depression (Beck 2001). Interventions that aim to provide support to emotional and psychological support to women during their pregnancy, childbirth and new motherhood experience may need to consider the effectiveness in terms of high and low self-esteem, as interventions may be differentially effective for those women.

Sleep and Pregnancy

Sleep problems are commonly reported in pregnant women, and it has been acknowledged for some time that sleep can be disturbed in pregnancy. (Santiago, Nolledo, Kinzler et al. 2001). Ample evidence indicates that hormonal changes in pregnancy alter sleep patterns (Santiago, Nolledo, Kinzler et al. 2001; Lee, McEnany and Zaffke 2000). Several physiological changes that occur during pregnancy are also acknowledged to lead to disturbance of normal sleep (Hytten & Chamberlain 1980; Worth, Onyeije, Ferber et al. 2002)

The existing evidence on sleep related problems in pregnancy prompted the American Sleep Disorders Association (ASDA) to propose the existence of "pregnancy-associated sleep disorder" (Uddin & Jarmi 2005). The International Classification of Sleep Disorders (Thorpy: ASDA 1990) describes increased sleep time and increased daytime sleepiness as part of the sleep features during early pregnancy whereas late pregnancy is associated with frequent waking and an overall decrease in sleep efficiency. Excessive sleepiness is a common complaint of women in early pregnancy. During the first trimester, total sleep time, daytime sleepiness, insomnia and nocturnal wakening increases and overall sleep quality decreases (Suzuki, Dennerstein, Greenwood et al. 1994; Schweiger 1972). In the third trimester women awaken more frequently, nap daily and experience worsening insomnia and diminished daytime alertness (Suzuki, Dennerstein, Greenwood et al. 1994; Schweiger 1972). Impaired sleep quality has been cited as typical in the weeks prior to parturition (Thorpy 1990; Schweiger 1972). Studies measuring changes in sleep during pregnancy by electroencephalogram found that that total sleep time in the third trimester was decreased and sleep patterns were significantly altered (Brunner, Munch & Beidermann 1994; Hertz, Fast, Feinsilver et al. 1992; Driver and Shapiro 1992). Various authors have investigated sleep in women of childbearing age with between 66% and 94% of pregnant women reporting alterations in sleep (Santiago, Nolledo, Kinzler et al. 2001).

A growing body of evidence appears to indicate that sleep disruption alters mood. A meta-analysis by Pilcher & Huffcutt (1996) confirmed that sleep deprivation has a significant effect on human functioning; specifically cognitive performance is more affected by sleep deprivation than motor performance and that mood is much more affected than both cognitive and motor performance. Mood, however, is usually assessed by self-reporting methodology and it is possible that subjects could be over estimating the effect of sleep deprivation on their mood. However the differences described in mood ratings between sleep deprived and non-sleep deprived subjects in this study would suggest that this is unlikely to be attributable to self-reporting error. It is more likely that sleep deprivation does have a negative effect on mood (Pilcher & Huffcutt 1996).

A study by Reeves, Pontempa & Gallo (1991) found fatigue in early pregnancy to be a significant problem for pregnant women, not relieved by rest. They discovered significant relationships between fatigue and psychological variables that included anxiety, depression, anger and confusion. Psychological variables for pregnant women appear to be influenced by the sleep changes that occur in pregnancy. These alterations to pregnant women's psychological state may well endure beyond the experience of pregnancy into the intrapartum and the postnatal periods. A study of women's subjective experiences following prelabour rupture of membranes, found that women's narratives produced consistent themes related to sleep (Jomeen 2002). Women in this study valued sleep during pregnancy and perceived it as preparation for childbirth and motherhood, expressing feelings of anger and resentment at external influences that disturbed their attempts to sleep.

The rapid fall in placental hormones has been implicated in the experience of post-partum emotional distress or 'blues' that occurs in 75% or 80% of new mothers three – five days after birth (Lee, McEnany & Zaffke 2000) although, as discussed earlier, this remains unproven. Links between the sleep changes of pregnancy and post-partum depressed mood have also been hypothesised (Karacan, Williams, Hursch et al. 1969). Wilkie & Shapiro (1992) investigated the effects of impaired sleep and sleep disruption during pregnancy and birth, its influence on the development of postnatal blues and the severity of the symptoms associated with the 'blues'. The study findings suggest that greater sleep disruption during pregnancy and labour is associated with higher ratings of 'blues' symptoms after the birth. This is significant because postnatal 'blues' have been cited as a risk factor for subsequent postnatal depression (Beck 2001). Lee, McEnany & Zaffke (2000), however, do not support such an association, claiming that post-partum mood state was unrelated to third trimester mood state or sleep disruption in the third trimester; rather suggesting that sleep and mood were significantly affected at one month post-partum because of awakenings during the night, similar to the findings of a previous study (Coble, Reynolds, Kupfer et al. 1994). Wilkie & Shapiro (1992) did also find, however, that subjective assessments of sleep quality in the early postnatal period were significantly associated with mood, in that the poorer the quality of sleep the higher the level of emotional distress (Wilkie & Shapiro 1992). Other studies that have followed women into the post-partum period have associated improved postnatal sleep efficiency in the postnatal period with reduced leg cramps and low back pain (Hertz, Fast, Feinsilver et al. 1992). Despite this, the altered patterns of sleep experienced by women during pregnancy continued into the post-partum period suggesting that the normalisation of sleep architecture may be a slow process, not merely resolved by the removal of the discomfort, aches and pains associated with pregnancy (Hertz, Fast, Feinsilver et al. 1992).

The difficulty in interpreting findings with regard to postnatal sleep lies with the confounding role of social and environmental factors associated with the presence of a new baby. Alterations in post-partum mood seem to be related to high fatigue as a result of interrupted or lack of sleep, characteristic of the early postnatal period (Lee, McEnany & Zaffke 2000; Coble, Reynolds, Kupfer et al. 1994). These symptoms may well mimic depressive symptoms or place the new mother at risk of post-partum depression. Lee et al's study, however, found a greater correlate to poor sleep postnatally is confusion/bewilderment (Lee, McEnany & Zaffke 2000), which raises questions more about the relationship of sleep to daytime cognitive functioning. This may have greater implications for the health and safety of the mother and infant than depressed mood (Lee, McEnany & Zaffke 2000). The acknowledgement by health care professionals of the role of sleep disruption in women's adjustment to motherhood seems essential, alongside validation of this as a normal process for women, ensuring that feelings of guilt do not ensue.

It seems apparent from the evidence presented that for most women pregnancy will result in a degree of variability of sleep habits. One method of examining the relationships between sleep and measures of health and well-being is to classify sleep into two components, sleep quantity and sleep quality. Sleep quality includes largely subjective indices of sleep such as depth of sleep, how rested one feels on awakening and general satisfaction with sleep (Pilcher, Ginter & Sadowsky 1997). The relationships between health and the two components of sleep, quality and quantity have been examined in some detail in clinical populations (Pilcher, Ginter & Sadowsky 1997). Sleep habits when examined in non clinical populations have found positive associations between seven to eight hours of sleep with self-report health status and longevity (Frederick, Frederich & Clark 1988; Bellec & Breslow 1972). A study examining sleep quality found positive relationships between good sleep quality and self-report health (Hyyppa, Kronholm & Mattler 1991). Pregnant women may fall someway between the two categories of clinical and non-clinical. Pregnancy is not a disease or illness, although the minor disorders experienced during pregnancy, such as nausea and vomiting in early pregnancy, which manifest themselves physically, may be labelled and treated as clinical phenomenon. Documenting physical health alone does not present a full picture of general health and the World Health Organisation (WHO) has identified three major components of health. To understand this more general concept of health, it seems necessary to examine both psychological and general well-being. There is some support for a relationship between measures of well-being and good sleep quality (Weller & Avinir 1993; Pailhous, Benoit, Goldenberg et al. 1988) although the relationship between these two components has not been investigated in pregnant populations. A study by Pilcher, Ginter & Sadowsky (1997) investigated a cohort of college students; findings

indicated that health and well-being measures were better related to sleep quality than sleep quantity. Poor sleep quality was significantly correlated with increased psychological and physical health complaints and with increased feelings of tension, depression, anger, fatigue and confusion. Sleep quantity as measured by average time in bed in comparison was not related to any measure of health and well-being. In addition sleep quantity and sleep quality were only marginally related. Thus it is the other components of sleep quality, for example night time awakenings or general satisfaction with sleep, that appear to be largely responsible for the relationship between sleep quality and measures of health and well-being (Pilcher, Ginter & Sadowsky 1997).

It seems clear that pregnant women undergo changes in sleep patterns over the course of pregnancy. Studies are conflicting about these changes but it seems clear that sleep patterns are at least altered from that of a non-pregnant state (Brunner, Munch, Beidermann et al. 1994; Hertz, Fast, Feinsilver et al. 1992; Driver & Shapiro 1992). The amount of time spent in bed for pregnant women may not change during the course of pregnancy but the quality of that sleep may well alter. Several of the above studies have indicated the deleterious effect of reduced sleep quality and its potential impact on mood, cognitive functioning, and general psychological well-being. A study by Doi, Minowa & Tango (2003) identified other correlates of poor sleep quality including being young, unmarried, less educated and those who perceived moderate or severe stress These are many of the same predictors of antenatal and postnatal depression, anxiety and worry in pregnancy already discussed. It could perhaps be suggested that these at risk groups are generally more vulnerable to stressors and cope less adequately with them. The ramifications of altered sleep patterns in pregnancy, childbirth and the postnatal period, alongside the subsequent risk of reduced sleep quality and its potentially negative association with psychological health, render this group particularly susceptible to increased emotional and psychological problems during pregnancy. This has the potential to become a cyclical process for pregnant women where the related aspects constantly interact throughout pregnancy, childbirth and post-partum. It seems pertinent then within a study aiming to assess pregnant women's psychological well-being that a measure of sleep quality should be an integral aspect of the assessment and as a result will be assessed within the quantative arm of this study.

Choices for Childbirth

Choice, control and women centred services have been high on the maternity agenda since the advent of Changing Childbirth (DoH 1993). Since that time, significant health policy documents, such as the NHS Plan (DoH 2000), National Service Framework for Children's services (DoH 2004a) and patient choice initiatives (DoH 2004b; DoH 2004c; DoH 2003),

have reinforced a woman's right to choose how and where she wants to receive her maternity care and by whom that care is delivered. The concept of such a service is premised on the view that a woman is capable of making decisions about the care she receives. This invokes a set of ideas about the relationship between rights and choices, adopting a democratic model, where the woman consumer is expected to be able to exercise her rights and make choices (Kent 2000). Choice in maternity care aims to enable women to feel involved and empowered. This is, in part, a recognition that a negative perception of care during pregnancy and birth can have adverse effects on psychological well-being, although noteworthy is that positive postnatal mood has been largely sidelined (Weaver 2000). Further to date the expected improvement in psychological outcomes as a result of offering choice has not been demonstrated. Women are clearly not a homogeneous group, which might suggest that some women have more choices than others. Reasons suggested for this have been inequalities caused by low income, poor housing and nutrition, which decrease choice and restrict access to services but also increase risk (DoH 2004a). Other less explicit barriers to choice have also been identified. Weaver (2000) demonstrated how midwives through their own personal opinions represent home birth as hazardous to women, which in turn leads women to express similar fears. The depictions of birth as risky and a process that can 'go wrong', which emphasizes both hospital and expert intervention as the means to assure the safety of the baby, can be traced back to the medical model. Women then are constrained in making choices for care by the fear that is created. Experts in the form of medical and midwifery personnel continue to be viewed as knowing best (Weaver 2000) and as such play a vital role in constraining or facilitating women's choice. Choice it seems may still have some way to go in achieving its aim and clearly merits further contextual consideration in the current maternity care climate on both psychological outcomes and experience.

Maternity Discourses

Only nine percent of women never seek or want a pregnancy (Morse 2000), suggesting that the majority of women do wish to produce a child and become mothers. Identified drivers for this include achieving some sense of importance and recognised adult status, being truly needed by another human being which affords the opportunity for exercising power and influence, providing a bridge to the future, diminishing the fear of one's own death and providing an opportunity for the expansion of oneself (Neal, Groat & Wicks 1989 in Morse 2000). Although feminist writers have dedicated themselves to demystifying motherhood, for many women motherhood continues to be described as a natural progression and ultimately fulfilling (Glenn 1994).

Discourses of pregnancy represent pregnancy as a potential crisis state, involving shifts in identity and the move from non-motherhood to motherhood (Raphael-Leff 1991 in Gross 2000) suggesting that pregnancy is a transition stage prior to motherhood. Realignment of these identities occurs within a personal and social context and the public visibility of pregnancy permits it to become the focus of public discourse. Discourses, such as the bio-medical model of pregnancy and contemporary discourses of choice permit others to comment on the pregnancy and the woman's actions and responses to it. Women reconceptualise themselves as part of a *'particular'club'* (Gross 2000 p.300) of like women. As members of this club they are expected to behave in certain ways and within certain boundaries, set by wider discourses. Such discourses expect women to make safe and responsible but informed choices about pregnancy and childbirth. It is within this arena that women are faced with a redefinition of their self and their identity.

Pregnant women renegotiate their identities within discourses that privilege mothering and deny women identities and selfhood outside motherhood (Glenn 1994; Ireland 1993 in Woollett and Marshall 2000). Women's accounts describe becoming a mother as ultimately fulfilling (Weaver and Ussher 1997). Western concepts of motherhood emphasise attachment, nurturing and intense fulfilling emotions, all of which are associated with the natural attributes of women (Vincent, Ball & Pietikainen 2004; Arendell 2000). It is by these standards that mothering practices are evaluated. Mothering consists of historically and culturally variable practices of nurturing and caring for dependant children. The practice of mothering is constructed in specific circumstances and is consistent with prevailing cultural beliefs. 'The ideology of intensive mothering' described by Hays (1996), declared mothering as exclusive, wholly child centred, emotionally involving and time consuming. The mother portrayed here is devoted to the care of others and self-sacrificing, intensive mothering acts as the dominant cultural script (McMahon 1995 in Vincent Ball & Pietikainen 2004) and reinforces a gendered female identity (Arendell 2000). Mothers who do not conform to the normative standard against which all mothering practices are judged, are affected by it in that their practices are evaluated by it and even those who contest it are immersed in it (Bell 2004).

The social policy discourse celebrates women's 'natural' abilities and understands good mothering as the key to a child's successful development, placing the responsibility and the onus on the mother. Both pregnant women and mothers consult expertise and 'engage in reflexive encounters with expert systems' (Giddens 1991 in Vincent, Ball & Pietikainen 2004) to make responsible decisions about the development of their children. Glenn (1994) suggests that women are powerful figures in children's lives giving them a valued position

and role, although this is often experienced as blame when things do not turn out right. This corresponds to the blame attributed to women who do not make the right decisions in pregnancy or behave in the right way, for example women who refuse screening can be construed as irresponsible (Browner and Press 1993 in Ennis 2000). Motherhood is construed as problematic for those women who do not bring children up in the right circumstances (Woollett and Marshall 2000), as is a pregnancy defined by a medical model which emphasises women's instrumental role in a successful, problem free pregnancy. The '*identification of a fetus as a potentially healthy baby could be interpreted as a means by which women are encouraged to adopt responsible behaviours*' (Gross 2000 p.298).

The transition to motherhood is traditionally conceptualised as the period after giving birth and this is reinforced by literature that considers the impact of motherhood on women's roles, identities and social relations including those with partners, the wider family and friends and through employment (Hakim 2003; McMahon 1995). Theories such as Mercer's maternal role attainment theory (Meighan & Wood 2004), describe pregnancy as an anticipatory stage. This is despite acknowledgment that pregnancy is a time of social and psychological adjustments where a woman prepares emotionally for motherhood, by seeking information, visualizing herself in the maternal role and demonstrating an attachment to the fetus and the beginning of an emotional bond. Taking on the mothering role does not begin until the formal stage following delivery. It seems possible, however, that the concordance of the characteristics which women display in pregnancy and mothering could potentially blur the pregnant woman and mother dichotomy and begin to question traditional theories about transition to motherhood. This might well have implications for how women experience maternity encounters, relationships, events, emotions and decision-making and as such will be one of the aspects explored in the following study.

Discussion

It seems clear that psychological well-being for women during their maternity experience should not be considered a unidimensional construct, measured simply by levels of anxiety or depression, but must include a comprehensive assessment of all the dimensions that attribute to mood and emotional well-being for women. It should be acknowledged that whilst the physical and psychological body are central to women's health, the way that women experience both their bodies and health care is always socially and culturally situated. Maternity care, in particular pregnancy and birth, receives a great deal of attention from healthcare professionals who may have very different perceptions of a maternity experience to women themselves. That women's subjective experiences may be different is

something that is often overlooked by health care professionals and researchers, yet it is central to care delivery and understanding of any particular health state.

Whilst the evidence that emotional lability is experienced by women throughout their childbirth experience and following the birth of their children is powerfully supported in the literature, it requires a broader and wider acknowledgement and understanding by those providing maternity care. It is highly possible, that models of care which differ from the traditional form of maternity care are better placed to both facilitate psychological health and recognise psychosocial deviations from the norm. Thus, offering the benefit of valuable support and intervention strategies to promote the best possible experience for mothers and their families. However to date the failure to prove those associations suggest that evaluation of women's psychological state must take place in the context of women's lives, as is intended in this study.

To date knowledge on the emotional experiences of women during pregnancy is limited. Much psychological research on childbirth has tended to focus not on the experience of a major life transition amongst normal healthy women but on an assumption that any emotional distress associated with childbirth must be abnormal and is inevitably biological in origin (Lee 2000). The evaluation of the dimensions of psychological well-being within the context of care options within maternity services may serve to alter the focus of psychological disturbance in pregnancy from an illness focussed model to one which is able to consider normal and abnormal adjustment, support women's knowledge and expertise in their own bodies and provide strategies and support to facilitate a woman's transition to motherhood. Current focus firmly implies that a woman who is not completely happy in the role of pregnant woman or with the challenges of caring for a new baby must be suffering from illness (Lee 2000). This assumption persists despite good evidence that depression, both antenatal and postnatal, must be explained in the context of psychosocial factors (Kumar 1994) including life events, lack of social support and unrealistic expectations of pregnancy and motherhood.

Little research focuses on women in the current maternity care climate where reconfiguration of services is attempting to promote the normality of birth and provide women with choices for maternity care, aiming for a more satisfying transition for women through pregnancy and into motherhood. A normal maternity experience is acknowledged to involve factors such as anxiety, fatigue, disturbed sleep, bodily changes and physical compromise and an effect on mood state could perhaps be perceived as a normal reaction (Lee 2000). However women themselves identified stress as a problem that bothered them,

suggesting that psychosocial health is important to women themselves (Walters 1993). At the same time, however, women themselves do not regard this as an illness, 'genuine sickness' is often seen as being physical. (Miles 1988). The need for psychological research to continue in pregnancy, childbirth and into motherhood is imperative, not merely by obtaining empirical measures of psychological well-being during pregnancy but also by interpretation of the subjective experiences of women that underlie their experience of pregnancy, childbirth and the postnatal period, in order to provide a more realistic and ethical psychology of women during pregnancy and childbirth.

Implications

There is now an official focus upon woman-centred childbirth and a move to encourage women to make choices and decisions about their care. This literature review has highlighted several outstanding issues that require attention. There is a lack of substantive and consistent evidence regarding the multiplicity of factors considered by women in making choices for the management of childbirth. This necessitates the need to ask women about their experiences of choice within maternity care. Whilst policy changes imply a move away from the medical discourse of childbirth, robust evidence as to such a change lacking and merits further investigation through women's own accounts. Evidence that choices for maternity care confer positive psychological benefit, for women during pregnancy and childbirth are both inadequate and inconclusive. One possibility is that this is a result of the often limited way in which psychological health is conceptualised within both maternity care itself and in empirical studies (Jomeen 2004). Such an omission clearly merits further investigation of the role of choice in maternity care as a mediating factor in psychological health outcomes. Finally an absence of a theoretical explanation of women's experiences of childbirth, on which to build service developments in the 21st Century, demonstrates substantial gaps in the current evidence base.

The study outlined in this thesis, aims to address those outstanding issues by exploring women's psychology and experiences of pregnancy, childbirth and early motherhood, within the context of choice in contemporary maternity care. Hence, the questions asked in this research are:

1. ***Does choice of maternity care impact on antenatal and postnatal psychological outcomes?***

2. ***What are women's subjective experiences of pregnancy, childbirth and early motherhood and the policy of choice within contemporary maternity care?***

3. ***How do the context of women's pregnancy, childbirth and early motherhood experience relate to the quantitative dimensions of psychological well-being?***

It has the following objectives:

- Using quantitative research methods to assess the impact of women's pregnancy and childbirth management choices on psychological well-being during pregnancy.
- Using qualitative research methods to examine the ways in which women perceive and relate their experiences of pregnancy and childbirth in the context of their choice for maternity care.
- To combine quantitative and qualitative research findings so that the potential of using a mixed methods approach can be demonstrated.
- To explore how these two streams of the study provide contextual understanding of women's experiences within the changing discourses of maternity care.
- To contribute to the development of research in midwifery studies in the UK.
- To inform developments in services, through improved research/evidence based knowledge.

How the aim, objectives and research questions are to be addressed will be discussed and explored more fully in the following chapters.

Chapter 2a: Methodological Overview

Introduction

This chapter presents the methodology for this research study, which evolved from the broad idea of the psychology of pregnancy, childbirth and motherhood within the context of women's subjective experiences of pregnancy, birth and the postnatal period. Chapter 1 has already outlined the aims and objectives of the study and made a clear statement of the research questions to be addressed. This chapter intends to explore how the aims and objectives can be best achieved and the research questions answered through a mixed methodological approach. The debate around methodological eclecticism and paradigm incommensurability will be explored and the case for a pragmatic approach, which seeks to prioritise women's voices within the research, will be presented. The study site and study design for both the qualitative and quantitative aspects of the study are discussed in a combined manner within this chapter to avoid repetition of information in chapters 3 and 5. However, chapters 3 and 5 will consider and justify separately study participants, procedures, methods employed to collect the data and analysis under quantitative and qualitative headings respectively.

The Choice of Research Methodology

Research methodology is concerned with both the research methods by which data are collected and the more general philosophies upon which collection and analysis of the data are based. Methodological debate is inevitably omnipresent in most fields of applied research. The undertaking of a research study requires great consideration as to the appropriateness and 'validity' of any chosen method (Perone & Tucker 2003). Research methodology is also determined by a number of practical factors including available resources and time, sampling possibilities, the types of data sought, what is to be done with the data and the skills of the researcher. This can create tensions between feasibility and desirability. It requires thought, reflection, planning and a clear understanding of the philosophical basis of the research strategy, which is important for a number of reasons. It helps to clarify research design, identify and create designs beyond past research experience and traditionally provides grounding for research methods within an accepted epistemological paradigm (Proctor 1998).

As individuals we hold a set of beliefs about the world, which can be described as our personal paradigms. A paradigm is a conceptual framework on or around which we can create and construct our ideas about knowledge. It is generally believed that researchers'

ontological and epistemological beliefs, that is how one firstly understands the nature of reality and then on which basis knowledge claims can be made, will lead to the resultant personal paradigm in which an individual situates themselves. This will in turn influence and guide methodological choices and actions during the research process (Norton 1999) and dictate the research strategy, methodology and method adopted. Traditionally in social research methodologies, the whole approach to research may be very broadly defined as qualitative or quantitative, or interpretivist and positivist respectively, with extreme approaches at either end of the research spectrum.

Paradigm Incommensurability

Many researchers support the notion that qualitative and quantitative refer to internally coherent and comprehensive research paradigms, founded on incommensurable philosophical and political presuppositions. Quantitative, positivist research aims to ascertain one truth based on robust measurement and deduction. This stems from a belief that there is a stable reality 'out there', in which phenomena such as health and diseases for example exist whether we study and understand them or not. The emphasis is on studying observable phenomena within the natural world and is grounded in experimental approaches which in turn can establish cause and effect mechanisms. Science in this frame is held to be separate from society as objective, rational, neutral and true (Green & Thorogood 2004). Positivists justify such an approach by being concerned to prevent a divorce of the social sciences from the natural sciences, others by expressing a desire to achieve in the social sciences the operational success of the experimental approach in the natural sciences.

The result of this concern to emulate the natural sciences however, from the perspective of interpretivism, is the denial of value of human subjectivity (Gill & Johnson 2002). Conversely, qualitative, interpretivist research aims to explore, understand and interpret individual's own explanations of their world. It sees the positivist view as unachievable and inappropriate in its research into human behaviour. Human beings make sense of their place in the world (Green & Thorogood 2004), have views on those who are researching them and behave in sometimes unpredictable ways. Qualitative researchers believe that research should aim not to explain, but to understand people, hence their emphasis is not on the reality of the world but about people's interpretations of it (Green & Thorogood 2004). The meaning, perceptions and interpretation that human beings attach to surrounding events and phenomena enable them to select courses of meaningful action. It is, qualitative researchers argue, these subjective processes that provide the sources of explanation of human action and therefore constitute the rightful focus for research within

the social sciences (Gill & Johnson 2002). Thus, interpretivist approaches reject what they see as positivists '*overdeterministic orientation*' towards an understanding of human action and behaviour (Gill & Johnson 2002 p.168).

These two main traditions of enquiry form the basis of most research activity. Much literature depicts these paradigms as the mutually exclusive opposites discussed, each encompassing a different view of reality or truth (Kelly & Long 2000). Consequently some researchers maintain that qualitative and quantitative methodologies are irreconcilable (Cupchik 2001). Critics of qualitative research argue that it is 'soft science' and consider it unscientific and methodologically inferior (Kelly & Long 2000) because it is subjective and full of bias (Denzin & Lincoln 1998), neither can it be generalised to large populations. Equally other researchers do not accept that investigation of the social world is possible using a positivistic approach (Porter 1993; Duffy 1985; Melia 1982). When attempting to draw on both perspectives in mixed method approaches, as in this thesis, it is important to acknowledge that such an approach remains the site of complex epistemological issues and at times antagonistic argument (Roberts 2002).

Methodological Pluralism

The apparently clear definitions that exist between paradigms at the philosophical level become less well defined at the social and technical level of research practice (Proctor 1998). Dootson (1995) suggests that disciplines such as medicine and nursing can be considered both an 'art' and a 'science'. Donovan (2000) supports this argument by suggesting that midwifery is a combination of both social and natural sciences. A study may have one goal or aim, but this can be divided into individual objectives that incorporate and necessitate both explanation and understanding (Donovan 2000). These authors would appear to advocate that disciplines such as midwifery and conditions/experiences such as pregnancy and childbirth exist on more than one level, are more than a single reality and hence require more than one way of being understood. Such thinking has led to the blending of qualitative and quantitative methods and data within a study and has become an escalating trend particularly within social science and health research (Perone & Tucker 2003). The choices of method made may not necessarily entail a simple paradigmatic decision between what appear as incommensurable alternatives.

Cresswell (2003) suggests that such a view of methodology, purely in terms of a dichotomy, is fundamentally flawed because it ignores the possibility of methodological pluralism (Gill & Johnson 2002). A key observation in the debate, when methods are aligned to paradigms, is that the use of both methods would imply a switch between

paradigms. However Roberts (2002) argues that method and epistemological assumptions are not logically linked and that the distinction is arbitrary, creating a case principled complementarity and for the employment of both methods within an interpretivist framework. Other researchers agree that paradigms, methodological approaches and linked methods are complementary (Cluett & Bluff 2000). Roberts (2002) essentially makes the case for an approach that sits within much of the wider argument for methodological pluralism. This approach focuses on the problem under investigation and the use of the most appropriate methods to address those problems (Gill & Johnson 2002). The difficulty remains that whilst '*a researcher may perceive areas in which a useful contribution may be made by both quantitative and qualitative methods, the epistemological issues are not* ***ipso facto*** *reconciled*' (Roberts 2002 p.7).

Roberts goes on to argue that if the link between epistemology and method is not self-evident but rhetorical, then rhetoric alone does not seem sufficient to constrain against the use of both methods within the same epistemological paradigm. Further he suggests that those who are so firmly entrenched in their identified paradigms that they are unable to accept any possible critique of how their utilisation of certain methods can produce anything other than compelling results, are not best placed to '*objectively evaluate from within that paradigm the use of methods associated with another*' (p.8). Often those who claim a direct causal link between epistemological position and method are not arguing against the use of mixed methods within the same research design but the use of the alternate paradigm and its associated methods *per se*. Therefore the argument is not one against complementarity but rather the arrogant privileging of one paradigm and one type of knowledge over the other. Popper (1963 in Roberts 2002) suggests that we should ask what the best sources of our knowledge are and proposes that no such ideal sources exist so we should ask rather 'how can we detect and eliminate error'.

Hammersley (1992) discusses some of the traditional distinctions in the paradigm debate. Within each paradigmatic approach there are a range of positions not just two. Systematic observation can involve quantification and direct interviewing can be employed under the remit of qualitative research. Quantitative data are ultimately accounted for in words involving some description and interpretation, so the traditional numbers and words dichotomy often used to explain the qualitative and quantitative divide is less axiomatic than some authors would suggest. Both quantitative and qualitative researchers use terms such as 'many', 'often', 'several' and 'generally', which adds an element of quantification that the qualitative researcher would claim not to utilise in their work. The use of these terms also undermines the levels of precision that quantitative researchers would claim

validates their research. Thus presentation and explanation of study findings often compromises researcher's own ideological commitments to one methodological paradigm or another. 'In all research' states Hammersley (1992) 'we move from ideas to data as well as from data to ideas'.

Although we can distinguish between theory generation and hypothesis testing, the paradigm view of the relationship suggests that we are faced with two standardised traditions that are internally coherent. In fact there are a considerable range of data collection techniques and analytical methods that are not so clearly wedded to particular paradigmatic views. In essence then epistemological issues and arguments must be acknowledged by any researcher embarking on mixed method research. However the argument that one cannot alternate between paradigms would seem misleading, because the above arguments suggest that method is not so fundamentally linked to epistemology in a manner that it implies a paradigmatic shift or that it prevents a mixed methods approach.

A Pragmatic Approach

Knowledge should be evaluated in terms of how successfully it may guide action towards the realisation of particular objectives, which are the expressions of particular needs or interests (Gill & Johnson 2002). What this requires from the researcher is a reflection upon the nature of the research with regard to human consequences (Gill & Johnson 2002). Midwifery research has been critiqued for traditionally adopting masculine models of knowing and midwives for being 'agents of the medical model' (Cluett & Bluff 2000 p.170). This definition of masculine knowing must imply feminine models of knowing and female ways of accessing it, which would seem more consistent with the concept of the midwife being 'with woman'. There is no consistent feminist orthodoxy and there are many different feminisms. However, what these different approaches share is a common agreement about the centrality of the critical analysis of relationships in research and theory, an appreciation that women are worthy of study in their own right and the recognition of the need for social change to improve the lives of women (Ussher 1999). Central to the values of this research was how to promote feminine ways of knowing when masculine ways of knowing traditionally dominate. This undoubtedly presented a challenge

The feminist perspective advocates qualitative studies as the most effective method of ascertaining women's subjective experiences in a childbirth context allowing a grasp of the realities of women too often ignored. However Millen (1997) argues that any methodology

can be considered feminist if women's voices are prioritised and that it is inaccurate to characterise feminist methodology as a static concept on which there is consensus. Two key concepts appear to prevail within feminist research, empowerment of women and the equality of the research relationship (Millen 1997), regardless of the methodology employed. Ann Oakley (1993), one of the pioneers of feminist research with pregnant women, suggests that research should be orientated towards the production of knowledge in ways and forms that can be used for women themselves. Although much of her original work was qualitative in nature, latterly she has been criticised for recanting her feminist values and converting to a positivist approach. Oakley (2005) continues to consider herself a feminist and her most recent justification for her methodological choices in her work with women rests on four key points.

- The first she describes as '*the requirements imposed on socially responsible social science by professional arrogance*' (p.248) and argues that it is precisely because professionals are prone to instigate interventions without knowing their effects that social science is required to utilise the best tools to study such activities. In opposition to traditional approaches, method should be essentially linked to the service of the social problem.
- Secondly she argues that a well conducted experimental study can assess the effects of such arrogance as well as providing access to the impact of such interventions
- Thirdly, in the eagerness to dismantle patriarchy, '*I had mistakenly thrown at least part of the baby out with the bathwater*' (p.249). She argues that women sometimes need quantitative research because it allows personal experience to be set apart from collective oppression. Large scale data allows access to the structurally differentiated situations of men and women to be determined. Women in particular, as targets of ever increasing numbers of health care interventions, need reliable evaluation to identify the safety or harm of such procedures
- The fourth concerns the purpose of research methods. It is unfashionable in an era of multiple meanings, she suggests, claiming '*that the aim of research methods is to provide some sort of approximation to what is really going on*' (p249). Yet she argues this is what should drive social scientists, just as we live our lives as a reality that exists and can be known about. The key criterion for any research should be trustworthiness, protection against bias and the possibility that we might end up with misleading answers to the questions we ask. Research methods should fit the question being asked but most importantly should be open, ethical and consistently applied

Personal interest in feminist thinking and methodology had undoubtedly revealed the need for research to be done on women and women's lives rather than generalising the conclusions of research on men to generic 'people'. The clear priority for this research was to ensure outcomes that would contribute and impact on women's care provision and health in pregnancy, childbirth and the period beyond. It was important to try and capture some sense of the impact of care delivery on women's psychological status. It was equally important to acknowledge and recognise the unique character of pregnancy, as more than a biological and psychological event but as a social and cultural construction, with a significant emotional content. It seemed apparent that explanation and understanding of women's experiences could only be captured by a methodological approach that could acknowledge the interplay of all the aspects which affect women during this time of identity renegotiation and transition. Women's maternity experiences and care consist of a mixture of established objective measurements, which as Oakley (2005) suggests requires reliable evaluation and personal, social and cultural adjustment. Therefore, it appears palpable that any research which aims to interpret women's experiences should seek to mirror women's life experiences. To dismiss dominant ways of knowing within any phenomenon as not important would be to ignore the 'what is' of women's maternity experience. There is clearly a physical reality of pregnancy that is experienced by all women demonstrated by visible effects such as the physical progression of pregnancy and the mechanism of labour. Yet the way that women experience, understand and enact pregnancy is clearly socially and culturally mediated. Morgan (1983) argues that the pursuit of knowledge is a particular form of human action that is essentially social in nature and as such must be understood as being not merely epistemological but ethical, moral, ideological and political. Therefore decisions on methodological approaches need to work within and accept the current ways in which women are treated within a maternity context.

One criterion for evaluating knowledge should be based on the consequences of knowledge, in the sense of what knowledge does to and for humans (Gill & Johnson 2002). Methods themselves are not innately anything and '*do not appear to have gender*' (Cluett & Bluff 2000 p.171). To eliminate potentially powerful tools such as positivist methods within a research design that can be used to attain valuable information on the basis that it is not traditional within a certain paradigm, is not beneficial to the researcher or the researched.

The focus for this research is motivated by feelings and concerns for the values of women, the potential of the research to help women, and centres on and aims to ultimately empower women within a maternity environment and culture. A central question was how to give women a voice within this research. Any knowledge claims made as a result of this study must be firmly embedded in the experiences of women. The emotional aspects of pregnancy as previously discussed, have been largely dismissed within the medicalised model of pregnancy and childbirth and are not an integral part of care delivery. In essence this study required a pragmatic approach, influenced by the feminist agenda but more importantly to use the right language to promote women's voices. According to the 'pragmatist' position, the truthfulness of any methodologically corroborated explanation would be ultimately available or testable through practice (Gill & Johnson 2002). Psychological health has been traditionally linked to clinical outcomes and the impact on the baby or the child, largely ignoring the impact of pregnancy and childbirth on the woman's own psychological outcomes and health. The use of psychometric questionnaires, although based on scientifically created constructs, not women's own experience, acknowledges that emotional health is an important aspect of the pregnancy experience. Although it must be acknowledged that the completion of these measures by the women does not allow the individual voices of women to be heard, it does nevertheless serve to give women a voice by raising the profile of psychological health in pregnancy, childbirth and beyond and providing a challenge to the dominant medical model.

Traditionally dogmatic approaches to methodology and method within pregnancy and childbirth have to date potentially hindered the profile and progress of women's health issues. The research described in this thesis, emerges from a feminist interpretivist standpoint and hence does not agree with the claim that clinical practitioners should ascribe to single method research situated within a chosen paradigm. It does however acknowledge the dominance of the positivist paradigm within maternity care. The consequence of this is a practical need to produce results within accepted frames of knowing and understanding. In the present culture of maternity care and the dominant frames of knowing, it is therefore of essence to be able to speak in a voice that will be understood and heard. The use of psychometric measures to explore psychological health in pregnancy allows women a voice but also produces results that are accessible and meaningful to many health professionals involved in maternity care. This does not suggest a privileging of the quantitative results over the qualitative. The suggestion is that the quantitative results provide a gateway to the qualitative aspect of the study and in so doing promote those feminine ways of knowing. It is not just the aim here to provide a multidimensional view of a phenomenon but also to speak to a diverse audience. By

utilising both approaches a doorway is opened to and via the other paradigms. What then is more important than the selection of particular methods is the ways in which these methods are used, the ways in which researchers interact with their research participants and the ways in which researchers attempt to represent the experience. Thus both 'numbers' and 'words' and the combination of these can be useful in discovering knowledge in any paradigm.

The suggestion that a quantitative researcher is totally removed from affecting their research findings in any way has also been criticised (Roberts 2002). It is also worth noting that this claim of objectivity is made by some interpretivist management researchers, who believe that the observer can stand back and neutrally capture what other knowers know and consequently describe their attributes (Gill & Johnson 2002). What this ignores is the researchers' proactive and creative influence over that which they apprehend. In addition it ignores the variability in how stimuli are perceived and experienced by individuals, who choose what they sense by giving attention to particular stimuli whilst de-emphasising, filtering out and ignoring others (Gill & Johnson 2002). The ways in which questionnaires are worded are open to subjectivity, beyond that all statistical data are based upon someone's definition of what to measure and how to measure it. Indeed the ultimate account of most quantitative data in words involves some interpretation based on the researcher's prior knowledge and experience and so claims of detachment and total objectivity could be considered somewhat false. The degree of subjectivity and bias lies in the researcher and the approach taken not in the methodological strategy adopted (Roberts 2002). Exploration of the quantitative data within an interpretivist framework acknowledges and accepts the reservation that any empirical observation can be theory neutral. Interpretations are unable to escape background preconceptions embedded in the language and lives of their authors and more than that are unable to escape the bounds of the constructed concepts. Measurement data is unable to represent an authenticity that exists beyond the defined concept being considered and so can only be knowable within that frame. It has in essence created a reality which attempts to be independent of human activity. The implications of this suggest a need to develop epistemologies capable of overcoming the evident critique. What the integration of qualitative data allows within this research is a representation of how women engage with those constructed concepts to make sense of their maternity worlds.

Further justification for the use of mixed methods within an interpretivist paradigm can be found within the philosophical and intellectual movement of postmodernism and its claims that there can be no ultimate epistemology upon which to base our search for knowledge

(Bowker 2001). The notion that one can work towards one absolute representation of reality is challenged as all forms of knowing are socially, historically and culturally mediated. As a reaction to modernism, postmodernism has integrated some of the values of modernist ideology. Graham (1992) suggests that positivism is an evolutionary intellectual product of the modern era and as a result we cannot exclude positivist research methods from a postmodern research agenda because of the integral connection with the intellectual practices of the past, from which it evolved. The postmodern enterprise argues for a wider pool of epistemological processes upon which to conceptualise and interpret the social world (Charmaz 1995). This leaves room for both greater theoretical and methodological cooperation.

The Importance of Applying a Pragmatic Approach in Psychology Research

Within psychology, the starting point for this study, the quantitative paradigm has been afforded a dominant position within the hierarchy of approaches to knowledge production (Bowker 2001). Within this paradigm, psychological health is assessed and understood through measures/questionnaires which, it is claimed, provide independent numerical scores representing what is seen to be an objective reflection of a material reality. This leads to a cause and effect model for understanding human behaviour. For psychology quantifying the phenomena it studies has been a perennial problem. Measuring phenomena such as anxiety, depression, personality etc, firstly requires the identification of measurable indices and sets of behaviours which display the state and '*what is of concern is the status of the things they purport to measure*' (Richards 2002 p.255). Within pregnancy this is a pertinent issue; many instruments claimed to be valid for all populations have not been thoroughly tested in pregnant populations, but have been developed in generic populations and then applied to pregnant women. Indeed studies utilising many such measures have identified problems. These include using research criteria cut off scores to identify clinically relevant anxiety in pregnant populations using the General Health Questionnaire (GHQ: Martin & Jomeen 2003). The utility of the Hospital Anxiety and Depression Scale has been questioned in pregnancy (Martin 2005; Karimova & Martin 2003). In addition concerns have been expressed with regard to one of the most commonly used measures of anxiety, the Speilberger State-Trait Anxiety Inventory in pregnancy by (Green 1990a), as well as those already mentioned above. Further, concerns about the utility of measures of anxiety in pregnancy contexts are supported by recent literature that distinguishes the worry and anxiety constructs (Green, Kafetsios, Statham et al. 2003). The literature on stress during pregnancy has been criticised for its neglect of stressors specifically related to pregnancy (Yamamoto & Kinney 1976). It is likely therefore that the measures developed and validated in non-

pregnant women and/or men may not adequately measure psychological health in pregnant women. This may be due to the context of pregnancy as a unique psychobiological event, or that issues relevant to these concepts in everyday life are replaced in pregnancy by situation specific issues. It could further be that these constructs are conceptualised differently by women during pregnancy and childbirth (Edge 2005). The usefulness of such measures in pregnant populations clearly merits further investigation. The utility of psychometric measures is in their claim to successfully identify associations and trends between and within groups and patterns of behaviour. However this can only take place within the terms that the measures themselves lay down, and it may be that the very act of measuring such concepts brings them into being for women and consequently women become 'programmed' to accept it as part of the pregnancy and birth experience. It cannot provide us, as a feminist perspective would argue, with the meaning and understanding that women themselves during pregnancy and following birth attribute to such concepts or the way in which they are culturally or socially absorbed and articulated. Hence the findings lack contextual explanation and ecological validity. Jerome Bruner in his construction of 'cultural psychology' distinguishes between paradigmatic/scientific and narrative knowing, recognising that both are essential facets of the human capacity to make sense of the world, but laments the dismissal of narrative knowing in psychology as '*irrational, vague, irrelevant and somehow not legitimate*' (McLeod 1997 p.28). Women are traditionally understood and explained within maternity care in largely scientific terms; this language has its place and needs to remain, as it is indisputable that the scientific validation of interventions in childbirth has contributed significantly to the current climate where maternal and fetal mortality and morbidity is low, within the developed world. Quantifiable measures able to assess and identify those women at risk from clinically relevant psychological ill health are undoubtedly of clinical utility, relevance and value. However, as already suggested, they are constructed as scientific abstractions and not from what women are actually experiencing. It is impossible now to escape the cultural concepts created by these scales because they have become an integrated part of maternity discourse. However a pragmatic understanding of women's emotional experiences during pregnancy and childbirth requires a broader approach, which centralises the women, facilitates understanding of how women make sense of these constructs, how they resist them, how they incorporate them into their childbirth experience and consequently how they inform their actions. The challenge then for any contemporary research into psychological health is to understand and interpret its results from within the context of participants' everyday interpretations of the world.

The qualitative paradigm presents an alternative means of accessing knowledge. Constructionism argues that what is deemed real is socially constructed, in different physical locations in time, under varying political systems and within diverse social and cultural practices (Bowker 2001). In essence qualitative research, undertaken within constructionist ontology, is primarily concerned with explaining, interpreting and understanding how people see their world. Each person's view of the world is different and therefore there are multiple realities (Cluett & Bluff 2000), although those realities will be informed by those external influences and discourses suggested above. Part of the aim in this study is to discover meaning and promote understanding from the women's own experiences to provide an illuminating perspective and assessment of psychological well-being and experience in pregnancy. Interpretation from within the context of women's lives may additionally present a challenge to the dominant ways of knowing. To date knowledge on the emotional experiences of women during pregnancy is limited. Much psychological research on childbirth has tended to focus not on the experience of a major life transition amongst normal healthy women. Illness focussed research, has aimed to classify women as suffering from antenatal anxiety or postnatal depression and consequently labelled them as deviant or inadequate in some way. This risks a failure to explore the influences, experiences and psychological processes that underlie these states and denies the impact of social and cultural factors in the aetiology of problems (Ussher 1999). Richards (2002) suggest that the use of psychometric measures alone cannot generate understanding and theory construction because they are unable to acknowledge the complexity of a gendered experience such as childbirth. The inherent risk is the creation of a false dichotomy between normal and abnormal adjustment (Lee 2000). An assumption that persists despite good evidence that antenatal and postnatal psychological health should be explained in a psychosocial context (Kumar 1994).

The combination of methodologies will allow exploration of these claims in a way that a single methodological approach would not allow. One of the weaknesses of the paradigm view is that it seems to imply a form of linear rationality whereby researchers first decide on their philosophical commitments and base their selection of research topics and study designs on those commitments, whereas decisions are often influenced by many other factors. Whilst the critique of methodological pluralism is being clearly acknowledged, this research is adopting an essentially pragmatic feminist approach which evolves out of a second body of authors (Gill & Johnson 2002, Ussher 1999, Hollway & Jefferson 2000). As such the careful and purposeful combining of methods will facilitate reconstruction and critique of theory, methodology and professional practice but also pose alternative solutions grounded in women's lives and maternity experience, contributing significantly

and in an original manner to midwifery research within the field of psychology and childbirth.

Triangulation

Triangulation is the term often called upon to explain the integration of quantitative and qualitative methods and as such cannot be ignored. The essential rationale of triangulation, is that the use of a number of different methods or sources of information to tackle a question means the resultant answer is more likely to be accurate, valid and reliable. Methods complement each other and cancel out each other's weaknesses to produce more convincing findings (Gill & Johnson 2002). Foster (1997) describes triangulation as 'the combination of research strategies to achieve a multidimensional view of the phenomenon of interest'. Different types of triangulation have been described and it is often critiqued. Despite its seemingly innate appeal, triangulation is not without its problems. Apart from the paradigmatic arguments, it can be very complex, time consuming, resource draining and each method must be fully investigated and understood. Quantitative and qualitative undoubtedly have contrasting strengths and weaknesses, but their differing emphases may suggest that the resulting data may not be as comparable as some advocates of triangulation suggest (Roberts 2002). Researchers have described the use of simultaneous data collection (one method is supplemented by the other) or sequential data collection (in which one method leads to the other). The problem with this can be that one method always dominates (QUANTITATIVE + qualitative or QUALITATIVE + quantitative). Further of course if the quantitative disagrees with the qualitative, which is to be believed? Researchers have themselves observed that it is difficult to decide whether or not the results have converged (Gill & Johnson 2002). However both convergent and discrepant findings may be equally valuable and enrich conclusions that assist in both the clarification and explanation of social action and meaning (Roberts 2002). Triangulation has also been conceptualised under other headings including facilitation and complementarity which advocate similar approaches.

A traditional approach to triangulation could not be adopted for this study because of the practicalities of some approaches but also because of many of the critiques outlined above. A framework for approaching the research design of this study was found in:

Conceptual Triangulation

Sandelowski (1995) took issue with the three-sided, two-dimensional image of a triangle, terming triangulation a misappropriated and misapplied concept, which within postmodern assumptions of multiple realities creates an interesting and pertinent semantic debate.

However in the absence of a more suitable term, whilst acknowledging its limitations, the term triangulation is used here for its recognisability, in representing a research design that brings to bear multiple points of view. Sandelowski (1995) further suggests that ways of combining findings derived from paradigmatically distinct and well executed studies of common phenomena whilst maintaining the integrity of both method and findings is imperative.

Conceptual triangulation first described by Jick (1979) is not offered as a panacea for the combination of methods but assumes that the researcher:

- Values qualitative and quantitative methods equally for their ability to explain human nature and ground midwifery/nursing interventions and actions
- Has drawn no '*a priori*' conclusions about each method's relative contribution to the study.

Conceptual triangulation involves "*a search for logical patterns of relationship and meanings between the variables, measured by either or both qualitative and quantitative methods*" (Mitchell 1986 p.25). Its design aims to achieve a more complex and contextual portrayal of the phenomenon of interest and involves five steps.

1. Conducting qualitative and quantitative research true to the paradigmatic assumptions of each method
2. Distinguishing pertinent results within each method
3. Examining confidence in the results
4. Developing a criteria for inclusion of the results in the conceptual model
5. Constructing one or more conceptual models

In this case paradigms and research methods are not the objects of triangulation, because the integrity and the unique contribution of each mode of inquiry is preserved, the objects of the triangulation are the resulting concepts and constructs, the generation of knowledge through the research findings. Relationships are linked between the two sets of research findings to understand conceptually how a phenomenon is known. Some have questioned whether one researcher can simultaneously hold two world views, an argument which has been explored above. Simultaneous conduct of these methods requires rigour to safeguard the diverse assumptions (Foster 1997).

Once data collection is complete the researcher must distinguish salient findings from those which offer little pertinent information. This task is often complicated by sheer volume of findings, requiring shrewd decisions about what to include and what to leave out of the final analysis. The salient results are in essence determined by the research question, however other interesting and unexpected findings were not discarded on the

premise that they might be of equal or even greater importance. Mitchell (1986) suggests that this triangulated approach should err on the side of inclusion rather than exclusion of the research results. To identify salient findings, within the assumptions of conceptual triangulation, results were examined within one method at a time. Premature judgements about the conceptual model must be avoided, which requires strict discipline and is not easily accomplished.

The conduct of each study true to its paradigmatic assumptions precludes a common set of criteria for examining rigour. Thus results are examined separately, using criteria appropriate to each paradigm and judgements must be in concert with philosophic, theoretic and methodologic underpinnings of the research. Conceptual triangulation highlights the strengths of both methods, rather than the compensatory approach posited by those who suggest that the strengths of one blunt the limitations of the other.

Results should be considered in a broad sense and pertinent results should be illuminated by the literature, providing empirical and theoretical support to place results in the context of existing science. Convergence of results can add strength to claims made, however the limitations of convergence may make fully convergent results seem rather redundant, whereas results that are unique to one method or to the study may demonstrate the value of multi-method research. In the process of identifying pertinent findings and assessing their credibility, researchers obtain a focussed perspective on study findings. Results that appear weak or fail to meet the inclusion criteria are eliminated at this point.

The final step involves examining credible relationships between the findings to construct models depicting the phenomena of interest. Central to this process is understanding that the concepts may be grouped in more than one way and may lend themselves to more than one conceptual model. The conceptual results may yield different pictures of the phenomenon depending upon the placement of the concepts within a model and whether one model can accommodate all the findings.

Summary

This preceding discussion has outlined the methodological approach to this study. It presents the case for a mixed methodological approach to address the aims and objectives of the study, and answer the research questions posed, which will be addressed in the following three sections of this thesis. The choice of the research methodology and the rationale for a mixed method approach has been discussed in detail. The ontological/epistemological and practical debates on paradigm incommensurability and

methodological eclecticism have been acknowledged, discussed, critiqued and countered; resulting in the suggestion that the dogmatic approaches to methodology and method have in fact to date hindered the profile and progress of women's health issues. One response to the incommensurability question has been provided by presenting a strong case for a pragmatic approach, which is motivated more by feelings and concerns for the values of women resulting in a voice for women within maternity research and maternity care. A further rejoinder is the use of the conceptual triangulation model, which allows each aspect of the study to be conducted true to its paradigmatic roots, addressing integration of the findings at the analytical stage of the research. This permits the quantitative aspect of the study, to follow a traditional structured and robust approach which can facilitate confidence in the subsequent findings. In contrast, it will allow the qualitative approach to be emergent and reflexive. The following section of this chapter has therefore limited itself to presenting only those aspects pertinent to both the qualitative and quantitative phases of the study, such as study site, study design and ethical considerations. The methodology approaches for the quantitative and the qualitative will be presented in chapters 3 and 5 respectively as immediate precursors to their findings.

Chapter 2b: The Study

Study Site and Care Provision

This study was conducted within Hull and East Yorkshire NHS Hospitals Trust, a large North of England maternity unit. Until early 2003 this unit had offered a traditional model of maternity care, which comprised of shared care between a woman's GP and hospital based visits at defined time intervals, when the woman would be reviewed by a member of the medical obstetric team. Antenatal midwifery care was provided in some localities of the city and accessed by some women, alongside or instead of visits to their GP. The care provided was inequitable and did not provide women with choices for maternity care. As a response to government policy and alongside the closure and amalgamation of two smaller units within the city, maternity care provision and services were reconfigured. Following amalgamation, maternity services comprised of the main maternity unit, with an average of 5,500 births per annum, which provides medical cover at all times, theatres for operative deliveries, anaesthetic cover and an epidural service and neonatal intensive care facilities. In addition a stand alone birth centre was created at the opposite side of the city and offered as a site for delivery, with an expectation of 300 births per annum. The birth centre is staffed by midwives and has no obstetric, anaesthetic or paediatric medical cover available. Antenatal care would be provided in antenatal clinics at both these sites as well as from within community antenatal clinics located throughout the city. The first point of contact for the women with regard to their pregnancy would be their GP as had traditionally been the case and options for both type of antenatal care and site for delivery would be discussed at this first visit. Women were given three main options for maternity care.

Midwifery led care in the acute unit: Women would receive antenatal care from a midwife throughout their pregnancy. Delivery, which would take place within the main maternity unit, and be supported by a midwife, provided no deviation from the norm was identified. If any problems were identified during pregnancy women would be referred to a consultant obstetrician for clinical review and a decision regarding care for the duration of their pregnancy and delivery. If problems were identified during delivery care would be transferred from midwifery led to medically led.

Midwifery led care in the Birth Centre: Women would receive antenatal care from a midwife throughout their pregnancy and during labour and delivery which would take place within the Birth Centre. If any problems were identified in pregnancy women would be referred to a consultant obstetrician for a clinical review and a decision regarding care

for the duration of their pregnancy and delivery. Women with identified high risk pregnancies would be excluded from choosing the birth centre as a site for delivery. If problems were identified in labour, or an epidural was requested women would be transferred by ambulance to the main maternity unit.

Consultant led care: Women who wished to follow a more traditional pattern of care were still given the option to choose to be seen by an obstetrician at defined time points and could be seen in between these visits by either their GP or a midwife.

Women made a choice regarding both their antenatal care and site for delivery at the antenatal booking appointment.

In the following section, the study design and ethical approval for both the qualitative and quantitative aspects of the study are discussed in a combined manner to avoid repetition. The participants, procedures, methods employed to collect the data and methods of analysis are described and justified separately under quantitative and qualitative headings in later chapters.

Study Design

Phase 1

A longitudinal prospective cohort study, using a 'one-between subjects', 'one-within subjects' 3 x 4 longitudinal design with repeated measures on the second factor was employed in the quantitative arm of this study. The between subjects independent variable is group type as defined by care type chosen, the within subjects independent variable will be four time based observation points, as outlined below. The dependant variables were psychometric questionnaires presented in the form of a booklet.

Much research that has considered psychological well-being and pregnancy gives rise to methodological concerns in that dimensions of stress or psychological health have only been measured at one point in pregnancy or the postnatal period, which cannot provide a comprehensive picture of women's experience of psychological health in pregnancy. The design of this study addresses the methodological concerns expressed by Paarlberg, Vingerhoets, Passchier et al. (1995) regarding the lack of attention to time dimension in the study of stress and pregnancy. By measuring psychological well-being over time during pregnancy and into the postnatal period these concerns are addressed. Psychological well-being in pregnancy may change over time in response to differing stimuli, as a result of the interventions that take place and/or the adoption of coping mechanisms by pregnant women. In order to further illuminate this concept a fourth group

of non-pregnant women was recruited to the study to demonstrate differences between pregnant and non-pregnant women in psychological status over time. These women completed questionnaires at the same time intervals as the pregnant groups, but did not take part in interviews for the qualitative aspect of the study.

Phase 2

Women were recruited to the qualitative arm of the study from within the quantitative study cohort, in order to obtain the women's subjective views of their experience at the four identified observation points.

First observation: All data was obtained from women when they attended for their antenatal booking visit; this is traditionally the first visit to the antenatal clinic for pregnant women. For the majority of women the appointment to attend the antenatal clinic is between ten and fourteen weeks gestation (Silverton 1993). At this appointment women were asked to make a choice of carer for their pregnancy and intended site for delivery. Women completed the study questionnaires whilst waiting in the antenatal clinic for their appointments.

Interviews took place within two weeks of the antenatal booking visit in order to explore women's emotional response to their pregnancies, their feelings and experiences of early pregnancy, of being pregnant and the rationale behind their choices for maternity care.

Second observation: All data was obtained from women at 32 weeks gestation. The aim was to collect questionnaires during the third trimester because studies have identified that psychological distress in late pregnancy is a powerful predictor of postnatal psychological sequelae (Matthey, Barnett, Howie, et al. 2003, Beck 2001, O'Hara & Swain 1996). In addition 32 weeks represented a convenient point where all women access the maternity system for routine bloods to be obtained. The women were sent their study questionnaires by post at approximately 30 weeks and asked to return them at their 32 week appointment.

A date for interview at 32 weeks had been arranged following the initial interview. The aim of the interview at this time point was to explore and capture women's feelings and emotions surrounding their pregnancies, their experience to date, alongside their thoughts and feelings about their developing babies, impending labour and to revisit their choices for care in the context of their experiences to date.

Third observation: All data was obtained at approximately 14 days after birth. The aim was to detect any early onset of psychological distress that might occur in the early postnatal period, but to avoid the recognised period of 'postnatal blues' found in at least two thirds of women in the first week postpartum and particularly on day five (Cox, Connor & Kendall 1982). Although a large number of high scores are likely to be obtained if questionnaires are given routinely in the very early weeks due to adjustments following birth, the turmoil of motherhood and changes in sleep patterns (Cox & Holden 2003), there is some accruing data to suggest that peridelivery depression scores are associated with an increased risk of postnatal depression (Lee, Yip, Chui et al. 2001) and that severe or sustained postnatal blues are a powerful predictor of subsequent depression (Henshaw 2000). It seems likely that there are powerful causal factors specific to the immediate postnatal weeks (Cox & Holden 2003).

Women were contacted in the first week following delivery and interviews were arranged within the following two weeks. These interviews were designed to explore their birth experience, to capture those early motherhood experiences, feelings and emotions, and to explore, after their babies had been born, their feelings about the choices they made for care during pregnancy and the site chosen for delivery.

Fourth observation: All data was obtained at 6 months following the birth of the baby, this was because previous research had suggested that psychological distress experienced during pregnancy and childbirth could be enduring (Martin and Jomeen 2004) and that conditions such as postnatal depression are described as a sustained depressive disorder occurring in women in the first year after childbirth (Oakley 1980). In addition observations at this time would allow the detection of psychological distress beyond any input from maternity services.

A date for interview at six months had been arranged following the immediate post delivery interview. The aim of this interview was to explore retrospectively their labour and birth experience and their feelings about the choices they made for care during pregnancy and the site chosen for delivery. In addition, it was hoped to capture some of their experiences and feelings during the first six months of motherhood and its associated emotions.

Ethical Issues

Hull and East Yorkshire local research ethics committee (LREC) approved the quantitative phase of the study on the 6th February 2003 and the qualitative phase of the study on the 1st

April 2003 (see appendices 1 and 2). In addition the study was approved by the Trust Research and Development department (see appendix 3) and the medical director approved all paperwork and precautions to ensure the protection and confidentiality of data (see appendix 4). All data was password protected and participants were identified only by number once data was entered onto the research database. Access to the names of participants in the study was limited to the researcher and a separate database was kept for this purpose.

Study participants had to be aged 18 or over and written consent was obtained in triplicate from all women participating in the study, one copy for the woman, one copy for research records and one copy to be kept in the medical records (see appendix 5). Additional and separate consent was obtained from the women who took part in the qualitative aspect of the study. Consent was also obtained from the non-pregnant women (see appendix 6). Women were informed that they were free to withdraw from the study at any point in time. To minimise any risk of coercion women taking part in the study were assured that refusal to take part in the study or withdrawal at any point would in no way jeopardise or impact on their care during pregnancy, labour and following delivery. All women were assured of anonymity, for those women taking part in interviews all names used in interviews were changed.

Summary

The immediately preceding section of this chapter has presented the aspects of the research study that are pertinent to both the qualitative and quantitative phases of the study. The conceptual triangulation approach, outlined earlier in the chapter, dictated that each phase of the study be conducted as independently as possible. Concordant with that approach each aspect of the study will be presented independently within sections b and c of this thesis. The methods employed for the quantitative and the qualitative aspects of this study will therefore be presented in chapters 3 and 5, respectively, as immediate precursors to their findings.

Section B

The Quantitative Study

The following section of the thesis will present the quantitative arm of the study. The aim of this aspect of the study is to address the first research question:

Does choice of maternity care impact on antenatal and postnatal psychological outcome?

Chapter 3, will firstly present the method employed, it will proceed to comprehensively outline and justify the measures used to collect the data and lastly describe the process employed to analyse the data. Chapter 4 will then present the quantitative findings, accompanied by the initial interpretations of the quantitative results. The discussion of the results, presented in Chapter 4, will be relatively brief. A fuller and more in-depth discussion of findings will take place in Chapter 8, where the results will be discussed in the context of and integrated with the findings from the qualitative arm of the study.

Chapter 3: Quantitative Method

Introduction

The following chapter presents the method employed for the quantative arm of the study. Firstly, the sample is presented and justified and a clear rationale for the eventual sample make-up is provided. The study procedure is then outlined, including how women were given information, approached, recruited and followed up. Each of the measures used to collect the data are discussed in turn, the reliability and validity of each measure is considered and comments are made with regard to the utility of each instrument. Lastly, the method employed to analyse the data collected is clearly outlined, providing a clear rationale for the analytical process and demonstration of how analytical choices were made.

Participants

A total of 165 pregnant women, who were referred for care between April 2003 and May 2004, were recruited by convenience sampling from a mixture of hospital and community antenatal clinics. In addition 55 non-pregnant women were recruited. Numbers for the study were determined by a power calculation, which identified that with a power of 0.80 and a small effect size specified (n2) with an alpha set at 0.05 (two-tailed) total sample size was calculated to be 200. Eligibility of the participants was ascertained using a specified inclusion and exclusion criteria (see appendix 7). All participants were volunteers who signed a written consent prior to inclusion in the study as described in chapter 2. The study comprised of four study groups. Three of the groups were sampled according to maternal choice of clinical management type. Although randomisation of these study groups, as the gold standard of quantitative research (Gallo, Perone, De Placido et al. 1995), would have been ideal, it was not possible to undertake an experimental study in order to demonstrate the presence or absence and magnitude of any causal relationship between the factors under investigation. The approach employed in this study clearly had to take into account that removal of choice from women entering the maternity system would be unethical. Therefore, the groups were designed to follow the options for maternity care as outlined earlier in chapter 2:

Consultant led care within an acute setting
Midwifery led care within an acute setting
Midwifery led care within a stand alone birth centre

The fourth reference group of 55 non-pregnant women recruited to the study were volunteers recruited by leaflets and posters from within the study site hospital, and two local universities. The purpose of the non-pregnant reference group was to assess rates of psychological distress in a non-pregnant population and to provide a picture of how psychological status is influenced by the experience of pregnancy and childbirth, regardless of choices for care.

The original intention was to recruit 50 women to each study group. However in reality the group sizes had to be adjusted. The system of midwifery led care was explained to the women by their GP and then repeated at the antenatal booking clinic. Women were embracing the opportunity to choose the midwifery led option for care; as a consequence the number of women with low risk pregnancies requesting Consultant led care dropped well below the anticipated level, which in itself is an interesting occurrence. This created difficulties in recruiting 50 required for the Consultant led care group. A pragmatic decision was therefore taken to recruit a minimum number of 25 women into this group. However, in order to maintain a total sample size of 200, an extra 25 women were recruited to the midwifery led care within an acute setting group. It should be acknowledged that with less data available for the Consultant led care women, a bias may be introduced in the comparison of the psychological profiles between groups. Such bias could be responsible for an increased likelihood of a type 2 error. Howell (2002) suggests, however, that studies conducted on intact groups have to contend with the fact that such groups nearly always vary in size. Justification for this decision was that it actually presented study groups that were in reality more reflective of the service setting, whilst still maintaining sufficient numbers in each group to meet the criteria for analysis. The issue of group sizes, drop out and study power will be addressed further in the following chapter.

Procedure

Women referred into the maternity system from April 2003 after local services had reconfigured were given an information leaflet (see appendix 8) about the study on attending for antenatal booking scan which preceded their antenatal booking appointment by at least a week. Eligibility for the study was confirmed on the day of the antenatal booking appointment by screening the obstetric records and the GP referral letter. The women were then approached on an individual basis when they attended for the antenatal booking visit and eligibility was further confirmed with the woman in case relevant information had been missed from the obstetric records. Women that met the inclusion criteria were invited to take part in the study, they were invited to ask questions about the

nature of the study and clarification about the options for maternity care was provided. Written consent was obtained from all women at this point. Recruitment took place from the antenatal clinics at both the main hospital and birth centre sites and also from within the community based antenatal booking clinics.

Women were encouraged to complete the first questionnaire booklet whilst in the clinic, which the majority of women did. Women who did not return their questionnaires prior to leaving clinic were sent a letter asking them to return their questionnaires with a stamped addressed envelope enclosed. Second reminder letters were sent to women who did not return the questionnaire within seven to ten days, if questionnaires were not returned after the second reminder then the woman was classified as a non-return. A form to withdraw from the study was included with the reminder letter and women who completed that form were classed as withdrawals.

The subsequent questionnaires were sent to the women as previously outlined in chapter 2. Women who did not return questionnaires were sent a reminder letter at all time points after seven days and a second reminder letter after fourteen days, women who did not return after the second reminder were not sent a further reminder, although they were still sent subsequent questionnaires throughout the study.

The women recruited to the non-pregnant group contacted the researcher directly following the distribution of an information leaflet, asking for volunteers. No incentive to take part in the study was offered. All non-pregnant volunteers gave written informed consent to be involved in the study and first questionnaires were usually returned by post. Follow up, to maximise questionnaire response, followed the same procedure as for the pregnant women described below.

Measures

The comprehensive literature review of the relevant psychological dimensions during pregnancy has outlined domains of psychological health pertinent to pregnancy, childbirth and the postnatal period. The domains identified for inclusion were anxiety and depression; worry; control; quality of life; self-esteem and sleep quantity and quality. A further literature search to identify currently existing validated generic and pregnancy specific instruments that would satisfactorily assess the identified dimensions of psychological well-being in pregnancy, childbirth and into the postnatal period was undertaken. The terms anxiety; depression; worry; control; quality of life; self-esteem and sleep quantity and quality were combined with the words measures; questionnaires and

assessment. Once identified their content was explored to assess their relevance to pregnant women and claims to validity in pregnant and childbearing populations explored through their use in other pregnancy related studies. On this basis, the questionnaires chosen for inclusion were:

- Hospital Anxiety and Depression Scale (HADS)
- Edinburgh Postnatal Depression Scale (EPDS)
- Cambridge Worry Scale (CWS)
- Multidimensional Health Locus of Control (MHLC)
- SF36 (Quality of Life)
- Pittsburgh Sleep Quality Index (PSQI)
- Culture Free Self-Esteem Inventory (CFSEI)

Hospital Anxiety and Depression Scale (HADS)

The Hospital Anxiety and Depression Scale (HADS: Zigmond & Snaith 1983) has become an increasingly popular instrument used both in clinical and research settings. It is designed to assess the dimensions of anxiety and depression in non-psychiatric populations (Herrmann 1997).

The HADS is a 14 item questionnaire that consists of two sub-scales of seven items designed to measure both levels of anxiety and depression. The HADS is quick and easy to administer, which has led to it being applied extensively in a variety of clinical settings. Its strength is its claim to be robust against confound due to physical symptoms, culture free and psychometrically robust and reliable. The questions are scored 0-3 and negative item scores are transformed, the higher the scores on the sub-scales or as a total global measure the greater the probability of anxiety and depression. Snaith & Zigmond (1994) advocate the use of anxiety and depression sub-scale scores as clinical indicators rather than a HADS total score being used, since the HADS total score only provides an index of general emotional disturbance. Other studies (Razavi, Delvaux, Farvacques et al. 1990) however, when studying cancer patients, found the HADS to be a unidimensional measure and suggested that the global score is used as an index of global psychological distress. This recommendation has not been widely accepted.

The HADS has been recommended as a reliable clinical index of self report anxiety and depression in studies concerned with quality of life issues (Slevin 1992). More recently the HADS has become popular and claimed to be reliable in the assessment of anxiety and depression amongst pregnant women (Cederholme, Sjoden & Axelsson 2001; Cordle and

Prettyman 1994; Prettyman, Cordle & Cook 1993). However, these studies have generally focused on research into physical pathology associated with pregnancy. A recent study utilising the HADS with women experiencing a 'normal' pregnancy in a cross cultural context, suggests that the HADS is not measuring two distinct dimensions of anxiety and depression (Karimova & Martin 2003). This study however, is the first to make this suggestion in a pregnant cohort and further studies would be needed to confirm these observations before the use of the HADS in a pregnant population could be discounted. The HADS remains the 'gold standard' psychometric measure for anxiety and depression and as such integral to any study measuring anxiety and depression as dimensions of psychological well-being. Assessment of the utility instrument was performed in this study group of pregnant women at the first observation point. The instrument total scale and HADS-A and HADS-D sub-scales demonstrated acceptable internal reliability but results of a confirmatory factor analysis (CFA) revealed that a three factor model provided the best fit for the data but still did not reach acceptability in terms of fit indices thresholds (Jomeen & Martin 2004a). These findings are consistent with those of Karimova and Martin (2003) that the HADS does not reliably assess distinct domains of anxiety and depression. Although the findings demonstrated by the HADS will be presented in this study, further research on this instrument is clearly required before it can be recommended for widespread use in pregnancy.

The Edinburgh Postnatal Depression Scale (EPDS)

The EPDS is a ten-item unidimensional self-report scale designed to identify the presence of depression in women following childbirth. Its questions relate to factors such as sadness, fear, anxiety, self-blame and ability to sleep. The scale was developed from the assumption that the established depression screening instruments were suboptimal when applied to postnatal women. Normal postnatal symptoms could be misconstrued as depressive symptomology. The Beck Depression Inventory (BDI; Beck, Ward, & Mendelsohn 1961) and the GHQ (Goldberg 1972), commonly used in the detection of depression, include somatic items on the scale which may be affected by the physiological changes of childbirth and result in new mothers disclosing normal worries. Sleep difficulty in particular, is difficult to evaluate when a baby is influencing sleep patterns (Cox & Holden 2003). Prior to the development of the EPDS, Zigmond and Snaith (1983) had already recognised the need to modify existing self-report scales for use in specific clinical situations with the development of the HADS.

The psychometric properties of the EPDS were originally assessed with a sample of 84 women with a mean of 12 postnatal weeks (Cox, Holden & Sagovsky 1987). Each item is

scored on a four point scale from 0-3, the minimum and maximum scores being 0 and 30 respectively. Scores are transformed so that higher scores indicate a higher intensity of depressive symptoms. The scale identified all women with a definite major depression and two of the three with a probable major depression at a cut off of 12/13. This cut off resulted in a total of 11 false positives. The sensitivity of the EPDS was 86% and the specificity was 78%. The positive predictive value was 73%. This suggested that the rate for failing to detect women with depression could be reduced to under 10% by using a lower cut off of 9/10 (Cox & Holden 2003). This is the cut off score recommended in the initial publication of the EPDS.

Several studies have compared the performance of the EPDS and other depression questionnaires. Although studies have challenged the supremacy of the EPDS for the detection of women at risk for postnatal depression, to date it remains the most widely accepted and validated screening instrument available.

Table 1: Studies Comparing Instruments used to screen for Postnatal Depression (Source: Cox & Holden 2003)

Study	Instruments Used	Population	Results
Harris et al. 1989	Comparison of EPDS with BDI	Welsh population	The BDI was markedly inferior to the EPDS in terms of sensitivity and specificity
Lussier et al. 1996	Comparison of EPDS with BDI	Canadian population	Low concordance between EPDS and BDI suggesting instruments differently attuned the various aspects of the presentation of postnatal depression
Thompson et al. 1989	Comparison of EPDS with HADS and Hamilton Rating Scale for Depression	Welsh population	Found EPDS to be superior to the HADS in identifying research diagnostic criteria (RDC) depression and similar to the observer rated Hamilton Rating Scale for Depression
Condon & Corkindale	Comparison of the EPDS, with depression	Australian population	Found a poor level of agreement and concluded

1997	sub-scale of the HADS the Zung self- rating depression scale (Zung SDS; Zung 1965) and the depression sub-scale of the Profile of Mood States (POM; McNair & Lorr 1964)		that this may reflect the different emphasis in the item content of the questionnaires
Guedeney et al. 2000	Compared EPDS with GHQ 28 and the Centre for Epidemiological Studies Depression Scale	French population	Suggested that the EPDS was better at identifying depression in postnatal women with anhedonic and anxious symptomology, but less satisfactory for psychomotor retardation
Muzik et al. 2000	Compared German EPDS with Zung SDS and the Symptom Checklist –90- Revised (Derogatis & Cleary 1977)	Austrian population	Authors concluded that the German version of the EPDS screened reliably for postnatal depression
Beck & Gable 2001	Compared Post Partum Depression Screening Scale (PPDS) with EPDS and BDI	American population	Found that the PPDS yielded the highest combination of sensitivity and specificity. However the PPDS has yet to be validated in a European population.

Although designed and validated as an instrument for postnatal depression, the EPDS has also been utilised in pregnancy (Evans, Heron, Francombe et al. 2001; Green & Murray 1994) and been validated in non-postnatal women (Cox, Chapman, Murray et al. 1996). Recent studies have suggested that the EPDS may actually be measuring both anxiety and depression in both pregnancy and the postnatal period (Ross, Gilbert Evans, Sellers et al. 2003; Brouwers, Van Baar & Pop 2001; Pop, Komproe & Van Son 1992). The

psychometric properties of this instrument were investigated in this study group at 14 weeks gestation. Both exploratory (EFA) and CFA revealed the EPDS to comprise of distinct but correlated anxiety and depression sub-scales, which could be considered a clinical advantage (Jomeen & Martin 2005a). The EPDS demonstrated reassuring factor stability and as such should continue to be utilised as a psychometrically reliable measure across the antenatal and perinatal period (Jomeen & Martin 2005a).

Cambridge Worry Scale (CWS)

The CWS measures women's worries during pregnancy and includes sixteen items listing pregnancy, health, relationship, socio-medical and socio-economic items of possible concern to pregnant women. The items vary with gestation at completion, as some early worries may not be relevant later in pregnancy, for example the possibility of miscarriage.

The rationale for the development of the Cambridge Worries Scale was the need to assess both the content and degree of pregnant women's worries (Green, Kafetsios, Statham et al. 2003). The items were originally sourced out of qualitative interviews with women attending antenatal clinics. Validity and sensitivity of the scale was increased by provision of a 6 point likert scale (0 'not a worry' to '5' extremely worried). For the purposes of future studies it may however be more appropriate to provide a five point likert scale as in Green et al's study there was no item that was not a worry to anyone, perhaps suggesting that zero worry is an unlikely concept. Indeed empirical evidence relating to other self report scales, for example the SF36, suggest that five level response scales greatly increase score precision (Ware 2004). The raw scores can be used in a variety of ways as either single item (Statham, Green Kafetsios 1997) or as aggregate scores (Green, Kafetsios, Statham et al. 2003).

The scale has been found to load on four factors of worry: Socio-medical aspects of having a baby; socioeconomic issues; health of the mother and the baby and relationships with family and friends. All four factors correlated highly with state and trait anxiety. The discovery of four factors indicates that CWS scores are not merely a reflection of a disposition to worry but that worries are independent of each other (Green, Kafetsios, Statham et al 2003).

Factor structure, reliability and validity has been established (Green, Kafetsios, Statham et al. 2003) and further studies have demonstrated the reliability of the CWS in differing pregnant populations (Georgsson-Ohman, Grunewald & Waldenstrom 2003; Homer Farrell, Davies et al. 2002; Hilvingsson, Radestad, Rubertsson et al. 2002; Sikorsky,

Wilson, Clement et al. 1996). The CWS then seems a useful instrument for the assessment of worry in pregnant women. This study also sought to establish the psychometric properties and clinical utility of the CWS in early pregnancy. Analysis of the data using EFA, CFA and Posteriori Exploratory Factor Analysis (PEFA), concurred with Green and colleagues (2003) that the CWS comprises four distinct but correlated sub-scales, in addition the CWS demonstrated acceptable internal reliability. The finding that the sub-scales were found to assess dimensions distinct from anxiety and depression, holds promise for its utility as a clinical predictor measure and would seem worthy of future investigation (Jomeen & Martin 2005b).

Multi-dimensional Health Locus of Control (MHLC) Scale

The dimension of Locus of Control (LOC; Rotter, 1966) is an important psychological domain of increasing clinical interest to health care professionals in terms of pregnant women's health outcomes prior to, during and following childbirth (Misra, O'Campo & Strobino 2001). The LOC (Rotter, 1966) construct has been studied extensively for several decades in relation to health behaviour (Martin, 1999) and has a rich psychological ancestry in terms of theoretical development, construct integrity, validity and clinical application (Martin, 1999).

There are a number of instruments available to assess health LOC, however the most widely accepted clinically applied index is the Multi-dimensional Health Locus of Control Scale (MHLC) developed and validated by Wallston and colleagues (1978). The MHLC Scale is comprised of 18 items rated on a 6-point Likert type scale ranging from 'strongly disagree' to 'strongly agree'. The MHLC Scale (forms A and B) contains 3 sub-scales assessing 'internal', 'chance' and 'powerful others' locus of control. Each sub-scale is composed of six items and scores are summed with a possible range of scores for each sub-scale of 6-36. Higher scores indicate greater belief in each sub-scale domain in terms of control over health. The MHLC-A and the MHLC-B instruments has been found to be a psychometrically valid and reliable instrument (Coelho, 1985; Gala, Musicco, Durbano et al 1995; Wallston, Wallston & Devellis 1978). The MHLC instrument has been used extensively in health care research (Steptoe and Wardle, 2001) and has been found to be a useful health outcomes predictor instrument. The psychometric reliability of the MHLC is increased by using the measure at all observation points in a study (Cooper and Fraboni 1990). The MHLC when recently utilised in a study of pregnant women with prelabour rupture of membranes was found to be a clinically useful instrument (Martin & Jomeen 2004).

Wallston, Stein & Smith (1994) developed and validated a refined version of the MHLC scale called form C or MHLC-C. This measure was developed as a general purpose but condition-specific measure that could easily be adapted for use with all medical or health-related conditions. A convincing rationale supporting the development of this new measure was the observation that health locus of control beliefs about a specific health condition may correlate differently with health outcomes than more general health locus of control beliefs (Brady, 2003). The MHLC-C reflects similar dimensions to Forms A and B, in particular the 'internal' and 'chance' sub-scales, however the 'powerful others' dimension comprises two distinct sub-scales referring to either doctors (doctors sub-scale) or all other powerful others (others sub-scale). This form of the MHLC has demonstrated impressive reliability and validity (Wallston, Stein & Smith 1994). The utility of the MHLC-C is based on the assumption that the measure assesses reliably these four relatively independent domains of LOC. Wallston, Stein & Smith (1994), based their assumption of four domains on the basis of *a priori* theory and a factor analysis of the data set during final scale development. Interestingly, though the MHLC scale forms A and B have been widely psychometrically evaluated in clinical and non-clinical populations (Brady 2003), no research has been conducted to determine the psychometric properties and factor structure of the MHLC-C in pregnant populations. Therefore, evaluation of the psychometric properties of this instrument was carried out in this study population at the first observation point (Jomeen & Martin 2005c). EFA and CFA revealed the MHLC-C to be comprised of three distinct and correlated factors of 'internal', 'chance' and 'powerful others' locus of control. A fourth sub-scale 'doctors' lacked acceptable internal reliability in this clinical group but demonstrated possible clinical utility as it was observed to be sensitive to the non-depressed/depressed status of participants.

SF-36 Version 2 (Quality of Life)

The SF-36 is the most widely used patient based health status survey in the world. The SF-36 has been proven to be useful in screening individual clients, differentiating the benefits produced by different treatments (Medical Outcomes Trust 2003). Quality of life measures can either be generic or disease specific, generic instruments such as the SF-36 attempt to capture a broad range of aspects of life quality that are important to all patients (Clark, Khan, Foon et al. 2002). They should detect possible consequences of the condition that may be harder to predict making it an appropriate measure to use in pregnancy.

The SF-36 is quick and easy to administer and is appropriate for self completion. The questionnaire consists of 36 items which produce eight health scores.

- Limitations in physical activities due to health problems

- Limitations in social activities due to physical or emotional problems
- Limitations in usual activities due to physical health problems
- Bodily pain
- General mental health (psychological distress and well-being)
- Limitations in usual activities due to emotional problems
- Vitality (energy and fatigue)
- General health perceptions

The SF-36 was developed for the Medical Outcomes Study and has been tested and validated extensively.

Table 2: Studies assessing reliability and validity of the SF-36 (Medical Outcomes Trust 2003)

Study	Study Population	Results
Brazier, Harper, Jones et al. 1992	GP patients Nottingham	The SF-36 is easy to use, acceptable to patients and fulfils stringent criteria of reliability (Cronbachs alpha > 0.85) and for construct validity in terms of distinguishing between groups with health differences.
Garratt, Ruta, Abdalla et al. 1993	GP patients with differing clinical conditions: Scotland	The SF-36 satisfied rigorous psychometric criteria for validity and internal consistency. Clinical validity was demonstrated by the different profiles generated for differing conditions. Sensitivity to health status over time needs further investigation
Jenkinson, Wright & Coulter 1994	Large randomly selected community sample	Internal consistency of the domains was found to be high. Criterion validity was demonstrated by comparison of the dimensions with a single global health question.
Lyons, Perry, & Littlepage 1994	Elderly community sample	Evidence for high degree of internal consistency (Cronbachs alpha > 0.8). Evidence for construct validity was good with the SF36 distinguishing between those with and without markers of poor health

Schulper, Bryan, Hutton et al. 1993	Women with menorrhagia	The SF-36 satisfied rigorous psychometric criteria for reliability and responsiveness.

Within the current study, an investigation sought to establish the psychometric properties of the SF-36 Version 2, in early pregnancy to evaluate the clinical appropriateness of using this measure. Findings demonstrated that the SF-36 sub-scales are measuring distinct but correlated constructs, supporting the use of the instrument as an eight sub-scale measure. The factor structure of the SF-36 comprised a general third-order superordinate domain of health and two second-order highly correlated factors of physical health and mental health. The SF-36 sub-scales were in addition observed to be sensitive to the affective status of participants. The findings supported the use of the SF-36 in this study as a clinical research tool comprising eight sub-scales. The relative merits of scoring the instrument as a two-sub-scale measure of physical health and mental health require further evaluation (Jomeen & Martin 2005d).

Pittsburgh Sleep Quality Index (PSQI)

Although sleep quality is a readily accepted clinical construct it represents a complex phenomenon that is difficult to define and measure objectively. The exact elements that compose sleep quality and their relative importance may vary between individuals. Given the importance of the construct and the inherent difficulties in its definition and quantification, it is important to have a clinical instrument that measures sleep quality.

Although various methods are available to study subjective sleep quality, many do not provide a comprehensive assessment of sleep quality and sleep disturbance. Methods such as single item scales, visual analogue scales and temporal sleep logs or sleep diaries tend to assess only one or two components of sleep quality (Carpenter & Andrykowski 1998). Although other standardised measures of sleep quality exist such as the Karolinska Sleep Diary, the Pittsburgh Sleep Quality Index (PSQI) is the most widely utilised.

The Pittsburgh Sleep Quality Index was developed with several goals; to provide a reliable, valid and standardised measure of sleep quality; to discriminate between 'good' and 'poor' sleepers; to provide an index that is easy for subjects to use and clinicians and researchers to interpret and to provide a brief, clinically useful assessment of a variety of sleep disturbances that might affect sleep quality (Buysse, Reynolds, Monk et al. 1989). The PSQI consists of twenty self rated questions and five questions rated by the bed partner. The latter five questions are used for clinical information only and are not

tabulated in the scoring of the PSQI. The twenty questions assess subjective sleep quality by measuring subjective sleep quality; sleep latency; sleep duration; habitual sleep efficiency; sleep disturbances; use of sleep medication and daytime dysfunction over the past month. These items are then grouped into seven component scores, each weighted equally on a 0 – 3 scale. The seven component scores are then summed to yield a global PSQI score, which has a range of 0 – 21. Higher scores indicate worse sleep quality. A global score of five or more indicates a 'poor sleeper'

Since its introduction in 1989 the Pittsburgh Quality Sleep Index (PSQI) has gained widespread acceptance as a useful tool to measure sleep quality in different patient groups. Its good reliability and validity has been shown for patients with psychiatric and sleep disorders (Doi, Minowa, Uchiyama et al. 2000; Buysse, Reynolds, Monk et al. 1989), with patients with different somatic diseases (Carpenter & Andrykowski 1997), for nursing home residents (Gentili, Weiner, Kuchibhatla et al. 1995), for healthy elderly subjects (Buysse, Reynolds, Monk et al. 1991) and in primary insomnia (Backhaus, Junghanns, Broocks et al. 2002) amongst others. All of these studies have commented on the reliability and validity of the PSQI. The results of these studies suggest that the PSQI is a psychometrically sound measure of sleep quality and sleep disturbance, which can be successfully self-administered.

The testing of this instrument by CFA within the current study suggests that the best model fit was offered by a two-factor correlated model comprising PSQI sleep quality, sleep latency, sleep duration and habitual sleep efficiency as factor one, sleep disturbance and daytime dysfunction as factor two and excluding the PSQI sleeping medications sub-scale from the analysis (Jomeen & Martin *in press*). This would seem to be an intuitive finding when sleeping medications are predominantly contraindicated in pregnancy. Further assessment of the PSQI (all seven component sub-scale scores) in the current study demonstrated a calculated Cronbach's alpha of 0.73 therefore exceeding Kline's (1993, 2000) criterion for acceptable instrument internal consistency and suggesting that the PSQI is suitable for clinical use in this group (Jomeen & Martin *in press*).

Culture Free Self-Esteem Inventory (CFSEI-2)

Self-esteem has been described as comprising a number of facets or components that include general, social and personal self-esteem (Battle 1990; Battle 1981; Coopersmith 1967). General self-esteem is that aspect of self-esteem that refers to individual's overall perceptions of their own worth; social self-esteem refers to individual's perception of the

quality of their own relationships with peers and personal self-esteem refers to individual's most intimate perceptions of self worth. Individuals who feel good about themselves are confident, take pride in their achievements and demonstrate respect and concern for themselves and others.

There are a number of different measures to assess self-esteem; two of the more commonly applied are the Rosenberg Self-Esteem Inventory (Rosenberg 1965) and the Coopersmith Self-Esteem Inventory (Coopersmith 1984).

Another popular measure, although not as frequently utilised as the Rosenberg scale, is the Culture Free Self-Esteem Inventory (CFSEI -2). The CFSEI-2 is a self report inventory which measures an individual's perception of self. The CFSEI-2 has been shown to be a valid and reliable tool in the measurement of self-esteem in adults (Battle 1981). The CFSEI-2 is a 40-item self-report self-esteem measure scored using a forced-choice (yes/no) format that has been found to be clinically useful (Ritter, Hobfoll, Lavin et al. 2000; Killingsworth Rini, Dunkel-Schetter Wadhwa et al. 1999; Hall, Kotch, Browne et al. 1996). An impressive characteristic of the CFSEI-2 is the instrument's ability to capture a variety of distinct domains of self-esteem that can be scored separately and evaluated independently in terms of predictive potential and discriminate utility. The measure contains four subsets

- General self-esteem (16 items)
- Social self-esteem (8 items)
- Personal self-esteem (8 items)
- Lie subtest (8 items)

The purpose of the lie subtest is to indicate defensiveness in the responses given. The items in the instrument are divided into two groups those that indicate high and low self-esteem. Raw scores for total self-esteem can be ascertained alongside scores for each sub-scale. The advantage of the CFSEI-2 over other available measures is that it is able to provide measures on the domains of self-esteem unlike the Rosenberg which is generally utilised to provide a measure of global self-esteem in pregnancy rather than differentiating between the differing dimensions of self-esteem (Ritter, Hobfall, Lavin et al. 2000; Killingsworth-Rini, Dunkel-Schetter, Wadwha et al. 1999; Hall, Kotch & Brown et al. 1996). Battle (1990) also argues for the culture free aspect of the scale by indicating that it has been translated into several languages with no objections to cultural bias by practitioners, although this has been challenged (Brooke 1995)

Within the current study, the predictive ability of self-esteem, assessed by self-report questionnaire, in predicting the psychological status of women early in pregnancy was investigated. The findings suggest that assessment of self-esteem in particular personal self-esteem may be a useful predictor of psychological disturbance, particularly anxiety and depression, supporting the clinical use of this instrument (Jomeen & Martin 2004b).

Other Outcome Measures

Additional questions were added to account for other identified predictors of postnatal depression as identified by O'Hara & Swain (1996) and Beck (2001), including unplanned unwanted pregnancy, number of other children, and marital status. Green (1990b) has also identified initial reaction to pregnancy to be a significant predictor of postnatal emotional well-being.

The questionnaires were incorporated into a questionnaire booklet, which remained in the same format for all time points. Demographic variables were assessed at the first time point and included age, parity and marital status. Information about the pregnancy and women's current care status were collected on all occasions. As the questionnaires were to be administered on four occasions over the period of a year, this section was adapted for each observation point so that they remained relevant to the gestation of pregnancy or time during the postnatal period (see appendix 9).

Data Analysis

All data were analysed using SPSS for Windows, version 11.5. Group comparisons of background characteristics, clinical and demographic data were analysed by Analysis of Variance (ANOVA) at an ordinal level and χ^2 at a nominal level. To answer the research question a 3 x 4 analysis of covariance (ANCOVA) was run. The between subjects independent variable (IV) was group type as identified above, the within subjects IV was observation point. The dependant variable (DV) was the scores on the psychometric questionnaires. The first premise of this analysis was that because groups were not randomly assigned, there is no basis for assuming that any differences in baseline data are due to chance (Hazard Munro 2005). The pre-test, one-way analysis of variance (ANOVA), allowed comparison of the baseline means of the different groups and demonstrated a statistically significant difference between groups for age ($F = 11.32$, $df 2$, $p =>0.01$).

It is possible then that variability in questionnaire scores could be directly attributable to age, which has nothing to do with the focus of the study, i.e. differences in care type.

Removal of the variance attributed to age (the covariate: CV), was hence necessary to provide us with a clearer test of our original hypothesis (Howell 2002). It was therefore necessary to continue the analysis, using ANCOVA. ANCOVA is used in quasi-experimental designs to adjust group means on the DV's to what they would be if all subjects scored equally on the CV and to reduce the error term (Hazard Munro 2005). Differences between subjects on CV's are removed so that, presumably, the only differences that remain are related to the effects of the groupings IV's, in this case group type and observation points. The ANCOVA provides a more precise look at the IV-DV relationship and increases the power of analysis i.e. the likelihood of correctly rejecting the null hypothesis. It should be noted that differences could also be due to attributes not used as CV's.

The purpose of this analysis was to determine whether group type (type of care chosen for antenatal, intrapartum and postnatal periods) affected psychological outcomes after adjustment for age. It was also important to assess whether change in behaviour over levels of one IV depend on levels of another IV, i.e. an interaction effect. In this case whether when observation point is added as a second IV are differences in psychological outcomes over group type the same for all observation points?

It was necessary to employ strategies to deal with the unequal group sizes. Analyses were performed by SPSS general linear model (GLM). SPSS provides an alternative for dealing with the unequal group sizes involved in this study and offers power analyses and effect sizes in the form of Partial Eta Squared. The GLM offers an approach to analysis in study designs such as this with within subjects IV's. Utilising the GLM approach in this study, the repeated measures (observation points) are adjusted by the interaction of the CV (age) with the within subjects effects. This model provides adjusted marginal and cell means. This strategy controls for any difference in the relationship between the DV and the CV, for different levels of the within subjects, in essence the GLM approach adjusts for interactions of the covariates with the factors (Wildt & Olli 1978).

Use of ANCOVA ensured that the data met all the assumptions necessary for the validity of the regression and ANOVA components of the test (Hazard Munro 2005).

- The groups were mutually exclusive
- The variances of the groups should display homogeneity of variance
- The DV's were normally distributed
- The CV must be a continuous variable

- The CV and the DV's must show a linear relationship
- The direction and strength of the relationship between the CV and the DV must be similar in each group (homogeneity of regression). The more this relationship is violated the greater the likelihood of Type II errors.

The homogeneity of regression was tested in SPSS by performing a custom factorial test prior to running the ANCOVA. This indirect test examines the interaction between the CV (age) and the grouping variable, allowing any significant interaction to be identified and indicating if homogeneity of regression had been violated. Because the interactions were not significant the assumption was met.

Descriptive statistics allowed minimum and maximum scores to be checked, to ensure that no scores exceeded the limits of the questionnaire scores due to data entry error. Any data entry errors were checked and adjusted as necessary.

The hypothesis that there are no differences between groups is tested in ANCOVA by the F ratio, formed by dividing the adjusted mean square between groups by the adjusted mean square within groups. Any main effects of interactions that were statistically significant, considered the estimated population parameters (adjusted means, standard deviations and confidence intervals). A computed F score of greater than one indicates greater variation between groups than within groups, from which it is inferred that the grouping variable does make a difference. It will then be found to be significant in the computed SPSS table (Wildt & Olli 1978). Examination of the original and adjusted group means for each level and combination of levels of the IV's will provide insight into the role of age as the CV.

The study design for this study utilised a mixed between and within subjects design. Age in this study, as a CV is only measured once, as suggested, The CV adjusts for any between-subjects effects within the study design, but does not provide adjustment to a within subjects effect, because it provides the same adjustment for each level of the effect. A complication of a repeated measures (within subjects effects) ANCOVA is the assumption of sphericity. The sphericity test is a special case of homogeneity of variance test for repeated measures ANCOVA, when using a repeated measures factor with three or more levels as in this study. ANCOVA assumes sphericity, which is when the variance of the difference between the estimated means for any pair of different things is the same as for any other pair. If the significance of the sphericity test is less than 0.05, then it is necessary to accept that the data are not spherical, thereby violating the sphericity assumption (Wildt & Olli 1978). To counter this, multivariate ANCOVA tests were used

to partial the CV from the entire set of dependant variables including Pillai's Trace, Wilks' Lambda, Hotelling's Trace and Roy's Largest Root.

Correcting the univariate F test can be done using the Greenhouse-Geisser Epsilon. F is the ratio of between groups to within groups mean square variance. The degrees of freedom for between groups is (k-1), where k is the number of groups. The degrees of freedom for within groups is k(n-1), where n is the number of cases in each group. Greenhouse-Geisser corrects F given a finding of lack of sphericity by multiplying the between groups degrees of freedom by the value of epsilon (Wildt & Olli 1978). For the purposes of this analysis when Mauchley's Test of Sphericity demonstrated significance, the Greenhouse-Geisser was used to examine the F value.

After the overall relationship was established by the F test, differences between pairs of group means were tested to determine which groups involved significant effects. These comparisons were made by a post hoc analysis using the Bonferroni correction. It should be acknowledged that investigating all possible paired comparisons on a post hoc basis, would find some significant differences just by chance.

Anxiety and depression caseness data defined by the HADS-A, HADS-D and the EPDS were compared using the χ^2 test.

Additional independent *t*-tests were used to compare differences between study completers and non-completers. Levene's equality of variance test was used to determine the acceptability of the data for parametric testing and where Levene's was significant equal variances were not assumed.

Summary

The above chapter has outlined how the quantitative data for this study has been collected and analysed, including justification for all methodological choices and decisions to promote confidence in the quantitative findings. The following chapter will present and briefly discuss the resultant findings. The major discussion of the findings however will take place in Chapter 8.

Chapter 4: Quantitative Findings

Introduction

The following section presents the findings related to the quantitative aspect of the study and the research question:

1. Does choice of maternity care impact on antenatal and postnatal psychological outcome?

Firstly it will present an overview and background characteristics of the study population and present and briefly discuss study completers and non-completers. Results will then be presented sequentially through each of the psychological domains studied; a brief narrative discussion will accompany these results although, as already made clear, a fuller discussion of the findings will take place in chapter 8. The focus of the following chapter will be on the statistically significant findings, although non-significant ANCOVA results will be presented for completeness of data presentation. Descriptive data for the non-significant scale and subscale findings will not be presented but can be found in appendix 10. Anxiety and depression caseness as defined by the HADS and the EPDS will also be presented and briefly explored. Results arising from data provided by a non-pregnant reference group will also be presented and the implications of those findings discussed in relation to the pregnant women in the study.

Descriptive Statistics

Mean scores and standard deviations of age and gestation for the three study groups are shown in Table 1.

Table 1: Background Characteristics of the Participants at Observation Point 1

Variable	Birth Centre (n = 48) Mean (SD)	MLC (n = 79) Mean (SD)	CLC (n = 21) Mean (SD)	Total (n = 148) Mean (SD)
Age	30.96 (5.26)	26.91 (4.58)	32.19 (4.25)	28.99 (5.23)
Gestation (wks)	14.84 (2.79)	13.74 (2.37)	13.86 (3.41)	14.11 (2.71)

Table 2 clarifies the key characteristics of the participants for each group. The parity and marital status data was collected at observation point one (14 weeks pregnant). Of the total sample of 148 women, 51% were married, 43% were with a partner and 6% were single. 37% participants were primiparous and the rest were multiparous. The labour onset and type of delivery data was collected at observation point 3 (14 days postnatal) 78% of women had a

normal delivery, 7% women had an emergency caesarean section, 5% women had an elective caesarean section and 6% had an instrumental delivery.

76% women had a spontaneous onset of labour and 14% were induced; the remainder had no recorded labour due to the nature of delivery.

Table 2: Background Characteristics by Study Group

Variable	Birth Centre (n)	MLC (n)	CLC (n)	Total (n)
Marital Status				
Married	31	33	12	76
With Partner	16	39	8	63
Single	1	7	1	9
Parity				
Primiparous	19	30	5	54
Multiparous	29	49	16	94
Labour Onset				
Spontaneous	39	58	16	113
Induced	7	11	2	20
No Labour	1	6	2	9
Type of Delivery				
Normal	42	56	17	115
Forceps	0	6	0	6
Ventouse	1	2	0	3
Elective LSCS	1	5	2	8
Emergency LSCS	3	6	1	10

Statistical comparison of background characteristics of the study groups

Comparison of the group data using the χ^2 test revealed no significant differences in marital status between groups ($\chi^2 = 7.4, 2\ df\ 4, p = 0.12$), in delivery mode between the groups ($\chi^2 = 8.80$, $df\ 8, p = 0.36$) or with regard to labour onset ($\chi^2 = 2.45$, $df\ 4, p = 0.65$).

The result of a one-way ANOVA to compare differences between the groups in ordinal level data at baseline (14 weeks) is shown in Table 3. A statistically significant difference was observed in age between groups. No other statistically significant differences were observed between groups in baseline data, suggesting that for other than age groups were fairly well matched in background characteristics.

Table 3: Baseline characteristics as a function of group type

Variable		SS	*df*	Mean Square	F	*p*-value
Age	Between Groups	721.93	2	360.97	15.92	>0.01
	Within Groups	3266.04	144	22.68		
	Total	3987.97	146			
Gestation	Between Groups	30.02	2	15.00	2.07	.13
	Within Groups	1049.41	145	7.24		
	Total	1079.41	147			
Feelings on finding out about pregnancy	Between Groups	.02	2	.01	.01	.99
	Within Groups	116.16	144	.81		
	Total	116.17	146			
Parity	Between Groups	1.62	2	.81	.77	.47
	Within Groups	153.05	145	1.06		
	Total	154.67	147			
No of Children	Between Groups	.58	2	.29	.49	.61
	Within Groups	86.14	145	.59		
	Total	86.72	147			

Clinical outcomes of study groups

The result of a one-way ANOVA to compare differences in clinical outcomes between the groups is shown in Table 4. No statistically significant group differences were observed in length of labour, duration of membranes to delivery, gestation at delivery or in apgar scores at 1 and 5 minutes after birth. Only 5 babies in total were admitted to the neonatal intensive care unit and comparison of the group data using the χ^2 test revealed no significant differences between the groups ($\chi^2 = 4.34$, *df 6*, $p = 0.63$).

Table 4: Length of labour, membranes to delivery, neonatal Apgar score and gestation at delivery as a function of group type

Variable		SS	*df*	Mean Square	F	*p*-value
Length of labour	Between Groups	7.59	2	3.79	.19	.83
	Within Groups	2795.78	139	20.11		
	Total	2803.37	141			
Membranes to delivery	Between Groups	301.76	2	150.88	.80	.45
	Within Groups	26066.30	138	188.89		
	Total	26368.06	140			
Apgar at 1 min	Between Groups	2.31	2	1.15	1.73	.18
	Within Groups	93.05	139	.67		
	Total	95.36	141			
Apgar at 5 min	Between Groups	.19	2	.09	.30	.74
	Within Groups	42.98	139	.31		
	Total	43.18	141			
Gestation at delivery	Between Groups	8.75	2	4.37	.86	.43
	Within Groups	711.14	140	5.08		
	Total	719.89	142			

Withdrawals and Non-Completers

Of the total women approached to take part in the study only 5 refused to take part. A further 5 women however either withdrew formally from the study after they had consented to take part and 9 further women failed to return their baseline questionnaires and so were counted as withdrawals. No further data on these women has been analysed due to ethical considerations.

Table 5 shows the response rates by study group at each observation point. The lowest response rate was at observation point three, where only 68% of the original study cohort responded. Such a finding might have been expected in a period where women are preoccupied with caring for their new babies. 101 (68%) women in total completed the questionnaires at all four observation points. 47 (32%) women completed the first questionnaire but failed to complete their questionnaires at all four observation points. It should be acknowledged, that valid inferences can only be extended to women similar to those who actually supplied study data, not to the larger study group. It is also noteworthy that the implications of such a drop out rate are that of an underpowered study, which may

run the risk of a type II error. However, it should be noted that the effect sizes demonstrated for the scale and subscales presented throughout this chapter, are in the main small suggesting that even a larger study sample would fail to demonstrate any real effect that is clinically meaningful (Martin & Thompson 2000). Further the reported data allows further power analyses to calculate realistic sample sizes for future research making this data a valuable resource for researchers in the field of maternity and psychological health.

Table 5 demonstrates that study group response rates, as a percentage of the total response rates at each observation point, remained relatively consistent. Confidence in the study findings presented here and reassurance that the drop out rate identified does not unduly compromise the conclusions drawn from this study is provided by statistical comparisons in group type between completers and non-completers (χ^2 = 2.00, *df* 2, *p* = 0.37). This importantly suggests that drop out did not affect one group more notably than any other.

Table 5: Response rates by study group

Variable	Birth Centre n (%)	MLC n (%)	CLC n (%)	Total n (%)
Response Rates				
14 weeks	48 (32%)	79 (54%)	21 (14%)	148 (100%)
32 weeks	35 (30%)	65 (55%)	18 (15%)	118 (79%)
14 days	39 (39%)	48 (47%)	14 (14%)	101 (68%)
6 months	36 (35%)	50 (49%)	16 (16%)	102 (69%)

Independent *t*-tests were run to compare baseline differences between the completers and non-completers in ordinal level data. A more conservative *p* criterion of 0.01 was utilised to guard against type I error. Results demonstrated one statistically significant difference in general self-esteem at observation point 1 (*t* = 2.88, *df* 145, *p* = 0.01). Comparison of data at a nominal level was conducted using the χ^2 test. A significant difference was shown in marital status (χ^2 = 9.00, *df* 2, *p* = 0.01). Significant differences were also observed in baseline HADS-D possible depression status (χ^2 = 6.14, *df* 1, p = 0.01), EPDS screen positive for minor/major (χ^2 = 7.85, *df* 1, *p* = >0.01) and major depression (χ^2 = 6.87, *df* 1, *p* = 0.01), no other significant differences were observed in baseline data between completers and non completers. These findings suggest that psychological concepts such as anxiety, depression and self-esteem affect an individuals motivation to engage with the research programme. It is possible that there are different perceived costs/benefits between completers and non-completers, which may have implications for the inferential statements made with regard to this study and will be explored further later chapters.

Socio-economic profile of study groups

The largest proportion of women recruited to the trial came from the HU5 (14%) and HU17 (15%) postal districts of Hull. Table 6 below, shows the distribution of study groups by postcode. Several areas had no birth centre and consultant led care bookings but only one area HU10 had no bookings for midwifery led care at the acute unit.

Hull is amongst the most deprived cities in England. The main headline indicators of the Indices of Deprivation 2000 showed Hull as one the 20 most severely affected (Haughton 2001). Appendix 11, illustrates the deprivation profile of the districts of Hull (National Statistics 2004). The indices of multiple deprivation, combine information relating to income, employment, education, health, skills and training, barriers to housing and crime into an overall measure of deprivation (National Statistics 2004). To provide some context, appendix 12 illustrates the postal districts of Hull. The most deprived areas of Hull are located within the HU7 and HU8 postcodes. Significant levels of deprivation are also evident within in the HU5, HU6 and HU13 postal districts. These deprived areas are highlighted in red in table 6. A pocket of severe deprivation exists in the HU9 postal district (highlighted in green), although this is largely a less deprived area. The areas identified within the recent neighbourhood statistics mirror those identified in a joint university and city council report of 2001, which stated "*All these areas exhibit in varying degrees serious problems of a decayed housing stock, low demand / high vacancy rates, low household incomes, high levels of unemployment and crime, and poor levels of health and educational attainment*" (Haughton 2001).

The women recruited to the trial from areas with significant deprivation account for 46% of the three study groups. 68% of the women from those areas chose to deliver under midwifery led care at the acute unit. The more affluent areas within the Hull boundary account for 15% of the study participants, with 68% of those women also choosing to deliver under midwifery led care at the acute unit. The areas outside the Hull boundary within East Yorkshire account for the remaining 37% of group participants. Many of the more prosperous suburbs lie outside the boundaries of the city (Haughton 2001). The ranked position of Hull in terms of the 2004 indices of deprivation is 9th out of 354 (National Statistics 2004: see appendix 13). The same national ranking for the East Riding of Yorkshire is 208th (National Statistics 2004: see appendix 13). Although the East Riding also suffers some significant deprivation, the indices show that both the concentration of deprivation and average rank that is less (National Statistics 2004: see appendix 13). The greatest proportion (56%) from the East Riding areas chose to deliver at the birth centre.

Table 6: Groups defined by postcode

Postcode	Birth Centre	MLC	CLC	Total
Not HU	0	0	3	3
HU2	0	4	0	4
HU3	0	9	2	11
HU4	2	2	3	7
HU5	2	15	4	21
HU6	3	3	5	8
HU7	1	6	0	7
HU8	0	9	0	9
HU9	2	10	1	13
HU10	7	0	3	10
HU11	2	1	0	3
HU12	0	1	0	1
HU13	7	3	0	10
HU14	4	1	2	7
HU15	1	1	0	2
HU16	4	3	1	8
HU17	13	7	2	22
HU20	0	2	0	2

The above findings might demonstrate that individuals socio-economic profiles dictate choice, with very few women from areas of social deprivation choosing to deliver at the birth centre. However, the data above demonstrates that women from within the Hull boundaries chose to deliver at the main maternity unit, regardless of socio-economic status, which might also suggest that choice is based on tradition in the Hull and East Yorkshire areas. This argument seems supported by the women from the East Yorkshire areas who predominantly chose to deliver at the birth centre, which is housed at the old East Yorkshire hospital site.

Cambridge Worry Scale

CWS Socio-medical Subscale

Evidence that women worry about the socio-medical aspects of pregnancy defined by questions about going to hospital, internal examinations, giving birth and coping with a new baby, regardless of the care type chosen is provided by the significant differences over time, demonstrated by the CWS socio-medical subscale scores.

To allow comparison between groups, descriptive statistics for the CWS socio-medical subscale scores are shown in Table 7.

Table 7: Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the CWS socio-medical subscale scores by study group

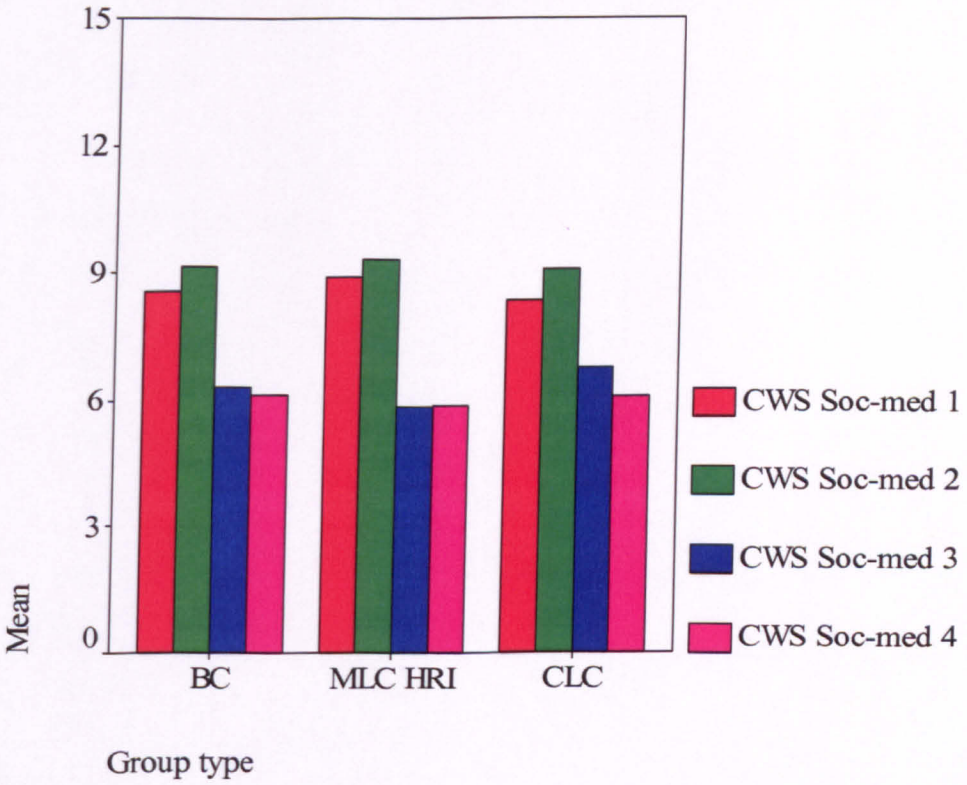
Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	8.55	3.26	8.77	.66	7.45-10.08
	32 weeks	9.13	3.61	9.23	.66	7.92-10.54
	14 days	6.32	2.83	6.29	.44	5.41-7.17
	6 months	6.13	2.40	6.00	.42	5.16-6.85
MLC HRI	14 weeks	8.88	3.49	8.66	.59	7.50-9.82
	32 weeks	9.29	3.23	9.19	.58	8.02-10.35
	14 days	5.83	1.40	5.87	.39	5.09-6.65
	6 months	5.88	1.71	6.01	.38	5.26-6.75
CLC	14 weeks	8.33	3.11	8.54	1.00	6.55-10.54
	32 weeks	9.08	2.97	9.18	1.00	7.18-11.17
	14 days	6.75	2.86	6.72	.67	5.38-8.05
	6 months	6.08	2.78	5.96	.64	4.68-7.24
Total	14 weeks	8.68	3.32	8.66	.43	7.81-9.51
	32 weeks	9.20	3.30	9.20	.43	8.35-10.05
	14 days	6.14	2.24	6.29	.29	5.72-6.86
	6 months	6.00	2.13	5.99	.27	5.45-6.54

Results of a mixed design ANCOVA are shown in Table 8 Significant results were obtained for the main effect of time within groups.

Table 8: Mixed Design ANCOVA Summary for CWS socio-medical subscale scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared (η^2)[a]	Power
Within Subjects							
Time	41.95	2.23	18.83	3.13	.04	.04	.63
Time x Group	4.89	4.46	1.10	.18	.96	.00	.09
Time x Age	10.89	2.23	4.89	.81	.46	.01	.20
Error	1085 46	180.44	6.02				
Between Subjects							
Group	1.28	2	.64	.03	.97	.00	.06
Age	1.01	1	1.01	.05	.82	.00	.06
Error	1532 03	81	18.91				

Figure 1: Bar chart for main effect of time within groups for CWS socio-medical subscale



Visual representation of the data as shown in Figure 1, demonstrates that scores for all four groups increased from baseline scores at observation point 2 and then decreased at

observation points 3 and 4. Examination of the main effect of group revealed no significant differences in CWS socio-medical subscale scores across the three groups. Whilst it seems unsurprising that women might demonstrate the highest socio-medical worry scores during pregnancy. The drop in scores in the postnatal period, despite the questions being adjusted to be gestation specific, may occur because the issues defined as socio-medical are no longer highly relevant in women's responses. The finding that all groups demonstrated similar score patterns across time suggests that choice of care does not mediate against worry about socio-medical issues.

CWS total and other subscale findings

The results a mixed design ANCOVA for the CWS total, health, relationship and socio-economic subscale scores are shown in Table 9. No significant differences were observed either for the main effect of time within groups or the main effect of group. This demonstrates, once again, that worries are not mediated by choice of care but also might suggest that worries about health, relationships and socio-economic issues remain more stable over time.

Table 9: Mixed Design ANCOVA summary for non-significant CWS total and subscale scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*	Parital eta squared (η^2)[a]	Power
CWS Total							
Within Subjects							
Time	119.20	2.46	48.50	1.83	.15	.02	.42
Time x Group	63.83	4.92	12.99	.49	.78	.01	.18
Time x Age	74.23	2.46	30.20	1.14	.33	.01	.28
Error	5281.07	199.08	26.53				
Between Subjects							
Group	223.12	2	111.56	.84	.44	.02	.19
Age	3.38	1	3.38	.03	.87	.00	.05
Error	10795.30	81	133.28				
CWS Health							
Within Subjects							
Time	17.61	2.09	8.43	1.40	.25	.02	.30
Time x Group	14.43	4.18	3.46	.57	.70	.01	.19
Time x Age	6.41	2.09	3.07	.51	.61	.01	.135
Error	1020.13	169.18	6.03				
Between Subjects							
Group	63.11	2	31.56	1.93	.15	.05	.39
Age	.05	1	.05	.00	.96	.00	.05
Error	1325.38	81	16.36				
CWS Relationship							
Within Subjects							
Time	.11	2.70	.04	.05	.98	.00	.06
Time x Group	2.23	5.40	.41	.49	.79	.01	.19
Time x Age	.63	2.70	.23	.28	.82	.00	.10
Error	182.57	218.77	.83				
Between Subjects							
Group	2.86	2	1.43	.40	.67	.01	.11
Age	.58	1	.58	.16	.69	.00	.07
Error	292.17	81	3.6				
CWS Socio-economic							
Within Subjects							
Time	2.06	2.56	.81	.32	.78	.00	.11
Time x Group	6.54	5.13	1.28	.50	.78	.01	.19
Time x Age	2.80	2.56	1.09	.43	.70	.00	.13
Error	529.45	207.62	2.55				
Between Subjects							
Group	2.34	2	1.17	.11	.90	.00	.07
Age	4.18	1	4.18	.39	.54	.01	.09
Error	872.94	81	10.78				

Multi-dimensional Health Locus of Control

MHLC Others Subscale

Women with regard the MHLC 'powerful others' subscale, regardless of group, demonstrated a similar, although less dramatic pattern of scores, to that identified for CWS socio-medical worries. To allow comparison between groups, descriptive statistics for the MHLC others subscale scores are shown in Table 10.

Table 10: Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the MHLC others subscale scores for each study group

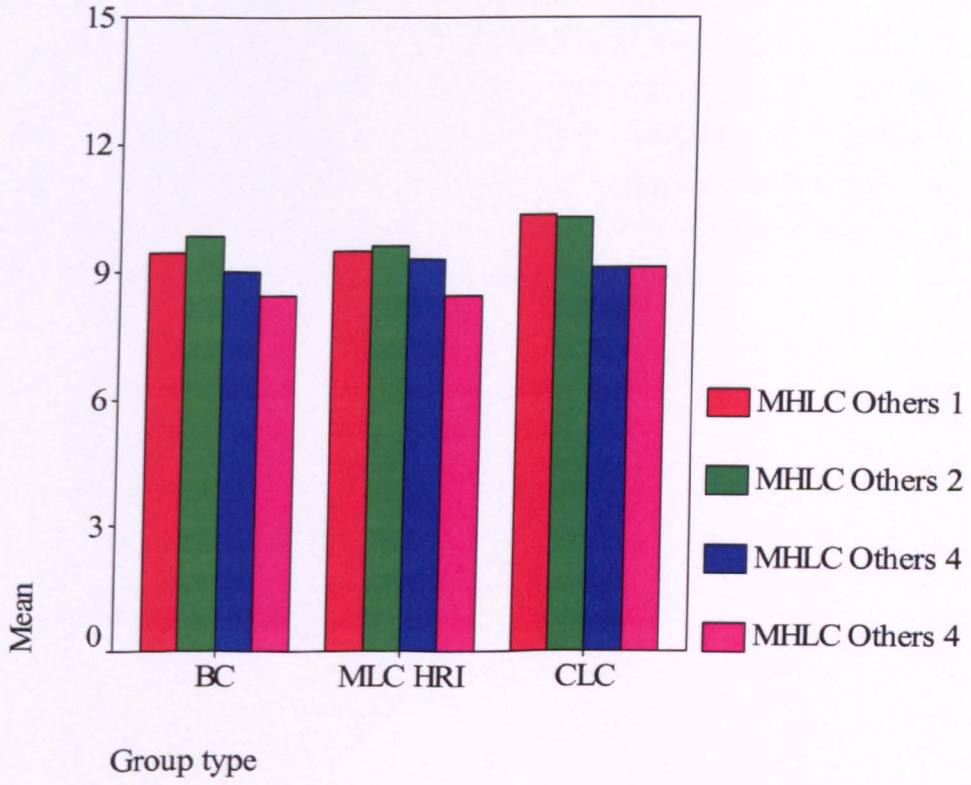
Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	9.47	2.76	9.78	.55	8.69-10.87
	32 weeks	9.83	3.29	10.12	.59	8.94-11.30
	14 days	9.00	2.95	8.87	.54	7.81 - 9.94
	6 months	8.47	2.53	8.15	.48	7.19 - 9.11
MLC HRI	14 weeks	9.50	2.70	9.20	.47	8.26-10.14
	32 weeks	9.62	2.59	9.35	.51	8.33-10.37
	14 days	9.29	2.47	9.41	.46	8.49-10.33
	6 months	8.45	2.49	8.75	.42	7.92 - 9.58
CLC	14 weeks	10.36	2.77	10.64	.84	8.96-12.32
	32 weeks	10.27	3.20	10.52	.91	8.71-12.34
	14 days	9.10	2.39	8.98	.83	7.33-10.62
	6 months	9.10	1.64	8.81	.74	7.33-10.29
Total	14 weeks	9.60	2.71	9.88	.36	9.17-10.58
	32 weeks	9.78	2.91	10.00	.39	9.23-10.76
	14 days	9.15	2.62	9.09	.35	8.39 - 9.78
	6 months	8.54	2.40	8.57	.31	7.95 - 9.20

The results of a mixed design ANCOVA are shown in table 11. Significant results were obtained for the main effect of time within groups.

Table 11: Mixed Design ANCOVA Summary for MHLC others subscale scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared (η^2)[a]	Power
Within Subjects							
Time	55.98	3	18.66	4.30	<.01	.05	.86
Time x Group	25.74	6	4.29	.99	.43	.02	.39
Time x Age	40.14	3	13.38	3.09	.03	.04	.72
Error	1027.85	237	4.38				
Between Subjects							
Group	10.36	2	5.18	.33	.72	.01	.10
Age	.83	1	.83	.05	.82	.00	.06
Error	1246.21	79	15.78				

Figure 2: Bar chart for main effect of time within groups for MHLC others subscale



Visual representation of the data as shown in Figure 2 demonstrates that scores for all four groups were higher at observation points 1 and 2 and then decreased at observation points 3 and 4. The subscale scores were similar for all three groups at all time points, with all groups demonstrating higher scores during pregnancy. Higher scores indicate greater belief in the subscale domain, in terms of control over health. This suggests that in pregnancy women believe that 'powerful others', which includes the midwife, have control over events governing their health in pregnancy. Following birth the perception of the control exercised by powerful others over the women's health decreases, this finding might be expected as it coincides with the decreased input from the midwifery services and a decreased need to seek health advice and support. Examination of the main effect of group revealed no significant differences in MHLC others subscale scores across the three groups, which demonstrates that perceptions of increased internal control are the same regardless of options of care.

MHLC internal, chance and doctors subscale findings

The results of a mixed design ANCOVA for the MHLC internal, chance and doctors subscale scores are shown in Table 12. No significant differences were observed either for the main effect of time within groups or the main effect of group. This reveals that as for the 'powerful others' subscale, women's experiences of control are not mediated by choice of care. In addition, however, it reveals that women's perceptions of these domains demonstrate greater stability over time. It is notable that although no significant differences were observed over time, that the means scores for the doctor and chance subscales were also higher in pregnancy than following delivery (see appendix 10).

Table 12: Mixed Design ANCOVA Summary for Non Significant MHLC subscale scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared (η^2)[a]	Power
MHLC Internal							
Within Subjects							
Time	11.41	3	3.80	.33	.80	.00	.11
Time x Group	65.47	6	10.91	.95	.46	.02	.37
Time x Age	8.84	3	2.95	.26	.86	.00	.09
Error	2721.80	237	11.48				
Between Subjects							
Group	171.15	2	85.57	1.48	.23	.04	.31
Age	7.32	1	7.32	.13	.72	.00	.06
Error	4570.34	79	57.85				
MHLC Chance							
Within Subjects							
Time	7.03	2.53	2.77	.22	.85	.00	.09
Time x Group	63.73	5.07	12.58	1.00	.42	.02	.36
Time x Age	2.69	2.53	1.06	.09	.95	.00	.06
Error	2512.14	200.20	12.55				
Between Subjects							
Group	198.14	2	99.07	1.08	.34	.03	.23
Age	5.75	1	5.75	.06	.80	.00	.06
Error	7237.06	79	91.61				
MHLC Doctors							
Within Subjects							
Time	16.59	3	5.53	1.20	.31	.02	.32
Time x Group	16.01	6	2.67	.58	.75	.01	.23
Time x Age	41.72	3	13.91	3.03	.03	.04	.70
Error	1089.21	230.07	4.73				
Between Subjects							
Group	49.58	2	24.79	1.47	.24	.04	.31
Age	.78	1	.78	.05	.83	.00	.06
Error	1330.82	79	16.85				

SF36 V2.

As might have been expected, significant differences over time were observed with regard to some quality of life domains.

36 Bodily Pain Subscale

To allow comparison between groups, descriptive statistics for the SF36 bodily pain subscale scores are shown in Table 13.

Table 13: Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the SF36 bodily pain subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	74.67	20.18	69.91	4.39	61.18-78.65
	32 weeks	67.60	19.98	62.54	4.12	54.34-70.73
	14 days	51.70	22.14	53.20	4.68	43.88-65.52
	6 months	83.73	20.75	82.54	4.47	73.64-91.45
MLC HRI	14 weeks	76.17	22.69	80.77	3.85	73.11-88.43
	32 weeks	66.56	21.50	71.47	3.61	64.29-78.65
	14 days	58.02	21.57	56.57	4.10	48.40-64.74
	6 months	86.90	21.46	88.06	3.92	80.25-95.86
CLC	14 weeks	68.81	28.06	64.62	6.78	51.13-78.11
	32 weeks	62.36	24.83	57.89	6.35	45.24-70.54
	14 days	54.27	31.14	55.60	7.23	41.21-69.99
	6 months	84.66	22.04	77.77	6.91	64.02-91.52
Total	14 weeks	74.63	22.43	71.77	2.86	66.08-77.46
	32 weeks	66.38	21.21	63.97	2.68	58.63-69.30
	14 days	55.21	23.10	55.12	3.05	49.05-61.19
	6 months	84.66	22.04	82.79	2.91	76.99-88.59

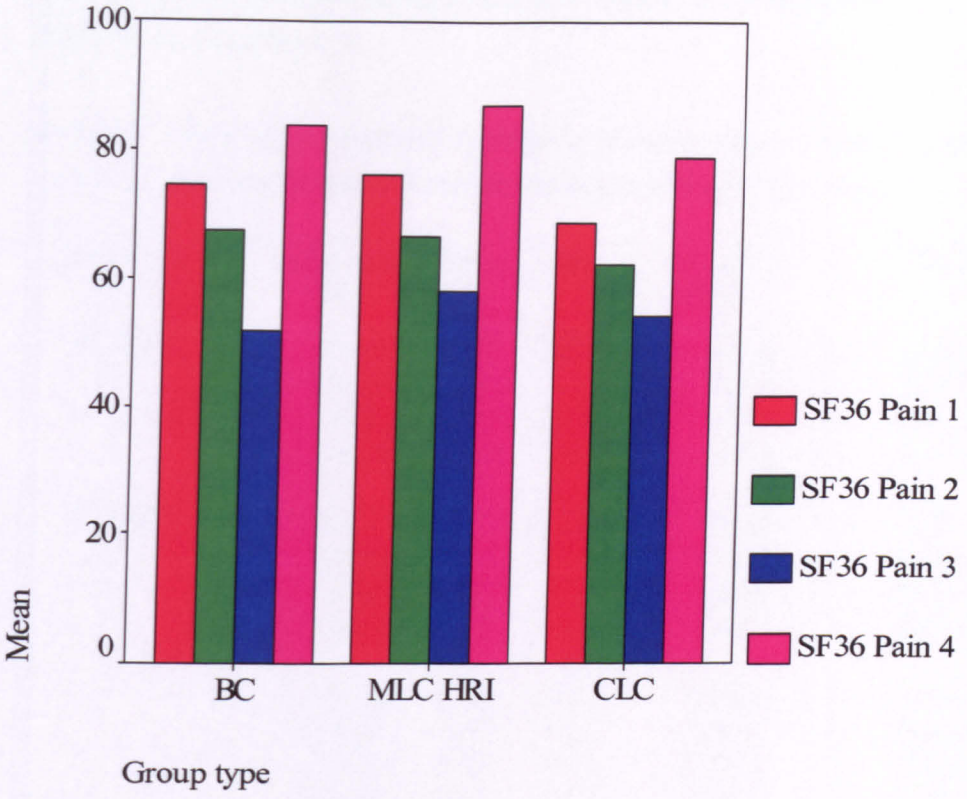
Results of a mixed design ANCOVA are shown in table 14. Significant results were obtained for the main effect of time within groups.

Table 14: Mixed Design ANCOVA Summary for SF36 Bodily Pain subscale scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared (η^2)[a]	Power
Within Subjects							
Time	3523.65	3	1174.55	3.45	.02	.04	.77
Time x Group	1029.49	6	171.58	.50	.81	.01	.20
Time x Age	4099.94	3	1366.65	1.02	<.01	.05	.84
Error	19609.66	234	340.21				
Between Subjects							
Group	3720.32	2	1860.16	2.05	.14	.05	.41
Age	3159.15	1	3159.15	3.48	.07	.04	.45
Error	70909.78	78	909.10				

Visual representation of the data as shown in Figure 3 demonstrates high scores in early pregnancy revealing that women in early pregnancy are experiencing little pain or limitations due to pain. Scores for all four groups decreased in late pregnancy (observation point 2) and decreased further at observation point 3, suggesting these periods as a time when bodily pain is significant in women's lives. These findings might suggest that bodily pain is a response to the physiological changes of pregnancy and childbirth, an argument supported by the increased scores at observation point 4. These 6 month findings demonstrate that postnatal bodily pain is not an enduring problem for women and it would seem logical to assume that this is associated with women's physical recovery to a pre-pregnant state. Examination of the main effect of group revealed no significant differences in SF36 bodily pain subscale scores across the three groups, suggested as might be expected that care type or the role of caregivers has no impact on bodily pain in pregnancy.

Figure 3: Bar chart for main effect of time within groups for SF36 Bodily Pain subscale



SF36 Vitality Subscale

To allow comparison between groups, descriptive statistics for the SF36 vitality subscale scores are shown in Table 15.

Table 15: Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the SF36 vitality subscale scores by study group.

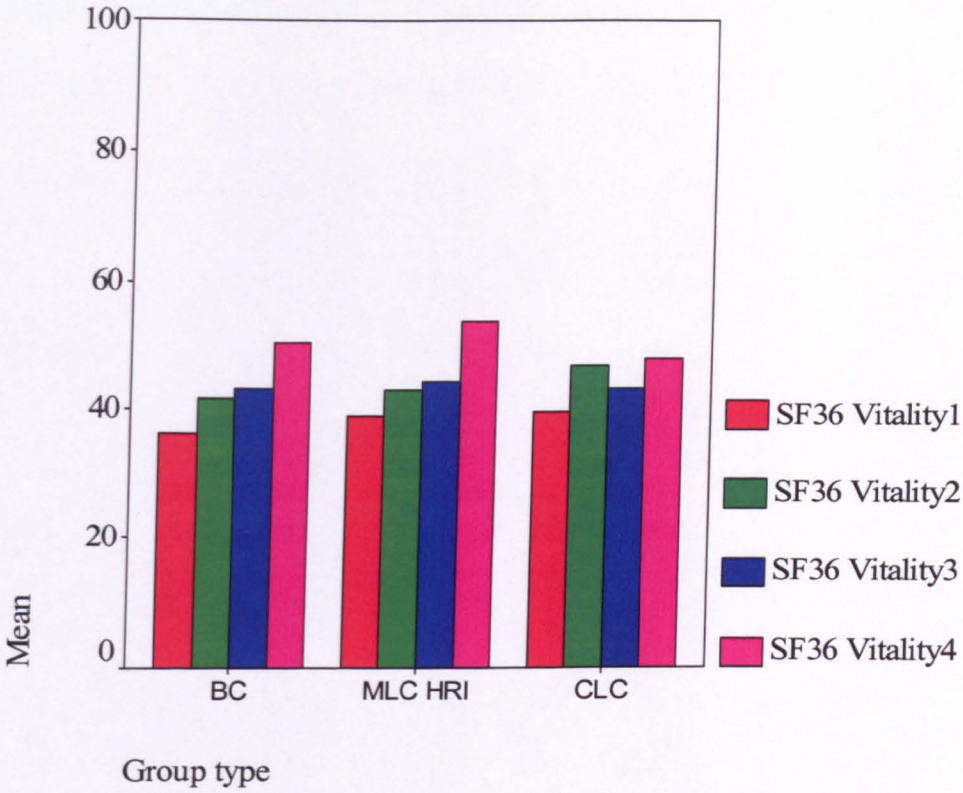
Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	36.29	22.79	35.14	4.15	26.89-43.40
	32 weeks	41.73	17.71	38.75	3.21	32.37-45.13
	14 days	43.35	16.05	44.94	3.02	38.93-50.94
	6 months	50.40	21.40	50.09	3.83	42.47-57.72
MLC HRI	14 weeks	39.02	18.05	40.21	3.73	32.79-47.64
	32 weeks	43.14	15.80	46.23	2.89	40.49-51.97
	14 days	44.21	15.27	42.56	2.72	37.16-47.96
	6 months	53.82	18.38	54.13	3.44	47.28-60.99
CLC	14 weeks	39.58	25.47	40.21	3.73	32.79-47.64
	32 weeks	46.88	17.17	46.23	2.89	40.49-51.97
	14 days	43.23	13.96	42.56	2.72	37.16-47.96
	6 months	47.92	16.71	54.13	3.45	47.28-60.99
Total	14 weeks	38.10	20.80	37.95	2.68	32.62-43.28
	32 weeks	43.15	16.60	43.00	2.07	38.88-47.13
	14 days	43.75	15.22	44.08	1.95	40.20-47.96
	6 months	51.71	19.24	50.62	2.48	45.69-55.54

Table 16: Mixed Design ANCOVA Summary for SF36 Vitality subscale scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared $(\eta^2)^a$	Power
Within Subjects							
Time	1884.30	2.59	728.99	3.38	.03	.04	.71
Time x Group	872.91	5.17	168.85	.78	.57	.02	.28
Time x Age	1669.30	2.59	645.81	2.99	.04	.04	.65
Error	44646.96	206.79	215.91				
Between Subjects							
Group	605.38	2	302.69	.40	.68	.01	.11
Age	313.97	1	313.97	.41	.52	.01	.10
Error	61272.58	80	765.91				

Results of a mixed design ANCOVA are shown in Table 16 above. Significant results were obtained for the main effect of time within groups. Visual representation of the data as shown in Figure 4 below demonstrates that with regard to vitality women experienced the greatest lack of energy in early pregnancy, revealed by low scores at observation point 1. Scores for all four groups increased in late pregnancy (observation point two) suggesting feelings of increased energy. Only the scores for the consultant led care group lowered slightly at observation point three, whilst vitality scores for the birth centre and midwifery led care groups remained fairly consistent between late pregnancy and the early postnatal period, although mean scores across the groups were similar at this observation point. Comparison with UK normative data of SF36 vitality scores for females' 18-24 years and 25-34 years of 55.5 and 54.7 respectively (Jenkinson, Wright & Coulter 1993) allow illustration of the compromise to energy levels that occurs in pregnancy and the early postnatal period. The scores for all four groups increased at the fourth observation point and when compared to the same UK norms, suggest that by 6 months postnatal, vitality has returned to largely normative levels. This increase for the pregnant women may well be concurrent with improved sleeping patterns of their babies. Support for this seems to be provided by the sleep profile of the study group, with the highest sleep scores, indicating poorer sleep observed at 14 days postnatal, whilst global sleep scores demonstrate improved sleep quantity at 6 months postnatal (see table 22).

Figure 4: Bar chart for main effect of time within groups for SF36 Vitality subscale



Examination of the main effect of group revealed no significant differences in SF36 vitality subscale scores across the three groups, suggesting that women's energy levels in pregnancy are not affected by the care type chosen.

SF36 General Health Subscale

To allow comparison between groups, descriptive statistics for the SF36 general health subscale scores are shown in Table 17.

Table 17: Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the SF36 general health subscale scores by study group

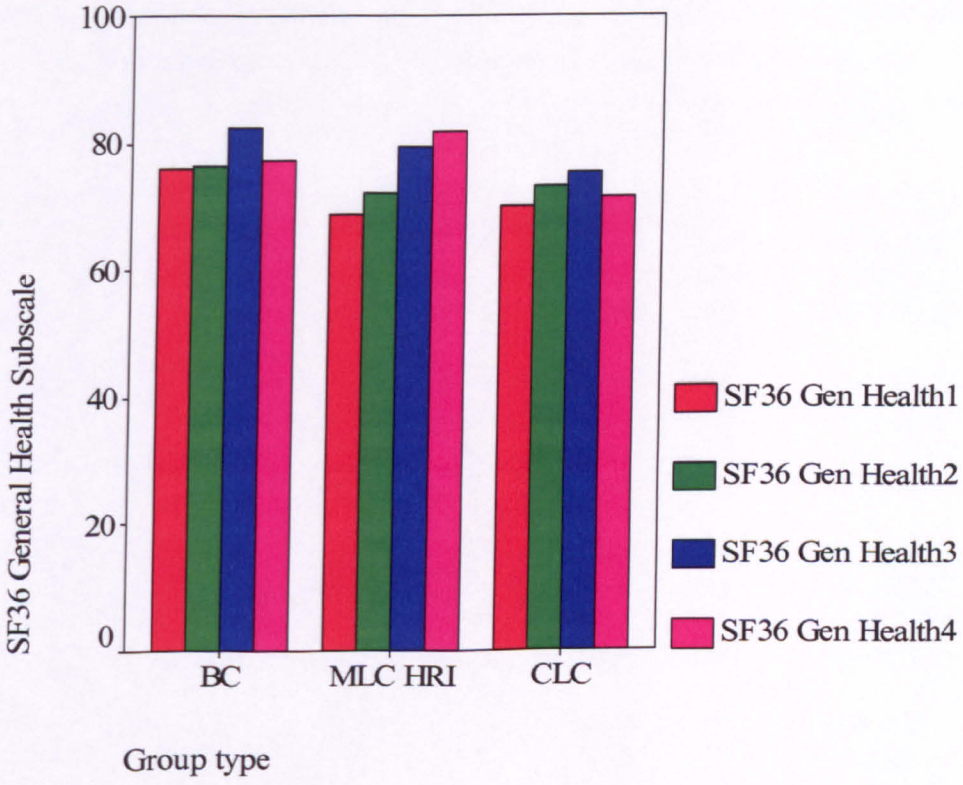
Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	76.16	18.38	72.15	3.16	65.87-78.43
	32 weeks	76.42	16.10	72.21	3.09	66.07-78.35
	14 days	82.58	16.32	80.41	2.87	74.70-86.11
	6 months	77.26	21.58	75.58	3.69	68.23-82.92
MLC HRI	14 weeks	68.87	15.95	73.03	2.84	67.39-78.68
	32 weeks	72.17	17.09	76.53	2.78	71.01-82.06
	14 days	79.39	13.20	81.64	2.58	76.51-86.77
	6 months	81.80	14.70	83.55	3.32	76.94-90.15
CLC	14 weeks	70.15	15.82	66.31	4.79	56.78-75.84
	32 weeks	73.25	16.39	69.23	4.69	59.90-78.55
	14 days	75.42	15.79	73.34	4.35	64.68-82.00
	6 months	71.50	23.25	69.90	5.60	58.75-81.04
Total	14 weeks	71.75	17.01	70.50	2.04	66.44-74.56
	32 weeks	73.89	16.55	72.66	1.99	68.69-76.62
	14 days	80.00	14.80	78.46	1.85	74.78-82.14
	6 months	78.65	18.90	76.34	2.38	71.60-81.08

The results of a mixed design ANCOVA are shown in Table 18. Significant results were obtained for the main effect of time within groups. It should be acknowledged that the UK female norm based mean scores for the personal health subscale of the SF36 for 18-24 years and 25-34 years are 69.5 and 73.8 respectively (Jenkinson, Wright & Coulter 1993), so although the pattern of scores in this study illustrates that women rate their personal health as lower in early pregnancy, their mean scores for the majority correspond with normal limits. Examination of the main effect of group revealed no significant differences in SF36 General Health subscale scores across the three groups, demonstrating that choice of care has no impact on women's perception of their antenatal or postnatal personal health.

Table 18: Mixed Design ANCOVA Summary for SF36 General Health subscale scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared $(\eta^2)^a$	Power
Within Subjects							
Time	1109.33	2.55	435.07	3.09	.04	.04	.67
Time x Group	482.79	5.10	94.67	.67	.65	.02	.24
Time x Age	758.76	2.55	297.58	2.12	.11	.03	.49
Error	28704.08	203.98	140.72				
Between Subjects							
Group	2428.32	2	1214.16	1.72	.19	.04	.35
Age	5630.53	1	5630.53	7.95	<.01	.09	.80
Error	56638.72	80	707.98				

Figure 5: Bar chart of main effect of time within groups for SF36 General Health subscale



Visual representation of the data as shown in Figure 5 above, demonstrates that general health scores for all groups were the lowest at baseline demonstrating that women's views of their personal health and their perception that it might worsen are lowest in early

pregnancy. This might coincide with women's low levels of vitality at this point. Indeed, at 32 weeks women evaluate their personal health higher than in early pregnancy, in the context of higher levels of bodily pain but greater levels of vitality. This perception of improved personal health continues in the early postnatal period. Scores for the birth centre and consultant led care groups decreased at observation point 4, but remained higher than the baseline scores for these groups. The midwifery led care at the acute unit group scores continued to increase at observation point 4. It should be noted that the consultant led care women report poorer personal health at 6 months, than the other two groups, which may be a context specific finding and is not a statistically significant difference as demonstrated in table 18 above.

SF36 Change in Health Subscale

To allow comparison between groups, descriptive statistics for the SF36 change in health subscale scores are shown in Table 19.

Table 19: Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the SF36 change in health subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	44.35	12.43	42.00	2.65	36.73-47.26
	32 weeks	51.61	21.35	48.71	3.44	41.86-55.56
	14 days	52.42	17.51	55.14	3.50	48.16-62.11
	6 months	63.71	23.13	62.31	4.12	54.12-70.51
MLC HRI	14 weeks	50.61	15.30	52.97	2.36	48.26-57.67
	32 weeks	50.00	14.79	52.90	3.08	46.78-59.02
	14 days	58.54	17.33	55.82	3.13	49.59-62.05
	6 months	65.85	18.33	67.25	3.68	59.93-74.57
CLC	14 weeks	45.45	10.11	43.32	4.16	35.04-51.60
	32 weeks	59.10	16.86	56.46	5.41	45.69-67.23
	14 days	54.55	21.85	57.01	5.51	46.04-67.97
	6 months	68.18	22.61	66.92	6.47	54.04-79.80
Total	14 weeks	47.59	13.87	46.09	1.75	42.61-49.57
	32 weeks	51.81	17.80	52.69	2.27	48.17-57.22
	14 days	55.72	18.03	55.99	2.32	51.38-60.60
	6 months	65.36	20.60	65.49	2.72	60.08-70.90

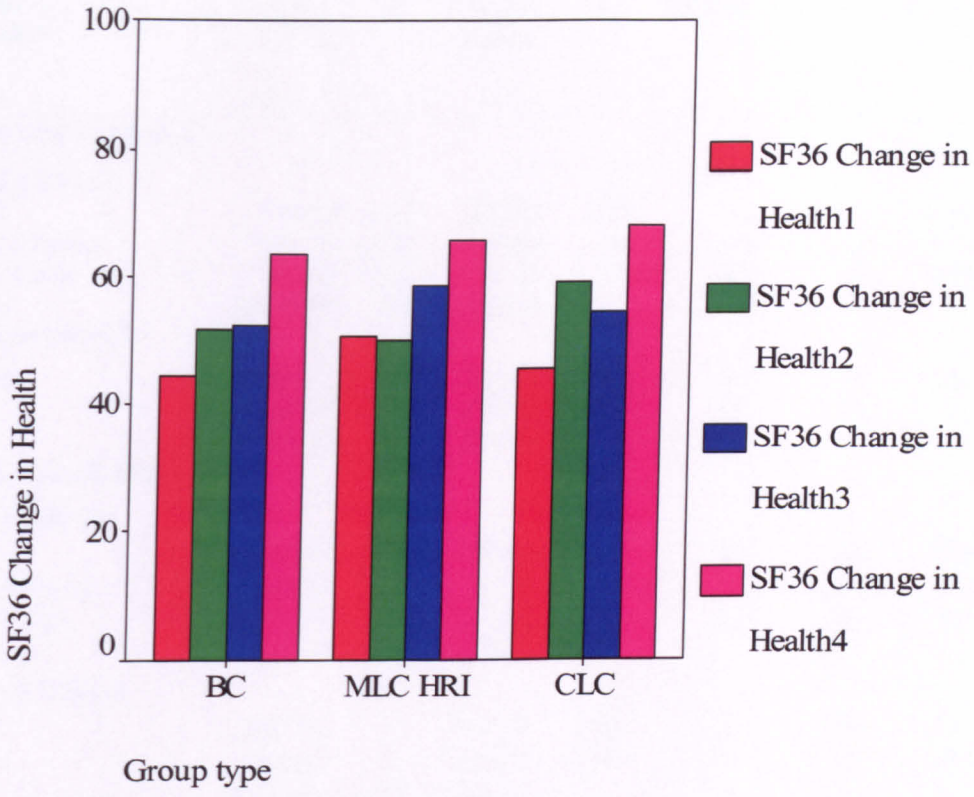
Results of a mixed design ANCOVA are shown in table 20. Significant results were obtained for the main effect of time within groups.

Table 20: Mixed Design ANCOVA Summary for SF36 Change in Health subscale scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared $(\eta^2)^a$	Power
Within Subjects							
Time	3408.60	3	1136.20	3.66	.01	.04	.80
Time x Group	1045.04	6	174.17	.56	.76	.01	.22
Time x Age	2888.08	3	962.70	3.10	.03	.04	.72
Error	73500.66	237	310.13				
Between Subjects							
Group	1410.71	2	705.36	2.33	.10	.06	.46
Age	576.90	1	576.90	1.91	.17	.02	.28
Error	23899.82	79	302.53				

Visual representation of the data as shown in Figure 6 demonstrates that women in early pregnancy report their health state as worse than 6 months ago. Interestingly at 6 months pregnant the birth centre and the consultant led care women then rate their health state as improved from 6 months, demonstrated by the scores at observation point 2, although scores for midwifery led care group at the acute centre demonstrate little change from their baseline scores. Scores indicated that positive changes in health continue into the postnatal period for the birth centre and midwifery led care at the acute centre women. Consultant led care women report a decrease in their health state at 14 days postnatal. Despite this apparent visual difference, examination of the main effect of group revealed no significant differences in SF36 Change in Health subscale scores across the three groups (see table 20). It is noteworthy that the difference may appear more apparent because the CLC women's 32 week scores are higher than the other two groups. All groups reported their health at 6 months postnatal as significantly better than at any other point in the study. The failure to find statistically significant differences between the groups, once again, suggests that choice of care is not a mediating factor in women's perceptions of change in their health state across the maternity period.

Figure 6: Bar chart of main effect of time within groups for SF36 Change in Health subscale



SF36 Non-Significant Subscale Findings

The results of a mixed design ANCOVA for the physical functioning, social functioning, role physical, role emotional and mental health subscale scores are shown in Table 21. No significant differences were observed either for the main effect of time within groups or the main effect of group. This reveals that as for the all the QoL subscales, women's experiences are not mediated by choice of care. Interestingly these findings also reveal that the physiological changes of pregnancy demonstrated by the changes over time in vitality levels, bodily pain and women's perceptions of their health neither influence women's perceptions of their ability to perform their physical or social roles over time or map on to the psychological components of the QoL scale.

Table 21: Mixed Design ANCOVA Summary for SF36 non-significant subscale scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared (η^2)[a]	Power
Physical Functioning							
Within Subjects							
Time	583.32	2.71	215.43	1.19	.32	.02	.30
Time x Group	286.15	5.42	52.84	.29	.93	.01	.13
Time x Age	92.34	2.71	34.10	.19	.89	.00	.08
Error	38890.49	237	164.10				
Between Subjects							
Group	994.73	1	994.73	1.66	.20	.02	.25
Age	466.64	2	233.32	.39	.68	.01	.11
Error	47366.39	79	599.58				
Social Functioning							
Within Subjects							
Time	931.89	3	310.63	1.20	.31	.02	.32
Time x Group	485.94	6	80.99	.31	.93	.01	.13
Time x Age	906.07	3	302.02	1.17	.32	.02	.31
Error	61224.59	237	258.33				
Between Subjects							
Group	3895.24	2	1947.62	1.62	.21	.04	.33
Age	1464.02	1	1464.02	1.22	.27	.02	.19
Error	95063.28	79	1203.33				
Role Physical							
Within Subjects							
Time	1576.33	3	525.44	1.49	.22	.02	.39
Time x Group	617.27	6	102.88	.29	.94	.01	.13
Time x Age	2106.67	3	702.22	1.99	.12	.03	.51
Error	83617.31	237	352.82				
Between Subjects							
Group	1953.88	2	976.94	.99	.38	.02	.22
Age	181.88	1	181.88	.18	.67	.00	.07
Error	78118.65	79	988.84				
Role Emotional							
Within Subjects							
Time	1824.68	3	608.23	2.48	.06	.03	.61
Time x Group	1823.11	6	303.85	1.24	.29	.03	.48
Time x Age	1443.36	3	481.12	1.96	.12	.02	.50
Error	58127.76	237	245.27				
Between Subjects							
Group	633.72	2	316.86	.41	67	.01	.11
Age	721.82	1	721.82	.93	.40	.01	.16
Error	61619.01	79	779.99				

Mental Health							
Within Subjects							
Time	141.54	3	47.18	.52	.67	.01	.16
Time x Group	328.03	6	54.67	.61	.73	.02	.24
Time x Age	118.75	3	62.92	.70	.55	.01	.20
Error	21632.60	240	90.14				
Between Subjects							
Group	8.37	2	4.19	.01	.99	.00	.05
Age	151.64	1	151.64	.27	.60	.00	.08
Error	44558.92	80	556.99				

Pittsburgh Sleep Quality Index

Global Sleep Scale

As might have been expected and as already referred to, significant differences over time were observed with regard sleep quantity as measured by the global sleep scale of the PSQI. To allow comparison between groups, descriptive statistics for the PSQI global sleep subscale scores are shown in Table 22. Low scores indicate greater quantities of sleep

Table 22: Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the PSQI global sleep scale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	5.00	2.80	4.38	.89	2.55-6.21
	32 weeks	8.93	2.49	9.35	1.05	7.19-11.51
	14 days	9.33	3.99	8.40	1.19	5.96-10.84
	6 months	7.53	3.93	6.69	1.31	4.00-9.39
MLC HRI	14 weeks	3.31	2.72	3.98	.96	2.01-5.94
	32 weeks	6.70	3.68	6.25	1.13	3.92-8.57
	14 days	7.69	3.52	8.70	1.28	6.07-11.33
	6 months	6.15	4.00	7.60	1.41	4.16-9.96
CLC	14 weeks	6.50	4.95	6.81	2.03	2.63-10.98
	32 weeks	9.00	7.07	8.80	2.40	3.87-13.72
	14 days	10.00	5.65	10.46	2.71	4.89-16.03
	6 months	8.00	8.49	8.41	2.99	2.28-14.55
Total	14 weeks	4.37	2.95	5.05	.77	3.48-6.63
	32 weeks	7.97	3.41	8.13	.91	6.27-9.99
	14 days	8.67	3.84	9.19	1.03	7.08-11.29
	6 months	6.97	4.13	7.39	1.13	5.07-9.71

Results of a mixed design ANCOVA are shown in table 23. Significant results were obtained for the main effect of time within groups.

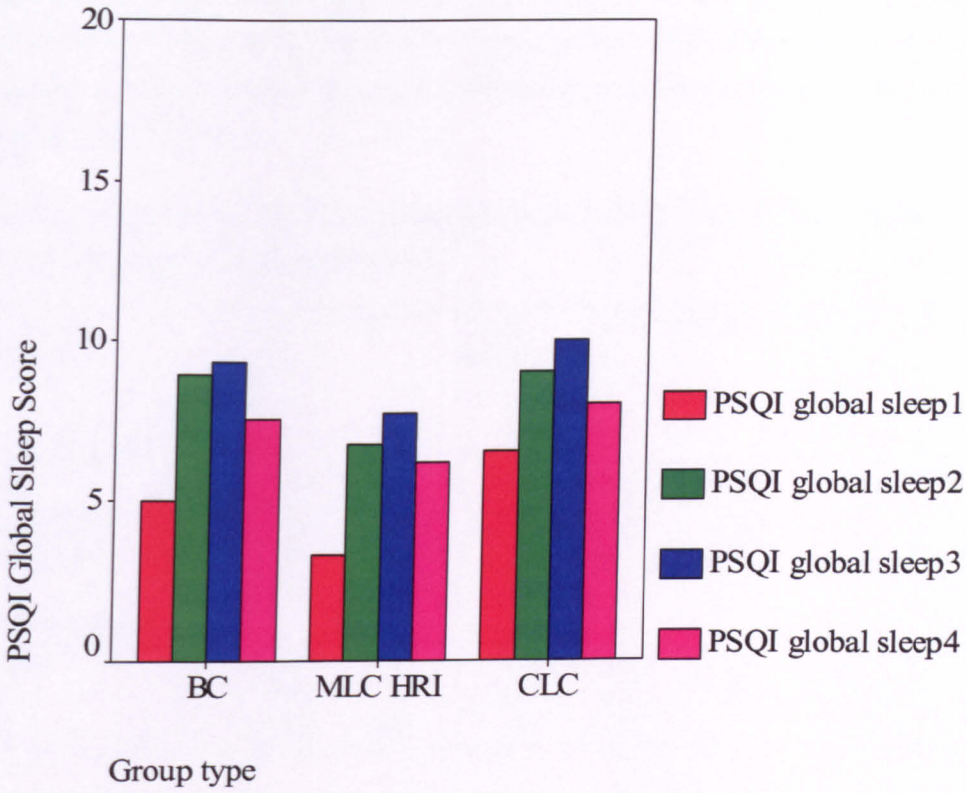
Table 23: Mixed Design ANCOVA Summary for PSQI Global Sleep Scale scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared (η^2)[a]	Power
Within Subjects							
Time	44.41	3	14.80	2.75	.05	.10	.64
Time x Group	30.81	6	5.14	.95	.46	.07	.35
Time x Age	37.07	3	12.36	2.29	.09	.08	.56
Error	420.28	78	5.39				
Between Subjects							
Group	32.06	16.03	16.03	.45	.64	.03	.12
Age	31.43	1	31.43	.89	.35	.03	.15
Error	917.72	26	35.30				

Visual representation of the data as shown in Figure 7 demonstrates that the lowest scores for all groups are obtained at the first observation (14 weeks pregnant), suggesting this as a time when sleep is the least affected. Global sleep scores for all four groups are higher at observation point 2 and highest at observation point 3. Whilst it would seem logical women report the least sleep is in the early postnatal days, a time traditionally associated with awakenings in the night, it is interesting that these findings suggest women enter the postnatal period sleep deprived. Sleep quantity for all groups increased at observation point 4, although remained less than early pregnancy levels, suggesting that changes in sleep architecture are enduring into the late postnatal period.

Examination of the main effect of group revealed no significant differences in PSQI Global Sleep Scale scores across the three groups. Such a finding might seem logical if reduced sleep quantity is associated with the physiological change factors associated with pregnancy and the presence of a new baby and it would seem unrealistic to expect choice of care to impact on factors such as those.

Figure 7: Bar chart of main effect of time within groups for PSQI Global Sleep subscale



Sleep Type Scale

The results of a mixed design ANCOVA are shown in table 24 Unlike sleep quantity as measured by the global sleep scale above, no significant differences were revealed in PSQI Sleep Type Scale scores within groups over time or across the three groups. This would suggest that whilst pregnancy and early motherhood affects clearly affects sleep quantity, the quality of women's sleep remains less influenced by either physiology or disrupted postnatal sleep patterns.

Table 24: Mixed Design ANCOVA Summary for PSQI Sleep Type Scale scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared (η^2)[a]	Power
Within Subjects							
Time	.48	3	.16	1.16	.33	.04	.30
Time x Group	.99	6	.16	1.18	.32	.08	.44
Time x Age	.28	3	.09	.68	.57	.03	.19
Error	10.83	78	.14				
Between Subjects							
Group	.32	2	.16	.36	.70	.03	.10
Age	.26	1	.26	.59	.45	.02	.11
Error	11.53	26	.44				

Culture Free Self-Esteem Inventory

Interesting findings were demonstrated for both general and social self-esteem, which will be outlined here but discussed in more detail in Chapter 8.

General Self-Esteem

To allow comparison between groups, descriptive statistics for the CFSEI general self-esteem subscale scores are shown in Table 25.

Table 25: Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the CFSEI General Self-Esteem subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	13.94	2.61	13.98	.48	13.04-14.93
	32 weeks	14.16	1.97	13.96	.49	12.99-14.92
	14 days	13.97	2.04	14.14	.75	12.65-15.63
	6 months	13.19	2.98	13.01	.55	11.92-14.09
MLC HRI	14 weeks	13.51	2.34	13.47	.39	12.69-14.25
	32 weeks	13.64	2.54	13.82	.40	13.03-14.61
	14 days	11.85	4.78	11.70	.62	10.47-12.93
	6 months	13.28	2.54	13.44	.45	12.55-14.34
CLC	14 weeks	13.23	2.20	13.27	.69	11.89-14.64
	32 weeks	13.08	3.28	12.91	.71	11.51-14.31
	14 days	13.15	2.91	13.29	1.09	11.13-15.46
	6 months	12.76	3.89	12.92	.79	11.35-14.50
Total	14 weeks	13.62	2.40	13.57	.30	12.98-14.16
	32 weeks	13.74	2.48	13.56	.30	12.96-14.17
	14 days	12.76	3.89	13.04	.47	12.11-13.98
	6 months	13.22	2.76	13.12	.34	12.44-13.81

The results of a mixed design ANCOVA are shown in table 26. Interestingly the within groups interaction of time and group was found to be significant.

Table 26: Mixed Design ANCOVA Summary for CFSEI General Self-Esteem subscale scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared (η^2)[a]	Power
Within Subjects							
Time	14.33	1.90	7.18	1.10	.33	.01	.24
Time x Group	71.06	3.99	17.81	2.72	.03	.05	.74
Time x Age	16.84	1.99	8.44	1.29	.28	.02	.27
Error	1134.69	173.53	6.54				
Between Subjects							
Group	29.26	2	14.63	.68	.51	.15	.16
Age	1.30	1	1.30	.06	.81	.00	.06
Error	1864.85	87	21.44				

This significant interaction effect was firstly examined using visual inspection of the data which revealed little differences at observation points 1, 2 and 4. A difference was apparent at observation point 3. Further post hoc analysis using the Bonferroni correction is shown in table 27. Results revealed that the birth centre group have statistically significant higher scores of general self-esteem at 14 days postnatal than the midwifery led care at the acute unit group. No other differences within groups were observed and examination of the main effect of group revealed no significant differences in CFSEI general self-esteem subscale scores across the three groups. This suggests that whilst care type overall did not impact on general self-esteem that there was something specific to MLC acute centre women's experiences at this early postnatal time point, which impacted on their overall feelings of self-worth.

Table 27: Post Hoc Comparisons of Within Groups Time x Group Interaction of General Self-Esteem at observation point 3.

Group Type	Group Type	Mean Difference	SE	*p*-value
MLC BC	MLC HRI	2.44	.99	.04
	CLC	.62	1.44	1.00
MLC HRI	MLC BC	-2.44	.99	.04
	CLC	-1.82	1.35	.54
CLC	MLC BC	-.62	1.44	1.00
	MLC HRI	1.82	1.35	.54

Social Self-Esteem

To allow comparison between groups, descriptive statistics for the CFSEI social self-esteem subscale scores are shown in Table 28.

Table 28: Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the CFSEI Social Self-Esteem subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	7.45	.77	7.34	.15	7.04-7.63
	32 weeks	7.39	.69	7.21	.21	6.79-7.63
	14 days	7.42	.72	7.45	.39	6.67-8.22
	6 months	7.13	1.06	6.91	.19	6.53-7.29
MLC HRI	14 weeks	7.33	.69	7.43	.12	7.19-7.66
	32 weeks	7.18	1.20	7.33	.17	6.99-7.68
	14 days	6.31	2.56	6.28	.31	5.66-6.91
	6 months	7.35	.86	7.53	.15	7.23-7.84
CLC	14 weeks	7.15	.99	7.06	.21	6.63-7.48
	32 weeks	6.85	1.21	6.70	.31	6.09-7.32
	14 days	6.77	1.42	6.79	.57	5.66-7.92
	6 months	6.74	2.03	6.51	.28	5.96-7.06
Total	14 weeks	7.34	.76	7.27	.09	7.09-7.46
	32 weeks	7.20	1.11	7.08	.13	6.82-7.35
	14 days	6.74	2.03	6.84	.25	6.35-7.33
	6 months	7.18	1.02	6.99	.12	6.75-7.22

The results of a mixed design ANCOVA are shown in table 29. The within groups interaction of time and group was found to be significant. This significant interaction effect was firstly examined using visual inspection of the data which revealed little differences at observation points 1, 2 and 4. A difference, as for general self-esteem, was apparent at observation point 3. Further post hoc analysis using the Bonferroni correction is shown in table 30. Results revealed that the birth centre group have statistically significant higher scores of social self-esteem at 14 days postnatal than the midwifery led care at the acute unit group. No other differences within groups were observed. And examination of the main effect of group revealed no significant differences in CFSEI social self-esteem subscale scores across the three groups. This adds further strength to the argument that something specific to MLC acute centre women's experience impacted on their feelings of social self-esteem suggesting that they felt less confident in this early postnatal period in the quality of the relationships with their peers. This could be a result of the environment in

which postnatal care was received or in the manner in which it was delivered. One possible explanation for the findings on both the general and social self esteem subscales could be the quality or quantity of care received, either immediately postnatally, in the place of delivery, or the level of early community postnatal support received. A further interpretation could be that women in a hospitalised environment, particularly those that have chosen midwifery led care, deemed to be less medicalised in its approach, feel that such an environment is non-conducive to either their needs or requests for support in the transition to a mothering role. Such interpretations will be explored further in chapter 8.

Table 29: Mixed Design ANCOVA Summary for CFSEI Social Self-Esteem subscale scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared $(\eta^2)^a$	Power
Within Subjects							
Time	4.52	1.61	2.81	1.29	.27	.01	.25
Time x Group	25.71	3.22	7.10	3.68	.01	.08	.81
Time x Age	5.66	1.61	3.52	1.62	.21	.02	.30
Error	311.18	143.10	2.18				
Between Subjects							
Group	8.01	2	4.00	1.27	.29	.03	.27
Age	9.69	1	9.69	3.06	.08	.03	.41
Error	281.63	89	3.16				

Table 30: Post Hoc Comparisons of Within Groups Time x Group Interaction of Social Self-Esteem at observation point 3.

Group Type	Group Type	Mean Difference	SE	*p*-value
MLC BC	MLC HRI	1.64	.56	.01
	CLC	.92	.81	.78
MLC HRI	MLC BC	-1.64	.56	.01
	CLC	-.72	.77	1.00
CLC	MLC BC	-.92	.81	.78
	MLC HRI	.72	.77	1.00

CFSEI Personal and Lie subscale findings

The results a mixed design ANCOVA for the CFSEI personal and lie subscale scores are shown in Table 31. No significant differences were observed either for the main effect of time within groups or the main effect of group. This demonstrates, once again, personal self-esteem and defensiveness of responses as measured by the lie subscale are, as for general and social self-esteem, overall are not affected by choice of care. However, personal self-esteem (i.e. an individuals most intimate perception of self-worth), and defensiveness of responses given are less sensitive to the observation specific event noted for general and social self-esteem, which caused the interaction effect.

Table 31: Mixed Design ANCOVA Summary for CFSEI non-significant subscale scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared $(\eta^2)^a$	Power
Personal							
Within Subjects							
Time	6.24	2.53	2.46	1.17	.32	.01	.29
Time x Group	20.20	5.07	3.99	1.89	.09	.04	.64
Time x Age	6.19	2.53	2.44	1.16	.32	.01	.28
Error	476.38	225.56	2.11				
Between Subjects							
Group	1.55	2	.78	.05	.95	.00	.06
Age	5.44	1	5.44	.38	.54	.00	.09
Error	1284.33	89	14.43				
Lie							
Within Subjects							
Time	.39	2.57	.15	.12	.93	.00	.07
Time x Group	13.56	5.14	2.64	2.15	.06	.05	.71
Time x Age	1.03	2.57	.40	.33	.78	.00	.72
Error	280.21	229.04	1.22				
Between Subjects							
Group	29.20	2	14.60	1.90	.15	.04	.39
Age	30.04	1	30.04	3.90	.05	.04	.50
Error	685.25	89	7.70				

Hospital Anxiety and Depression Scale

HADS Anxiety and Depression Subscale

The results of a mixed design ANCOVA are shown in table 32. No significant differences were revealed in HADS-A or HADS-D scores within groups over time. Examination of the main effect of group revealed no significant differences in HADS-A and HADS- D scores across the three groups. These findings suggest that choice of care has no impact on anxiety or depression status as measured by the HADS and that results stay relatively stable over time

Table 32: Mixed Design ANCOVA Summary for HADS-A and HADS-D subscale scores from 14 weeks to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared (η^2)[a]	Power
HADS-A subscale							
Within Subjects							
Time	2.97	2.71	1.09	.26	.83	.00	.01
Time x Group	24.12	5.43	4.45	1.06	.38	.02	.40
Time x Age	2.73	2.71	1.01	.24	.85	.00	.09
Error	1269.73	303.87	4.18				
Between Subjects							
Group	39.89	2	19.95	.63	.53	.01	.15
Age	73.25	1	73.25	2.31	.13	.02	.33
Error	3551.91	112	31.71				
HADS-D subscale							
Within Subjects							
Time	10.60	2.37	4.47	1.00	.38	.01	.24
Time x Group	20.84	4.75	4.39	.98	.40	.01	.34
Time x Age	10.26	2.37	4.32	.97	.34	.01	.24
Error	1187.45	265.71	4.47				
Between Subjects							
Group	47.74	2	23.87	1.03	.36	.02	.28
Age	37.57	1	35.57	1.63	.21	.01	.24
Error	2586.28	112	23.09				

Edinburgh Postnatal Depression Scale

The results of a mixed design ANCOVA are shown in table 33. No significant differences were revealed in EPDS scores within groups over time. Examination of the main effect of group revealed no significant differences in EPDS scores across the three groups. These findings suggest that choice of care has no impact on depression status as measured by the EPDS.

Table 33: Mixed Design ANCOVA Summary for EPDS scores from 14 weeks gestation to 6 months postnatal

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared (η^2)[a]	Power
Within Subjects							
Time	39.27	2.79	14.10	1.69	.17	.02	.42
Time x Group	10.82	5.57	1.94	.23	.96	.01	.11
Time x Age	43.67	2.79	15.68	1.87	.14	.02	.46
Error	2027.03	242.29	8.37				
Between Subjects							
Group	3.78	2	1.89	.03	.97	.00	.05
Age	17.90	1	17.90	.29	.59	.00	.08
Error	5407.97	87	62.16				

Depression and Anxiety Status as a Function of Group Type

The essence of measures such as the HADS and the EPDS is as anxiety and depression case detectors. Whilst utilising the measures in this way undoubtedly loses some of the power of the data, the research question of whether choice of care impacts on psychological outcomes necessitated the exploration of levels of anxiety and depression caseness by group. Manual based interpretations of scores are used to determine the numbers of participants, at each observation point, who revealed clinically relevant levels of anxiety/depression. In addition, the levels of clinically relevant anxiety/depression for each group are illustrated as a percentage of the total respondents. Comparison of the group data was performed using the χ^2 test to determine any significant differences between groups.

Hospital Anxiety and Depression Scale - Possible Anxiety

Frequency of HADS defined possible anxiety at each observation point, defined by manual-based (Snaith & Zigmond 1994) interpretation of HADS-A scores of 8 or over, as a function of group type is shown in Table 34.

Observation 1 (14 weeks): 46 participants (31%) of the total 148 respondents at the first observation point demonstrated possible clinically relevant levels of anxiety. Of the 31% identified as possibly anxious 10% were birth centre women, 17% MLC women and 4% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of possible anxiety status ($\chi^2 = 0.07$, $df\,2$, $p = 0.96$).

Observation 2 (32 weeks): 47 participants (40%) of the total 117 respondents at the second observation point demonstrated possible clinically relevant levels of anxiety. Of the 40% identified as possibly anxious 14% were birth centre women, 20% MLC women and 6% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of possible anxiety status ($\chi^2 = 0.60$, $df\,2$, $p = 0.74$).

Observation 3 (14 days): 41 participants (33%) of the total 124 respondents at the third observation point demonstrated possible clinically relevant levels of anxiety. Of the 33% identified as possibly anxious 9% were birth centre women, 18% MLC women and 6% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of possible anxiety status ($\chi^2 = 1.76$, df 2, $p = 0.42$).

Observation 4 (6 months): 40 participants (32%) of the total 126 respondents at the fourth observation point demonstrated possible clinically relevant levels of anxiety. Of the 32% identified as possibly anxious 10% were birth centre women, 17% MLC women and 5%

CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of possible anxiety status ($\chi^2 = 0.84$, $df\ 2$, $p = 0.66$).

Table 34: Comparison of groups by HADS-A subscale defined possible anxiety at all observation points

Group Type	Affective status	
	No Anxiety (n)	Possible Anxiety (n)
14 weeks		
Birth Centre	33	15
MLC	54	25
CLC	15	6
Total	102	46
32 weeks		
Birth Centre	23	17
MLC	39	23
CLC	8	7
Total	70	47
14 days		
Birth Centre	33	12
MLC	41	22
CLC	9	7
Total	83	41
6 months		
Birth Centre	33	12
MLC	42	22
CLC	11	6
Total	86	40

Hospital Anxiety and Depression Scale - Probable Anxiety

Frequency of HADS defined probable anxiety at each observation point, defined by manual-based (Snaith & Zigmond 1994) interpretation of HADS-A scores of 11 or over, as a function of group type is shown in Table 35.

Observation 1 (14 weeks): 16 participants (11%) of the total 148 respondents at the first observation point demonstrated probable clinically relevant levels of anxiety. Of those 11% identified as probably anxious 5% were birth centre women, 5% MLC women and 1% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of probable anxiety status ($\chi^2 = 2.82$, $df\,2$, $p = 0.25$).

Observation 2 (32 weeks): 18 participants (15%) of the total 117 respondents at the second observation point demonstrated probable clinically relevant levels of anxiety. Of those 15% identified as probably anxious 8% were birth centre women, 6% MLC women and 1% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of probable anxiety status ($\chi^2 = 2.40$, $df\,2$, $p = 0.30$).

Observation 3 (14 days): 15 participants (12%) of the total 124 respondents at the third observation point demonstrated probable clinically relevant levels of anxiety. Of those 12% identified as probably anxious 6% were birth centre women, 4% MLC women and 2% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of probable anxiety status ($\chi^2 = 2.20$, $df\,2$, $p = 0.33$).

Observation 4 (6 months): 18 participants (14%) of the total 126 respondents at the fourth observation point demonstrated probable clinically relevant levels of anxiety. Of those 14% identified as probably anxious 4% were birth centre women, 7% MLC women and 3% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of probable anxiety status ($\chi^2 = 1.56$, $df\,2$, $p = 0.46$).

Table 35: Comparison of groups by HADS-A subscale defined probable anxiety at all observation points

Group Type	Affective status	
	No Anxiety	Probable Anxiety
14 weeks		
Birth Centre	40	8
MLC	72	7
CLC	20	1
Total	132	16
32 weeks		
Birth Centre	31	9
MLC	55	7
CLC	13	2
Total	99	18
14 days		
Birth Centre	38	7
MLC	58	5
CLC	13	3
Total	109	15
6 months		
Birth Centre	40	5
MLC	55	9
CLC	13	4
Total	108	18

Hospital Anxiety and Depression Scale - Possible Depression

Frequency of HADS defined probable anxiety at each observation point, defined by manual-based (Snaith & Zigmond 1994) interpretation of HADS-D scores of 8 over, as a function of group type is shown in Table 36.

Observation 1 (14 weeks): 16 participants (10%) of the 148 total respondents at the first observation point demonstrated possible clinically relevant levels of depression. Of those 10% identified as possibly depressed, 5% were birth centre women, 5% MLC women and none were CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of possible depression status ($\chi^2 = 4.76$, *df 2*, $p = 0.09$).

Observation 2 (32 weeks): 25 participants (21%) of the total 117 respondents at the second observation point demonstrated possible clinically relevant levels of depression. Of those 21% identified as possibly depressed, 9% were birth centre women, 9% MLC women and 3% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of possible depression status ($\chi^2 = 1.40$, *df 2*, $p = 0.50$).

Observation 3 (14 days): 25 participants (20%) of the total 124 respondents at the third observation point demonstrated possible clinically relevant levels of depression. Of those 20% possibly depressed, 10% were birth centre women, 8% MLC women and 2% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of possible depression status ($\chi^2 = 1.92$, *df 2*, $p = 0.38$).

Observation 4 (6 months): 25 participants (19%) of the total 126 respondents at the fourth observation point demonstrated possibly clinically relevant levels of depression. Of those 19% identified as possibly depressed, 11% were birth centre women, 6% MLC women and 2% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of possible depression status ($\chi^2 = 5.81$, *df 2*, $p = 0.06$).

Table 36: Comparison of groups by HADS-D subscale defined possible depression at all observation points

Group Type	Affective status	
	No depression	Possible depression
14 weeks		
Birth Centre	40	8
MLC	72	7
CLC	21	0
Total	133	15
32 weeks		
Birth Centre	29	11
MLC	51	11
CLC	12	3
Total	92	25
14 days		
Birth Centre	33	12
MLC	53	10
CLC	13	3
Total	99	25
6 months		
Birth Centre	31	14
MLC	56	8
CLC	14	3
Total	101	25

Hospital Anxiety and Depression Scale - Probable Depression

Frequency of HADS defined probable depression at each observation point, defined by Manual-based (Snaith & Zigmond 1994) interpretation of HADS-D scores of 11 or over, as a function of group type is shown in Table 37.

Observation 1 (14 weeks): 3 participants (2%) of the total 148 respondents at the first observation point demonstrated probable clinically relevant levels of depression. Of those 2% identified as probably depressed, 1% were birth centre women, 1% MLC women and none were CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of probable depression status ($\chi^2 = 1.77$, $df\ 2, p = 0.41$).

Observation 2 (32 weeks): 4 participants (4%) of the total 117 respondents at the second observation point demonstrated probable clinically relevant levels of depression. Of those 4% identified as probably depressed, 1% were birth centre women, 2% MLC women and 1% of CLC women Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of probable depression status ($\chi^2 = 0.59$, $df\ 2, p = 0.75$).

Observation 3 (14 days): 6 participants (5%) of the total 124 respondents at the third observation point demonstrated probable clinically relevant levels of depression. Of those 5% identified as probably depressed, 2% were birth centre women, 2% MLC women and 1% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of probable depression status ($\chi^2 = 0.09$, $df\ 2, p = 0.96$).

Observation 4 (6 months): 8 participants (6%) of the total 126 respondents at the fourth observation point demonstrated probable clinically relevant levels of depression. Of those 7% identified as probably depressed, 3% were birth centre women, 1.5% MLC women and 1.5% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of probable depression status ($\chi^2 = 2.45$, $df\ 2, p = 0.29$).

Table 37: Comparison of groups by HADS-D subscale defined probable depression at all observation points

Group Type	Affective status	
	No depression	Probable depression
14 weeks		
Birth Centre	46	2
MLC	78	1
CLC	21	0
Total	145	3
32 weeks		
Birth Centre	39	1
MLC	60	2
CLC	14	1
Total	113	4
14 days		
Birth Centre	43	2
MLC	60	3
CLC	15	1
Total	118	6
6 months		
Birth Centre	41	4
MLC	62	2
CLC	15	2
Total	118	8

The findings with regard to levels of anxiety and depression revealed by the HADS demonstrate some consistency with current literature on antenatal and postnatal anxiety and depression (Rubertsson, Waldenstrom & Wickberg 2003; O'Hara & Swain 1996). When the less conservative cut-point criterion were utilised the frequency of cases was obviously higher. The pattern of HADS-A, HADS-D defined caseness is similar, with incidence rising at 32 weeks gestation. This can be compared to the EPDS scores in the next section, which demonstrate a similar pattern. It is striking that when the more conservative cut-point of 11 for HADS-D was utilised, considerably fewer cases than might have been anticipated were identified. It is possible that this is a result of the generic nature of the HADS. Conversely, however, the following data will demonstrate that the percentage of women defined as minor/major depression is greater using the EPDS. This led to EPDS identified caseness using the 9/10 cut-point being higher than might have been anticipated and above the prevalence rates for postnatal depression of between 10-15% identified in the literature (O'Hara & Swain 1996). This could well be due to the differing cut-point thresholds but is worthy of further discussion and will be given greater attention in chapter 8. The levels of caseness identified for both anxiety and depression are highest in late pregnancy and as can be seen, for both measures, these levels largely appear to persist into both the early and the late postnatal periods. This raises questions about whether postnatal depression in indeed a distinct clinical state or whether it is more likely a continuation of an antenatal anxiety or depression state.

Edinburgh Postnatal Depression Scale – Minor/Major Depression

Frequency of EPDS screen positive for minor/major depression at each observation point, using Cox and Holden's (2003) interpretation of EPDS scores at the cut-point of 9–10 for screening for postnatal depression, as a function of group type is shown in Table 38.

Observation 1 (14 weeks): 38 participants (26%) of the total 148 respondents at the first observation point screened positive for minor/major depression. Of those 26% screened positive, 9.5% were birth centre women, 13.5% MLC women and 3% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of depression status ($\chi^2 = 0.80$, $df\,2$, $p = 0.67$).

Observation 2 (32 weeks): 40 participants (52%) of the total 117 respondents at the second observation point screened positive for minor/major depression. Of those 34% screened positive, 10% were birth centre women, 20% MLC women and 4% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of depression status ($\chi^2 = 0.55$, $df\,2$, $p = 0.76$).

Observation 3 (14 days): 23 participants (23%) of the total 98 respondents at the third observation point screened positive for minor/major depression. Of those 23% screened positive, 10% were birth centre women, 11% MLC women and 2% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of depression status ($\chi^2 = 0.65$, $df\,2$, $p = 0.72$).

Observation 4 (6 months): 32 participants (29%) of the total 109 respondents at the fourth observation point screened positive for minor/major depression. Of those 29% screened positive, 10% were birth centre women, 15% of MLC women and 4% of CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of depression status ($\chi^2 = 0.03$, $df\,2$, $p = 0.98$).

Table 38: Comparison of groups by EPDS screen positive for major/minor depression at all observation points

Group Type	Affective status	
	No depression	+VE major/minor depression
14 weeks		
Birth Centre	34	14
MLC	59	20
CLC	17	4
Total	110	38
32 weeks		
Birth Centre	28	12
MLC	39	23
CLC	10	5
Total	77	40
14 days		
Birth Centre	28	10
MLC	36	11
CLC	11	2
Total	75	23
6 months		
Birth Centre	27	11
MLC	39	16
CLC	11	5
Total	77	32

Edinburgh Postnatal Depression Scale – Major Depression

Frequency of EPDS screen positive for major depression at each observation point, using Cox and Holden's (2003) interpretation of EPDS scores at a cut-point of 12-13, as a function of group type is shown in Table 39. This cut-point is the more conservative criterion recommended for use in primary care settings for screening for postnatal depression

Observation 1 (14 weeks): 19 participants (13%) of the total 148 respondents at the first observation point screened positive for major depression. Of those 13% screened positive, 5% were birth centre women, 6% MLC women and 1% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of depression status ($\chi^2 = 0.98$, $df\,2$, $p = 0.61$).

Observation 2 (32 weeks): 23 participants (19%) of the total 117 respondents at the second observation point screened positive for major depression. Of those 19% screened positive, 7% were birth centre women, 9% MLC women and 3% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of depression status ($\chi^2 = 0.61$, $df\,2$, $p = 0.73$).

Observation 3 (14 days): 11 participants (11%) of the total 98 respondents at the third observation point screened positive for major depression. Of those 11% screened positive, 5% were birth centre women, 5% MLC women and 1% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of depression status ($\chi^2 = 0.32$, $df\,2$, $p = 0.85$).

Observation 4 (6 months): 17 participants (15%) of the total 109 respondents at the fourth observation point screened positive for major depression. Of those 15% screened positive, 4% were birth centre women, 8% MLC women and 3% CLC women. Comparison of the group data using the χ^2 test revealed no significant differences between groups in terms of depression status ($\chi^2 = 0.31$, $df\,2$, $p = 0.85$).

Table 39: Comparison of groups by EPDS screen positive for major depression at all observation points

Group Type	Affective status	
	No depression	+ VE major depression
14 weeks		
Birth Centre	40	8
MLC	70	9
CLC	19	2
Total	129	19
32 weeks		
Birth Centre	32	8
MLC	51	11
CLC	11	4
Total	94	23
14 days		
Birth Centre	33	5
MLC	42	5
CLC	12	1
Total	87	11
6 months		
Birth Centre	33	5
MLC	46	9
CLC	13	3
Total	92	17

Reference Group

To allow comparison of the study group findings normative data was obtained from a reference group of non-pregnant women from within the same geographical area. The mean age of the reference group was 32.78 years (SD = 8.91). Further insight into some of the domains assessed and the impact of pregnancy on psychological outcomes, irrespective of choices for care, is provided by the reference group data. In general, scores for all the domains measured have a propensity to remain more stable over time in the non-pregnant group than is found in the pregnant sample. This is demonstrated by the descriptive data for the questionnaires scores of the reference group at all observation points shown in appendix 10.

Multi-dimensional Locus of Control

The pregnant women as a group demonstrate higher scores on the MHLC others, doctors and chance subscales. Indeed, running an ANCOVA which included the reference group data, revealed interesting findings with regard to the impact of pregnancy on women's feelings of control. Highly statistical significance for the main effect of group for the internal and doctors subscales is demonstrated in table 40. These findings would suggests that in pregnancy and the postnatal period, regardless of the choices made for care, women clearly experience higher levels of control from external sources, than non-pregnant women.

Table 40: Between Groups ANCOVA Summary for Internal and Doctors MHLC subscale scores including non-pregnant reference group for all observation points.

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared $(\eta^2)^a$	Power
Internal							
Between Subjects							
Group	1491.40	3	497.13	8.92	>0.01	.19	.99
Age	1.37	1	1.37	.02	.88	.00	.05
Error	6410.97	115	55.75				
Doctors							
Between Subjects							
Group	122.65	3	407.22	19.69	>0.01	.34	1.00
Age	13.08	1	13.08	.63	.42	.01	.12
Error	2378.85	115	20.69				

SF36

The non-pregnant reference data relating to the SF36 also produced some noteworthy findings. The descriptive data (appendix 10) suggest that with regard to the physical aspects of pregnancy, non-pregnant women consistently score higher. The earlier findings with regard to QoL demonstrated that women experienced significant changes over time with regard to vitality, bodily pain, general health and change in health status as assessed by the SF36. Comparison with the UK normative data suggested that pregnancy and the early postnatal energy levels, in particular, are compromised for the women in this study. Noteworthy then is the support for this claim provided by the non-pregnant reference data in this study which demonstrates significant differences between pregnant and non-pregnant women with regard vitality and bodily pain.

Table 41: Between Groups ANCOVA Summary for SF36 Vitality and Bodily Pain subscale scores including non-pregnant reference group for all observation points.

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared $(\eta^2)^a$	Power
Vitality							
Between Subjects							
Group	25090.25	3	8363.42	10.23	>0.01	.21	1.00
Age	426.92	1	426.92	.52	.47	.00	.11
Error	94861.60	116	817.77				
Bodily Pain							
Between Subjects							
Group	30287.45	3	10095.82	11.12	>0.01	.23	1.00
Age	5.82	1	5.82	.01	.93	.00	.05
Error	103449.67	114	907.45				

The changes over time demonstrated for pregnant women were not matched by similar findings with regard to physical and social daily functioning. This might suggest that women, despite the physical changes experienced as a result of pregnancy, do not perceive these changes as compromising to their daily lives. However, the results of a 'between subject's ANCOVA shown in table 42, which included the non-pregnant reference data, demonstrate that women in pregnancy and the postnatal period do indeed display physical and social limitations in comparison to non-pregnant women. Further, what is interesting is that whilst there are clearly physical consequences and limitations of pregnancy and childbirth on women's usual physical and social functioning and roles, this does not map onto the psychological components of the scale, with no significant differences observed between pregnant and non-pregnant women in the psychological components of the scale.

Table 42: Between Groups ANCOVA Summary for SF36 Physical Functioning, Social Functioning and Role Physical subscale scores including non-pregnant reference group for all observation points.

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared (η^2)[a]	Power
Physical Functioning							
Between Subjects							
Group	23648.92	3	7882.97	14.05	>0.01	.27	1.00
Age	117.74	1	117.75	.21	.65	.00	.07
Error	64544.05	115	561.25				
Social Functioning							
Between Subjects							
Group	11396.64	3	3798.88	3.34	.02	.80	.75
Age	2813.59	1	2813.59	2.48	.12	.02	.34
Error	130656.23						
Role Physical							
Between Subjects							
Group	62845.80	3	20948.60	24.61	<0.01	.39	1.00
Age	161.37	1	161.37	.19	.66	.00	.07
Error	97903.73	115	851.34				

Hospital Anxiety and Depression Scale

Other findings of note with regard to the reference group of non-pregnant women are the HADS-D subscales means, which might imply differences between pregnant and non-pregnant women. Non-pregnant women display lower HADS-D means and when the non-pregnant data is included in a 'between subjects' ANCOVA, statistically significant differences are observed as demonstrated in table 43. As shown earlier, no differences were observed between the pregnant groups so it can be surmised from these findings that it is pregnancy and the postnatal experience that has an effect on women's HADS-D scores. Interestingly this pattern is not reflected in the EPDS scores. It is also noteworthy, that HADS-D means scores for the pregnant groups all remain below the levels considered clinically relevant for these measures.

Table 43: Between Groups ANCOVA Summary for HADS-D subscale scores including non-pregnant reference group for all observation points.

Source of Variance	SS	*df*	Mean Square	F	*p*-value	Parital eta squared (η^2)[a]	Power
HADS-D							
Between Subjects							
Group	497.90	3	165.97	8.03	>0.01	.13	.99
Age	12.77	1	12.77	.62	.43	.00	.12
Error	3266.43	158	20.67				

Summary

A summary and a brief interpretation of the quantitative findings, from this study, have been presented in this chapter. The major discussion of these findings, integrated with the qualitative findings, will take place in chapter 8. The quantitative study results presented here have addressed the first research question, revealing little impact on psychological health outcomes for women with respect to the choices they make for maternity care and childbirth. Indeed, no statistically significant differences were observed between the three pregnant groups within any of the psychological domains assessed. However, careful unpacking of the data has revealed some theoretically interesting and clinically pertinent psychological findings in relation to this study group as a whole. Corresponding psychological profiles have been demonstrated regardless of care type chosen, suggesting that women experience similar psychological challenges across the maternity spectrum, which are largely unaffected by the choices they make for care. It seems possible, however, that differences in experience or environment can have an impact on women's psychological experience. A claim which seems supported by the interaction effect demonstrated for general and social self-esteem. Such a finding clearly merits further interpretation, which will be afforded in chapter 8. Further, the non-pregnant reference group data has clearly demonstrated that the maternity experience, from early pregnancy through to the late postnatal period, does indeed involve both physical and psychological challenges for women. As stated, these findings will be explored further in a later chapter, which will utilise the narrative data presented in the following section of this thesis to underpin the above findings. The qualitative findings explored in chapters 6 and 7 will allow an interpretation of the quantitative findings, illuminated by the context of women's own personal antenatal and postnatal experiences.

Section C

The Qualitative Study

The following section of the thesis will present the qualitative arm of the study. The aim of this aspect of the study is to address the second research question:

What are women's subjective experiences of pregnancy, childbirth and early motherhood and the policy of choice within contemporary maternity care?

Chapter 5 below will firstly present the method employed to address that question and proceed to describe how participants were recruited to this aspect of the study. It will comprehensively outline and justify the interviewing approach employed to generate narrative data and lastly, describe the framework developed to analyse the data. It should be noted that due to the methodological model adopted in this research, this chapter does not consistently adhere to a single academic writing tradition. Whilst, this might feel uncomfortable to some readers, to write it any other way would have repudiated the authors claim, made in chapter 3, that the conduct of each aspect of the study should remain true to its paradigmatic roots. Therefore whilst the quantitative chapter of the study was written in the third person, true to the academic tradition within that paradigm, the qualitative methodology, presented in the following chapter is predominantly written in the first person and is interwoven with reflexive thought. This reflexivity is particularly apparent in the development of the framework for analysis, which is unique to this study and evolved out of a synthesis of narrative and semiotic models. Chapter 6 and 7 will then present the results of the qualitative study. Chapter 6 will focus on women's initial and late pregnancy narratives and chapter 7 on women's early and late postnatal accounts. Both of these chapters will be interwoven with interpretation due to the nature of the analytical model applied. However a discussion integrating the qualitative findings with those from the quantitative aspect of the study will take place in chapter 8.

Chapter 5a: Qualitative Methododology

Introduction

The following chapter explains and explores how the qualitative data for this study were collected. It explores the use of a feminist narrative approach to interviewing and considers the value of utilising such an approach to explore issues in maternity care. The analytical framework, which is unique to this study, is then introduced and justified. The development of the framework synthesised narrative and semiotic models has been demonstrated reflexively, showing how the model developed and changed over time and through various metamorphoses.

Participants

The women involved in this study had already consented to and been involved in the quantitative aspect of the study. For recruitment of these women, a form was placed at the end of the questionnaire booklet (see appendix 9) during July and August 2003 asking women who would be prepared to be interviewed to complete their name and contact details. Information about the possibility of being asked to participate in an interview had been included on the information sheet that these women had received. A total of 15 women agreed to be interviewed about their experiences. Five of the women were either unable to be contacted or were not available for interview within the allotted time scale. Out of the 10 remaining women there were representatives from within all three defined care groups. These women were then contacted directly and an appointment for interview was made.

Interviewing the Women

The interviews were arranged to be at the convenience of participants. Each was given the option of being interviewed either at home or in the hospital when she attended for care. All ten women were interviewed in their homes at the third and fourth time points following the birth of their babies and only two women chose to be interviewed in the hospital at the first and second time points, mainly due to the fact that they were still working and it was convenient to combine their interviews with antenatal visits. The interview setting undoubtedly impacts on the data generated, the same person may stress different aspects of their identity in different settings. It is considered good practice to interview in a private space that the interviewer feels is 'theirs' (Green & Thorogood 2004). As above, this was not always practical for the women involved and for an

interviewer to invite themselves to the woman's home would have been inappropriate and intrusive.

The women were assured that all information given would remain anonymous and confidential; the tapes would not be used for any purposes other than the research. My aim was to promote women's voices about their experience, encourage the telling of stories around their experiences and give them a degree of personal satisfaction from participating in these interviews. Oakley (1981a) describes interviewing women as

> *"a strategy for documenting women's own accounts about their lives.....a new awareness of the interviewer as a tool for making possible the articulated and recorded commentary of women on the very business of being female"*

Interviews approached in this way have the potential to authorize the knowledge of ordinary people (Fraser 2004) in this case 'ordinary' pregnant women. Anderson & Jack (1991 in Fraser 2004) describe the interview as a critical tool for developing new frameworks and theories, founded on women's lives. The very act of entering into dialogue with others potentially unearths hidden or subordinated ideas and casts doubt on official accounts and established theories (Fraser 2004). In the case of maternity, the feminist perspective adopted in this thesis locates official accounts and established theories as traditionally patriarchal in origin. The women were keen to relate their experiences of pregnancy, their labour, birth and the postnatal period.

The content of the interviews was determined by questions around choices for care and their expectations and feelings surrounding their experience at that time. Narrative research is orchestrated around story telling and as such researchers often use a conversational style of interviewing (Fraser 2004). A conversational approach was adopted for these interviews, the freedom of which would allow women to explore those aspects that were important to them, with regard to their feelings and experiences. Engaging with participants in this relatively informal way allowed stories and comments that did not appear immediately relevant to be explored (Hollway & Jefferson 2000). Women often referred to their previous birth experiences to explain and explore their feelings during their current experience and they were encouraged to do so. The belief was that the articulation of their previous experience enabled them to make sense of their current birth, labour and postnatal experience. Traditionally stories are considered to have conventional structures, which are arranged to provide coherence and causal sequence, they have a beginning, middle and an end, however Hollway and Jefferson (2000) draw attention rather to the principle of 'free association' as defined in psychoanalysis. By

eliciting a narrative structured according to the principles of free association, it is possible to secure access to concerns which may not be visible using more traditional methods. Whilst it is a common concern to elicit detail, free association does not have the same preoccupation with coherence and tends to defy traditional narrative conventions. This hands control of the interview to the woman herself and so the interview schedule merely guides not governs the interview. Free association allows the respondent to begin by answering the question but then 'go off' the question and refer to sometimes intimate or sometimes only loosely related issues that are of greater emotional concern. 'It is the emotional concerns that produce this pathway of associations' (Hollway & Jefferson 2000 p41), which in turn will often lead to the core concerns of the respondent. It is important to appreciate that personal stories often contain circular, overlapping and slightly chaotic utterances (Coates 1996 in Fraser 2004) and as researchers we need to be sensitive to the ways fragments of ideas might be expressed and facilitate the creation of women's personal stories. To restrict or confine the interview to direct answers to the questions posed, could risk a misunderstanding of the meaning ascribed to pregnancy, birth and early motherhood in the women's lives.

The method employed for this study was that of in depth one-to-one interviews, designed as conversational in approach. This contradicts the earlier paradigm representation of a 'proper' interview based on such values as objectivity, detachment, hierarchy and science; such typifications 'owe a great deal more to masculine social and sociological vantage point than to the feminine one' (Oakley 2005). In these traditional approaches, successful interviewing is considered to be a matter of good technique (Hollway & Jefferson 2000). Interviewers have historically defined the interviewees as subordinates, but feminist researchers have criticised the unequal power relations in the interview. This criticism is part of a wider demand to counter the objectification of the interviewee, which follows on from the scientific model of knowledge discovery. Women's accounts can be constrained by the interviewer, but further, analysis can be taken out of their hands and produce outcomes that are actually against their interests (Hollway & Jefferson 2000). Hence feminist researchers stress 'the importance of achieving symmetry in the social identities of the interview pair' (Hollway & Jefferson 2000). It was important to me that women were not utilised merely as sources of data, women were giving me a great deal in terms of their time and access to their intimate thoughts and feelings at this time in their lives therefore, some personal investment of myself in the research relationship seemed imperative. Oakley (1981a) states that

> *"it becomes clear that, in most cases, the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her personal identity in the relationship"*

Oakley (2005) relates her experience of interviewing women in a research project concerned with the transition to motherhood. In this study she considers she was present '*during a critical phase in their lives*' (Oakley 2005 p.222), interviewing the women twice during pregnancy and twice after the birth of their babies, much the same as this study. She cites the difficulties that she encountered as twofold. Firstly the number of questions the women asked her and secondly that repeated interviewing 'involving the intensely personal experiences of pregnancy, birth and motherhood established a rationale of personal involvement' (Oakley 2005 p.223) which defies the representation of the 'proper interview'. Oakley further suggests that avoiding this personal involvement is ultimately unhelpful. Interviewing in the literature is often presented as a 'one off' affair, where detachment is easier to maintain than in a longer-term research relationship. The women in this study volunteered for interview, so it would be expected that they wanted to talk about their experiences, however, as found by Oakley (2005) they were also interested in my own situation. In addition they also often set the scene for the interview relationship as something beyond questions and answers and welcomed me into their homes offering drinks and even on occasions, lunch. Declaration of my status as a mother within these interviews appeared to be regarded as a position of empathy, understanding and equality with the women's own experiences. Oakley (1981a), comments that where both interviewer and interviewee share the same gender, socialisation and critical life experiences, social distance can be minimal. All questions about personal experience of pregnancy, birth and motherhood were answered honestly, although always from a positive perspective. My role as a midwife was integral in gaining access to these women as participants in the research, however that status was deliberately underplayed throughout, with the aim of minimising the power relations implicit in any interview situation. Women did, however, take the opportunity to ask for clinical advice, and as with the personal questions, I had made a conscious decision that I would answer these questions, which I did so as fully as I could without access to the case notes. I stressed that these were generic answers based on my midwifery experience not necessarily based on the interviewees' own situation. These approaches seemed to foster a feeling of intimacy and trust and seemed to aid and not hinder the informal atmosphere of the interviews. Women seemed to feel equally able to narrate negative as well as positive experiences with regard to midwives and their care generally, which suggests that my professional role

although it undoubtedly impacted on the interview relationship, did not discourage them from narrating their relevant stories.

Narrative Approaches

The narrative approach adopted here stands outside of the traditional approach to interviewing of question and answer. Narrative and stories are fundamental ways of giving meaning to experience. Most stories concern social interaction and concern events as experienced by specific actors. Telling stories allows narrators to communicate what is significant in their lives and how things matter to them (Rosaldo 1986 in Mattingley & Garro 2000). Narratives have a primary function which involves bringing order to disorder, in telling a story the narrator is trying to organise the disorganised into some form of meaning (Murray 2003), narrative mediates between an inner world of thought and feeling and an outer world of states of affairs (Mattingly and Garro 2000). Tension can then exist for narrators in trying to give meaning to the various challenges and disruptions to the order of everyday life. Pregnancy is clearly such a disruption and a challenge to women and narrative is a primary means of restoring such order. Therefore stories can provide a powerful medium for learning and gaining understanding about others, by affording a context for insights into personal experiences. They can promote understandings of social, cultural and moral orders. Jerome Bruner (1986) contends that narrative offers a way of constructing reality that deals in purpose and action and the change of state and consequences that mark their path.

The meaning that the women interviewed here attribute to childbirth, will then reflect their expectations and understandings gained through participating in a specific social and moral world of pregnancy and motherhood. '*Humans are action centres that strive within bounds to create their own worlds*' (Murray 2003 p.115). As a consequence women will narrate experiences that imply their role or lack of it in shaping events. Paul Ricoeur (1984 in Murray 2003), developed an immense body of work of the centrality of narrative for meaning making and argues that individuals need to create narratives to bring order and meaning, but further that narrative is central to how we conceive of ourselves, to our very identity and self definition. It is through narrative that we construct connectedness to others but also how we distinguish ourselves from others (Murray 2003). The interactions with the women, in this study, aimed to promote a better understanding of the emotional, cultural and social grounding of their experiences through the stories they construct. Narratives unlike discourses have a finished structure, although the full dimensions of the structure require the reader to complete the narrative (Murray 2003). It is this completion that draws on the established social narratives within which both teller and audience live.

Hence, it is necessary to acknowledge that narrative is open to alternative readings as it deals with human possibilities not fixed beliefs (Bruner 1986). It is also important to note that all narratives are provisional, they are subject to change as new information becomes available, women in their early pregnancy narratives were not aware of the outcomes of their pregnancies, their birth experiences or their adaptation to motherhood but could only relate their worlds and identities as they saw them at that point in time or in the context of expected outcomes. These women's narratives could not be complete until the final interview and only complete as far as this study was concerned. This approach is supported by Hollway and Jefferson (2000) which suggests that the form of a person's account is the sum of all the links that have been made within the available material.

Mattingly and Garro (2000) have been inspired by the possibilities of narratives from patients and healers that have served to illuminate practices and experiences that surround illness but otherwise remain unrecognised. Although childbirth cannot be defined as an illness it remains undoubtedly situated within a bio-medical model. Sacks (1987 in Mattingly and Garro 2000) critically distinguishes authorised medical discourse obtained from traditional medical history taking from the narrative proper in which the human subject and experience rather than the pathology is the central character. The possibility of narrative discourse within this study was a way to bring women and their particular experiences of pregnancy, childbirth and motherhood into focus alongside the recognition that there is more to the story of being a 'maternity patient' than can be captured by a medical synopsis. Hence narrative provides an opportunity to distinguish childbirth as a phenomenon seen from a practitioner and professional's perspective, from childbirth as phenomenon seen from the perspective of the women who experience it. As a theoretical concept narrative fits well with the feminist agenda to reorient medical practices with regard to women within society. It enables the subjective situation of women to become more visible in society. The interviewer works as a tool for making possible the articulated and recorded narratives of women on the very personal business of being female in a patriarchal society (Oakley 2005).

Narrative Psychology

The narrative turn in psychology began in the 1980's with work which suggested that narrative could be a form of representation. This led to a movement in clinical psychology towards the development of narrative therapy, based upon exploring alternative stories. Crossley (1999), amongst others, has argued that narrative provides a means of making sense of the disruption of illness. A narrative psychology recognises that narrative

accounts are not created in a void, but are shaped by social context. Hence the study of narrative allows understanding of a more psycho-social subject (Murray 2003).

Narrative and a Sense of Self

Narrative has also been claimed to provide a structure to our sense of selfhood (Murray 2003). The stories we tell about our lives to both ourselves and others create a narrative identity by which we recognise ourselves (Riceour 1988 in Murray 2003). It is possible to hold a number of different narrative identities, each of which is connected to different social relationships, an aspect which I was particularly interested in. Narrative identity and its connected social relationships, in turn provide a sense of localised coherence and stability (Murray 2003). At times of instability, we can make connections to other aspects of our narrative identities. Women in pregnancy and new motherhood are in a process of creating new social relationships defined by both their pregnancy and their baby but also in renegotiating relationships with their partners, family and friends etc. Narrative affords us access to those experiences as described by the women themselves and to how women define themselves at this time in the context of their lives.

The construction of a personal narrative selects the different aspects of our lives and connects them with others, creating a certain order to our lives. This process of identity formation occurs in a changing social and personal context and the values attached to different experiences in that context influence the character of the events recalled (Murray 2003). Although women then will be able to tell their life stories, the actual structure of the story and the pattern of their lives will be shaped by a multiplicity of social, cultural and psychological forces both conscious and unconscious (Hollway & Jefferson 2000). Women are active agents who are part of and engage with a social world, and as such their narrative accounts are shaped by social and cultural contexts, as well as the collective narratives which define and distinguish them as pregnant women and mothers from other collective narratives (Murray 2003). Collective narratives overlap with personal narratives such that women can define themselves as part of a group as well as individuals. In essence women are enmeshed in a world of narrative; exploration of that narrative allows us access to women's maternity worlds, how they make sense of that world and how they renegotiate their position and identity within it.

Narrative Interviewing

This narrative approach demands that the interview agenda be open to development and change, depending on the narrator's experiences (Hollway & Jefferson 2000). Mishler (1986) argues that question and answer interviewing tends to suppress respondent's

stories. It is important to be open to stories within the responses however, this alone may not be enough. A participant must feel able to convey relevant experiences outside the interviewer's agenda. This requires an altered conception of what interviews are and how they should be conducted (Hollway and Jefferson 2000). The aim is to create meaning within the research pair. Many semi-structured interviews come under the question and answer typology, where the interviewer sets the questions and takes control of the production of information. In narrative the agenda must be left open to change and development. Adopting this approach would allow my interviewees the opportunity to talk freely about their experiences. Story telling can be differentiated from the products of traditional research interview by the narrator's own role in taking responsibility for making the relevance of the story clear (Hollway and Jefferson 2000).

Interviews practices which aim to facilitate narratives should be approached as conversations in which both participants develop meaning together, requiring considerable freedom for both interviewer and interviewee (Kohler-Reissman 1993), to construct a story, rather than record a neutral account of a pre-existing reality (Hollway and Jefferson 2000). An informal feel to the interviews opened up topics for exploration and assisted respondents to say more about their experiences, without offering interpretations, judgements or imposition of the interviewer's own relevancies. The women were encouraged to respond freely and expand on their answers when appropriate. Understanding the experience of respondents through narrative accounts requires allowing them freedom to verbalise their thoughts. The aim therefore was to allow this without imposing my personal views on them, whilst investing in the relationship to create a collaborative and facilitatory approach alongside a conversational context. Interviews are conversations in which both participants develop meaning together, a stance requiring interview practices that give considerable freedom to both (Kohler-Reissman 1993). In this sense the feminist and narrative approaches to interviewing seem to fit together well.

An interview schedule outlining key aspects to address during the interviews was utilised (see appendix 14). It would have been ideal to ask just one opening question, but this research provided a particular frame, which needed to be addressed. The questions were as suggested above utilised to provide a catalyst for the interview conversation, which intended to give the women a sense of control and ability to talk about the issues they felt were of importance. Although my aim was to dispense with the traditional power status normally adopted during research interviews, it of course should be acknowledged that my presence as a researcher, the environment and the cultural context would all continue to have influence. For instance, by asking questions we produce answers only through one

frame, and no frame is ever neutral. This approach has also been criticised for it's over confidence in the existence of true or genuine experiences and in the possibility of capturing these (Hollway 1989). In addition other questions about the appropriateness of narrative method ask '*what is the relation of the story to the events to which it refers*' and '*how is the truth compromised by the story-teller's motivations and memory*'? (Hollway and Jefferson 2000 p.32). In response they state that 'the focus of our analysis is the people who tell us stories about their lives: the stories themselves are a means to understand our subjects better. '*While stories are obviously not providing a transparent account of through which we learn truths, story telling stays closer to actual life events, than methods that elicit explanations*' (Hollway and Jefferson 2000 p.32). Further Hollway and Jefferson (2000) reflect that the diversity of stories elicited, demonstrate that answers are not produced merely through the discursive frame of the questions, but through individual's biographic unique reality that can be elicited through open-ended questioning.

Intersubjectivity and the Research Relationship

Women's research is often characterised by an approach which sees the subjectivity of both researcher and subjects studied as central, in the first case through empathy and commitment and in the second through personal experience. A mutual relationship of trust is essential, for without it we cannot be confident that our research on women's lives actually represents what is significant to them about their experience. Furthermore it assists in the acquisition of significant and meaningful data (Oakley 1981a). A feminist interviewer 'is by definition both '*inside' the culture and participating in that which she is observing*' (Oakley 2005 p.230) and involves the political considerations, which flow from the researcher's own identity. Narratives resulting from interview are always a product of the relationship between the interviewer and interviewee. In the case of these interviews, some were more difficult than others and some women were undoubtedly easier to relate to than others. It is relevant then to consider how the women themselves must have perceived me. Some interviews required much more prompting and intervention in order to encourage response but also to develop a sense early on that what these women had to say was actually of importance and value. This seemed to have the desired effect as even the most difficult interview relationships seemed to evolve over time and exchanges became more fluent and storied in their content. Women felt able to challenge the points I was making and take more control of the interview. The importance for me was in the privileging of women's experiences and treating all those experiences as equally valid. At times this required digression from the traditional narrative approach of asking the question and then engaging in good listening (Hollway and Jefferson 2000). Hollway and Jefferson (2000) further contend that the researchers interventions can be positive and

instrumental in promoting mutual understanding, enhancing trust and ultimately beneficial rather than exploitative for the interviewee.

Transcription

Taping and transcribing are absolutely essential to narrative analysis and is the beginning of the translation process and aimed to produce actual talk rather than a tidy version (Green & Thorogood 2004). Transforming talk into written text precisely because it is a representation involves selection and reduction (Kohler-Reissman 1993). The transcription of these interviews began with a first draft of each interview. Much time was then spent familiarising myself with the data. Thus the focus for analysis began to emerge and features generated by the women began to emerge.

Identifying where the narratives begin and end are textual as well as analytical issues. There is no one true representation of spoken language. Boje (2001) states that "*stories are exemplars of the messy process of human sensemaking*". He suggests that no story moves from beginning to end, at most it pretends to come back and to unfold, but it does not trace or replicate the original telling. A story may only be the possibility of meaning (Boje 2001). The form of representation reflects the transcriber's views, concepts and values about what is important. Meaning can be constituted in very different ways with alternative transcriptions of the same stretch of talk (Mishler 1986).

At this point it should be noted that one woman's transcript had to be abandoned, due to the inaudible quality of a significant amount of the recording. Although this was disappointing and unfortunate the decision was made on based on the pressure of the time available.

Chapter 5b: Developing a Framework for Analysis

Having worked with a narrative approach to analysis previously (Jomeen, 2002), I knew that narrative analysis would be more effective than other forms of data analysis in revealing women's emotional experiences and interpretations of being pregnant, giving birth and being a mother. Sarbin (1989, in McLeod 1997) points out that persons are fundamentally social beings and that emotions must be viewed within a social and interpersonal perspective. My previous work had shown that women use their birth stories to emplot their emotions. Emotions are used to explain what happened but more than that provide a story that supplies the justification for those emotions, this reveals a multiplicity of influences that create narrative in pregnancy, childbirth and motherhood. Previous studies of motherhood (Coates 1997, in Sunderland 2004) have identified competing discourses of maternity, one the dominant traditional image, the second more subversive and less socially acceptable but a clear product of the women's actual experiences. Coates does not suggest that women are unthinking victims of maternity and motherhood discourses but that their linguistic representations and constructions of their maternity identities will be based on the selection of some discourses and the rejection of others (Sunderland 2004). There is clearly a physical reality and an embodied experience of being pregnant for women but it seems apparent that there is additionally a social and cultural establishment of pregnancy to which women subscribe albeit to differing degrees. The thematic narrative method I had used previously was therefore inadequate because although it was able to reveal convergence in individual women's narratives about the explicit discourses which influence delivery decisions, it would be unable to identify how pregnancy and birth shape an individual woman's sense of identity and the reasons why she represents herself by certain narrative constructions either consciously or subconsciously. In addition it would be unable to reveal the underlying foundation and basis for emotional responses and behaviours that women experience at this time in their lives. An exploration of the literature on narrative analysis (Kohler-Reissman 1993; Mishler 1995; Parker 1999; Hollway & Jefferson 2000; Boje 2001) revealed that these existing approaches had flaws, which did not enable me to give focus to the individual woman's stories. Murray (2003) recommends experimenting with narrative analysis, rather than imposing a framework or simply describing the account, '*narrative analysis requires that the analyst play with the account*' (Murray 2003 p.121), so as to adapt its potential to suit the study. Following this advice, I gathered several texts together (Parker 1999; Boje 2001; Czarniawska 2004) on narrative analysis and began to work with one

transcript, experimenting with the different methods detailed in those texts, seeking a combination of methods which would provide most insight into the data.

The immersion in the transcript that this required resulted, firstly, in the striking observation of the different ways in which the women in the interviews seemed to be referring to their 'fetus', i.e. as; 'my baby'; 'the baby'; 'baby'.
The fetus never seemed to be referred to as 'our baby' despite the fact that women spoke about trying to get pregnant, and recognised pregnancy as a joint decision and product. The fathers in the early 12 -14 week interviews seemed strangely absent from the women's narratives, yet their role in the pregnancy cannot be denied.

This initial observation contradicts the philosophy underpinning much narrative analysis, for rather than what was in the text, in the form of stories, being important what was *not* in the text seemed to offer something equally, if perhaps not more, important. As researchers we sharpen our perception to avoid ascribing meaning to or overwriting our data, at the same time however we risk overlooking or ignoring the meaning of what is absent (Rogers, Casey, Ekhert et al. 1999). Reading of Paul Ricoeur's hermeneutic theory of interpretation in Crotty (1998) initially seemed to offer some promising thoughts. Ricoeur distinguishes two different kinds of interpretation. The *hermeneutics of meaning-recollection* aimed at faithful disclosure of people's life worlds and the *hermeneutics of suspicion*, which aims to discover, behind the thing being analysed, a further reality which allows a much deeper interpretation to be made and which can challenge the surface account (Murray 2003). Hermeneutics is defined as a method for deciphering indirect meaning, a reflective practice of unmasking hidden meanings beneath apparent ones. Interpreters may end up with an explicit awareness of meanings that the authors themselves would have been unable to articulate (Crotty 1998). This approach seemed to offer some possibilities, a method for understanding why women articulate their pregnancy and birth experience in the way that they do and in addition for discovering the meanings they are unable to articulate because they have no language to do so. However the hermeneutic circle, a consistent theme in the literature of hermeneutics felt either too literary in its approach or too laden with spiritual and ontological overtones to be directly applied to my analysis. My debt to it however is twofold: The notion that authors' meanings and intentions often remain implicit and go unrecognised by the authors themselves and the notion that the correct inquiry can allow us as researchers' access to those meanings and intentions that are hidden in the text but unarticulated.

My reading of the literature on narrative analysis and the search for some kind of framework that I could apply had encompassed the work of some of the structuralist scholars (Czarniawska 2004). Their work seemed to further offer ways of thinking to analyse voices that are within the text but are not articulated, alongside those actually being articulated.

Structural Analysis

Structuralist analysis was first described by Propp (1928 in Czarniawska 2004). He aimed to classify fairy tales according to their component parts and the relationship of these components to each other. His analysis noted that the same character can perform different actions and different characters may perform the same action. His analysis presented a single structure of seven possible characters and thirty-one possible actions (Czarniawska 2004). There was some attraction in a structuralist approach which seemed to suggest that a framework could be developed that identified characters in a narrative and the role/roles that they could occupy. His work listing the functions associated with the actions of the narrative's characters was never completed. Later structuralists such as Levi-Strauss praised but critiqued Propp's principles (Belsey 2002), suggesting that his approach ignored the thematic content inherent in narratives. What structuralism aimed to achieve was to find common cultural elements that would identify universal structures ultimately embedded deep in the human mind. Human beings are the effect of these structures that escape their awareness (Belsey 2002). Structuralism is extremely seductive, promising a key to all human practices and, for me for a while, seemed to offer a potential framework for analysis that could be applied to the women's narratives. In 1966 A-J Greimas (translated 1983) published Structural Semantics bringing together the works of Levi-Strauss on binary opposites and Saussure on the signs and signifiers of language to rewrite Propp for Structuralism. It is this work which eventually offered some promise for analysing my interview data.

The Actant Model

Greimas utilised Propp's work to develop a model for understanding the organising principles of all narrative discourses (Czarniawska 2004). Not dissimilar from Ricoeur, Greimas distinguished between a discursive level and a narrative level, between the ways a narrative is told and the narrative itself.

> *"...the qualification of the subject, which introduces into life; its 'realisation' by means of which it acts; and finally the sanction – at one and the same time retribution and recognition – which alone guarantees the meaning of its actions and installs it as a subject of being"* (Greimas and Courtes 1982: p.204).

I was intrigued here by the use of the pronoun 'it' and the suggestion that a grammatical subject might or might not reveal itself as a person.

Greimas replaced the term 'character' with 'actant' since it applies not only to human beings but also to animals, objects or concepts. The description of an actant is something or someone that accomplishes or undergoes an act within the narrative. This allows us to see how actants change role throughout a narrative. An actant might also be an actor, i.e. have a distinct character. Building on my first initial observations of how the women referred to the fetus, this concept of actants alerted me to the potential of capturing the role of the fetus within the woman's narratives; does the fetus acquire a character of its own or create a character for the woman within her narratives? It seemed possible that the fetus had a much deeper role to play than had been credited previously. The fetus has generally been assigned a passive role within women's pregnancy experience but could it be the fetus is more than just the object of somebody else's actions e.g. the pregnant woman, but that it is actually invested of its own agency within the woman's narratives. This might begin to afford some insight into the way the women referred to their babies within their narratives. An additional question was whether the fetus's role changes as the pregnancy progresses as it certainly does following birth? Adopting this term 'actants' offered a way to discover who or what was important and influential to women throughout their maternity narratives. This approach opened up the possibility that actants could be defined in the women's narratives and may play roles which hold differing importance at different times. For Greimas the hero will only be a hero in certain parts of the narrative, not a hero before and may well not be the hero afterwards.

> *"So defined an actant is not a concept which is fixed once and for all, but is virtually subsuming an entire narrative trajectory"* (Greimas 1982 p.207)

This concept of actants appealed as a way of potentially revealing the main characters of the woman's narratives but also provided a way of giving a more important place to those non-human influences in the story. It raised the possibility of maternity discourses as actants within the women's stories, or at least of characters shaped and produced out of cultural and societal discourse. The possible questions therefore to ask of the women's narratives were, who are the important characters of the piece and how can these characters be revealed? The exposure of the actants seemed a way of potentially revealing the characters and providing some understanding of why some actants can also become characters whilst others fail. The utility then was seemingly twofold: Actants could

provide the key to revealing the characters in these pregnant women's narratives but also could become characters themselves within the story.

My interest in Greimas's approach and in this concept of 'actants' as the potential key to identifying those voices in the story that seem clearly there and influential but remained implicit rather than explicit, led me to explore his framework for analysis further. Levi-Strauss (1976 in Czarniawska 2004) who provided much of the basis for Greimas's work, seemed to offer further affirmation of the usefulness of this approach, describing the actors within their narratives as '*a bundle of differential elements*' (Greimas 1983: p.xli). One actor can perform more than one actantial role offering the potential for the pregnant woman to be a nodal point for a matrix of actants which all shape her identity. This seemed to sit well with the theory of competing discourses of maternity, but also with my interest in narrative identities and the creation of a dominant narrative identity which the women chooses to reveal, alongside those that she either consciously or subconsciously represses. These hidden identities may in turn create new discourses by which to understand women's maternity experience. A potential framework for analysis seemed to be emerging.

The difficulty here was although I found Greimas's concepts of actants useful I felt unable to work effectively with Greimas's framework in its entirety. His framework is very linguistic/semiotic in its approach and although I was searching for a structured approach on which to base my analysis it was 'too structural' relegating the women to mere 'vessels of their functions'. As a researcher adopting a feminist approach this didn't fit with the whole philosophy of my research. Greimas is also concerned to identify a structure which can be applied to all stories and following some interpretation of Barthes (in Belsey 2002), writing at the cusp of structuralism and poststructuralism, it became clear that applying a single model to all narratives would by definition lose the difference of the text and become repeated instances of the same. Further, the need to identify the subject and the object of the narrative, which is also integral to Greimas's framework for analysis, didn't seem able to reveal those suppressed voices, which I was certain were there within the transcripts. Through reading and working with the transcripts I seemed to be finding deeper and deeper meaning within the text and making increasing links with emerging method. The transcripts were firmly dictating the direction of the analytical framework, eventually I let go of my need for a framework and just went with this intuitive approach. Despite this, I couldn't let go of this concept of actants. I felt it was the way to identify the unspoken voices within the text, it seemed to be the key but it needed incorporating into a framework that worked with my transcripts. Other researchers had utilised aspects of

Greimas's work without applying it in its entirety. Latour's (1992) study (cited in Czarniawska 2004) and Budniakiewicz (1992) had both modified and expanded Greimas's model. The efficacy of utilising this concept of actants could only be tested by its application to my data. In order to explore this potential framework it was firstly necessary to organise the data into some kind of manageable format. Most researchers use a pragmatic mixture of approaches to analysis (Green & Thorogood 2004) and the 'work in progress' model comprised of the following:

- Thematic analysis
- From within each theme elucidate the narratives
- Identifying the characters and actants
- Revealing the discourses exposed by the actants

Step 1: Thematic analysis

Inductive theme analysis as described by Spradley (1980 in Boje 2001) was utilised as step one of an eventual four stage analytical process. The aim here was to obtain a basic analysis of the content of the data to categorise the recurrent or common themes (Green & Thorogood 2004). By systematic examination of one woman's transcript, themes were identified within the interview from an 'emic' perspective and utilised the 'emic categories' in use by the woman in her narrative. It should be acknowledged that this type of analysis inevitably involves an 'etic' perspective, informed by theoretical perspectives, which here included feminist perspectives on the medicalisation of pregnancy, risk society, psychology of pregnancy, ideologies of motherhood, personal experiences of pregnancy, birth and motherhood as well as professional experience as a midwife.

Thematic analysis here was merely the search for patterns, searching for units of cultural meaning; cultural in this case being the culture of the pregnant women within their narratives. This was essentially a comparative process; threads of stories within the narratives were clustered together under thematic headings merely by cutting and pasting the data. Thematic analysis in this case was utilised as the basis for the more sophisticated analysis which intended to ask more complex questions about what relationships are developing within the themes, what is not being said and what actants may be emerging. The initial thematic headings included:

- 'My Baby' – Ownership
- Responsibilities of motherhood
- Change of status
- GP/Gatekeeper

- Midwives, obstetricians and experts
- Physical changes in pregnancy
- Emotional pregnancy
- Physical reality conflicts with idealised image
- Family, friends and knowledge
- Experienced realist

Step 2: From within each theme identify the narratives

The organisation of the interview transcript into themes provided workable pieces of transcript but was clearly not adequate in terms of identifying the influences within a maternity context or the personally constructed experiences of pregnant women. Neither was it adequate to reveal the actants within the women's stories. A number of experimental approaches were attempted in trying to identify the actants in the woman narratives.

The women within their narratives are clearly the primary actors of the piece, however the phrase '*a bundle of differential elements*' (Levi-Strauss 1976 in Greimas 1983 p. xli) kept resurfacing and seemed to be the key to the analytical framework. The transcripts themselves seemed to be clearly driving the analysis. Women's experiences and the subsequent emotions and responses aroused clearly seemed to need to express something more than the spoken narrative would allow. An example of this early analysis within the themes illustrates how something more than was actually being articulated seemed to be emerging. The red annotation denotes the tentative early analysis.

Responsibilities of Motherhood [Mary_1_1]

'yes yes going back to last question actually it is something you do worry about things going wrong definitely its.....and now I can feel it [still not referred to as a baby] *moving around all the time* [the baby has a physical presence – this reality causes fear about the fact that things may go wrong and the role of mother/protector has already begun in the conscious noticing in the reduction of movements] *I notice that if it hasn't done for a while I'm consciously waiting for it to do so but I know its probably part and parcel of what's natural isn't it? [I: mm yes its become real to you now hasn't it, its like there's no going back now] absolutely yeah that's definitely happened in the last month'.*

'mm yeah... I suppose that's something else I thought I'd feel more attached than I do I guess [guilt that feelings are not a strong as they should be – who sets the standard?] .....

but I am in that I'm making sure I do everything right I try and sort of do the right things and I'm talking to it and I'm trying to imagine he or she as a person [wants to see her baby as an existing being but finding it difficult because this is someone she doesn't yet know but feels that she should] *and erm this kind of thing* [good mothering begins early – attending not just to physical well-being of the baby but also to emotional well-being by talking to it][I: mm mm] but *I think C is more he's more emotionally bonding already* [this suggests that M feels she is not emotionally bonding] [I:mm] *than I am he'll sit and talk but you see I thought when I first started to feel it move I thought I'd be absolutely overwhelmed with this that's my* ***baby*** [this is the 1st time that she actually refers to the fetus as a baby] *you know and it hasn't been quite that intense.....* [physical movement makes the baby a reality but the intangibility of the baby seems to make it difficult for M to make the emotional bonds that she feels she should] *but I think that will maybe come more gradually for me [I: yeah, yeah and I don't think that's abnormal because it's the first time you're experiencing everything* [she doesn't really know how to feel and almost dare not feel too much because then she will be totally exposed if things go wrong] *and you don't know what the end result is going to feel like... yeah yeah that's probably why you know there's still a long road to travel and yeah its just so new* [I: and whether for some people I don't know really that's maybe a bit of a protective mechanism?] *yeah I was just thinking I was just wondering than that's probably why C is more he thinks everything will be fine and we'll go along fine and.....*[husband is situated as someone who is unable to be as insightful about the pregnancy] *you know when we had our 12 week scan I noticed a big difference in me then from before it to after it you know things are alright...* [reality of the baby conflicts with recognition that things may go wrong and to be pregnant and remain successfully pregnant]

The early thoughts here with regard to this excerpt of narrative were that Mary's failure to emotionally bond as much as she feels she should appears to be intimately connected with her fear that things may go wrong; she has accepted the responsibility of motherhood unlike her husband, who has engaged with the idealised fictional accounts and aspects of having a baby in contrast to herself, who has from the very early stages of pregnancy recognised the responsibility of parenthood.

Considering that one of the primary drivers of this research was to allow the previously subordinated voice of women to be heard, it felt important to continue to follow this intuitive feeling. One way of achieving this seemed to be to expand on this early approach to analysis. This concept of 'differential elements' continued to resonate alongside the concept that one actor can perform more than one role. The above interpretations of the

narratives seemed to hold promise of these elements within the narratives. A method that supported allowing these differential elements to be revealed was required.

Languages of the Unsayable

The method applied here to access the suppressed and unarticulated aspect of the narrative followed the work of Rogers, Casey, Ekert et al. (1999). They discuss the potential inherent in interpretivist poetics, which allows a reconceptualised approach to research analysis, reflecting the complexity of experience. Poetic images cannot be assigned to single categories without losing their multiple connotations and their capacity to evoke fresh responses every time they are encountered. This emphasis on variational images allows a useful model for approaching data, because we can acknowledge the presence of complex and multifaceted interpretation of narrative, drawing on the human capacity to hold multiple interpretations simultaneously. What is unsaid cannot be directly pinned down but the doublings of meaning that mark the dynamic interplay between the said and unsaid can be illustrated. Rogers and colleagues (1999) further suggest that the significance of what is present depends on what is absent, absent because it is too difficult or dangerous to articulate or because it simply cannot be expressed in the context of the interview. This presupposes that there is a range of other possibilities. From this frame what is said depends on what is not said for its full significance. Hence, this approach must systematically attend to what is said to 'define the landscape of the interview' but simultaneously be aware of the unsaid and the interplay between them. In this sense '*what is unspoken becomes an opening and a resource for exploring the layers of another person's experiences and understandings*' (Rogers, Casey, Ekert et al. 1999 p.81). A further example of how this seemed to be working in practice might be salient here, utilising one woman's narrative under the theme '***Change of Status***'

'erm..... shock I think I don't know why because we had been trying for 9 months.... I think you get to a point its almost as if you almost I I'd suddenly gone into this phase where I thought I'm putting it out of my head now I'm not worrying about it so much and erm.... I was getting used sort of not being pregnant every month and I think I was day later than the longest I'd ever been and I suddenly thought oh no now I'm going to be thinking oh dear am I am I am I I better go and do a test just so I can and put it out of my head literally but erm but I didn't expect it to be positive erm shock and then I cried and ran round the house screaming my head off [laughs] really really pleased.' [Mary_1_1]

The unsayable here seemed to be the inconceivable thought that Mary might never be pregnant. An underlying fear that she might never be a pregnant woman is not something that she feels able to articulate. She provides a smokescreen response to this situation by suggesting that it's the worry that prevents her from becoming pregnant and if she stops worrying then it will happen. Society's emphasis on contraception makes women believe that getting pregnant is easy. So to accept that, despite trying, pregnancy was not happening for Mary is to acknowledge that she is unable to perform one of the primary functions expected of a woman. In this narrative there is simultaneously an attempt to reconcile not becoming pregnant with a desperate need to confirm the pregnancy. Her shock and excitement at the positive result of the pregnancy test, which creates the reality of pregnancy, is clearly narrated. When Mary recognises that she is now pregnant, two characters are created as she recognises that she is no longer the 'non-pregnant woman' of yesterday but the 'pregnant woman' of today. Yet the spectre of the 'non-pregnant woman' remains.

"...although even within the first few months feeling so much better than I thought I mean I can remember somebody I talked to and they said I must have that day felt a bit queasy or something and they turned round and said 'oh oh that's really really good' you know 'when you start to feel really sick it's a really really good sign because that means your pregnancy's all going you know your hormone levels are going up as they should be' and all this and like a few days after because I was feeling well again I was thinking I was thinking ooh....I know logically because I know people you know who have had good pregnancies as well which doesn't mean anything but that's the information you see cos I already knew that if I didn't know that I could be worrying about sort of..." [M_1_1]

There seems to be an underlying fear here of losing the baby or not actually being pregnant and returning to that non-pregnant state which existed prior to the positive pregnancy test and confirmation of the pregnant status.

Step 3: Revealing the Identities[1]

Immersion in the data within the change of status theme, had resulted in the emergence of a suppressed voice that was that of the woman always preparing for pregnancy ('always pregnant women') and that of a woman waiting to be a mother ('mother in waiting'). These suppressed voices however, seemed to offer the way of accessing more than the

[1] Identities are not being used in this thesis in any theoretical way

singular identity and actions of pregnant women. In essence they seemed to provide the key to revealing the hidden voices within the narratives, which all serve to comprise 'the narrative woman' and collectively construct her own personal and communal identity in pregnancy. The emphasis here remains on pregnant women because my early analysis was undertaken with the early pregnancy transcripts. The thematic analysis had revealed that one maternity narrative comprises of many different aspects but what seemed to now be more clearly emerging was that 'the narrative woman' comprised of more than one single voice.

What was becoming apparent following further analysis of the unsayable within the transcripts and utilising the Greimasian concept that one actor can perform more than one role, was that the actor (woman) can also be 'pregnant woman', 'mother', 'desired/undesired partner' all exposed by the narratives that she relates either explicitly or implicitly. Each woman consists of a number of identities, which are part of what makes them 'what/who they are'; these identities in turn are invested of their characteristics by the matrix of actants that surround them. The woman is at the intersection of this matrix of actants. The women narrated their experiences but in doing so seemed to reveal identities that are brought into being by their emotional and physical responses to the actants within their social and cultural sphere of experience.

Step 4: Revealing the Actants/Actantial Influences

Actants perform functions that are not immediately apparent in the actions of the actors but are present in their narratives. The woman as an actor is distinguished by an historical anchoring in name and time but represents a number of identities defined and created by the actants present within her experience. For example: The system tells women how to be good mothers right from the moment of conception/confirmed pregnancy. Health professionals provide instruction in eating well, avoiding risky behaviours and responsible pregnancy. Women are not critical of this system but conform, it is necessary to access the system to validate their pregnancy and confirm their new identity (pregnant woman). In addition adopting the recommended behaviours confirms their identity within the collective 'pregnant woman' but also presents them as 'good pregnant woman' who adopts responsible behaviours in order to assure the well-being of her baby. Their narratives are an effect of the meaning and values in current circulation.

It seemed that others had roles to play within the narratives, however many of these serve to consolidate the women's identities. The GP is a clear character within the early narratives but potentially performs several roles, one of which is the actantial role of

validating the pregnancy and being the gatekeeper to the process and the system that recognises the woman as 'pregnant woman'. The pregnancy test, visiting the GP, accessing antenatal care all signify 'pregnant' and bring with them certain properties of a collective identity that is pregnant woman/mother. This seemed to be developing into something quite interesting.

I needed to clearly define what an actant would mean in terms of my analysis. Greimas states:

> *"A semantic micro universe cannot be defined as a universe, that is to say, as a whole of meaning unless it can surge forth at any moment before us a simple spectacle of actantial structure" (1983)*

This seemed to provide a useful analogy to think about the framework for analysis in this study. Each woman is at the centre of an orbiting structure of actants, which allow us to explore the universe that is in this case the maternity experience. Each orbiting actant will have its own sphere of activity, which in turn will influence the woman and create the multiplicity of identities, which constitute her. The woman is the primary actor but she appears to consist of a number of identities. The identities within each narrative are in a sense shaped by one or more actants within the orbiting universe. The actants become apparent through the identities and in turn reveal the discourses and influences, which serve to construct women's contemporary maternity experience. An actant then can be clearly present in the text but may also be absent. Examples of actants that create the woman's multiple characters include:

- The pregnancy test
- The GP
- Midwives
- The fetus
- The maternity system
- Maternity Discourses – medical, social, cultural, psychological etc.
- The partner

The results of the early analysis suggested a workable framework on which to base subsequent analysis. An analytical process seemed to have evolved

- Identify the themes within the whole narrative
- From within each theme interpreting the language of the unsayable
- Identify the identities which are exposed

- Revealing the actants and actantial influences/discourses that construct women's pregnancy, birth and motherhood experience.

It seems clear that women require the maternity system to be pregnant but as part of that system are not enabled to have a voice – it is unacceptable to step outside that frame – their articulated stories are constrained by the frame of the interview and their current status and only allow them to articulate firstly the things associated with pregnancy/motherhood and secondly the acceptable discourses of their maternity experience. What this model for analysis seemed to be allowing was firstly, both an identification of the unspoken voices and a way of accessing women's multiple voices/identities within the text. Secondly, how those multiple identities are created and what discourses/influences bring about their creation. Thirdly, how women construct and experience pregnancy, birth and motherhood in the way that they do. What discourses, advice and influences do they accept and which do they reject and what informs both this acceptance and rejection. This framework would than seem to be useful to create an illuminating account of women's physical and emotional maternity experience but also the influences and discourses that inform their choices and decisions during this time.

Summary

This chapter has outlined the emergent and reflexive approach employed in the qualitative aspect of this study to address the research questions stated at the start of this chapter. The chapter has explained and explored how the accounts presented in the following two chapters were collected through a feminist narrative approach to interviewing and interpreted utilising a unique narrative/semiotic framework. One aim has been to ensure a transparency in the analytical frameworks development, which promotes confidence in the interpretations to follow in chapters 6 and 7. Chapter 6 will present interpretations of the women's antenatal accounts in both early and late pregnancy. Chapter 7 will focus on the postnatal accounts, which were obtained at fourteen days and 6 months following the birth of the women's babies.

Chapter 6: Pregnancy Narratives

Introduction

The following 2 chapters present the narrative themes identified in the antenatal and postnatal interviews undertaken in the qualitative arm of the study; to address the research question:

2. What are women's subjective experiences of pregnancy, childbirth and early motherhood and the policy of choice within contemporary maternity care?

This chapter will concentrate on pregnancy narratives and the themes, which appeared in the narratives of all nine women, are identified and discussed. One interviewee's account, as previously discussed in chapter 5, was abandoned due to the poor quality of the recordings. However, in order to assist in the presentation of a coherent narrative which is difficult given the number of interviews and the amount of data gathered, the themes will be illustrated and discussed using the narratives of just two participants. (Hollway and Jefferson 2000). Excerpts from the other interviews will be used to demonstrate not only that the recurrent themes in each participant's story are reflected in other women's narratives, but also to develop understanding of the 'choice in childbirth' narratives. The focus in both this chapter and the following chapter, which will focus on postnatal narratives, is upon Mary and Helen. These women were chosen because of their differing profiles and preferences for place of delivery. What is shown is both how individual and unique is each woman's story, but also, strikingly, how each is influenced by many similar underlying actantial influences. Utilising the analytical framework described in chapter 5, this chapter will expose the identities that the actantial influences construct within the women's stories and reveal those actants/actantial influences within the women's narratives. To aid clarity, throughout this chapter and the next, the actants/actantial influences will be depicted in blue and the women's identities in red.

It is important to emphasise these interviews are with a specific group of women, with no known significant medical or obstetric problems when recruited and so suitable for choice within maternity care. In addition they were all motivated and able to access all available maternity care. It must be acknowledged that there are many other women whose circumstances in pregnancy are more personally or medically adverse and as such would not be seen at booking to be suitable for choice.

Brief pen portraits of Mary and Helen are presented to provide background information.

Mary: A thirty-one year old nurse, married to Matt with her own home and pregnant for the first time, with a planned pregnancy after a period of trying and delighted to be pregnant. Mary is surrounded by a local network of family and friends.

Helen: A thirty-six year old housewife and mother, with a stable partner but unmarried. Living in local authority housing, she already has two girls, one eleven year old from a previous relationship and one four year old with her current partner Phil. Pregnant for the third time with an unplanned pregnancy and initially unhappy with the situation, Helen has very little in terms of family support, as her own family do not live locally.

Chapter 6a: Early Pregnancy (14-18 weeks pregnant)

Introduction

The following section presents the narrative themes identified in early pregnancy. The themes identified here were common across all interviews and establish much of the context for women's maternity experience as a whole. Firstly these themes will be summarised and include:

- A New Identity
- Physical Pregnancy
- The New Identity, Ownership and Choice
- The GP Gatekeeper
- The New Identity, Naturalness, Responsibility and Emotions
- Promoting Motherhood/Relegating Fatherhood
- Perfect Babies and Screening Choice
- Experts and Expertise

Each of these themes will be explored in turn, exposing within the themes the women's identities and the actants/actantial influences that create those identities. A conclusion of the early pregnancy findings will lead into the late pregnancy findings and consider which identities might remain consistent.

'A New Identity'

The result of a 'pregnancy test' creates a change of status from that of 'non-pregnant woman' to 'pregnant woman' and it seems that some kind of transition begins at this stage. The 'pregnancy test' therefore emerges as an actant very early within the narratives. Mary here shows that although previously pregnancy tests had confirmed that she was non-pregnant, there had always been a sense of expectation. By the time of the interview she is no longer 'non-pregnant woman' but 'pregnant woman'. This recognition that she is no longer what she was prior to the 'pregnancy test' is both shocking and exciting.

> *'erm...shock I think I don't know why because we had been trying for 9 months .... I was getting used sort of not being pregnant every month and I think I was day later than the longest I'd ever been and I suddenly thought oh no now I'm going to be thinking oh dear am I am I am I, I better go and do a test just so I can and put it out of my head literally but erm but I didn't expect it to be positive, erm shock and then I cried and ran round the house screaming my head off [laughs] really really pleased.'[Mary_1_3]*

Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

The 'pregnancy test' result, which was discussed by all interviewees, appears to play an integral role in the shift from non-pregnant to pregnant woman. This can be seen in Helen's account. Having been pregnant twice before, 'personal knowing', meaning an innate sense of her own body, leads her to suspect that she is pregnant, however the 'pregnancy test' is still necessary to confirm her as a 'pregnant woman'.

> *"I did a home testing kit, I **knew** before I'd even missed a period I sort of and he said 'well you can't be' and 'I know that I'm pregnant' so before I'd even missed a period I knew that I was pregnant, cos I'd had the same sort of sickness before even before I'd missed a period I'd had a few days of not feeling too well. 'I think I'm pregnant', 'Well you haven't even missed a period', 'I don't need to I know I'm gonna be late'. A few days passed and I thought 'I haven't started' so I did a kit and it came back positive and I took one into the doctors about a week later."[Helen_1_2]*

Kate similarly relates how, despite previous experience of pregnancy, 'personal knowing' is insufficient, again highlighting the importance to women of the 'pregnancy test' result in confirming them as 'pregnant woman'.

> *"I don't know because I never had regular periods anyway [I: right] erm I think it was just the fact that my boobs felt heavy and that's what I kind of had when I was expecting this one so I just thought I might be pregnant. I did one test er a couple of weeks before hand and it said I wasn't and then I did one a couple of weeks later and it said I was so...I was a bit like am I or aren't I but then I went for my scan and I wasn't as far on as I thought I was, I was only 8 weeks where as I thought I was actually 12"[Kate_1_1]*

Mary's story tells that both she and her partner are ready for new roles (motherhood/fatherhood). The transition to the role in a planned pregnancy begins with the decision to have a baby, but the reality of the situation is only provided by the concrete evidence of the positive 'pregnancy test'. Initial delight at the positive result is replaced by concerns about the reality and responsibilities of this new parenting role.

> *'....suddenly you realise you're in this for nine months and you have to face things.....we were ready for a new chapter in our lives we were ready for that [I: mm mm] but then wanting it and then having it are two different things aren't they [I: mm] so you've still got that adjustment to make haven't you?'[Mary_1_3]*

Jan's account also supports the importance of the 'pregnancy test' in constructing the 'pregnant woman'. When the result is positive, the recognition that things are different occurs immediately.

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> *...and they're all saying you know 'go to the toilets and do one now... do it now' and I said 'oh it'll be negative I've you know I've just got PMT bit longer than usual' I couldn't believe it... but I went white apparently as I came out I was as white as a sheet ...[I: So how did you feel about being pregnant then?] erm...disbelief really at first but I was really happy.....I felt a bit numb to be honest [I: mm] my 3rd pregnancy, I thought I'm a bit older and to balance 2 children with working and the house and that I thought 'oh crikey how will I cope' but erm I was happy... I couldn't believe it yet I was shocked with my other two I think even if you plan pregnancy its still a big shock [I: mm I think you're right] when it happens and those lines appear [Jan_1_1]]*

The confirmed presence of a fetus via the 'pregnancy test' creates an identity that did not exist before. What becomes apparent is that recognition of themselves as 'pregnant women' means that women now situate the fetus as an actant; it cannot be a character because although it has agency it has no physical reality for the woman. For example, Mary above suggests that having a baby is both the start of a new chapter and something more than that, i.e. the acceptance of a responsibility implicit in parenthood. The presence of the fetus demands of both Mary and her partner that they become something new, taking on a role that hasn't existed for them before the pregnancy.

Helen's feelings about her pregnancy are less positive, but it also leads to the realisation that she is different to before and that there are associated implications.

> *"I wasn't at first, it wasn't planned I mean I was taking the pill and it was a total out of the blue shock it was you know we didn't want any more, got two so you know sort of huge shock to the system really.... No, no we did sort of think well should I go ahead with it or shouldn't I you know we had 2 or 3 days where we both sat thinking mm don't think we can afford it, we haven't got no room next thing was I think we could probably manage and then it was we can't manage, we can manage, we can't manage and we spent a whole 2 days one minute we was having it then we weren't, we were, we weren't, we were, we weren't ...I think if now like obviously I'm 15 weeks not I think if I'd have looked back and thought well decided not to keep it I think it probably would have haunted me I think well come next year when it would have been due I'd have probably regretted it." [Helen_1_2]*

In all these accounts the influence of the 'fetus' via the 'pregnancy test' in achieving the transition to 'pregnant woman' is clear. What is also apparent in Helen's narrative is that once the presence of the 'fetus' is confirmed it plays an actantial role (*'it probably would have haunted me'*) in decisions to maintain the pregnancy. Helen's unplanned pregnancy demonstrates that the repositioning from 'non-pregnant woman' to 'pregnant woman' may be difficult or unwelcome.

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Women's identities are depicted in red

The active role women ascribe to the 'fetus' is supported by the apparent emotional connection and inherent responsibility women discuss in relation to the fetus. In Helen's description of making the right decision, where to terminate would be a wrong decision, the actantial role of the fetus is demonstrated through its having a potential which will be prevented if it is not allowed to become a baby. This sentiment about terminations is clearly echoed by Kate.

> *I wasn't happy but... it's on its way now I don't agree with terminations [Kate_1_1]*

The above narratives show that women experience a new identity from early in pregnancy. The transition to this new identity is affected by the desire or not to be pregnant but is reinforced by the confirmed existence of the fetus and early feelings of responsibility and attachment that women display with regard to the 'fetus'.

Physical Pregnancy

It seems that concurrent with this new identity of 'pregnant woman' is the importance of physical symptoms in the normality of this new identity. The 'fetus' causes physiological changes, which allow confirmation of the pregnancy by the 'pregnancy test', and create the 'pregnant woman' identity. In addition, its presence is believed to cause a bodily response in symptoms such as nausea and vomiting, which are associated with 'cultural recognition of the pregnant state' (Chou, Lin & Cooney 2003; Munch 2002). Mary's narrative shows that physical symptoms are a visible and accepted way of reinforcing the 'normal pregnant woman' identity. The absence of feeling ill in early pregnancy is a source of anxiety that she is an 'abnormal pregnant woman'.

> *...I can remember somebody I talked to and they said I must have that day felt a bit queasy or something and they turned round and said 'oh oh that's really really good' you know 'when you start to feel really sick it's a really really good sign because that means your pregnancy all going you know your hormone levels are going up as they should be' and all this and like a few days after because I was feeling well again I was thinking I was thinking ooh....I know logically because I know people you know who have had good pregnancies as well which doesn't mean anything but that's the information you see cos I already knew that if I didn't know that I could be worrying about sort of [Mary_1_3]*

This sentiment was echoed by Polly.

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> *"...I haven't had any effects that you should normally get like the morning sickness, tiredness erm anything like that its been very very straight forward to the point where I've not really believed that I am..." [Polly_1_1]*

That physical symptoms should approximate to some norm is shown from the other extreme by Helen. She suffers all the expected physical symptoms and is concerned that, as they extend beyond the expected period of time, they are not consistent with 'western depictions of pregnancy'. She is therefore an 'abnormal pregnant woman' who is concerned that her symptoms will impact on the well-being of the baby. This is implicit in the suggestion that she will feel reassured after having a 'scan', which plays an actantial role in confirming her baby as normal and healthy.

> *"**Horrible,** sickness, all the usual, headache... not feeling too well at all...It did go it did sort of 7 -12 weeks I was really violently ill all day long couldn't eat anything drink anything and it stopped I thought yes I was eating alright for 2 weeks and its come back again headache, heartburn so if I do have a nice meal I get really bad heartburn so I'm eating these anti-acid things like sweets and so I can't win got blinding headache its ...I think. I've been suffering for about 3 months I think I'll feel a bit better when I've been for my scan and I've sort of seen it [Helen_1_2]*

Other women's accounts narrate a pattern that is concordant with the 'western depictions of pregnancy', where nausea and vomiting are a temporary state. Women show that there is a norm in these depictions by which they judge their performance as 'normal pregnant women'.

> *Fine...the first 12 weeks I just felt tired and crappy and sickly, I wasn't actually sick I just felt very very sick and then I felt a lot better... [Sally_1_1]*

> *...a bit more sick a lot more nausea I haven't actually been sick but erm I've been off my food a bit but its come back with a vengeance my appetite now for about 4 or 5 weeks ...[Jan_1_1]*

It can therefore be seen that 'western depictions of pregnancy' has an actantial role in women's expectations of their physical experience in early pregnancy and in reinforcing their identity of 'normal pregnant woman'. The significance of this is the apparent anxiety provoked in women that they are an 'abnormal pregnant woman' if their experiences do not entirely concord with those depictions

A further actant influencing the narratives above for both Mary and Helen is that of 'cultural ideas about what women represent in society'. Despite feminist challenges and

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the changing demographics with regard to working mothers, social attitudes and policies continue to lag behind (Gattrell 2005). A woman's role for many remains institutionalised; women have a clear and distinct role, which fundamentally involves producing normal healthy children. Although informed by completely different experiences both Mary and Helen's narratives suggest a fear of being an 'abnormal pregnant woman', which suggests a failure in adequately performing one of women's essential life roles as defined by cultural ideas about womanhood. This cultural expectation is a powerful socialising force that defines a restricted range of options within which women's individual pregnancy experience is located. All these discourses and actants are located within a pronatalist society, infertility or lack of ability to carry a pregnancy to a successful conclusion creates a crisis for women in fulfilling their social role It seems reasonable then to claim that the perfusion of these discourses can be identified in the way that despite the distinctively unique experience for each woman of being pregnant, they each demonstrate how similar the actants are within each account.

The New Identity, Ownership and Choice

The positive pregnancy test has created a new 'pregnant woman'. The existence of the 'fetus' is now a reality that brings with it responsibilities. In these early interviews the woman sets the scene and develops her role as the integral/central character in the story. What also emerges in these accounts of early pregnancy is women's ownership of their pregnancies; by 'ownership' I mean 'her property'. Pregnancy is located as a physical event that is happening to her and which excludes her partner. Mary's partner had been clearly involved in the decision to try for a baby and Helen's partner had been similarly involved in the consideration of a termination. However as these women recount the progression of their pregnancies; partners are excluded from their accounts. It seems that even if women initially refer to the pregnancy as jointly owned, they proceed to take ownership of the pregnancy and the decisions associated with it. Decision-making is accepted as a personal responsibility. This can be seen in their repeated use of the pronoun 'I' and use of the first person, suggesting that women regard their pregnancies as a personalised rather than a dualised event and in doing so choices and decisions are made within that context of individual ownership. If pregnancy were perceived as a shared experience we would expect recurring references to 'we' and 'our' within these early narratives. Although there are some uses of the plural, slippage clearly occurs and what begins as a plural experience changes largely to a singular one. This can be illustrated through the ways in which advice is taken from 'experts', either in the form

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of informed friends or professionals, who are perceived as being in touch with women's feelings and concerns. Mary's account demonstrates this and the use of 'I' is highlighted in bold to illustrate the interpretation.

> *"...it was talking to friends erm... a couple of people had said really nice things about Mr X, having said that **I** feel felt very relaxed about being pregnant **I** wasn't **I** knew that the tests that you go for were standard ...and **I** have a lot of confidence in midwives so ... having sort of though all of that and also talking it all over at that first check ...**I** have a check up with a midwife every time...[I: so you didn't feel you needed that consultant input antenatally?] No [I: but you felt you wanted to deliver at the consultant unit?] yessss...erm I suppose I mean as times going on its erm **I** sort of wonder you see **I** know the Birth Centre they don't its just midwifery led [I: yes] and as times going on **I** feel more confident that that would have been alright but with it everything being such a first for me you know **I** know that if anything happens or interpret expressions on peoples faces during labour the wrong way **I** will start getting worried about it that **I** would feel happier being in somewhere if things go wrong then they can do something about it quickly [Mary_1_3]*

This is mirrored in Polly's account.

> *"**I** went to see the doctor and she sat down and explained you know ... then asked me to make a decision of which hospital **I** wanted to go to...That's how **I** made the decision"[Polly_1_1]*

Interestingly, there is no questioning of the necessity of the input from the health care professionals during pregnancy. Mary's account shows she makes her decisions for antenatal care based on convenience to her, but also shows how in early pregnancy women feel that the normality of a pregnancy can only be judged in retrospect, i.e. after the pregnancy is completed. This is part of the acknowledged 'medical discourse' (Gross 2000) that surrounds maternity care and what is important for this analysis is the influential actantial role 'the medical discourse' plays in informing Mary's decisions and her presentation of herself as a 'responsible pregnant woman' (e.g. '*I would feel happier being in somewhere if things go wrong then they can do something about it quickly'*). Her choices are then made within that context out of a belief that this is the best way to ensure her pregnancy ends with a live, healthy baby. Kate's and Sally's responses to choice of place for delivery also show how 'the medical discourse' plays an actantial role in promoting them as 'responsible pregnant woman' and the underpinning rationale of their accounts mirrors Mary's.

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> *Well **I** chose to go to the Royal because....if **I** did have any problems, **I** wouldn't want to lose the baby [Kate_1_1]*

> ***I'd** rather be in a hospital where there's everything **I** need so that would no **I** wouldn't have made any difference and if they had told me then **I** wouldn't have taken all the information in you can't take everything in so I think it's been fine [Sally_1_1]*

Polly's account similarly reflects the influence of 'the medical discourse'. Although proximity and ease of access is an important consideration for some women when making choices for delivery, these do not supersede the ultimate well-being of the baby. Decisions are made based on ensuring the best care provision for their babies should problems arise, and it is 'the medical discourse' that informs how these decisions are considered.

> *...I went to see the doctor and she sat down and explained all the you know all the availability of care in the area and then asked me to make a decision of which hospital **I** wanted to go to I think she gave me a choice of three..., for me **I** felt that one was nearer although I did ask the question obviously if any of them had better care than the others and she said 'no all three were generally the same' erm one was probably more specialised and therefore if there were any problems at all then myself and the baby would probably be transferred to one of them during labour and that's how **I** made the decision ... [Polly_1_1].*

Helen's story demonstrates the slightly different way in which 'the medical discourse' continues to pervade the contemporary model of choice for maternity care. Her narrative is reported in some length here, as it illustrates well the actantial influence of 'medical discourses'. She begins with recounting a visit to her GP.

> *...he sort of just said 'what type of birth did you want?' and I said **I** would have liked a home birth 'I don't agree with home births and that was his 'I don't agree with home births and erm I think you should go to..' and I said well **I** would really like a home birth purely for I wouldn't have to try and sort the kids out but no he didn't agree with a home birth and he basically said 'I don't agree with a home birth I think you should go here blah blah blah' but when you go to the booking in clinic discuss it with them basically that was it that was all he said but he didn't really agree with a home birth and he didn't even agree with then birth centre... he's all for the new hospital [I: So what did he say then about them then?] Yea he said he didn't agree with the...birth centre purely because it was run by midwives, there's no doctors or obstetricians there and he thinks that by having your baby there if anything goes wrong you're then putting not just my life in danger but the baby's life as well ...so he thinks I should go straight to the new one, but from our point of view the birth centre's just up the road. [I: So did his opinions influence your choice in any way?] Well I thought 'have **I** got a choice' I went to the booking in clinic and said 'well judging by the doctor **I** haven't*

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> *got a choice' and he basically said 'he doesn't want me to have a home birth, he doesn't agree with it, he doesn't agree with the birth centre' the only choice then is the new one. I spoke to the midwife at the booking in clinic and she said you can go where you want basically, so* ***I've*** *booked in for the birth centre and then she rung me back to say that I'd been told to go to the new one if I go before 38 weeks. [I: So what made you choose the birth centre, I know you've already said it's easier and nearer but are there any other reasons you would want to deliver there rather than at the main maternity unit?] Erm……well for one it's nearer and two* ***I've*** *had two straightforward births with no complications they've both been very quick so from that point of view* ***I*** *just couldn't have gone there ...[Helen_1_2]*

Helen's story demonstrates the numerous issues surrounding choice. On first reading, it could be construed that Helen is an 'irresponsible pregnant woman' basing her choices on ease and access, rather than the well-being of her baby. Her rationale for her choice however is more complex. It involves the actantial influence of 'personal knowing'. Her two previous early but unproblematic births make her feel no need for the support of that medical intervention, which Mary, as a first time mother, feels is necessary. Helen's previous experience within the frame of 'expert knowing' does however limit her choice, because she does not entirely fit within the medically defined frame of normality. Her choice, being that of a 'responsible pregnant woman' as defined by 'medical discourse', is made, like Mary's, with the well-being of her baby in mind. The precipitate nature of her previous deliveries generates concerns that she might not actually reach the main hospital. Therefore, delivering at the birth centre or by home birth assures the presence of an 'expert' in case any problems should arise. This interpretation is supported in her account of her last delivery.

> *oh yea I know that if it comes before 38 weeks then the new hospitals got to be the best place to have my baby regardless of whether I want to go there or not, I mean the main concern is getting to the new one with my second one she was extremely quick I mean we was living at Wxxx at the time and we had to travel to the hospital and I mean we got there at 8.30 on the Friday night and she was born at 8.35 on the Friday night, we literally just got through the doors, got on the bed and out she popped [I: right, right]...she sort of just popped out and that was it and poor Phil... so I really want to be somewhere close cos I think if I do go in I'm gonna you know.. [I: you don't want an unplanned home birth] No, No [Helen_1_2]*

Jane refers to her choice to deliver at the birth centre. Her choice does not seem based predominantly on her baby's well-being but on considerations of personal anxieties and perceptions of the support she feels will be necessary in labour. The infusion of the medical model is less apparent in this narrative but delivery still relies on the presence of an 'expert' which in this case is the midwife. While Jane appears to be rejecting 'the

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medical discourse' ('*I hate needles*'), she is still acting through the discourse of 'expert'. Through choice Jane rejects the medical model but it remains intrinsic within her story.

> *Because I hate needles and the thought of it just makes me feel..... I'd rather have the pain. I don't know how I'm going to be with the pain but I'll just deal with it and Paul will be there and the midwife will be there to help me. [Jane_2_1]*

Women have outlined choice here as extremely complex, based on consideration of a number of orbiting actantial influences. The ultimate choice women make seems dependant on which of these influences they accept and which they reject. Within that claim however it needs to be acknowledged that the actants implicit in the women's narratives actually limit the possibilities of choice. In her new identity as firstly 'pregnant woman' and then 'responsible pregnant woman', the woman takes ownership of the pregnancy from her partner. That ownership then appears to be ceded to the medical/midwifery professions, because of the dominance of the culturally accepted knowledge that expertise is the best way of ensuring a successful birth outcome. Quality of care is important but in the main remains secondary to their baby's well-being. Even women such as Jane who choose the birth centre for delivery are still ensuring the presence of an 'expert' and so are not entirely rejecting 'a medical model'. The 'consumerist discourse of choice' does seem to offer the 'possibility of resistance to 'the medical discourse' even if it does not fundamentally question the necessity of expertise or remains unfulfilled. Helen epitomises this unfulfilled resistance and how she feels that she has no real choice. Helen's narrative around choice afforded a clear role to the GP and it is therefore important that the GP is individually considered as part of 'the medical discourse' that demands he is accessed as part of pregnancy.

The GP Gatekeeper

The GP is an unmistakable and influential character who appears to hold a powerful position within the women's early pregnancy experiences. All the women define him/her as the first point of contact following the positive pregnancy test.

> *'erm..... rang my GP I think yea .... I wasn't I wasn't sure cos I mean I really made an appointment and went to see him and he said 'oh yea fine' they don't do they don't bother testing you now do they [I: no] come back in a few more weeks when you're a bit further along and...yes he gave me some do and don'ts ...he sort of outlined really whatever I wanted to do and it was fine [Mary_1_3]*

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The importance of the GP being the first point of contact is illustrated in Jan's narrative, which suggests that visiting the GP is a step in a process, because the 'GP expert', as a medical expert, plays an actantial role in further validating the pregnancy that has been confirmed by 'the pregnancy test'. He acts as a 'GP gatekeeper', opening the doorway to the maternity system, which ratifies the pregnancy and further confirms her as a 'pregnant woman'.

> *I contacted my doctors and asked if I could pop in real early in the morning on the way to work, to get erm.. you know one of those a urine test bottle thing [I: mm] and I had to hand that it so that you know I'd know for definite, I think he likes you to do that my GP here, then its confirmed and it really hits home as well doesn't it? I mean I know those tests are 99% that are in shops but that's a 100% that one [laughs] so that was the next step [Jan_1_1]*

The GP's actant role as a 'GP expert' and a 'GP gatekeeper' is supported in Sally's account.

> *... so then I did a test and I thought that looks positive I'll do another test and show it to John and he was like 'well it looks positive to me' so we went to the doctors and I said 'I think I am I've done two tests ...and he said that we were and confirmed it for definite [I: right] ... I went back again ...to the doctors and he said that it was all confirmed and that everything had been OK and he referred me at that point [Sally_1_1]*

The actantial role of the 'GP gatekeeper' lies in defining or not defining the woman as 'normal pregnant woman' and thus eligible to make choices. One of the ways in which the GP does this is through the amount and content of the advice proffered. Mary was offered an explanation of the options for care and place of delivery and given the opportunity to consider them. Her 'GP expert' situates her as a 'normal pregnant woman' who fits the criteria for choice. For Helen, however, despite local service reconfiguration, her 'GP expert' acts as an actantial barrier to choice. Acting as the mouthpiece for 'medical discourse' he removed all sense of choice from Helen at her first visit, thus preventing her from being a 'normal pregnant woman'. The main blame for Helen's perceived lack of choice can be attributed to the GP, however, the midwife also only offers limited choices. Authors have suggested that midwives have been complicit in ways of working and advising that incorporate a medical model (Kent 2000). In Helen's case she is only able to access a home birth or midwifery led care if she can redefine herself as a 'normal pregnant woman', which glosses over how normal comes to be socially, culturally and historically defined. She describes the 'GP gatekeeper/expert' as having won, suggesting that choice is a battle. Situating Helen as

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an 'abnormal pregnant woman' renders her powerless to enforce her own choice, because as a responsible pregnant woman she is unprepared to challenge expertise.

> *... I sort of got the impression from what he said that if I decided I was going to have a home birth then he sort of said I wouldn't want to deal with the pregnancy so from my point of view he was trying to say to me if you choose to have a home birth then I don't want you at my antenatal you'll go through another doctor but I mean from that point of view I think its won, in a way you don't feel you've got a choice I don't think, it's a case of well the doctor's said no, the midwife said no I'll have to have a baby where they say [I: yeah] so when she said I was having it at the Birth Centre I thought oh that's fine but then she said unless you go to 38 weeks you're going to the new one so I thought, I was a bit, I was a bit gutted....[Helen_1_2]*

Jan's narrative suggests a similar experience in the referral that the 'GP gatekeeper' makes without any real discussion. She has been labeled abnormal due to her previous experience and her age, despite a normal delivery with her daughter.

> *...but I've not been very pleased with what my doctor been saying to me actually [I: in what way] erm....I sat down today and he said 'so you're pregnant again' and I said 'a bit of a surprise' like this and he said 'what didn't work..... I would have thought at your age you'd know about contraception' he wasn't joking; I thought 'oh' I just felt like walking out I couldn't believe it, so ...that's the attitude really that's what I got...I said 'I realize at my age I'll have to have well I don't have to but I'll be offered extra tests and things and it might come back high risk or whatever' and he said 'of course it will at your **age**' ...that's made me a bit paranoid I know I'm not a spring chicken ...but I'm not the oldest mother in the world either .....[Jan_1_1]*

The 'GP expert' here, as an actant again, acts as the mouthpiece of a 'medical discourse' that positions older women as at risk, and creates a fear and anxiety in Jan that wasn't present before her visit to him. In positioning her as an 'abnormal pregnant woman' he refers her without any discussion about options for care, despite the fact she would not have been excluded from midwifery led care options. Jan's identity as a 'responsible pregnant woman' makes her, despite her annoyance, complicit in accepting this referral as the best thing and justifies it as the option she would have chosen.

> *Erm...yes he said were you under a consultant when you Sam because he knew he had intrauterine growth retardation, I wasn't with that GP at the time [I: right] when I had Sam, so I said yes Mr Z so he said right I'm going to write to him ...I was thinking blimey hurry up I want to know what's going on ... I was actually pleased with that anyway, Mr. Z cos I used to work next door to the women's and children's health anyway and he used to wave to me*

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> *in the canteen I quite liked Mr. Z [laughs]. I would have approached my GP and said could I do that with my history. [Jan_1_1]*

The GP is both a character within the story but also as an actantial 'GP gatekeeper' and 'GP expert' constructs women as 'normal pregnant women' or 'abnormal pregnant women' at almost the earliest point in their pregnancies. This powerful role of GP's as, most often, the women's first point of contact can clearly create difficulties in offering women choices for care. Indeed, these narratives would suggest that choice for some women is as difficult to achieve now as it was in the 1980's when authors like Oakley (1981b) described lack of choice and control in pregnancy and childbirth. The actantial role of the 'GP expert' in defining women as 'normal' or 'abnormal' suggests they are gatekeeping in a way different from anticipated, making decisions about who is suitable for the gate marked 'choice'. For those marked 'abnormal', their identity as a 'responsible pregnant woman' encourages complicity in the refusal of choice.

The New Identity, Naturalness, Responsibility and Emotions

Mary and Helen exemplify the women in this study in their articulation of a clear acceptance of the responsibility inherent in being pregnant. Texts around pregnancy and the maternity care system construct pregnant women as made whole, as a vessel or incubator for the baby (Kent 2000). Their role therefore is one of nurturance and protection, the providers of the environment for the fetus and as such responsible for their baby's health (Gross 2000). The most relevant ideological discourse here is the naturalness of practices associated with 'mothering'. Althusser (cited by Sunderland, 2004) refers to naturalness as something imposed but without the appearance of imposition. The naturalness discourses of the women's narratives are located within natural gendered parenting discourses. 'Cultural representations of mothers' frequently idealise motherhood and prescribe what 'good mothers' do and how they should behave (Kent 2000), and the above discussion has shown how this even penetrates to how they regard their morning sickness during pregnancy. This provides a framework for society and women themselves to evaluate the behaviour of women as mothers. Where previous accounts locate the naturalness of mothering late in pregnancy or following the birth (Kent 2000), what is striking in these accounts is that women are aspiring and displaying this naturalness of mothering in early pregnancy, demonstrating feelings of nurturance and caring traditionally associated with good mothering after the birth. Mary, for example, narrates about adhering to advised behaviours promoting herself as a 'good mother', nurturing and protecting her baby.

Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

> *...I'm making sure I do everything right I try and sort of do the right things [Mary_1_3]*

Similarly Polly and Kate narrate 'good mother' behaviours

> *...as long as I'm feeling well and I'm trying to do the right thing by eating by having a healthy diet and staying off the alcohol and all of those and maybe exercising its to me that's the right way to go [Polly _1_1]*

> *I made an appointment at the doctors because I knew I needed folic acid anyway, so I went to see them to get some folic acid [Kate_1_1]*

What is interesting as Mary's narrative continues is that ensuring the well-being of the baby is both a physical and emotional act. The emotional aspects of Mary's narrative take a dichotomous format; the emotional relationship with the baby, which she refers to below and the personal psychological/emotional impact of pregnancy on her, which will be discussed later in this section.

> *I suppose that's something else I thought I'd feel more attached than I do I guess... I'm talking to it and I'm trying to imagine he or she as a person and erm this kind of thing [I: mm mm] ...you see I thought when I first started to feel it move I thought I'd be absolutely overwhelmed with this that's my* ***baby*** *you know and it hasn't been quite that intense...but I think that will maybe come more gradually for me [Mary_1_3]*

This naturalness of mothering that involves an emotional invisible bond with the child seems to be influential in shaping Mary's own views of motherhood and expectations in pregnancy. Mary's first narrative expresses a sense of guilt that her feelings towards her baby are not as strong as they should be. This suggests the need to adhere to some kind of 'cultural standard of bonding'. Bonding and maternal instincts are accepted concepts that are socially reinforced (Kent 2000) and act here as actantial influences by creating an expectation in Mary that this emotional bond should be an instinctive rather than learnt emotion. Mary throughout her narratives has presented herself as a 'good mother', evident in her physical actions but also in a clear attachment to her fetus, which has motivated her to act appropriately and make responsible decisions. Inadequate mothers conversely are characterised by a lack of sufficient care, positive emotion, knowledge, insight and action (Singh 2004). Despite Mary's successful fulfilment of these characteristics, she questions her ability to attain this 'cultural standard of bonding' and make an emotional connection to her baby, which she considers as a failure. In an attempt to promote a feeling of bonding Mary tries to

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Women's identities are depicted in red

imagine her baby and attribute it with characteristics and a personality, but for her the baby remains unknown and intangible. This culturally mediated expectation creates conflict for Mary between two identities, the 'good mother' who is acting responsibly in her behaviours and the 'bad mother' who is unable to form a significant relationship or emotional bond with her baby.

The 'scan' again acts as an important actant. Whilst it earlier served to confirm for some women their 'pregnant woman' status, it now provides confirmation of them as 'good mothers'. This provides 'expert' reassurance that through their efforts to behave appropriately and responsibly, the pregnancy is progressing normally and the baby is healthy.

> *...you know when we had our 12 week scan I noticed a big difference in me then from before it to after it you know things are alright ...[Mary_1_3]*

Polly also attaches importance to the 'scan images' to confirm normality.

> *Obviously I've had an initial scan to put my mind at rest I think there is always that erm.....there's always that concern in the back of your mind is everything going to be OK but obviously from what I've read they can't really tell you a great deal from this 14 week scan its more your 20 week scan where they go into it into the pregnancy in more depth ...but for me its more to put my mind at rest that everything is progressing as it should be and everything is growing as it should be and everything's in place erm [Polly_1_1]*

Sally expresses the ability of the 'scan's' to reveal abnormality as well as normality. The pictures she receives depict a normal healthy fetus and so reassure her that she is both a 'normal pregnant woman' and a 'good mother' because everything is normal.

> *Fine yea yea fine I've got some pictures of it so that's ok [I: Were you looking forward to it?] ...A bit nervous cos I mean they're checking more and things like that so a bit nervous [Sally_1_1]*

For Helen knowledge of the sex is additionally important, with some suggestion that this might promote an emotional connection, although this is quickly countered by Helen's 'good mother' identity, which suggests that it is the normality and health of the baby that is a priority.

> *Yeah, my scan's 4 weeks on Friday [I: right, are you looking forward to that] I am yeah, yeah basically to find out what it is [I: you want to know] oh yeah*

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Women's identities are depicted in red

> *I do yeah [I: do you mind] .... Erh, I'd like a boy because we've already got two girls and I know he'd like a boy as well but you get what you're given [I: you do] as long as its all there and its healthy it doesn't really matter but its going to be the last one definite, so you know I'd like it to be a boy, both his sisters have got all the boys [I: right] and I've got all the girls so [I: it would be nice though wouldn't it] she wants to try again but she doesn't want another boy, you get pregnant the same time just swap, but you get what you're given...[Helen_1_2]*

Psychological health appears to involve more than just efforts at maternal bonding. Women also acknowledge the personal aspect of emotional/psychological health as an integral part of the maternity experience. It is becoming an increasing aspect of the maternity experience to acknowledge that psychological health is as important as physical health. Some writers suggest that this is located in medical expert's attempts to reassert control within a landscape of increasing choice for women (Weaver 2000), but it is in addition a possible consequence of living within a therapy-saturated culture where the relationship between the body and the mind is clearly acknowledged (Steward 2004). Women informed by 'experts' in the form of health care professionals, the media, and parenting magazines are increasingly aware of the impact of psychological distress on both themselves and related pregnancy outcomes. Women themselves expect to be at the mercy of their sweeping hormones, as this is how 'normal pregnant women' are traditionally displayed (Crawford & Unger 2004; Gross 2000). Despite the apparent excess of such discourse within the popular pregnancy literature (Sunderland 2004), Mary seems hesitant and concerned about whether her emotional feelings and responses are a normal reaction and so firmly attributes them to an external source – hormones – early in the narrative. Women are unsure how this contemporary model of a psychological pregnancy should be depicted, they expect some hormonal/emotional reaction to the pregnancy but seem to express a concern that they are unsure at what point they become 'abnormal pregnant women' and it becomes a problem.

> *OK a lot of sweeping hormones you get to that ten weeks and you know you dissolve into tears at things that are on the telly and I suppose that has been more but still not as I still really haven't been as sensitive as I thought I might have been you know...I think probably when you get to about three months you get over the more hormone swings and ... and now I notice that I'll be fine for days and days and days and days and then I'll just get one evening and just like that I'll just .... feel really irritable and cross and **worried** absolutely **paranoid** absolutely worried about things that may happen or the effect that it might have on me and Matt and you know irrational really ... you know good to have a bit of a cry [I: mm] and let yourself go and it passes really but that's only every week or so [Mary_1_3]*

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Jan's account also refers to fears that her emotional response to a previous pregnancy was abnormal.

> *I think you change and something that used to make me very emotional, which is probably pregnancy hormones when I was expecting Ellie I didn't know the sex... I used to come home, come home in tears, the babies healthy and they keep saying 'I bet you want a girl, I bet you do' and Barbara came to see me my midwife and I think just fell on her crying, people keep saying 'you must want a girl and I'm not bothered Barbara' she must have thought I was mad, looking back I used to say such mad things, strange things [Jan_1_1]*

The complexity of the women's responses around their responsibilities to their babies is clear. The early narratives located the 'fetus' as an active actant within the women's narratives creating the 'pregnant woman'. This then appears to impose a set of rules to which they are expected to conform, including rules about the body and the emotions, in order to be a 'normal pregnant woman'. The difficulty for women here is that the discourses are at time themselves confused, leaving women unsure of the emotional standard they need to attain to be a 'normal pregnant woman'.

A consistent theme in these early pregnancy narratives is that women are influenced by 'ideologies of mothering', which display the identity of 'a mother' through behaviours/characteristics identified as mothering functions; nurturing, advocacy, protection, responsibility for a dependant that relies almost exclusively on the biological mother, child centred, emotionally involving and accountable. There is a clearly defined schema (the images of identity a subject has) of motherhood with defined functions, behaviours and characteristics, which the 'good mother' identity is striving to attain in relation to the 'fetus'. The 'GP expert's' location of some women as 'abnormal pregnant women' covertly suggests that they are already failing to fulfil the most basic mothering functions of nurturing, advocacy and protection, creating tension between a 'good mother' and 'bad mother' identity. For others some of these functions seem more easily fulfilled. However, the good mother ideology, which supports notions of maternal instinct and connection/bonding, seems more difficult for all these women to attain. The 'good mother' views this as a failure and a maternal inadequacy, with fears that it could in the long term threaten the well-being of their unborn child, either physically or emotionally; consequently she locates herself as a 'bad mother'.

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Promoting Motherhood/ Relegating Fatherhood

As shown women personalise and own their pregnancies from a very early point in pregnancy. They display a responsibility to the fetus that involves making the right decisions for care and delivery, to ensure their baby's well-being during pregnancy alongside a safe and healthy outcome. The central role that women ascribe themselves is promoted further by the apparent exclusion of their partners. It is important to acknowledge the support of this exclusion by a care system that focuses on the mother and her well-being, in turn securing the babies' well-being, but as an unintended side effect excluding the father from the decision making and responsibility sphere. This was acknowledged by Polly.

> *... obviously for the father to see on the screen for the first time because I think it becomes a bit more real to both of you when you actually see it [I: and that's important] absolutely for him to be involved because you know all of these changes are happening to* ***you*** *and all the attention is focussed on* ***you*** *erm and you've got to remember that because its quite easy to neglect the other partner and yet he has an equal part to play in all of this the pregnancy and the labour erm but even more so with people around you they tend to ...It's quite nice for him to be at the scan this morning so it makes it real for him [Polly_1_1]*

Although Polly's narrative suggests that the father has an equal part to play, this contradicts her earlier narrative around decisions for place of delivery. This exclusion of the father by the pregnant woman can be read as part of an embodied mothering ideology where ideals and expectations are simply part of knowledge. Women recognise the inherent difficulties for men in experiencing a reality of pregnancy but reinforce this detachment by the ownership and decision making that they display in early pregnancy. This appears to propose that gendered parenting roles are adopted by women and assigned to their partners from a very early point in pregnancy.

We have seen women take on many of the characteristics associated with motherhood. In contrast to the characteristics of motherhood that women seem to aspire to and describe, partners when talked about at all are portrayed as bystanders, ascribing them the actantial identity of 'latent father'. Mary here suggests that she is already beginning to consider herself 'a mother', an identity reinforced by the actantial 'latent father' role she has assigned to Matt. Mary portrays herself as taking on 'a mother' identity that prepares her for life after birth in contrast to Matt who, because he is a 'latent father', she thinks is less prepared for the role to come.

Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

> *...and how you'll cope with it [I: yeah and how you will cope as a couple] I don't really have worries there but.... I think its going to shock Matt more than he realises [laughs] I don't think he really has much idea at all. I think he has a picture in his mind of how it's going to be [Mary_1_3]*

Despite Matt's apparent concern about the 'fetus', He remains situated by Mary as a 'latent father' not only unprepared for parenthood but unable to relate to the physical and emotional aspects associated with pregnancy, which Mary believes renders him incapable of being 'a father' in pregnancy.

> *...if I got a sharp pain and 'oh that was' you know your ligaments and things you just suddenly get a twinge or whatever straight away he would worry about it so it must be there somewhere in his mind that something could go wrong but no he wouldn't consciously sit and think about that ...[Mary_1_3]*

Relegating their partners to an actantial 'latent father' role confers and reinforces a greater level of responsibility to women for their babies and promotion of themselves as 'mothers'. Analysis of Helen's narrative provides more information about this concept of the 'latent father'. Her story of her previous delivery describes her husband's behaviour. The 'media' plays an actantial role here, which through its constant barrage of images and information maps out the role of the subject and creates an expectation that those roles must be accepted and fulfilled (Mills cited by Sunderland 2004). A gendered role dichotomy, fuelled by modern parenting magazines, creates an expectation for women that their partner's role is not a fathering role but one that provides support with regard to key points in the pregnancy and particularly during labour (Sunderland 2004).

> *...I mean he came last time with me and he was useless basically [I: in what way] ...and he got there, got me on the bed and the midwife said, and I was huffing and puffing and she said would you like to look, 'no no', and I said just have a look and he said 'no I don't want to' and he decided he'd have a quick peek, he'd gone on the floor out cold [I: oh no], so then they obviously had to step over him and get on with it and I was thinking if I go with him and its going to be a long one, I'd rather him stay clear, wait outside maybe ...its just the fact I didn't want to go to hospital on my own and nobody be there [I: yeah] I mean at least I can shout him if I need to [I: yeah] but I don't think, he may want to come in but he's often said I hope I'm 500 miles away when you go into labour which is nice isn't it?...but at least five minutes afterwards he thought it was all wonderful and glorious you know [Helen_1_2]*

Helen's narrative demonstrates that she perceives her partner's role to be one of support and her dissatisfaction with his lack of support is apparent. These maternal narratives suggest that women are influenced by the discourses that afford partners a role to play

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Women's identities are depicted in red

in pregnancy but clearly not as 'fathers', which directly contrasts with the maternal discourses that shape women's roles in pregnancy.

Perfect Babies and Screening Choice

The 'choice in maternity care' debate requires consideration of some of the other choices faced by women (and their partners), for example, with regard to genetic screening. It would seem a reasonable assumption that women desiring and choosing a more 'natural birth experience' might also make non-interventionalist choices with regard to screening. Further analysis of whether this was the case and how screening decisions were made seemed to offer potential in illuminating the choice concept. Women's choices, as already illustrated, are complex bound up in their previous maternity experiences (personal knowing), their acceptance of the authority of 'the medical discourses' and 'ideologies of mothering'. The actantial role played by the 'scan' in reaffirming women's 'pregnant woman' 'normal pregnant woman' and 'good mother' status has already been illustrated. This conflicts with the purpose of the 'scan' as viewed by 'experts' who consider even the early 'scan' an opportunity to look for soft markers of abnormality and part of the screening process which situates woman as 'abnormal pregnant women'. Women are willingly complicit with the scan because of its role in reaffirming their identities, as Polly demonstrates below.

> *I did express my concern that I obviously didn't feel pregnant and erm one way of putting my mind at ease was the fact that she gave me the scan erm and she said to me it wasn't an official scan but she could see that I was quite anxious that I didn't think I was pregnant so she would do that just to show me that there was a heart beat etc there and that was really... [Polly_1_1]*

The aim of genetic screening is to allow couples to make informed reproductive choices. However, when explored through the narratives of these women, 'prenatal testing' emerges as an actant that reinforces the idea that it is both natural and right to want a 'perfect baby' (Chadwick 1990). Mary and Helen both identify the 20 week anomaly 'scan' as an intervention to confirm normality: it is not given the same screening status attributed to other screening tests. Their narratives illustrate that other screening test choices are far more multifaceted than those displayed with regard to scanning. Screening underplays the emotional and experiential aspects of pregnancy that are inherent in these women's pregnancy stories. The 'ideology of mothering' positions women as caring, nurturing and protective, yet screening demands a willingness to abort a damaged child. Mary feels in some way that she has to justify her decision to go for screening. 'Personal knowing' plays a significant role in informing

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her decision, with recognition that a high risk result would have undermined all her embodied feelings about her pregnancy, her baby and made her question the new identities that pregnancy has created. Mary's narrative depicts 'a disabled child' as one that is always a baby and never fulfils its potential. It never achieves the markers of success, e.g. going to college, by which parents are judged to have been successful in their roles. For Mary a disabled child reflects a 'bad mother' on two levels, the first in her failure to protect and nurture in the womb, the second, lack of achievement by which to measure her parenting success. 'Abnormal motherhood' is a role given by the child that never ends; a dark journey with no light at the end. Women however, who bring up disabled children are often perceived as highly self sacrificing (Singh 2004), a characteristic usually associated with 'good mothering'. Women are expected to be able to judge the right course of action. The conflict entrenched in Mary's narrative between the 'good mother' and 'bad mother' identities, is exemplified in her hesitancy about what her decisions would be in the face of a negative screening outcome

> *...even just like having the triple test was a huge thing just for us to talk through and go through [I: and did you have it in the end] yeah yeah I did I did I still don't know if it came back it was 1 in 12,000 or something I still don't know what I would have done if you know if the ratio had been really low but I'm glad I had it [I: What made you think what made you make the decision to have it...?]Loads of things, lots of different practical issues around having a child who was severely disabled except you wouldn't know it may be a healthy little Downs child who goes to college and all sorts you don't know that's the difficulty the other thing is my cousin has got severe Downs Syndrome and he's my age and he can't do anything he's still in nappies and everything and I know what a massive impact he had on the family and they've really been through some dark times so you know it would mean a massive massive change a massive impact.....so I thought I'd be better equipped at knowing what to do if I had some facts ...having the facts and then making a decision based on them [I: hard though isn't it?] yeah because you do have to think through these things like what will I do if... then we go down and have a amniocentesis and then what would we do then cos the very fact you're having a test shows that you need to know for some reason [Mary_1_3]*

Helen's narrative, below, as with choices for care, demonstrates less autonomy in the choice process. Screening is a professional discourse which many 'experts' feel compelled to advocate for women's own and societal good (Kent 2000). Helen seems to neither want nor feel able to challenge that. The decision to maintain a pregnancy for Helen is based on her judgements about what constitutes 'a disabled child' and on her ability to cope and be a 'good mother'.

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Women's identities are depicted in red

> *They do all these tests, the doctors do them regardless, I mean you have your options of having them done or you don't, I think if they're offering them then you take them I mean the earlier you know there's anything the matter then the better really [I: yeah so it wasn't a difficult decision] oh no they said at the booking in clinic do you want this that or the other and I said 'oh yeah I'll have them all' as I said the earlier I know there's something the matter the better [I: How would that affect your feelings about your pregnancy?]I obviously didn't really...if it was disabled, it would depend as to what sort of severity, if I went if I went to my 20 week scan and they said its got a foot missing or a hand missing or whatever that wouldn't bother me, I don't think it would bother me [coughs] but if they said it was something more serious then maybe I don't know spinabifida or whatever then.....I'd have to think twice....its a full time job isn't it [I: mm mm] I mean my personal point of view I don't think I could do that ...[Helen_1_2]*

Polly makes a decision not to have screening based on the perceived preciousness of her pregnancy and her need to be a mother. The risk of not getting pregnant again outweighs the concerns about disability. This decision is not made lightly, clearly creates anxiety and demonstrates the same conflict between 'good mother' and 'bad mother' articulated by Mary.

> *....at this moment in time the biggest concern for me is the screening for Downs syndrome because on seeing the consultant she was very adamant that I took the screening and also the test and when I asked the question why all she could really say was that it was predominantly to do with my age and that there is a high risk factor at my age of 36 erm...and that she would recommend every woman of my age to go through this screening process. So that's the biggest worry and concern to me at this moment because I'm quite adamant that I don't want to go through it. [I: So what makes you so adamant, what makes you think you don't want that screening?] Because they couldn't give me a hundred percent erm... on either the screening or the other test erm... to actually yes you are carrying a Downs Syndrome baby erm and if they could give me a hundred percent accuracy then I may be swayed toward it but its also the fact that I also know there's a risk involved with the second test of actually going through miscarriage and erm obviously getting to my age now and trying for a baby miscarriage is the last thing I want to go through so its quite and important factor for me not to put the baby at risk....[Polly _1_1]*

Polly is able to resist the 'expert' who clearly advocates that the correct choice would be to accept screening; however Helen's unquestioning acceptance of the dominant discourse around screening is reinforced by Jan.

> *I've gone through some screening, I'm getting a blood test back on Monday...its more like worrying about Downs cos my friend...her first baby was Downs and she was younger than me a few years younger we were all a bit shocked about that....its a bit close to home its frightened me a bit.....paranoid person [laughs]... [Jan_1_1]*

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What is apparent in these narratives, contrary to previous literature (Shickle & Chadwick 1994), is that women are capable of ranking their needs with regard to screening choices. With regard to choice, decisions are based on individual circumstances and subjective perceptions of 'a disabled child'. The influence of the 'fetus' and the need to be a 'good mother', which is more difficult in the face of disability as for Helen '*…if they said it was something more serious then maybe I don't know spinabifida or whatever then…I'd have to think twice….its a full time job isn't it'*, consistently infuses these narratives.

Experts and Expertise

The well-documented sociological history of childbirth recognises changes over time in the continuing conflict between women, doctors and midwives about who knows best and an exercise in power (Kent 2000). Current policy claims to return power to women, proffering a model of maternity care that is women centred, premised on the view that women make informed and considered choices. The very foundation of this research, demonstrates that structural changes have occurred in the delivery of maternity services; perhaps more fundamental however, is whether a transformation in the power relations between these groups is really taking place. The integral influential role played by the 'GP expert/gatekeeper' in influencing and controlling woman's maternity choices, as well as 'personal knowing', acceptance of the 'medical discourse' and the need to be a 'good mother' have already been highlighted. What is apparent from these interview narratives is that 'expert' intervention remains undisputed. More interesting perhaps is how women define who maternity experts are and how those definitions impact on their decision-making. Several experts are defined within these early narratives; the narratives about ultrasound scanning locate the 'scan' as an actant and an 'expert', providing reassurance of normality and a healthy pregnancy. As may be expected however the main reference to maternity expertise refers to midwives and obstetricians who are obvious individual characters within the narratives. As actants however they are often afforded the joint role of 'expert', and women's deference to the 'experts', as in Polly's account below, to assure the well-being of their pregnancies locates them as 'maternity patients'.

> *I think my outlook on it is if the doctor and midwife are happy with the progress of my pregnancy then I'm quite happy' [Polly_1_1]*

Midwives and doctors are at other times conceptualised differently. Mary has made a choice to have midwifery led care but to deliver at the acute hospital unit. Mary's narrative only situates herself as a potential 'maternity patient' requiring 'expert' advice in the face of a serious event. The 'expert' that has the ability to reassure her 'normal

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pregnant woman' status is the midwife but she also has the capacity to locate her as a 'maternity patient' by referring her to the doctor.

> *[I: So if anything happened if something happened that you were unsure about ...what would be your first point of contact?] Erm.....I don't know really, depending on what it was I may well check with friends and family if I thought I suppose really it could be anything serious I suppose I'd ring the midwife, ring the Health Centre and ask them [I: mm mm] for advice [Mary_1_3]*

Sally echoes Mary's sentiments about the midwife.

> *I'd probably contact the midwife I think or the doctor but probably the midwife because they're doing it all the time....the doctors dealing with so many different things and I'd rather just go to someone who deals with that one specific thing and speak to them about it ...because that's all they do day in day out and you can tell by the er...they got a lot of experience and they know what's what... but I'd just....think I'll just go to my midwife, a bit like if I had a problem with my eyes I'd go to my optician not my doctor...[Sally _1_1]*

Helen's narrative response to the same question however, suggests differently. She views the midwife and the doctor as interdependent and working together, rather than dichotomous as suggested by the other women's stories. In some ways once again the GP acts as the 'gatekeeper' to the appropriate maternity services. This seems to be in opposition to Helen's choice of a birth centre delivery, at which care is provided wholly by midwives. A possible explanation for this is that Helen, as we have seen previously, considers herself a 'normal pregnant woman' consequently she does not need medical input. Identification of a problem however, would locate her as a potentially 'abnormal pregnant woman' and necessitate the need for a 'medical expert' to identify her as a 'maternity patient'.

> *The doctor [I: so you would choose to see the doctor, you could phone the midwife directly but you would choose the doctor?] yea of course, you can talk to them and see what your options are or...what to do next or whatever [I: Why would it be the doctor? Not that there is anything wrong with that] No particular reason just because they're round the corner, they sort of do doctors, midwives together, they work together don't they? [Helen_1_2]*

Polly awards both the doctor and the midwife expert status situating them both as 'experts' who can confirm her 'normal pregnant woman' identity but later distinguishes the midwife as the pregnancy 'expert' and the one she would contact with her initial concerns.

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Women's identities are depicted in red

> *Yea yea because I feel that they're the experts (doctors and midwives) in that that's what they specialise in and they see this every single day this for me is something completely new and so if they said to me if I have anything and I see them every four weeks and they turn round and say its quite normal don't worry about it you know all women go through this then I will be quite happy that will put my mind at rest...[I: Do you think it would make any difference whether it was a doctor or a midwife?] Erm...yes I think it would and I think it would probably get down to the midwife because as I say that's what she specialises in every day of her working career so you know she comes across so many different issues and so many different women with different experiences... [Polly_1_1]*

Polly's narrative supports Helen's that the midwife is the practitioner to go to as 'normal pregnant woman' and thus locates the midwife, as she has been traditionally portrayed, as the health care professional most able to confirm and reassure normality. This fits with the depiction of midwives as 'guardians of the normal' (Downe 1991) and a midwifery model of care, which emphasises the naturalness and normality of pregnancy and birth. This narrative however still fails to support a model of care where the woman has control and power, relying on the expertise of her own body. Bryar's (1995) claim that women shift their thinking about childbirth according to different contexts and circumstances is supported by Mary's comments about her choices for place of delivery. Despite feeling happy to be cared for by midwives and reassured by the normality of her pregnancy, Mary's choice for place of delivery continues to be infused by 'medical discourse' and the claim that a hospital with medical presence remains the safest place to give birth, despite a recognition through policy that this claim cannot be justified and a plethora of available literature supporting that view.

> *yessss...erm I suppose I mean as times going on its erm I sort of wonder you see I know the birth centre they don't its just midwifery led [I: yes] and as times going on I feel more confident that that would have been alright but with it everything being such a first for me you know [Mary_1_3]*

Polly's narrative further highlights the actantial role of 'experts'. Despite women's acknowledgement that the midwife has the power to locate them as maternity patients, the 'midwife expert' is firmly linked with the identity of 'normal pregnant woman' and the 'medical expert' with the identity of 'abnormal pregnant woman'.

> *Something that's wrong, rather than a midwife is oh yeah general yes and everyday thing you get pregnant you see a midwife you just put the two together it's a natural you see a consultant you automatically think is there something wrong [Polly_1_1]*

Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

Mary here suggests that 'expert' knowledge is also provided from other sources including 'personal knowing', 'official pregnancy literature' and 'magazines', as well as 'friends and family' as in Mary's narrative.

> *erm...I've got younger sisters, my youngest sister is twelve so I've always been around babies quite a lot but a lot of my friends my age have just gone through all this so they're the ones so hearing what they say.... not really my Mum cos she's not in your face with things like that and she knows that things have changed a lot and you do get some people telling you saying certain things to you but you don't let them bother you and books I've read loads of books[Mary_1_3]*

Sally also refers to 'books and magazines' as well as 'friends' as 'experts'

> *I bought a book Miriam Stoppard book which seems is really good and I've also found useful the information that I get from my doctors and my midwife when I go you know the information things and I read some bits of it and stuff like that they've been brilliant really I've got enough information really the bounty book I've got a lot of the information I'm getting from there... so yea you get information from doctors, midwives and from friends [Sally_1_1]*

It seems that whilst women enjoy reading these magazines they do not replace the expertise provided by midwives and doctors. 'Personal knowing' is not considered as informative or reliable as 'expert knowing'.

> *Er...I've got **the book,** I got given the book and that goes week by week tells you what you should be doing and where you should be going for this that and the other and you know... but as I say I've had two already sort of I know those things, it has slightly changed slightly since I had my last one you know... [I: So where would say most of your information about your pregnancy comes from?] The majority of it comes from having the other two and as I said the little book that I got given and magazines I get quite a few of the mother and baby magazines, I quite like reading some of the stories in there [Did they give you a lot of information at the booking clinic?]Not a great deal no, not a great deal, I think with me having previous pregnancies its just a case of tick the boxes as you go along [I: mm] ...I mean I had to ask quite a few questions and she was kind of looking at me as if to say you should know that and I didn't... [Helen_1_2]*

Throughout women's narratives expertise is consistent. Experts however, take many different forms and are accessed depending on a woman's personal assessment of the situation. Different experts such as midwives and doctors are often combined within the women's stories to signify expertise and are segregated dependant on individual events. This could suggest that choice can only ever be an evolving decision and that choice of lead carer/expert cannot be the singular decision that it is presented as in early pregnancy.

Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

Summary of Early Pregnancy Findings

This section of the chapter considering early pregnancy narrative has identified themes which demonstrate how the confirmation of a pregnancy causes women to adopt a new 'pregnant woman' identity. This status locates the 'fetus' as a powerful actantial influence and initiates the transition to motherhood. This invests them with a personal responsibility to act appropriately in pregnancy, make responsible choices to maintain the pregnancy and ensure their baby's well-being. Tensions for women exist as they as situated by the various actantial discourses and influences that surround them in pregnancy as 'responsible/irresponsible', 'normal/abnormal pregnant women' and as they aspire to promote themselves as 'good mothers'. Whilst the narratives around screening demonstrate that women are capable of ranking their desires and concerns to make choices, that choice only exists within the frameworks defined by 'experts', 'culturally mediated discourses, ideologies and standards'. Whilst some of these actantial influences offer the promise of choice, others clearly restrain it, presenting choice in maternity care as a complex phenomenon, which is not merely based on the type of pregnancy and birth experience desired. What is interesting and will be seen in the following late pregnancy accounts is that many of these themes set the context for the rest of pregnancy and remain consistent or are influential within new themes identified.

Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

Chapter 6b: Late Pregnancy (32-36 weeks pregnant)

Introduction

The following section presents the narrative themes identified in late pregnancy. Many of the themes identified here build on the early pregnancy themes. As pregnancy progresses many of the identities and actantial influences surrounding women during pregnancy are reinforced. Narratives, as would be expected, are gestation specific and so the themes emerge from a slightly different context. Themes consistent with early pregnancy include:

- The New Identity: Pregnant back to Non-Pregnant
- Identity, Ownership and Choice
- Promoting Motherhood/Relegating Fatherhood

A new theme is identified specific to impending labour:

- Labour Expectations

Other themes less relevant to this stage of pregnancy have disappeared including:

- The GP Gatekeeper
- Physical Pregnancy
- Perfect Babies and Screening Choice

Experts and Expertise and the New Identity, Naturalness, Responsibility and Emotions, rather than being individual themes now infuse the other identified themes.

The New Identity: From Pregnant back to Non-Pregnant

The actantial role of the 'fetus' in reinforcing the 'pregnant woman' identity continues to be consistent in the narratives. There is an evident change in their physical appearance as the fetus referred to by Jane.

> *I'm very obviously pregnant... [Jane_2_1]*

This changing shape also facilitates recognition and acknowledgement from others of their 'pregnant woman' status.

> *Completely different because you can see that I'm pregnant and I feel so proud when I'm walking around....and people stop you and it's the attention you get and it's lovely...and they want to talk about you and the baby and you come out glowing with this sense of pride... [Polly_2_1]*

The fear of returning to 'non-pregnant woman' is diminished, although Helen's account shows a readiness to return to 'non-pregnant woman' created by the birth of the baby.

Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

> *I am (ready to deliver) I've had my bags packed since 26 weeks. I got my last bits yesterday and I'm just waiting now... [Helen_2_2]*

Sophie expresses a similar readiness to return to 'non-pregnant woman'. Both of these narratives suggest that women need to feel prepared for birth and they intimate that physical preparation facilitates psychological preparation.

> *All the clothes are prepared now and the baby's bedroom's done I've got my bottles and everything so I'm ready [Sophie_2_1]*

Mary's account embodies the suggestion that physical and psychological preparations for birth are intimately connected. The mothering role following birth seems acknowledged as something different to the current 'mother' role she is engaged in. A feasible interpretation is that the mothering role that women aspire and create for themselves in pregnancy is different, particularly in emotional content, to the mothering that women feel they will have to fulfil following birth.

> *Only in that, it suddenly it made everything ever so kind of real in a sense of...you see the other thing when they admitted me, I was getting regular tightenings like every 10 minutes for about 24 hours or something and they were sort of muttering about that all the time and all night long I had visions of going into labour and I suddenly thought crikey, you know and they did say it may be at this stage it sort of comes early and this kind of thing and that sort of shocks you [I: yea] in that oh, I've nothing ready, I'm not prepared for this emotionally, I'm still in my head I've still got all this way to go ... I've been sort of getting a few bits and bobs ready just in case [Mary_2_2]*

Polly, enjoying being a 'pregnant woman', is reluctant to relinquish that status.

> *Erm, now its feels exactly the same as probably when I was 14 weeks. I still feel really well I'm still enjoying being pregnant [Polly_2_1]*

Helen story continues as she goes on suggest that the 'fetus' will be active in contradicting her desire to return to her 'non-pregnant woman' identity.

> *I think it will late, I've just got a feeling it will be late, I do. I do, I think it's going to be awkward and really late. You know it'll only come when it's ready. I did think it would come early but... [Helen_2_2]*

This short narrative above is quite complex, Helen is anxious to end the pregnancy but this conflicts with her desire expressed in early pregnancy to deliver at the birth centre. This choice can only be facilitated by the baby arriving at a later gestation than her

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Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

previous pregnancies. This supports the earlier suggestion that choice is a complex phenomenon that evolves throughout the pregnancy, with gestation-specific events and experience, dictating women's feelings and decisions as pregnancy progresses. Helen's ongoing 'physical symptoms' in pregnancy inform her desire to return to a 'non-pregnant woman', perhaps due to a need for reassurance that the baby is normal and well despite her ill health and thus confirming Helen as a 'good mother'. This appears to supersede her desire for a birth centre delivery.

> *...not been feeling too well ...I've been like all the way through, lots of problems, low blood pressure, headache, heartburn, you name it I've had it. I'm hating it, it's been the worst one of all three of them. The other two weren't too bad this one's just...so horrible, definitely no more, definitely. I couldn't cope with another 9 months of feeling like this ...I've had headaches all the way through the whole thing and they say it's caused by my low blood pressure and I just have to slow down. It's a bit difficult when you've got two kids and you don't get any time to yourself.*

Helen's account locates the 'fetus' as the cause of the physical problems and suggests that the 'fetus' has a part to play in dictating its arrival. This clearly merits further interpretation. The 'fetus', which in early pregnancy as an actant created a 'pregnant woman' identity, is now ascribed a role in Helen's return to 'non-pregnant woman' Helen's labelling of the 'fetus' not only ascribes the 'fetus' agency and self will , it also attributes it with characteristics. A later gestation will actually facilitate Helen's choice for delivery, yet Helen still labels the 'fetus' as awkward, building a multifaceted picture of negative feelings. This narrative portrays the actantial 'fetus' as having rational, decision making capabilities, when it is still a dependant being with no existence beyond the mother. No conclusive scientific evidence identifies the fetus as the catalyst to the onset of labour, but Helen ascribes her 'fetus' a defined and active role to play in terms of pregnancy events and outcomes. It seems that this baby will be conceptualised as awkward whenever Helen delivers, awkward because it is maintaining Helen's pregnancy when she would rather deliver or awkward because it prevents her from delivering early. This baby creates tensions for Helen because she is trying to be a 'good mother' to both her existing children and this baby. 'Experts' through medical knowledge and the 'physical symptoms of her pregnancy' have situated her as an 'abnormal pregnant woman', advising her to act in a certain way to ensure her well-being and so her baby's. Adhering to their advice forces her to be a 'bad mother' to her other children. Attributing her 'fetus' with an active role allows Helen to devolve some of the responsibility for the perceived failures of a 'bad mother'.

Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

Identity, Ownership and Choice

The intricacy of Helen's pregnancy experience is augmented by the actantial role of the 'experts' in labelling her as an 'abnormal pregnant woman'. She feels that this unfairly represents her as a 'bad mother', despite her having always delivered healthy babies (good mother). Although she has been given choice it is restricted; she feels as a consequence unfairly categorised and as a result controlled. The health professionals are lumped into one category and referred to as 'they', although in this case she is primarily talking about the doctor as a 'medical expert' controlling her choices and he is depicted as bad. Helen defines herself as a 'normal pregnant woman' constructed though 'personal knowing' and feels cheated that she is unable to have a true choice. Whilst her experiential knowledge reassures her that there will not be any problems at delivery she permits 'expert medical knowing', which plays on fears about the safety of her baby, to dominate, diminishing her personal ownership of the pregnancy. Helen reinforces her early pregnancy concerns that her choices are actually to ensure 'expert' attendance at delivery.

> *...I haven't had any problems with my other pregnancies so I couldn't see why I couldn't go there, but like I tried to explain to the doctor, a woman who's 40 weeks pregnant can have complications, so a woman who's 35 weeks pregnant can be straight forward, but they don't look at it like that. [I: I suppose what they're thinking of is the special care unit] Well that's what he says, no because there's no doctors up there. [I: So then if you had the choice, and I said the choice is at 37 weeks you'll have to go to Hull or 38 weeks you can go to the birth centre] I'd go to the birth centre, yeah I would yeah [I: Much as you've felt awful] Yeah I would I'd rather go there, I've heard the other one's real nice but I'd still rather go there it's nearer, more convenient. This is it I'm thinking am I going to get there in time... [Helen_2_2]*

Helen has already placed a responsibility on the 'fetus' for her delivery. Claims that her propensity to premature delivery is hereditary further devolve the responsibility. It's not that she's a failure, an 'abnormal pregnant woman' or a 'bad mother' it is just something that she is powerless to prevent.

> *It runs in the family, I was 7 weeks early, my middle sister was 5 weeks early, my eldest sister was 6 weeks early. My sisters have had kids and they've both been 2/3 weeks early... I think it just runs in the family. [I: So it's not been specific reasons?] No, no, I think my mum had me at 33 weeks and she had high blood pressure with me... but the other two just came when they were ready to come I think.[Helen_2_2]*

Mary's account tells a different story, but equally demonstrates choice to be a privilege that can be rescinded. She has developed 'physical symptoms of pregnancy', which necessitate surveillance and potential intervention and play an actantial role in situating

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Mary as an 'abnormal pregnant woman'. Mary's experience justifies her early pregnancy choice to deliver at the acute unit in case of problems. The midwife as an 'expert' has defined Mary as a 'maternity patient'. Problems have arisen in her pregnancy and choosing antenatal midwifery led care has not detracted from her or her baby's well-being. Therefore she made the responsible decisions of a 'good mother'

> *... I did want to have midwifery led care...they've all been the same midwives which is really nice, I think that makes a big difference ...[I: Have you felt confident in seeing the midwives, you've not felt at any point, oh I wish I'd seen the GP?] No, no I feel every confidence, and as I say the second anything is sort of out of line she was straight onto it, checking blood pressure and we'll do this walked in and she said oh hi Mary, how are you doing, she said the first girl at 9.00 has just fainted on me, the second girl I've just had to admit..., she said you're going to be straightforward, and I said I hope so and I wasn't but she's still so, you know, she wasn't oh now I've got to go and do this and you know and she was oh never mind I've got to do this and that, really smashing [Mary_2_2]*

Other women reassert their rationale for the choices made in early pregnancy based on their individualised perceptions of risk generated by the continued infusion of the 'medical discourse', i.e. making choices to ensure the well-being of their babies and promote their 'good mother' identities. Kate, despite preferring the birth centre, chooses the acute unit.

> *Yea, well I do want the Birth Centre but if anything goes wrong then I don't want any doubt about it [Kate_2_1]*

Sally equally reinforces her original choice.

> *I'm quite happy to come here (acute unit) I think there's a lot of people who know what they are doing and no I'm quite happy and it makes sense...erm I think if there was anything wrong everything's handy doctor and all that sort of stuff, whatever you need is all nearby...I know I haven't had a problems with my pregnancy but I just rather be in this environment for my first time... [Sally_2_1]*

Jane is able to justify her choice through the experience of her sister in law. Her account remains less influenced by 'medical discourse' and quality of care is an important consideration judged however by the input perceived necessary to facilitate 'good mother' skills following delivery.

> *I think that suite (birth centre) through there is absolutely lovely and... my sister-in-law, she had hers at the Royal and even though it was at the new place*

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Women's identities are depicted in red

> *she said it was absolutely awful...[I: Why do you think that was?]I just think its because they've been so busy and she was in a side room and she wanted help with breast feeding and it was like, she'd been breast feeding for most of the afternoon, nobody had been to see her, and she just wanted to go home and nobody had been to see her and nobody was helping her, and I think coming down to it they were just so busy but that didn't help her [I :So that's reinforced your decision for the Birth Centre?]Yeah, absolutely...I've got absolutely no qualms about making that decision [Jane_2_1]*

The 'good mother'/ 'bad mother' dichotomy is exhibited throughout and across all the women's narratives. Mary, now labelled as an 'abnormal pregnant woman', needs to reassert her 'good mother' identity through narrative claims that she was well until 30 weeks pregnant, describing the '*wobbly moment*' when she fears she is losing a grasp of that identity. Mary's narrative, unlike Helen's, apportions no blame to the fetus. Mary rather questions her innate sense of her own body ('personal knowing'). Her narrative implies denial that there was a problem, evident in the alternative explanations she offers for her raised blood pressure. An inherent contradiction of identities exists for Mary here. Failed 'personal knowing' as an actant, locates Mary as a 'bad mother' failing to be an advocate for the baby's well-being, an identity reinforced by the hand over of the nurturing and protecting role inherent in good mothering to the 'experts'. Mary no longer has a choice in decisions; her care is now dictated by the fact that she is now a 'maternity patient', which necessitates surrendering of choice and control. Her unquestioning acceptance of this handover of choice and control however reasserts her 'good mother' identity.

> *Erm, it was moving along quite nicely really, up to about say 30 weeks when I had blood pressure problems... I mean looking back I think I can tell now when it's sort of going up, the difficulty is with you not being pregnant before you don't know what's what, you know and like every night after tea I'd be getting this pounding in my head but I just thought you get extra blood volume don't you [I: yea yea] at the end of the day and things but no I didn't feel unwell, there was no indication really.[I: So was it just a general antenatal check then you went to?]Yeah, yeah, I checked it at work a couple of times during the week and I thought oh that's a bit up but you sort of think well I'm at work I've just done a shift and its gonna be up a little bit and then I went ...she said we'll just get you into the Antenatal Day Unit at Castle Hill and it was about the same there and then it was 160/100 over the weekend so... Yeah which was erh, that was really the only sort of wobbly moment really because as you're sat there I was looking at the dial and I saw it start to go to the 160 mark and I thought 'oh no' its really gone up... I've suddenly developed this problem because my blood pressure was 100/60 every week and she said its suddenly gone up this much she said erm we'll need to watch you closely because I've got a feeling you're on the brink of maybe pre-eclampsia... [Mary_2_2]*

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Women's identities are depicted in red

Like Helen, Mary abdicates some responsibility for her 'abnormal pregnant woman/bad mother' status by attributing the problem to a hereditary condition.

> *...my mum had it with me I don't know if it's familial but erm she said we'll just monitor you closely [Mary_2_2]*

Mary continues to assert her 'good mother' role, suggesting she has done enough to protect and nurture her baby to ensure its survival, even if premature. Interestingly, the 'expert' of choice here is the 'pregnancy book', rather than the health professionals who indirectly elevate her 'bad mother' identity.

> *... I thought I was at 30 weeks, I thought everything would probably be okay and I think that week I'd read in my book that if the baby was born now it would stand an excellent chance of survival and this kind of thing [Mary_2_2]*

Early pregnancy demonstrated how women individually make choices based on a plethora of orbiting social and cultural discourses as well as being influenced by the 'fetus', the 'GP gatekeeper', expertise in many different forms and experiential knowledge. As pregnancy progresses this choice is reinforced and justified by several women. For others who become 'maternity patients' however it becomes an elusive concept removed or dictated by pregnancy specific events.

Labour Expectations

Thoughts and worries about labour, which are not really expressed in early pregnancy, now begin to become more prominent. Mary narrates her thoughts about labour and her perception that it will be out of her control. Coping and control appear intimately related and women articulate them as both physical and emotional events. Her perception of labour is based on actantial 'experienced labourer' discourses that surround her, these are predominantly '*horror stories*'.

> *...I think it was just that I thought it was way away, I knew it was coming, I'd read lots about it, psychologically you think you're prepared but I mean you're bound to be frightened to some extent because it's something that is happening out of your control that's never happened to you before... its just a bit scary really (laugh) how you're gonna cope, if you'll cope, what'll happen, you know all the different things you always hear about all the horror stories... my auntie and then my dad's wife she had two bad births as well and I think when people do go onto you about it a bit and how horrendous it is, you know it does sort of, ...I mean it must be so difficult to explain what it is like but there's no other way of understanding it is there. [Mary_2_2]*

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The 'experienced labourer' accounts, which inform Mary's account above, juxtapose with her desire to have the normal, fulfilling emotional experience that some women describe and is portrayed in some of the 'media and pregnancy literature' (Gatrell 2005). Negative 'experienced labourer' discourses generate similar expectations of labour as necessitating intervention and it seems feasible that Mary's expectations of lack of control are generated with these stories. Mary's fear of labour, her perception that pregnancy and birth are inherently risky and her construction of labour as a natural but unpredictable and undisciplined experience illuminate her choice for delivery site. Delivery at an acute unit does not inherently imply a willingness to relinquish all control but rather a desire for when to relinquish control. Mary expects a point in her labour where she is no longer able to act as an advocate or be responsible for the well-being of herself (uncontrolled labourer) and consequently her baby and her choice implies a willingness to hand over control at that point, promoting herself as a 'good mother'.

> *I imagine a lot of pain but hope that I can cope with it, the only thing I don't want it to turn into an experience where it becomes a really big trauma for me you know what I mean, ...you want it to be a positive experience as well don't you [I – yeah absolutely] and people, there are lots of people that do tell you that as well and course it's really painful but at the same time it's an amazing experience to go through so yes I'm expecting lots of pain, I'm not expecting it to be easy..... I'm expecting things to happen that I don't expect to happen, erm... but I want it to sort of stay within that realm of almost..... this is all normal, it's what's supposed to happen, it's physically wildly out of my control, you know this experience but I get something good out of it as well....if they told me I needed a caesarean section then I would be really disappointed... [Mary_2_2]*

Jane's narrative emphasizes the constructed nature of her first experience of labour and fears of how she will react, underpinned by similar actantial discourses to Mary.

> *I don't know really, I think I've heard too many people and their stories that I think that's part of my trouble really, that I don't really know what to expect. I've been reading about the signs and things like that erm ... but if I'm honest I don't really know actually. I'm just going to have to see how it goes and I know it's going to be painful and things like that erm ... I'm just going to have to wait and see [Jane_2_1]*

For Helen her choices for delivery are bound up with a slightly different concept of control. Attempts to maintain control in labour are based on her own 'experienced labourer' discourse where her previous deliveries have not created feelings of control. 'Cultural norms' suggest that society feels uncomfortable witnessing the expression of basic human emotions and this paints a picture of women out of control in labour as

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something unattractive/animalistic (Oakley 1993). Hence women feel that being out of control is an unacceptable way to behave in labour and are pressured to conform to the serene Madonnaesque picture of a 'good mother' even in labour.

> *Very quick ones, the second one was awful, we only just got there 8.30 to hospital, she was born at 8.35 and it was just a case of on the bed and out she popped. From that perspective it was rather quick and a bit of a shock to the system, I expected to be there for hours and hours, no out she popped and that was it...I think it's from a past experience really, I would sort of say I expect the same sort of labour as I had with the other two... [Helen_2_2].*

Some women's accounts reveal that choices are made based on the availability of 'epidurals', which play an actantial role in facilitating the 'controlled labourer'.

> *I'm going to the main unit it's just if I want an epidural which I had last time you see [I: right] I want to have that option [Sophie_2_1]*

Though there is an expectation that labour will be painful and recognition that some expression of pain is acceptable it still is expected to be within a frame of control, e.g. quiet moaning is acceptable but loud screaming and swearing is not. Midwives traditionally encourage women to control pushing in the second stage of labour to facilitate a smooth, less traumatic, delivery both for baby and mother. Hence both 'cultural and expert discourses' bolster notions of a 'controlled labourer.' Sally's narrative, as Mary's, supports a willing hand-over of decision making and elements of control to the 'expert'.

> *...I'm not sure what my pain threshold going to be like and whether I'll need an epidural but from what they've said the midwife will guide me... [Sally_2_1]*

Helen's narrative illustrates other labour concerns that impact on choice. These suggest that despite her claims to normality, Helen clearly worries about abnormal events in labour, possibly manifested by her categorisation from early pregnancy as an 'abnormal pregnant woman' which inherently denies her personal control. Her choices for the birth centre as the nearest site assured of 'expert' input have already been discussed. Her earlier narrative also suggests that a quicker admission may also facilitate a greater level of control. Her choice may equally be based on hopes for a less interventionist approach to her delivery and affirmation of her 'normal pregnant woman' identity. Helen once again utilises the narrative to promote her 'good mother' identity displaying characteristics of protection and self-sacrifice.

Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

> *My worst fear is caesarean section, I don't know why but uh ... it frightens me I don't know why, why ... I've just never wanted a section, no. I think that would be my worse fear if they said you're gonna have a section I'd think oh no. I don't know really it's just the thought of being cut open...it's just the thought of having it. I'm just not keen on it. Its difficult cos even if you don't want one at the end of the day it's about your baby isn't it? If I had to have, if they said to me, well I'm going to have to cut you open or there's a chance it could go wrong then cut me open, I wouldn't sort of say, I'm not going to let you do it I'd say go ahead and do it. [Helen_2_2]*

Kate mirrors this self-sacrificing role of a 'good mother'. Her narrative suggests a complete absence of control '*If it needs to be done it needs to be done you can't stop it'.*

> *No I'm alright about it (labour) at the moment, my only worry is when I come out will I be able to manage living on my own ...as long as I don't have a caesarean section I'm sure we'll be able to manage...* [I: *Would it bother you if you had to have a section?]No not particularly...If it needs to be done it needs to be done you can't stop it...I have thought about it but it doesn't really bother me [Kate_2_1]*

Shown in Helen's account the 'fetus' is once again a significant actant around labour. Further negative images of her baby appear stimulated by 'expert' comments. Helen expresses fears that having a big baby will make her labour more painful and different to her expectations, this articulated fear could again be a consequence of the expert labelling of her as an 'abnormal pregnant woman'. Once again however she devolves responsibility for a potential problem, this time to her partner.

> *...they've told me it's a big baby so that frightens me a bit. On his side all his side are over 10lbs so that frightens me that it might be a massive baby. It is going to hurt me and that you know is it going to be over real quickly but I can't really say. I just want an average size and over real quick, go in and go out. [Helen_2_2]*

Helen's narrative is again reflected in Kate's

> *[I: Do you tend to base your information about the labour that's coming on your past experience?]Yes and no... it would be easy if it was like that but you just don't know what to expect do you like I said this baby's bigger so it might be different [Kate_2_1]*

Women's expectations of labour appear to be constructed from a number of different influences. These narratives suggest that even multigravida women's own 'experienced labourer' discourses do not entirely explicate their construction of their expectant labour

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Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

and for all women 'cultural, societal and expert discourse' continue to play a pervasive actantial role.

Promoting Motherhood/Relegating Fatherhood

Women in late pregnancy have reinforced and rationalised their choices in a slightly different way from early pregnancy. Implicit in their narratives however remains the actantial influence of 'ideologies of motherhood' by which women measure their performance as 'good mothers'. Ownership and responsibility for pregnancy events, choices and decision-making, even when devolved to an extent within the women's accounts, remains their domain. Fathers continue to be situated as actantial 'latent fathers' largely absent from decision-making or real involvement with regard to the pregnancy and delivery. Mary's narrative displays that even in late pregnancy women relegate fathers to a latent role. Matt continues to display an obvious emotional connection to the pregnancy but, in contrasting him with herself, Mary still perceives him as incapable of engaging with the reality of pregnancy.

> *Erm ... everything scares him... I mean the second the midwife went out the door he just burst into tears... he just didn't know what to do, like oh what's happening, what's happening, and I'm saying it's alright, it's alright you know, erm I was fine by that point and I've been absolutely fine through it all really ...[Mary_2_2].*

Kate supports this, her preference for her mother to be with her at delivery rather than her partner is because of her Mum's ability to understand the labour and birth experience. Kate's partner is relegated to an absent position and not included in this decision making.

> *As long as me Mum's there, don't know I had them both for the first one so as long as I've got one there for the second.[I: Right, so if you had a choice out of the two?]Mum would be my first choice [I: Why?] I think cos she's been through it four times and she knows what it's like so [Kate_2_1]*

Sophie's narrative demonstrates her perception that men relegate themselves to a 'latent father' role.

> *Last time I was in labour my Mum and Karl came with me erm ...he was sort of sat on the sidelines but this time he'll be there with me so they both don't have to come... [Sophie_2_1]*

Women's narratives suggest that their expectations of support from their partners are essentially practical. Helen describes her partner as fulfilling the organising role she

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Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

would normally undertake with regard to the other children, rather than being essential to the labour outcome.

> *...I'd like him to come home, sort the kids out and follow me. [Helen_2_2]*

Sophie articulates concerns about how her husband is important in the practicalities of getting to hospital.

> *...my husband is luckily on a course and he's working a different job for a while so he's not going to be on nights but I think what if I went into labour and there's only me and Jack here that's the only thing that worries me a bit what will I do ... [Sophie_2_1]*

Helen's account goes on to illustrate the fundamental reason she wants her partner present at delivery, despite earlier narratives that articulate his failure to support her in labour. She demonstrates fears of being an 'absent mother'. Despite the incidence of maternal mortality being extremely low in this country, the 'historical legacy of childbirth', probably reinforced by the 'medical discourse' which has firmly situated Helen as an 'abnormal pregnant woman' from an early point in her pregnancy, is inscribed in her mind. Helen needs her partner to be present. Her narrative suggests she believes birth transforms the 'latent father' into 'a father' ensuring a parent for the baby if things go wrong in labour.

> *No as long as I know he's there outside the door, but I think if he was sort of Isle of Wight then I think I'd sort of panic a bit, I'd think what about if this goes wrong, what if that goes wrong, what if I die. [I: Well I'm sure you won't] I know but you never know though do you. [Helen_2_2]*

Implicit in women's narratives is that pregnancy, labour and birth remain firmly situated as a female institution. Clearly the 'physical experience of pregnancy' plays a fundamental part here. However it appears that women are actively complicit in keeping fathers-to-be in this secondary role. The role ascribed to their partners is at worst absent and at best one of support, whilst women are elevated to a role that is fundamental to their babies' survival and requires of them to be 'a mother' during pregnancy to ensure a successful outcome.

Summary of Late Pregnancy Findings

Late pregnancy continues to see the fetus play an influential actantial role in reinforcing women's 'pregnant woman' identity but also it is now attributed with agency in the return

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to a 'non pregnant woman'. These late pregnancy narratives display the powerful role played by 'experts' in the form of doctors and midwives in situating women as 'normal pregnant women' or 'abnormal pregnant women'. Expertise has been lucidly present in women's narratives from early pregnancy but the level of authority appears to increase and be questioned less as pregnancy progresses. Women firmly locate pregnancy, labour and birth as a female institution, for which they are ultimately accountable. Those women labelled as abnormal and positioned as 'maternity patients', find their personal ownership of the pregnancy weakened as control over the pregnancy is ceded to the 'experts' and choice is removed. Women are ultimately complicit with this in order to maintain their 'good mother' status. Expectations of labour narratives demonstrate the continued actantial influence of societal and cultural discourses in illuminating the choices women made in early pregnancy and further illustrate how women strive to promote themselves as 'good mothers'.

Summary of Pregnancy Narratives

This chapter has explored how during pregnancy women are influenced from a very early stage by the presence of the fetus and their acceptance as women of pregnancy as a personal responsibility. Consequently their desire to promote themselves as 'good mothers' motivates them to behave in the right way, make responsible decisions and choices and cede control to experts. These behaviours occur in the belief that they will ensure that status and safeguard the well-being of their babies. The legacy of the medical model is ubiquitous in women's accounts, which might explain why the surrendering of control to experts is often not an unwelcome event, particularly as pregnancy progresses. Women are clearly able to rank their needs with regard to maternity care choices and choose to relegate personal desires through their aspirations to promote themselves as good mothers. The 'good mother' identity does not evolve out of one singular theme but is context specific to gestational events. This queries how the 'good mother' identity might be revealed in women's postnatal narratives. Whilst it might be assumed that the dominance of expertise would diminish following delivery, the strength of expertise and women's reliance on it in pregnancy, raises questions as to whether this will be the case. Throughout pregnancy, women have promoted their good mother status through their relationships with others, including the fetus and their partners, and through their perception of the relationship between their partners and the fetus. Of interest in the postnatal narratives will be if and how those parental relationships are renegotiated, following the birth of the baby. The following chapter will continue to reveal and explore both the actants present in women's narratives and the identities that these create through the narrative themes identified, at fourteen days and 6 months following the birth of the

women's babies. The relationship of the postnatal actants and identities will be considered their relation to those already explored in the antenatal period.

Chapter 7: Postnatal Narratives

Chapter 7a: Early Postnatal Period (2-4 weeks after delivery)

Introduction

A third set of interviews took place following delivery when women generally related their labour and perinatal stories. Actantial characters revealed in earlier narratives, such as 'experts', as well as actantial identities, such as 'good mother/bad mother' and 'maternity patients', continue to infuse the themes that arise. These appear alongside other characters and identities, which have replaced or evolved from those identified earlier.

The following themes evolved but remained from pregnancy.

- Experts and Expertise: Being a Maternity Patient
- Promoting Motherhood/Relegating Fatherhood

The new themes apparent in the early postnatal period include:

- Fetal Role in Labour
- Birth creates Real Mothers

Experts and Expertise: Being a Maternity Patient

Women's late pregnancy narratives illustrated how women, such as Polly, indirectly situated themselves as 'maternity patients' through deference to 'experts' to affirm the status of their pregnancies. For others, such as Mary, the 'physical symptoms of pregnancy' located her as an 'abnormal pregnant woman' and through subsequent monitoring by 'experts' as a 'maternity patient'. For most women in late pregnancy however a 'maternity patient' identity did not feature and in Helen's case was firmly resisted. Narratives following delivery saw most women articulate some loss of control or choice and emergence of a 'maternity patient' identity, irrespective of their original choices for delivery.

In Mary's late pregnancy accounts raised blood pressure situated her as a 'maternity patient'; devolved not unwillingly, as shown in those narratives, of personal control over events relating to her pregnancy. Mary as 'abnormal pregnant woman' was placed under the control of 'medical experts' to assure her well-being and that of her baby.

> *... I was about 38 weeks and I went in and my diastolic was 110 again on the tablets so she said, and I'd really blown up you know like you really do and one thing and another and erm the bloods that they took that day were starting to really show so they got me in to induce me so when the monitored me they said*

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> *they think you're in early labour anyway ...so they let me go on and I got through to about midnight I think and erm... and my blood pressure went sky high absolutely... so they said we can't mess about now so they said we'll put a pessary..., and then I got to about 3-4cm then they broke my waters and erm then started. I'd had an epidural for when they started me on a drip as well and they'd wanted me to have an epidural for my blood pressure so I'd been getting ready for it ...I went all through the day and erm they were monitoring all afternoon because of my blood pressure and I was absolutely fast asleep and I woke up really suddenly and I just knew, it was so really weird and I looked and it (baby's heartbeat) was really dipped on the monitor and the nurse was there and within half an hour they had me in for a caesarean [Mary_3_1]*

This post delivery account demonstrates the language used by the 'experts' as her pregnancy progresses, suggesting urgency and potential danger, which only they as 'experts' have the knowledge and skill to manage. Mary as shown is completely disempowered by the chain of events but relates this as a heroic tale. The 'experts' allowed her a chance to labour and she '*messed about*', conferring her with a 'failed woman' identity, unable to independently conclude her pregnancy when necessary. Hence 'experts' who have greater knowledge and expertise step in. Mary, as a consequence of her 'maternity patient' identity and the need to maintain her 'good mother' status, acting to ensure her baby's well-being readily and unquestioningly accepts interventions such as induction and an epidural. She earnestly articulates however, her own personal contribution to maintaining and asserting her 'good mother' identity. Claims that she was in spontaneous labour signify that despite her location by 'experts' as a 'failed woman' she had an innate reaction to the intrinsic danger, which initiated action. Mary's account further suggests that her construction as an 'abnormal pregnant woman' albeit through events beyond her control requires her to compensate for being a 'bad mother', who has failed to maintain a normal healthy pregnancy, affecting her body and consequently her baby. This is reinforced in the above narrative when she demonstrates herself as a 'good mother' through her innate sense of her baby's well-being. The fetal monitor provides actantial technological confirmation of her 'good mother' identity. Mary above demonstrates no fear for the ramifications on her own health, emphasising further the self-sacrificing act of a 'good mother'. Mary in her narrative is unquestioning of the expert decisions and the necessity of intervention. It seems reasonable to suggest that this is a consequence of her rationale for her choice of site for delivery, expressed in both her early and late pregnancy narratives. Despite desires articulated in late pregnancy for a normal delivery the expectation of problems was ever present and resulted in a pragmatic attitude to pregnancy and labour.

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Jane's narrative will be explored in some detail in this section, because of its direct relevance to the theme. In contrast to Mary, as was shown in early and late pregnancy narratives, Jane articulates a desire for a non-medical, non-interventional approach to her delivery and here reinforces her rationale for choosing a birth centre delivery. Her suggestion that the main unit is associated with trauma conflicts with 'culturally romantic notions of birth' as normal and natural, which Jane appears to desire and the birth centre as a 'home from home' environment appears to support. This narrative below suggests that the ability to act independently and maintain control resists a 'maternity patient' identity and promotes the image of a relaxed and 'controlled labourer' that women's narratives in late pregnancy demonstrated as important.

> *I don't like hospitals and obviously the main unit has got a very hospital atmosphere and that the birthing centre is just like being at home so you can walk about when you wanted you can go and make your own drinks and things like that so I just liked the whole atmosphere, the fact that it was so relaxed, and I liked the birthing pool, I mean I know they've got a birthing pool at the main unit as well but I just liked the whole atmosphere but all in all I think its that its more like being at home and a bit less traumatic than being hospital but...[Jane_3_2]*

Jane's story continued below shows that despite a very clear preference for the type of environment and experience desired, pregnancy related events resulted in a removal of choice and transfer to the acute unit for delivery.

> *Horrific, (Jane crying) no it wasn't horrific I'm being melodramatic there but it just didn't go to plan erm...my waters broke on the Friday morning and nothing else happened erm so we went up to the birth centre... nothing still had happened so they went through the ... if you want it up there then 72 hours is the limit, they like them out before 72 hours don't they so they said we need something to be happening shortly, so they sent me off sent me off home, I kept having contractions on and off ...by Sunday afternoon, 3.00, I was only 3cms [I: were you contracting though] yea I was contracting but nothing opening so she said I'm sorry you're gonna have to go (to the main unit)... we're running out of hours now to get him out, so they put me on a drip and obviously they're monitoring him and monitoring me and then I obviously had the gas and air but time was banging on and the consultant had said that I might have to have a caesarean because it still wasn't but the midwives were excellent up there and they said look you really should..... [I: was this the midwives at the main unit then?] At the main unit yea, they were absolutely fantastic for all my reservations about actually going up there and being left I had two...and one was with me all the way through and they said look to relax you we suggest you have an epidural and that was the worst thing the thing I really did not want an epidural at all, so they said its either that or caesarean really because we need to get you fully dilated and I thought well I don't want to be laid up for so I thought well...lesser of two evils and I felt fantastic and I thought why didn't I have one of these to begin with (laughs) but there you go but then I slept for a while and by the time I'd woken up I was 9cms so there you go ...[Jane_3_2]*

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'Professional guidelines' are utilised here as the mouthpiece of 'experts' acting under the remit of ensuring a safe and healthy delivery outcome and prevent Jane from remaining at the birth centre. Jane becomes labelled as an 'abnormal pregnant woman' under the remit of 'medical experts' and thus relegated to the status of 'maternity patient', on a drip being monitored, placid, compliant and disempowered. There is an acknowledgement that the hospitalised experience was not as bad as envisaged, however the removal of control and choice conflicts with Jane's idealised notions of birth and is a significant emotional experience apparent in these early postnatal narratives. The 'experts', as for Mary, play a fundamental actantial role in locating Jane as a 'failed woman', stating *'we need something to be happening shortly'* suggesting that the responsibility for becoming an 'abnormal pregnant women' by failing to go into labour is Jane's. This can be read as a transference of responsibility for failure to fulfil the promise of choice from the 'experts' and the system and directly on to the woman. Clear reference to the safety of the baby based on actantial 'expert knowing' means failure to comply would indicate irresponsibility and construct Jane as a 'bad mother'. Jane clearly demonstrates the dominance of her 'good mother' identity, despite her obvious distress she prioritises the well-being of her baby and diminishes the importance of personal choice and experience.

> *...the most important thing was him and there would have been no questions about it, but he was fine...I'm alright now [Jane_3_2]*

Mary also demonstrates how women rank their baby's well-being above their own personal desires and satisfaction with their birth experience.

> *I don't think you can, I think its erm I don't know that anything can prepare you for it really, like you say if not perhaps the best experience in the world and the rush down to theatre, you still get that feeling, it seems to make all that seem quite irrelevant [Mary_3_1]*

Unlike Mary who does not differentiate 'experts' in her above narrative, referring to 'they', there is a clear separation of the experts in Jane's narrative between 'midwife experts' and consultants as 'medical experts'. Jane and Mary present converse narratives about who is afforded the more significant 'expert' role in their labours. For Mary it is the doctors; this is implicit in her acceptance of her 'maternity patient' identity.

> *...You just go with the flow and have complete confidence with everything, what everyone was doing, I mean the staff were great, the doctors were lovely [Mary_3_1]*

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Women's identities are depicted in red

Jane, despite having been situated as a 'maternity patient', clings to her 'idealised notions of labour' and desire for a normal delivery and credits the midwives with supporting her resistance against a 'maternity patient' identity.

> *No, no I did think I might have ended up with one (a caesarean) but no the midwives said no we'll get him out, no I mean they were excellent considering the consultant kept coming in and wanting me to go for a caesarean and they were like you've really got to start pushing now I had sort of resigned myself to the fact that well it would be so much easier if I had a caesarean and they were like Jane you don't need this you can deliver naturally, you're not gonna need one and we're gonna make sure and that encouraged me a bit but there were times when I just thought oh for gods sake just get him out, if she'd come in again I probably would have said yes but the midwives were like no you're going to do it, I'll keep telling her that you're getting there you're getting there but there were times when I thought it was the best option [Jane_3_2].*

Apparent in both narratives is how decision making choice and personal control was completely removed by the 'experts', but is articulated as a positive action and as good care in light of a successful labour outcome. Polly and Sally's narratives also demonstrate that removal of personal control is not perceived as a negative action, supporting the argument that more important to many women than direct control is *personal control over when to relinquish control (*Green & Baston 2003; Weaver 2000*)*.

> *That last stage of pushing was the hardest when I really didn't think I had it in me but fortunately, the midwife who was supervising the ward came in and gave me that sharp shock treatment I needed and she was born at 5.25... [Polly_3_1]*

> *...it was ventouse in the end ...they just wanted to get it I wasn't bothered by that time because I was tired and I just wanted her out... [Sally_3_1]*

Helen's labour account echoes the fears she articulated in both early and late pregnancy about delivering without 'expert' input. Premature labour confirmed Helen's suspected status as an 'abnormal pregnant woman' and necessitated delivery at the acute unit as a 'maternity patient' which she had tried to avoid.

> *Well, it was very quick, I expected to be early and I was...we organised the kids and went to the hospital ...I arrived about 3.10 and she was born at 3.47 [I: Not much time then, how did you feel?]Very panicky that I wasn't going to be there in time ... [Helen_3_1]*

Her labour, concordant with the expectations expressed in pregnancy, is a negative one. Although she does not refer to a lack of personal control, it seems implicit in her narrative

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that her desire to have been a 'controlled labourer', which she believed would have been facilitated by delivery at the nearer birth centre, is unfulfilled.

> *Horrible, horrible the pain was horrible and I only had time for gas and air, it was the worst of all three, the contractions were really painful and the pushing erm...the crowning was awful really painful, I don't know why but it was the worst of all three of them [Helen_3_1]*

One of the apparent difficulties in offering women choice in maternity care appears to be the powerful role that 'experts' play in locating women as 'maternity patients' when it conflicts with women's personal desires. Jane, Helen and Kate all articulate the emotional consequences of a negative birth experience, which situated them as 'maternity patients' and devolved them of choice and control.

> *...my midwife said, she said 'if you could have second babies first then there would be no problems, I think it's just the unknown as well, as I said I don't think you're prepared and if someone had told me it was going to be like that I don't know whether I'd have done it, I don't think I would have had kids at all ...People say that, that you'll forget but I won't, I won't forget [Jane_3_2]*

> *No I'm getting sterilised...I'm on the waiting list ... [Helen_3_1]*

> *No my labour wasn't as long, but it was painful though... never again, that's it now... that's finished me, it wouldn't have been so bad if it had happened straight away, it was 2 hours after they got it in (the drip) [Kate_3_1]*

An interesting aspect of this particular theme is the women interviewed who were constructed as 'normal pregnant women' in labour, tended to narrate extremely positive birth experiences. Even in those circumstances however, some narratives display the role 'experts' play in influencing women's labour events and choices, as in Julie's account below with regard to an epidural.

> *I mean they were just absolutely fantastic...I had two really young midwives and they never left me all night she was rubbing my back, she got me the birthing ball... the midwife just stood and watched me if I wanted my back rubbing she'd rub my back for me, it was only in the early hours of the morning when I wanted some pain relief and I wanted to know how I was doing and she said 'shall we just look and see how you're doing' and she examined me and my waters still hadn't gone....she said 'your waters are bulging' and I was five centimetres dilated ...I was absolutely shattered so I said I want an epidural but they seemed reluctant to give you the epidural, you know 'once you have an epidural then things can go wrong you know, what about pethidine' so she gave me the pethidine which just helped me to rest in between contractions [I: just took the edge of] then she just gave me some gas and air...then I said I wanted something else and they talked me into having Meptid but that did absolutely*

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> *nothing...and when that did nothing I demanded an epidural so the midwife went to get the anaesthetist who was in theatre...by the time he came back with his mate she was at the foot of the bed...just three pushes and she was out, so I was glad at the end of it I didn't have an epidural [Julie_3_1]*

In contrast to Julie, Sally demanded an epidural and was given one. Sally narrates the midwives role as an 'expert' in situating her as a 'normal pregnant woman', which despite medical intervention in the form of an epidural left her feeling she had retained personal control over choice and decision making in labour.

> *...I think I had two lots of pethidine and I sat on the birthing ball, I was going to go for a water birth but when I sat in the bath and it was so painful I thought no I don't think so [I: So you decided not to?] yea so I spoke to the girl and said I wanted an epidural and the anaesthetist was in theatre so she said she'd book me in for the next slot and within half an hour that was in and as soon when I got the epidural it was brilliant just enjoyable really... I don't think it was too bad, I was quite pleased with that...the midwife was fantastic...she was just great...she stayed with me all the time [Sally_3_1]*

This theme illustrates two key concepts. Firstly that women often have 'romantic ideas of childbirth', which are overridden not only by labour events but by the physical pain of childbirth, which renders them out of control. More importantly however it highlights the role that 'experts' play in locating women as 'maternity patients'. Women's narratives demonstrate the disempowering consequences of being given this identity in labour. For women like Mary who made original choices influenced by 'medical discourse' this was accepted and even praised. For others who wanted a normal and natural experience the emotional distress is apparent. It seems that there may be inherent consequences in offering choice and failing to fulfil that choice, which may be more emotionally damaging to women than if choice did not exist.

The Fetal Role in Labour

Helen's accounts in late pregnancy afforded the 'fetus' a clear role with regard to labour, and these post delivery narratives clearly echo that sentiment. Most women now ascribe the 'fetus' agency and an active role in labour. Mary describes how her caesarean delivery was due to her baby's position, which was not conducive to a normal delivery.

> *...they were going to try and use forceps but he was brow presentation as well and it was still really high up so they said it would have made a mess of him and was a bit messy for me and upsetting even more [Mary_3_1]*

Sally's account also supports an active role for the fetus in dictating labour interventions and outcomes.

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> *...her heartbeat was up and down normally they would have let me do it but with her heart beat out was up and down they just wanted to get it ... [Sally_3_1]*

Jane attributes her 'fetus' with a responsibility for getting into the wrong position and prolonging her labour.

> *...unfortunately he was the wrong, his back was to my back so erm so it was a long drawn out because they were trying to turn him I think but he came eventually[Jane_3_2]*

The 'fetus' throughout pregnancy is afforded a powerful role in influencing women's choices, decision and events. Despite the dependant status of the 'fetus' up to the point of delivery, which women clearly recognise, personhood is conferred on the 'fetus' particularly with regard to labour narratives where it is ascribed a very active role in determining events. This clearly merits further interpretation, particularly as we saw the difficulties some women had in late pregnancy in visualising their babies as real. The language used in these accounts could provide one explanation. Women refer to their babies as he or she, which for many women remains unknown until after delivery. It seems feasible to suggest that when women narrate their labour experience it inevitably incorporates and reflects the developing relationships with their babies in the early postnatal period. This allows them to visualise their babies not only by gender but also as individuals within their labour experience and attributes them a clear role.

Babies create real Mothers

Pregnancy has seen the actantial role played by the 'fetus' in creating 'mothers' and the dichotomous 'good mother'/'bad mother' identity as women take on characteristics of the mothering role. Above we have also seen the fetus being ascribed personal characteristics in labour. Following the 'birth of the baby', the baby becomes an actual character within the story with its own individuality, rather than the proxy actantial character with agency that existed for women in pregnancy. The 'birth of the baby' formally facilitates societal and personal recognition of the woman as 'a real mother'. The 'fetus' as an actant during pregnancy, compelled women to aspire to a 'good mother' identity depicted by 'ideologies of mothering'. Women's early post delivery narratives suggest that their mothering, although aspiring to the same ideology, takes on a different content from that apparent in pregnancy.

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In late pregnancy Mary narrated as elusive an emotional connection to her 'fetus' promoting her fears of being a 'bad mother'. This account of her response to the birth fills the emotional gap, meets the 'cultural depictions of maternal response to birth' (Kitzinger 1992 in Kent 2000) and captures that emotional connection affirming her as both 'a real mother' and a 'good mother'

> *...it's so much more emotional and you do love them so much don't you, it just bowled me over, you know the whole emotional experience just bowled me over, yeah it's wonderful, it's amazing the sort of things you go through... nothing prepares you for [Mary_3_1]*

Jane who worried, in pregnancy, about her lack of experience with children and so also feared being a 'bad mother' describes how following birth she is 'a real mother' with an innate mothering ability and sense of how to care for her own son.

> *...obviously it has changed my life but I think although I'm not particularly maternal with other peoples children I was thinking what will I be like with my own and even simple things like just picking him up and simple things I was thinking but him I'm not you feel just so its just so easy [Jane_3_2]*

Polly supports the emotional response that accompanies the 'birth of the baby' but in addition recognises that 'a real mother' identity brings with it a reality of mothering that did not exist before birth.

> *...you feel completely elated because you've got this tiny miracle laid in your arms and you can't believe that you've been carrying that for 9 months and suddenly it's real [Polly_3_1]*

Sally further supports how the mothering role she played in pregnancy does not carry the same demands as being 'a real mother' and articulates a reality that is different to the expectations depicted by 'romantic notions of motherhood' as a wonderful and fulfilling experience for women (Woollett & Marshall 2000).

> *She dictates everything you do, if we go out it's when she says and I didn't really expect it [Sally_3_1]*

Helen's story illustrates how being 'a real mother', brings to reality the emotional dimensions that were intangible for women in pregnancy.

> *OK at first but then pretty horrible [I: why?] well she (baby) got jaundice and had to go in HRI, [I: oh no] they were brilliant there though, I stayed all the*

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> *time, she had to have phototherapy and they gave her a drip...it was horrible I really thought she was dying [Helen_3_1]*

The 'bad mother' identity revealed in women's narratives during pregnancy based on fears that their physical state, actions and decisions might be linked to bad pregnancy outcomes, is now created by an inescapable reality of visible events and outcomes. An 'unhealthy/abnormal baby', as in pregnancy, can signify a failure to nurture and protect. The fear narrated by Helen here is consistent with that articulated in the pregnancy narratives but the strong emotional connection with the baby is apparent, generated by the reality of 'the birth of the baby', creating Helen's status as 'a real mother' who loves her baby. Her failure however, is now visible and can be directly attributed to her bad decisions and failure to notice a problem. Her narrative below demonstrates both intrinsic feelings of guilt and failure and how her 'bad mother' identity is reinforced by the blame afforded by others.

> *Really upset and I just wanted to cry all the time erm.....I just didn't really know what to make of it and he thought it was my fault because I wanted to come home quickly and I didn't need that.....I said 'she's been examined and they said everything was OK' so you believe that don't you? I was worried that it was my fault anyway and he just made it worse .....You just assume the worst don't you [I: mmm] I really did think the worst when she was ill [Helen_3_1]*

As women did in pregnancy, Helen is quick to try and reinstate her 'good mother' identity by describing her actions when her daughter was ill. Helen narrates the characteristics of a 'good mother'; i.e. responsibility, advocacy and a self-sacrificing relegation of her own personal needs. She reinforces herself as a 'good mother' by contrasting her behaviour to that of other 'bad mothers'.

> *...I couldn't sleep I was listening all the time for her and I didn't dare leave her...some parents left their kids I can't understand it, one day I came home for a shower and to get some clean clothes and try and get a bit of rest but I felt really guilty leaving her even for two hours in case something happened erm... [Helen_3_1]*

Mary, Sally and Jane tell less dramatic accounts but still go on to further describe the physical realities of being 'a real mother' that make demands beyond those that mothering in pregnancy requires.

> *It is hard work, you're just constantly on the ball aren't you...I think it's true that your life totally changes [Jane_3_2]*

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Sally again shows how being 'a real mother' fails to meet 'romantic notions of motherhood' and how that leaves her feeling unprepared and alone. There is both a physical recovery and emotional adjustment taking place in Sally's narrative which is clearly traumatic.

> *Mixed emotions really...nothing can prepare you for it, nothing at all obviously been a bit tired because I've lost so much blood but I've been a bit weepy as well and obviously then he went away and I was like 'thanks a lot she's only two weeks old'....and suddenly when he went away it was like 'oh I've got to do this on my own'...I think as well I never get a break [Sally_3_1]*

Mary also narrates about tiredness, which she acknowledges impacts on the emotional adjustment to being 'a real mother' which contrasts sharply with the earlier euphoria.

> *I was just on a high for about two weeks and then probably about a week ago I got a bit of a oh heck, I was tired, I was really tired and thinking oh no, I'll never get a decent nights sleep....and the thing is if I get tired everything goes down with me my mood goes I don't seem to be able to get on with it really and the first sign of me not feeling happy and that sounds awful because I've got this baby and I should be over the moon but I wasn't at all I was tired and fed up and he was crying and I probably had sore nipples too and he wasn't latching on properly [Mary_3_1]*

Mary as 'a real mother' provides emotional narratives which display a sense of shock, frustration and overwhelming responsibility and also seem to hint at some loss of personal identity as identified in other work on the transition to motherhood (Gattrell 2005, Oakley 1981b). She is however quick to assert her 'good mother' identity with claims that motherhood is '*lovely really*'

> *Its 24 hours isn't it and as you know, there's no break from it, you don't get a couple of days off, its always thinking of them, what they need, what the matter and the fact they can't tell you things and they're utterly in your hands and if things go wrong you sort of feel as if its your fault really but erh lovely really.[Mary_3_1]*

What all these narratives show is that the 'birth of the baby' creates 'a real mother', an identity which incorporates many of the characteristics aspired to in pregnancy including nurturing, advocacy, protection, responsibility for a dependant that relies almost exclusively on the biological mother, being self-sacrificing and accountable. However 'a real mother' created by the 'birth of the baby' demands from women a totally child centred approach and contains the emotional involvement that was lacking for women in pregnancy. These women's accounts suggest that mothering following birth is a significantly more physically-emotionally-demanding role than mothering performed

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when pregnant and women's adaptation to 'a real mother' role appears to be affected by their expectations, physical recovery from labour and post delivery events.

Promoting Motherhood/Relegating Fatherhood

As the pregnancy test hails the woman as 'pregnant woman', so 'the birth of the baby' hails her as 'a real mother'. There is recognition that 'the birth of the baby' creates a new type of mothering, creating an identity different in mothering content to before birth. Women who in pregnancy have relegated their partners to an actantial 'latent father' status, following delivery now articulate a perception of their partners which affords them an actantial 'fathering' role. Their partners are clearly characters within the story and fathers, however, women still construct their partners as 'a father' in a certain way that is an extension of the pregnancy construction; this continues to afford women a higher parenting status with regard to their baby than their partners. Helen's narrative below supports traditional 'gendered parenting discourses', situating her husband as simply less capable than her, but more importantly unable to be self-sacrificing and relegate his needs as secondary to the children in the way that mothers are expected to be. She further suggests that despite the inherent difficulties of being 'a real mother' she has no option, because to shirk the responsibility would render her a 'bad mother', whilst she perceives that as 'a father' he retains an opt out clause which does not categorise him as a 'bad father'

> *He had to look after the kids whilst I was in hospital with her and he realised how hard it is to look after the kids, do the housework, make sure they do all their homework and everything...he actually said to me he realised that its hard to be a woman and he didn't realise how much there actually was to do... He feels neglected, he's complaining all the time that there's no time for him so I said 'there's no time for myself never mind you' he just makes me cross...he just doesn't see all the things I have to do, I know women can multi-task but there's a limit... [Helen_3_1]*

Jane supports the depiction of the man as less culturally bound to his new role as 'a father' than hers as 'a mother', even though parenthood was wanted by them both and considered a joint venture. Her need to assert her 'good mother' identity remains consistent in her claims that she '*wouldn't have it any other way*', and that her mothering is successful. Her story, however, also highlights the pressure that 'gendered parenting discourses' exert on women to unquestioningly behave in a way that conforms to the gendered depiction of mothers.

> *...I think its true that your life totally changes and theirs doesn't, I mean Paul does a lot of climbing and he's still out, I mean I wouldn't stop him going unless*

Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

> *I felt really below par he wouldn't go, but no he goes out to football on a Monday night and he still goes climbing for 2 hours, whereas the best I get is nipping down the shop in between feeds...and you just think gosh your life is just you know.... I just feel like a big feeding machine you know but I wouldn't have it any other way, he's very content and very healthy but... [Jane_3_2]*

Sally supports Helen in suggesting that as 'a father', her partner's sense of responsibility and innate understanding of the baby's needs is simply not as strong as hers. Her narrative goes further than Jane's in questioning the fairness of imposed 'gendered parenting roles'.

> *...his life hasn't changed and yours has changed completely, I haven't said anything but I do think 'its not fair, you know its not fair I mean he'll help out a bed time and that which is nice but he's not I'm always with her totally throughout the day... trying to get him to see she was crying yesterday and he just put her in her pram and left her and I said 'you can't just leave her crying' and he said 'you can't pick her up all the time' and I said' yeah but she's been crying quite a long time' and he can do that he can cut off from her or whatever but I can't leave her to cry I can do it for so long but then I have to pick her up and check she's alright...and than I get mad because things have changed and he's got to be different and I see that. He can go away and have a bit of a break and adult conversations and I get a bit you know [Sally_3_1]*

Kate supports the concept of an 'opt out clause' for fathers in narrating how fatherhood for her partner, because they are separated, does not carry the same intrinsic responsibilities that motherhood carries. Kate's role as 'a real mother' involves an inescapable responsibility for the baby despite the end of an intimate relationship.

> *I was worried about how I would manage, but his dad hasn't seen him, I just don't know when or if he'll get over... [Kate_3_1]*

Mary goes on to demonstrate that significant actantial influence that the 'institution of motherhood' plays in defining the designated roles that denote 'good mothers'. She shows the personal emotional impact that responsibility carries when women feel they are failing and are 'bad mothers'.

> *...he was screaming he was obviously hungry and I just couldn't get him on I couldn't get me head around it and I couldn't think and I was just crying 'I'm just not being a very good Mum...the responsibility overwhelms me a little bit [Mary_3_1]*

Polly here narrates the responsibility for the baby as hers, underpinned by a fear of being a 'bad mother', with no reference to her partner at all. There seems as with Mary earlier an implicit loss of personal identity, that of a person in control who existed prior to the 'birth of the baby'.

Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

> *I've got to admit the first three weeks I've been absolutely petrified to the point where I've felt like a frightened little child...I like to be in control and to all of a sudden have this massive responsibility and not really know what to do with it because you've never experienced it before I found quite overwhelming... [Polly_3_1]*

'Midwife experts' as Polly's story continues, go on to exacerbate a 'bad mother' identity. The midwives create an actantial identity where a 'good mother' breastfeeds and Polly's failure to achieve this locates her as a 'bad mother' and a failure.

> *I wanted to be the best mother I could and by not achieving the breastfeeding aspects I was actually failing...the other things are insignificant, the nappy changing the bathing etc but the breast feeding is such a big issue and the midwives and everything leading up to it in your pregnancy give such an importance to breastfeeding...but when its not happening it makes you feel you're failing [Polly_3_1]*

Polly accepts total responsibility for feeding choices and so her guilt and feelings of failure are personal. Her partner is sidelined and located as someone who is unable to engage with or understand a prioritising of the baby's well-being over Polly's own.

> *You completely change once you've had that baby and anybody like James saying don't worry its (breastfeeding) not a matter of life and death it was to me [Polly_3_1]*

Helen reinforces how being a 'good mother' is inexorable and linked to her baby's very survival.

> *...I just wanted to do what was best for her; I really did think the worst when she was ill, I thought she was going to die... [Helen_3_1]*

There are 'culturally mediated standards' of the 'institution of motherhood' to adhere to and things to do right that depict a 'good mother'. There is importance attached to coping, even though her partner is present as 'a father' and undertaking childcare tasks. Rob below is actually depicted as being detrimental to the organised family environment. This might suggest that the relegation of fatherhood is actually fundamental to women in promoting their status as a 'good mother'.

> *Before she was born I had everything done by a certain time....so it was getting to half past twelve and I wasn't dressed and Amelia wasn't dressed, I'm tripping over Rob, he's doing bottles, it was just organised chaos and I'm*

Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

thinking I'm never gonna get the hang of this...I was saying I can't cope and I'm not doing it right [Julie_3_1]

The actant 'ideologies of mothering 'and the 'institution of motherhood' set the cultural and societal standards that women strive for as 'a real mother'. These standards invest women with a 'gendered parenting role' and a fundamental responsibility for their children; such a responsibility is absent from their perceptions of fathering. Despite contemporary notions of parenthood as a joint venture, in which both parents have responsibility, in their narratives women remain constrained by the societal norms of themselves as both the natural and default carer and are complicit in relegating their partners to the traditional support and back up role.

Societal expectations have a powerful effect on women; whilst they strive to achieve traditional depictions of a 'good mother' constrained by 'culturally mediated standards of motherhood', complexity is added by 'contemporary notions of fathers' as active parents. In some narratives women locate themselves as part of a fulfilled and loving family, based on cultural and media depictions of 'an ideal modern family life'. References to bonding depict an actantial 'father' investing in an emotional relationship with his baby, in contrast to the previous depictions of him as simply less involved and responsible.

...Matt and I felt a need to bond together as a family ...you need to don't you, to get to know him first [Mary_3_1]

I wanted us all to bond together [Julie_3_1]

The experience of being 'a real mother' for women is physically and emotionally demanding. In addition there is a suggestion that women feel they are only 'a mother and unable to be what they were before birth. 'A father' in general is not perceived as having to adhere to equivalent standards or make the same life changes. This depiction of the fathers as less involved, less responsible and less engaged in their roles is an apparent extension of the role women allocate their partners from early pregnancy.

Summary of Early Postnatal Findings

Early postnatal narratives, which reflected on labour, emphasise the powerful role that 'experts' play during women's labour experience in depriving them of control and choice. The continued aspiration to be a 'good mother' disempowers women in labour and reinforces 'expert' power. Moreover the language used by experts suggests that it is women's own inadequate labouring performances that are responsible for any loss of

Actants/Actantial Influences are depicted in blue
Women's identities are depicted in red

choice and control The emotional ramifications for some women of being located as a 'maternity patient' and robbed of the desired birth experience promised through choice are apparent. Consumerist discourse offers women access to 'romantic notions of birth' whilst 'the medical discourse' retains the authority to override such aspirations. Whilst women have performed a form of mothering during pregnancy the reality of mothering following birth is narrated as both different in content and as a shock to women in this early postnatal period. The actantial role that societal discourses around 'parenting' and 'traditional gendered roles' play is inherently forceful in women's adaptation to a 'real mother'.

Chapter 7b: Late Postnatal Period (6 months)

Introduction

The fourth interviews took place six months after the women had given birth. In this late postnatal period, the 'good mother'/'bad mother' dichotomy, as it has throughout, remains a consistent actantial identity for women. Many of the actantial discourses and influences present from early pregnancy including 'experts', ideologies of motherhood, and 'idealised notions of birth' can still be seen, though they are articulated differently by this time. One theme remains consistent with earlier findings:

- Experts and Expertise

The new themes evident include:

- Reflecting on Labour
- Choice and Satisfaction
- What about Postnatal Choice?
- Maternity Experience, Choice and Postnatal Depression

As in earlier findings Helen and Mary's narratives will feature strongly, with quotes from other women being used to illustrate the themes identified.

Reflecting on Labour

Women's reflection on their birth experience tended to be much shorter, more general and less graphic than in their early postnatal narratives, and reflect a more positive story of labour than in the early postnatal period as in Helen's account.

> *No, no, I'm just glad it was a quick one, not a long drawn out thing. I was quite happy with a nice quick one, I don't think I could be 24 hours and I can't stand pain but I expected it to be quick though, I expected to be early and I expected to be quick and I was [Helen_4_1]*

Some women's memories are not reflective of actual events, but are consistent with their early postnatal accounts which situate labour as a positive experience. Others however who were negative in the early postnatal days continue to remember labour in negative terms. Polly is typical of the first group of women. During this interview she focussed on feelings rather than the experience of labour itself. In addition she reinforces the idea of an idealised experience '*it was almost like a textbook pregnancy and birth*'.

> *It was such a nice experience and it was enjoyable really all the way through, I was never in any real discomfort I remember everything as if was ...all the memories I have are nice and pleasurable and I wouldn't hesitate to go through*

> *them again ...everything went smoothly and it was almost like a textbook pregnancy and birth [Polly_4_1]*

Jane typifies the second group of women; again there is a focus on feelings and a refusal to recount the actual experience of labour. These feelings clearly inform her intentions not to have any more children.

> *Yea I'm over it now, it's still upsetting but I'm still not planning another one ...we don't dwell on it... [Jane_4_1]*

Sophie's account of her disappointing labour experience is like Jane and Polly's devoid of any detail but reflects the ramifications of unfulfilled choice.

> *I was going to write a letter to complain, I just think I can't be bothered...it was bad at the time...I think if I'd known that I could have gone through it without an epidural which is the only reason why I went to the main unit I would have preferred to have gone to the birth centre it sounds a lot more chilled out and you get a lot more better care but you can't undo it now [Sophie _4_1]*

Experts and Expertise

Despite the comparative brevity of these accounts at this stage, 'experts' remain an essential aspect of the women's labour experiences. In Sophie's account (above), she is suggesting that choices for site of birth are made on judgements of available expertise. Failure to be able to access the type of expertise which informed her choice leads to dissatisfaction with her experience. Mary here, as early post delivery, does not question 'expert's' decisions and advice. Here we see the continued promotion of her 'good mother' status as she stresses her contribution towards spontaneous labour.

> *Gosh it's much harder to remember now, they were monitoring my blood pressure anyway, and they sent me in because it was high and decided to induce me, I had some prostaglandin and I think about 12ish they came to break my waters but they thought I was going into labour myself. Then about 9 o'clock I was starting to get some pains. I coped quite well I thought then a bit later the pains were starting to get a lot stronger and the midwife came in and suggested an epidural because the anaesthetist was going into theatre and it might be a while before I could have one, so I did. [Mary_4_1]*

Mary's narrative depicts her as willingly relinquishing control of decision making in labour. A feasible proposition is that offering choices for maternity care has failed to facilitate a fundamental shift in power from 'experts' to women in labour. Midwives and doctors are often not clearly differentiated and both hold powerful if slightly differing roles as 'experts'. Hence, women question their own innate sense of their bodies

('personal knowing') and consequently their judgement and their choices. Mary was devolved of decision-making and personal control by midwives with regard to pain relief in labour, 'expert knowing' was accepted as superior and overruled 'personal knowing'.

> *...I was glad she suggested it really, because the pains were getting much worse, I was coping but didn't think I would for much longer. I didn't know when to ask for pain relief, I didn't know whether the pains were really bad or whether I just wasn't coping and I didn't want to seem like a wimp, I mean I'd asked for gas and air earlier on and they said 'oh no you don't want that' so I sort of thought 'oh I must seem like a right wimp'. Also they were going to start syntocinon and she said the pains would get really bad... [Mary_4_1]*

This earlier removal of power and decision-making created an environment in which Mary felt unable to articulate her personal choice with regard to delivery preference.

> *...The doctor came in and examined me and I'd got to 10 centimetres and Josh was face down so he said that he could do a high forceps, which was the only thing I really didn't want, or a section, I thought 'I wish they'd just go for a section because I really didn't want a forceps delivery anyway he came back and he said he'd spoken to the consultant and that he said to go straight for a section and that was it... [I: Did you say you would have preferred a section?]No, no I didn't... [Mary_4_1]*

Jane equally did not feel able to question an unwanted intervention based on 'expert' advice to ensure the safe delivery of her baby. She also displays her 'good mother' identity in the self-sacrificing of her own personal satisfaction for her baby's well-being.

> *yea that's it at one point I thought I was going to have to have a caesarean and that was another thing I just didn't want but at the end of the day it doesn't matter what more important is that he just comes out OK [Jane_4_1]*

Models for choice assume that women feel able to exercise their rights and make choices when in fact they remain constrained by the belief that 'experts' know best and to question that knowledge may well result in detrimental outcomes, which can then be directly attributed to the women themselves as 'bad mothers'. What has remained consistent throughout is that women prioritise their baby's well-being above their own in all choice and decision making throughout the maternity period.

> *I mean I was upset because things weren't going to plan and I don't like that and then I just thought he's got to come out and that's the main thing and he's gonna be alright and that's the most important thing just get on with it... [Jane_4_1]*

Despite the disempowerment that women clearly experienced, a good outcome particularly when women are labelled as 'abnormal pregnant women' and situated as 'maternity patients' acknowledges the 'experts' as playing a heroic role.

> *I was quite frightened at that time about Josh I mean and my baby was paramount, more important than me. I happily relinquished that responsibility; they were brilliant all the midwives were great and the doctor [Mary_4_1]*

'Experts', despite claims to support choice in pregnancy, retain control over when choice is appropriate for women and hold the power to remove choice. Women through their 'good mother' identity prioritise their babies and relegate their own personal desires, which consequently reinforces the role of 'experts' in retaining control over women's maternity care and choice.

Choice and Satisfaction

Choice which is offered in early pregnancy has been illuminated as complex and certainly not the simple concept that is presented to women. 'Consumerist and feminist discourses' play actantial roles in constructing women as desiring the right to make choices about the type of birth experience they want. Many women however make choices with no real knowledge of what is ahead in pregnancy or labour and choices made based on the type of experience desired, for example 'romantic notions of childbirth', may not be fulfilled. When events mirror the choices they have made women are generally more satisfied as seen in Mary and Polly's account below. Indeed women's narratives mirror their rationale for choosing a certain type of care and site of delivery and demonstrate they made the responsible choices of a 'good mother'.

> *No I was happy really with everything, although my GP would want to see me next time apparently he likes to see his pregnant ladies but I didn't know, I was really happy with the midwives they're more confident anyway and whenever they were concerned they referred me. I still would have made the choice to deliver at the main unit regardless of my blood pressure I felt happier having that safety net, I mean I was happy with the midwives but then the doctors were around just in case. [Mary_4_1]*

> *...with regard to the labour I was happy all the way through and happy with the midwife although I liked the reassurance of the doctor... [Polly_4_1]*

Helen, following a third normal delivery despite having been labelled as an 'abnormal pregnant women', now claims she feels empowered to challenge the system. By denying 'expert' labelling three times and proving herself a 'normal pregnant woman' she feels authorised to demand the type of delivery that she feels would be best for her, her baby

and her existing family. She reiterates here the role of the 'GP gatekeeper' as a barrier to choice. Her earlier narratives however demonstrate that previous normal deliveries did not facilitate her ability to be assertive, constrained by notions of responsibility and fears of being labelled as a 'bad mother'. This illustrates how barriers to choice are multi-faceted and illuminates some of the difficulties this presents in offering real choice.

> *I'd want a home birth this time, next time, I mean, if I had another one, I would elect for home birth but I wasn't given that choice, I was basically told that if I made that choice he wouldn't be my GP [I: Would you act differently another time?] Yeah I would I'd put my foot down and demand a home birth. If you're not going to be my GP fine, I'll find another one that will...I mean I've had three, I've had no complications, they've all been early but no complications... [Helen_4_1]*

Jane's narrative is an example of those women who suffered from unfulfilled choice. Her story exemplifies how the concept of choice can be unrealistic.

> *I don't think we realised how big a thing it was and nobody can say this will happen and that will happen and that's the worst thing you just don't know what's gonna happen to you, you can have all the birth plans in the world but potentially it can still go wrong [Jane_4_1]*

The result of unfulfilled choice for Jane is a sense of failure to achieve the natural birth that had been offered by options for care. This 'idealised notion of birth' that natural is better generates a 'failed woman' identity in women who feel they missed an experience that is fundamental to their womanhood.

> *I would still choose to have a natural one at the Birth Centre I'd still like to experience that and I feel a bit robbed in a way that I haven't experienced it...* [Jane_4_1]

Mary equally suggests that natural creates a greater sense of satisfaction and achievement.

> *...you know given the choice I would have wanted a natural, you've got to try [Mary_4_1]*

Choice is presented to women as a simple consumerist decision which asks them to consider lead carer during pregnancy and birth environment, linked to the type of maternity experience to which they aspire. These women's narratives have consistently shown however that choice and decision making in pregnancy is much more intricate. What seems significant here is in offering choice, the failure or refusal to fulfil that

promise has clear ramifications which may have more negative repercussions than never offering choice at all.

What about Postnatal Choice?

Women's accounts throughout have demonstrated the actantial roles of 'societal depictions of motherhood' and the standards that women feel compelled to achieve in order to depict themselves as 'good mothers'. Many women perceived postnatal input as significant in facilitating their 'good mother' status. Postnatal care is the one aspect of maternity care in which women are offered no real choice. Care is provided by the midwife for a maximum of 28 days following birth and often removed earlier based on the midwife's judgement of the mother's needs (Silverton 1993). The puerperium involves the maternal recovery from labour as well as adaptation to the role of 'a real mother'. Studies have heralded modern maternity care as highlighting the social and psychological aspects of care, reducing emphasis on physical care in the postnatal period (Ball 1988). In contrast to the constructions of women's health in pregnancy and during birth, it is assumed that postnatal recovery is more rapid and requires much less in the way of care (Woollett & Marshall 2000). Mary narrates how such an approach left her feeling uncared for, unsure of what was expected of her and unsupported in her attempts to be a 'good mother' and care for her baby following surgery.

> *...the community midwives were great but the care on the postnatal ward was a bit inconsistent it depended who was on really. I mean they were obviously really busy but sometimes I was just left on my own some shifts, I was OK but I did think gosh if I was on any other ward I wouldn't be doing so much after abdominal surgery. I mean the first day I got up and bathed him and everything, I felt great but I did suffer that night I was really stiff and in a lot of pain, but no-one told me how much to do. The midwife that night was really nice, she gave me an injection and it was fabulous but then I asked for one the next night and the midwife was horrified 'oh no you don't need an injection' and she gave me two tablets instead, she made me feel like a wimp really, I felt awful for asking [Mary_4_1]*

Polly goes further and implicates the postnatal staff as detrimental to her 'good mother' status through their failure to support her to breastfeed.

> *The only thing I would do differently was on the postnatal side ... Next time I'd just really like to crack the breastfeeding and you don't get the one to one on the postnatal ...I felt that if I rung the bell I was a burden and that everything you had to do for your baby was up to you and I think if I'd had more time in that first 48 hours trying to resolve the feeding issue that I wouldn't have had the problems when I got home [Polly_4_1]*

Sophie narrates an almost complete absence of care. Her account here suggests that midwives use their expertise to make judgements about who is the most deserving of their support which does not involve any consultation with the mothers about their personal needs for care and support.

> *I was put in a four bedder completely on my own but I felt a bit in the middle of nowhere and I only buzzed once and they came but I never saw them again maybe they think its because its not your first that you can just get on with it... [Sophie_4_1]*

All the above accounts narrate an 'absent expert', who fails to support the women in their own recovery and return to 'non-pregnant woman'. Kate describes how postnatal care gave no consideration to her personal needs and afforded her no choice in decision making.

> *...I didn't like it there (postnatal ward), the only down thing was when you want to go I got told in the morning I could go home but I didn't get to go until later on in the day so I'd rather they didn't say anything to you at all. [Kate_4_1]*

Helen narrates a different story of satisfaction with the postnatal care. Her increased input however was based on a clear clinical need for 'expert' involvement and care.

> *Yeah I wasn't really in long enough to find out but they were alright, real nice and that and the after care was alright as well. The midwives who came to see me at home were real nice...she (health visitor) always pops in cos she knows I was post natal (depressed) so she pops in about once a fortnight to make sure that I'm still here, to make sure I haven't done anything daft, yeah she's real nice. So my postnatal care has been better than before she was born... [Helen_4_1]*

Sally in contrast felt that the midwife through 'expert' judgement withdrew postnatal care at a time when she still felt the need for support. Sally given a choice would have preferred continued input.

> *You had all this midwife coming round and people coming round then it all stops and leaves a big gap...everything just seemed to stop ... [Sally_4_1]*

Women's narratives suggest that postnatal input both in the hospital and in the community plays a key role in women's early adjustment to 'a real mother' identity. Beyond that they believe it is fundamental in helping them to achieve a 'good mother' identity. Postnatal care however presents no real choice in a maternity culture, where choice, although often elusive is being actively promoted. Women receive significant input during both the

antenatal period and labour, yet at a point where support is perceived by them as equally if not more important and as integral to their 'good mother' identities, skills and self-confidence, women feel let down and disappointed.

Maternity Experience, Choice and Postnatal Depression

Four of the women, Helen, Sally, Jane and Sophie, suffered from significant but differing levels of emotional distress post delivery. Helen and Sally were both clinically diagnosed with postnatal depression and their narratives will be explored in depth in order to further explicate the findings from the quantitative study. What became apparent in trying to provide some interpretation of these experiences is the contrast between the women's stories when relating their experiences but also the evident actantial similarities. What is also marked is the need to consider women's pregnancy, birth and postnatal experience as a whole, and the complex interplay of women's individual physical, social, and personal biographic realities.

Helen's story has featured throughout this chapter. Her maternity narrative to date tells of an unwanted pregnancy, plagued by physical health difficulties. Categorised and reinforced throughout her pregnancy by 'experts' as an 'abnormal pregnant woman', she felt unfairly labelled and devoid of a real choice. Her wishes for a birth centre delivery remained unfulfilled, premature labour situated her as a 'maternity patient' and although her labour was clinically straightforward, it is generally described in negative terms. Experiences throughout pregnancy challenged her 'good mother' identity and promoted her fears of being a 'bad mother'. In the early postnatal period Helen's baby daughter became ill and was hospitalised, leaving Helen with a dominant 'bad mother' identity infused with feelings of guilt and failure. Her late postnatal account tells a story of complete exhaustion and is consistent with the findings of Graham (1993 in Gatrell 2005) who described women as feeling a responsibility to 'keep going', leading them to try and ignore fatigue, amongst other physical symptoms. Her narrative epitomises this claim but also demonstrates how the 'keeping going' is through a continued need to promote a 'good mother' identity. Here the pressure of being a 'good mother' to her new baby, conflicts with her need to be a 'good mother' to her other children and to continue to effectively perform her perceived domestic labour role.

> *...the first 4 months she was an absolute nightmare. She was asleep all day and awake all night. She would literally come to life at 10pm and not go back to sleep until 6am. No matter what you did to keep her awake during the day nothing worked... [I: How did you manage?] With great difficulty! I just never got any sleep at all...during the day I'd go to bed as soon as she went up in the*

> *morning and then the housework was piling up so I was doing the housework at like 2am and 3am, ironing, washing and cleaning to get it done but she was 17 weeks before she slept through. She was asleep during the day no bother but night time .... even during the day I wasn't getting much rest either, I mean she'd go over at 6am and then the other two were getting up... Knackered! I felt really, I didn't know what day of the week it was... [Helen_4_1]*

Helen's feelings of inadequacy build on early guilt that she had been a 'bad mother' not instinctively noticing an early postnatal problem, which resulted in her baby being hospitalised. This comment that *'she's gonna be one of these babies'* acknowledges her attempts to provide an alternative explanation for her baby's behaviour, which she as a 'good mother' should have recognised as abnormal. Explanation for this normalising of her baby's behaviour, however, could feasibly be grounded in Helen's late pregnancy narrative. In late pregnancy we saw Helen begin to determine her baby's characteristics, by using the adjective '*awkward*'. This labelling of her baby continues into the postnatal period and results in a failure to recognise a problem, which despite seeking 'expert' advice, Helen takes responsibility for.

> *I blame myself in a way because I think why didn't I pick up on it? I mean she was born the Tuesday and I had a real bad night with her the Tuesday night, not really feeding properly just about 5 minutes, she wasn't really feeding properly and she was crying all night, and I just thought a new baby she's gonna be one of these babies and then Wednesday night she was a bit better but a bit the same and Thursday she wasn't very well and I spoke to the midwife and the midwife said she's probably got jaundice but I did sort of feel it was my fault I should've taken her on the Wednesday and said I think there's something the matter with her, I just ignored it really [Helen_4_1]*

Sally's maternity profile is entirely different to Helen's. Her initial thoughts about her pregnancy were somewhat ambivalent, however her pregnancy and birth experience were generally good and she was satisfied with the choices she made for care. Interpretation of her postnatal depression seems apparent in her articulation of the whole experience of 'a real mother' as a new social role completely overwhelming and traumatic. Her narrative is infused with feelings of vulnerability, loneliness and isolation, which in addition highlight the failure of postnatal aftercare to adequately assess her psychological health needs and necessary input in the postnatal period

> *I just felt really miserable, everything in my life had changed completely it was just me and her, I couldn't go anywhere or do anything I just felt also I missed people because I'd always worked with people and I just felt really isolated I felt I needed people around me but it was like a chicken and egg because the minute they disappeared I just sit down and start crying really really crying [Sally_4_1]*

Sophie had a good pregnancy but as shown previously a negative birth experience, created by the feeling of loss of choice and control during pregnancy. Her own account does not make a direct link between her experiences and her subsequent emotional response, nor does she describe herself as depressed but she does articulate a state of emotional vulnerability that is out of character.

> *I would have days where I'd just have outbursts of tears and then I'd take it out on Karl and then I'd be crying in bed which just wasn't me you know I'd never been like that before...[Sophie_4_1]*

Interestingly Jane, who in the early postnatal period was very emotionally distressed and tearful about the lack of control and loss of choice she experienced in labour, is in the late postnatal period much more pragmatic. The enduring emotional impact of her experience is evident in her decision not to have more children, yet her narrative does not display the emotional vulnerability visible in Sophie's account.

> *Oh yea I'm alright about it now, as you can see I'm not in tears, I've got over that... I'm over it now, it's still upsetting and I'm still not planning another one ...we don't dwell on it but if it's brought up its still distressing [Jane_4_1]*

The guilt inherent in Helen's previous account is also evident in Sally's narrative below, although revealed in a different context. Here 'cultural standards of bonding' which influenced women during pregnancy feature strongly in positioning Sally as a 'bad mother'. She articulates feelings of failure, exacerbated by the reaction of others around her, hence sending her further down the spiral of emotional distress.

> *I think the worst bit was that I felt I wasn't bonding with her and then I started to get upset about that because it was another stress because everybody bonds I didn't feel I wanted to play with her or do things with her, my Mum said one day I was lucky to be able to spend time with her and I said 'I'm not lucky' and she was really upset... I just felt so low and isolated and I thought nobody understood and I also felt like I was the only one and I thought as a mother this shouldn't be happening you should be bonding with your baby... [Sally_3_1]*

Pressure from significant others also featured significantly in Helen's narrative. Here, she refers to pressure exerted by her partner. Her account echoes the traditional construct of the woman as 'the domestic labourer' (Gatrell 2005), despite the demands of new motherhood and the specific difficulties encountered by Helen following the birth of her daughter. This confounds her feelings of failure and results in worryingly irrational and extreme thoughts.

> *Yeah, yeah, I would have tried anything including jumping off the ... Bridge. I would have tried anything and he was getting on my back when he came back from work on a weekend saying the house was a tip, can't you do no bloody cleaning these days... [Helen_4_1]*

As discussed by Gatrell (2005) the 'gendered discourse' that traditionally depicts women as responsible for childcare and domestic tasks was evident. Sophie reflects Helen's positioning by her husband as 'the domestic labourer'

> *...he's got it easy and sometimes he'll say you don't do any tidying up and I think god if that's all you've got to worry... [Sophie_4_1]*

The 'domestic labourer' identity was particularly evident in the narratives of women suffering emotional distress post delivery. This fostered resentment towards their partners which was expressed, but the perceived inequity, although questioned did not appear to be fundamentally addressed with their partners. It is possible that this failure to challenge is a consequence of their emotionally vulnerable state.

> *I was thinking I've got three kids, nobody to help me, he's never at home to help me, he's only home at a weekend, she's like she was, I wasn't getting any sleep, so ...[I: Did you feel quite resentful towards your husband then?]To start with yeah, even when he came home on a weekend, he wouldn't do anything on a weekend he works all week and doesn't see why he should have the kids on a weekend...he doesn't see why he should have to get up and sort her in the night...I mean it wouldn't have hurt him to get up, you know ...while I went to bed for 12 hours but he wouldn't do it. [I: Did he not realise how difficult it was for you?]Well he did but, he just classes it as he works all week and I don't do anything so... he works all week so his weekends are his time for relaxing and unwinding [Helen_4_1]*

Partners as in the early postnatal period are cited as unprepared for and insensitive to the adjustment in social identity that goes with motherhood, compounding the emotional distress women experienced. Sally narrates how once again the 'institution and ideologies of motherhood' place demands and expectations on women that are beyond those associated with fatherhood. This account reports a continuation of the lack of being cared for, that many women articulated in the early postnatal period.

> *I felt that John wanted this baby but it was me stuck with her and doing everything, his life hadn't changed and mine had changed so dramatically and I just felt so low and isolated and I thought nobody understood and I also felt like I was the only one and I thought as a mother this shouldn't be happening you I sometimes found him not as supportive as he could have been I found my Mum and Dad supportive...I needed looking after and he couldn't do that and because I had my Mum and Dad he didn't feel obliged even now he doesn't*

understand... I really don't think Men can understand it and I think they could do with education a bit more [Sally_4_1]

Jane, however, recognises that it is her compliance with the social constraints of 'gendered parenting discourses' in identifying herself as a 'good mother' that dictated her postnatal emotional adjustment, rather than a failure on her husband's part to meet the expectations of his role as 'a father'.

I think the smallest things like if Paul was late home from work I'd just create and I can't really explain why I was like that...his life hadn't changed at all he could still go climbing and play football and I couldn't go out because I had to feed Luke and I felt awful I shouldn't feel like that but I did start to resent it ...it was me feeling guilty and even asking Paul to have him I was bigging it up if you like that I shouldn't want to leave him [Jane _4_1]

Partners exerted other additional pressures, which challenged women's tentative 'good mother' identities, as in Sally's account. She feels threatened by her husband's apparent ease and ability to bond with their daughter, and the relationship that is evolving between the two.

I always feel like every now and again I have to step back he'll walk through the door and she's laughing I am bonding with her now definitely but she doesn't laugh as much with me and I have to take a step back and think I'm not such a bad mother I care for her and feed her and just because I don't make her laugh 24 hours a day doesn't make me a bad mother and that was another thing I was beating myself up over... [Sally_4_1]

The guilt that infuses these narratives is exacerbated by feelings that women have no right to feel miserable or unable to cope and that they should be grateful for a healthy baby, particularly when there is no identified tangible reason for depression, as in Sophie's case

...just crying because I felt miserable but there wasn't really a particular problem people would think what's your problem with Billy he's such an easy baby but there was just lots of things...[Sophie_4_1]

You get this little person and your world turns upside down and I just couldn't get over how I was an intelligent person with a good job and yet I couldn't cope...I had more company than I'd ever had yet I felt so lonely [Sally_4_1]

All women expressed feelings of loneliness and isolation.

I think I just needed adult conversation more than anything, I think that's what I really needed. I'd had the kids all week you and he's home on a weekend and

> *I've still got the kids, if I was going anywhere it was like take all the kids with you and I just didn't get any adult conversation.... [Helen_4_1]*

> *I just felt really miserable, everything in my life had changed completely it was just me and her, I couldn't go anywhere or do anything I just felt also I missed people because I'd always worked with people and I just felt really isolated... [Sally_4_1]*

Work is mentioned by Sally above and clearly articulated by Sophie as a way of regaining the 'personal identity', the 'me' they perceive they have lost following the 'birth of the baby'.

> *I do feel a bit lonely and think there must be more I do think god it will be nice to get back to work just to be around adult people I do see my friends but just to do something different... [Sophie_4_1]*

Jane's narrative demonstrates how returning to work was key in regaining her 'me' identity and perhaps affords some explanation of why her emotional distress despite a traumatic delivery was less enduring.

> *...I needed adult conversation I mean even though I was seeing adults everyday all the conversations revolved around Luke and its nice to go to work I knew I had to get back to work even now months on I am getting out and Paul is very good but ...I'm only just starting to get my own life back [Jane_4_1]*

It is significant that Helen, Sally and Sophie narrate the difficulty of openly acknowledging mental health problems and the stigma associated with antidepressants.

> *I didn't tell my husband I was on them though, he is one of these that doesn't believe in things like that he thinks it's just a cop out of saying that you can't cope... [Helen_4_1]*

> *...close people said go to the doctors but I didn't want to go down that line because once you start on tablets that I can't get off and then going back to work on antidepressants won't do me any good but its gone full circle and me and Karl have been talking more [Sophie_4_1]*

Sally articulates a desire to avoid being labelled as 'postnatally depressed'.

> *It took me a while to go to the doctors because I really didn't want to go down that route but I did because I just needed to get on with my life [Sally_4_1]*

Helen narrates how behaviour can become extreme in the face of postnatal depression and how this behaviour finally revealed the severity of the situation.

> *I think the final straw for me was before I went to the doctors, he came in at tea time and said I want my tea on the table at 5 o'clock and he sat down ...at the table so I did put his dinner on the table, meat, peas, carrots, gravy all on the table and he said what's this, and I said you never said you wanted a plate, you wanted your dinner on the table so there it is on the table and the kids were sat there howling with laughter. And he said I think you should see a doctor and that was the final straw cos I thought maybe I have gone a bit over the top...I locked myself in the bathroom and cried my eyes out, I was in floods of tears and I wouldn't open the door for about half an hour...[Helen_4_1]*

Both Helen and Sally's accounts tell of a frightening reality which made it imperative to seek some help. Although previous work has suggested that GP's often fail to take women's depression seriously (Kitzinger 1992 in Gatrell 2005), both Helen and Sally found support from their GP's

> *I mean it had got to the stage where I was screaming blue murder, I could've killed the kids I really could've. It got to the stage where all they'd do is walk past and I'd just scream at them, throwing pots and smashing them, and I'd walk into town and burst into tears in the middle of Woolies, I just felt absolutely awful. And I just went to the doctors and told him how I felt and he put me on the tablets and you know [Helen_4_1]*

> *I ended up living at my Mums for 3 months I got worse as the weeks went on ...but then they were going away and I needed to be able to cope on my own and so I went to see the doctor and he put me on some tablets basically and they've been brilliant I'm still on them now [Sally_4_1]*

Despite the support experienced from their GP's neither Helen nor Sally were offered any alternatives to medication. Both, interestingly, have gone on to build their own informal support networks, which seem to address the isolation and loneliness aspects of suffering postnatal depression.

> *...we get together every week, every Tuesday and there's a woman whose husband works offshore so she understands and I feel its not just me because we talk about babies, we talk about other things but we talk about how we feel as well so its just good support [Sally_4_1]*

> *...I have coffee mornings across the road when the kids are at school [I: Is that a friendship you've built up since you've had her?] No we've always been friends, but since I've had her obviously I couldn't really do it because she was always asleep during the day, she was always in bed so it's only in the last few months that I've been able to start going across [Helen_4_1]*

Women with postnatal depression remain plagued by 'ideologies of motherhood', 'gendered parenting discourses' and 'traditional notions of domestic women', positioning

themselves as 'bad mothers' during their period of depression, out of control and unable to function effectively in their role as 'a real mother'.

> *I felt like I'd jumped out of an aeroplane and the parachute was failing, I couldn't get control of anything, the house, the kids, the dog, I just couldn't shake it off and I was thinking why am I getting out of bed this morning, I just didn't want to get up, didn't want to go out. [Helen_4_1]*

> *I feel guilty that for the first few months she was shunted around just to be with people and I didn't interact with her and I felt guilty and now I feel better I've decided to take the year off to make up that lost time with her... [Sally_4_1]*

The context of the emotional distress articulated by these women was very different and evolved out of a milieu of individual antenatal intrapartum and postnatal events, circumstances and adjustment following delivery. The women themselves did not directly attribute their psychological distress post delivery to any pregnancy or labour events or to unfulfilled choices, they saw their distress merely in the context of postnatal events. Failure to fulfil choice whilst seeming to impact on some women's emotional maternity experience is only one of the many negative factors experienced by these women and cannot, in these narratives, be attributed the status of a single causative factor. The guilt, sense of failure, loneliness, isolation, loss of control, inability to cope, loss of personal identity, stigma and lack of support that is inherent in the experience of postnatal depression displayed in these women's narratives is both frightening and distressing. The continued perfusion of many idealised societal discourses position these women as 'bad mothers', at a time when they lack the emotional resources to restore their 'good mother' identities; as they are equally struggling to cope with the physical recovery of pregnancy and permanent tiredness, compounding the downward spiral of psychological distress. Their accounts clearly support an individual, multidimensional, psychosocial model of postnatal depression. Unless necessity forced them to seek help, there was no accessible postnatal aftercare other than routine care. This is withdrawn, based on 'expert' judgement rather than through an interactive and negotiated discussion with the woman. Particularly for this small yet extremely vulnerable group of women, this appears to be a serious omission in the choice debate.

Summary of Late Postnatal Findings

These late postnatal reflections highlight the embedded nature of 'experts and expertise' within women's labour experiences, reinforcing both the pregnancy and early postnatal suggestion that the consumerist choice discourse in maternity has not been accompanied by a fundamental shift in power away from 'experts' to women. Expert knowing maps

onto women's aspirations to be 'good mothers' and constrains their ability to exercise their rights, maintain control and make choices. The choice discourse furthermore fails women in the postnatal period. In contrast to the 'expertise' that assails them in pregnancy and labour, the postnatal period is depicted as a time of minimal support which is then withdrawn without any consultation with the woman herself. For those women who suffered postnatal emotional distress their narratives depict a complex psychosocial experience in which societal discourses position them as 'bad mothers' and the promotion of themselves as 'good mothers' becomes increasingly difficult.

Summary of Postnatal Narratives

This chapter has explored how following birth the mothering role adopted in pregnancy is strengthened by the birth of the baby, but is different in content and as such a shock and overwhelming to many women. The personal responsibility for the well-being of the baby continues from pregnancy. Partners roles although now perceived differently by women, are largely informed by gendered discourses around parenting. This continues to relegate fathers to a secondary parenting role and additionally pressures women's good mother aspirations. The role of experts and expertise remains a powerful narrative, answering the question raised at the end of chapter 6 as to whether the dominance of expertise would diminish following delivery. Indeed the surrendering of control to experts, as in the antenatal period, is not only often welcome but desired and is perceived by women as facilitating their 'good mother 'status. The postnatal findings reinforce the suggestion that women, throughout their maternity experience, sit within a complex matrix of actantial influences and discourses. Within this multifaceted environment for many women, choice is often an elusive or unfulfilled concept, the ramifications of which clearly merit further consideration. These findings will be explored further in chapter 8, which will utilise the interpretations of the women's maternity narratives to underpin and contextually illuminate the quantative findings of chapter 4.

Section D

Integration, Illumination and Conclusion

The following section presents the concluding section to this thesis. Chapter 8 will present an integrated discussion of both the quantitative and qualitative findings, across women's maternity experience. The presentation of the results in this way, is in line with the conceptual triangulation approach adopted and presented in chapter 2. Chapter 8, in addition, fundamentally addresses the third research question posed in this study.

How do the context of women's pregnancy, childbirth and early motherhood experiences relate to quantitative dimensions of psychological well-being?

Chapter 9 outlines the study limitations and provides both a reflexive account and some methodological thoughts with regard to this research. This aims to promote transparency and confidence in the conclusions presented in chapter 10 of this thesis. This final chapter will utilise the discussion of the integrated research findings in chapter 8 to theorise, critique and draw some final conclusions around choice in maternity care.

Chapter 8: Integration and Illumination

Introduction

The following chapter presents the integrated discussion of both the quantative and qualitative findings and aims to address the research question:

3. How do the context of women's pregnancy, childbirth and early motherhood experiences relate to quantitative dimensions of psychological well-being?

The chapter will be structured through the quantative findings in order to provide a coherent structure. It will show how the women's narrative accounts presented in chapters 6 and 7 underpin and illuminate the quantitative findings from chapter 4. This chapter will be structured through the psychological domains of worry, control, quality of life, anxiety and depression, and self esteem.

Worry

The following section explores the statistically significant differences over time across groups for the socio-medical subscale of the CWS. Interpretation of the finding emerges from the women's subjective accounts, as their narratives underpin and reflect the pattern of worries revealed by this subscale. Early pregnancy responses on this subscale appear intimately connected with the identities exposed in the 'a new identity'; 'the new identity, ownership and choice'; 'GP gatekeeper'; 'the new identity, naturalness, responsibility and emotions' and 'experts and expertise' narratives. The narratives of 'identity, ownership and choice' and 'labour expectations' strongly reflect the worries expressed on the CWS in late pregnancy. Early postnatal accounts facilitate exploration of the CWS scores through the 'maternity patient' and 'babies create real mother' narratives themes, interpretations which are strengthened, in the late postnatal period, as women's accounts illuminate why socio-medical worries become less important following a healthy birth outcome.

Evidence that women worry about the socio-medical aspects of pregnancy, defined by questions about going to hospital, internal examinations, giving birth and coping with a new baby, regardless of the care type chosen, is provided by the significant differences over time, demonstrated by the CWS socio-medical subscale scores. Women demonstrated the highest socio-medical worry scores during pregnancy. All groups demonstrated similar baseline worries scores, with scores across the groups increasing in later pregnancy. This concurs with previous findings from Green, Kafetsios, Statham et al. (2003), that worries were highest at 16 and 35 weeks gestation and that socio-

medical worries as measured by the CWS displayed the highest mean scores at 35 weeks gestation.

Interpretation of the women's narratives would seem to both support and underpin the quantitative findings with regard to worry throughout pregnancy. For all the women interviewed, the part played by the fetus in situating them in a mothering role from almost the earliest point in their pregnancies was a consistent narrative. Pregnancy has long been acknowledged as a transition stage in women's lives (Gatrell 2005). Birth however, has been traditionally recognised as the point at which mothering starts (Oakley 1981b) and few writers have acknowledged pregnancy as the beginning of mothering. What seems apparent for women is that the recognition of themselves as pregnant creates a vision of the fetus as a life they have created and thus a baby. Narratives show that from almost the earliest point in their pregnancies women begin to consider how having a baby will impact on their lives. They articulate worries about how they will cope with a new baby through the recognition that following a positive pregnancy test they are different to what they were before.

Conceptualising themselves as mothers to their fetuses, in this way, quickly invests them with an inherent personal responsibility and accountability analogous to that expected from mothers. The pressure to provide care to their fetuses that conforms to the standards of good mothering is apparent even within the first trimester of pregnancy. Whilst women clearly aspire to be a good mother and a responsible pregnant women, they wrestle with other identities, such as normal and abnormal pregnant woman, which remain predominantly defined through a medical model, where the woman is regarded as the vessel of containment for the fetus and at the mercy of unpredictable forces which might endanger the contents of the vessel (Gross 2000). Within this framework, birth remains conceptualised by all women as unknown and unpredictable, and by some as inherently risky and potentially feared. Women's narratives present a complex picture where numerous circulating discourses and influences are absorbed, accepted or resisted to provide justification for the choices they make regarding site of delivery. Quality of personal experience is not generally articulated as the primary driver for the choices requested or made. In early pregnancy women make very little reference to labour or birth itself so it seems reasonable to suggest that it is not worry about giving birth that is reflected in the early CWS scores but more whether they have made the right choices with regard to their birth environment, which might be conceptualised as worries about going to hospital.

It should be considered that, for the different groups, interpretation of some of the questions on the CWS may be contextual. For example, birth centre women may interpret 'going to hospital' as meaning they will be unable to deliver in the birth centre but have to be transferred to the main hospital site for delivery. Indeed, negative perceptions of care at the main hospital site were articulated by women who had selected to deliver at the birth centre. This perceived lack of care was depicted as preventing the type of birth experience desired but also as failing to facilitate good mothering skills post delivery.

The assumption that interpretation and responses to this question on the CWS might be affected by women's individual pregnancy experiences is also supported by the women whose choice was restricted or remained ambiguous throughout their pregnancy. Barriers to, or ambiguity regarding site for, delivery surface early in pregnancy through the unavoidable medical advice that woman receive at the very first point of entry to the maternity system. Some women fall at the very first hurdle of normality, when the GP utilises 'expert knowledge' to decide which women are allowed through the choice gateway and which are unsuitable to be allowed such choice. The GP was unquestioned by women as the first point of contact and acknowledged as part of the process necessary to confirm the pregnant woman identity. Women are motivated by factors including personal knowing and acceptance/rejection of the authority of medical discourses to make the right decisions with regard to their site for delivery. It is apparent, however, that it is pregnant women's desire to promote themselves as 'good mothers' which renders them powerless to question superior 'expert knowing'. Such questioning might result in a risk to their fetuses and so permit public criticism of their mothering abilities. The outcome being that some women feel not only deprived of choice but also have increased worries about going to hospital, which was not their first choice for delivery. These worries could well be reflected in the CWS socio-medical findings.

Socio-medical worries however, measured by the CWS, followed a similar pattern across groups, suggesting that regardless of the interpretation of the questions, these are issues of concern for all women. All women within their accounts, to some extent, wrestle with the dominance of the medical discourses of pregnancy and birth that consider the hospital environment the safest place to deliver their babies. Throughout pregnancy women justify and reinforce the rationale behind those choices, as they seek to reassure themselves that as 'good mothers' they have made the right choices, causing worries about going to hospital to remain prominent throughout pregnancy.

As pregnancy progresses CWS socio-medical worry scores increase and again these findings can be further explored through the qualitative findings. Women in early pregnancy narratives do not dwell on labour; however narratives in late pregnancy demonstrate that thoughts and fears about the impending labour become more prominent. Some late pregnancy fears and worries reflect early pregnancy concerns about choice of site for delivery and women express concerns about not meeting the 'normal pregnant woman' standards which would facilitate their choice. Other worries articulated however, are more concerned with expectations of the birth experience itself and conforming to depictions of a 'controlled labourer'. Maintaining control and coping in labour were central to women's labour expectation narratives as they felt pressured to conform to the composed and calm depiction of a 'good mother' even in labour. Worries were generated by experienced labour discourses which were predominantly '*horror stories*' and were congruent with women's desires to have a 'normal and natural' delivery. Additional fears about labour interventions and mode of delivery are also prominent within women's accounts. This corresponds with other studies considering worry in pregnant women, which found that giving birth was one of the most widespread sources of extreme worry (Ohman, Grunewald & Waldenstrom 2003; Statham, Green & Kafetsios 1997), so in that sense could be considered unsurprising.

The level of worry across all groups decreased following delivery, suggesting that socio-medical worries become less once the baby is safely delivered. Women's pregnancy accounts see them promoting their 'good mother' status throughout their pregnancies. Safe delivery of their babies affirms their pregnant 'good mother' status as one who nurtured and protected, as an advocate who made responsible choices and decisions and, if necessary, was self-sacrificing in labour to ensure a safe and healthy outcome. In addition fears about not coping with a new baby are partially assuaged by the emotional connection and innate mothering ability that women report they experience at, or soon after, the birth of the baby. In contrast to the experience of the majority of women however, through some women's narratives we see the consequences of negative early postnatal events and the overwhelming nature of the new reality of motherhood, individual findings that the quantitative results are unable to reflect.

Mean scores on the CWS socio-medical subscale are lowest for all groups at 6 months postnatal. However, the drop in scores from 14 days to 6 months postnatal is in fact negligible. The suggestion that socio-medical worries are moderated by the safe arrival of women's babies appears to be reflected in both the quantitative and qualitative

findings. A possible explanation for the additional slight drop in worry scores at 6 months, is that the CWS questions substituted on the postnatal version of the scale to be time relevant to events, and the worries that constitute this subscale may simply become less relevant to women's lives. Women's accounts suggest that it is the earlier postnatal days when the adjustment to real motherhood is the most difficult and has the greatest level of worry and concern about being a 'good mother'. These worries generally diminish in the late postnatal period. Even in late postnatal narratives, women locate their worries about caring for their babies and being a 'good mother' in a much earlier postnatal period and late postnatal concerns do not prominently feature for the majority of women. Exceptions to this are clearly depicted in the accounts of those women who suffered emotional distress into the late postnatal period and this will be discussed later in this chapter.

This significant change over time across the groups was specific to this particular content of women's worries and this was not mirrored in any of the other CWS subscales assessed.

To summarise it seems that the CWS socio-medical findings reflect women's aspirations to be responsible pregnant women and good mothers. Throughout pregnancy choice is simultaneously promised by the consumerist choice discourse and inhibited by the medical model, through the GP and 'expert knowledge'. The medical discourse of birth as a risky event generates worries for women about whether they have made appropriate and responsible choices of a 'good mother'. Contemporaneously, the normal/abnormal pregnant woman dichotomy engenders worries about whether choices will be fulfilled. Women's preoccupation with labour in late pregnancy underpins the higher CWS socio-medical scores at 32 weeks. Worries about site for delivery merge with worries about giving birth, which evolve out of constructions of labour that are infused with experienced labourer 'horror stories'. Concurrent with fears about giving birth are concerns about meeting the ideal standard of a 'controlled labourer'. Lower worries on the CWS socio-medical subscale in the postnatal period could be a result of those issues being no longer relevant to women's responses, however that questions are altered postnatally to be situation specific might rather suggests that worries are reconciled through the safe delivery of the baby which reassures women's 'good mother' status.

It would seem that care providers need to be acutely aware of how their language and interactions increase women's worries in pregnancy. Further, it provides a message for

policy makers about the dangers inherent in homogenising women within one frame with regard to the concept of choice. In the current maternity climate where choice is both expected and desired, it must be openly and honestly presented and discussed so that women have realistic expectations about what choice means. These implications will be discussed in the concluding chapter of this thesis.

Control

Women, regardless of group, mirrored a similar but less dramatic pattern of scores to those of the CWS socio-medical subscale with regard to the MHLC 'powerful others' subscale. These findings will be interpreted and supported through women's narratives. Two powerful and enduring narratives which feature across women's maternity experience enable an illuminating interpretation of the quantative data with regard to the MHLC 'powerful others' subscale findings. These include the role of 'experts and expertise', as an unquestioned and fundamental aspect of women's maternity experience, alongside women's aspirations to be 'good mothers'.

The MHLC 'powerful others' subscale demonstrated similar scores for all three groups at all four time points, with all groups demonstrating higher scores during pregnancy. Higher scores indicate greater belief in the subscale domain, in terms of control over health. This suggests that in pregnancy women believe that 'powerful others', which includes the midwife, have control over events governing their health in pregnancy, indicating that women believe the help and actions of others play a significant role in determining health during pregnancy. It is notable that, although no significant differences were observed over time, the mean scores for the doctors' and chance subscales were also higher in pregnancy than following delivery.

These findings combined with the CWS results perhaps reflect the findings of Lowe (2000), who found that fear and apprehension regarding labour were associated with high levels of 'powerful others' and 'chance' LOC. Explication of these findings can be again provided by the qualitative interpretations of women's narratives. The continued pervasiveness of experts and expertise is clear throughout women's maternity accounts. Very little difference in scores is demonstrated between early and late pregnancy and narratives at both time points suggest no fundamental rejection of the medical model or shift in power away from experts to women. This adds clarity to any posited relationship between worry and control. The medical model promotes birth as risky, which indirectly restricts choice and generates worry in pregnancy, this requires women to both expect and seek expert advice and intervention during pregnancy.

Whilst those women choosing the birth centre could be viewed as opting for a less medicalised approach to their delivery, in a less hospitalised environment, it remains nevertheless perceived as an environment of expertise. Midwives and doctors are consistently united under the heading of 'experts' and expert intervention within the maternity arena remains unchallenged by women. Midwives, whilst often associated with normality by women, in the face of 'deviation from the norm' retain 'expert knowing'; this enables them to identify women as 'abnormal pregnant women' and to situate them as 'maternity patients'. This increases the amount of control that they, as midwives, exercise over women and as such is likely to at least reduce or at worst remove completely women's choice and control over pregnancy events.

Further explanation is provided by the identification, in women's accounts, of the midwife as the pregnancy 'expert' and the first point of call in the face of a problem in pregnancy. These findings would seem to negate the suggestion that offering alternatives for care allows women to make choices that facilitate increased levels of personal control. It has been argued, however, that women in pregnancy and childbirth make a conscious decision to hand over elements of personal control, whether to a midwife or a doctor (Green & Baston 2003). Narrative accounts here also support the notion that whilst there is an increase in levels of control by 'powerful others' across pregnancy, with levels remaining high into the early postnatal period (which may well reflect overlap from women's birth experiences), this may not be the detrimental decision in psychological terms that has previously been suggested. Women's accounts demonstrate that they make decisions about when they feel they wish to relinquish control. Women's accounts established that this can happen in pregnancy either for reassurance of normality or through a pregnancy related problem, where their need to be a 'good mother' and ensure the well-being of their baby supersedes the desire to maintain personal control. This willing surrender of control is also depicted in their reflections on labour, again, emerging for some women out of the actions of a 'good mother' or because of pain. Although women did not complete measures in labour and as such results cannot be directly compared, these findings seem to support the argument that external control from powerful others is not unwelcome to women. Women openly articulate that they look for guidance from the midwife. Further, many women have made care package choices based on the premise that as 'good mothers' they are prepared to relinquish control to the 'experts' at any point in their pregnancies to ensure the well-being of their babies.

Pain was another important factor associated with maintaining control in labour, and for some women choices for care were based on the availability of pain relief to facilitate a controlled labourer identity. External control by powerful others in this context was not unwelcome. This is reinforced by labour narratives in which 'experts' were praised when they facilitated women's requests for pain relief and castigated when they failed to do so, supporting previous findings of Mander (1993) and Green & Baston (2003).

Apparent in the 'reflecting on labour' narratives, and probably relevant to pregnancy as well, is that it is not being located as a 'maternity patient' by the midwife *per se* that impacts on women's sense of control, but rather how that transfer to 'maternity patient' is handled. Although the language used by experts can be seen in women's accounts to be disempowering and detrimental to personal control, if camouflaged within a remit of caring women do not articulate it as a problem or as feeling deprived of control. This furthers Green & Baston's (2003) findings that obstetric procedures were found to be relatively unimportant in relation to personal control but considerate caregivers were of importance. Some women who criticised their labour experience did narrate feeling uncared for. Overall, however women's accounts in this study with regard to labour, whether they felt they had retained control or not, ultimately narrated positively about the 'experts' involved.

Following birth the perception of the control exercised by powerful others over the women's health only decreases slightly. The postnatal period remains a time when women remain within the remit of midwives to provide care and support and the scores on this subscale would seem to reflect that involvement. Women narrate a perceived need to continue being *cared for* into the postnatal period. They articulate a reliance on postnatal support to facilitate their 'good mother' status, buffering the shock of the new and easing the transition to 'a real mother'. Women perceive that midwives have a powerful role to play in helping them to achieve the standards of a 'good mother' including competent baby care skills and successful breastfeeding. Women also articulated a need for, but lack of, advice with regard to physical recovery from childbirth. The slight drop in scores on this subscale following delivery however, may reflect the perceived failure of midwives to facilitate those aspects and the result is shown by the disappointment and lack of care that several women narrated in the early postnatal period, particularly with regard to immediate postnatal care in the hospital.

The greater drop in scores in the late postnatal period might be expected, depicting a general decreased need to seek health advice and support. It should be noted here,

however, that for some women the drop in external control by powerful others was not a welcome occurrence. Lack of choice in the amount and length of input from health care professionals was cited by some women as detrimental to their perceived ability to be a 'good mother' and to their general postnatal recovery. This clearly merits further discussion within the choice debate.

Further insight into the impact of pregnancy on women's feelings of control is provided by the descriptive reference group data. The pregnant women as a group demonstrate higher scores on the MHLC others, doctors and chance subscales and lower scores on the internal subscale. Indeed significant differences were found between pregnant and non-pregnant women on the doctors and internal subscales would add strength to argument that during this maternity period, women perceive internal control as compromised and their health as much more externally controlled than their non-pregnant counterparts. However, the interpretations of the findings, provided above, do not suggest that this is necessarily a negative experience for women.

To summarise, in both the quantitative and qualitative data 'experts' are presented as playing a significant role in women's maternity experiences. Without the interpretation provided by the women's narratives, initial interpretations might have suggested such a finding as detrimental, not only to women's satisfaction with their maternity experience but also to their psychological health. What is apparent is that 'external control' from 'experts' remains unchallenged regardless of the type of birth experience desired. However, MHLC 'powerful others' subscale scores appear not only to reflect women's experience but also women's desire for levels of 'external control', which serves to both reassure and facilitate their 'good mother' status.

There are several considerations that the above findings and interpretations raise. Firstly, the potential predictive ability of socio-medical worries on women's control needs and the amount or type of input that they may benefit from during pregnancy and the labour period. Unfortunately, this type of analysis does not allow us to predict the direction of the relationship between the two variables. Whilst it could be suggested that high socio-medical worry scores could determine women's care and support needs, it could equally be contested and supported by earlier interpretations that conferred 'expert' input, has the power to increase women's socio-medical worries. Secondly, recognition by care providers that although women are not unwilling to relinquish control in pregnancy and particularly in labour, removal of that control needs to be within the context of a negotiated level of support and a sense of feeling *cared about* as

well as *cared for* (Green & Baston 2003). This has the potential to facilitate more satisfying, if not always ideal pregnancy and birth experience for women. The expectation to feel *cared about* and *cared for* continues into the postnatal period but does not appear to be mirrored by service provision, particularly in the hospital setting. The uncertainty of the new in the early postnatal period sits alongside women's uncertain knowledge about their physical recovery from childbirth. It appears that women following birth feel expected to make an immediate return to 'non-pregnant women', but women themselves clearly wish midwives to maintain a role of care and support equivalent to that provided in pregnancy and birth. This conclusion not only requires acknowledgement from both local service providers and planners, but at a broader level must be recognized as a fundamental aspect of the choice within maternity care debate.

Quality of Life

Significant differences over time were observed with regard to some quality of life domains. These might have been expected as a result of the physical experience of pregnancy. However, these findings can be further explored and underpinned by women's accounts of their pregnancy, birth and postnatal experiences. As for the discussion around control, the influential normal/abnormal pregnant woman and good mother/bad mother dichotomies aid important and revealing interpretations of the quantative Quality of Life findings. Scores can also be afforded a particularly powerful interpretation by the cultural ideals of pregnancy and the norms to which women aspire throughout their maternity experience.

Bodily Pain

Bodily pain scores were high for all women in early pregnancy, demonstrating that women in early pregnancy are experiencing little pain or limitations due to pain, these scores lowered for all groups in later pregnancy, concurring with the literature that suggests that the physiological changes of pregnancy and their associated discomfort is at least to some extent limiting to women in terms of lifestyle (Attard, Kohli, Coleman et al. 2002). Scores on this subscale were at their lowest and most limiting in the immediate postnatal period where the woman is continuing to recover physically from labour (Symon, MacDonald & Ruta 2002; Okubo, Mitsuhashi & Saito 2000). An interesting dimension to these findings can be offered by the women's narratives. The qualitative data support the suggestion that women in the early postnatal period are coping with the physical recovery of pregnancy. As already discussed, however with regard to control, women's experience in the early postnatal period occurs within a

perceived context of inadequate support and lack of care, which often fails to meet with their needs. It seems apparent that women struggle to make the transition from the dependency and intervention with regard to their health they experience in pregnancy and labour to the independence expected from them in the early postnatal period. Expectations that they should perform as 'good mothers' immediately after delivery forces them to perform physical cares for their babies, which undoubtedly has ramifications for the somatic symptoms of postnatal recovery such as pain. High scores at 6 months in this study however suggest that bodily pain is not an enduring problem for women.

Vitality

With regard to vitality women experienced the greatest lack of energy in early pregnancy, with energy levels increasing by 32 weeks. The SF36 asks for an assessment of feelings over the last 4 weeks, and findings are consistent with the literature (Kitzinger 1984), which suggests women experience a burst of energy in the mid trimester of pregnancy. Insight from the qualitative data suggests that more than merely reflecting a physiological response to pregnancy, women aspire in pregnancy to conform to traditional cultural depictions of the pregnancy experience. Western depictions of a normal and ideal pregnant woman, suggest that early pregnancy is synonymous with low energy levels, tiredness and nausea and vomiting (Chou, Lin & Cooney 2003, Munch 2002), whilst in mid pregnancy women traditionally are depicted as blooming and energetic. Women's accounts demonstrate how they aspire to ideal physical symptoms in order to reinforce themselves as 'normal pregnant women'. Women who don't conform to these culturally mediated standards by either suffering too much or too little of an expected response such as nausea and vomiting express fears of being abnormal. One possible interpretation is that within that context women are reporting in the questionnaires how they think they should feel, rather than how they actually feel. Indeed, it is a well acknowledged problem within the research literature that questionnaires engender a danger of respondents reporting how they think they should feel (Leung 2006). A further interpretation could be that whilst women are reporting actual feelings, quantitative responses and scores are reflecting how women conform to agreed cultural and societal models of maternity. Women strive to be part of the collective of pregnant women from an early point in their pregnancies and as such aspire to the normative ideal of a pregnancy and birth experience. It is important to note that the suggestion is not that women *do not* experience the feelings they report in the questionnaires, but rather that this is how they expect to feel, so they enact a normative societal construction of pregnancy, birth and the postpartum. This reading would seem

to be supported by the concerns that women express when they fail to meet normative expectations.

Vitality scores for the birth centre and midwifery led care groups remained fairly consistent between late pregnancy and the early postnatal period, with the consultant led care group demonstrating lower scores postnatally than at 32 weeks pregnant, although mean scores across the groups were similar at this observation point. The comparison with the UK normative data made earlier in chapter 4, would suggest that energy levels are compromised for the women in this study in both pregnancy and the early postnatal period. Some women's narratives support this finding, articulating a readiness to return to a non-pregnant state, with the difficulties in performing normal everyday tasks cited as a reason for this. Vitality levels increased for all women by 6 months postnatal, to largely normative levels. This increase may well be concurrent with improved sleeping patterns of their babies. Support for this seems to be provided by the sleep profile of the study group, with the highest sleep scores, indicating poorer sleep observed at 14 days postnatal, which is also consistent with the tiredness that women refer to in their early postnatal accounts. Global sleep scores demonstrate improved sleep quantity at 6 months postnatal.

An interesting observation is that global sleep scores are also high in late pregnancy, which seems consistent with the claim that many women enter the postnatal period sleep deprived (Hertz, Fast, Feinsilver et al. 1992). Indeed global sleep mean scores for the non-pregnant reference group were similar at baseline but remained much more stable over time, reinforcing Hertz' and colleagues (1992) suggestion that sleep architecture is clearly affected by pregnancy and is enduring into the postnatal period. This sleep deprived pattern that women report in late pregnancy does not appear to be reflected in women's vitality scores, which would seem to support the claim that women present a culturally constructed self within questionnaires.

Personal Health

Personal health as measured by the general health subscale of the SF36 demonstrated that women's views of their personal health and their perception that it might worsen are lowest in early pregnancy. It is noteworthy, as presented in chapter 4, that the UK female norm based mean scores for the personal health subscale of the SF36 for 18-24 years and 25-34 years are 69.5 and 73.8 respectively (Jenkinson, Wright & Coulter 1993), so although the pattern of scores in this study illustrates that women rate their personal health as lower in early pregnancy, their mean scores for the majority

correspond with normal limits. A possible explanation for lower scores in early pregnancy might be that the medicalisation of pregnancy causes women to perceive it within a medical frame, regardless of their choices for care. Kitzinger (1978) suggests that women in pregnancy find their state of health being enquired after, implying that they should be looking and feeling unwell. Women's accounts within this study demonstrate that medical advice is unavoidable in early pregnancy. In particular, those who feel labelled as an 'abnormal pregnant woman', by the GP, consequently express intensified concerns about their health in early pregnancy. The influence of the 'medical model' also surfaces in the narratives of those women situated as 'normal pregnant women'. Here it is articulated through their expectations that the normality of pregnancy can only be judged in retrospect and reinforced by the choices they make for care. This may then create an expectation for women that their health will worsen as pregnancy progresses. In reality however, at 32 weeks women evaluate their personal health higher than in early pregnancy, this increase continues in the early postnatal period. Placing these findings in context with those for bodily pain, which demonstrated a rise in scores at 32 weeks and 14 days postnatal, an initial interpretation might be that women perceive this as a normal part of pregnancy and the postnatal period. As such they do not consider the discomfort suffered in terms of their health or a detriment to their personal health status state. However, when the interpretation provided by the qualitative data around vitality is considered, these findings appear to reinforce the argument that pregnant women's QoL score patterns reflect the desire to be seen as normal. Not only does a 'normal pregnant woman' identity facilitate choices for care but it reinforces a 'good mother' identity, because they are behaving in a correct and conformist manner. It should be noted that the women in the consultant led care group report poorer personal health at six months. As the data did not suggest that women in this group were subject to greater delivery interventions it is a finding which could be specific to non pregnancy related events within that group.

Change in Health

The change of health domain of the SF36 suggests that women in early pregnancy report their health state as worse than 6 months ago and at 6 months pregnant as improved from 6 months ago, reflecting the results of the personal health and vitality subscales. Scores indicated that positive changes in health continue into the postnatal period for the birth centre and midwifery led care/acute centre women. Consultant led care women report a decrease in their health state at 14 days postnatal, which is perhaps more apparent because their 32 week scores were higher than the other two groups. Further insight again seems embedded in the women's own accounts.

Previously discussed are the difficulties that women face in making the transition from dependence to independence with regard to their health in the early postnatal period. A viable interpretation could be that consultant led care women choose that option because of their wish to be more dependant on intervention and support. Hence, the effects of the sharp drop in support and care that women articulate as they enter the postnatal period magnifies this group of women's negative perceptions of their health. The profile demonstrated overall seems consistent with normal postnatal recovery, both from a physiological and cultural perspective, with all groups reporting their health at 6 months postnatal as significantly better than at any other point in the study. Physical health did not feature as something of concern in women's late postnatal accounts with women generally narrating satisfaction with their return to 'non-pregnant woman'.

The non-pregnant reference data relating to the SF36 domains suggest that with regard to the physical aspects, non-pregnant women consistently score higher. On first reading this would seem to add strength to the argument that women are physically compromised in pregnancy. In this study however, physical compromise did not map onto the psychological components of the SF36 scale and similar scores were demonstrated on the mental health and role emotional subscales for non-pregnant and pregnant women. An initial interpretation of the quantative data might suggest that, despite physical compromise, women are less troubled by the physical changes of pregnancy than some of the literature assumes. However the illuminating interpretation provided by the women's narratives makes it conceivable that whilst the ensuing discomfort and reduced energy levels are undoubtedly a problem for some women, they are considered by others an inherent or even an imperative part of pregnancy and perhaps even relished as such. They not only confirm the 'pregnant woman identity' but conform to some ideal of normality that women feel they must reach to perform pregnancy well and ultimately be judged as good mothers.

To encapsulate the above discussion, it seems that the QoL scores reflect women's aspirations to meet the cultural depicted norms of maternity behaviour, depicted in part by the medical model, but also through pregnancy literature and the media. This is seen specifically in the vitality, personal health and change in health subscales. Whilst it should be acknowledged that scores in all probability mirror actual experience particularly where they reflect the tiredness and bodily pain reported by women in the early postnatal period, and the physical consequences of the lack of support they feel they receive in the transition from dependence to independence. There can be two

further interpretations here. It seems a reasonable conclusion to suggest that scores either reflect women's aspirations to present themselves as normal pregnant women through their responses to this questionnaire or that women's feelings are reflecting conformity to societally and culturally agreed models of the maternity experience.

Comparison of Pregnant and Non-Pregnant Data for the HADS-D

Other findings informed by the reference group data from non-pregnant women which seem worthy of comment are the significant differences in the HADS-D subscales means, which imply differences between pregnant and non-pregnant women. Interpretation of the findings emerge from the women's subjective accounts, as their narratives demonstrate a plethora of emotional responses to their maternity experience that both emerge out of cultural constructions of pregnancy but also aspire to meet with traditional norms. Women narrate the maternity experience as a period of emotional lability. This section considers how women may actually experience such emotional lability because it is located in their culturally constructed feelings and ideals, as previously discussed. In other words, this is not to suggest that women's feelings are not real, but that societal constructions precede and so inform pregnant women's feelings. Interpretations are provided from women's accounts in which they depict themselves as 'hormonal', aspiring to meeting cultural standards of bonding, wrestling with dichotomies of identity, continually striving to promote themselves as 'good mothers', euphoric, uncared for, unsure of expectations and the boundaries of normality and suffering loss of personal identity in the face of gendered parenting roles.

The findings of the HADS-D subscale reveal that non-pregnant women display lower HADS-D means, which might suggest that pregnant women do suffer from some psychological detriment in terms of mood. It is noteworthy however, that HADS-D means scores for the pregnant groups all remain below the levels considered clinically relevant for these measures and as such was not indicative of levels of psychological distress. This pattern however, is not reflected in the EPDS scores, making the interpretation of these findings ambiguous and complex.

In general, scores for all the domains measured have a propensity to remain more stable over time in the non-pregnant group than is found in the pregnant sample, suggesting that mood during the maternity period does have a tendency to be more labile. This is mirrored in women's narratives as they represent themselves in pregnancy as more emotional and irrational than their non-pregnant selves. Further than that, they have an expectation of being at the mercy of their sweeping hormones and represent themselves

through that traditional depiction, supporting the claim that women are informed by existing societal constructions of pregnancy. Through their awareness of psychological health as important in pregnancy in terms of both pregnancy and birth outcomes, mother-child relationships, child development and long term maternal mental health, women express concerns about what is a normal or abnormal emotional hormonal response. Narratives depict women's emotional response to pregnancy as even more than that, as throughout their pregnancies they aspire to reinforce their 'good mother' identities. They believe these should include an emotional connection to the fetus informed by cultural standards of bonding; failure to achieve this connection leads to articulated anxieties that a lack of positive emotion is an abnormal emotional response. As delivery approaches women express concerns about giving birth through both the quantitative and qualitative mediums. Women in their post delivery accounts depict an experience, which sees the immediate euphoria following the birth of their babies being replaced by often overwhelming feelings of shock, frustration, responsibility and exhaustion. Additionally this takes place within a context of physical recovery, including pain and reduced sleep, with uncertainties about how much independence they should be aspiring to. Late postnatal narratives display some women's distress at a loss of personal identity, as they feel constrained by gendered parenting roles, which creates both distress and resentment towards their partners and thus conflicts with their need to be perceived as an 'ideal modern family'. Where such extremes and uncertainties about emotions characterise women's experiences it would seem unusual if these did not manifest in increased scores and a labile response to questionnaires administered over time, which enquire after their emotional status.

One possible explanation, in light of the above reading of the study findings, is that the HADS is tapping into the uncertainty that women narrate about appropriate and inappropriate, right and wrong emotional responses across their maternity experience. Women's narratives depict a plethora of different discourses and influences which imbue clear but often hesitant emotional responses to pregnancy, birth and the postnatal experience. In other words women expect to feel emotional but because psychological depictions of pregnancy are less determining than the physical depictions, they are unsure how these emotions should be enacted. It is perhaps reasonable to suggest that as with quality of life scores that HADS-D scores reflect women's desire to present themselves as normal, meeting the traditional expectations of the maternity experience as a significantly emotional time in women's lives. A contrasting explanation could be that the HADS-D means scores reflect women's anxieties about whether they are attaining culturally depicted norms. If this were the case however it would be expected

that HADS-A mean scores would also be higher in the pregnant group. That the EPDS failed to pick up a similar pattern, raises questions about the difference between the two measures and may support the suggestion that one measure is accessing a response that the other is not. The utility of a questionnaire to tap into women's culturally constructed responses to pregnancy should not be dismissed as it may provide health providers with a useful tool to monitor women's emotional responses over time and provide reassurance and support about what is perceived to be normal. It may conversely however reinforce culturally regulated norms of pregnancy, which afford health professionals even greater power to define women as abnormal. It also raises potential questions about identifying psychological distress when it may not exist. The HADS has demonstrated instability in other pregnant population studies (Karimova & Martin 2003) and the subjective interpretations presented here might proffer some explanation for that.

The conclusions drawn above suggest a twofold explanation of the HADS-D scores. Women clearly experience emotional responses in pregnancy, which are periodically quite extreme, as they are bombarded by many different influences, discourses and events and aspire to ideal identities. Women seek to match their emotions to the conventional representations that surround them across their maternity experience, within the remit of what is available to them to experience. Narratives demonstrate that women are less clear about an ideal emotional response and thus apprehensive about meeting expected norms and ideals. It seems possible that women's questionnaire responses expose that apprehension and their desires to promote themselves as normal. Further, it should be acknowledged that by giving women questionnaires to measure their psychological responses to pregnancy and birth, they are being presented with only one possible way of expressing their feelings, which is also constructed within the constraints of available societal discourses.

General and Social Self-Esteem

The interesting findings provided by the post hoc tests for general and social self-esteem, i.e. that the birth centre group have statistically significant higher scores of general and social self-esteem at 14 days postnatal than the midwifery led care at the acute unit group, necessitate further discussion. It should be noted that the findings could be due to a type I error, due to the number of different attributes measured. However, that possible interpretations of these findings emerge out of women's early postnatal accounts would seem to refute that possibility. The 'babies create real mother' narratives elucidate how the reality following birth fails to meet 'romantic notions of

motherhood'. Women are not supported by 'experts' to meet the physical and emotional demands of mothering following birth, which results in women feeling exposed as 'bad mothers'. In late postnatal narratives women reinforce the unsupportive nature of immediate postnatal care and implicate staff as largely absent and detrimental to a 'good mother' status, locating them as failures, which clearly impacts on their sense of self-worth.

A primary and plausible explanation for the finding that the birth centre group have statistically significant higher scores of general and social self-esteem at 14 days postnatal than the midwifery led care at the acute unit, could be that the quality of postnatal input differed between the groups. The birth centre has a greater ratio of midwives to women and as such may be able to provide more intensive support in the immediate postnatal period. The result of this may be that the birth centre women feel more confident in their ability to mother and care for their babies following discharge in the early postnatal days. Unfortunately, as discussed in the methodology chapter and as a result of pregnancy and labour events, none of the women interviewed, in this study, received postnatal care at the birth centre. Despite that however, women's narratives appear to provide potentially powerful support for the initial interpretation above.

Women throughout pregnancy narrate an ownership of their pregnancies which invests them with a responsibility to be 'good mothers' to their fetuses. Following the birth of the baby this individual sense of responsibility takes on a new dimension that involves the physical care of the baby. This is underpinned by the emotional dimension of mothering that was often elusive in pregnancy, now informed by a visible reality of success or failure in their mothering abilities. Unlike pregnancy and labour where women were able to divest some responsibility to either the fetus for problems or difficulties, or to hereditary factors, the materiality of the care and nurturing they provide postnatally renders them open to greater potential criticism of their mothering skills. Women are inherently conscious of this yet, whilst in pregnancy the boundaries of normality have been clear, postnatal norms are much more ambiguous. The puerperium is traditionally depicted as a time of recovery from childbirth, but women feel they are pushed too rapidly towards independence and a return to non-pregnant woman, which as already suggested results in them often feeling *uncared for* and *uncared about*. Women report difficulties in providing care and in breastfeeding which situates them as 'bad mothers'. This occurs because experts in the form of midwives promote breastfeeding as the best thing for the baby and the thing that 'good mothers' do. Midwives, paradoxically however, are cited by women as necessary and

instrumental in achieving confidence and competence in caring for their babies. Hence midwives simultaneously set the standards of good mothering but through insufficient care and support position women as 'bad mothers'

Another reasonable explanation for the quantitative findings, could be provided by the setting in which postnatal care is given. The birth centre provides a home from home environment; the acute centre, because of the nature of the care it may need to provide, retains many elements of the standard hospital setting. Enkin, Keirse, Neilson et al. (2000) suggest that such an environment impinges on a woman's self confidence to care for herself and her baby, and fails to enhance her self-esteem. It seems credible to suggest that the midwifery led care/acute centre women feel they are being perceived as inadequate mothers, which in turn affects their social confidence with their new babies and general sense of self worth. Although women do not directly narrate difficulties with being in a hospitalised environment, they do underpin their complaints of lack of care, with acknowledgement that midwives were busy and that they need to prioritise their workload. It is perhaps reasonable to suggest that because of the hospitalised environment women do not push their requests for support because they are more constrained by a 'maternity patient' identity, which does not permit 'expert knowing' to be questioned.

The interpretation of the findings here and those discussed previously around control suggest the early postnatal period in particular is a time when women desire but experience a lack of support. Women express the belief that postnatal care particularly in the early postnatal period is not only fundamental in making the adjustment to 'a real mother' but also plays a facilitatory role in women's attainment of a postnatal 'good mother' identity. Failure to provide women with individualised and adequate levels of support leaves them lacking confidence in the ability to care for their babies and infused with feelings of guilt and failure. At the same time as having implications for the postnatal care provided in hospital, these interpretations could have significant ramifications for the amount of community postnatal support that women require. One woman's postnatal account clearly showed the deleterious and enduring ramifications of leaving hospital feeling a lack of confidence in caring for her baby, resulting in significant postnatal psychological distress.

Anxiety and Depression Case Detection

The essence of measures such as the HADS and the EPDS is as anxiety and depression case detectors, where a cut-off score is used to determine the number or percentage of

respondents suffering clinically relevant anxiety and/or depression. The use of the measures in this way undoubtedly loses some of the power of the data, but examination of the findings is merited, particularly when interesting and insightful interpretations of these findings are provided from within women's subjective accounts. Explication of the findings in pregnancy appears to be provided once again by women's conformity to a 'normal pregnant women' identity and desires to be 'good mothers'. The highest scores demonstrated at 32 weeks can be further understood through the narratives of 'identity, ownership and choice' and 'labour expectations' which reflect the infusion of the medical model and 'experienced labourers' in women's concerns about labour itself. Early postnatal accounts facilitate exploration of the scores through the 'maternity patient' and 'babies create real mother' narratives themes, which demonstrate how the 'good mother' identity remains a dominant aspiration for women but within an altered reality of mothering, which following birth holds differing demands and challenges. The 'what about postnatal choice' narratives illuminate how women feel unsupported and candidly demonstrate how these feelings, for some women, can endure into the late postnatal period.

The levels of anxiety and depression, identified in this study, demonstrate some consistency with current literature on antenatal and postnatal anxiety and depression (Rubertsson, Waldenstrom & Wickberg 2003; O' Hara & Swain 1996). When the less conservative cut-point criterion were utilised the frequency of cases was obviously higher. The pattern of HADS-A, HADS-D and EPDS defined caseness is similar, with incidence rising at 32 weeks gestation. This finding might have been expected, because anxiety and depression have been observed to be correlated across the first and third trimesters of pregnancy (Jomeen & Martin 2004a; Karimova & Martin 2003). The pattern here mirrors the findings with regard to socio-medical worries, which also increased in late pregnancy. The earlier consideration of the worry findings through the integrated data, reflected women's desires to maintain a 'normal pregnant woman' status and concerns when they did not. Their desire throughout pregnancy to promote themselves as 'good mothers' was threatened, for some, by pregnancy events which labelled them as abnormal, generating fears of unfulfilled choice, a negative labour experience and a poor delivery outcome. Even for those 'normal pregnant women' fears about labour were prominent. A cogent extension of such an interpretation is that worries would also be reflected in the anxiety and depression measures that women complete, in particular when worry has been shown to correlate with anxiety (Green, Kafetsios, Statham et al. 2003), as anxiety has been shown to correlate with depression (Jomeen & Martin 2004a; Karimova & Martin 2003). This also seems to support the

suggestion, made early in this thesis, that psychological domains in pregnancy are interrelated.

It is striking that the percentage of women defined as minor/major depression is greater using the EPDS. This led to EPDS identified caseness using the 9/10 cut-point being higher than might have been anticipated and above the prevalence rates for postnatal depression of between 10-15% identified in the literature (O'Hara & Swain 1996). This could obviously be a result of using the lower cut-point scores. However, one further possible explanation, considering the socio-economic profile of the study group, is that incidence of postnatal depression in particular, has been shown to be higher in urban areas of deprivation (Cryan, Keogh, Connolly et al 2001). The rates of cases screened positive using the less conservative cut-point criterion for the EPDS were similar to the 28.6% identified by Cryan et al. (2001). Another possible interpretation of these high EPDS depression rates may be provided by the claim the EPDS actually contains embedded anxiety items (Jomeen & Martin 2005a), which might elevate scores when women's anxiety scores follow similar patterns to those for depression. Conversely the more conservative cut-point of 11 for HADS-D identified considerably fewer cases than might have been anticipated. This is interesting in light of the earlier discussion which identified pregnant women's HADS-D scores as higher than those of non-pregnant women.

The levels of caseness identified for both anxiety and depression are highest in late pregnancy. Women's accounts display late pregnancy as a time when they begin to consider the return to a non-pregnant state. This inevitably involves concerns about labour, with worries about coping in labour and maintaining control prevalent in all narratives. For those women who have been labelled 'maternity patients', additional concerns about the nature of their delivery merge with those around coping and maintaining emotional and physical control. The construction of birth as inherently risky stimulated by a continued authority of the medical model, infuses all women's narratives in late pregnancy to a greater or lesser extent, with women articulating a willingness to sacrifice their own well-being for the good of their babies. The severity of some women's concerns is exposed by the narratives in late pregnancy including a fear, expressed by one women, of dying in labour, which thus provides greater insight into why anxiety and depression casesness might increase as pregnancy progresses.

For both the EPDS and the HADS these levels of high anxiety and depression appear to persist into both the early and the late postnatal periods. The subjective findings have

already highlighted the postnatal period as a time for women of extremities of mood, where euphoria at the emotional connection they make with their babies is mixed with feelings of overwhelming personal responsibility, not equalled by anyone else including their partners and with, frustration, exhaustion and the shock of the new. Women are clearly anxious about the role now demanded of them as 'real mothers' and the dominant need to promote themselves as 'good mothers' is reinforced by the materiality of their actions following the birth of their babies. It has already been discussed how they feel unsupported in achieving a 'good mother' status in the early postnatal period, often generating feelings of failure and guilt. It is clear in the vivid and expressive accounts, that women provide six months after the birth, that many of these feelings are enduring, which has momentous psychological ramifications for some women. The 'what about postnatal choice' narratives illuminate how women feel unsupported and candidly demonstrate how these feelings can endure into the late postnatal period.

To sum up it seems that the patterns of anxiety and depression and depression scores reflect women's aspirations to be 'normal pregnant women' and 'good mothers'. In late pregnancy this is superimposed with worries about labour and the return to a non-pregnant state. The medical discourse of birth as a risky event generates worries for women about labour complications and mode of delivery. Experienced labourer discourses engender expectations of pain and fears of being an uncontrolled labourer. It seems reasonable to suggest that it is women's preoccupation with labour in late pregnancy that underlines the higher anxiety and depression scores at 32 weeks. The prevalence of higher scores into the postnatal period again exposes the dominance of the good mother/bad mother dichotomy, in the context of fluctuating emotions and the physical demands of mothering following birth. Despite an overall articulated confidence in their mothering abilities by six months following the birth of their babies, women's continuing reference to early postnatal deficiencies in care and support suggests that these deficiencies can indeed have a lasting effect for women. Late postnatal narratives also demonstrate the constraints of 'gendered parenting' and 'domestic labour roles' and the physical and emotional difficulties these present for some women. It seems feasible that these interpretations explicate the high levels of anxiety and depression apparent into the late postnatal period.

Providing a Subjective Understanding of Postnatal Depression

It could be argued that the above statistical findings furnish the argument that postnatal depressive symptomology is a continuation of the antenatal state (Brugha, Wheatley, Taub et al. 2000; Brugha, Sharp, Cooper et al. 1998). Whilst it is possible to ascertain

from the quantitative data whether those women identified as suffering clinically relevant anxiety and depression in the antenatal period, are the same as those in the postnatal period, this was not done in this study due to time constraints. The incidence of significant psychological distress and clinically diagnosed postnatal depression revealed in the accounts of women interviewed, however, provides an opportunity to explore this assumption contextually. There has been a traditional preoccupation within maternity settings with postnatal depression and it is apparent in the interview accounts that women themselves articulate their depression through a postnatal lens. However, there is no one consistent causative factor which characterises their experiences of psychological distress. Individualised experiences of psychological distress rather evolve out of a disparate milieu of antenatal, intrapartum and postnatal events.

It seems imperative for the context of women's postnatal depression to be understood from a perspective that takes account of their entire maternity experience. The consumerist choice debate reinforced by policy, academic and popular literature depicts choice in maternity care as increasing satisfaction with pregnancy and birth experiences (Hodnett, Downe, Edwards et al. 2005) and so directly contributing to emotional well-being. For women who achieve their desired birth experience, it seems that this may well be true. However, what is significant within women's subjective accounts is how offering choice can conversely render women disempowered, guilty, angry and distressed. Women from the earliest point of contact are scrutinised under a defined framework of normality. Those who expect, yet fail, to meet the normality criteria at any point in their pregnancies are labelled as abnormal and denied choice or charged with a remit of proving their normality before their choice can be fulfilled.

Unfulfilled choice, whilst seemingly, for some women, playing a contributory role to subsequent psychological sequelae, cannot be given the standing of a single causative factor. Women throughout their pregnancy strive to promote themselves as 'good mothers', act responsibly and make appropriate decisions. Many other discourses, influences and events serve to reinforce their status as 'good or bad mothers' throughout pregnancy. Women who maintain only a tenuous grasp of their 'good mother' identity are rendered emotionally vulnerable as pregnancy progresses. It seems apparent that those women who leave pregnancy emotionally vulnerable enter the postnatal period in the same state, regardless of delivery events. Postnatal events build on this level of emotional vulnerability, which appears to manifest in perceived failures to adequately fulfil 'good mother', 'gendered parenting' and 'domestic labourer' roles, which perpetuates the descent into significant psychological distress.

For some women the location of emotional vulnerability is less apparent in their antenatal narratives, yet implicit in their postnatal accounts is a similar state of emotional vulnerability. This emerges from accounts of disappointing delivery experiences that did not meet with expectations of the desired experience, and/or the overwhelming nature of being a 'real mother' characterised by loneliness, isolation and resentment. Many of these postnatal accounts are infused with some articulated loss of personal identity, as women feel constrained and pressured, in the postnatal period, by 'gendered parenting' and domestic labour' roles. Resentment is articulated through narratives which compare female to male parenting roles. Whilst some women narrate an emotional vulnerability in the early postnatal period often as a result of individualised experiences this emotional vulnerability does not manifest in enduring postnatal depression, suggesting that some women are equipped with better personal resources and more empowered or enabled to restore personal identity than others. However, the differences among those women who narrated emotional distress and did not feel pushed to seek help and those who did, appears to be located in feelings of failure and inability to function rather than feelings of low mood. Those women pushed to seek help did so out of their perception of themselves as 'bad mothers' and an apparent inability to adequately fulfil idealised roles.

These accounts clearly illuminate a multi-faceted image of postnatal depression. The privileged insight into postnatal depression that emerges from women's narratives appears to enable the conclusions that whilst women's accounts depict an individualised biography, they are underpinned by perceived failures to meet the idealised cultural and societal depictions that surround pregnancy and childbirth. There is no one consistent causative factor which characterises the experience of postnatal distress. The level of postnatal distress is perhaps mediated by personal resources, but is more clearly located in women's abilities to perform and perceive themselves as 'good mothers'. Hence, care givers need to be aware of the role they can play in women's aspirations to be 'good mothers' both antenatally and postnatally. Equally they should be reminded that postnatal depression is not necessarily a distinct postnatal event and can neither be viewed nor explained in purely postnatal terms. Psychological distress rather evolves out of a psychosocial matrix of maternity events, discourses, influences and aspirations.

Completers versus Non-Completers

The comparison of completers (those completing all four questionnaires) compared to non-completers (those completing the first but not all subsequent questionnaires) revealed that completers were more likely to be married and to have significantly greater self-esteem. It

is also noteworthy, that non-completers had higher depression (EPDS; HADS-D) and anxiety (HADS-A) scores and that significant differences were observed between completers and non-completers in, HADS-D probable depression status and EPDS major/ minor anxiety. It has been discussed through women's narratives how throughout their maternity experiences they conform to idealised societally and culturally constructed norms. As previously, these accounts enable a discerning and supportive interpretation of the quantitative findings.

These statistical findings above appear to demonstrate that psychological concepts such as anxiety, depression and self-esteem affect an individual's engagement within the research programme. It may be that there are different perceived benefits/costs between completers and non-completers. Motivation to remain engaged with the programme is likely to be reduced in those who have lower self-esteem and are suffering mood disturbance. Women's subjective accounts throughout their maternity experience present a narrative of conforming to idealised norms as an integral part of being a 'normal pregnant woman' and a 'good mother'. Those women who drop out may do so because they do not wish to be identified as not meeting that conformist depiction of pregnancy or the postnatal period. This adherence to cultural norm might also suggest that marital status may be an important variable in any future maternity study. The narrative accounts in this study demonstrate the importance for women of adhering to cultural depictions of ideal modern family life, where women bring their children up in the right circumstances of a loving family where the father acts as an active parent. Whilst narratives show that this is clearly constrained by gendered parenting roles and notions of the woman as both the natural and default carer, it remains a critical influence on women's maternity experience. Fears of failure to adhere to those depictions and as such be judged through them may play a key role in some women's failure to remain engaged in a research programme, which inherently involves evaluation of its participants responses. Therefore a critical variable to assess in non-completers in future research may be motivational status, as this may also impact on an individual's engagement with care and support systems in pregnancy and the postnatal period. Addressing the issue of marital status may be countered by simply not asking the question, however this may be more difficult if marital status is perceived as a key demographic variable. Strategies that present themselves as ambivalent about marital status may have some success, although more fundamental is how society continues to move forward in ceasing to conceptualise single mothers as lower in status than their married counterparts.

Whilst it would seem intuitively feasible that low mood would impact on a woman's desire to engage with research studies, the desire not to be judged as not meeting societal norms also seem to offer an alternative explanation of the differences found between completers and non-completers particularly in terms of marital status.

Summary

In summarising the above findings, what is apparent is that a combined methodological approach has enabled an 'emic' understanding of women's psychology and experience of choice in maternity care, emerging out of women's own narrative accounts. Several initial interpretations of the quantitative data were broadened and explored and readings of the qualitative data present an understanding of the statistical findings, which would otherwise have remained unconsidered. The subjective accounts of the women in this study offer enlightening reasons why choice of care type, as the 'between groups' independent variable, failed to impact on any of the psychological domains measured. Women's pregnancy experiences, while undoubtedly individualised in nature, are patently subject to the same orbiting influences, societal and cultural discourses, whether implicit or explicit, which engender all women with similar aspirations, desires, and fears. That quantitative and qualitative findings appear mutually reflective and supportive, is clearly both an exciting and paradigmatically interesting concept.

The dominant and most powerful influence within women's maternity experience, this study suggests, is the need to be a 'good mother'. This posits a theory of mothering that begins from the earliest point in the maternity experience, when women confirm their pregnancies. Women represent themselves as good mothers through their actions which include the responsible choices that they make for care and site of delivery. Despite policy moves which promote pregnancy and birth as normal and natural (Downe 2005), the authority of the medical model remains implicit in women's narratives, as choices are constrained or supported by the normality of their pregnancies. The desire and aspiration to be seen as normal is both reflected and embedded in the responses women make to questionnaires. This occurs predominantly because women perceive that normality epitomises a good mother. How the normal/abnormal pregnant woman dichotomy facilitates choice is generally less prevalent in women's accounts, although for those women subsequently deprived of choice it remains an important and influential pressure. It is clear that whilst choice is offered to women it remains a concession from experts, who retain the power to remove it at any time under the guise of ensuring fetal well-being.

Despite the premise of choice being to empower women to achieve the birth experience they desire, no fundamental rejection of the medical model of childbirth or devolution of power to women is apparent within the qualitative or quantitative findings of this study. Throughout pregnancy, choice is simultaneously promised by the consumerist choice discourse and inhibited by the medical model, initially through the GP, but then subsequently and continually by 'expert knowledge'. The medical discourse of birth as a risky event remains a powerful and influential discourse, which continues to locate pregnancy and childbirth within a domain of expertise. No credence is given to women's own expertise of their own bodies. Women desire choice and aspire to a birth experience perceived as normal and natural, as the gold standard, and choices for some are based more on normal and natural aspirations. However, women are visibly preoccupied with labour in late pregnancy and worries for many emerge from their engagement with the medical model and are reinforced by experienced labourer accounts, which are predominantly deviant from the normal and natural. Against this backdrop, women's aspirations to be a good mother often suppress personal desires, as they make choices they believe will safeguard the well-being of their babies. These fears clearly manifest in the CWS socio-medical scores and women's accounts, which reveal that women are concerned about birth and the environment within which it takes place. Contemporaneously, fears about giving birth merge with concerns about meeting the ideal standard of a 'controlled labourer', which is often perceived to be facilitated by pain relief only available in medical units. Whilst these women could be perceived to have made choices, it is clear that personal desires are not the primary driver for those choices.

Whilst the authority retained by the medical model in childbirth continues to impact on and/or rescind a woman's right to choice, women in both the qualitative and quantitative study do not suggest a wish to remove childbirth from the realm of expertise. The significant input provided by 'experts' is not only experienced by women but evidently desired. Choice has been suggested as intimately connected to the level of control that women seek in pregnancy and birth. However, for all women choices are made with the expectation that control will be handed over to experts at some point in their pregnancies and certainly in labour. This is embedded in women's desires to be cared for particularly in labour, with experts also seen as facilitating a culturally acceptable 'controlled labourer' status. This handover of control is as prevalent in the narratives of women choosing to deliver at the birth centre as it is at the other units. What are strikingly different are the emotional consequences for the birth centre women who were unable to fulfil their desires for birth as normal and natural.

Women clearly perceive experts as fundamental to both reassuring and facilitating their 'good mother' status throughout their maternity experience. This creates the greatest difficulties for women in the postnatal period when the disparity between articulated experience and questionnaire defined desire widens as expert input decreases. Women express the belief that postnatal care particularly in the early postnatal period is not only fundamental in making the adjustment to 'a real mother' but also plays a facilitatory role in women's attainment of a postnatal 'good mother' identity. Failure to provide women with individualised and adequate levels of support leaves them lacking confidence in the ability to care for their babies and infused with feelings of guilt and failure. Lack of care is most apparent for women in the early postnatal period where they feel uncared for and too quickly pushed from dependence to independence. The implications for the choice debate are that this concept needs to be extended into the postnatal period and postnatal women should be afforded negotiated options for care that meet individualised needs. There are evident deleterious and enduring ramifications for individual women, of leaving hospital feeling a lack of confidence in caring for their babies, which result in significant postnatal psychological distress.

The narrative accounts of women reveal the pressures and challenges that women are faced with as they progress through the pregnancy, birth and postpartum cycle. It seems equally apparent in their questionnaire responses that women in pregnancy are faced with both physical and psychological challenges. What is also clear is that offering choices for care alone does not impact on the psychological domains assessed in this study. Women clearly experience emotional responses throughout their experience, which are periodically quite extreme, as they are bombarded by many different influences, discourses and events and aspire to ideal identities. All women regardless of the choices they make for maternity care conform to the conventional representations that surround them across their maternity experience. It is apparent in women's narratives that choice is a potentially powerful concept, which might create greater pressure for women to prove themselves as normal in order to realise their ideal maternity experience. Predominantly however, desired experience is secondary to the well-being of their babies and choices are made based on that rationale. The legacy of the medical model remains powerful in women's assessment of how well-being is assured and to a great extent provides the justification for the choices that women make. For others, who are less engaged with the medical model and who seek a normal and natural experience, albeit under the remit of experts, the removal of promised choice has explicit emotional consequences. However, even that emotional distress is moderated and rationalised through the healthy outcome of a normal, live baby.

The failure of the questionnaires to access any psychological distress by group could be afforded a twofold explanation. Maternity care continues to be the domain of experts, whether doctors or midwives, who as clinicians retain expert knowing which is privileged above personal knowing. Midwives are perceived by women as guardians of the normal and indeed acknowledged as such, yet while providing women with distinctive support, as clinicians they simultaneously speak through the medical model, constraining women's choices and freedom to act, irrespective of women's choices for care. Women perceive the maternity system as a fundamental necessity to both validate their pregnancies and reassure their good mother status. Within that context, perhaps women are realistic about choice in its current format; recognising and accepting that choice is restrained by normality and, whilst choices made reflect a desired ideal experience, they are also made in the knowledge that choice can be removed by experts. Overwhelmingly women display a willingness to sacrifice choice and control at any point in their pregnancies. Hence, choice may be made on the premise of which professional women feel happiest with or prepared to cede control to. Therefore, whilst choice is important to women it is not the key influence for psychological health within their maternity experiences that has previously been suggested.

It also seems possible that women's questionnaire responses predominantly expose their conformity to the normal and ideal, which although might be associated with a desire to facilitate choice appears more fundamentally associated with their desires to be good mothers. This seems supported by the corresponding pattern of responses across time for all groups, which appear to reflect the dominant discourses underpinning women's experiences narrated at these points in their pregnancies.

A further and even more pertinent explanation for why choice fails to impact on psychological outcomes is the disparate nature of women's psychological distress. The psychological distress depicted in women's accounts, whilst underpinned by perceived failures to meet the idealised cultural and societal depictions that surround pregnancy and childbirth, evolved from individualised biographies of maternity events and circumstances. Unfulfilled choice whilst perhaps identifiable as a contributory factor in some accounts did not achieve the status of a single contributory factor and was entirely absent from other accounts. The unmistakable multi-faceted nature of women's experience renders choice an important but on the whole small aspect of their maternity experience, which rather evolves out of a psychosocial matrix of maternity events, discourses, influences and aspirations. The level of postnatal distress is perhaps

mediated by personal resources, but is more clearly located in women's abilities to perform and perceive themselves as 'good mothers'.

The integrated findings presented in this chapter will be utilised to inform some final conclusions around choice in maternity care and to inform the recommendations for practice, service delivery and future research made in chapter 10.

Chapter 9: Study Limitations, Reflexive and Methodological Thoughts

Introduction

This chapter will begin by presenting the limitations of the study undertaken and a reflexive account, the purpose of this chapter is in part to provide transparency to the claims made and the conclusions presented in chapter 10 of this thesis. This chapter will also provide some methodological thoughts which will include suggestions for how the methodological process undertaken in this study has raised questions for future research.

Study Limitations

There are a number of obvious limitations to the study.

- The sample size of the quantitative arm of the study was relatively modest. However, numbers for the study were determined by a power calculation, which identified that with a power of 0.80 and a medium effect size specified (n2) with an alpha set at 0.05 (two-tailed) total sample size was calculated to be 200. In addition effect sizes demonstrated by the partial eta squared are small suggesting that even a larger study sample would fail to demonstrate any real effect that is clinically meaningful.

- The quantitative groups in this study comprised of unequal sample sizes. It should be noted that this problem was both unforeseeable and unavoidable and has been discussed in the methodology chapter. The smaller group (CLC) was made as large as possible and in order not to compromise the power of the study a further twenty-five women were recruited to the MLC/Acute unit group. It is noteworthy that this in reality was more reflective of actual service delivery in the clinical environment.

- The qualitative data demonstrate that there are psychological implications for some women when choice is removed, that were unable to be detected through the research design of the quantitative study. Although this could be considered a methodological flaw, it rather appears to demonstrate further the strength of an integrated methodological approach, which is more able to pick up the salient details of change difficult to access with a less flexible, purely quantitative research design.

- No women who agreed to participate in interviews gave birth or received postnatal care at the birth centre. This was an unfortunate and unforeseeable occurrence. However although this potentially limits the experiences that can be accessed through the postnatal interviews, this would in part seem to be countered by the theories that have been presented with regard to women's pregnancy experience regardless of choices for care.

Reflexive Notes

The researcher's prior knowledge and experiences in this study as a woman, a clinical midwife, a mother and an academic will inevitably be reflected in the chapters of this thesis. The following reflexive notes are not intended to provide a confessional of the researcher's personal experience, but rather to demonstrate methodological and theoretical openness and an awareness of the social interactions between the researcher and the women who agreed to take part in this research.

The opposing constructions of the researcher's role, within the positivist and interpretive paradigms, posed the first methodological problem within this research. In positivist approaches, whilst it is a stance that can undoubtedly be challenged, the researcher aims to be invisible so that results are untainted by prior knowledge, interactions and social values. Alternatively in qualitative interpretative approaches the researcher's own personal experience, knowledge, the relationships and interactions that characterise the research are acknowledged as a fundamental aspect of the data production, analysis and resultant conclusions. Attempting to be true to the paradigmatic roots of both the quantitative and qualitative aspects of this study, as through a conceptual triangulation framework, required each methodology to be written in its traditional format. This clearly creates possible problems for a reader of this thesis and potentially for how it is judged when a mixture of the third and first person is used. However it was felt that to write it otherwise would compromise the eventual credibility of the research. One of the fundamental aims of this research influenced by feminist theory was prioritising the voice of women. Hence, it could have been argued that the use of the first person throughout the methodology section would have provided the greatest transparency of how that could be achieved. To write the quantitative in that way would however have fundamentally jarred with academic tradition and seemed a risk too far. Conversely reflexivity was an integral part of the qualitative methodology. When writing the qualitative methodology and justifying the framework for analysis, in particular, as credible and legitimate, an honest and clear account of the rationale,

personal thought and procedures seemed essential to the final coherence and trustworthiness of the research. This dilemma demonstrates a reality of the inherent difficulties that methodological eclecticism presents for researchers.

Consideration must also be given to whether one set of findings was prioritised and potentially informed the eventual interpretations and conclusions. This suggestion might seem a greater possibility given that the integrated findings were presented through the quantitative results. Whilst both studies were run simultaneously, it was a practical impossibility for analysis to be concurrent and so completely independent. Analysis was interwoven, in part, due to the longitudinal nature of the study. The first observation quantitative analysis, because of its nature, was completed first and may well have influenced the initial interpretations of the women's accounts. The transparent way in which the framework for analysis has been presented hopes to counter such arguments. Identities and themes that emerged from the early qualitative analysis, such as the powerful influence of the fetus and the good mother/bad mother dichotomy, could not in any way claim to have been informed by the quantitative findings. In addition although several initial interpretations of the quantitative data were able to be supported, many other alternative interpretations and broader and wider concepts were developed through integrating the findings.

The conclusions to follow in chapter 10, could never have been envisaged at the start of this research. Whilst a personal conviction to the benefits of a mixed method approach was consistent throughout this study, reading around methodological eclecticism was somewhat disappointing. It seemed that many of the methodological models posited were actually fairly superficial. A clear case for complementarity existed but the case for integration was less powerful than hoped for. Despite best attempts, many approaches and arguments for methodological eclecticism failed fundamentally to address the ontological arguments. Due to time constraints and the need to progress, the intended deep exploration of methodology had to be addressed by adopting a pragmatic argument and the use of conceptual triangulation. This, to all intents and purposes, appeared to be an abandonment of the integrated methodological approach that was intended at the start of this study. However, it would seem, the extremely successful fusion of the qualitative and quantitative findings in this study heralds the advantages of an integrated approach.

Methodological Thoughts

The underpinning ethos of this study was always a belief that psychological health must be understood from a multi-dimensional perspective. Hence, the use of a mixed method approach in this study was pursued in order to understand as comprehensively as possible the relations between choice and psychological outcomes and experience in maternity care. The outcome measures were intended to present a generalisable depiction of whether one care option conferred psychological benefit over another. The women's biographies were intended to help to generate and underpin a theory of how choice impacted on psychological health and experience through subjective collective experiences. Whilst individual biographies clearly became an important and illuminating aspect of analysis, they were not initially the primary interest. What became apparent, however, is that women's psychological health was best understood when it was seen in the wider context of women's whole experience and everything that was told by the person either qualitatively or quantitatively. Some of that wider context was inevitably lost in the necessity of breaking up the whole into categories which could then be compared and integrated. However the qualitative comparative analysis attempted to be faithful to women's unique biographies throughout as well as to their shared characteristics and identities.

It seems apparent however, that both the subjective and objective findings present women in the same way, that is, through their constructions of the self in pregnancy. Women understand and enact both the material and emotional reality of pregnancy within the circulating discourses surrounding maternity; they both conform to and represent themselves through those same discourses regardless of the medium of expression. This could claim to support the view that interpretivist and positivist methodologies are not as incommensurable as some purists would like to suggest. The first draft of the quantitative findings discussion was based on building up a series of feasible interpretations through the researcher's own knowledge and experiences within the subject area. The subjective accounts provided by the women have allowed conclusions to be drawn that offer an enriched, multi-dimensional, more complex, nuanced and arguably more ethical view of women's psychology of childbirth. Further, it might be suggested that the use of a mixed method approach has indeed resulted in an integrated theoretical model of choice in maternity care, which neither methodological design in isolation could have accessed, demonstrating a practical and potentially powerful way of designing future research studies. The powerful arguments created through the integrated findings present both the qualitative and quantitative findings as emerging out of cultural and societal discourses. If both sets of results present women in the same way and both sets of

knowledge arise out of the same culture, so it could be suggested that the ontological distinction that underpins incommensurability is a false one. Further discussion of these issues is beyond the scope of this thesis but will be further explored in post-doctoral work. It seems entirely possible that the methodological success of this study, provides a platform for the development of integrated methodological approaches that challenge the fundamental underlying ontological premise and satisfactorily address paradigm incommensurability.

One suggestion might be that the apparently successful fusing of methodological approaches where the quantitative is interpreted and broadened through the qualitative, affords sensitivity to the objective findings which would otherwise not have been revealed. One potential utility being, hypotheses for further investigation of choice in maternity care can be based on subjective theoretical knowledge rather than scientific assumption. A further if more tentative question is whether there is a mutual recompense, where reading the subjective accounts through the quantitative can claim to make the qualitative more generalisable? This could have the pragmatic benefits suggested earlier in the thesis of presenting integrated findings through a mutually reflective lens. In a health care arena qualitative research is often seen as simply less credible and easily marginalised. Presenting the data through the quantitative may indeed provide a gateway to claim that qualitative findings can equally relate and provide inference for populations wider than just study participants.

The utility of measures for health care professionals to aid recognition of psychological distress during routine clinical care clearly merits further debate and discussion. The utility of psychometric measures is in their claim to successfully identify associations and trends between and within groups and patterns of behaviour. Corresponding rather than differing response patterns were plainly identified within this study between the study groups. However, this can only take place within the terms that the measures themselves lay down, that is, scientifically defined definitions of the psychological domains measured. The measures themselves arise out of a culture which recognises and represents pregnancy, childbirth and postnatal adjustment as a time of emotional vulnerability. Measures currently limit the language through which women can express their psychological status during pregnancy. As such it seems that they simultaneously co-create and allow women to represent their cultural constructions of maternal psychological health. The very act of measuring such concepts brings them into being for women, limits the way their emotions can be understood and perpetuates a dominant and normalising discourse to which women then conform. A common critique of

psychological measures is that they cannot provide us, however, with the meaning and understanding that women themselves during pregnancy and following birth attribute to such concepts or the way in which they are culturally or socially absorbed and articulated. Hence the findings lack contextual explanation and ecological validity. Whilst measures will always struggle to access the complexity of individual experience, they also potentially appear to provide a medium to understand women's construction of themselves through societal and cultural normalising discourses, which clearly merits further investigation. Quantifiable measures able to assess and identify those women at risk from clinically relevant psychological ill health are undoubtedly of clinical utility, relevance and value. Indeed, the development and evaluation of predictive measures/risk identifiers for antenatal and/or postnatal psychological distress would be of significant clinical value. What seems apparent, however, is that greater clarity and contextual sensitivity is needed over what psychometric measures are measuring and representing about women's maternity experiences. Hence, further assessment of psychometric research instruments should be conducted within a psychobiological, psychosocial and 'psychocultural' context to develop a contextually sensitive account of what they actually measure in a maternity setting.

It should be acknowledged that whilst the findings of this study undoubtedly fused and integrated to generate some powerful conclusions, there are potential ethical implications if research findings are divergent or contradictory. Although it can be argued that divergence is as useful as convergence, this clearly creates difficulties in interpreting the findings. Within a model, such as the one adopted for this study, where neither methodological approach or set of findings should be prioritised, this then begs the question which set of results should be firstly believed as the 'true account' and secondly, does one set of results become prioritised because of the context of the aims and objectives of the research. This raises both an interesting question and potential dilemma for researchers. Participation in a research study could firstly be considered more burdensome to participants than they might first envisage and so to disregard findings could be considered unethical. Further, there is an inherent responsibility for the researcher to be true to the accounts they generate whether quantitative or qualitative in nature.

Summary

The above chapter is an attempt to provide an honest and transparent context to the conclusions presented in the following chapter. It has openly acknowledged both the study's limitations and the researcher's role within the process. Further, in an attempt to

be provide a critical appraisal of its own methodological approach it has aimed to increase and inspire confidence in the conclusions to follow.

Chapter 10: Conclusion

Introduction

The following chapter will utilise the discussion of the integrated research findings, from Chapter 8, to draw some final conclusions around choice in maternity care. In essence the conclusions will highlight the complexity of choice in maternity care. Barriers to choice will be explored, some recommendations made as to how those barriers might be overcome and how further research might further illuminate the phenomenon. It will be theorized however, that women's own personal and collective constructions of the maternity experience constrain their maternity choices. An acknowledgement, that to date, has been fundamentally absent from the choice debate. The role of choice as a psychological remedy/safeguard will be questioned and conversely it will be suggested that offering women options for maternity care, potentially creates additional emotional challenges. The failure to extend a model of choice into the postnatal period will be critiqued and some thoughts on the role of caregivers and future practice will be presented.

Choice in Maternity Care

In a submission to a House of Lords debate on maternity services in 2003 the Royal College of GP's wrote '*It is extremely difficult to define the extent to which women have choice in maternity care*' (House of Commons Health Committee on Maternity Services 2003, p.5). The findings of this study have been able to provide a fascinating theoretical and psychological insight into the concept of choice in maternity care. The quantitative findings of the study, that there were no statistically significant differences between the 'options of care' groups, might not be entirely unexpected. The women in this study were all volunteers and self-selecting to their preferred care options, so could be assumed to have achieved their desired package of care resulting in comparable levels of emotional health. More psychologically pertinent and in need of further consideration and interpretation through women's experiences were the statistically significant differences observed over time for socio-medical subscale worries, MHLC 'powerful others' scores, QoL subscales scores and the interaction effects for general and social self-esteem in the early postnatal period. The corresponding profiles across the groups of HADS and EPDS anxiety and depression caseness and the relatively high levels of those identified, particularly by the EPDS, would suggest that choice is not conferring the improvement in psychological outcomes that might have been expected. The integration of the qualitative with these quantitative findings has supported, elaborated and provided a unique insight into the findings outlined above.

It has been demonstrated that choice is a far more complex phenomenon than both policy makers and consumerist discourse suggest and have women believe. Maternity choice is presented as a simple concept, which involves women making decisions about a lead professional for their pregnancy and birth and preferred site for delivery, in order to facilitate a desired birth experience, increase personal control and decision-making and promote satisfaction resulting in subsequent emotional well-being. Interpretation of the quantitative findings suggests that offering choice *per se* fails to impact on positive psychological outcomes and that no one care option confers any significant psychological benefit. It is apparent however, that such simplicity is not reflected in women's experiences. For women making maternity choices, there are inherent tensions. Desires are themselves multi-faceted, surreptitious influences affect women's actions and decisions, and choice also includes risk assessment and a rational thought process which results in an ordering of preferences.

That changes in service delivery have occurred facilitates the very undertaking of this study. However, this leads to other fundamental questions which are firstly, whether this has led to a major rethinking of the way in which pregnancy and childbirth are now perceived and secondly whether women have secured autonomy and honesty within the new maternity services. Choice is now a concept firmly embedded in the societal discourse that surrounds care during pregnancy and birth and as such has become not only expected and desired by women, but also, as this study has shown, another normative requirement to which women need to conform. Indeed, the establishment of choice as another idealised norm, in opposition to the claim that choice increases satisfaction and emotional well-being, can be seen to create additional pressures for some women who feel that they must firstly not only prove themselves as normal, but maintain that normality in order to realise their idealised maternity experience through choice. For others, their choices are made on the premise that normality cannot be assured until after birth. For these women they can only consider themselves normal after birth when everything has gone to plan (if it has). This group of women consider pregnancy and birth as something potentially problematic and as such choose to deliver at a hospital unit to have a safety-net. Both rationales seem reflected in the high socio-medical worry scores and HADS and EPDS defined anxiety and depression profiles at thirty-two weeks gestation. This inference is underpinned by the powerful nature of idealised normative representations of maternity, that women construct themselves within and through, and which inherently make choice complex.

As this thesis has suggested from the start, women are not the homogeneous group that the choice discourse assumes. Health policy (DoH 2004a), acknowledges that social inequalities in income, housing and nutrition inherently restrict choice and access to services. The claim that '*choice in maternity care is really a choice for the articulate middle classes*' (House of Commons Health Committee on Maternity Services 2003, p.7), would seem supported by the socio-economic profile of the groups in this study. Very few women from areas of social deprivation chose to deliver at the birth centre and the majority of birth centre bookings were from the more affluent areas. However, it could also be suggested that choice is based on tradition within the Hull and East Yorkshire areas. Women from within the Hull boundaries chose predominantly to deliver at the main maternity unit, regardless of socio-economic profile and women from the East Yorkshire district chose to deliver at the old East Yorkshire hospital site, which now houses the birth centre.

The findings of this study, however, reveal other more embedded, less explicit, constraints to choice that apply to a broader group of women. These implicit constraints exist in the form of the discourses and influences which construct normative and idealised identities which demand conformity from women. This conformity is apparent in both women's subjective and objective pregnancy accounts. The strongest and most dominant identity for women from early pregnancy is that of a 'good mother'. The drive to adopt the characteristics intrinsic in good mothering and to meet the ideology of motherhood is a key influence in women's experiences from the earliest point. This identity causes women to represent themselves within constructed childbirth norms, demonstrate advocacy and make responsible choices which prioritise the well-being of their babies. This as a consequence renders personal desires for a pregnancy and birth experience, which inform a key premise of maternity choice, less important although not non-existent. Whilst women clearly have personal desires about type of birth experience and environment for birth and pain relief, needs are ranked and predominantly rationalised through a safety premise. Thus birth choices involve no fundamental rejection of professional input, which is embedded in women's minds as the way to ensure a healthy birth outcome. Expert advice is both sought and recommendations for care are mostly listened to. Whilst these women are perceived to have made choices about their maternity care, they have often been presented with recommended care options rather than alternatives of care set out in the context of advantages and disadvantages, leaving the woman to make the decision. This is a key aspect of the maternity experience that clearly makes it difficult for women to have legitimate, meaningful and beneficial choice.

Involving women in choice and control aspects of their maternity experience has been part of the shift towards an acknowledgement of the psychology of childbirth. Choice as a concept aims to facilitate women's desires for the amount of control they wish to receive (Weaver 2000), in recognition that negative perceptions of care and lack of control, particularly during labour and birth, can be detrimental to postnatal psychological well-being (Green & Baston 2003). The study findings here add coherent extensions to those previous claims. Choice, more than facilitating women's desired birth experience, does appear to allow women to consider and make decisions about the professional input and type of control they desire or are prepared to accept, whatever their underpinning rationale. This would provide one feasible explanation for why no one care option conferred any significant psychological benefit in this study. That external control from 'powerful others' is highest in pregnancy regardless of care option is apparent in women's MHLC responses. Whether high levels of external control necessarily compromise internal control is less clear from these findings, however, the pregnant women in this study did demonstrate significantly lower MHLC internal control scores than their non-pregnant counterparts. There would clearly be clinical utility in being able to assess to what extent high levels of external LOC compromises internal LOC, particularly when LOC orientation has been linked to postnatal depression (Jomeen & Martin 2005c).

The LOC findings combined with the CWS results in this study reflect previous findings (Lowe 2000), that fear and apprehension regarding labour were associated with high levels of 'powerful others' and 'chance' LOC. This adds another interesting dimension to the issue of choice and control. Fear and apprehension causes women to willingly cede control to experts and indeed they both expect and desire to do so, particularly in late pregnancy and labour. They do, however, express desires to control how and to whom the mantle is handed over and choices are partly made on that premise. This rationale remains entrenched in the powerful way that pregnancy, birth and postnatal recovery are both constructed and represented within society. Women are driven to make responsible choices to assert their 'good mother' status, but responsible choices in turn remain informed by a depiction of birth as hazardous and the domain of 'expert knowing'. Choice gives women an active role in their maternity experience, which also leaves them open to criticism of making the wrong choice, that is, one which might endanger their babies. Women fundamentally, whilst often having a desired ideal experience, see challenging expert knowing, particularly in the face of a pregnancy or labour problem, as a risk which they are generally unprepared to take. The inherently problematic image of childbirth and the consequent expert management is embedded in

women's minds and reflected in the MHLC and socio-medical worry findings, the anxiety and depression profiles of women over time and further supported by women's personal accounts regardless of choices for care. So long as doctors and midwives as experts continue to devalue and dismiss women's 'personal knowing' and assert themselves as experts, then the childbearing women's right to choice regarding their own personal care, is liable to be limited.

The powerful role played by the GP in facilitating or impeding women's choices at the earliest point based on perceived normality, has been previously acknowledged (House of Commons Health Committee on Maternity Services 2003). The recommendations of that report suggest this could be addressed by alternative models of care such as direct access to midwives programmes. First and foremost this requires a culture change by women themselves, making choices and participating in decisions regarding maternity care remains an unusual and infrequent concept for women. Secondly, changes to practices and procedures will fail to address the problem, if midwives themselves fail to accept the level of control they are perceived by women to hold or that their professional attitudes are also culpable in restricting women's choices at the earliest point. Midwives are linked by women to normal and natural childbirth but paradoxically they are also clinical experts who, like the GP can act as the mouthpiece of the medical model. Changing systems and places of birth does not inherently provide the answer to this paradox. In this study, control by 'powerful others' was perceived to be the same regardless of options of care, indicating that midwifery led care is not as inevitably women centred as advocates would suggest and does not automatically lead to increased personal control for women. Whilst the obvious and recommended response (House of Commons Health Committee on Maternity Services 2003) is to advocate models for care that offer alternatives to the GP as the first and only point of contact, such schemes need to be piloted and evaluated empirically, in the context of women's experiences. The direct access to midwives programmes currently under consideration should not automatically be assumed to offer greater access to 'real' choice for women. All care providers, including midwives, need to be aware of how they reinforce dominant childbirth norms and the influence they assert over women's choices. The role of care providers in facilitating and constraining choice could be further illuminated by future research into the impact of interprofessional and intraprofessional relationships on choice in maternity care.

Midwifery led care is envisioned by women as a route to a more normal and natural pregnancy and birth experience, within a safe framework of expertise. The expectation

and desire for professional input in pregnancy is firmly embedded in women's minds, regardless of choices for care and is reflected in the combined findings of this study. Indeed, women feel uncared for and let down when needs and expectations for professional input are unmet. Choice and control are linked in women's minds and women seem to believe that one facilitates the other. Control, however takes many different guises and is about more than maintaining control over decision-making and maternity events but is also conceptualised by women in other ways. Choices can also reflect desires, for example, to retain control in labour facilitated by pain relief. Choices for women may be less about maintaining personal control throughout pregnancy and birth or a rejection of expert knowing, as has been previously suggested, and more about options, as suggested by Renfrew and colleagues (2003), that allow women to feel respected and treated as individuals and the manner in which that is handled by care givers. This would also provide a further explanation for the lack of significant differences in psychological outcomes between groups. Women are making decisions based on the type and amount of control they are willing to cede and to whom, therefore they are largely satisfied because the levels and nature of control experienced are as expected. Choice should perhaps be discussed in terms of women's desires for control within their experience regardless of site for delivery and not necessarily in terms of idealised birth experience.

The hegemony of expertise, monitoring and surveillance, in pregnancy and childbirth which occurs regardless of the type of care, undoubtedly facilitates the early recognition of abnormality. The ability to quickly identify and treat serious conditions or complications of pregnancy can claim success in reducing maternal and fetal mortality and morbidity. However, within a choice framework it creates difficulties for some women. Choice offered, within a framework of monitoring and potential abnormality, allows experts to rescind choice at any point during the pregnancy and birth experience. Women's accounts indeed suggest that, for some, choice remains almost a luxury and a privilege rather than a right. Whilst the foundation of women's choices is so multi-faceted and complex, choices made in early pregnancy with no knowledge of how the pregnancy will progress create a risk of unfulfilled choice. The ramifications of unfulfilled choice seem dependant on women's underpinning rationale for choice. A realistic vision of choice as constrained by normality, and recognition that choice can be removed by experts, appears to have less personal emotional consequences when choice is removed. However, there are also apparent emotional repercussions of unfulfilled choice. For example, the tensions inherent between women's idealised notions of birth as normal and natural and medicalised interventionalist approaches can

generate more damaging emotional consequences than if choice was never offered. The implications of promoting birth as fundamentally normal and natural whilst not being critiqued, as such, must recognise its impact on those women who fail to achieve a normal or natural pregnancy or birth. Choices to deliver under midwifery led care to provide access to pain relief and/or feelings of safety should not be dismissed as less valid and choice discourses must acknowledge the legacy of the medical model within women's decision-making in pregnancy. The problem of unfulfilled choice and its potential negative consequences could be further addressed by providing women with information but not asking them to make a choice about site for delivery in early pregnancy. Choices should be made in light of pregnancy progress and events and at a much later stage in pregnancy when choice then can be offered realistically to women.

The emotional consequences of unfulfilled choice revealed in individual women's accounts were unable to be detected through the quantitative research design employed in this study. This suggests that theories of choice in maternity must be supported by empirical evidence, accrued from within sensitive research designs, with the ability to detect individual as well as the collective consequences of unfulfilled choice. Choice should be part of maternity care but this does demand that care providers are able to present a realistic and honest depiction of what choice means. Expectations of care and site of delivery need to be realistic within the present climate and not idealised. Consumerist discourse is currently misleading; choice is not necessarily 'a right' for all women and needs to be candidly acknowledged. Choice if rescinded should be done so with full understanding, cooperation and consent from the woman. Further, this requires a consideration of the language care givers use to deprive women of choice, which potentially affords the blame for unfulfilled choice to the woman herself. The potentially negative emotional consequences of unfulfilled choice should be understood, acknowledged and monitored by maternity care providers. Care providers should be openly accountable to women for limited or unfulfilled choice. In addition, valuable insight could be provided by future research which considers the psychological outcomes and experiences of women openly excluded from choice due to medical or obstetric reasons.

Pregnant women regardless of their choices for care are bound by the psychological consequences of maternity discourses and influences, whether negative or positive. They are restricted by the limited images of childbirth and motherhood to which they have access; by the attitudes and language of the health professionals who look after them, the continuation of maternity care as a domain of expertise and the language to

which women themselves have access in order to express their emotional status. Pregnancy is clearly a time of emotional lability for women, as demonstrated by the HADS and EPDS caseness profiles in this study, which is enduring into the postnatal period. Further support for the impact of childbirth on emotional status is provided by the differences observed between the pregnant groups and the non-pregnant reference group data. Of particular interest are the HADS-D scores. Whilst these scores were not reflective of clinically relevant depression, they potentially acknowledge pregnancy's impact on mood and suggest that women themselves experience, recognise and express psychological aspects of pregnancy. The HADS has been questioned as a stable measure of anxiety and depression in pregnancy (Martin 2005; Karimova & Martin 2003) and as such any findings must be treated with caution. However, the insight provided by women's subjective accounts potentially suggests that the HADS-D, as the SF36 appears to, has the ability to access aspects of women's socially constructed self in pregnancy, childbirth and the postnatal period. An interesting concept, which would clearly merit further attention in future research studies.

The physical and psychological profiles of all groups as measured by the psychometric instruments in this study are in line with women's experiences at that time, such as physical changes, impending labour or postnatal adjustment. These profiles also predominantly reflect normative physical and psychological depictions of pregnancy and childbirth, depicting women's conformity to societal and cultural representations of childbirth. Choice, although not unimportant to women, rather than facilitating desired experience often rather facilitates the necessity to conform to desired idealised identities. It is the failures to meet these identities which appear to mediate enduring psychological distress rather than failures to fulfil a desired birth experience. This proffers a further explanation for the lack of effect that choice of care as a single variable makes with regard to psychological outcomes. Psychological distress when it does occur is individualised, disparate and emerges from a multifaceted psychosocial matrix. Choice although a possible risk factor for some women, cannot be afforded the status of a single causative factor. More relevant is an acknowledgement of the necessity women feel to conform to the dominant discourses and representations of pregnancy and the individualised crises this causes for women when they fail to achieve conformity.

Jean Ball in 1995 reporting her study of reactions to motherhood wrote;

> *"...although major changes have taken place in the way that maternity care is organised, and in the policies of delivery suites and neonatal units, comparatively little attention has been paid to postnatal care..."* (p.116)

First Class Delivery (Audit Commission 1997) noted that women made more negative comments about hospital postnatal services than any other aspect of their maternity care and it seems apparent that the ongoing changes in maternity service delivery have failed to have an impact on this status quo. Postnatal care although acknowledged in the NSF for Maternity Services (DoH 2004a) generally remains less considered in policy aims and objectives and a serious omission in the choice debate. Discrepancies between women's expectations and desires for support from care givers and received levels of support are clearly demonstrated in both the quantitative MHLC and CFSEI data and women's narratives. Lack of care reduces self worth by threatening the 'good mother' identity and engendering feelings of failure and guilt. This would seem to be reflected in the interaction effect revealed for general and social self esteem, although it should be acknowledged, that this interaction effect, as a consequence of choice, could not be explored fully through women's accounts because no postnatal birth centre narratives were available. Potential explanations for the discrepancies between expectation and receipt of care can be proffered by the assumed naturalness of mothering, the focus of maternity care on the well-being and safe delivery of the baby and the subsequent withdrawal of medical interest following that outcome as well as the often inadequate resourcing of postnatal services.

The qualitative results of this study have shown how personal and complex is women's adjustment to motherhood after birth. This highlights the need to focus attention on the individuality of women's experiences, particularly important when the mother is emotionally vulnerable because of factors or events over which she has no control. The skills and tools to recognise emotional vulnerability across the maternity spectrum alongside providing negotiated levels of individual care in the postnatal period would seem to be the key to identifying potential postnatal psychological distress. Self-esteem has been negatively correlated with both anxiety and depression in pregnancy (Jomeen & Martin 2004b). The clinical value of the quantitative findings around self-esteem, in the postnatal period, is the potential significance of self-esteem as an important psychological domain of relevance to the presentation of psychological disturbance. Midwives are ideally placed to ascertain self-esteem, through clinical interaction to identify indicators of low self-esteem. Further, investigation is warranted of the ability of these easily administered subscales to identify signs of underlying psychological vulnerability and risk of subsequent psychological sequelae. Psychological distress,

however, is undeniably about how women themselves experience their pregnancies, relationships and individual events over the whole maternity period. The multi-faceted nature of psychological distress must be understood and acknowledged and appropriately assessed by care providers. Clinical skills to recognise emotional vulnerability and lack of personal resources must be supported by strategic responses and clinical pathways should be developed to facilitate the monitoring of women's psychological well-being throughout pregnancy. Further, the way in which care is provided by midwives during the postnatal period has a clear and potentially enduring effect on women's emotional health. 'Debriefing' and reflection with women on their birth experience, particularly when choice is unfulfilled should be an integral part of postnatal care. This may be best facilitated by midwives who have built up relationships with women through continuity of care provider, although it should be assessed dependant on women's individual situations and needs. The failure to extend the consumerist model into the postnatal period appears to be a failure of the system to firstly fulfil its promise of choice and secondly an omission with consequences that unequivocally requires attention. It seems imperative that choice, as suggested in the NHS plan, should be extended to women about the type and duration of postnatal care they receive. Models of care should facilitate individualised and negotiated levels of postnatal support, which should clearly be made in partnership with the woman.

Caregivers have the potential to make a significant difference to a woman's psychological experience of childbirth regardless of her choices for care. This is likely to operate at many different levels, from the expert judgements that are made, the language that is used, how normality is presented, perceived and reinforced, how psychological vulnerability is recognised, understood and managed, to what extent women feel they are being cared for and cared about, supported, and able to make decisions affecting their care. Therefore, what an effective model of choice requires is a greater understanding, acknowledgement and respect of the complexity of how women understand and engage with not only their pregnancy, birth and postnatal experience but with the care system and its providers.

Summary

Choice is clearly here to stay within the healthcare arena and invests care givers with need to acknowledge choice with both integrity and responsibility. Models of care which offer choice need to be designed to take into consideration the dangers of offering choices that may not be fulfilled and of not extending choice into the postnatal environment. Foremost however, choice needs to be presented within a realistic, open and honest forum that acknowledges choice, even within the current politicised health landscape, as a limited

possibility. Women even as consumers, remain unequal partners as they struggle with a contemporary complexity of childbirth that involves the constraints of normalising discourses, their unique biographies, their potential vulnerability and the materiality of pregnancy and birth.

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Appendices

HULL AND EAST RIDING LOCAL RESEARCH ETHICS COMMITTEE

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Ms J Jomeen
Practice Development Midwife
Hull Maternity Hospital
Hedon Road
Hull

6 February 2003

Dear Ms Jomeen,

LREC/ 01/03/022
Protocol number: 04.01.03 version 1 The Pregnancy Well-being Study: An Investigation into the impact of choice of management on the psychological well-being of women during pregnancy and the postpartum

The Chair of the Hull and East Riding REC has considered the amendments submitted in response to the Committee's earlier review of your application on 20th January 2003 as set out in our letter dated 23rd January 2003. The documents considered were as follows:

- Your letter dated 4th February 2003 addressing the concerns of the committee

The Chair, acting under delegated authority, is satisfied that these accord with the decision of the Committee and has agreed that there is no objection on ethical grounds to the proposed study. I am, therefore, happy to give you the favourable opinion of the committee on the understanding that you will follow the conditions set out below.

Conditions

- You do not undertake this research in an NHS organisation until the relevant NHS management approval has been gained as set out in the Framework *for Research Governance in Health and Social Care.*

- You do not deviate from, or make changes to, the protocol without prior written approval of the REC, except where this is necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases the REC should be informed within seven days of the implementation of the change.

- You complete and return the standard progress report form to the REC one-year from the date on this letter and thereafter on an annual basis. This form should also be used to notify the REC when your research is completed and in this case should be sent to this REC within three months of completion.

- If you decided to terminate this research prematurely you send a report to this REC within 15 days, indicating the reason for the early termination.

- You advise the REC of any unusual or unexpected results that raise questions about the safety of the research.

Yours sincerely

Prof. S R Killick
Chair of the Hull and East Riding REC

LREC/ 01/03/022	**Please quote this number on all correspondence**

HULL AND EAST RIDING LOCAL RESEARCH ETHICS COMMITTEE

Room C24
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Ms J Jomeen
Practice Development / Research Midwife
Room 00-040 / Ground Floor
Women and Children's Hospital
Anlaby Road
Hull

1 April 2003

Dear Ms Jomeen,

LREC/ 01/03/022
Protocol number: 04.01.03 version 1 The Pregnancy Well-being Study: An Investigation into the impact of choice of management on the psychological well-being of women during pregnancy and the postpartum

Thank you for your letter dated 31st March 2003. The Hull and East Riding Local Research Ethics Committee acknowledges receipt of the following documents:

- Study Protocol – for Interviews version 1 dated 04/01/03
- Participant invitation letter
- Participant information leaflet
- Participant consent form
- Interview schedule

The Chair acting under delegated authority has reviewed the documents listed above and feels that the addition of the interviews to the study gives rise to no ethical issues providing that the interviews are carried out as per protocol version 1 dated 04/01/03.

Approval is therefore granted for this extension of the original protocol

Yours sincerely

Prof. S R Killick
Chair of the Hull and East Riding REC

LREC/ 01/03/022 Please quote this number on all correspondence

Hull and East Yorkshire Hospitals NHS
NHS Trust

Castle Hill Hospital
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HU16 5JQ

Research & Development Department
Clinical Governance Directorate
Admin Porta Cabin
01482 875875 Ext 3137/3936

Our Ref: LA/BH/

Your Ref: 2787

24 March 2003

Ms J Jomeen
Midwife
Hull Maternity Hospital

Dear Ms Jomeen,

Re: The Pregnancy Well-Being study: an Investigation into the impact of choice of management on the psychological well-being of women during pregnancy and the postpartum. ELSY ref. 2787

I am pleased to notify you formally that this study has been approved by the Trust and may now proceed. The Trust is required to return information on the progress of studies to the National Research Register, and to report research findings. We will, therefore, ask you every quarter for such updates, and would be very grateful if you would provide this information. I would like to wish you every success with this project.

Yours sincerely

Liz Allen

Liz Allen
Research & Development Facilitator

Hull and East Yorkshire Hospitals NHS
NHS Trust

INTERNAL MEMORANDUM

JD/JL/W&C

7 April 2003

Hull Royal Infirmary
Anlaby Road
Hull
HU3 2JZ

Ext. 5245
Fax. 4857/5940

From: Dr J F Dyet, Medical Director
To: Julie Jomeen, Practice Development Midwife

Thank you for your letter dated 3 April regarding your Pregnancy Well Being Study. I have had a look at the consent form and am happy with the arrangements you have made.

John Dyet

Hull and East Yorkshire Hospitals NHS Trust

Patient Identification Number:
Patient Maternity Number:

CONSENT FORM

Title of Project: Pregnancy Well Being Study

Name of Lead Researcher: Julie Jomeen: Midwife, Hull and East Yorkshire NHS Trust

1. I confirm that I have read and understood the information sheet dated 13.01.03 (Version 2) for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that sections of any of my medical notes may be looked at by responsible individuals from Hull and East Yorkshire NHS Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐
4. I understand that the information collected as part of this study may be looked at by responsible individuals from the Universities of York and Leeds where it is relevant to my taking part in this research. I give permission for these individuals to have access to the information I provide as part of this study. ☐
5. I agree to take part in the above study. ☐

Name of Patient	Date	Signature
Name of Person taking consent	Date	Signature
Researcher	Date	Signature

1 for patient; 1 for researcher; 1 to be with hospital notes

Hull and East Yorkshire Hospitals NHS
NHS Trust

Hull and East Yorkshire Women and Children's Hospital
Anlaby Road
Hull
HU3 2JZ

Patient Identification Number:

CONSENT FORM

Title of Project: Pregnancy Well Being Study

Name of Lead Researcher: Julie Jomeen: Midwife, Hull and East Yorkshire NHS Trust

1. I confirm that I have read and understood the information sheet dated 04.01.03 (Version 3) for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐
3. I understand that the information collected as part of this study may be looked at responsible individuals from the Universities of York and Leeds where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐
4. I agree to take part in the above study. ☐

Name of Patient	Date	Signature
Name of Person taking consent	Date	Signature
Researcher	Date	Signature

Pregnancy Well Being Study

Inclusion Criteria

- Pregnant women referred for maternity care within Hull and East Yorkshire NHS Trust
- Women whose first language is English

Exclusion Criteria

- Under 18 years of age
- Significant medical problems that may necessitate additional medical intervention during pregnancy (see list below)
- Significant obstetric problems that may necessitate additional medical intervention during pregnancy (see list below)
- Multiple Pregnancy
- IVF pregnancy
- Significant history of mental health problems
- Women who decline to be involved in the trial

Medical Exclusions

- Diabetes
- Hypertension or diastolic > 85, or systolic > 160 at booking
- Cardiac / renal disease
- Epilepsy
- Thrombosis or thrombophilia
- Any autoimmune disease – e.g. systemic lupus erythematosus / thyroid problems / rheumatoid disease
- Drug users
- Alcohol misuse
- Poorly controlled asthmatics – previous hospital admissions / oral steroid use

Obstetric Exclusions

- previous baby of birth weight < 2500g
- previous IUD, stillbirth or neonatal death
- 3 or more recurrent miscarriages preceding this pregnancy
- Previous termination for fetal abnormality

Hull and East Yorkshire Hospitals NHS Trust

Congratulations on your pregnancy, I am writing to ask for your help.

In the next week you will attend the hospital for a booking interview, so that you will receive the care required during your pregnancy. You should also have received a leaflet and information from your GP about the choices that are available to you for care during your pregnancy. These should include

- Midwifery Led Care with planned delivery at Hull Royal Infirmary
- Midwifery Led Care with planned delivery at the Birth Centre Castle Hill Hospital
- Consultant Led Care with planned delivery at Hull Royal Infirmary

You many well have decided which type of care you would like to opt for. As doctors and midwives we are now aware that emotions play a part in a healthy pregnancy and adjustment to motherhood. We are conducting a study into how much emotions change during pregnancy and following the birth of a baby and whether the type of care that you opt for has any impact on this. Therefore we would be very grateful if you would consider completing some questionnaires as part of this study. A detailed information leaflet about the study is attached.

We would need you to complete these questionnaires on 4 occasions, at your very first visit, when you attend for the routine 32-week appointment, approximately two weeks after the birth of your baby and finally when your baby is 6 months old. The questionnaire will take approximately 10 – 15 minutes to complete on each occasion

When you attend for your booking interview you will be asked by a midwife if you are interested in being involved in this study and will then ask you to sign a consent form.

A small selection of women will also be approached to ask if they would consider being interviewed In order to try and understand even better how women feel during their pregnancies and after the birth of their babies. If you are approached you would need to agree to be interviewed on the same four occasions that you fill in the booklet.

The interviews are planned to take about thirty minutes, although in total I would probably need about forty-five minutes of your time. The interviews will be taped although all information used from them will remain anonymous and you will not be able to be identified in any way. The interviews can either take place in your own home or at the hospital which ever is preferable to you.

We would be very grateful if you could take the time to be involved in our study as we are trying to ensure that the women of Hull are receiving the best care. However we do not in any way wish you to feel pressured into taking part in this study and if you decide not to be involved then it will in no way be detrimental to your care.

Many Thanks for your time in reading this letter

JULIE JOMEEN: PRACTICE DEVELOPMENT/RESEARCH MIDWIFE
(On behalf of midwives and doctors at Hull and East Yorkshire NHS Trust Maternity Services)

Hull and East Yorkshire Hospitals NHS Trust

Pregnancy Well being Study: Patient Information Leaflet

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Feel free to ask if there is any thing that is not clear or if you would like more information. Take your time to decide whether or not to take part and do not feel pressured in any way, if you refuse it will be in no way detrimental to your maternity care.

This study aims to identify the best care type for women both during and after pregnancy by exploring the impact of women's choice of care on emotional well being both during and after pregnancy. This is so that in the future we can provide the best maternity service possible to the women we care for. In total we hope to recruit 200 women to this study so your help is very important to us.

You have initially been identified by the fact that you are booking for maternity care within Hull, obviously we need a selection of women who choose different care options. That is why we have selected you to take part in this study

It is up to you to decide whether to take part or not. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are free to withdraw at any time without giving a reason. A decision to withdraw at any time or not to take part will not affect the standard of care that you receive.

A sticker will be placed on your hand held maternity record so that any health care professionals that you may see during your maternity care will be aware of your

involvement in this study, although your involvement will not in any way change the care you receive.

As part of this research you will be asked to complete a questionnaire booklet on four occasions. At your very first visit, when you attend for the routine 32 week appointment, approximately two weeks after the birth of your baby when you community midwife is visiting and finally when your baby is 6 months old.

The questionnaire will take approximately 10 – 15 minutes to complete on each occasion. For the first and second times you fill in the booklet, you will be asked to complete it following your appointment and leave it in the box that will provided prior to leaving. The third questionnaire booklet will be collected by your community midwife on her visit at about 10 – 12 days, and the fourth booklet will be sent to you for completion at home and a stamped addressed envelope will be included for return.

Although we ask for some personal information at the beginning of each booklet this is purely as a means to identify for future questionnaires. We will remove this information form the questionnaires before we look at the answers that you have given, so all your answers will be anonymous and the information you have given will be strictly confidential.

You may also be approached to ask if they would consider being interviewed In order to try and understand even better how women feel during their pregnancies and after the birth of their babies. If you were approached you would need to agree to be interviewed on the same four occasions that you fill in the booklet.

The interviews are planned to take about thirty minutes, although in total I would probably need about forty-five minutes of your time. The interviews will be taped although the tapes will be erased once the study is complete. All information used from them will remain anonymous and you will not be able to be identified in any way. The interviews can either take place in your own home or at the hospital which ever is preferable to you. Even if you have agreed to fill in the booklets this does not mean that you have automatically agreed to be interviewed. You will be approached separately for this and asked to sign a separate consent form. If you do not wish to be

interviewed please do not let this put you off filling in the questionnaires, as you will not be pressured in any way to be interviewed.

We are hoping to use the results of this research to inform future practice within maternity services both locally and nationally. We would hope to publish the results in a health care journal, within which you will not be identified in any way. As we are aware that many women will not read healthcare journals it is intended to hold an informal feedback evening to which you will be invited following completion of the study to present the study results.

Both the Hull and East Riding Local Research Ethics Committee and the Hull and East Yorkshire Hospitals NHS Trust have approved this study.

For further information please contact

Julie Jomeen: Practice Development/ Research Midwife
Hull and East Yorkshire NHS Trust

Tel: (01482) 382750
Pager: 07699 711814

Hull and East Yorkshire Hospitals
NHS Trust

NHS

Pregnancy Well-being Study

Introduction to the booklet

Firstly, thank you for your time in helping us with this important study.

As doctors and midwives we are now aware that emotions play a part in a healthy pregnancy and adjustment to motherhood. As part of a study we are conducting into how much emotions change during pregnancy and following the birth of a baby we would be very grateful for your help in completing the following questionnaires.

Most of the questionnaires either require you to put a tick in a box or circle a number. Please make sure you read the instructions for each set of questions carefully.

We hope that you will fill in these questionnaires on four occasions, *twice* during your pregnancy and *twice* after your baby has been born.

Although we do request some personal details from you at the beginning of this questionnaire, these are simply for the purposes of identifying you to send you questionnaires when you are 34 weeks pregnant 2 weeks and 6 months after the birth of your baby. We will remove this information from the questionnaires before we look at the answers you have given, so all your answers will remain strictly confidential.

We look forward to receiving the questionnaires back from you and hope you enjoy being part of this study.

Please fill in

Your Name .....

Your Address .....

(including your postcode) .....

1. How did you feel about finding out you were pregnant?
   - Overjoyed ☐
   - Pleased ☐
   - Mixed Feelings ☐
   - Not Very Happy ☐
   - Very Unhappy ☐

2. How many weeks pregnant are you now? .....

3. When is your baby due? ...../...../.....
   Date Month Year

4. What type of care have you chosen for your pregnancy?
   - Midwifery Led care/Birth Centre ☐
   - Midwifery Led Care/HRI ☐
   - Consultant Led Care ☐

5. How many previous pregnancies have you had? .....

6. How many children do you have? .....

7. Are you
   - Married ☐
   - With a Partner ☐
   - Single ☐

8. Here is a list of words that some women have used to describe their feelings about being pregnant. Please circle all of the words that describe how you feel at the moment.

Excited	Resentful	Confident
Happy	Anxious	Nothing Special
Fulfilled	Depressed	Protective
Maternal	Beautiful	Angry
Invaded	Powerful	Out of Control
Ugly	In Control	Stressed
Vulnerable	Detached	Serene

HAD Scale

Name: Date:

Doctors are aware that emotions play an important part in most illnesses. If your doctor knows about these feelings he will be able to help you more.

This questionnaire is designed to help your doctor to know how you feel. Read each item and place a firm tick in the box opposite the reply which comes closest to how you have been feeling in the past week.

Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than a long thought-out response.

Tick one box only in each section

1 I feel tense or 'wound up':
- Most of the time ☐
- A lot of the time ☐
- Time to time, Occasionally ☐
- Not at all ☐

2 I still enjoy the things I used to enjoy:
- Definitely as much ☐
- Not quite so much ☐
- Only a little ☐
- Hardly at all ☐

3 I get a sort of frightened feeling as if something awful is about to happen:
- Very definitely and quite badly ☐
- Yes, but not too badly ☐
- A little, but it doesn't worry me ☐
- Not at all ☐

4 I can laugh and see the funny side of things:
- As much as I always could ☐
- Not quite so much now ☐
- Definitely not so much now ☐
- Not at all ☐

5 Worrying thoughts go through my mind:
- A great deal of the time ☐
- A lot of the time ☐
- From time to time but not too often ☐
- Only occasionally ☐

6 I feel cheerful:
- Not at all ☐
- Not often ☐
- Sometimes ☐
- Most of the time ☐

7 I can sit at ease and feel relaxed:
- Definitely ☐
- Usually ☐
- Not often ☐
- Not at all ☐

8 I feel as if I am slowed down:
- Nearly all the time ☐
- Very often ☐
- Sometimes ☐
- Not at all ☐

9 I get a sort of frightened feeling like 'butterflies' in the stomach:
- Not at all ☐
- Occasionally ☐
- Quite often ☐
- Very often ☐

10 I have lost interest in my appearance:
- Definitely ☐
- I don't take so much care as I should ☐
- I may not take quite as much care ☐
- I take just as much care as ever ☐

11 I feel restless as if I have to be on the move:
- Very much indeed ☐
- Quite a lot ☐
- Not very much ☐
- Not at all ☐

12 I look forward with enjoyment to things:
- As much as I ever did ☐
- Rather less than I used to ☐
- Definitely less than I used to ☐
- Hardly at all ☐

13 I get sudden feelings of panic:
- Very often indeed ☐
- Quite often ☐
- Not very often ☐
- Not at all ☐

14 I can enjoy a good book or radio or TV programme:
- Often ☐
- Sometimes ☐
- Not often ☐
- Very seldom ☐

Number: Date:

As you are pregnant, we would like to know how you are feeling now. Please tick the answer that co closest to how you have felt in the past 7 days, not just how you feel today.

Tick one box only in each section

1 *I have been able to laugh and see the funny side of things:*
- As much as I always could ☐
- Not quite so much now ☐
- Definitely not so much now ☐
- Not at all ☐

2 *I have looked forward with enjoyment to things:*
- As much as I ever did ☐
- Rather less than I used to ☐
- Definitely less than I used to ☐
- Hardly at all ☐

3 *I have blamed myself unnecessarily when things went wrong:*
- Yes most of the time ☐
- Yes, some of the time ☐
- Not very often ☐
- No, never ☐

4 *I have felt worried and anxious for no very good reason:*
- No, not at all ☐
- Hardly ever ☐
- Yes, sometimes ☐
- Yes very often ☐

5 *I have felt scared or panicky for no very good reason:*
- Yes, quite a lot ☐
- Yes, sometimes ☐
- No, not much at all ☐
- No, not at all ☐

6 *Things have been getting on top of me:*
- Yes, most of the time I haven't Been able to cope at all ☐
- Yes, sometimes I haven't been Coping as well as usual ☐
- No, most of the time I have coped quite well ☐
- No I have been coping as well as ever ☐

7 *I have been so unhappy that I have had difficulty sleeping:*
- Yes, most of the time ☐
- Yes, sometimes ☐
- Not very often ☐
- No, not at all ☐

8 *I have felt sad or miserable:*
- Yes, most of the time ☐
- Yes, quite often ☐
- Not very often ☐
- No, not at all ☐

9 *I have been so unhappy that I have been crying:*
- Yes, most of the time ☐
- Yes, quite often ☐
- Only occasionally ☐
- No, never ☐

10 *The thought of harming myself has occurred to me:*
- Yes, quite often ☐
- Sometimes ☐
- Hardly ever ☐
- Never ☐

Worry! Worry! Worry! Worry! Worry! Worry! Worry!

Most of us worry about something. This list is not meant to give you more things to worry about, but we would like to know if any of these things are worrying you at all. Please circle a number for each to show how much of a worry it is to you at the moment – from 0 if it is not a worry to 5 if it is something that you are extremely worried about.

	Not a Worry				Major Worry
1. Your Housing	1	2	3	4	5
2. Money Problems	1	2	3	4	5
3. Problems with the law	1	2	3	4	5
4. Your relationship with your husband/partner	1	2	3	4	5
5. Your relationship with you family and friends	1	2	3	4	5
6. Your own health	1	2	3	4	5
7. The health of someone close to you	1	2	3	4	5
8. Employment problems	1	2	3	4	5
9. The possibility of something being wrong with the baby	1	2	3	4	5
10. Going to hospital	1	2	3	4	5
11. Internal examinations	1	2	3	4	5
12. Giving birth	1	2	3	4	5
13. Coping with a new baby	1	2	3	4	5
14. Giving up work (if applicable)	1	2	3	4	5
15. Whether you partner will be with you for the birth	1	2	3	4	5
16. The possibility of miscarriage	1	2	3	4	5

MHLC **FORM C**

Each item below is a belief statement about your pregnancy, with which you may agree or disagree. Beside each statement is a scale which ranges from strongly disagree (1) to strongly agree (6). For each item we would like you to circle the number that represents the extent to which you agree or disagree with that statement. The more you agree with a statement, the higher the number you circle. The more you disagree with a statement, the lower will be the number you circle. Please make sure you answer **EVERY ITEM** and that you circle **ONLY ONE** number per item. This is a measure of your personal beliefs: obviously there are no right or wrong answers.

1 = STRONGLY DISAGREE (**SD**)
2 = MODERATELY DISAGREE (**MD**)
3= SLIGHTLY DISAGREE (**D**)
4 = SLIGHTLY AGREE (**A**)
5 = MODERATELY AGREE (**MA**)
6 = STRONGLY AGREE (**SA**)

1. If my condition worsens, it is my own behaviour which determines how soon I will feel better again.

   1 2 3 4 5 6

2. As to my condition, what will be will be

   1 2 3 4 5 6

3. If I see my doctor regularly, I am less likely to have problems with my condition

   1 2 3 4 5 6

4. Most things that affect my condition happen to me by chance

   1 2 3 4 5 6

5. Whenever my condition worsens, I should consult a medically trained professional

   1 2 3 4 5 6

6. I am directly responsible for my condition getting better or worse.

   1 2 3 4 5 6

7. Other people play a big role in whether my condition improves, stays the same or gets worse

   1 2 3 4 5 6

8. What ever goes wrong with my condition is my own fault.

   1 2 3 4 5 6

9. Luck plays a big part in determining how my condition improves

1 2 3 4 5 6

10. In order for my condition to improve, it is up to other people to see that the right things happen

1 2 3 4 5 6

11. Whatever improvement occurs with my condition it is a matter of good fortune

1 2 3 4 5 6

12. The main thing which affects my condition is what I myself do

1 2 3 4 5 6

13. I deserve the credit when my condition improves and the blame when it gets Worse

1 2 3 4 5 6

14. Following doctors orders to the letter is the best way to keep my condition from getting any worse

1 2 3 4 5 6

15. If my condition worsens it is a matter of fate

1 2 3 4 5 6

16. If I am lucky my condition will get better

1 2 3 4 5 6

17. If my condition takes a turn for the worse, it is because I have not been taking proper care of myself

1 2 3 4 5 6

18. The type of help I receive from other people determines how soon my condition improves

1 2 3 4 5 6

SF36 V2.

These questions ask for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer each question by marking a cross in the appropriate box. If you are unsure on how to answer a question, please give the best answer you can.

1. In general, would you say your health is:
(please place a cross in one box)

Excellent	Very Good	Good	Fair	Poor
☐	☐	☐	☐	☐

2. **Compared with six months ago,** how would you rate your health in general **now**?
(please place a cross in one box)

Much better now than six months ago	Somewhat better now than six months ago	About the same as six months ago	Somewhat worse now than six months ago	Much worse now than six months ago
☐	☐	☐	☐	☐

3. The following questions are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

(please place a cross in one box on each line)

ACTIVITIES	Yes, limited a lot	Yes, limited a little	No, not limited at all
a) **Vigorous activities,** such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
b) **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
c) Lifting or carrying groceries	☐	☐	☐
d) Climbing **several** flights of stairs	☐	☐	☐
e) Climbing **one** flight of stairs	☐	☐	☐
f) Bending, kneeling or stooping	☐	☐	☐
g) Walking **more than a mile**	☐	☐	☐
h) Walking **several hundred yards**	☐	☐	☐
i) Walking **one hundred yards**	☐	☐	☐
j) Bathing or dressing yourself	☐	☐	☐

4. During the **past 4 weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

(please place a cross in one box on each line)

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a) Cut down the **amount of time** you spent on work or other activities	☐	☐	☐	☐	☐
b) **Accomplished less** than you would like	☐	☐	☐	☐	☐
c) Were limited in the **kind** of work or other activities	☐	☐	☐	☐	☐
d) Had **difficulty** performing the work or other activities (for example, it took extra effort)	☐	☐	☐	☐	☐

5. During the **past 4 weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious) ?

(please place a cross in one box on each line)

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a) Cut down the **amount of time** you spent on work or other activities	☐	☐	☐	☐	☐
b) **Accomplished less** than you would like	☐	☐	☐	☐	☐
c) Did work or other activities **less carefully** than usual	☐	☐	☐	☐	☐

6. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

(please place a cross in one box)

Not at all	Slightly	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

7. How much **bodily** pain have you had during the **past 4 weeks**?

(please place a cross in one box)

None	Very mild	Mild	Moderate	Severe	Very severe
☐	☐	☐	☐	☐	☐

8. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)

(please place a cross in one box)

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

9. These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks...**

(please place a cross in one box on each line)	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a) Did you feel full of life?	☐	☐	☐	☐	☐
b) Have you been very nervous?	☐	☐	☐	☐	☐
c) Have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐
d) Have you felt calm and peaceful	☐	☐	☐	☐	☐
e) Did you have a lot of energy?	☐	☐	☐	☐	☐
f) Have you felt downhearted and depressed?	☐	☐	☐	☐	☐
g) Did you feel worn out?	☐	☐	☐	☐	☐
h) Have you been happy?	☐	☐	☐	☐	☐
i) Did you feel tired?	☐	☐	☐	☐	☐

10. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting friends, relatives, etc.)
(please place a cross in one box)

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

11. How TRUE or FALSE is **each** of the following statements for you?
(please place a cross in one box on each line)

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a) I seem to get sick a little easier than other people	☐	☐	☐	☐	☐
b) I am as healthy as anybody I know	☐	☐	☐	☐	☐
c) I expect my health to get worse	☐	☐	☐	☐	☐
d) My health is excellent	☐	☐	☐	☐	☐

Pittsburgh Sleep Quality Index

The following questions relate to your usual sleep habits during the past month *only*. Your answers should indicate the most accurate reply for the *majority* of days and nights in the past month.
Please answer *all* the questions.

1. During the past month, when have you usually gone to bed at night?

USUAL BED TIME: _____

2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

NUMBER OF MINUTES: _____

2b. How long have you usually been awake during the night?

NUMBER OF MINUTES: _____

3. During the past month, when have you usually got up in the morning?

USUAL GETTING UP TIME: _____

4. During the past month, how many hours of *actual* sleep did you get at night? This may be different to the number of hours you spend in bed.

HOURS OF SLEEP PER NIGHT: _____

4b. How many nights per week do you usually have difficulties sleeping?

NUMBER OF NIGHTS PER WEEK: _____

5. During the past month, how often have you had trouble sleeping because you:

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
(a) Cannot get to sleep within 30 minutes				
(b) Wake up in the middle of the night or early morning				
(c) Have to get up and use the bathroom				
(d) Cannot breathe comfortably				
(e) Cough or snore loudly				

(f) Feel too cold				
(g) Feel too hot				
(h) Had bad dreams				
(i) Have pain				

(j) Other reason(s), please describe_____

_____

_____

_____

_____

How often during the past month have you had trouble sleeping because of this?

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

6. During the past month, how would you rate your sleep quality overall?

Very good ____ Fairly good _____ Fairly bad _____ Very Bad _____

7. During the past month, how often have you taken medicine (prescribed or 'over the counter') to help you sleep?

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

8. During the past month, how often have you had trouble staying awake while driving, eating meals or engaging in social activity?

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

No problem at all _____ Only a very slight problem _____ Somewhat of a problem _____ A very big problem _____

10. Do you have a bed partner or room-mate?

No bedpartner or room-mate _____ Partner/ room-mate in other room _____ Partner in same room, but not same bed _____ Partner in same bed _____

If you have a roomate or bed partner, ask him/ her how often in the past month you have had:

(a) Loud snoring

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

(b) Long pauses between breaths while asleep

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

(c) Legs twitching or jerking while you sleep

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

(d) Episodes of disorientation or confusion during sleep

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

(e) Other restless while you sleep; please describe

_____

_____

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

Please mark each question in the following way:

If the question **describes how you usually feel**, make a check mark (√) in the yes column. If the question **does not describe how you usually feel**, make a check mark (√) in the no column.

Check only one column (either yes or no) for each of the 40 questions: This is **not** a test, and there are no right or wrong answers

	Yes	No
1. Do you only have a few friends?	☐	☐
2. Are you happy most of the time?	☐	☐
3. Can you do most things as well as others?	☐	☐
4. Do you like everyone you know?	☐	☐
5. Do you spend most of your free time alone?	☐	☐
6. Do you like being female?	☐	☐
7. Do most people you know like you?	☐	☐
8. Are you usually successful when you attempt important tasks or assignments?	☐	☐
9. Have you ever taken any thing that did not belong to you?	☐	☐
10. Are you as intelligent as most people?	☐	☐
11. Do you feel you are as important as most people?	☐	☐
12. Are you easily depressed?	☐	☐
13. Would you change many things about yourself if you could?	☐	☐
14. Do you always tell the truth?	☐	☐
15. Are you as nice looking as most people?	☐	☐
16. Do many people dislike you?	☐	☐
17. Are you usually tense or anxious?	☐	☐
18. Are you lacking in self-confidence?	☐	☐
19. Do you gossip at times?	☐	☐
20. Do you often feel that you are no good at all?	☐	☐
21. Are you as strong and healthy as most people?	☐	☐
22. Are your feelings easily hurt?	☐	☐
23. Is it difficult for you to express your views or feelings?	☐	☐
24. Do you ever get angry?	☐	☐
25. Do you often feel ashamed of yourself	☐	☐
26. Are other people generally more successful than you are?	☐	☐
27. Do you feel uneasy much of the time without knowing why	☐	☐
28. Would you like to be as happy as others appear to be?	☐	☐
29. Are you ever shy?	☐	☐
30. Are you a failure?	☐	☐
31. Do people like your ideas?	☐	☐
32. Is it hard for you to meet new people?	☐	☐
33. Do you ever lie?	☐	☐
34. Are you often upset about something?	☐	☐
35. Do most people respect your views?	☐	☐
36. Are you more sensitive than most people?	☐	☐
37. Are you as happy as most people?	☐	☐
38. Are you ever sad?	☐	☐
39. Are you definitely lacking in initiative?	☐	☐
40. Do you worry a lot?	☐	☐

As part of this study we would also like to interview some ladies about their experiences of pregnancy and childbirth.

The interviews are planned to take about thirty minutes, although in total I would probably need about forty-five minutes of your time. The interviews will be taped although the tapes will be erased once the study is complete. All information used from them will remain anonymous and you will not be able to be identified in any way. The interviews can either take place in your own home or at the hospital which ever is preferable to you. Even if you have agreed to fill in the booklets this does not mean that you have automatically agreed to be interviewed.

If you would be prepared to be interviewed please could you fill in your name and telephone number below and I will be in touch with you over the next few days to arrange an appointment.

Name .....

Telephone Numbers

Daytime .....

Evening .....

Non-significant Descriptive Statistics

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the HADS-A subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	6.03	3.41	6.25	.51	5.24-7.26
	32 weeks	6.64	3.76	6.89	.57	5.77-8.01
	14 days	6.10	3.61	6.26	.54	5.19-7.33
	6 months	6.15	3.70	6.44	.60	5.26-7.62
MLC HRI	14 weeks	6.32	2.89	6.12	.41	5.31-6.94
	32 weeks	6.94	3.03	6.72	.46	5.82-7.62
	14 days	6.40	2.89	6.26	.43	5.40-7.12
	6 months	6.21	3.44	5.96	.48	5.02-6.91
CLC	14 weeks	5.87	2.56	6.11	.80	4.52-7.69
	32 weeks	7.33	3.60	7.59	.89	5.84-9.35
	14 days	7.86	3.25	8.04	.85	6.36-9.71
	6 months	6.87	3.58	7.16	.93	5.32-9.01
Total	14 weeks	6.16	3.01	6.16	.34	5.49-6.83
	32 weeks	6.89	3.35	7.07	.38	6.32-7.81
	14 days	6.49	3.22	6.85	.36	6.15-7.56
	6 months	6.28	3.52	6.52	.39	5.74-7.30

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the HADS: -D subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	3.92	2.64	4.10	.40	3.30-4.90
	32 weeks	3.81	2.31	5.41	.47	4.49-6.33
	14 days	5.23	3.49	5.25	.54	4.19-6.31
	6 months	5.10	3.73	5.35	.54	4.28-6.43
MLC HRI	14 weeks	3.81	2.31	3.65	.32	3.01-4.29
	32 weeks	4.90	2.61	4.72	.37	3.98-5.46
	14 days	4.89	2.88	4.87	.43	4.02-5.72
	6 months	4.11	2.88	3.89	.44	3.03-4.76
CLC	14 weeks	3.00	2.07	3.18	.63	1.93-4.44

	32 weeks	5.13	3.02	5.35	.73	3.91-6.79
	14 days	4.53	3.36	4.56	.84	2.90-6.21
	6 months	4.07	3.24	4.33	.85	2.65-6.02
Total	14 weeks	4.43	3.24	3.64	.27	3.12-4.17
	32 weeks	5.03	2.74	5.16	.31	4.55-5.77
	14 days	4.96	3.14	4.89	.35	4.19-5.59
	6 months	4.44	3.24	4.52	.36	3.81-5.24

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for EPDS scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Mean	SE	CI (95%)
MLC BC	14 weeks	6.28	5.04	6.73	.85	5.05-8.41
	32 weeks	6.69	5.01	7.03	.89	5.27-8.80
	14 days	6.75	5.13	6.49	.87	4.76-8.22
	6 months	6.38	5.53	6.53	.99	4.57-8.49
MLC HRI	14 weeks	7.04	4.07	6.61	.73	5.17-8.06
	32 weeks	7.63	4.27	7.29	.77	5.77-8.81
	14 days	6.96	4.18	7.21	.75	5.72-8.69
	6 months	6.28	4.82	6.13	.85	4.45-7.82
CLC	14 weeks	6.15	3.36	6.59	1.25	4.10-9.08
	32 weeks	7.15	4.47	7.49	1.32	4.87-10.11
	14 days	7.54	3.53	7.29	1.29	4.72-9.85
	6 months	6.54	4.48	6.69	1.46	3.78-9.59
Total	14 weeks	6.65	4.33	6.64	.54	5.58-7.71
	32 weeks	7.23	4.54	7.27	.56	6.15-8.39
	14 days	6.97	4.42	7.00	.55	5.90-8.09
	6 months	6.35	4.99	6.45	.62	5.21-7.69

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the CWS total scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	29.03	6.27	29.52	1.41	26.71-32.32
	32 weeks	28.90	7.39	28.99	1.33	26.34-31.64
	14 days	26.32	8.18	26.51	1.38	23.75-29.26
	6 months	26.39	7.74	25.93	1.41	23.13-28.73
MLC HRI	14 weeks	28.71	7.83	28.22	1.25	25.74-30.71
	32 weeks	28.40	5.57	28.32	1.18	25.9830.66
	14 days	24.31	5.59	24.12	1.23	21.69-26.56
	6 months	25.33	5.72	25.80	1.25	23.32-28.28
CLC	14 weeks	29.42	6.87	29.88	2.14	25.62-34.14
	32 weeks	31.58	8.58	31.66	2.02	27.64-35.69
	14 days	28.17	8.19	28.34	2.10	24.16-32.53
	6 months	27.83	9.77	27.39	2.14	23.14-31.65
Total	14 weeks	28.93	7.09	29.21	.91	27.39-31.02
	32 weeks	29.04	6.74	29.66	.86	27.95-31.37
	14 days	25.59	7.06	26.32	.89	24.54-28.10
	6 months	26.07	7.12	26.37	.91	24.56-28.18

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the CWS health subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	9.10	2.72	9.25	.59	8.08-10.43
	32 weeks	7.94	2.66	7.88	.51	6.87-8.90
	14 days	7.32	2.84	7.36	.49	6.40-8.33
	6 months	7.06	2.64	6.96	.52	5.92-7.99
MLC HRI	14 weeks	8.64	3.10	8.48	.52	7.44-9.53
	32 weeks	7.79	2.14	7.84	.45	6.95-8.74
	14 days	6.60	2.06	6.56	.43	5.70-7.41
	6 months	6.45	2.20	6.56	.46	5.64-7.48
CLC	14 weeks	9.67	3.34	9.82	.90	8.03-11.61
	32 weeks	9.92	3.65	9.86	.77	8.32-11.40
	14 days	7.83	2.69	7.87	.74	6.40-9.34
	6 months	7.75	3.84	7.65	.79	6.08-9.22
Total	14 weeks	8.95	2.99	9.19	.38	8.42-9.95

	32 weeks	8.14	2.65	8.53	.33	7.87-9.18
	14 days	7.04	2.48	7.26	.31	6.64-7.89
	6 months	6.86	2.65	7.06	.34	6.39-7.73

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the CWS relationship subscale by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	2.58	.81	2.66	.17	2.32-3.00
	32 weeks	2.61	.95	2.63	.23	2.17-3.09
	14 days	2.64	1.17	2.69	.24	2.20-3.17
	6 months	2.94	1.57	2.92	.29	2.34-3.51
MLC HRI	14 weeks	2.38	.79	2.31	.15	2.01-2.61
	32 weeks	2.76	1.21	2.74	.20	2.34-3.15
	14 days	2.69	1.29	2.65	.21	2.23-3.08
	6 months	3.12	1.42	3.13	.26	2.62-3.65
CLC	14 weeks	2.67	1.23	2.74	.26	2.22-3.25
	32 weeks	2.92	1.51	2.93	.35	2.24-3.63
	14 days	2.92	1.08	2.95	.37	2.22-3.69
	6 months	3.33	1.44	3.32	.44	2.44-4.21
Total	14 weeks	2.49	.87	2.57	.11	2.35-2.79
	32 weeks	2.73	1.16	2.77	.15	2.47-3.07
	14 days	2.71	1.21	2.76	.16	2.45-3.07
	6 months	3.08	1.47	3.12	.19	2.75-3.50

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the CWS socio-economic subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	4.90	2.61	5.05	.49	4.08-6.02
	32 weeks	5.32	2.18	5.40	.38	4.64-6.16
	14 days	5.35	2.07	5.48	.41	4.66-6.30
	6 months	5.19	1.64	5.17	.34	4.50-5.84
MLC HRI	14 weeks	5.26	2.61	5.11	.43	4.25-5.98
	32 weeks	5.21	1.88	5.13	.34	4.46-5.81
	14 days	5.14	2.01	5.02	.36	4.29-5.74
	6 months	5.26	1.74	5.29	.30	4.69-5.88

CLC	14 weeks	4.83	1.40	4.97	.74	3.49-6.45
	32 weeks	5.08	1.31	5.16	.58	4.01-6.31
	14 days	5.67	2.39	5.79	.62	4.54-7.03
	6 months	5.75	1.76	5.73	.51	4.71-6.75
Total	14 weeks	5.07	2.46	5.05	.32	4.42-5.68
	32 weeks	5.24	1.91	5.23	.25	4.74-5.72
	14 days	5.29	2.07	5.43	.27	4.90-5.96
	6 months	5.31	1.70	5.39	.22	4.96-5.83

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the MHLC internal subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	18.57	5.34	18.57	1.02	16.53-20.61
	32 weeks	17.17	5.01	16.88	1.00	14.89-18.87
	14 days	18.03	4.68	18.04	.99	16.08-20.01
	6 months	18.67	3.96	18.48	.85	16.78-20.18
MLC HRI	14 weeks	18.67	5.00	18.66	.88	16.90-20.42
	32 weeks	19.17	5.02	19.44	.86	17.72-21.16
	14 days	20.98	5.17	20.97	.85	19.27-22.66
	6 months	19.98	4.22	20.16	.74	18.69-21.62
CLC	14 weeks	18.09	4.35	18.09	1.58	14.95-21.23
	32 weeks	18.00	4.43	17.75	1.54	14.68-20.82
	14 days	17.73	4.05	17.74	1.52	14.71-20.77
	6 months	18.91	4.85	18.74	1.32	16.12-21.36
Total	14 weeks	18.55	4.99	18.44	.67	17.12-19.77
	32 weeks	18.29	4.97	18.02	.65	16.73-19.32
	14 days	19.48	5.04	18.92	.64	17.64-20.19
	6 months	19.36	4.21	19.13	.55	18.03-20.23

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the MHLC chance subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	17.40	4.92	17.43	1.16	15.12-19.74
	32 weeks	17.17	5.38	17.33	1.12	15.10-19.56
	14 days	15.03	4.85	15.22	1.04	13.14-17.29
	6 months	16.27	5.32	16.30	1.15	14.01-18.59
MLC HRI	14 weeks	18.83	6.37	18.80	1.00	16.81-20.80

	32 weeks	19.48	5.74	19.32	.97	17.40-21.25
	14 days	18.19	4.99	18.02	.90	16.23-19.81
	6 months	17.40	5.87	17.37	.99	15.39-19.35
CLC	14 weeks	20.64	5.07	20.67	1.79	17.10-24.23
	32 weeks	18.55	4.99	18.69	1.73	15.25-22.12
	14 days	17.64	6.47	17.80	1.61	14.60-21.00
	6 months	16.45	5.84	16.48	1.78	12.95-20.02
Total	14 weeks	18.55	5.75	18.97	.76	17.47-20.47
	32 weeks	18.52	5.56	18.45	.73	17.00-19.89
	14 days	16.98	5.30	17.01	.68	15.66-18.36
	6 months	16.87	5.63	16.72	.75	15.23-18.21

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the MHLC doctors subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	12.17	2.48	11.96	.48	11.00-12.92
	32 weeks	13.30	3.24	12.90	.60	11.71-14.10
	14 days	10.73	2.95	11.01	.57	9.87-12.15
	6 months	10.50	3.00	10.68	.57	9.54-11.81
MLC HRI	14 weeks	13.02	2.31	13.22	.42	12.39-14.05
	32 weeks	13.31	3.24	13.68	.52	12.66-14.71
	14 days	12.57	2.61	12.31	.50	11.32-13.30
	6 months	11.57	2.46	11.40	.49	10.42-12.38
CLC	14 weeks	13.55	2.46	13.36	.74	11.88-14.84
	32 weeks	13.18	1.83	12.83	.92	11.00-14.67
	14 days	10.82	3.49	11.06	.89	9.30-12.83
	6 months	10.27	3.55	10.43	.88	8.68-12.18
Total	14 weeks	12.78	2.41	12.85	.31	12.22-13.47
	32 weeks	13.29	2.96	13.14	.39	12.37-13.92
	14 days	11.67	2.96	11.46	.37	10.72-12.20
	6 months	11.01	2.84	10.84	.37	10.10-11.57

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the SF36 physical functioning subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	80.00	13.17	78.34	3.14	72.09-84.58
	32 weeks	59.52	14.96	58.88	3.34	52.24-65.51

	14 days	86.61	17.95	85.27	3.99	77.34-93.21
	6 months	97.42	4.98	95.89	2.39	91.12-100.65
MLC HRI	14 weeks	77.32	16.59	78.98	2.80	73.40-84.56
	32 weeks	62.20	18.41	62.84	2.98	56.91-68.77
	14 days	83.90	20.69	85.24	3.56	78.15-92.33
	6 months	93.54	15.90	95.07	2.14	90.81-99.32
CLC	14 weeks	75.00	20.37	73.50	4.93	63.67-83.32
	32 weeks	60.45	15.24	59.87	5.24	49.44-70.31
	14 days	81.36	23.78	80.15	6.27	67.68-92.63
	6 months	94.10	23.78	92.70	3.76	85.21-100.19
Total	14 weeks	78.01	15.85	76.94	2.07	72.81-81.06
	32 weeks	60.96	16.65	60.53	2.20	56.14-64.91
	14 days	84.58	19.98	83.56	2.63	78.32-88.80
	6 months	95.06	12.21	94.55	1.58	91.41-97.70

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the SF36 social functioning subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	72.58	27.47	70.41	5.00	60.45-80.38
	32 weeks	75.00	21.16	71.80	4.06	63.72-79.88
	14 days	64.52	23.30	64.61	4.32	56.01-73.21
	6 months	83.06	22.49	82.06	4.12	73.87-90.25
MLC HRI	14 weeks	73.78	23.02	75.95	4.47	67.05-84.84
	32 weeks	80.18	18.54	83.38	3.63	76.16-90.60
	14 days	73.17	18.23	73.08	3.86	65.40-80.76
	6 months	88.41	18.20	89.42	3.68	82.10-96.74
CLC	14 weeks	69.32	27.59	67.36	7.87	51.70-83.02
	32 weeks	72.73	27.85	69.83	6.39	57.12-82.54
	14 days	68.18	28.70	68.27	6.80	54.74-81.79
	6 months	80.68	24.60	79.77	6.47	66.89-92.65
Total	14 weeks	72.74	25.09	71.24	3.31	64.66-77.82
	32 weeks	77.26	20.86	75.00	2.68	69.66-80.34
	14 days	69.27	21.85	68.65	2.85	62.97-74.33
	6 months	85.39	20.74	83.75	2.72	78.34-89.16

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the SF36 role physical subscale scores by study group.

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	70.56	26.18	67.82	4.55	58.77-76.87
	32 weeks	56.05	20.19	54.97	4.02	46.98-62.96
	14 days	42.94	27.47	45.40	5.59	34.27-56.52
	6 months	88.51	19.24	87.67	3.43	80.83-94.50
MLC HRI	14 weeks	69.05	19.96	71.80	4.06	63.71-79.88
	32 weeks	60.06	19.26	61.14	3.59	54.00-68.28
	14 days	59.76	28.09	57.31	4.99	47.37-67.25
	6 months	89.79	15.92	90.63	3.07	84.52-96.73
CLC	14 weeks	72.72	25.51	70.24	7.15	56.01-84.48
	32 weeks	61.36	24.01	60.39	6.31	47.82-72.95
	14 days	50.00	31.62	52.22	8.79	34.72-69.72
	6 months	89.77	16.60	89.01	5.40	78.26-99.75
Total	14 weeks	71.11	22.93	69.95	3.00	63.98-75.93
	32 weeks	58.73	20.12	58.83	2.65	53.55-64.11
	14 days	52.18	29.06	51.64	3.69	44.29-58.99
	6 months	89.31	17.12	89.10	2.27	84.59-93.62

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the SF36 role emotional subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	87.63	18.86	87.26	3.48	80.32-94.19
	32 weeks	87.10	18.24	83.33	3.71	75.94-90.73
	14 days	77.42	23.69	76.94	4.63	67.73-86.16
	6 months	86.83	21.50	87.04	3.42	80.22-93.85
MLC HRI	14 weeks	84.55	17.63	84.93	3.11	78.74-91.13
	32 weeks	84.35	19.47	88.11	3.32	81.51-94.71
	14 days	83.54	22.55	84.01	4.14	75.78-92.25
	6 months	92.28	14.24	92.07	3.06	85.98-98.15
CLC	14 weeks	90.15	12.26	89.81	5.48	78.90-100.71
	32 weeks	78.79	22.16	75.38	5.84	63.76-87.01
	14 days	82.58	25.13	82.15	7.28	67.65-96.64
	6 months	93.18	13.34	93.37	5.38	82.66-104.09
Total	14 weeks	86.45	17.45	87.33	2.30	82.75-91.91

	32 weeks	84.64	19.32	82.27	2.45	77.39-87.16
	14 days	81.12	23.21	81.03	3.06	74.95-87.12
	6 months	90.36	17.24	90.83	2.26	86.33-95.33

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the SF36 mental health subscale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	76.77	15.73	75.99	2.67	70.67-81.31
	32 weeks	74.03	16.40	72.90	2.91	67.12-78.68
	14 days	74.03	14.11	74.39	2.61	69.19-79.59
	6 months	75.00	18.53	74.58	3.10	68.41-80.76
MLC HRI	14 weeks	72.56	11.73	73.37	2.41	68.58-78.16
	32 weeks	73.54	13.29	74.71	2.61	69.51-79.91
	14 days	72.80	12.35	72.44	2.35	67.76-77.11
	6 months	76.95	13.08	77.38	2.79	71.83-82.94
CLC	14 weeks	75.83	13.29	75.09	4.06	67.00-83.17
	32 weeks	75.83	15.05	74.74	4.41	65.97-83.52
	14 days	70.83	13.62	71.17	3.97	63.28-79.06
	6 months	75.42	15.88	75.02	4.71	65.65-84.39
Total	14 weeks	74.58	13.54	74.82	1.73	71.38-78.26
	32 weeks	74.05	14.59	74.12	1.88	70.3977.85
	14 days	72.98	13.08	72.67	1.69	69.31-76.02
	6 months	76.01	15.52	75.66	2.01	71.67-79.65

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the PSQI sleep type scale scores by study group

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	.40	.50	.30	.15	-.01-.61
	32 weeks	.93	.26	.96	.13	.69-1.23
	14 days	.80	.41	.77	.14	.48-1.05
	6 months	.73	.46	.66	.16	.34-.98
MLC HRI	14 weeks	.23	.44	.34	.16	.00-.67
	32 weeks	.46	.52	.44	.14	.14-.73
	14 days	.69	.48	.73	.15	.42-1.04
	6 months	.53	.52	.62	.17	.27-.96
CLC	14 weeks	.50	.71	.55	.35	-.16-1.26
	32 weeks	.50	.71	.49	.30	-.13-1.11

	14 days	1.00	.00	1.02	.32	.36-1.67
	6 months	.50	.71	.54	.36	-.20-1.27
Total	14 weeks	.33	.48	.40	.13	.13-.66
	32 weeks	.70	.47	.63	.11	.40-.86
	14 days	.77	.43	.84	.12	.59-1.08
	6 months	.63	49	.60	.14	.33-.88

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the CFSEI Personal Self-Esteem subscale scores by study group.

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	5.55	2.08	5.49	.42	4.67-6.32
	32 weeks	5.87	2.00	5.62	.44	4.75-6.50
	14 days	5.45	2.01	5.46	.45	4.56-6.35
	6 months	5.45	2.30	5.39	.44	4.52-6.25
MLC HRI	14 weeks	5.41	2.16	5.45	.34	4.79-6.12
	32 weeks	5.41	2.44	5.62	.35	4.92-6.33
	14 days	4.94	2.55	4.93	.36	4.21-5.65
	6 months	5.49	2.27	5.55	.35	4.85-6.24
CLC	14 weeks	5.08	2.02	5.03	.61	3.83-6.24
	32 weeks	4.92	2.10	4.71	.64	3.45-5.98
	14 days	6.00	1.73	6.01	.66	4.71-7.31
	6 months	5.46	1.66	5.41	.63	4.15-6.66
Total	14 weeks	5.41	2.10	5.33	.26	4.81-5.85
	32 weeks	5.49	2.25	5.32	.28	4.77-5.87
	14 days	5.26	2.30	5.47	.28	4.91-6.03
	6 months	5.47	2.18	5.45	.27	4.91-5.99

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for the CFSEI Lie subscale scores by study group.

Group Type	Observation Point	Mean	SD	Adjusted Means	SE	CI (95%)
MLC BC	14 weeks	4.71	1.55	4.54	.29	3.96-5.13
	32 weeks	4.68	1.60	4.49	.30	3.88-5.09
	14 days	5.10	1.68	4.87	.35	4.17-5.57
	6 months	5.19	1.66	4.92	.34	4.25-5.59
MLC HRI	14 weeks	4.47	1.49	4.61	.24	4.14-5.08
	32 weeks	5.29	1.66	5.45	.25	4.96-5.93

	14 days	5.04	1.96	5.23	.28	4.67-5.80
	6 months	5.37	1.86	5.60	.27	5.06-6.14
CLC	14 weeks	4.31	1.49	4.17	.43	3.32-5.02
	32 weeks	4.85	.99	4.69	.44	3.81-5.57
	14 days	3.92	1.55	3.74	.51	2.72-4.76
	6 months	5.08	1.44	4.85	.49	3.88-5.82
Total	14 weeks	4.53	1.50	4.44	.18	4.08-4.81
	32 weeks	5.02	1.57	4.88	.19	4.50-5.25
	14 days	4.90	1.84	4.61	.22	4.17-5.05
	6 months	5.27	1.73	5.12	.21	4.71-5.54

Mean scores, standard deviations, adjusted means, standard error and confidence intervals for all questionnaire scores by non pregnant reference group.

	Observation Point	Mean	SD	Adjusted Means	SE	CI 95%
HADS						
ANXIETY	14 weeks	6.28	3.20	6.23	.46	5.31-7.14
	32 weeks	6.44	3.20	6.49	.50	5.51-7.48
	14 days	6.51	3.07	6.70	.47	5.77-7.63
	6 months	6.45	3.68	6.69	.53	5.64-7.73
DEPRESS	14 weeks	2.32	1.88	2.29	.34	1.63-2.96
	32 weeks	2.45	2.55	2.47	.41	1.67-3.27
	14 days	2.79	2.64	2.87	.45	1.98-3.76
	6 months	2.72	2.92	2.88	.47	1.95-3.80
EPDS	14 weeks	6.63	4.20	6.51	.69	5.14-7.88
	32 weeks	7.00	4.80	6.91	.75	5.43-8.39
	14 days	7.33	4.50	7.40	.72	5.98-8.83
	6 months	6.70	4.69	6.83	.79	5.25-8.40
MHLC						
DOCTORS	14 weeks	9.16	3.22	9.17	.45	8.28-10.06
	32 weeks	8.27	2.77	8.28	.49	7.31-9.25
	14 days	8.59	3.08	8.71	.49	7.75-9.68
	6 months	8.24	2.94	8.34	.48	7.39-9.29
OTHERS	14 weeks	8.11	2.53	8.24	.45	7.36-9.12
	32 weeks	8.16	2.24	8.23	.46	7.32-9.15
	14 days	8.51	2.10	8.55	.42	7.72-9.38
	6 months	8.11	2.21	8.11	.40	7.33-8.90
INTERNAL	14 weeks	22.59	4.49	22.60	.82	20.97-24.22
	32 weeks	22.62	3.96	22.56	.78	21.01-24.11
	14 days	22.43	4.44	22.49	.80	20.91-24.07
	6 months	22.27	4.43	22.20	.72	20.78-23.63

CHANCE	14 weeks	16.11	5.08	16.23	.93	14.39-18.07
	32 weeks	16.92	5.21	16.85	.91	15.04-18.66
	14 days	16.92	5.57	16.94	.89	15.18-18.70
	6 months	16.95	5.28	16.93	.94	15.08-18.78
SF36						
GEN HLTH	14 weeks	80.18	20.02	79.36	2.99	73.45-85.28
	32 weeks	81.22	18.98	80.62	2.91	74.85-86.39
	14 days	80.95	17.41	80.24	2.61	75.07-85.42
	6 months	82.41	15.05	81.87	2.97	75.98-87.75
MEN HLTH	14 weeks	75.68	14.73	75.62	.34	70.98-80.26
	32 weeks	72.30	16.31	72.25	2.57	67.17-77.33
	14 days	74.59	14.64	74.36	2.30	69.81-78.91
	6 months	73.65	14.98	73.44	2.60	68.28-78.59
ROLE PHY	14 weeks	90.20	20.44	89.72	3.76	82.28-97.17
	32 weeks	88.85	17.25	88.89	3.26	82.43-95.35
	14 days	94.76	10.88	95.77	4.06	87.73-103.82
	6 months	94.59	11.61	94.86	2.65	89.61-100.62
ROLE EMO	14 weeks	87.16	16.85	87.15	2.92	81.37-92.93
	32 weeks	86.26	18.96	85.36	3.21	78.99-91.73
	14 days	88.28	18.47	87.70	3.68	80.40-94.99
	6 months	87.61	19.60	87.24	3.03	81.24-92.23
PHY FUNC	14 weeks	94.19	14.36	93.66	2.59	88.52-98.80
	32 weeks	94.46	16.28	94.89	2.80	89.35-100.43
	14 days	95.54	14.37	95.17	3.12	89.00-101.35
	6 months	97.43	6.41	97.19	1.81	93.60-100.77
SOC FUNC	14 weeks	85.47	21.35	84.69	4.06	76.65-92.72
	32 weeks	81.08	23.13	80.35	3.62	73.17-87.53
	14 days	85.47	19.88	84.57	3.54	77.56-91.59
	6 months	89.19	19.13	88.10	3.37	81.42-94.78
VITALITY	14 weeks	61.82	17.17	61.70	3.35	55.06-68.33
	32 weeks	58.61	20.85	58.10	3.04	52.09-64.11
	14 days	58.11	17.79	57.94	2.72	52.56-63.33
	6 months	62.50	17.24	61.96	3.14	55.74-68.18
PAIN	14 weeks	84.84	18.95	84.39	3.62	77.22-91.55
	32 weeks	62.36	24.83	86.71	3.55	79.68-93.73
	14 days	89.84	15.70	89.97	3.56	82.92-97.02
	6 months	87.86	15.71	87.99	3.43	81.20-94.78
CHG HLTH	14 weeks	59.72	18.20	58.31	2.50	53.36-63.26
	32 weeks	51.39	17.87	50.84	3.02	44.85-56.83
	14 days	55.56	17.02	55.85	3.02	49.87-61.83
	6 months	53.47	14.82	52.78	3.25	46.34-59.22

PSQI						
GLOB SLP	14 weeks	4.00	2.54	4.01	.87	2.25-5.77
	32 weeks	6.00	3.30	6.00	1.07	3.84-8.17
	14 days	5.00	2.49	5.02	1.08	2.82-7.22
	6 months	4.20	1.75	4.21	1.19	1.80-6.62
SLP TYPE	14 weeks	.20	.42	.20	.15	-.10-.50
	32 weeks	.60	.52	.60	.14	.31-.89
	14 days	.50	.53	.50	.14	.21-.80
	6 months	.30	.48	.30	.15	-.01-.61
CFSEI						
GEN SE	14 weeks	12.98	2.72	12.96	.40	12.17-13.75
	32 weeks	13.27	2.82	13.26	.41	12.44-14.07
	14 days	11.44	4.58	11.40	.65	10.12-12.68
	6 months	13.20	2.83	13.13	.44	12.26-14.01
PERS SE	14 weeks	5.54	1.85	5.50	.33	4.85-6.16
	32 weeks	5.31	2.18	5.25	.36	4.54-5.97
	14 days	4.97	2.33	4.93	.37	4.19-5.67
	6 months	5.36	1.99	5.33	.35	4.64-6.02
SOC SE	14 weeks	7.22	1.21	7.21	.15	6.92-7.50
	32 weeks	7.15	1.20	7.13	.18	6.77-7.49
	14 days	6.39	2.38	6.40	.34	5.74-7.06
	6 months	7.37	.94	7.31	.16	7.01-7.62
LIE SE	14 weeks	5.29	1.58	5.22	.24	4.75-5.70
	32 weeks	5.59	1.77	5.54	.26	5.03-6.05
	14 days	5.29	2.14	5.25	.31	4.64-5.85
	6 months	5.39	1.97	5.28	.28	4.72-5.84

national STATISTICS

Indices of Deprivation for Super Output Areas, Rank of IMD Score (Rank, Areas, Jan04)

Use this map to illustrate another topic

Indices of Deprivation for Super Output Areas, Rank of IMD Score (Rank, Areas, Jan04)

Map Settings and Legend | Local services e.g. schools | Trends and Comparisons

Legend

- 25 - 4,726
- 4,727 - 9,427
- 9,428 - 14,128
- 14,129 - 18,829
- 18,830 - 23,530

Change your map colour: Purple

Change the number of shades: Five

Shade the map to show how areas: Compare to each other

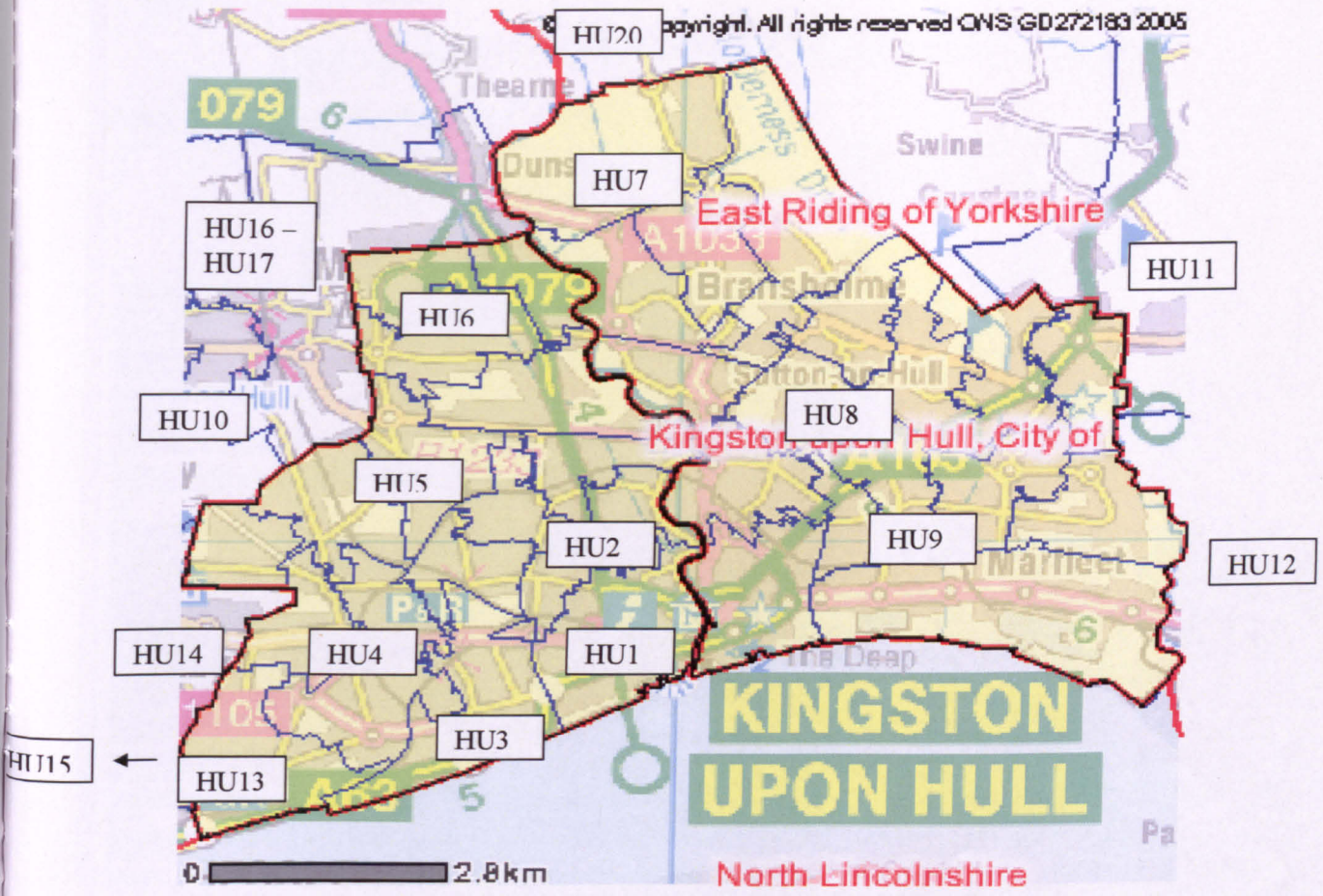
To view important map information click here

To view indicators available at Local Authority level click here

Print | Help | Show map background | Full Screen

Super Output Area Lower Layer areas within Kingston upon Hull, City of(Unitary Authority) - NeSS Geography Hierarchy

Postal Districts of Hull



national STATISTICS

Neighbourhood Statistics

Table Indices of Deprivation - Local Authority Summaries, 2004

Area selected: Yorkshire and The Humber (*Region*)

	Indices of Deprivation: Local Authority Summaries, Average Score[1] *Areas Score Jan04*	Indices of Deprivation: Local Authority Summaries, Rank of Average Score[1] *Areas Rank Jan04*	Indices of Deprivation: Local Authority Summaries, Average Rank[1] *Areas Rank Jan04*	Indices of Deprivation: Local Authority Summaries, Rank of Average Rank[1] *Areas Rank Jan04*	Indices of Deprivation: Local Authority Summaries, Extent[1] *Areas Score Jan04*
Barnsley *Metropolitan District*	32.99	28	23,455.03	27	0.43
Bradford *Metropolitan District*	32.93	30	21,826.43	51	0.43
Calderdale *Metropolitan District*	25.44	86	19,556.8	87	0.25
Doncaster *Metropolitan District*	31.5	40	22,274.21	44	0.41
East Riding of Yorkshire *Unitary Authority*	15.34	208	12,417.94	219	0.08
Kingston upon Hull, City of *Unitary Authority*	41.13	9	25,756.58	11	0.57
Kirklees *Metropolitan District*	26.15	77	19,741.13	81	0.28
Leeds *Metropolitan District*	27.68	68	19,446.7	91	0.31
North East Lincolnshire *Unitary Authority*	29.36	52	20,377.59	69	0.37
North Lincolnshire *Unitary Authority*	21.23	121	16,756	134	0.16
Rotherham *Metropolitan District*	28.19	63	21,143.95	58	0.32
Sheffield *Metropolitan District*	28.42	60	19,741.11	82	0.35
Wakefield *Metropolitan District*	29.08	54	21,492.27	53	0.35
York *Unitary Authority*	14.51	219	11,652.29	230	0.08
North Yorkshire *County*	..	..	..	..	..

	Indices of Deprivation: Local Authority Summaries, Rank of Extent[1] *Areas Rank Jan04*	Indices of Deprivation: Local Authority Summaries, Local Concentration[1] *Areas Score Jan04*	Indices of Deprivation: Local Authority Summaries, Rank of Local Concentration[1] *Areas Rank Jan04*
Barnsley *Metropolitan District*	28	31,608.69	40
Bradford *Metropolitan District*	31	32,113.25	11
Calderdale *Metropolitan District*	83	30,851.74	65
Doncaster *Metropolitan District*	32	31,532.48	43
East Riding of Yorkshire *Unitary Authority*	171	27,922.09	153
Kingston upon Hull, City of *Unitary Authority*	12	32,230.78	6
Kirklees *Metropolitan District*	73	30,804.29	68
Leeds *Metropolitan District*	64	31,800.28	24
North East Lincolnshire *Unitary Authority*	43	31,714.73	31
North Lincolnshire *Unitary Authority*	117	30,480.97	76
Rotherham *Metropolitan District*	62	31,139.34	56
Sheffield *Metropolitan District*	51	31,720.23	30
Wakefield *Metropolitan District*	56	31,011.04	61
York *Unitary Authority*	170	27,403.93	162
North Yorkshire *County*	..	..	..

Interview Schedule: PWS Study

Interview 1 (12-14 weeks pregnant)
Tell me a little bit about how you found out you were pregnant
Tell me about how you felt when you found out you were pregnant
What happened then?
How did you decide who you wanted to be cared for by?
Tell me a bit about why you made that choice
What has your pregnancy been like so far?
How does your partner feel about your pregnancy?
How are your family and friends feeling about your pregnancy?
What information have you collected about your pregnancy?
Where did that information come from?
If you could think forward a year, what sort of things do you think you will be saying about your pregnancy?
What are your thoughts about screening?

Interview 2 (32-26 weeks pregnant)
Since last time we spoke, what has your pregnancy been like?
How are you feeling about your pregnancy now?
How are family and friends feeling about your pregnancy now?
How do you feel about the changes that are happening to your body?
What do you expect from the birth?
What information have you collected about giving birth?
How do you feel about the choice you have made for delivery?
How does your partner feel?
Can you describe you antenatal visits
If you could think forward a year, what sort of things do you think you will be saying about your pregnancy?

Interview 3 (2 weeks postnatal)
How are you feeling now?
Tell me about the birth
How do you feel about the birth?
Was it like you expected it to be?
Did you feel prepared for the birth?
Did the antenatal care you received prepare you for the birth?
How does it feel to be a new Mum?
How is your baby?
How has your partner been since the birth?
How do you family and friends feel?
What do you feel about the choices you made?

Interview 4 (6 months postnatal)
How are you feeling?
Tell me about your labour experience?
How do you feel about the birth now?
How does been a Mum feel now?
How is your partner?

How do you feel about the choices you made for your care in pregnancy and for delivery?

This is intended to be an interview guide only and it is intended to explore any areas that are important to women as they arise. It is intended that the interviews will be quite informal and will become more so as the relationship between the women and the interviewer develops over time.