Labour and birth in water: women's narratives

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Abstract

Waterbirth is currently a marginalised practice within midwifery in the United Kingdom (UK). This research explored women's stories of labour and birth in water and how these were constructed to reflect transitions to motherhood and changes in identity. This study sought to answer the question: What do women's stories of waterbirth reveal about a woman's self and social identity around birth?

A feminist framework guided the research design adopting a narrative inquiry methodology to explore the stories of ten women who birthed in water. A single in-depth interview facilitated elicitation of the women's stories of waterbirth. Stories were analysed using the Voice Centred Relational Method (VCRM) with an emphasis given to the socio-cultural and relational contexts individual to the woman. Three key narratives that emerged from the women's stories were identified. These were: the 'visible self,' the 'agent self' and the 'connected self.'

The narrative of the 'visible self' spoke to how waterbirth offered the women protection and privacy during childbirth, it allowed them to retain a sense of their private self. Women valued the presence of the midwife during the birth in two ways. First, when the midwife valued the woman's intuitive knowledge of her own body and second, when the midwife maintained a non-interventionist stance in the birth process. The narrative of the 'agent self' illuminated storylines from the women of resistance, negotiation and compromise in order to achieve birth in water. Activation of the women's agent self, afforded them feelings of control leading to an embodied sense of self. Continuous support from the midwife offered women reassurance enhancing their perceptions of autonomy and empowerment. Finally, the narrative of the 'connected self' illuminated water as a means of preventing disconnection instead fostering contemporary socio-cultural concepts of the 'good mother' for the women. It promoted connection between the woman and her newborn and helped to initiate a close family bond at birth. In a relational sense the women valued the emotional connection with the midwife which was further strengthened when they mirrored the woman's desire for waterbirth. The thesis concludes that taken collectively these key narratives reflect how waterbirth enabled the women to maintain a secure identity during a time of transition.

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Introduction

This thesis explores what women's stories of waterbirth reveal about their self and social identity around birth. Centrally it aims to provide a platform for women's voices to be heard by sharing their stories and ensuring the narratives co-constructed are situated within these. Ten women's stories of waterbirth were examined through a qualitative study in the East Midlands.

Birth narratives are not considered to 'reflect reality' (Akrich and Pasveer, 2004:65) instead they constitute the reality I am interested in, the subjective reality of the individual woman. A narrative inquiry methodology supports the central assumption guiding my research that is, to learn about waterbirth and the meaning women ascribe to it, it is a prerequisite that we listen to their personal accounts. Childbirth is considered an intimate experience therefore exploring women's stories of birth allows us to view this subjective experience mediated through use of water. It is critical to understand how women understand themselves, other people, and the society in which they live and the data analysis approach employed, the Voice Centre Relational Method (VCRM) allowed for this to be explored. This, I believe, is the key to understanding how waterbirth influences the construction of the three central narratives of 'self'. Identified within the findings of this study were narratives of the 'visible self', the 'agent self' and the 'connected self' and exploring what these revealed about the woman's change in identity as they transition to motherhood.

Childbirth is enmeshed in every society's norms and values, in the UK this positions it in both a private and medicalised domain, potentially isolating women from more marginalised practices, including waterbirth (Garland, 2017). Women's childbirth stories have historically been viewed within dominant medical narratives of birth (Pollock, 1999). Told from an outside perspective, the embodied perspective of the birthing woman often remained absent (Martin, 2003). Waterbirth provided a meaningful birth choice for the women in this study enabling them to; remain visible during childbirth; promote perceptions of agency and enhance connection with the birth and her newborn. In a relational sense the narratives welcomed (in)visibility of the midwife, midwives who used agency to empower women and midwives emotionally connected with the

woman and her choice of childbirth in water. Socio-cultural influences in the stories speak to an increasing visibility of waterbirth narratives within television childbirth documentaries. Collectively these elements combine to reflect how waterbirth enabled the women to maintain a sense of their identity as autonomous individuals as they made the transition to motherhood.

Within the context of a feminist research perspective, I present my own autobiography with the intention of making visible how this led to my research interest. Deemed an academic necessity by many feminist researchers (Letherby, 2005:7). The idea to focus my research study on women's stories of birth in water emerged partly from links between my own private and public 'voices'. By acknowledging myself in my research, the aim is to make visible my influence on the study by presenting explicitly the multiple identities I own as a researcher, midwife, woman and mother who birthed in water. My intention is for this interest to be discerned reflexively as a continuous thread running throughout all stages of my study, from the research question, methodology, findings, through to the conclusion and justify why I am well placed to complete the study.

In adopting a feminist perspective, I place the women's 'voice(s)' at the fore of this study, thereby challenging the exclusion of female intuitive knowledge from research surrounding childbirth, which has often been presented as both deviant and deficient in relation to the male norm (Gilligan, 1982). As such I defend my decision to write in the first person both as a way of taking responsibility for what I write, as well as a way of challenging traditional academic 'authority'. In my study, the issue of 'I' is a central consideration firstly due to the feminist stance that informs the research, secondly in acknowledging the social elements integral to the study. Webb (1992) supports the use of the first person in qualitative feminist studies as demonstrating a congruency with the epistemology of the research and in the pursuit of reflexivity. I therefore begin by introducing myself and my voice, detailing how my professional and personal connection with waterbirth began. I do not consider my own voice to be more important than the women involved in this study, I start in this way only to demonstrate transparency as to how my own story has fundamentally shaped the focus and design of this study. It will then be for the reader to determine how this influenced my findings and conclusions.

Researcher's perspective

In the context of this study this is where my own story began.

Commencing my midwifery education in 1995, I practised as a student midwife in a large urban hospital at a time when waterbirth had just been introduced into maternity care in the UK. The unit had a permanent birthing pool and I worked with mentors who regularly supported women choosing to labour and birth in water. Immediately I felt a connection to the practice of waterbirth recognising, even then, that this was physiological birth at its finest. I embraced every opportunity to support women who chose to birth in this way.

After qualifying as a midwife, I obtained my first post in a smaller, more rural hospital where it was clear at that time, the use of water for labour and birth was far more limited. Colleagues would often state that they had not received additional education in the practice of 'waterbirth' as though it was somehow different to physiological birth. For me, having participated in waterbirths during my training, it was a familiar experience and reflected my professional philosophy of childbirth. Only now as I reflect, can I appreciate some of the anxieties experienced by many midwives due to safety concerns that abounded at that time. Widely publicised reports of two newborn deaths in water, coupled with a lack of exposure to the practice would undoubtedly present an unfamiliar and challenging environment for midwives to practise in. My sustained curiosity however led me to question further; was it a lack of confidence in the practice of waterbirth or did waterbirth change traditional dynamics of control in childbirth in favour of the woman?

My interest was reignited when I was pregnant for the first time with my own child and hoping for a waterbirth. Anxieties surrounded this time for me, bound to issues such as; lack of birthing pool availability; lack of confidence to support my choice; as well as my own lack of courage to challenge if the need arose. My due date arrived, two days later my labour began. Shortly after arriving on labour ward, I was examined and told I was in the advanced stages of labour. Tentatively I asked if I could use the birthing pool, fully anticipating resistance from the midwife, to my surprise she agreed. A colleague came in to support me and I had an uneventful waterbirth a few hours later. I would experience pregnancy and childbirth again, but this was to be the only one of my children to

be born in water. I often mused as to how my own birth story would have been altered if my choice for waterbirth had not been supported, how it may have influenced my own sense of self and identity as a woman, midwife, mother?

Around this time, I moved from working as a clinical midwife within the NHS to a new role as a midwifery educator working in higher education. Despite this change in roles I never lost my interest in waterbirth. Often reignited when facilitating sessions and speaking with students about the practice. I also began to supervise students during their undergraduate dissertation and recall a student wanting to explore women's experiences of waterbirth by means of a literature review. At that time waterbirth had been part of UK maternity services for well over a decade but the literature search identified a paucity of qualitative studies in this area. The focus of the review was amended to explore women's views of water as a form of non-pharmacological pain-relief in labour which held a more established evidence base. Once again, it led me to question why there were so few studies exploring women's experiences of birth in water?

It is these experiences described in my own journey as a student midwife, midwife, mother, midwifery educator and more recently researcher, which ultimately led to the focus of my thesis. At this time a local NHS Trust partner gained funding to design an Alongside Midwifery-Led Unit (AMU). The physical environment of the AMU replaces the traditional bed, with a birthing pool in the centre of each room. Coupled with a philosophy of care which embraces childbirth fundamentally as a physiological process, the AMU presented an ideal location for this exploration. It provided me with access to a sample of women, who could share their stories, which I hoped would answer my questions. I wanted to understand their choice to birth in hospital, essentially a medicalised environment entwined within society's principles of biomedical birth. Yet by choosing to birth in water women appeared, consciously or unconsciously, to indicate resistance to this dominant model.

I believe that waterbirth has a complexity that exists outside of purely physical outcomes for the woman, yet this is where we find the substantial body of literature currently resides. I argue that it cannot be separated from socio-cultural factors that influence a woman's sense of self and identity. It is this dimension that is yet to be explored in the context of waterbirth from the emic

perspective of the woman. My belief before the start of this research was that whilst waterbirth is instinctively valued by some women the inconclusive nature of current academic literature surrounding it has prevented its acceptance by women, midwives and wider society in the UK. My curiosity therefore lay with the women who, like me, chose this birth option in the absence of conclusive evidence.

Rationale

Individualised choice is a central concept within maternity services in the UK (NHS England, 2015) yet whilst current National Institute for Health and Care Excellence (NICE, 2014) guidelines support the practice of water immersion during labour, the overall evidence base to support waterbirth is less conclusive (Cluett and Burns, 2009). Past decades have witnessed an increasing influence of support for women's choice regarding how they experience labour and birth which has led to the growth of birthing pool provision in maternity units across the UK. Yet regardless of increased provision figures suggest the subsequent actuality of women choosing to labour and birth in water appears to remain negligible (Care Quality Commission (CQC), 2015).

There is growing evidence of dedicated case loading services offering high levels of midwife continuity for women (Sandall *et al,* 2016; Forster *et al,* 2016; Tracy *et al,* 2013). Evidence shows an increase in positive outcomes both physically and emotionally for the woman and often result in high rates of homebirth (O'Connell *et al,* 2012) well above the national average of just over one to two percent (ONS, 2017). Whilst many of these women will use water during labour and childbirth, I suggest they reflect a motivated sub-group of women who experience labour and birth differently in some way due to increased continuity. My interest lay with the ninety-seven percent of women who continue to birth in a hospital environment in the UK (ONS, 2017). Whilst a proportion of these women need to access this essentially medical environment due to health or obstetric complications, a significant proportion will not require support in this way but still choose to birth in hospital. Acknowledging the juxtaposition of these women classified 'low risk' in childbirth, requesting the 'low tech' choice of waterbirth whilst choosing to remain in an environment located in a medicalised setting fundamentally based on the biomedical model of birth.

Beyond my own professional and personal interest in this area of practice, evidence explored in chapter one and the empirical literature reviewed in chapter two both illustrate the timely need for a qualitative study to be conducted in this area. Whilst the practice of waterbirth has been a feature of mainstream maternity services in the UK for more than twenty years now (Burns and Greenish, 1993; Garland and Jones, 1997; Nightingale, 1994; Beech, 1996), there remains a paucity of qualitative research. Nationally the NHS Constitution is a driver for service users to be placed at the heart of the NHS (DH, 2015) and women and their families at the centre of maternity services (Wenzel and Jabbal, 2016; NHS England, 2016). Yet the literature revealed only four studies which focus specifically on women's experiences of labour and birth in water (Waters, 2011; Maude and Fourer, 2007; Wu and Chung, 2003; Richmond, 2003). Only one of these studies having been conducted in the UK, over a decade ago now (Richmond, 2003).

Whilst statistics are not currently collected nationally for rates of waterbirth, a recent report reveals an increase in the number of women who make the choice to use water for pain relief in labour (Care Quality Commission, 2015:42), with a smaller associated increase in those choosing to birth in water (Care Quality Commission, 2015:39). Little is known about the motivations of this smaller group of women conveyed through their individual stories of waterbirth and this study seeks to explore this. By interpreting their stories and offering this understanding to a wider audience my aim is to support the continuation of waterbirth as a choice for women in the future.

Aim

The research question guiding this research was: What do women's stories of waterbirth reveal about a woman's self and social identity around birth?

The aim was to gain insight into the meaning ascribed by the women in their stories of labour and birth in water and how these were constructed to reflect transitions to motherhood and changes in identity. The study's objectives outlined below supported the aim and sought to offer a platform for women's stories of waterbirth giving 'voice' to the co-constructed narratives created.

Birth stories provide critical insight that can inform practice (Farley and Widmann, 2001). In this sense the objectives focussed on revealing the meaning

women attributed to waterbirth whilst critically examining how their personal stories reflected or contested public narratives surrounding waterbirth, childbirth and motherhood. It is important to establish where these women's narratives reside in relation to current provision of birthing pool facilities available in maternity services, with the possibility of contributing to new guidance. Finally, this study will make a contribution to theoretical knowledge regarding childbirth in water.

Thesis outline

The following chapter titled 'constructions of birth' provides some background and context regarding waterbirth. I will define waterbirth introducing the reader to its origins, continue by discussing government policy and clinical guidance on waterbirth, and broadly outline the international perspective. I further this by exploring concepts of medicalised childbirth, theories of motherhood and the concept of childbirth and risk viewed through a feminist lens. Chapter two presents a review of the empirical literature. Following the feminist perspective of the study wanting to avoid compounding androcentric views, primary qualitative research surrounding labour and childbirth in water will be presented as a meta-synthesis in this chapter associated with women's and midwives' experiences of waterbirth. It will also acknowledge the dominance of quantitative studies in this area justifying the need for this aspect of clinical practice to be further explored.

Chapter three presents the study's theoretical feminist framework, justification for my choice of methodology and philosophical position of interpretivism. The latter part of chapter three describes the research design and methods used to undertake the study exploring challenges encountered and how these were overcome. Illustrated in the final part of this chapter are the findings of the study. Chapters four, five and six will each present one key narrative integrating discussion of this study's findings with that of previous studies of childbirth and motherhood identifying new insights that emerge. Within these three chapters key passages (vignettes) from the stories told at interview are used to further illustrate how I have co-constructed the women's stories to create these key narratives of self. I discuss how women shaped their identities through their stories of labour and birth in water as part of their transition into motherhood.

The final chapter seven provides a conclusion to the thesis. This closing chapter will illustrate my original contribution to the research on waterbirth; present my reflections on the research process; make recommendations for future research and crucially, as the study is the culmination of a professional doctorate, it will identify the contribution made to clinical practice.

Chapter 1

Constructions of birth

To enable an understanding of childbirth, waterbirth and motherhood within the context of this study this chapter explores socio-cultural concepts of childbirth reviewing how they influence constructions of modern-day birth and motherhood within discourses of risk, blame and safety. Furthermore, I contextualise the historical and cultural evolution of waterbirth in the UK and review is position internationally. All these elements seek to illustrate where waterbirth is situated within the biomedical approach to childbirth adopted by present-day maternity services in the UK providing a foundation for the study.

1.1 Medicalisation of childbirth

Given current debate regarding the medicalisation of childbirth it is important to reference the origins of 'medicalisation' as a concept initially identified as a form of social control (Pitts, 1968; Zola, 1972). Illich (1975) first acknowledged the expansion of medicine into other areas including childbirth subsequently furthered by Conrad's (1975) work on hyperkinesis (now classified as ADHD) exploring whether this reflected 'deviance' or 'illness' (Conrad, 1975:18). Later writing "medicalization is a process by which non-medical problems become defined and treated as medical problems, usually in terms of illness and disorders" (Conrad, 1992:209).

Feminists also witnessed this influence extend to women's lives specifically in relation to matters such as contraception, reproduction, pregnancy and childbirth (Ehrenreich and English, 1972, 1973). Fundamentally they recognised how patriarchal control exercised power and dominance for women and their lives throughout history (Harding, 1986), witnessing medical dominance during childbirth (Crossley, 2007; Tew, 1995; Graham and Oakley, 1986; Oakley, 1984; Riessman, 1983; Oakley, 1979). Defining the male body as the norm has placed women's bodies as substandard, abnormal, pathological, and even deviant (Rudolfsdottier, 2000) legitimising authority via 'gendered power' (Lee and Kirkham, 2008). Recognising that this assisted in redefining childbirth as a mechanical process of pathology requiring technological management in hospital as a means to justifying its control (Hewer *et al*, 2009; Cahill, 2001; Davis-Floyd, 2001). Childbirth was no longer regarded as a physiological and social

process situated in the home, which Tew (1995) argues was one of the most significant sociological changes in the industrialised world.

Contributing to the understanding of how a woman's situation is different from a man's in modern society, Oakley's (1980) seminal work identified how society and culture shaped perceptions, approaches and institutions of pregnancy and childbirth. O'Sullivan (1987) proposed that women lack power within health care settings suggesting information was withheld from them and often encountering a paternalistic approach to decision making which they found demeaning and distressing. Hierarchical relationships are inherent within maternity care systems and women often feel obliged to conform to these leading to frustration with their lack of empowerment and control over their own bodies (Stewart, 2001) leading to considerable dissatisfaction and discontent following childbirth (Oakley, 1980).

Medicalisation of childbirth is complex and a more detailed review can be located in works by Henley-Einion (2003), Illich (1975), Cahill (2001) Oakley (1993) and Squire (2003). Comparatively however it is recognised as having led to advances for some women, for example where pre-existing medical complications occur, it has allowed women to conceive and birth safely. Many women identify with it as a means of achieving freedom from the pain of labour through pharmacological pain relief and analgesia, with some even experiencing it as a means of liberation, empowering them to remain in control of an uncontrolled biological experience, childbirth (Davis-Floyd, 1994). As an integral part of the medicalisation of childbirth within the UK there will be women who also appreciate the perceived safety and support offered by a hospital environment whilst recognising a smaller number who reject technological intervention deciding to birth at home (ONS, 2017). Increasingly in the UK however it is AMUs that provide midwife-led care to those women categorised as low risk (Hodnett *et al*, 2010) seen by many as a solution to providing women with the perceived safety they desire within a hospital environment (Birthplace in England Collaborative Group, 2011), along with the choice and individualised maternity care many desire (Coxon *et al*, 2014).

Proponents witnessing the reduction in maternal and perinatal mortality over the past fifty years (Knight *et al*, 2017) widely attribute it to medical advances.

Despite the lack of evidence to support this theory it was used to support the move of childbirth out of the home and into the hospital (Goer *et al,* 2007; Enkin *et al*, 2000). Many argue (Walsh, 2012; Downe, 2004; Tew, 1995) that this was far from the singular, linear symbiotic relationship traditionally promoted which overlooked advances in environmental factors, sanitation, nutrition and preventative antenatal care when links were made to improved health and wellbeing of childbearing women and their babies (Crossley, 2007). Maternity service strategies maintained this influence publishing policy recommendations that all births should occur in a hospital setting (DH, 1970) further marginalising non-authoritative knowledge systems and associated discourse (Davis and Walker, 2010a). Consequently, this continues to influence the place where childbirth occurs whereby current statistics confirm that ninety-eight percent of all births in the UK take place in a hospital environment (ONS, 2017).

Evidently this appears to have supported the on-going erosion of discourse surrounding normal birth, tacit midwifery knowledge, and women's intuitive knowledge (Jordan, 1997). Kirkham (1999) suggests the institution of a hospital, constructed and organised on phallocentric ideas presents the opportunity for tense gender relations in the organisation of care as most midwives are women. The social implications of this are significant both in terms of disempowering women, as well as leading to the subordination of predominantly female providers of maternity care: midwives (Benoit *et al*, 2010).

Women's dissatisfaction with their birth experience is an emerging theme in the debate surrounding the continuation of medical intervention in childbirth (NHS England, 2015; Ross-Davie and Cheyne, 2014; Beech and Phipps, 2004). In an exploration of the meaning of 'normal birth' I wrote on how dominant discourses in society, including policy guidance (NICE, 2014; NICE 2011); still promote a managed childbirth in hospital as one equating to safety (Clews, 2013a). These powerful narratives have been vigorously endorsed throughout society over the years leading Savage (2006) to suggest it led to many women distrusting their ability to birth without medical intervention. Taken together this has led to normal birth having limited temporal existence whereby Scamell and Alaszewski (2012: 213) propose that it can only exist in the past, after the birth has occurred. Part of this reclamation may be in the small increase of AMU and Freestanding Midwifery Unit (FMU) provision being developed in the UK (RCM,

2016). Data from the Healthcare Commission illustrates that five percent of women gave birth in these environments in 2008 (Healthcare Commission (HCC), 2008) increasing to approximately nine percent in 2015 (CQC, 2015). In the future an increase in the provision of AMUs may enable midwives to practice in an environment that supports the physiology of childbirth and offers women who choose it the option of birth in water.

1.2 Birth environment

In recent decades, there has been accelerated growth in 'home-like' settings within maternity hospitals in high-income countries (Sandall, 2013). AMUs provide low-technology care to women whose pregnancies are categorised as 'low-risk' (Hodnett *et al*, 2010) providing the additional 'safety net' of easy access to high-technology care, should this be needed. Such environments are considered an attempt by hospital institutions to address exactly this need to manage the perceived uncertainty of birth with an 'in-between' setting, that is more home-like but with rapid access to high-tech facilities if required. Expanding rapidly in the UK over recent years Redshaw *et al* (2011) refer to how they are seen by many increasingly as the preferred solution to the 'problem' of providing women with both choice and safe, high-quality, individualised maternity care.

Further supported by studies which show that hospital birth remains associated with safety for many women (Houghton *et al*, 2008; Pitchforth *et al*, 2009, 2008). More recently the Birthplace Cohort study (Birthplace in England Collaborative Group, 2011) compared the safety of births when planned in four settings: home, FMUs, AMUs and Obstetric Units (OUs). The study analysed nearly 80,000 births over a three-year period with just under a quarter of the sample comprising 'low risk' nulliparous women (Birthplace in England Collaborative Group, 2011). The findings of the study concluded that 'low risk' nulliparous women, who planned births in an AMU or FMU resulted in fewer interventions and more 'normal births' with low incidences of adverse perinatal outcomes (Birthplace in England Collaborative Group, 2011). Further evidence supports the suggestion that birth in a non-OU setting minimises 'unnecessary intervention' providing opportunities for labour and birth to be fulfilling fostering a positive relationship formation between mother and child (Kitzinger, 2005;

Fahy *et al*, 2008). The Birthplace Cohort study (Birthplace in England Collaborative Group, 2011), does however support a fetocentric view due to its focus on outcomes for the newborn, almost at the exclusion of the opinions of women thereby removing the potential to provide a fuller understanding of the choices the women made.

A secondary analysis of the original data set (Birthplace in England Collaborative Group, 2011) was conducted analysing women's immersion in water during labour (Lukasse *et al,* 2014). In the analysis immersion in water for pain relief was common in fifty percent of planned homebirths, fifty-four percent of births in FMUs and thirty-eight percent of births in AMUs (Lukasse *et al,* 2014) identifying those aged between 30-34 years as those most likely to use water immersion for this reason. The study identified a significant positive correlation for immersion in water when used for pain relief suggesting lessened pain and a reduction in the need for further analgesia as an associated, lower relative risk, for transfer to an OU prior to birth (Birthplace in England Collaborative Group, 2011). This finding occurred across all birth settings with a risk reduction ranging from forty-one percent in FMUs to eleven percent in planned homebirths (Lukasse *et al,* 2014). After adjusting for the influence of maternal characteristics, water immersion was also associated with a lower risk of intrapartum caesarean section, by as much as twenty percent (Lukasse *et al,* 2014).

Lukasse *et al* (2014) detected that newborns recorded higher Apgar scores at five minutes with no increase in rates of admission to a neonatal unit, suggestive that water use was not associated with poor 'long-term' outcomes for newborns in any group. Acknowledged as a strength of their study was the homogenous, low risk population included in the sample and their ability to account for several maternal characteristics. As a secondary analysis however there remained limitations including that the women who used immersion in water were a self-selected group with the potential for unmeasured differences, such as a lower tolerance for obstetric intervention. Also recognising that women's use of water in labour was not the focus of the original birthplace cohort study (Birthplace in England Collaborative Group, 2011), it restricted the data available for them to analyse regarding water immersion (Lukasse *et al,* 2014). Therefore, meaning they were unable to determine the duration of immersion in water, water

temperature, size of the pool and whether the birth took place in water. Due to the nature of the study being one of secondary analysis it implies the findings need to be interpreted with caution however is suggestive that water immersion has the potential to affect labour positively.

1.3 Theories of motherhood

Feminist literature (Rich, 1979; Oakley, 1979; Ruddick, 1989; Davis-Floyd, 1992; Ribbens, 1994; Letherby, 2003) identifies how social constructions of motherhood are fashioned within established patriarchal systems, involving concepts of ownership, hierarchy and the imbalance of power in society. Within the social framework of Western society, the role of 'mother' has been idealised, constructed and reconstructed by political, social and cultural influences (Oakley, 1979). In her work exploring representations of motherhood, Woodward (2003) explores ways in which motherhood can be seen as an identity in and of itself having 'different meanings at specific times and in specific places' (Woodward, 2003:18). The role of the 'mother' is subject to scrutiny that Jackson and Mannix (2004) suggest does not occur in the same way for fathers. Decisions and choices made by women in this capacity are judged by society which can lead to 'mother blaming' when idealised norms of motherhood are not achieved (Jackson and Mannix, 2004). Not achieving standards required of the institutional nature of motherhood in society can lead to feelings of guilt, blame, shame and even marginalization leading a woman to question her ability to be a 'good mother' (Allan, 2004).

Contemporary discourses of parenthood, examples of which are found in media debates on parenting, advertising targeted at parents, parenting magazines and advice provided by professionals involved in supporting parents and parents-to-be, ensure parents are made aware that they must be seen to be responsible, effective 'risk managers' in relation to birth, upbringing and infant feeding (Scamell and Alaszewski, 2012; Scamell 2011; Lee and Kirkham, 2008; Green 1999). The concept of the 'good mother' promoted in Western patriarchal societies takes a fetocentric reductionist view, requiring a woman to be selfless in her choices, ultimately placing her own desires aside in the interests of a healthy fetus (Stoppard, 2000; Byrne *et al*, 2017). Such constructions minimise

a woman's own health and emotional wellbeing, potentially affecting her identity and development as a mother.

Concepts of childbearing and motherhood are inextricably intertwined with one another (Miller, 2007; Miller, 2005). Experiences of labour and the birth can have far-reaching consequences both positive and negative for a woman and her newborn often spanning decades beyond the actual experience, these present the possibility for an intergenerational effect on a child's health (Ayers *et al,* 2006; Olde *et al,* 2006; Beck, 2004). Stoppard (2000:160) refers to the concept of 'intensive mothering' as dominating cultural constructions of motherhood as someone who is willing to forego their own birth choices for the 'safe' delivery of the newborn. The continuing dominance of authoritative knowledge speaks to the courage of the women in my study to disclose their choice to birth in water in a society that supports the view of the mother as a selfless entity potentially placing them in the context as 'selfish' or 'risk takers'.

Transition to motherhood theory derives from the work of Rubin (1967) who in the 1960s introduced the concept of 'maternal role attainment'. Mercer (2004) subsequently furthered Rubin's (1967) work developing with the concept of 'becoming a mother' detailing the initial transformation and continuing growth of the mother identity. Both theories have been criticised for assuming universality of the experience of motherhood for all women, promoting a child centric approach rather than acknowledging changes for the woman, as well as pathologizing women if they do not adjust to motherhood within a prescribed time limit. As Miller (2005) identifies, feeling like a mother can be a gradual process which may not be completed until nine months after the baby's birth or beyond. Subsequently childbirth narratives published on topics including the transition to motherhood have gained greater acceptance (Martell, 2001; Nelson, 2003; Sawyer, 1999; Bergum, 1997).

Society reinforces standards of the 'good mother' and women identifying with these standards when developing a motherhood identity. A form of social control this promotes acceptance of perceived behaviours suitable for a mother often in conflict with the lived reality of motherhood (Choi *et al*, 2005; Shelton and Johnson, 2006). Identities are subsequently adjusted by women when they become a mother (Laney *et al,* 2015) often representing internal tensions with

their identity prior to motherhood (Nicolson, 1998) leading them to modify their understanding of themselves and who they are in relationship to other people (Steinberg, 2005). Beginning in pregnancy for many this is recognised as a time of self-evaluation and self-reconstruction (Smith, 1994) whereby new mothers compare themselves to culturally endorsed ideals of motherhood leading to tension over their perceived shortcomings (Miller, 2007). Laney *et al's* (2015) study suggests this as a form of 'fractured identity' where becoming a mother fractured or compressed the women's own identities. Through negotiation the women were able to incorporate a motherhood identity however this was subsequently accompanied by a sense of self-loss.

1.4 Waterbirth

In present day maternity services, the option for 'water immersion' and 'waterbirth' are available for the woman to use during labour and childbirth. 'Water immersion' in this context refers to the immersion in water by a pregnant woman during the first stage of labour where the abdomen is completely submerged (Cluett and Burns, 2009). In this context 'waterbirth' refers to women who enter a birthing pool during the first or the second stage of labour and remain there to give birth. Compared to waterbirth the benefits of water immersion as a means of pain relief in labour has a more established and growing presence in the literature (Rosales *et al*, 2017; Henderson *et al*, 2014; Kolivand *et al*, 2014; Dahlen *et al*, 2013; Burns *et al*, 2012; Mollamahmutoğlu *et al*, 2012; Eberhard *et al*, 2005).

1.4.1 The origins of waterbirth

The first official recording of waterbirth was dated 1805, published in a French medical journal (Embry, 1805). The practice of birthing in water, however, was not championed until the 1960s. At this time, Igor Charkovsky, a Russian male-midwife, postulated that the lower pressure gradient in water would protect the fetal brain during birth (Kitzinger, 1993). In 1975, French Obstetrician, Leboyer (1918-2017) published his book 'Birth without Violence', in which he proposed that the practice of delivering newborns into noisy, brightly lit rooms and separating them from their mothers at birth could cause emotional trauma (Leboyer, 1975). Not until 1983 did the waterbirth movement gain acknowledgement when Michel Odent documented his experiences of conducting

one hundred waterbirths in Pithivier, France in his book 'Birth under Water' (Odent, 1983). Whilst his preference was for water immersion during labour, inevitably births in the water did occur (Odent, 1984).

The practice of waterbirth itself does not have a history within traditional English midwifery culture prior to the twentieth century (Kitzinger, 2003), having only been popularised following publication of the 'Changing Childbirth' report (DH, 1993). This report, perceived as groundbreaking for its time, included a recommendation that women should have access to birthing pools when in labour. This led to the professional regulatory body for midwives, the United Kingdom Central Council (UKCC), to include water immersion within a midwife's scope of practice at the time (UKCC, 1994), sparking a movement by a small number of midwives to champion the practice of waterbirth in the UK (Burns and Greenish, 1993; Garland and Jones, 1994; Nightingale, 1994). This coupled with studies published at the time by Hall and Holloway (1998) and Otigbah *et al* (2000), which highlighted the physical and psychological benefits when women used water immersion in labour, the movement started to advance around the world (Garland, 2017: 15-16).

In 1995 the first 'International Waterbirth Conference' was held in the UK (Beech, 1996), offering an opportunity for midwives, women and obstetricians to share their experiences of labour and birth in water. The conference presented reports that water immersion in labour offered a sense of safety, space, peace and tranquillity for women and that it could be used as a form of pain relief in labour with no associated side effects (Beech, 1996). Later this would lead to the suggestion that water immersion during labour could enhance normal birth physiology through associated means of promoting maternal mobility in the first stage of labour and aiding women in adopting upright positions in the second stage of labour (Otigbah *et al*, 2000; Da Silva *et al*, 2009). Evidence continued to support the calming and soothing effect of water when used during labour, subsequently reducing women's need for additional forms of pharmacological analgesia (Eberhard *et al*, 2005) culminating in the publication of a Cochrane review on waterbirth (Cluett and Burns, 2009). It synthesised the results of eleven randomized controlled trials (RCT's) concluding that water *immersion* during labour, reduced women's need for epidural/spinal anesthesia in the first stage of labour. Due to intervention and outcome variability in the studies

contained within the review, Cluett and Burns (2009) were unable to confirm additional outcomes due to considerable heterogeneity. They suggested however, that the evidence did not support the hypothesis that labour in water or waterbirth increased adverse effects to the woman or fetus/newborn when labour in water or waterbirth occurred. Supporting the findings of the Cochrane review a further two RCT's involving waterbirth have been conducted since (Gayiti *et al*, 2015; Ghasemi *et al*, 2013) again suggesting some positive maternal outcomes in waterbirth groups.

1.4.2 Waterbirth policy

Significant national policy guidance can be traced throughout the decades in the UK for the practises of labour and to a lesser extent birth in water. In response to the publication of the Winterton Report (1992), and the Changing Childbirth report (DH, 1993), the RCOG and the Royal College of Midwives (RCM) published their first 'Position Paper' on the use of water in labour and birth in 1994. At that time the position statement endorsed the use of water in labour, stipulating that those supporting the birth should have appropriate skills and confidence to assist women choosing to labour or give birth in water (RCOG and RCM, 1994). Subsequent revisions in 2001 led to continuing acknowledgement of benefits for women when using water during labour which included: a reduction in the use of pharmacological analgesia; women's perceptions that contractions were less painful; shorter labour durations; and less need for augmentation. Despite not identifying evidence of any adverse effects for the woman the revision failed to endorse birth in water, instead identifying what it referred to as "……a rare, but clinically significant risk of umbilical cord [injury] for neonates who were born under water" (RCOG and RCM, 2001: 1-2).

In 2003, The National Childbirth Trust's (NCT), Better Birth Environment Survey reported the views of over 2,000 women. Whilst waterbirth was not the focus of the study, most women voiced that access to a bath or birthing pool had enhanced their experience of labour (Newburn and Singh, 2003). Following this, the National Service Framework (NSF) for Children, Young People and Maternity Services (DH, 2004) was published illustrating the government's support for hospitals to ensure access to birthing pools for women. The NSF (DH, 2004:28) recognised that birthing pools were valuable in promoting normal birth within a

hospital setting suggesting that staff required the skills necessary to facilitate women's choice for water immersion during labour.

Following this, 2006 saw professional bodies (Maternity Care Working Party (2007) jointly exploring how to increase the normalcy of birth without increasing risk, stating "It is also known that some factors help to facilitate straightforward birth without evidence of additional risks, including one-to-one support, immersion in water……." (Maternity Care Working Party, 2007:4). Commitment for pregnant women to exercise choice continued in the Maternity Matters document (DH, 2007) followed by a maternity service review in England, by the Healthcare Commission (HCC, 2008) identifying birthing pool provision in 95% of National Health Service (NHS) hospitals at the time. They also identified that 11% of labouring women used water immersion; however, a smaller figure of only 3%, gave birth in water each year (HCC, 2008). Two years later the Care Quality Commission (CQC) identified a small increase of 13% of labouring women using water immersion during labour in England but failed to report whether a similar increase was seen in the percentage of waterbirths (CQC, 2010).

In 2012 the RCM updated the guideline on immersion in water during labour and birth. This new guideline collated some of the key international literature available on waterbirth at the time - again advising caution. It cited the differences between UK maternity service structures when compared to other countries, implying a potential influence on any findings identified. It concluded that "…..use of water during labour and birth continues to be an area with limited high quality evidence……However, the use of water encourages a woman centred approach to care, complements the normalising agenda and is an important consideration in terms of maternal choice." (RCM, 2012: 5).

More recently the UK NHS Five Year Forward Plan (NHS England, 2017) referred to the need for future models of maternity care to ensure they support choice for women. Clinical guidelines issued by the National Institute for Health and Care Excellence on 'Intrapartum care for healthy women and babies' (NICE, 2014:25) recommend water immersion as "….a means to reduce pain during the latent stage of labour", supporting the opportunity for women "…..to labour in water for pain relief" during the first stage of labour. This guideline only refers to the use

of water during the second stage of labour highlighting the role of the midwife to "Inform women that there is insufficient high-quality evidence to either support or discourage giving birth in water", (NICE, 2014:64) ultimately failing to recommend waterbirth.

This brief overview illustrates policy guidance in the practice of waterbirth from key organisations influential in maternity service development. Policy direction has been inconclusive at best leading to a lack of clarity for thousands of women on the issue of waterbirth in the UK. The absence of clear and robust public guidance on waterbirth continues to the present day and fails to assist women in their decision making. It could be argued that this has led to undermining midwives' ability to offer meaningful advice to women, inhibiting the practise of waterbirth.

1.4.3 Waterbirth: an international perspective

Waterbirth, in various forms, is an option now available in more than 90 countries (Harper, 2014:132). It has seen its greatest opposition in the United States of America (USA). In a country with a highly medicalised and privatised maternity system, it is estimated that the number of hospitals offering water immersion as an option for labour and birth in the USA is lower than ten percent (Harper, 2014). Controversy continues to surround waterbirth influenced partly by the continuing publication of individual case studies citing poor initial outcomes for a small number of newborns when born in water, originating mainly from the USA (Wright and Abdel-Latif, 2016; Demirel *et al,* 2013; Carpenter and Weston, 2012; Mammas and Thaigarajan, 2009). It could be argued therefore that narratives such as these compound fear by suggesting a lack of safety in waterbirth possibly as a means to undermine the practice and maintain the status quo of the biomedical model of childbirth.

Although case studies constitute a small proportion of the overall evidence, these are often sensationalised disproportionately in the media further supporting a risk perspective. This challenges midwives' abilities to positively affect their day-to-day practice when discussing the risks and benefits of waterbirth with those women who may be considering the option during childbirth. This in turn limits women's autonomy and informed decision making surrounding their individual birth experience, which studies show can negatively

impact mental health and emotional wellbeing postnatally and beyond (Cook and Loomis, 2012; Goodman *et al*, 2004; Green and Baston, 2003; Green *et al,* 1990).

In contrast the American College of Nurse-Midwives (ACNM) supports women's choice to remain in water during labour and birth (ACNM, 2014:1), the American Academy of Paediatrics (AAP) and the American College of Obstetricians and Gynaecologists (ACOG) are influential bodies in the USA and both discourage waterbirth. They define waterbirth as "an experimental procedure that only should be performed within the context of an appropriately designed clinical trial with informed consent" (ACOP and AAP, 2014:3). The American Association of Birth Centres (AABC) response to this was to analyse data collected from their online data registry over a three-year period and concluded that when careful selection criteria are applied, and experienced providers support the process, waterbirth did not negatively affect women or newborns (AABC, 2014). It is questionable however, that waterbirth will gain mainstream acceptance in a country in which there is an established culture of medicine associated with a high prevalence of medical litigation, in conjunction with a society that lacks universal healthcare for all.

Garland (2006b:24 -25) cites examples of other countries worldwide including Japan, Russia, Belgium, Germany, Austria, Malta and Switzerland where doctors and midwives are championing the opportunity for women to give birth in water. Garland (2006b:24) suggests that waterbirth in other countries will be challenging for women to achieve due to a lack of consistency in maternity care systems worldwide. More recently however, studies exploring waterbirth and its effects have been published using participants from countries including Australia (Maude and Fourer, 2007), Iran (Kavosi *et al,* 2015) and South Africa (Ros, 2009), promoting positive associated outcomes for childbirth in water and begins to provide evidence of a mounting appeal for women around the world.

1.5 Risk and childbirth

Historically childbirth has been inherently viewed within the dominant discourse surrounding risk, a genuine concern prior to 1950 in the UK. At the time, factors such as grand multiparity and associated haemorrhage as well as issues of poor sanitation leading to infection, were far more commonplace with the risk of

mortality in childbirth high, for both the woman and newborn (Tew, 1995). Society at the time accepted the narrative which viewed hospital births in high tech environments as 'progressive' and inextricably bound with 'safer' childbirth a viewpoint that persists to the present day. Despite maternal health having vastly improved and mortality rates at their lowest in decades (MBRRACE, 2017), it is acknowledged that this has not been matched by a return of childbirth into the social domain nor by midwives increasingly being seen to practise within a paradigm of normality in the UK (Chief Nursing Officers, 2010; Sandall *et al*, 2009; Gould, 2000).

In childbirth the discourse of risk has intensified amongst women in higher-income countries who remain highly sensitised to the presumed risks of birth (Lankshear *et al*, 2005). Paradoxically however mortality in childbirth in the UK remains low (MBRRACE, 2017) particularly when compared to low-income countries that do not provide universal healthcare such as those located in sub-Saharan Africa (Taylor-Gooby, 2000; Beck, 1992; Giddens, 1991). Described as 'timid prosperity' by Taylor-Gooby (2000:4) whereby the perception of risk is disproportionate to the reality. The dominant narrative of childbirth in society, whereby anywhere other than a hospital setting is promoted as unsafe further encourages the maintenance of patriarchal systems of power over childbirth. Use of water during labour and delivery is a direct threat to this narrative. Even in a hospital setting water creates a birth environment that removes the ability for intervention and control (Hewer *et al*, 2009) and has therefore been promoted as 'risky', 'unsafe', and only used by women labelled 'alternative'.

An individual's freedom to make choices and negotiate risk in life is considered a basic human right (Chadwick, 2014: 69). Whilst this may be true 'freedom' of choice remains challenging for women when contextualised within the milieu of biomedical birth, which situates women as irresponsible unless accepting of advice from 'experts' (obstetricians and midwives). Expert knowledge is acknowledged as 'objective' or 'rational' with folk wisdom or intuitive knowledge categorised as 'non-rational' (Zinn, 2008: 439).

The concept of the 'birth machine' refers to the definition of birth within a biomedical context (Wagner, 1994) whereby the observation of pregnancy searches for the absence of abnormality and pathology. Contrary to this Scamell

and Alaszewski (2012:208) highlight normal childbirth as being highly valued and associated with good outcomes paradoxically however, having 'no language of its own' within midwifery discourse. Inevitably this leads to defining normality in childbirth against the dominant discourse of 'high risk' (Kress, 1989) whereby normality can only be signified through 'absence' or in retrospect (Scamell and Alaszewski, 2012:216). Ultimately this offers credence to imagined possibilities of 'what if things go wrong', and with it poses the prospect of affecting a woman's confidence in her own body's ability to birth her baby successfully (Scamell and Alaszewski, 2012:217).

The deaths of two babies born in water at a hospital in Bristol were reported in by the media in 1993 (Rosevear *et al*, 1993). Whilst a causal relationship was not identified Rosevear *et al* (1993) did identify the possibility of increased oxygen requirements in a compromised fetus. A further death was reported in Stockholm in 1994 following a waterbirth where the post-mortem revealed the baby had inhaled contaminated water into its lungs (Rosser, 1994). What was not explored in this case study was that the baby made respiratory movements whilst in the water. In and of itself this suggested a compromised fetus prior to birth and poses the question as to whether the woman should have been encouraged to leave the pool prior to delivery. Considering these findings waterbirth protocols and guidelines in UK maternity units will reference the need to remove foreign material from the water and determine the accepted range of water temperature to maximise maternal and fetal physiology (Garland, 2017). Authors (Veltman and Doherty, 2013) have suggested the chance of reoccurrence in present day waterbirth practises due to these same factors would be negligible but recognise childbirth can never be deemed 'risk free'.

Waterbirth is seen as supporting a normality agenda but concerns regarding the safety of labour and birth in water continue to be expressed (Simpson, 2013). In the mother these risks focus on rare possibilities of water embolism, maternal sepsis and maternal haemorrhage (Chapman and Charles, 2009); whilst in the fetus concerns relate to fetal thermoregulation whilst in utero during labour, as well as the risk for cord injury, delay in the onset of respiration at birth and subsequent neonatal infection (Schafer, 2014; Mammas and Thiagarajan, 2009; Pinette *et al,* 2004). Analysis of these studies suggests evidence of violation in published waterbirth criteria within the sample population, which may have

negatively influenced the findings (Demirel *et al,* 2013). Moreover, recent evidence by way of a systematic review assessing neonatal outcomes when born in water (Taylor *et al,* 2016) identified that current evidence does not suggested waterbirth causes harm to neonates when compared to landbirth.

As a consequence, it appears that in allowing negative theories to go unchallenged, midwifery practises corroborate a process of pathology where birth can never be imagined to be normal prospectively, only in retrospect (Scamell and Alaszewski, 2012:218). The concept of 'normality' within childbirth has been difficult for midwives to define, leading to society creating an 'ever closing window of normality' (Scamell and Alaszewski, 2012:218). Viewed within the context of safety by means of minimising risk, this social construct implies waterbirth is dangerous for a newborn and corresponds to ensure the number of women choosing waterbirth remains low. Consequently, recent figures (CQC, 2015) illustrate how the practice of waterbirth has failed to become an established part of mainstream maternity services despite having been introduced over twenty-five years ago.

Although a biomedical model of childbirth favours objectivity and science over the perceived subjective experience of the individual (Munro and Spiby, 2010) the well-documented physiological basis to support a fetus' ability to be born in water are frequently overlooked (Garland, 2017; Pedroso *et al*, 2012). Neonatologists and obstetricians continue to promote the potential for fetal compromise (Mills and Stirrat, 1996; Doniec-Ulman *et al*, 1987) despite mechanisms hypothesised to inhibit a healthy newborn from breathing whilst underwater (Johnson, 1996). Johnson's (1996) review of respiratory physiology has long been established in the literature suggesting in a non-stressed newborn protective mechanisms such as the diving reflex will prevent the initiation of respiration underwater. Further studies published around this time failed to associate a causative link between compromise in the newborn and water (Gilbert and Tookey, 1999; Alderdice *et al,* 1995).

Continued discussion of possible risks and frequent publication of case studies detailing negative outcomes for newborns birthed in water infer but fail to prove a causal link (Carpenter and Weston, 2012; Wright and Abdel-Latif, 2016). Findings of a recent systematic review exploring neonatal outcomes (Taylor *et*

al, 2016) identified a lack of definitive evidence for compromise when neonates are born in water it subsequently contradicts this by suggesting insufficient evidence to support the idea that there are no additional risks. Similarly, a recently systematic review exploring neonatal outcomes in waterbirth specifically when in a hospital environment (Vanderlann *et al,* 2018) suggested no increase in poor neonatal outcomes when born in water suggesting that water may even reduce the incidence of bacterial colonisation. In light of this it is imperative that midwives have clear and detailed understanding of fetal physiology to enable support of women in this environment.

This paradigm of evidence-based practice (EBP) has long been established within the health professions including midwifery (Sackett *et al*, 1996). Although the concept has been critiqued in midwifery (Stewart, 2001; Wickham, 1999) due to its inability to attend to the nuance of individuality and clinical decision making, it remains prominent within dominant discourses (Walsh, 2007). Premised on research which is 'ranked' locating the randomised controlled trial (RCT) as definitive in proving or disproving a hypothesis it is viewed as key in challenging long held views and practise (Chambers *et al,* 1989). As a result, it appears that practises such as waterbirth are destined to remain unproven due to the unethical nature of randomising women who have chosen waterbirth in a non-waterbirth control group and vice versa. As seen in the study by Woodward and Kelly (2004) whose attempt to undertake a waterbirth RCT contained a very small sample as well as other issues meaning they were unable to assess the efficacy of waterbirth. The only other UK based RCT allocating women into either water immersion or non-immersion in the second stage of labour is now over 20 years ago (Nikodem *et al*, 1995), the study was never published in full in peer-reviewed literature, so we are unable to draw conclusions from its findings.

A literature review by Young and Kruske (2013) explored three main clinical concerns focussed on the use of water in labour and birth: water aspiration, neonatal and maternal infection and neonatal and maternal thermo-regulation. Their review of the literature considered maternal and neonatal studies from a range of quantitative methodologies and concluded that there was no supporting evidence base for the three clinical concerns raised against waterbirth. The review also identified minimal cases of water aspiration and of those reported, no causal link was determined along with similar incidences of maternal and

neonatal infection between the waterbirth and land birth groups (Young and Kruske, 2013). Ultimately, the review found that of the studies included, those that monitored maternal temperature when in water, largely found no difference between the two groups. They determined that when maternal pyrexia and associated fetal tachycardia were identified in those women using water, basic measures such as adding cold water to the pool rectified these abnormalities with no long-term effects detected in the sample groups (Young and Kruske, 2013).

1.6 Summary

This chapter provides context for the reader in relation to the evolution of waterbirth globally as well as in the UK. It considers this within the context of past and current maternity services policy as well as within the concepts of safety, risk and maternal choice. These are all embedded within patriarchal influence seen within society which in this study specifically relates to the medicalisation of childbirth presented within a feminist viewpoint surrounding theories of motherhood. The following chapter will develop this discussion by presenting a review of the primary research in the area of waterbirth.

Chapter 2

Empirical literature

This chapter presents a review of the empirical evidence base focussing on qualitative studies which explore waterbirth, both from the woman and midwife's perspective. A comprehensive review of the literature was undertaken at the beginning of the research and repeated several times ensuring the inclusion of emerging research. Findings from qualitative studies have important implications for knowledge development, to have impact however, they must be situated in a larger interpretive context such as a meta-synthesis (Sandelowski *et al*, 1997). Epistemologically, meta-synthesis supports an interpretivist approach (Heyman, 2009), contributes to the development of more formalised knowledge (Zimmer, 2006) and seeks to enhance the focus of this thesis. Reviewing the empirical literature in this way is important for furthering understanding about how the findings are conceptually related to one another, thereby enhancing our understanding of the phenomenon waterbirth.

2.1 Literature search strategy

A systematic literature search was initially conducted in 2014 then updated annually until December 2017 using a combination of search strategies to maximise the identification of relevant studies. The aim of the review was to identify primary research studies which explored childbirth in water, waterbirth. Database searching using keywords, titles and abstracts were conducted via seven databases: British Nursing Index (BNI), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Allied and Complementary Medicine Database (AMED), Maternity and Infant Care (MIDIRS), Medical Literature Analysis and Retrieval System Online (MEDLINE), Applied Social Sciences Index and Abstracts (ASSIA) and Web of Science. Search terms used are detailed in table 1 with the same search terms repeated across all databases. Manual searches were also carried out using citations of the selected studies to identify further papers. Grey literature was searched using the ETHoS thesis database to identify any unpublished works and specialist sites including the Royal College of Midwives (RCM) and the National Childbirth Trust (NCT). Reference lists from resulting articles and book chapters were scanned to ensure that no relevant studies were

missed and in addition regular electronic journal alerts and manual searches of key midwifery journals were used to survey newly published material.

Table 1: Terms used to search the literature

("waterbirth" OR "water birth" OR "water-birth" OR "water" OR "birth in water" OR "birth underwater" OR "underwater birth" OR "birthing pool")
AND ("labour" OR "labor")
AND ("childbirth" OR "child birth" OR "child-birth" OR "birth" OR "delivery")
AND ("women" OR "woman" OR "mother" OR "mothers" OR "motherhood" OR "maternal")
AND ("midwifery" OR "midwife" OR "midwives" OR "maternity" OR "maternity care")

The initial searches revealed that much of the work published in this area adopted a positivist approach, exploring maternal and neonatal outcomes when comparing physiological birth and waterbirth. Due to the Cochrane review 'Immersion in water in labour and birth' (Cluett and Burns, 2009) incorporating quantitative studies on water immersion and birth prior to this date, only studies from 2009 onwards were reviewed. Search parameters of 2009 to 2017 were set resulting in thirteen quantitative studies being located which focussed on outcomes associated with labour and birth in water for either the woman and/or the newborn (Rosales *et al*, 2017; Lim *et al,* 2016; Kavosi *et al*, 2015; Kolivand *et al*, 2014; Henderson *et al*, 2014; Demirel *et al*, 2013; Dahlen *et al*, 2013; Mollamahmutoğlu *et al*, 2012; Burns *et al*, 2012; Carpenter and Weston, 2012; Cortes *et al,* 2011; Torkamani *et al*, 2010; Ros, 2009).

Of these, nine involved comparative analysis of both maternal and neonatal birth outcomes on land birth compared to labour and birth in water (Rosales *et al*, 2017; Lim *et al,* 2016; Kavosi *et al*, 2015; Kolivand *et al*, 2014; Henderson *et al*, 2014; Dahlen *et al*, 2013; Mollamahmutoğlu *et al*, 2012; Burns *et al*, 2012; Torkamani *et al*, 2010). Three of the studies focussed solely on neonatal outcomes following waterbirth (Demirel *et al,* 2013; Carpenter and Weston, 2012; Ros, 2009) and one study used the single outcome of perineal trauma and postnatal pelvic floor function in women following waterbirth (Cortes *et al,*

2011). Most of these studies failed to seek the views of women themselves, the few that did were tokenistic.

When conducting the systematic review of the literature, papers that drew on secondary data analysis, literature, systematic or Cochrane reviews, case studies, audits and opinion pieces were all excluded. A clinical audit on waterbirth did not meet inclusion criteria of primary research (Menakaya *et al,* 2013) and was excluded. Bovbjerg *et al's* study (2016) involves a secondary analysis of an original data set from the Midwives' Alliance of North America Statistics (MANA Stats) project 2004-2009. Varela *et al* (2014) presented their research study at the International Confederation of Midwives (ICM) conference but are yet to publish this in a peer-reviewed journal to date. Three theses were identified via ETHoS, one met the inclusion criteria, two did not. Russell's (2016) work involved action research with midwives and increasing waterbirth, this study met the inclusion criteria for this review (Russell *et al,* 2016). Burns (2014) thesis was quantitative in approach and therefore excluded. A thesis by Woodward (2011) was located which centrally focussed on the challenge of conducting a randomised controlled trial for waterbirth (Woodward and Kelly, 2004). The thesis did collect survey data from women regarding their expectations and satisfaction with waterbirth; however, this qualitative element of the thesis has not yet been published in a peer-reviewed journal. Finally, a primary research study (Pagano *et al,* 2010) was located within the parameters of the literature search, specifically comparing economic outcomes between water and land birth but was excluded from the review as it was quantitative and sought one assessment outcome, perineal trauma.

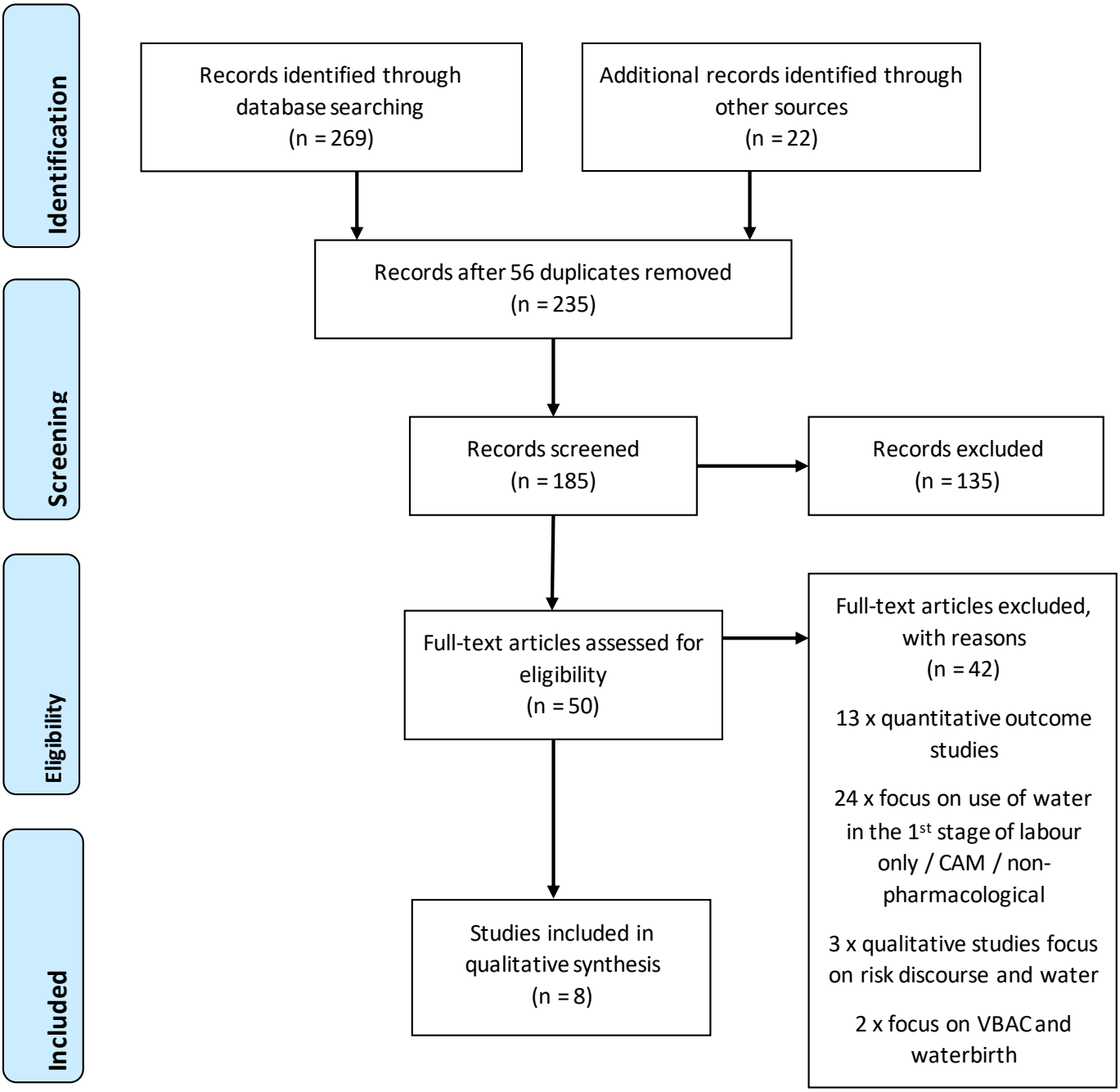
2.1.1 Selection of studies

For the purpose of this thesis papers were selected for inclusion if they, sought women's views and experiences of birth in water, waterbirth, and were published in English. Those qualitative studies that reported on use of water: immersion solely during the first stage of labour; as a form of complementary and alternative therapy in childbirth; as a form of non-pharmacological pain relief in labour were excluded as these were all considered to be different phenomena to that of waterbirth. As, however this study sought to explore women's stories of waterbirth told through their individual socio-cultural context, it was anticipated

that a relational element involving the midwives who had cared for the women during their birth may emerge. Therefore, primary research studies exploring waterbirth qualitatively from the midwife's perspective were also included.

Eligible papers were shortlisted and full-text articles accessed. 269 records were identified through database searching and an additional 22 were identified through other sources. After removing duplicates (n=56), 235 records remained and were screened using keywords, title and abstracts. Following screening, 185 studies were excluded on the basis they did not report primary research resulting in 50 full-text articles being read to assess for eligibility. 42 studies were excluded resulting in a total of 8 primary research studies which met the criteria for inclusion (see figure 1).

Figure 1: PRIMSA flow diagram illustrating the literature search



Guided by the need for the review to have application to clinical practice, as part of a professional doctorate, an eight-year parameter was set for study inclusion. The Code (NMC, 2015:7) stipulates that "midwives should practice in line with the best available evidence when informing or advising women." Four qualitative studies exploring midwives' perspectives on waterbirth (Nicholls *et al,* 2016; Plint and Davis, 2016; Russell *et al,* 2014; Meyer *et al,* 2010) and one qualitative study seeking the views of women (Waters, 2011) were located. The timeframe for inclusion was subsequently revised and extended to fifteen years, from 2002 to 2017, whereby a further three studies exploring women's views on waterbirth were identified for inclusion (Maude and Foureur, 2007; Richmond, 2003; Wu and Chung, 2003). Ultimately, eight studies were taken forward for quality appraisal (see Appendix 1).

2.1.2 Quality appraisal

Once qualitative studies had been identified, each one was reviewed according to criteria described by Walsh and Downe (2006) as a means of providing a standardised mechanism for appraisal. Appraising each study for its scope and purpose; study design and sampling strategy used; analysis and interpretive framework; issues relating to reflexivity and ethics; the relevance and transferability of the study; and a narrative summary of the study's quality (Walsh and Downe, 2006).

No studies were excluded from this literature review based on quality appraisal however it is recognised that, the research by Wu and Chung (2003) fails to clearly outline the ethical approval obtained to undertake the study and therefore their findings were viewed with caution. Two of the studies (Wu and Chung, 2003; Richmond, 2003) were identified as being analytically weak, most likely attributed to the length of time ago the studies were undertaken. One other study (Meyer *et al,* 2010) experienced issues with the reliability of their sample of certified nurse-midwives, some of whom had not witnessed or participated in waterbirth.

2.1.3 Data summary and synthesis

Previous examples of maternity focussed meta-syntheses of qualitative studies were identified including Beck's (2002a) examination of mothering multiples as well as her account of postpartum depression (Beck, 2002b) and Clemmens'

(2003) exploration of adolescent motherhood. More recently, Norhayati *et al* (2015) explored women's experiences of severe morbidity and Earle and Hadley's (2017) synthesis of men's views and experiences of infant feeding.

Walsh and Downe (2006) recognise that the qualitative researcher's interpretation of data is legitimately influenced by prior beliefs and requires a high degree of reflexivity. To this end I acknowledge my own preconceptions including; that waterbirth is valued by many of the women who choose it; it is situated as an 'alternative' form of childbirth; it can be synonymous with physiological birth; and that some midwives will not value waterbirth as a safe form of childbirth and may actively avoid supporting women who chose this birth method. Considering these preconceptions and with the aim of maximising credibility of my interpretations, established techniques were used to support the robustness of each stage of the synthesis process. Both data saturation and actively searching for disconfirming data were employed during analysis.

Keen to avoid reductionism when analysing and synthesising the study findings, thematic analysis of each study was undertaken. Initially identifying preliminary concepts these were analysed to identify emerging themes and ultimately synthesised into the final six themes presented in appendix two. These final themes represent an interpretation across the studies of women and midwives' perceptions and experiences of waterbirth.

2.1.4 Findings

The eight included studies were based within a range of methodological approaches. Half of those identified employed a survey design (Plint and Davis, 2016; Russell *et al*, 2014; Meyer *et al*, 2010; Richmond, 2003), one involved a modified form of grounded theory (Nicholls *et al*, 2016), one phenomenology (Wu and Chung, 2003) and two broadly identify as either qualitative research (Waters, 2011) or interpretive inquiry (Maude and Fourer, 2007). Qualitative methods used for purposes of data collection from women, most commonly involved semi-structured or unstructured interviews (Waters, 2011; Maude and Fourer, 2007; Wu and Chung, 2003). Frequently the studies involving midwives (and one exploring women's views) adopted the use of questionnaires (Plint and Davis, 2016; Russell *et al*, 2014; Meyer *et al*, 2010; Richmond, 2003). Plint and Davis (2016) adapted the questionnaire originally developed by Russell *et al*

(2014) and one study employed a combination of interviews along with a single focus group (Nicholls *et al,* 2016).

The studies focussed on women reported on a total of 203 women (Maude and Foureur, 2007; Wu and Chung, 2003; Richmond, 2003), a further 16 'parents' participated in Waters (2011) study and whilst she fails to define this term she does identify some participants as 'mothers'. The smallest sample size was in Maude and Foureur's (2007) study with a total of five participants, whilst the largest sample was in Richmond's (2003) study reporting on 189 women. In the other four studies a similar total number of participants included 196 midwives and 13 obstetricians (Plint and Davis, 2016; Nicholls *et al,* 2016; Russell *et al,* 2014; Meyer *et al,* 2010). The smallest sample was in Nicholls *et al's* (201) study with 26 midwives in total with the largest being in Plint and Davis (2016) study with a total of 75 participants, 62 midwives and 13 obstetricians.

The eight studies represented the views of women and midwives from mainly five countries, two from the UK (Russell *et al* 2014; Richmond, 2003), two from Australia (Plint and Davis, 2016; Nicholls *et al,* 2016), one from New Zealand (Maude and Foureur, 2007), one from Taiwan (Wu and Chung, 2003) and two from the United States of America (USA) (Waters, 2011; Meyer *et al*, 2010). Whilst Waters (2011) was based in the USA and most participants were recruited from different states in the US (n=11), five participants were from other countries including, Canada, New Zealand, Australia (n=2) and the UK.

The earliest papers were published in 2003 (Richmond, 2003; Wu and Chung, 2003) representing half of those studies exploring women's views. This contributes to the rationale for this thesis to be undertaken with the aim to provide a more contemporaneous knowledge base surrounding, women and waterbirth. The papers exploring midwives' experiences constituted a more contemporary body of knowledge having been published between the years 2010 to 2016 (Plint and Davis, 2016; Nicholls *et al,* 2016; Russell *et al,* 2014; Meyer *et al,* 2010). Recruitment to the studies were conducted differently between those seeking views of women and those seeking views from midwives. Whilst those seeking the views of midwives frequently adopting a pragmatic approach identifying midwives and obstetricians working in one maternity unit. The studies recruiting women themselves did so accessing several maternity

units and one used a media platform to recruit women from a variety of different countries.

Initial concepts identified the views and experiences of women who had birthed in water as well as midwives who had knowledge of or had participated in waterbirth. Following analysis of the eight papers emerging themes were formed, interpretations of these within the meta-synthesis ultimately formed six themes: three across women's experiences and three across midwives' experiences of waterbirth. Similarly, to Earle and Hadley's (2017) meta-synthesis the aim here was to remain "close" to the primary data of the studies whilst allowing for synthesis of the studies to emerge. Therefore, where possible, quotes are used to illustrate each analytical theme.

2.2 Labour and birth in water: women's experiences

Half of the studies identified in the literature search specifically focussed on women's experiences of labour and birth in water (Waters, 2011; Maude and Foureur, 2007; Richmond, 2003; Wu and Chung, 2003). Initial concepts developed into emerging themes and ultimately three main themes were identified across the studies that of: women's knowledge of waterbirth; women's perceptions of physiological birth; and women's sense of autonomy and control (see appendix two).

2.2.1 Theme One: Women's knowledge of waterbirth

All the studies (Waters, 2011; Maude and Foureur, 2007; Richmond, 2003; Wu and Chung, 2003) identified women's knowledge of waterbirth as fundamental in their decision for this choice of birth. Wu and Chung (2003) identified that knowledge and support from the woman's husband was particularly important in enhancing the woman's own confidence in her ability to birth in water, suggesting a relational component to the study.

> *I passed some reports about waterbirth to him and asked him to accompany me when I had my antenatal exams at the midwifery clinic, where he would watch videos and read relevant information. Hence he became less worried after he had more knowledge about waterbirth. (Wu and Chung, 2003: 265)*

Waters (2011) study too highlighted women who actively researched waterbirth:

> *……..[I] engaged in in-depth self-directed research on natural childbirth and discovered waterbirth (Waters, 2011: 5)*

Media influence was an emerging theme in two of the studies (Waters, 2011; Richmond, 2003) and formed the basis of Waters (2011) ethnographic study. In Richmond's (2003:26) research she talks of how women reported their knowledge of waterbirth as having been spread largely through television (65.5%), magazines and books (39.5%) with the smallest percentage (17.5%) having been formed by their midwife. This suggests that media can be an influential tool in the promotion of waterbirth:

> *One woman saw it [waterbirth] on television and was curious about the experience (Richmond, 2003:27)*

Richmond (2003:29) suggests that "middle class women tend to read more antenatally…" suggesting that at the time the study was conducted it was this group of women who would more likely request waterbirth due to their knowledge of the birth choice as spread through the literature. Interestingly, by the time Waters (2011) study is published eight years later, it is the internet specifically the media of 'YouTube' video channel that the women credit for birth networking and education. This suggests the potential for waterbirth to be 'visible' to a larger audience involving all groups in societies due to the audio and visual nature of digital media:

> *I chose to post the video on YouTube.com because the videos that I had watched during both pregnancies were so helpful and I wanted to be able to provide that for other women who are looking to have a homebirth or waterbirth (Waters, 2011:3)*

Waters (2011:7) refers to women using the internet in this way as a means to phase out more traditional forms of authoritative cultural knowledge in favour of creating a new paradigm of social change driven by mothers and women themselves. She concludes that "the influence of online visual birth media and mother's textual narratives published on the internet will continue to influence the personal childbirth decisions of pregnant women who use the internet as an educational tool".

2.2.2 Theme two: Women's perception of physiological birth

Most of the studies identify women's intuitive knowledge in choosing waterbirth as a fundamental element of physiological birth (Waters, 2011; Maude and Foureur, 2007; Wu and Chung, 2003). As an element of this, the studies all refer to waterbirth as a positive part of childbirth for the women. Many of these women however had difficulty articulating exactly how waterbirth positively affected their experience. Maude and Fourer (2007) suggested the water appeared to provide a "temporal stabilising effect" for the women whereby a natural balance between pain and relaxation was achieved:

> *It [the water] made me feel better. It didn't really take the edge off the pain I don't think; it made me feel much better in myself (Maude and Fourer, 2007: 22)*

While Waters (2011) refers to how most women in her study felt that standard maternity protocols were not serving their interests or providing evidence-based practice, with one woman stating:

> *The more I watched videos of Baby Story and saw everybody go through epidural, add [syntocinon], add more epidural and then get a c-section and nobody seemed to blink an eye that there was something wrong with that, I was little by little getting more uncomfortable with the idea of birthing in the hospital (Waters, 2011:6)*

Similarly, a sentiment echoed by women in Wu and Chung's (2003) study:

> *We were born with the ability to deliver naturally, not necessarily by CS (Wu and Chung, 2003: 266)*

Women from Richmond's (2003) study also referred to their desire for a 'natural' birth. Similarly, the women failed to define what they meant by this term, however Richmond (2003) suggests it referred to minimal use of 'drugs' and monitoring during labour. This appears to suggest that women used waterbirth to actively resist standardised interventions in labour such as vaginal examinations and fetal monitoring describing water as:

> *….a blanket of security from the outside world (Richmond, 2003: 30)*

Furthering this many of the women in Waters (2011) study spoke of the memorable impression reading natural childbirth books by authors such as Ina May Gaskin and Sheila Kitzinger, had impressed on them in pregnancy. One of the women in the study went so far as to state that:

> *……that the thought of interventions and pharmaceutical pain relievers never entered [my] mind because of the powerful physiological effects of water (Waters, 2011:6)*

Maude and Foureur (2007) identified the connection women had with water on an intuitive level as one of the women in the study spoke of delaying childbirth until the pool had arrived at her house later that day:

> *……some of it was that I knew that everything wasn't ready yet, everything wasn't there that I needed, so I kind of just slowed down and waited…. (Maude and Fourer, 2007:19)*

Maude and Foureur (2007) acknowledge their recruitment of women from Pakeha and New Zealand European groups in their research. Acknowledging the unique spiritual importance of Maori birthing they recognise that this may present differently in those women from other cultural groups.

2.2.3 Theme three: Water, autonomy and control

All the studies, in varying degrees, report on women's choice of waterbirth as a means for autonomy and control over their birth experience (Waters, 2011; Maude and Foureur, 2007; Richmond, 2003; Wu and Chung, 2003). For many women this was a direct reaction to a previous negative birth with one woman stating:

> *……ended up getting an epidural during birth when the intention had been to give birth naturally. After this birth [I] was left feeling like birth was meant to be a different way…….(Waters, 2011: 5)*

Dissatisfaction with the current medical care system referred to a desire for waterbirth as in direct opposition to childbirth practice in Taiwan at that time which frequently promoted caesarean section (Wu and Chung, 2003).

> *I carefully examined the information about both deliveries at hospitals and childbirth methods outside hospitals. I decided to choose waterbirth in the*

last month of my pregnancy. I received antenatal examinations at both hospitals and midwifery clinics. So it was not the way other people said – that I did it simply as an idea! (Wu and Chung, 2003: 264-265)

Finding women employed strategies to achieve their goal of waterbirth when views of relatives did not support this practice (Wu and Chung, 2003). Women reported engaging strategies to influence their relatives until a consensus was reached or alternatively using techniques to conceal their intentions until after the birth occurred.

The pressure came not only from my husband's parents but also my friends. They had no reason to object to my plan since they certainly had less knowledge about waterbirth than I did (……) All I wanted to do was achieve my goal. So, I kept a low profile during the whole process……I was willing to put up with any stress in order to achieve my dignity of my life. (Wu and Chung, 2003: 265)

The same was true in Waters (2011) study whereby one of the women, rather than receive the free maternity care provided by the Canadian government (meaning she would need to birth in hospital) paid $2,500 to ensure her choice to have a waterbirth at home. She spoke of her desire to:

…..avoid another incident of having [my] membranes ruptured artificially, being augmented with [syntocinon], or being pressured to birth in the lithotomic position (Waters, 2011: 5)

Maude and Fourer (2007) refer to the water creating a barrier, offering privacy and control. One woman recalls how she moved to the far side of the pool so no one could touch her:

Every time I had a contraction I'd move……..and away from them as well, they couldn't reach me-when I didn't need them, there was no way they could have touched me because I was over the other side of the pool……I was nowhere near anyone else (Maude and Fourer, 2007:22)

Reiterated by another woman in the study who described the pool as a protective place for her, a little cocoon:

It was my space……..I could get away from all that stuff that was going on. I think the water was more about being able to block everything out in between and being able to completely relax…….. (Maude and Fourer, 2007:22)

Richmond (2003) echoed this citing that many women used waterbirth as a way of preventing unnecessary interference as a means to:

…control their environment (Richmond, 2003: 30)

Strikingly in Richmond's (2003) study, she highlights a vivid memory during waterbirth for over half of the women in her study. Many referred to the fact that:

No one took [my] baby away from [me] immediately after birth (Richmond, 2003:30)

Interestingly is seems that some of the most significant responses in Richmond's (2003) study came from the women's free-text responses outside the standardised choices in the questionnaire. When asking women what they particularly liked about waterbirth, free-text responses identified a clear sense of autonomy afforded to them by their choice to birth in water:

They felt more dignified giving birth in water (Richmond, 2003:28)

Richmond (2003) also highlights the value the women placed on support provided by the midwife helping them to facilitate this sense of autonomy:

The social support [they] got during waterbirth (Richmond, 2003:28)

……welcomed the 'hands off' approach from midwives, providing a great sense of achievement (Richmond, 2003: 28)

Maude and Fourer (2007) identify 'bliss' as a sub-category of 'getting to the water' in their findings. One of the women states:

…….so I had the whole enclosed warmth and yeah, the support of the water, yeah, it was my space (Maude and Fourer, 2007:21)

Wu and Chung (2003) identified the importance of being afforded autonomy to choose waterbirth. A demonstration of the women's attempts to identify birthing methods residing 'outside' of the normal systems:

My husband supposes that every mother should be able to have a normal spontaneous delivery. When one goes to hospital, the doctor cannot wait too long, so they will perform a CS after a certain point of time……(pause). My labor pains were so hard to bear then, that I might have changed my mind (……..) I had to insist [on waterbirth], otherwise all my efforts would have been in vain…….Why I insisted was because doctors dominate everything at hospitals (Wu and Chung, 2003: 264)

One woman in Waters (2011) study talked of the lack of [perineal] tearing when she birthed a ten-pound baby which she attributed to the water:

…..allowing [me] to be in a really good position [squatting] for birthing without physically being really tiring (Waters, 2011:6)

Women used largely positive words to describe their experience including, "less interference, quicker labours, more personal, satisfying, calmer, more natural and less restricted" (Richmond, 2003).

2.3 Labour and birth in water: midwives' views

Four papers focussed on midwives' experiences of facilitating labour and birth in water, all were published within the last seven years. One study focussed on UK practice (Russell *et al*, 2014), one study on midwives in the USA (Meyer *et al*, 2010) and the most recently published studies from practice in Australia (Nicholls *et al*, 2016; Plint and Davis, 2016). Walsh and Downe's (2006) review criteria were applied to all four papers allowing for emerging themes to be identified. Across the papers three main themes were identified that of: midwives' knowledge and experience of waterbirth; the impact of professional and organisational cultures on the practice of waterbirth; the midwife's skills and confidence in waterbirth (see appendix two).

2.3.1 Theme One: Midwives' knowledge and experience of waterbirth

All the studies (Nicholls *et al,* 2016; Plint and Davis, 2016; Russell *et al,* 2014; Meyer *et al,* 2010) referred to midwives' knowledge and experience of waterbirth. In Meyer *et al's* (2010) study most certified nurse-midwives (CNM) cited significant benefits of waterbirth in terms of pain reduction, positive birth experience, quicker labour as well as relaxation for the mother. CNMs identified their own exposure to waterbirth as via reading an article, receiving a question

about waterbirth from a woman, watching a video about it, with 30% having received education about waterbirth in their training (Meyer *et al,* 2010).

Similarly, Russell *et al* (2014) identified midwives' personal knowledge of waterbirth practice as being significantly higher following their attendance at a waterbirth workshop compared to those who did not attend. Nicholls *et al* (2016) support this within their category themed, 'what came before the journey'. Discussing factors that influence midwives' perception of waterbirth prior to witnessing it, they also identify waterbirth education. One midwife highlights:

> *It [waterbirth] was gradually rolled out over about 7 months, we had some in-house training sessions which were good because it was new and we were all in the same boat – you could ask questions and not feel silly (Nicholls et al, 2016:76)*

Another midwife identified:

> *Better to learn from a good DVD than a not so good mentor (Nicholls et al, 2016:76)*

The findings from Plint and Davis (2016:210) study also cites the positive influence of staff training and support.

2.3.2 Theme two: Professional and organisational culture

All four studies (Nicholls *et al,* 2016; Plint and Davis, 2016; Russell *et al*, 2014; Meyer *et al,* 2010) discuss the impact that professional or organisational culture can have on the promotion of waterbirth. Meyer *et al* (2010) specifically posed a question to the CNM asking 'to what extent they opposed or supported the introduction of or greater emphasis of waterbirth in the facility where they practised?' Despite many CNMs having never witnessed or been involved in waterbirth, 64% welcomed a greater emphasis on waterbirth in practice.

One of the major categories in Nicholls *et al's* (2016) study explored midwives' perceptions of facilitating waterbirths themed 'What came before the journey'. Discussion surrounding professional 'attitudes' towards waterbirth illustrated conflict for some, with one midwife stating:

> *Why would you want to have a baby in water? We don't have fins! (Nicholls et al, 2016:76)*

In Russell *et al's* (2014) study the importance of professional to professional support and modelling behaviours by labour ward co-ordinators are highlighted. This assisted in normalising waterbirth as a valued part of the midwife's role practising on labour ward. Russell *et al* (2014) attribute this to the introduction of problem-solving workshops used in the study, which appeared to enhance the leadership of the labour ward co-ordinators ability to take action to promote waterbirth practice. They suggest that by providing an opportunity for the behavioural norms of the labour ward to be developed it directly increased the practice of waterbirth.

Organisational factors and the influence of 'place' was also identified as influential in Russell *et al's* (2014) study. They suggest the environment where midwifery practice occurred had the ability to minimise or normalise waterbirth practice, particularly when based in a hospital environment. Finding that through prolonged education engagement, institutional culture could positively influence support for waterbirth practice.

Nicholls et al (2016) also identified organisational culture as influential particularly referring to 'midwifery initiation' to waterbirth. They discuss the influence a practice environment can have on a midwife's practice of waterbirth:

> *As I graduated as a midwife and began to practice, I spent two years on birth suite when I was first qualified - I spent six months on the low risk [birth centre] side so got very comfortable and familiar with low risk care (Nicholls et al, 2016:76)*

This theme suggests that professional and organisational cultures can both hinder or assist the practice of waterbirth and identifies the environment of clinical practise as significant for many midwives.

2.3.3. Theme Three: Midwives' skills and confidence in waterbirth

Most of the studies (Nicholls *et al,* 2016; Plint and Davis, 2016; Russell *et al,* 2014) specifically refer to the confidence of the individual midwife as a significant factor in promoting or preventing waterbirth from occurring. Nicholls *et al* (2016) identify the theme of 'Becoming confident – the journey' exploring how midwives develop their confidence as they start to practice waterbirths. During this time, many midwives referred to the support they located via, having

robust clinical guidelines, peer support with other midwives, exposure to waterbirths and consistency of such, having an inner confidence in their abilities as well as, unlearning skills and practice. Illustrated by one midwife who states:

> *Initially it was really hard to keep your hands off…….and I think because you are so used to hands on, the hardest bit was keeping your hands out the way and changing practice……(Nicholls et al, 2016:77)*

Finding that midwives were much more likely to identify with waterbirth as safe, when compared to obstetricians, Plint and Davis (2016) explored how low rates of waterbirth persisted in the unit. Most midwives in the study indicated they had experience with waterbirth but identified that this was not a routine occurrence. Plint and Davis (2016) found that despite a desire from delivery suite midwives, staffing levels in this area were suggested as a reason that facilitation of waterbirths were inhibited. In contrast they identified continuity midwives were more likely to support women in their use of water and choice for waterbirth.

A major study finding in Nicholls *et al's* (2016) research was 'Staying confident' illustrating the factors affecting a midwife's ability to remain confident when supporting women who chose waterbirth. One midwife refers to how waterbirth largely emulates physiological birth:

> *I really do not think it [waterbirth] is a big deal or strange or wonderful……..To me waterbirth is exactly the same as a baby born in its own membranes. If the membranes aren't ruptured and it's born in it's own caul, it's a waterbirth and that's a perfectly natural thing to happen and then you break the waters and the baby breathes. Waterbirths are the same as that but it comes through the water instead of being born within the water. So to me it was never a weird thing, it happens anyway in nature, so what's the big deal about it (Nicholls et al, 2016:78)*

Similarly supported by another midwife in the study:

> *A lot of confidence in doing waterbirths is regaining confidence in birth as a normal process (Nicholls et al, 2016:78)*

Nicholls *et al* (2016) however also identified the opportunity for 'knocking confidence' to occur illustrated by the comments of a midwife:

> *Some things can knock your confidence, every now and then when you have something that doesn't go exactly as it should……..(….)a big blood loss or something and that kind of knocks your confidence a little bit ….it's not till you get back on there and have another nice normal waterbirth that you think, yeah that's good I can do it now (Nicholls et al, 2016:78)*

All the studies (Plint and Davis, 2016; Nicholls *et al*, 2016; Russell *et al*, 2014; Meyer *et al*, 2010) identify a form of 'journey' for midwives in their participation and confidence with waterbirth. Collectively the studies appear to suggest this journey will likely be influenced by personal philosophies of childbirth, professional and organisational cultures as well as peer support, role modelling positive behaviours and exposure to opportunities to support women choosing this birth medium.

All four papers that studied midwives' experiences of facilitating labour and birth in water (Plint and Davis, 2016; Nicholls *et al*, 2016; Russell *et al,* 2014; Meyer *et al*, 2010) add to our understanding of how midwives' own experiences of and confidence in facilitating waterbirth's can affect women's choice. All the studies identify midwives who want to support women during labour and birth in water but experience limited opportunity to participate in this preventing increased confidence in their own skills.

2.4 Discussion

The meta-synthesis of the four qualitative empirical studies (Waters, 2011; Maude and Foureur, 2007; Richmond, 2003; Wu and Chung, 2003) reveal a mainly positive experience of waterbirth provided by women when their perspectives are sought. Alternatively, the four studies exploring midwives' perceptions of waterbirth present a more conflicted picture (Plint and Davis, 2016; Nicholls *et al*, 2016; Russell *et al*, 2014; Meyer *et al*, 2010) highlighting findings that illustrate a form of professional journey for all the midwives involved. Some studies reported increased midwife confidence when waterbirth was supported by an ethos of care and confident mentors (Russell *et al*, 2014). Others identified a lack of confidence in this area of practice which in turn had the potential to negatively impact acceptance and promotion of waterbirth in clinical practice (Nicholls *et al*, 2016; Russell *et al*, 2014; and Meyer *et al*, 2010).

A major strength of this meta-synthesis is that it explores the experience and perceptions of women who have birthed in water and those of midwives and obstetricians who witness and practise waterbirth. It provides insight into factors that may influence women who decide to birth in water, their desire for a physiological birth experience and the autonomy and sense of control they experience when this is achieved. Equally it is the ability of midwives to work within a supportive professional culture coupled with their knowledge of waterbirth that allows for experience and in turn confidence in this area.

In contrast to the main body of quantitative literature on waterbirth, which remains inconclusive, this review found that the women in the studies viewed their experience of waterbirth positively and that there is a willingness on the part of midwives to support the practice (Waters, 2011; Maude and Foureur, 2007; Wu and Chung, 2003; Richmond, 2003). Russell *et al* (2014), Plint and Davis (2016) and Nicholls *et al* (2016) all identify the need for midwives to gain and maintain confidence in their skills of supporting women who chose to birth in water most commonly through education, constant exposure and opportunity.

Nicholls *et al* (2016) highlights the influence the maternity setting itself and a positive culture towards supporting physiological childbirth can have on a midwives' confidence to support women who chose waterbirth. Such cultures appear to reside in Alongside Midwifery Unit's (AMU) currently within the UK (Birthplace in England Collaborative Group, 2011) and similar models in other countries i.e. continuity midwives in Australia (Nicholls *et al,* 2016). It is suggested that collectively these studies (Plint and Davis, 2016; Nicholls *et al,* 2016; Russell *et* al, 2014; Meyer *et* al, 2010) should be used as evidence to support mandatory education and training for midwives around waterbirth. This would provide an opportunity to foster social support between midwives as a means to increase individual's confidence in the practice. Increased confidence of midwives may then assist in positively increasing the number of women who experience waterbirth in hospital settings.

This review is not without limitations. Earle and Hadley (2017) recognise that there is no single approach agreed when conducting a qualitative systematic review. Like many other qualitative research studies, it is not possible to draw conclusions on causality or generalizability. This meta-synthesis review was

based on the summary and thematic analysis of the eight primary research studies and the findings they identified. I acknowledge that I did not exclude any papers based on quality appraisal, due to the paucity of primary studies in this area this was based on principles of pragmatism. A further limitation of the review will be that during the synthesis stage, the poorer quality studies contributed less.

Despite the limitations however this meta-synthesis contributes to our knowledge in the area of waterbirth both from the woman and midwives' perspective. As such, it presents important findings as part of the justification for conducting this study, for clinical practice and future research. Critically it illustrates how some women can actively benefit from a positive birth experience when their choice to deliver in water is promoted by midwives (Waters, 2011; Maude and Foureur, 2007; Richmond, 2003; Wu and Chung, 2003).

The meta-synthesis illustrates a gap in the evidence seen in qualitative research surrounding waterbirth from the emic perspective of the woman. This is an important consideration in clinical practice whereby midwives need to ensure that care is provided to promote choice and is woman centred. Future research in this area should also seek to redress the imbalance in the research paradigm adopted, considering a wider range of methodologies and increasing the number of qualitative studies seeking views of women accessing maternity services. There is also scope to widen research to include women who oppose the idea of waterbirth and research in this area may help midwives, students and educators to gain an understanding of the views of these women adding to knowledge in this area.

2.5 Summary

This chapter provides a review of qualitative empirical studies in the form of a meta-synthesis of both women's and midwives' perceptions and experiences of waterbirth. A total of six main themes were identified across the studies, three across each category. The synthesis of empirical studies reveals a mainly positive experience of waterbirth when women's perspectives are sought (Waters, 2011; Maude and Foureur, 2007; Richmond, 2003; Wu and Chung, 2003). Women actively sought knowledge of waterbirth, valued it as a means of

supporting physiological birth and expressed that it allowed then a sense of autonomy and control in their childbirth experience.

Alternatively, the four studies exploring midwives' perceptions of waterbirth present a more conflicted picture (Nicholls *et al,* 2016; Plint and Davis, 2016; Russell *et al*, 2014; Meyer *et al*, 2010; Nicholls *et al*, 2016). The synthesis presented increased midwife confidence when waterbirth was supported by a professional and organisational culture fostering positive role modelling behaviours and social support (Russell *et al*, 2014). Others identified midwives who lacked knowledge and confidence in waterbirth due to limited exposure which in turn had the potential to negatively impact acceptance and promotion of waterbirth in clinical practice (Nicholls *et al,* 2016; Plint and Davis, 2016; Russell *et al*, 2014; Meyer *et al*, 2010). This is an important consideration in clinical practice whereby midwives need to ensure that care is provided to promote choice and is woman centred.

Despite the meta-synthesis illustrating women who valued waterbirth, it is clear from the paucity of qualitative studies located in the review that further research is required. This gap in the evidence surrounding waterbirth from the emic perspective of the woman urgently requires redress. This study aims to contribute to our understanding of waterbirth by maintaining the focus on the woman's individual story. The following chapter discusses the methodological approach and methods chosen to undertake this research.

Chapter 3

Methodology and Methods

The previous chapter examined the primary literature and evidence surrounding waterbirth. As little is known about these women there is a need for further research in this area exploring how waterbirth affects women's sense of self and in what way this influences their identity as they journey into motherhood. This study seeks to contribute to this process by foregrounding the women as central within the study by adopting a feminist perspective and employing a narrative approach.

This chapter will open by presenting the theoretical framework of this research, identifying why a feminist perspective was deemed most suitable to inform the study. The second part of the chapter presents the research design justifying the methodology deemed most suitable for this study: narrative inquiry. This methodology encompassed three of the following features: it was qualitative, it was narrative, it emphasised the importance of listening to women's voices and perspectives. This is followed by a description of the research process including sampling, accessing the participants and the data gathering method used. The chapter concludes with discussion of the approach taken to data analysis, the ethical approval process and the role of reflexivity as it applies to this study.

3.1 Interpretivist framework

The literature search presented in chapter 2 supports that quantitative studies have dominated evidence surrounding use of water in labour and waterbirth over the past decade. This type of research supports a positivist approach seeking to objectively quantify waterbirth within the context of physical outcomes for women and their newborns. Despite this body of evidence none of the studies, nor the Cochrane review, demonstrated conclusive outcomes, either positive or negative, specifically relating to waterbirth. It was clear therefore that an additional study using a positivist approach would be of limited value at this time and may only compound the uncertainty surrounding waterbirth. I therefore felt the most useful and important way of contributing to the field both theoretically and to inform clinical practice at this time would be to carry out a qualitative research study.

Critique of the qualitative approach focuses on the subjective nature of the research findings generated (Bowling, 2014; Green and Thorogood, 2009) however this is also recognised in quantitative studies, whereby the researcher predefines which factors will be explored (Stanley and Wise, 1993). Qualitative research values the importance of encouraging the expression of personal experiences in the participants' own words (Rees, 2011) and is deemed suitable for exploring topics that have been under-researched, as in this study, to give a voice to the population under study (Barker *et al*, 2002). Therefore, my emphasis was two-fold: first, exploring the ways in which the women themselves presented their stories; secondly, understanding how women interpreted and made sense of their waterbirth within the context of their own lives (relational and cultural), past experiences and the society in which they live.

This study is located within an interpretivist paradigm, fundamentally recognising that there is no one single truth or unchanging reality, which can be uncovered by the researcher (Denzin and Lincoln, 2005; Letherby, 2003; Walsh and Wiggens, 2003; Mauthner and Doucet, 2003). The aim of this study reflects the multiple meanings attributed by the women to waterbirth influenced by their lives, values and previous experiences, as well as the multiple interpretations of their stories which are all equally-valid relative truths. As such my study is not seeking to provide a definitive explanation as to why women chose to birth in water. Rather, I sought to explore how women use their own stories of childbirth in water to develop their sense of self and reflect meaningful experiences as they negotiate their journey into motherhood.

3.2 Feminist theory - Hearing women's voices

Numerous definitions of feminism have been developed however fundamentally, the feminist perspective recognises oppression and explores the reasons for it (Woodiwiss *et al*, 2017; Letherby, 2003; Fine, 1992; Harding, 1987). With agreement amongst feminist researchers (Letherby, 2003; Harding, 1992; Harding, 1987) that feminist research should seek to redress the androcentric assumptions upon which positivist research paradigms are based. It is in the researcher's clarity in the application of methods within a research study that will speak to the feminist nature of it due to interchangeable and varying

methods, methodologies and epistemologies used within feminist research (Harding, 1987).

Mies (1983) referred to how research itself can serve dominant groups in society by further dominating or even exploiting existing marginalised groups as a means to legitimise power, historically this has included women. A feminist stance requires us to listen to women's individual stories of waterbirth recognising that these stories occurred within the context of UK maternity care, which promotes choice for women situated within the context of patriarchal dominance and control over childbirth practices (Clews, 2013a). In presenting women's own words, perspectives and stories as the primary source of knowledge about their experiences, this study resists a tradition in healthcare recognised by Harding (1986) whereby voices of those women who have experienced childbirth have been dismissed and devalued.

Feminist research is unique because first, it deals with women's experiences, second it is for women and third that it locates the researcher as an obvious presence in the study. This is contrary to the traditional positivist view which deems the researcher should be an 'invisible, anonymous voice of authority' (Harding, 1987:9). This suggests an active intention to promote a non-hierarchical relationship between participant and researcher (Lee, 1993). Resisting discourses in bias and research due to this relationship, Gilligan (1992:28) writes "rather than blurring perspective or clouding judgement with feelings, relationship is the way of knowing…….an avenue to knowledge". Strategies aimed at addressing this throughout the design and applications of my study are discussed later in this and other chapters presented through reflexivity.

This perspective values women's experiences and seeks to understand the actions that can be taken to change a situation (Kralik and van Loon, 2008). The feminist view seeks to deconstruct the knowledge of patriarchal society, historically a male-dominated culture which used positions of power to define issues, language and theories from women's experiences (Harding, 1991). Feminist empiricism (Quine, 1963), feminist standpoint theory (Hundleby, 1997) and feminist postmodernism and post structuralism (Harding, 1991; Scott, 1991; Harding, 1986) are all key theories that developed from these primary

positions. It is argued that feminist standpoint theory is particularly important regarding issues of reproduction. As only women can experience reproduction, pregnancy, birth, and lactation directly, their voices and perspectives on these issues are of central feminist concern (Woliver, 2002). With the intention of uncovering assumptions about power differentials within a patriarchal society (Woliver, 2002) where power is knowledge, socially situated within and comprised of a culture's beliefs and opinions (Harding, 1991) with women's knowledge excluded as a direct result of their marginalised status within patriarchal society (Woliver, 2002).

Knowledge has been intimately tied to the domination and oppression of women (Letherby, 2003) and feminists contest that, due to their exclusion women's experiences and ways of knowing the world are not represented (Ramazanoglu and Holland, 2002). Whilst feminism celebrates difference, 'it also has to balance this with a focus on women as a collective with some common interests and experiences' (Sang *et al*, 2013). The concept of being equal and yet different is one of importance for this study, for women are different to men by the nature of giving birth. Being a woman who experienced waterbirth is the commonality, yet how this is interpreted by the women in their stories and I as the researcher will be influenced by differences arising from life experiences, previous birth experiences, culture, and their values and beliefs. Each woman will feel and interpret this differently within relational and sociocultural contexts.

3.3 Alternative methodologies

Selecting the most suitable methodological approach to answer the question involved examining key methodologies. A phenomenological approach remains popular when exploring women's experiences of childbirth (Nilsson and Lundgren, 2009; Gibbins and Thomson, 2001) and was considered for this study. Originating from Husserl's (1859–1938) descriptive phenomenology and Heidegger's (1889–1976) interpretive phenomenology, it places emphasis on the lived world focussing on how phenomena are experienced by individuals (Creswell, 2013; Bloor and Wood, 2006; Denzin and Lincoln, 2005; Van Manen, 1997; Polkinghorne, 1989a). Husserlian phenomenological requires two aspects that rendered it unsuitable for this study firstly, the need to adopt a reductionist approach (Giorgi, 1997) during data analysis where data is coded to assesses

the value of each of the participants' statements grouping them into themes (Kleiman, 2004; Holloway and Wheeler, 2015). Fundamentally, my study does not seek to group all participants' experiences collectively into themes instead aiming to acknowledge and embrace differences located in the individuality of the women's stories of waterbirth. Secondly is the requirement for the researcher to 'bracket' their own beliefs and values (Elliott *et al*, 1999; Smith *et al,* 1999), which would potentially compromise the integrity of my study as well as my positionality within it as the researcher. 'Bracketing' my position both professionally as a midwife and personally as a woman having experienced waterbirth would not have attended to the feminist perspective employed in my study.

Discourse analysis was another alternative considered for this study due to the exploration of women's stories of waterbirth. As a methodology it seeks to identify through language the discourses and interpretive repertoires that individuals draw on to construct meaning and make sense of their world (Silverman, 2011; Fairclough, 2003; Wetherell, 2001; Potter, 1996). Whilst the use of language and the influences of social discourses were of interest in the study, these specific elements were not the focus of my research question. Similarly employing a reductionist approach to analysis did not allow for the holistic aim of this research to be met subdividing data into category units, rather than preserving the integrity of an entire event (Riessman, 2008). Consequently, a different approach was required.

In seeking an alternative methodology that remained true to the feminist perspective of my study it was important to adopt an approach which foregrounded the woman's own story of labour and birth in water. It was important to explore the emic perspective of these women and allow an opportunity for private experiences to be voiced (Pope and Mays, 2006; Denzin and Lincoln, 2005; Mauthner, 2002; Mauthner, 1998). Narrative inquiry methodology was therefore considered a more suitable fit for this study allowing for exploration and interpretation of the women's own stories of waterbirth. It also privileged my role as researcher, in co-constructing the narratives ensuring they were situated within sociocultural contexts in which women lived as well as the wider context of medicalised childbirth.

The value of adopting a narrative approach is that the voice and story of the narrator are heard (Stephens, 2011). A literature review illustrated how nursing and health research have increasingly adopted use of narrative inquiry to help practitioners understand their patients more readily (Haydon and van der Riet, 2017; Wang and Geale, 2015; Green, 2013) with a growing corpus in midwifery research (MacLellan, 2015; Souza *et al*, 2009; Akrich and Pasveer, 2004). As the story telling process is central to my study, the choice to use narrative inquiry enabled the women to describe and attribute meaning to the experience of waterbirth told through their stories.

The transition to motherhood borders both biological and social aspects of life (Miller, 2005). Childbirth results from a biological process and yet the contexts in which women live their lives as mothers are socially constructed, relational, historically specific and culturally varied. Women's experiences of motherhood will therefore reflect this diversity. Callister (2004a) and Walsh (2010) all note the marginalization of women's voices and experiences within public and academic discourses about pregnancy, labour, and birth. Thus, illustrating the need for a narrative approach to my study as a means to explore ways in which women tell their stories of birth and negotiate their transition to motherhood (Miller, 2005).

3.4 Storytelling and narratives

Many authors have written on the terms 'narrative' and 'story' referring to how such terms are often used synonymously in the literature (Wang and Geale, 2015; Sandelowski, 1991; Polkinghorne, 1988b). Storytelling holds the purpose of clarifying complex issues in health and society for individuals. In their original form, stories are often trivialised as forms of evidence, however Koch (1998) argues that in listening to and asking questions of the stories, rich data can be provided. Reissman (2008) connects storytelling to the process of identity construction which recognises variants depending on the audience told and an individual's position in society (Yuval-Davis, 2006).

Polkinghorne (2007) remarked on the ubiquitous nature of stories suggesting that personal descriptions of life experiences can offer illumination and clarity to often neglected aspects of human life. They are not intended as a transparent

account of 'truth' but rather "to convey a specific perspective or meaning of an event as portrayed through story form" (Holloway and Jefferson, 2000:32). In the same way recognising that experiences are not conveyed as standalone entities, instead co-constructed through negotiated and constantly shifting meanings. As storytelling includes elements of concept, character, theme, structure and voice (Brooks, 2011) it is in the telling of stories that we can see how people select, organise and connect events in a particular way for a particular audience (Reissman, 2008). Suitable when research explores the representation of the self as reflected in the aims of this study (Elliott, 2005). Whilst a limitation is that it cannot be generalised to a larger audience due to its inherent subjectivity it does provide a 'window' into the inner world of the individual and their identity (Lieblich *et al*, 1998).

The study of narrative has been traditionally associated with literary and linguistic traditions concerned with analysing the formal structures of stories including the formation of language and linguistic codes (Labov, 1982; Labov and Waletzky, 1967). As a methodology it experienced a renaissance when Connelly and Clandinin (1990) advanced its application within the field of education by exploring the personal stories of teachers and their pupils. Since the 1990s narrative has been applied frequently across the human and social sciences (Riessman, 1993; Mishler, 1995; Hinchman and Hinchman, 1997) as a means to offer deeper understanding of the subject (Riessman, 2008).

A key aspect of narrative is the construction of events within their social context, rather than an unassuming chronicling of them (Chase, 2005). Elliot (2005:3-4) contends that narratives organise a "sequence of events into a whole so that the significance of each can be understood through its relation to the whole", told differently depending on the values and interests of the teller (Reissman, 1993). Offering the narrator, the opportunity to identify the most salient aspects of the phenomenon themselves giving "voice and the printed page to those who require mediation to get their voices into the public arena" (Wengraf, 2001:140). Essentially a representation, interpretation by the 'audience' is inevitable (Plummer, 1995, Riessman, 1993) therefore interplay between storyteller and listener is a key feature. These features of narrative supported the feminist aims of my research confirming its suitability.

Differences between narratives and stories are recognised as being at an analytical level seen at the intersection of data gathering and analysis (Riley and Hawes, 2005: 227). Frank (2000) suggests that people tell stories, however narratives come from the researcher's analysis of those stories (Frank, 2000) their role being an intermediary to bring the participants tale to public attention (Koch, 1998; Polkinghorne, 2007) and the end product is therefore a "co-construction" between the two (Polkinghorne, 2007; Riessman, 2008).

3.5 Narrative inquiry methodology

Narrative inquiry methodology is guided by several fundamental beliefs, firstly that people's accounts of themselves are storied, and the social world is also storied; that narrative is a key means through which people produce an identity; that narratives link the past to the present; that there are no unbiased accounts of the past (Webster and Mertova, 2007). Narrative inquiry methodology offered key benefits to this study: first, narratives facilitate an in-depth approach; second, narratives are closely related to real-life experience, which was part of what I was keen to capture (Lieblich, 1998:5); and third, narratives have been described as a fundamental communication method through which our experiences, interpretations and priorities are revealed (Grbich, 2007:124), so I was hopeful that the approach would reveal much of the complexity of factors influencing women's choices to birth in water and how this affected their transition to motherhood, both endogenous and exogenous.

The philosophy of narrative inquiry provides an opportunity to hear voices that may otherwise have remained silent (Trahar, 2013) particularly important in the feminist roots of this study. As a methodology, narrative inquiry would privilege the 'voices' of the women involved in my study, affording women the space to share their stories of labour and birth in water in their own words, foregrounding the uniqueness of the personal context in which these stories occurred (Sandelowski, 1991; Polkinghorne, 1988; Mishler, 1986). Women's stories of their birth experience in water provide an opportunity for the researcher to interpret their representation of self both in what people choose to say or do not say; the information they select to account for their decisions; as well as the sociocultural meanings they ascribe to their experience (McAdams, 2003).

My belief is that we can come to understand the meaning women attribute to waterbirth by listening to what they say. Disentangling concepts of birth experience, use of water, women's autonomy and choice, biomedical narratives of childbirth and risk are undoubtedly complex and challenging. It would be in the process of the woman telling her story that would offer insight as an individual, the researcher and wider society.

Women's stories can take the form of written accounts, spoken word or visualised images (Andrews *et al*, 2008) it is the storyteller and researcher who are co-creators, through narrative construction and reconstruction. As I interpreted the stories of the ten women in my study and made visible their narratives, my aim was to create an opportunity for what Webster and Mertova (2007) describe for readers engage with and experience the individual's story and reactions from their own individual perspective, at that moment in time.

3.5.1 Narrative in midwifery research

Use of narrative approaches have been evident in midwifery and nursing research for nearly two decades (Brown and Addington-Hall, 2008; Kennedy *et al*, 2004). Callister (2004b:484) suggested through the use of birth stories midwives and practitioners should 'listen with increasing sensitivity to the voices of the women for who we provide care'. Having decided that a narrative approach would most appropriately address the aims of my study I undertook a more detailed literature search for previous studies that had used the approach to explore childbirth or identity construction in mothers. I identified four peer-reviewed studies (Miller, 2000; Dara and Murphy, 2016; Montgomery *et al*, 2015; MacLellan, 2015) that had all explored childbirth and/or motherhood using narrative inquiry. Miller (2000) undertook a longitudinal study using narrative methodology exploring the process of what is publicly defined when becoming a mother. The studies by Darra and Murphy (2016) and Montgomery *et al* (2015) undertook narrative research exploring how new mothers described childbirth (Darra and Murphy, 2016) and how childhood sexual abuse affected women's experiences of maternity care (Montgomery *et al*, 2015), whilst MacLellan (2015) explored women's birth stories of trauma shared on the Internet.

3.6 Methods

Having identified my research design, this final part of chapter three will present the methods used in this study and the processes employed in generating the data. It will present the description and rationale for the data collection process, including how this was shaped by the feminist research approach and research methodology. It will outline the recruitment strategy, data gathering method, approach to data analysis and outline ethical considerations specific to this study. It will identify the challenges experienced within each of these areas and discusses how these were addressed.

3.7 Data gathering

The data gathering method chosen was required to have theoretical and methodological 'fit'. Feminist researchers have the potential to use all methods available for data gathering (Harding, 1987). This study required a data gathering method congruent with the feminist research approach ensuring that women's own voices were distinct and discernible within data collection and analysis (Letherby, 2003). Synergy was required between all elements of the research process; the feminist perspective required a method of data gathering that continued to focus on the woman. The research question posed requested women's stories of waterbirth leading to the narrative methodology but fundamentally it was the co-constructive relationship between the women's stories and my interpretation of them as the researcher that led to the selection of in-depth, unstructured interviews. A method well established within research literature (Holloway and Wheeler, 2015; Kvale, 2007; Edwards and Holland, 2013) it allowed the opportunity for me to clarify with the women any aspect of their story that remained elusive to me. 'Narrative' interview (Stuckley, 2013) mirrored my role as a midwife in clinical practice, whereby I would share in the woman's story of childbirth. This form of interview provided each woman with 'space' to capture her own story, choosing what *she* felt was important to disclose and share. The interviews use of a single 'narrative eliciting' question at the beginning of each interview ensured it did not constrain or direct the participants other than in the focus of the study (see figure 2).

Figure 2: Narrative eliciting interview question

> "I want to ask you to tell me the story of how you gave birth in water. The best way to do this would be for you to start from the point where you decided you wanted to give birth in water, and then tell all the things that happened leading up to and during that time until you feel you have completed. You can take your time in doing this, and also give details, because for me everything is of interest that is important to you."
>
> Adapted (Herman, 1995: 182)

The aim in narrative interviewing is to generate detailed accounts rather than brief answers and reflexively the researcher needs to create opportunities for this to happen (Riessman, 2008). The sensitivity of the subject under study, as well as the feminist foundations of the research identified a need for a non-hierarchical method of data gathering allowing women to retain an element of control. Mishler (1986) advocates the use of narrative interviews as they empower the participant to set the agenda preventing their experiences from becoming fragmented; they enable participants to control and direct the focus of the story, exploring and sharing elements important to them; they also afford them opportunity to retain aspects they want to remain private. Ethically, it was important that women did not share more than they were comfortable with, a recurrent concern in qualitative research due to the unpredictable direction of unstructured interviews (Lee, 1993). Such interviews cannot claim to access an objective truth, they will be context specific, acknowledging the contrived nature of the interview encounter as well as my own influence as the researcher, a midwife, a woman who has birthed in water and a mother, all aspects influencing the accounts given.

3.7.1 Data gathering process: in-depth interviews

To provide transparency and authenticity in research, researchers using qualitative methods are encouraged to recognise their own personal beliefs, values and experiences and how they can shape the way in which they approach and undertake qualitative research and interpret the data (Creswell, 2013). As

Clandinin and Connelly (2000: 56) note, researchers' interests often derive from their own life experiences; it is these experiences that will contribute and "shape the lines of narrative inquiry".

Qualitative research relies on the establishment of a relationship that encourages disclosure with research itself being 'product orientated' (Hendry 2007: 496). Kvale (2007) recognises, the dilemma where an interview situation could lead to participants disclosing more than they are comfortable with recommending ethical sensitivity and respect of the researcher in knowing how far to delve with questioning. I was cognisant that I required a non-hierarchical approach during interview in line with the feminist perspective of my study (Lee, 1993). Recognising that I conducted this study as the thesis in my doctoral studies I acknowledge that the balance of power inevitably rests with me it would be naïve to assume that there would be no power differentials in research of this type. This issue required greater scrutiny given the role of power and control in childbirth and was an important consideration in my method of data gathering as I would be initiating the interviews, steering their content and drawing them to a close (Kvale 2007). Active listening, avoiding interruption, using confirmatory cues to put them at their ease and allowing the time needed for them to share their stories were all strategies I employed in this study.

Storytelling should be recognised as a thoroughly embodied performance, punctured by bodily eruptions, the sounds of laughter and excessive speech. To truly foreground women's stories, moments of excess need to be considered as part of the analysis (Langellier and Peterson, 2004). As Chadwick (2014:48) acknowledges "if we only pay attention to logical, descriptive and coherent elements of narratives we are in danger of missing possible moments of strangled articulation, resistance and narrative insight, which may signal the beginning of a counter-storying process".

A single, recorded in-depth interview was conducted with nine of the ten participants in the study. The interview was led by a stimulus, a broad trigger question, in the case of this study being the woman's experience of birth in water. Holloway and Freshwater (2007b) discuss the requirement for careful consideration in developing the singular interview question to ensure it constitutes a combination of open, probing and affective inquiry required. The

desire to elicit a long narrative account from the women with minimal direction or interruption from the researcher is fundamental in narrative interviews, I therefore only used confirmative expressions such as "yeah", "yes", "umm" and "uh huh" when the women were telling their stories. Clarification was sought at the end of the woman's story and was facilitated by structuring the questions within the words used by the participants during the narrative, an example from Sophie's interview was:

> Interviewer: You mentioned that you felt you wanted more control over your birth this time, can you elaborate on that for me?

Narrative interviews can be affected by the relationship between the researcher and participant requiring high levels of interpersonal skills to foster collaboration in the process of co-construction (Mishler, 1986). Empathy, interpersonal skills, genuineness and accurate listening skills were engaged during interviews (Holloway and Freshwater, 2007b). All are associated with the clear need for the participant to feel comfortable enough to lead the sharing of their narrative following the initial trigger question (Kvale, 2007). If time had allowed, a longitudinal approach to the study may have provided opportunity to create a more established relationship with the women recognising this may have led to the co-construction of altered narratives.

The nature of narrative interviews has been well documented as an opportunity for the participant to tell their story in a way that has meaning for them as individuals (Frank, 1995; Letherby, 2003; Chase, 2005). In this study, I was keen to avoid interruption of the flow of the story employing skills of active listening along with those of questioning (Kvale, 2007). What is shared in the stories of participants, how these are told during the interview, combined with the researcher's contribution is part of the co-creation of the final narrative (Plummer, 1995: 20).

In my invitation letter to participants (see appendix three) I introduce myself as a 'midwife, lecturer and student' and this may have affected the story told. It was interesting however that some of the participants wanted to clarify my position and knowledge surrounding childbirth before sharing their story. An example being when Hope started her interview with the question:

> Hope: Do you want all the gorey details? [laughs]

Researcher: Yeah [laughs] the gorey details are the best!

Hope: [laughs] OK erm, well actually I decided that I wanted a waterbirth with my first son…….

Discussion of childbirth processes such as 'crowning' at birth, defecation, and blood are recognised by Kitzinger (2005) and Kirkham (2007) as being deemed inappropriate for public consumption in western cultures. So, it was important for me to reiterate my role as a midwife, as someone used to such discussion as part of their normal everyday practice, who would not be offended by such discussion, offering reassurance to the participants. As the researcher, I conversed with all participants and did so specifically before starting the interview recording by introducing myself more fully, explaining the purpose of the study, as well as how the interview would be conducted. Whilst some participants were happy to start sharing their story, others appeared to find it difficult to start verbalising their thoughts as the beginning of Leonie and Ava's interviews show:

P: OK. Ummm I initially wanted to give birth in water from when I had my son, ummm even before he was born, ummm…… [Leonie]

P: Alright erm, yeah I think my sort of desire to have a waterbirth came from before I had my first child er …… [Ava]

There appeared to be differing degrees of preparation in some of the stories shared, this particularly applied to Nicole's story, the only written story within the study. I recognise that this offered Nicole the opportunity to consider which elements of her story she wanted to disclose as well as those she wanted to remain unseen or hidden. Writing her narrative gave her the potential to exert greater control over the story she wanted to tell, with the ability to review, rewrite, restructure, amend, add and delete numerous times before sending it to me. Acknowledging that in its written form it failed to afford me the opportunity to observe Nicole's body language, points of emphasis, and hesitation as observed during a face-to-face interview. Yet valuing Nicole's contribution to the study in making visible parts of her story that communicate most meaning for *her* as an individual, and its inclusion in my study supports the feminist viewpoint of giving voice to marginalised individuals such as Nicole.

3.7.2 The interview setting

Interview settings are acknowledged as having the potential to affect the depth of story, information or events shared with the researcher (Patton, 2015). All the interviews were conducted in a place of the woman's choosing to ensure they felt at ease in the environment where they shared their narrative; the options being in their own home or alternatively a room at the University. The majority (nine women) invited me to carry out the interviews in their homes, whilst Nicole declined to be recorded during an interview and chose instead to write her experience having been e-mailed the narrative trigger question. Whilst a neutral setting was offered, being interviewed in their own home appeared to be a catalyst for the women to feel able to share intimate details of their waterbirth and may have organically redressed the imbalance in power recognised in the researcher/participant relationship.

3.7.3 Interview transcription

Literature proposes that in-depth interviews are anticipated to last between forty-five to ninety minutes, suggesting the longer interview as optimal (Hermanowicz, 2002; Seidman, 1998). Callister (2004a) suggests the researcher should allow enough time for social interchange, catharsis and closure, acknowledging therefore that the length will be largely determined by the participant. In this study, the shortest interview was Elisha's which lasted twenty-four minutes, yielding fourteen pages of text or approximately four thousand words, with Ava's interview lasting the longest at forty-seven minutes, yielding thirty-six pages or eight thousand words.

Elliott (2005) suggests it is impossible to capture all meaning that was communicated in the encounter itself during transcription. Validity therefore can be enhanced by the level of detail included in the transcripts as a vital element in interpretation, balancing the preservation of additional meaning conveyed by the speakers, including intonation, pauses, rhythm, hesitation, and body language. Original transcripts referenced laughter, emphasis and pauses both long and short by participants. An example excerpt seen in Sarah's transcript in appendix two.

Whilst pseudonyms are used and identifying details have been removed (NMC, 2015), illustrative supporting quotations are used directly from the transcripts

within the finding's chapters. These aim to maintain a holistic sense of the woman within her own story, reflecting the study's feminist perspective, narrative inquiry methodology and use of the VCRM approach to analysis. In quotes used, momentary pauses are recorded as [pause] whereas pauses of three seconds or more are denoted by an ellipse within square brackets [……]. Non-bracketed ellipses indicate that some text has been removed, usually to shorten the quote, whilst un-altering and maintaining the sequence ensuring the meaning of the story remains.

3.8 Sampling

The purpose of this study was not to generalise from the sample to the population but to explain, describe and interpret the stories of women who chose to birth in water. This led to adopting a purposive approach to sampling as appropriate when a study employs a narrative inquiry methodology (Patton, 2015; Creswell, 2013; Holloway and Freshwater, 2007b; Morse, 1994). This approach was the most suitable in identifying a homogenous group of individuals who met the inclusion criteria, living in a defined geographical area that had experienced waterbirth within the last six months. Whilst acknowledging the risk of bias with this approach to sampling, it is recognised by Patton (2015) that it may constitute a practical decision given the time and resource limitations in the research as in this study. This may be viewed as a limitation of this study with the potential for bias in over or under representation within the sample group.

The question of how large a sample size should be within qualitative research studies has been contested in the literature (Gutterman, 2015; Creswell, 2013; Charmaz, 2006). Further Emmel (2013) explains in qualitative research it is unlikely to be a single planning decision as it would be in quantitative studies, instead viewing it as an iterative series of decisions throughout the research process. Led by the research question, method of data collection, analysis and resource limitations Merriam (2009:80) suggests "there is no answer" to what is found to be a suitable sampling approach or size in qualitative research. In studies by Creswell (2013) and Morse (1994) they identified qualitative sample sizes consisting of anywhere between one to fifty participants depending on the methodological approach.

Equally, methodologists have discussed the concept of theoretical saturation as a marker for sufficient sample size (Guest *et al*, 2006) however O'Reilly and Parker (2012) counter the relevance of this technique outside of a grounded theory methodology. Adopting this approach would have presented practical concerns so I chose to be guided by other qualitative studies of waterbirth with samples of between five and nine women (Maude and Fourer, 2007; Wu and Chung, 2003) and congruent with Mason's (2010) concept identifying that a qualitative sample size should be needs to be of a suitable size to answer the research question, but so as to compromise a nuanced focus. With the intention to ensure a suitable depth of data to address the focus of the study, a sample of between eight and ten women who had delivered their baby in water in one of two local NHS Trusts was identified.

3.9 Recruitment

Ten women were recruited during a fourteen-month period between August 2015 and October 2016. A recruitment poster was displayed in both NHS Trust one and two. Participant Information Leaflets (PILs) were also distributed via midwives at both sites to women who had undergone a waterbirth and who met the inclusion criteria for my study. In the first six months of my study, I had only recruited one participant which appeared linked to my initial inclusion criteria of seeking stories solely from primigravid women. Considering strategies to positively influence this, I focussed on additional recruitment methods at NHS Trust One. These focused first on recruiting a wider breadth of gatekeepers (midwives) leading me to visit all community teams across the county requesting that they distribute the PIL to eligible women prior to discharge from maternity care. Secondly, I widened my inclusion criteria to include multigravid as well as primigravid women. Due to the focus of my study, the parity of the woman is considered within their socio-cultural context therefore, past experiences of childbirth may contribute deeper meaning to the data and findings.

I was reliant on the good will of the midwives to identify and recruit women for me. As a midwife I was acutely aware that these professionals would have significant and complex caseloads of women to care for day-to-day and recruiting to my study was unlikely to be a priority. Alice's interview highlighted

the importance of engaging with gatekeepers when she specifically referred to her community midwife providing her with a PIL as she was due to be discharged from her care:

> I: Yeah, good, and how did you find out the, about me doing the research?
>
> P: Erm my midwife…
>
> I: O right!
>
> P: When she came round to do the, what was it the ten day check or whatever it was? She brought that leaflet round and said about it….
>
> I: lovely
>
> P: ….and I said "absolutely I'll e-mail her about it straight away, I'd love to give some feedback on that"…..
>
> (Alice)

In 2016, I also sought localised research ethics and governance permissions to recruit participants from a second local NHS Trust, located geographically close to NHS Trust one. Whilst this maternity unit did not have a purpose-built AMU, a small-scale audit I had conducted three years previously on their use of water in labour and birth suggested their rate of waterbirth mirrored national figures (Clews, 2013b, unpublished). All the strategies aimed to boost recruitment to my study and ultimately increase the sample size resulting in a further nine women participating from across the two NHS Trusts: ten women in total.

3.9.1 Reflexivity in recruitment

Over the course of my study, a substantial number of PILs were made available at central points within both NHS Trust: in the hospital environment and with the community midwifery teams. It is therefore presumed that a greater number of women were approached by the midwives than the ten women who chose to participate. It is recognised that some women may not have wanted to talk about their experience of waterbirth, for some this may have been considered too personal and private a subject to share with a stranger. Some women may have been too busy; the majority will have been approached immediately following birth up to the point of discharge from midwifery care at ten days

postnatally, often a challenging time for women when caring for a newborn baby. As there were no mechanisms for reminders to be sent to women, I had to consider that they had forgotten to reply or thought it was too late. Whilst some may view this as a limitation of my study I wanted to ensure the aims of my feminist-based study were maintained by offering women self-determination regarding their participation or non-participation.

3.9.2 Contacting the women

As the study based itself in a feminist approach, it was important to consider reflexively the issues of power imbalances in the researcher/participant relationship (Harding, 1986). This was fundamental in the planning of the study and led to a recruitment approach initially based around self-selection. Recruitment posters placed prominently in NHS Trusts one and two outlined the focus of the study and included my e-mail address, as did the PIL, providing women an opportunity to consider whether they wanted to participate.

The requirement for research recruiting women by nature of their childbirth experience requires a detailed participant invitation letter (see appendix three). I recognise the length of this may have been a barrier for some, so I chose to e-mail this to women once they had made initial contact with me as the researcher. Once initial contact was made with me, I answered any questions the woman had and e-mailed them the participant information sheet (PIS) (see appendix four) and consent form (see appendix six). I was conscious not to overwhelm the women with information about the study, instead aiming to stagger this process. Once the women had an opportunity to read both forms, they contacted me to arrange a convenient date and time to meet for the interview. This allowed for choice regarding participation or non-participation, minimising possible coercion regarding their involvement.

Table 2 shows the characteristics of the women who took part in the study, all of whom have been given pseudonyms to protect their anonymity (NMC, 2015). All ten women who participated had given birth in water within six months prior to interview and all spoke English.

Table 2: Characteristics of the women

Pseudonym	Number of weeks since water birth	Birth environment	Ethnic Origin	Age in years	Marital status	Occupation	Parity
Sarah	2	NHS Trust 1 AMU	White British	19	Co-habiting	Student	Primigravida
Leonie	4	NHS Trust 1 AMU	Black British	34	Married	Professional/Managerial	Multigravida (second baby)
Nicole	3	NHS Trust 1 AMU	White British	36	Married	Administrative	Multigravida (third baby)
Elisha	2.5	NHS Trust 2 Labour Ward OU	White British	34	Married	Professional	Multigravida (third baby)
Ava	4	NHS Trust 1 Home	White British	29	Co-habiting	Managerial	Multigravida (second baby)
Helena	11	NHS Trust 1 AMU	White British	27	Married	Not seeing employment	Primigravida
Hope	10	NHS Trust 2 Labour Ward OU	White British	33	Married	Professional	Multigravida (second baby)

Alice	3	NHS Trust 1 Labour Ward OU	White British	38	Co-habiting	Administrator	Multigravida (second baby)
Polly	20	NHS Trust 2 Labour Ward OU	White British	30	Married	Professional / Managerial	Primigravida
Sophie	2.5	NHS Trust 2 Labour Ward OU	White British	30	Married	Clerical / Administrative	Multigravida (second baby)

3.9.3 An overview of the women

Of the ten women in the study, six were recruited having birthed within NHS Trust one and four birthed at NHS Trust two. All the women at NHS Trust two (Elisha, Hope, Polly and Sophie) delivered in a pool located in a traditional labour ward environment in an OU. Of the women recruited via NHS Trust One: Ava had a waterbirth at home; Alice on the labour ward (OU) and four women (Sarah, Leonie, Nicole and Helena in the AMU). All the women interviewed laboured and birthed in water, culminating in a vaginal delivery; however, the length of time women spent in the birthing pool prior to birth varied from five minutes to five hours. All the women interviewed reported being in heterosexual relationships with the father of the baby, all cohabiting or married. Except for one woman who described herself as 'Black' the other nine women described themselves as 'White'. The lack of diversity in the sample is therefore recognised as a limitation of my study.

At the time of the interview women were aged between 19 and 38 years. Seven of the women already had children prior to this birth and three women (Sarah, Helena and Polly) were first time mothers. Seven women had birthed in water two to four weeks prior to interview; two women (Helena and Hope) birthed ten to eleven weeks prior to this and Polly birthed in water twenty weeks prior to interview. Inevitably the potential for recall bias may have been present within Polly's story due to the length of time elapsed since her experience of waterbirth. However, Simkin (1992) and Takehara *et al* (2014) suggest that women recall the labour and birth of their children clearly, even when a substantial period of between 5 and 20 years has lapsed due to its significance as a life event.

3.10 Ethical considerations

The research was carried out in accordance with the NIHR Good Clinical Practice guidance (NIHR, 2016) and the Nursing and Midwifery Council Code (NMC, 2015) guided by the principles of beneficence, non-maleficence, justice and respect for autonomy. The study was guided by the Declaration of Helsinki (World Medical Association, 1964) asserting that participants are informed about the nature and outcomes of any study and are free to decide whether to participate or not without fear of repercussions (Hewitt, 2007). I present the

potential ethical aspects of my research study and how I managed these in this section.

3.10.1 Ethical approval

Ethical approval was sought from the School of Health Research Ethics Committee at the University. I understood that to access participants who had experienced waterbirth I would need to make an application for NHS HSC Research Ethics Committee approval via the Integrated Research Application System (IRAS). This was submitted in January 2015 with approval granted by the committee in February 2015 subject to local NHS Trust governance approval (see appendix five). Subsequently an application to the local NHS Trust research governance committee was made and approval received in June 2015. Further to this I met with the manager of the AMU to discuss my study and gain her permission to display my Participant Recruitment Poster in the unit.

The ethical parameters of my study outlined that the women would initially contact me as the researcher if they chose to be involved, rather than me initiating contact. Working as a senior lecturer in higher education at the time I did not have permission to access the women's maternity records as an aid to participant recruitment. The women's ability to self-select to the study supported the NHS Trusts adherence to data governance processes and ultimately ensured my research was in accord with the Data Protection Act (1998).

Whilst women were given the Participant Information Leaflet by midwives, once they contacted me they were e-mailed a copy of the Participant Information Sheet (see appendix four) containing further detail regarding my study's expectations of participants. It was important to give the women clear information via recruitment materials, so they could make an informed decision about participation or non-participation. This is even more important when research focusses on women shortly after childbirth who clearly need to know the length of the interview to be able to consider care needs, such as feeding their newborn, encouraging them to feel at ease. A participant-centred approach offered all women a choice of location, times and dates, aiming to minimise inconvenience of participating in the research and valuing them by reassuring that I would work to accommodate their needs (Punch, 2005).

3.10.2 Maintaining the wellbeing of participants

A common theme articulated within the concept of 'sensitive' research is that it discloses behaviours or attitudes which under normal circumstances would be private and/or personal which may cause discomfort or disapproval (McCosker *et al,* 2001). Lee (1993) suggested that sensitive research may also involve themes considered 'sacred' such as birth, sexuality or death. This study identifies with the concept of sensitive research with its focus on women's stories of waterbirth and possibly previous childbirth experiences. Normally a private time in their lives, the women chose to share this with me as the researcher and a wider audience as those reading the research findings in the future. There are inherent dangers in research involving narrative inquiry, in that participants may reveal thoughts and feelings that they intended to keep to themselves (Holloway and Freshwater, 2007; Atkinson and Silverman, 1997).

Referring to the socially constructed concept of vulnerability, Marsh *et al* (2017) suggest a variety of definitions exists, suggesting researchers need to demonstrate a non-paternalistic approach in their research. This requires a study designed ethically but also inclusively, whereby participants determine their own vulnerability autonomously deciding to participate or not in the research. Recognising an individual's autonomy to make decisions and choices about their own lives is paramount but to make such choices they must be free from coercion (Beauchamp and Childress, 2009). Narrative encounters can provide a therapeutic environment but there is the possibility that "raw emotions may arise" (Holloway and Freshwater, 2007:55), a consideration in this study due to its focus. As part of the ethical parameters of this study it was negotiated within each of the NHS Trusts that participants could access a maternity specific debriefing service if they felt they needed to.

Risk in this study referred to the potential of physical or psychological harm, discomfort or stress to participants, which was both considered in the initial design of the study and minimised where possible. All participants were informed of the potential risks and benefits of participation, both verbally and in written form, via the participant information sheet prior to giving consent. Whilst there were no direct benefits in participation for the women it was intended, they would feel valued as a contributor to a research study with the hope of informing

practice regarding waterbirth. Risks were identified as the potential for the woman to become emotionally distressed when remembering birth through the interview process. Being sensitive and reactive to any signs of distress I would offer to stop or pause the interview and offer verbal and formal support. This did not present as a reality in any of the one-to-one interviews I conducted.

In receiving Nicole's written story, it was clear she presents a traumatic experience with the birth of her first child however as she had chosen not to be interviewed it did not allow for me to explore this further with her. I had sent Nicole the participant information sheet which included details of additional support services available within her local NHS Trust and the Birth Trauma Association which offers information and contacts for women who are experiencing Post-Traumatic Stress Disorder (PTSD) following childbirth. As I reflected on this, it highlighted the impossibility of separating my own multiple identities as a woman, a midwife, a mother, as well as a researcher. As a midwife I would have contacted Nicole directly and actively offered more support such as a debrief session; a referral to a specialist support group and a follow-up visit. I recognised however that as a researcher my role was purely to offer advice and information, but it was for Nicole to decide what action to take, if any. This was an important learning point for me, reflecting the feminist research approach of my study which seeks to avoid labelling women paternalistically as being 'damaged' or 'incomplete' due to their experience.

3.10.3 Confidentiality and Anonymity

Confidentiality within the realm of narrative inquiry research raises unique issues due to its holistic and contextual nature, meaning difficulty for the researcher in ensuring anonymity (Frith and Draper, 2004; Kaiser, 2009). In this study this was true on multiple levels including the methodological approach, form of data analysis, as well as the focus of the study being on waterbirth. Since the number of women having waterbirth's remains low overall in the UK, there is the potential for identification of the women involved. Women will often share their birth story with family and friends, including via social media and therefore make it possible for participants to be identified by those who know them. Women were therefore made aware that complete anonymity could not be guaranteed

due to the nature of the study topic area and consent was obtained within these parameters.

In any study it is important that participants can be assured as to how their data will be used and that it will be stored securely (Data Protection Act, 1998). As per ethical approval for my study via the NHS research ethics committee there was a requirement not to store original data on a USB stick due to the possibility of it being accessed by others. Data was therefore password protected and stored on a secure area of the University's main IT server, only accessible to me as the researcher. To safeguard privacy and confidentiality I transcribed all interviews myself and stored then securely on a password protected main IT server. It was agreed that the NHS trusts used to recruit participants would not be named, other identifying details would be removed and pseudonyms would also be given to the participants during the data collection, writing up and dissemination of the study, again with the aim of maximizing rights to anonymity and meeting professional requirements (NMC, 2015).

3.10.4 Consent

Key principles of informed consent were addressed in this study. The consent form presented in appendix six outlines the aspects women consented to as part of being involved in this study. This form was e-mailed to them in advance of the interview, with the opportunity to clarify any issues prior to starting the recording offered. Nicole returned the consent form to me with her written story consenting to all elements other than the recording.

3.10.5 Ethical reflexivity

Reflexivity is a dynamic process of interaction between ourselves and our participants, as well as our actions and interpretations at all stages. As a researcher I recognise and acknowledge that I am not 'value-free' and present a 'conscious subjectivity' (Stanley and Wise, 1990; Cotterill and Letherby, 1993). Operating on several different levels at the same time, it is necessary for me as the researcher to consider how aspects including disclosure about my own experiences of waterbirth, both professional and personal, might affect a woman's story, including what she is comfortable voicing during an interview. I informed all of the women that I was a midwife prior to their decision to

participate and again prior to their formal consent to be involved in the study. I chose not to share my personal experience of waterbirth during the interview itself but did disclose this to some women prior to or after the interview. Self-disclosure prior to the interview was part of my 'introduction' to the study and aimed to place women at their ease if they seemed nervous about what was expected of them in the interview. Disclosing after the interview was part of my 'conclusion', thanking the women for their participation and sharing that I had had a similar experience of my own.

3.11 Approach to data analysis

There are diverse modes of data analysis used within narrative studies focusing on how a story is structured (Labov and Waletsky, 1967; Riessman, 1993) to mapping or charting stories against five criteria (Beck, 2006). These approaches to analysis may not reveal the full relational or cultural meaning as ascribed by participants to the phenomena, therefore do not reside within the feminist approach adopted for this study (Riessman, 1993). The idea was not to reveal determinants explaining why narratives were organised in that way. Rather, I wanted to gain insight into the features of women's relationships with their own identity(ies) of self within their choice to birth in water. It is the depth with which the women's own words are observed within their sociocultural contexts when analysing relational perspectives of waterbirth that required an approach encompassing direct quotations from the women to ensure the narratives ultimately constructed remain inextricably bound to the women's stories.

Reflexivity remained essential between the research approach, methodology, data collection and approach to data analysis, with the aim of ensuring that the women themselves remain visible and central from beginning to end. Coupled with the study's methodology of narrative inquiry requiring co-construction, I recognised the need for an analytical approach that avoided further compounding masculine models of childbirth located within patriarchal discourses. One approach stood out as offering the opportunity to address these concerns; identified as the Voice Centred Relational Method (VCRM) of data analysis associated with Gilligan (1982); Brown and Gilligan (1992); and also, Mauthner (2002, 1994) and Mathner and Doucet (1998).

3.11.1 Voice Centred Relational Method (VCRM)

VCRM of data analysis has been employed in several studies that have researched sensitive issues including: postnatal depression (Mauthner, 2002); experiences of miscarriage in older mothers (Frost 2007) and more recently exploring the maternity care experiences of women who were sexually abused in childhood (Montgomery *et al,* 2015). With its roots in educational psychology, Brown and Gilligan (1992) and Gilligan's (1993) seminal work explored the psychological development of women and girls. During the research Gilligan identified she was listening to distinct voices, representing divergent ways of viewing the world and proposed girls sought and valued relationships with others (as opposed to men who sought separation) which at the time was not valued in the masculine area where Gilligan worked (Gilligan, 1993).

Brown and Gilligan (1992) realised that they were uncovering a complex situation in which a multitude of voices were present within individual accounts. The questions they considered to be key in this process were: who is speaking? In what body? Telling what story about relationship (from whose perspective or what vantage point) and in what societal and cultural frameworks? (Brown and Gilligan, 1992), leading to the development of a 'listener's guide' (see appendix ten). The method was subsequently developed by Mauthner (2002, 1994) and Mauthner and Doucet (1998) who identified reflexivity as intrinsically vital in VCRM when listening to women's stories.

The VCRM approach to data analysis requires an iterative process in which the data is examined on several occasions. On each occasion the researcher specifically attends to a different aspect of the narrative, setting participants within social, structural and cultural contexts (Mauthner and Doucet, 1998). Given the nature of my subject - childbirth in water - this would be an important consideration for me, I therefore used their four 'readings' of the data to guide my analysis although in practice, returning to the data many more times than this suggests. The readings structured around: reading for the plot and the researcher response; reading for the voice of the 'I'; reading for relationships; reading for the socio-cultural context (Brown and Gilligan, 1992; Mauthner and Doucet, 1998).

More recently, Gilligan *et al* (2006) outline ways in which their original listening guide has developed. Their presentation of the 'voice of the 'I' was of particular interest to me. This remains a means of tuning in to how the participant speaks of herself and the authors proposed the use of 'I-poems' here. In these, each instance of the pronoun, connected verb and other related words are extracted and placed on a separate line, thus building a skeletal version of the text, which has the appearance of a poem. Gilligan *et al* (2006) suggested that this could capture something not necessarily immediately evident from the text but nonetheless central to its meaning. I found it a helpful way of identifying moods and changes in the way participants were speaking.

3.11.2 Co-constructing narratives from stories

The fourth reading described by Gilligan *et al* (2006:226) represents a shift away from consideration of the social and cultural context to 'composing an analysis'. This requires the researcher to synthesise what has been learned about the participant in relation to the research question and in comparison, or contrast, to other participants' accounts. I considered this a key phase for my study given that I wanted to inform clinical practice. It formally recognises the imperative of the researcher to move beyond a collection of intricately considered anecdotes - illuminating as they may be - to provide an analysis that lays claim to a wider application. Although Brown and Gilligan (1992) did not originally detail such a process, other researchers have tended to employ it in analysing their data. For example, Mauthner and Doucet (1998) recount their need to move from detailed case studies to confront the data set as a whole. I therefore recognised my own need to present the data in a meaningful way for the reader to maximise their engagement with it; these represent the co-construction of three key narratives from the women's stories, those of *the 'visible self'; the 'agent self' and the 'connected self'.* These narratives address the primary research question in providing insight into how women's stories of labour and birth in water are (co)constructed to reflect meaningful experiences of the journey into motherhood. Also addressing the key aims of the research, in providing a platform for women's stories of waterbirth in giving 'voice' to the co-constructed narratives created.

Table 3: Co-constructed narratives

Stories	Self	Key Narratives
Exposing the 'messy' side of childbirth Water allowed for less exposure and greater privacy Water as a protector The midwife	Childbirth exposes a 'private' self Water offering protection of the private self Some midwives made the woman feel invisible Some midwives empowered a sense of self and identity in women through invisibility	**The 'visible' self** **Relational visibility**
Waterbirth promoted agency.	Promoted an agent self - helped maintain identity	**The 'agent' self**

'It was all on my terms' feelings of control	Protecting personal agency through control	
Choice	Protecting personal agency through choice	
Water offered support and mobility	Water supported the 'active' self	
Presence	Present self	
Self-belief	Embodied self	
Midwives Empowering	Agent Midwives	**Relational Agency**
	The connected self	
Connected to newborn	Water supports dual identity (woman/mother)	**The 'connected' self**
	Water altered perceptions of a previously detached self	
Conflicting past experiences	Continuing sense of self - maintain identity	

Women connected to water Newborn connected to water Connected family (trio)	Secure sense as mother Secure sense of family identity Connected midwives	**Relational connection**

Waterbirth for many women presented a birth landscape that was one of difference yet familiarity. Difference in their choice for water, situated in direct opposition to the master medical narratives of birth, tightly bound to socio-cultural contexts of risk and intervention, yet innate familiarity and comfort previously found in water which organically led them to choose this for their birth.

The VCR method offers a data analysis framework for close, intuitive yet systematic reading of a narrative, based on multiple listening's/readings of the data, demanding a significant investment of time. Indeed, the amount of time required to conduct analysis with VCRM is a common criticism of the approach (Paliadelis and Cruickshank 2008; Fairtlough 2007; Frost 2004; Mauthner and Doucet 1998). Countering this I found significant benefit in its ability to embed the relational narrative within its social context delaying the fragmentation of an experience into researcher-imposed narratives until detailed analysis of the whole has taken place.

Strength of a narrative methodology is that the focus on the participants' stories is retained. The aim therefore is for the findings to be considered in conjunction with the biographies or 'plots' for each woman which are presented in appendix thirteen. These plots are of necessity a shortened abstract but nevertheless aim to represent a tangible presence of the women and their often, emotional stories. Although these accounts are not first hand, they attune readers to the women's individual lives. The women's voices will be heard in the direct quotations taken from their stories when presenting the narrative findings.

3.12 Summary

This chapter has described both the theoretical perspective underpinning my study; methodology; data collection methods and analysis techniques, as well as ethical considerations for my study. I have offered discussion around issues related to undertaking narrative research. I used a single unstructured interview to gather data in the form of the women's stories, and the 'listening guide' (Mauthner and Doucet, 1998; Gilligan and Brown, 1992) was followed in the analysis of these leading to the co-construction of my findings.

I have discussed the VCRM approach to analysis of the stories using the 'listening guide' as a way of representing each woman individually and

collectively within the three key narratives. Synergy amongst all four readings is essential in establishing how the three key narratives have been co-constructed from my interpretation of the women's own stories. Findings will be presented individually in chapters four, five and six whilst recognising there will inevitably be intersections across each of the co-constructed narratives. These chapters incorporate my analysis of the interview data using the four readings. Narratives presented specifically focus on the third and fourth readings within the VCRM method of narrative analysis: those of relationships and that of socio-cultural influence, all of which will be discussed within the context of existing supporting literature.

The following three chapters will present my findings with each of the key narratives explored.

Chapter 4

Narratives of the 'visible self'

The previous chapter presented the methodology and methods used in my study. This chapter situates the key narrative of the visible self. It is acknowledged there is fluidity and overlap across the three key narratives this is embraced as reflective of the complex inter-relational landscape of birth.

Throughout this chapter, participants will be referred to by their pseudonyms. References to other people and places have also been altered to protect anonymity and will be represented by use of text within square brackets. In presenting the direct quotations that illuminate the key narratives, the women will be identified by their pseudonym. The intention is to ensure the reader can determine how the narratives have been co-constructed in support of the feminist approach to the study, methodology adopted as well as the VCRM approach to analysis in maintaining the focus on the women who participated.

4.1 The visible self

This chapter explores the first narrative that emerged from the stories of the women that of the '*visible self'*. The women's stories spoke in several different ways to this key narrative. The perception by some women was that waterbirth supported the opportunity to maintain the invisible or private self; acknowledging that for others it disrupted this concept making visible the private self in allowing exposure of the 'messy realities' of childbirth. Reflecting Kirkham's (2007) work whereby she makes links to the historical influence of birth pollution in her book entitled 'Exploring the Dirty Side of Women's Health'. In the 21st century, society's perspective of 'normal childbirth' is no longer viewed as a physiological and social process situated in the home (Hewer *et al*, 2009). Birth now occurs 'behind closed doors' in a hospital environment, meaning it is only viewed by most women within the context of media which reflects an 'edited' perspective of childbirth.

This key narrative of the *visible self* establishes how identity is influenced both as an individual woman and a mother, exploring the relational impact on the woman's perception of her character as a wife/partner. This chapter is structured in two parts: first, exploring how the women's stories of waterbirth influenced

their perception of the *visible self*; second the impact the *(in)visible midwife* had on the *visibility* of the woman during her waterbirth.

A study by Longhurst (2000) identified fear in pregnant women that their bodily containment may break down in public which would display their lack of control over their bodies. Kirkham (2007) coined the term 'leakages' as referring to menstrual blood, bodily fluids during childbirth and breastmilk as both obvious and visible illustrations from the body that change had occurred. For some women such as Sarah these leakages were perceived as magnified in the water. Sarah was adamant that she wanted a waterbirth yet despite her significant educational background in early year's childcare, she had minimised some of the realities of childbirth which subsequently became a significant storyline within the retelling of her waterbirth story:

> I don't really like blood and all that, so when I see like all this blood just leak out I was just like "O my god I need to get out there's so much blood" so they like helped me get out quite quick cause I didn't want to be sitting in it……..I think that's the only like downfall about water births though cause obviously if you like have a bed they like put pads down and take them away quite quick, in water birth they can't…….and it kind of like seems more as well cause it was just liquid blood and not lumps it expands in the water and I was just like "[gasp], O my god" and they were like "it's not a lot, it's not a lot" I was like "yeah it is get me out quick" [interviewer and Sarah laugh together] so that's the only thing I wouldn't like, I don't like about it…….[Sarah]

Sarah returned to the 'messy' part of her story again later in the interview, feeling that after delivery she was 'sat in her own mess' in the water [Sarah]. Hope echoes this in her waterbirth, as well identifying her perception of heightened visibility to the point of feeling 'exposed' as the delivery approached. Further identifying how the water presented a relational affect for her when her husband was asked to become involved in removing 'debris' from the water. She referred to this on a number of occasions throughout her story. This supports findings of other studies which explore transition to motherhood, leading women to reassess their own self-image as well as how others see them (Choi *et al,* 2005; Miller, 2005). Subsequently, as I listened to the voice recording alongside

reading the transcript, I analysed the number of times Hope 'laughed'. In listening for the pitch and nature of her laughter it clearly supported Hope's feelings of embarrassment:

> …..[laughs] but I became aware of obviously [pause] you know you're pushing out a baby erm and everything else that comes with that is coming out into the water [reference to blood and faeces] [chuckles] …..yeah and my husband, bless him has to get a, get a sieve…… I don't think he was expecting that! [laughs] so yeah I think, when I think back I think like "o my gosh he did that!" [laughs] It's something that he doesn't want to talk about again! [laughs] [Hope]

Leder's (1990) writings on the 'absent body' explore how bodily functions are viewed with an eye to concealment and alienation. This part of Hope's story speaks strongly to the 'dys-appearance of the body' (Leder, 1990) characterised by the body's dual regime of absence-presence concurrently visible and invisible. The internal functioning of the body is normally hidden, it is this that enables us to be open to the outside world. Leder (1990) proposes that the body reappears when harmony is disturbed, as happens during labour and childbirth. Hope's 'visible' self was a strong theme throughout her story and clearly, she found this a very exposing time, despite having experienced birth previously, suggesting that the use of water this time enhanced these negative perceptions for her. Price's (1995) work on changing body boundaries suggests the potential for some women to present with feelings of trauma due to altering their own body image during and following birth when boundaries no longer remain intact. Reflected in Hope's silence at certain points in the re-telling of her story supported her inability to qualify this as a normal part of labour and birth as some other women were able too.

The story Hope tells however presents a conflicted self, which despite, in one sense feeling visible and exposed in the water due to the reappearance of the normally absent body (Leder, 1990), at the same time she felt the water offered her protection, in turn fostering confidence in her ability to birth:

> Erm I felt very, erm I'm not particularly erm [pause] confident erm I'm lacking in confidence I guess as a person erm and so in terms of, you know being stripped off [clothes] and bearing all er, I felt quite

> uncomfortable the first time round but there was something quite protective about being in water, erm [pause] I felt a lot more confident about what I was doing erm and that I could be in any position I wanted to erm, you feel a bit more enclosed [in water] [Hope]

Several of the women spoke to the waters ability to offer protection and privacy, reducing their perception of exposure at a time of vulnerability and providing an environment whereby the invisible private self could be preserved. Elisha appeared prepared to accept 'visibility' in the associated elements of childbirth due to the freedom water offered her from the physical discomfort she had experienced following her first birth:

> …..but in the water it just, it kind've [pause] it wasn't as uncomfortable as when you're sitting in it it's horrible and actually although, yes the pool was not the greatest colour it was all in the pool, and not all sticking me up and everything, erm so I wasn't in the least bit bothered by that…. [Elisha]

Alice also spoke to this within her sense of a visible self, telling how she had felt more exposed in her first birth on the bed, emphasising how the water had offered her privacy this time:

> …..and the other thing I will say is erm, it was, I felt less nervous about weeing and pooing and everything like all that nasty stuff that comes with it [laughs] which when I was on the bed the first time, I felt more aware and embarrassed of. I remember apologising saying "I think I'm [pause] poo myself or wee myself…..I think it felt much more erm, what's the word I'm looking for, but yeah you just, your privacy, it feels a lot more comfortable being in the water everything feels sort of less 'on show'…….. [Alice]

The perception that water offered privacy was also recalled by Nicole:

> I felt so relieved when I climbed into the pool. I was able to hold a normal conversation between contractions; I did not feel so exposed being in the water. It felt more private. [Nicole]

The perception that water offered privacy led some women to retell how the water and depth of the pool itself offered a sense of protection. For Alice this

meant she felt able to wear minimal clothing during her labour and birth due to feeling 'less conscious'. The water gave confidence to Elisha to remove her clothes as an instinctive act, despite this in her retelling she recalls a friend's surprise that she was naked in this environment:

> …….I was naked and my friend said to me so you have a top on? I said "no I didn't" but I didn't plan that I just, I obviously got my bottom halves off and I think I got my p, no I got my dress on cause I'd been out and so I took my dress off and I must have just instinctively took my bra off and that just felt really natural…….had I planned that in my head, I probably would've thought there's no way I'm getting in that pool naked! [Elisha]

There is a body of literature (Houghton *et al*, 2008; Lothian, 2004; Odent, 1992; Odent, 1987) which identifies the importance of maintaining a private and protective environment for women during labour and birth as a way of enhancing normal physiology of labour. These findings are echoed within the key narrative of the visible self for some of the women in this study such as Alice, Elisha and Nicole, who all told of how the water offered feelings of protection and privacy, allowing them to maintain a private identity. For others, however, such as Sarah and Hope, their stories illustrated how waterbirth forced them to confront their private self as an element of their transition to motherhood.

4.2 The (in)visible midwife

In this study, women spoke of relational encounters with the midwives largely as ones of empowerment with foundations of supporting the women during their waterbirth both visibly and invisibly. Two of the women, Sarah and Ava, told their stories describing a lack of mutuality in the relationship whereby the midwives fostered feelings of (in)visibility in the women. Sarah recalls this when her partner asked the midwife how long she thought labour would take. Sarah describes a dismissive response from the midwife, possibly due to this being Sarah's first child. Sarah tells that she instinctively knew that birth was imminent:

> …..I was just like "honestly she's coming", she got like a mirror and she was like "OK I can see a head, I'm gonna call for my colleague now" and I was just like "no don't she's out" [interviewer and Sarah laugh together] and before the colleague was there she was already out. [Sarah]

Despite Sarah's laughter in this part of her story, she refers to this storyline repeatedly throughout her interview, signifying feelings of alienation in her relationship with the midwife. A perceived lack of belief in Sarah's intuitive knowledge of her own body and progress of her own labour, until physically visible to the outside world, led Sarah to distance herself from her midwife; effectively classifying her as unimportant within her story. Berg *et al* (1996) refer to this in their study as the 'presence' of the midwife. They determined that if trust was lacking, if women felt undermined and unsupported and felt that the midwife did not see them as individuals, they perceived the midwife as 'absently present', as in Sarah's story.

Ava spoke of this differently, having experienced high levels of continuity and support from her midwife due to the case loading nature of the local homebirth team, she cited a connection and shared ethos of care. When she went into labour however her midwife was not available, so a colleague from the team attended:

> Unfortunately I had a midwife to start with, the midwife that got here was a bit umm, she was sort of determined to do it her way, so I had to keep turning over for her to monitor the baby every [sighs] I mean, well it was every 5 minutes but because, obviously they want to monitor for a minute but I was having contractions every minute for about 40 seconds [laugh].....so that was obviously a bit like, arrgghhh [Ava]

Ava is unable to verbalise her frustration in words here, possibly due to social conventions of politeness in an interview situation. It is clear however in the tone she used there is an inference she was made to feel (in)visible in her own birth experience at this point. Ava went on to recall the difference when a second midwife attended, who still completed the physical checks required, but in such a way as to maintain her sense of visibility:

> The next lady came [midwife] and she just did it round me. So she basically just sort of reached under and just found the heartbeat without me having to move which made life so much easier. [Ava]

Part of the 'visible self' narrative presented by several of the women was of midwives who were physically present in the room yet created an (in)visible presence which in turn empowered many of the women in their ability to birth in

water. Many of the stories of the midwife/woman relationship focussed on empowerment through the visible or invisible support they provided:

> I had the peace of mind that the midwives were there but at the same time it was like it was just me and my husband having our baby ourselves. [Nicole]

Polly's story tells of a basic concept of the midwife simply being present during her labour, reflecting (in)visibility:

> …….I just liked the fact that the midwife stayed with me the whole time……I probably would have been fine had she [midwife] have gone but it was just nice if anything had happened that I was, that she [midwife] was there. [Polly]

> Cause I don't remember very much of what she did [laughs], yeah [laughs] but it was great that she was just there all the time and constantly [pause] keeping her eye on me and making sure I was OK….. [Polly]

Using observational methods, Ross-Davie and Cheyne (2014) study assessed the effects of a midwife's frequency or lack of being in the room with the woman during labour. They identified when midwives were not present in the room it increased anxiety for the woman; reduced opportunities to build rapport and found they were less supportive of the women when they were in the room. The Cochrane review by Bohren *et al* (2017) and Leap and Hunter's (2016) work on supporting women in labour identifies continuous or one-to-one midwifery support as gold standard practice which leads to improved labour outcomes. Leap and Hunter (2016), Robertson (2007) and Kitzinger (1988) all refer to a midwife's role as one of creating an environment of safety, peace, reflected in the stories of women in this study identifying that birth was allowed to unfold.

4.3 Summary

The narrative of the 'visible self' presents both positive and negative aspects of waterbirth. Disparate yet allied in that for some women water facilitated protection and privacy during childbirth but for others it enhanced feelings of exposure of the usually invisible and private self and for one woman it allowed for both, simultaneously. The relational element of this key narrative suggests

midwives can empower women in their choice to birth in water through making the woman feel visible in her own waterbirth by creating her own invisible presence. Alternatively, if they project a lack of belief in the woman, they fail to foster a sense of self belief in her. This enhances women's perceptions that they were invisible in their story of waterbirth.

This chapter has presented the first key narrative of the 'visible self' both in the context of the woman and in a relational sense with the midwife. The following chapter explores the second key narrative from the findings of this study, that of the 'agent self'.

Chapter 5

Narratives of the Agent Self

The previous chapter examined women's narratives of the '*visible self*'. This chapter continues to acknowledge that each woman is an individual within her own story of childbirth and will therefore inevitably seek to construct her evolving identity as she transitions to motherhood. This second narrative is the '*agent self'.* I explore how this influenced the women's perception of their 'self' as well as their pre-birth identity as a woman (and for some a mother) and how this affected their post birth identity.

This chapter is made up of five parts, each exploring elements within the narrative of the agent self. Waterbirth '*does what it says on the tin'* will explore how women voiced the image of water physically supporting them in their choices surrounding mobility and positioning. Control was a central storyline within this key narrative with women referring to the idea that labour and birth in water was *'on my terms'* enabling them to maintain a stable sense of self and identity during and after birth. Presence defined as '*not following the rules'* explores many of the women's embodied sense of self as individuals in childbirth supporting the continued presence of their own identity(ies). I also consider the relational sense of agency with others as voiced by the women, both in new relationships with the midwife and established relationships with their birth partners.

5.1 Waterbirth 'does what it says on the tin'

Several of the multigravid women in the study spoke of their desire to have a waterbirth with their first baby but were unable to do so, seeming to drive their choice this time. Alice spoke of the lack of pool facilities previously at her local maternity unit, with only one pool which was in use when she went into labour which fostered Alice's sense of agency and determination to choose waterbirth for her second baby.

By definition, the birth of the first child is a new experience where often women are unable to recognise what is happening with their bodies and are unfamiliar with medical protocols surrounding childbirth (Oakley, 2016). Sophie's story begins in this way, placing her as a 'childbirth novice' during the birth of her first

baby, identifying that it was her husband who raised the use of water with the midwife when she was in labour. She refers to entering the birthing pool with her first baby which she found 'comforting' and which helped with the pain of the contractions. As her story progressed, she told of how her labour had to eventually be augmented, so she had to leave the pool and delivered on a bed. Sophie recalled this part of her story using words that illustrated the 'blame' the midwife placed on her for having 'lost her contractions'. Sophie reiterated these words herself, implying that her body had been defective in some way during her first labour. Language used by midwives illustrates how established medical lexicons and master narratives continue to be dominant in cultural storytelling, which often becomes accepted as truth by women (Chadwick, 2014). Telling of her disappointment that she had been unable to deliver in water, influenced her choice and determination to have a waterbirth with her second baby:

> ….I knew more about you know, the birthing pool, the waterbirth and the experience so I knew I really wanted to have [baby] in the water but I didn't know if it was a possibility cause they've only got two birthing pools in [the hospital]…….[Sophie]

Hope also recalled her desire to use the birthing pool with her first baby, this had not happened leading to her determination to do so this time. It is interesting that whilst Hope knew she wanted to labour in water, she had not decided prior to her labour as to whether she wanted to deliver in water or not. It was only when she realised that labour was progressing quickly that she made the choice:

> ……because I'd only just got in [the pool] erm, and I'd anticipated you know having a while in there, so you know because I'd only just got in and I, I was thinking "right the baby's coming now!" I thought "O I've either got to get out now [laughs] and not have any of the pool experience or I've just gotta go with it!" Erm, and I just thought "I wanna go with it, I don't wanna get out, I feel nice in the pool, erm and I don't want to be out of it" so I just thought "this is, this is going to be a waterbirth" [laughs] [Hope]

Many of the women in this study chose a waterbirth in their first pregnancy and it was their inability to experience this which often led to activating their agent

selves promoting their wish to have a waterbirth the second time. Hope was the only woman who expressed that waterbirth itself was not her initial aim this time, instead evolving as her labour in water progressed, although she recalled this as a positive element of her most recent birth.

An element of the 'agent self' recalled by several of the women tells of a sense that agency was lacking and was multifactorial. Fundamentally, this centred on storylines of negotiation and compromise for some of the women for different reasons. Hope experienced this with her first baby when she requested a waterbirth and was advised that the pool room was already in use by another woman:

> So it would have been that they only had just the one then erm, so it was a case of "sorry somebody else has got it!" so I was, I was quite disappointed erm when they said that, it's not like you can say, "well I'll hold on then and wait for them to finish!" [laughs]. It's kind of "sorry but you've got to change your plans" [laughs] which was yeah quite disappointing, so I was really pleased this time and I'd heard they'd got another one [birthing pool] in there…. [Hope]

Alice's story voices complexity in her desire for a waterbirth when she was categorised differently in her pregnancy. Feminists suggest pathologising the birth process undermines and alienates women's sense of authority and control over their own bodies (Martin, 1987). Alice becomes more reflective in her story and frustrated in her tone at this point using imagery of being 'in battle' at this point in her story to achieve a waterbirth:

> …..in my head I was like "please don't treat me differently, let me have that" but I do feel like I had to fight for it a little bit cause I had to go and see the matron and you know the consultant you know, wasn't saying "you can't do that" but……it was a little bit of negotiation… [Alice]

Alice uses emotive language and imagery in recalling her desire to have a waterbirth; determined she did not want to be 'robbed of the chance' of having a waterbirth again this time [Alice]. Even as her story comes to its conclusion Alice voices regret that she did not have a waterbirth with her first baby:

> …..it's been absolutely brilliant and you know if anything, I just feel gutted that I didn't do it the first time…… [Alice]

A feminist critique of the biomedical model highlights the importance of birth satisfaction for women, linking low-tech childbirth with the best physiological and psychological childbirth outcomes for mothers and newborns (David-Floyd *et al*, 2009). Recent findings by Van Stenus *et al* (2017) and Jafari *et al* (2017) support the influence of previous care experiences on women's expectations for childbirth in the future, as well as an association between the sense of control and maternal satisfaction.

5.2 Control

Within the narrative of waterbirth and the agent self was the storyline of control for most of the women interviewed. The importance of control for many women during labour and childbirth and its positive affect on a woman's sense of self already exists in the literature (Lundgren and Dahlberg, 1998; Simkin, 1992). In their study of labour in water, Hall and Holloway (1998) identify an emerging core category of 'staying in control' for the women; both in managing their pain and having the confidence to exercise choice. Elisha refers to herself as a 'control freak' and recalling her first birth raises the issue of control, or lack of it, when she nearly birthed her baby without any professionals being present in the room; whereby she talks of vulnerability in her 'self', not unfamiliar to most women in labour. Memories of how overwhelmed she felt physically during this time she describes a picture of chaos and panic in her delivery room when birth, which was not anticipated, became imminent. This had the potential to threaten her pre-birth identity as 'a woman in control' causing her to actively seek to maintain control with this birth:

> I wanted to be more in control of my delivery. I wanted to feel like I was doing this and….as much as I was happy to take on professional viewpoints, don't get me wrong……I, I wanted to feel more in control. [Elisha]

This part of Elisha's story presents a conflicted self, representing that she wanted control but placed within the socio-cultural context of a medical master narrative of childbirth (Chadwick, 2014) in her reference to taking 'on professional viewpoints'. This master medical narrative of childbirth operates

from the assumption that childbirth is a 'risky and dangerous process requiring medical expertise' (Chadwick, 2014:44). Elisha is keen to present her choice as a rational person, a professional and a good mother who would not request waterbirth if it was in opposition to professional views and medical advice, implying that it was unsafe. Leonie refers to the perception that this is a less medicalised environment but based within a hospital 'just in case':

> I just think too many times we just sort of interfere when we don't necessarily need to with……I think those alternative ways in order to get things done and our bodies are amazing so naturally we can do certain things that erm, I think the people are too quick to want to go down the medical route sometimes when it's not necessarily needed. Erm so I think that's why as well with the birthing centre, it was kind of everythink was natural as it can be……Erm [pause] it didn't feel like there was a, you didn't feel like you were in a medical place [laughs]…..as much as if anything happened you'd know that you're just right there erm but it just felt like a more natural experience as well. [Leonie]

Ava appears different as the only woman in the study to have experienced a homebirth as a means to foster control. Similar to Elisha's story, here Ava refers to 'unless it wasn't right for me or the baby' [Ava]. Whilst she presents her choice for homebirth as a means of exerting control over her childbirth, her story continues to be shaped by medical master narratives of safety and risk (Chadwick and Foster, 2012). Ava went on to confirm that her decision to have a homebirth was to ensure that she could guarantee the use of a birthing pool, voicing this as the most important element for her:

> Whereas having a homebirth kind of guaranteed you had some control over, like I say as much control as you ever have in that situation……yeah massively for me I think, I think it would be more strange for me now to kind of do a birth out of water……without a doubt but if it was kind of "Right you can either have a homebirth without the water, or a water birth but in hospital?" I think I'd go with the water birth in hospital." [Ava]

The idea of choosing a homebirth had also occurred to Leonie to ensure she could have the waterbirth she wanted:

> …….when I really thought about it, I thought "well as long as I can get in the birthing centre, I'm gonna get my waterbirth anyway." I think the water birth was the thing that wanted me to have the birth at home cause I'd get that experience then. [Leonie]

Chadwick (2014:45) notes that the meaning of 'natural childbirth' is fluid, slippery and multiple, intersecting in complex ways. At times therefore, this storyline can potentially generate alternative representations to biomedical frameworks of childbirth. On an everyday level, women frequently remain caught between medical master narratives and the 'alternative' discourse of 'natural childbirth' when making sense of their own birth experiences and telling birth stories (Chadwick and Foster, 2012). Hope spoke of her wish for a 'drug free' labour ensuring she remained in control of her 'self':

> Erm [pause] and I guess all the reasons remained the same the second time around. Erm basically I'd done a lot of reading on all the different types of pain relief and different types of birth you could have and it just really appealed to me, erm in terms of lack of drugs basically……the thought of having er lots of drugs and not being in control of myself in labour was not nice to me, I wanted to feel like I was in control erm, I knew what was going on! [Hope]

Hope later refers to the historical socio-cultural narrative of childbirth which sees birth taking place on the bed, enabling others to manage and control it. In her challenge to the normative bio-medical model of birth, Hope appears to seek a more individualised choice for birth. Illustrated in her use of expressive and positive language '*it's all tailored to you and what you want'*, '*where you wanted to be in the pool or what position you wanted'* she presents herself as having had a different, more personalised experience to others due to her use of water in labour and waterbirth [Hope].

Historical evidence suggests a direct relationship between choice during pregnancy and childbirth and improved outcomes for women and newborns (Hallgren *et al,* 1995; Berg *et al,* 1996). Developed further by Nicholls and Webb (2006), who identified that satisfaction in childbearing was multifactorial including the process of labour and birth, rather than the singular outcome of a live and healthy newborn. Some of the women shared their feelings regarding

the lack of facilities for the provision of waterbirth, potentially limiting their choice to birth in this way. This was significant for both Leonie and Ava:

> ……. just a shame that there's only a few rooms there as well, erm, I think if they were to expand it and everything and give people more that choice erm it would be a lot better. I think as well I don't know if, I don't necessarily think it's pushed. Erm, not that it should be pushed but I think giving people that option…….the whole waterbirth should be maybe promoted a little bit more. [Leonie]

> ….I ideally wanted a water birth but obviously I had the erm, concerns that there's not as many available with being in hospital you're not guaranteed [Ava]

Both NHS Trusts had additional facilitates when using the birthing pool, such as mood lighting and music (Hosseini *et al,* 2013; Hauck *et al,* 2008; Browning, 2000), which appeared important to some of the women and less so to others. Sophie appeared unconcerned when she needed to use the smaller birthing suite in her local maternity unit due to lack of availability of the other pool:

> No, no I don't think it would've, no my husband didn't get in the pool with me, erm I don't I wouldn't have liked that actually cause I feel like its [pause] I don't know, not private but……..it wouldn't have made any difference really…..[Sophie]

For Hope these additional facilities were a surprise when she entered the pool room, enhancing her feelings of being cared for:

> …….the pool room was very spacious and your got your own bathroom……they were asking me questions like "what music do you like?" And "What colour lighting would you like?" and I thought "O I didn't know you got all of that in the pool room!"……..it was very nice and it felt like they were really looking after me. [laughs] [Hope]

Studies (Nieuwenhuijze *et al*, 2016; Annadale, 1988) have identified how freedom of movement in labour can be one of the key characteristics in a woman's perception of her control. Johnson (1996:202) described a 'physiological effectiveness and emotional satisfaction of labour and birth', citing the spontaneity that a woman can achieve in choosing a comfortable position

when in the water, suggesting this would not being possible in the same way on a delivery bed.

Perceived in western cultural narratives of society as a trivial element of childbirth, the freedom and ability to actively adopt a position of their choosing was recalled by most of the women in my study as positive. The fact that they were not reliant on others to assist them appeared to foster a sense of their self as an autonomous individual remaining active at a time of immense disruption and change. The water enabled a continuation of their ability to conduct everyday activities during the pain of contractions in labour, fostering a sense of normality. Leonie identified this at several points in her story:

> ……being in water I just felt like I could move about how I wanted to move?……. [Leonie]
>
> Erm so I think generally the fact that I could move freely, I mean I went from being on my back, to being on my front [baby screams] to gripping the sides……[Leonie]

This freedom of movement was reflected in Polly's story:

> Erm [pause] I was, I was sitting and then every time I had a contraction, I don't know why I would like flip over onto my belly and I would be like over the side of the pool?.....Erm and then I would be back on my back again [pause] in-between yeah. [Polly]

Sophie referred to the pool facilitating a comfortable position for her in labour due to the fact the baby had adopted an occipito-posterior position:

> …….the most comfortable for me because she was back to back was to be on my knees and to have the, the tub support me, so kind of like leaning over that was the best one for me, I did try and sit back also but because of her position it was just too painful, so I pretty much stayed on all fours over the pool for most of the time…… [Sophie]

The option to remain active and mobile during labour was significant in Ava's story, referring to how the 'water just kind of took me', offering her a sense of control over her labour [Ava]. This element of the key narrative of the agent self identifies how choice and control are important to women. For some the choice

to have a waterbirth offers them control in and of itself and for others the choice and ability to adopt differing positions in labour without assistance other than that of the water fosters as sense of control.

5.3 Presence

Over half of the women in this study centred their story on wanting to have a 'natural' birth; wanting to remember birth; wanting to be aware of the experience; to be an active presence coupled with a desire not to use pharmacological pain relief perceived as having the potential to dull the memories of their birth. This is consistent with the literature on natural birth (Downe and McCourt, 2008; Walsh, 2007; Gaskin, 2003). Interestingly this was particularly strong in Sarah's story as one of the primigravid women who participated in the study:

> …..my Mum was like "O I loved the gas and air"……..she was like "yeah I don't remember anything I was just high off gas and air" and I was like "I don't really want to feel like that, I want kind of like be aware of what's happening"……..just so I could like in a way kind of experience it cause [short pause] like you don't, I know like people choose an epidurals but then you don't always have children to have like, just go for it to be taken out of you [interviewer "yes"] so I kind of like wanted to experience it in a way…..it probably sounds crazy? [Sarah]

Recent research by Kay *et al* (2017) explores birth stories told by women across two generations. She identified those who were pregnant in the 1970s-80s framed their stories in the language of safety, whilst those pregnant in 2012 told their stories in the language of choice. Similarly, Sarah refers to the intergenerational birth story told by her mother as one where she chose not to be present at the birth, instead choosing pain relief that supported her absence. Sarah, however, appeared to resist this narrative.

Discourses of 'natural childbirth' have traditionally been positioned as diametrically opposed to medical birth models and are often cast as an alternative counter-discourse to biomedical frameworks (Davis-Floyd, 2003; Oakley, 1980). Sophie appeared to voice this within her choice to use water which was instinctive on her part, but did not view this or herself within the image of 'earth mother':

> But I really wanted to have [baby] in the water and for the pain relief really cause I didn't, I didn't want to have epidurals and all of that, I wanted it to be as natural as possible because I knew, I know that waterbirth is better on the body as well and I just, yeah I'm not like an earth mother or anything but I just really wanted, I didn't want to put medicine in my body, unless I had to, unless I had to, I just, I do like all of the benefits of a waterbirth and I do feel like I missed out on that last time, yeah. [Sophie]

Das (2017) refers to how the mode of birth and the use or rejection of pain relief can also become moralised indicators of ideal and less-than-ideal births. This can present an opportunity for the emergence of graded nuances in terms of how 'well' a mother is perceived or perceives herself to have done in giving birth (Das, 2017). For many of the women in this study, actively choosing the non-pharmacological method of water as the sole method of pain relief fostered a perception of achievement, facilitating a connection with their labour and birth.

5.4 Embodied Self

Many of the women in this study appeared to connect with their body in labour, presenting a form of embodied self (Chrisler and Johnston-Robledo, 2017). Defying disembodiment these women in part resisted society's dominant biomedical narrative of childbirth by actively choosing to labour and deliver in water based on intuition, as described by Leonie:

> Ummm its just always been my ideal way of thinking that's how I was gonna give birth, umm there wasn't anything in particular that influenced me, other than the fact that I just thought it'd be an easier experience, it's more what I think would be, how my ideal way of giving birth….[Leonie]

The influence of society's biomedical narrative continues to be seen in Ava's story whereby she acknowledges the 'risks' associated with her birth choices. Whilst she does not expand on whether this refers to homebirth, waterbirth or both she intuitively refers to it as the right choice for her:

> I obviously understood the risks and knew what I couldn't do but it was kindda, ummm but yeah, so like I say, for me it couldn't have been, I'd

> definitely 100% would do it the same way again erm, without a shadow of a doubt there's not one person I've spoken to that I've not recommended it to cause I just you know, I just, I don't know it's hard to describe isn't it? [Ava]

Elisha's story spoke to her unmet desire for waterbirth with her first two children and despite achieving it this time her tone remained tinged with sadness that whilst she had achieved it this time, this would be her last baby and therefore could not be repeated. For Ava and Alice there was a sense in their telling they had achieved a degree of self-actualisation in their reproductive journeys in achieving the waterbirth desired:

> So yeah, so then I got in the pool and the relief that I just, I can't completely describe that relief. (1) in being able to do it and knowing I had kind of succeeded in getting what I had wanted ….[Ava]

> …….for me I think it was just, I was probably fixated on "I wanna have this chi", this is gonna be my last child so I wanted that opportunity to have that waterbirth, to experience it? [Alice].

Achieving waterbirth this time fostered an embodied sense of self to such an extent it led some women to attribute positive outcomes to their waterbirth:

> …..I didn't have any tears or anything like that which was, I was really chuffed about because that was something that I was probably more nervous of……I don't know if that's just because it helped because I was in the water because I didn't feel [pause] I didn't feel like I felt as much pain you know? [Alice]

Ava referred to this in terms of her perceived quicker 'recovery' from birth in the postnatal period returning her to a pre-pregnant self:

> Yeah and I managed not to get any tears, just like a graze [pause] and like I say I think a lot of that was down to being more relaxed in the water. I know a lot of people say you tend to tear less in the water……. [Ava]

> …….yeah healing and everything just seemed to be so much quicker this time. I don't know how much is attributable to the waterbirth or if it's just a different birth……. [Ava]

It is interesting to note in Ava's story that whilst she clearly does attribute the positive outcomes of swift 'recovery' from birth to her use of water, she is reluctant to state this with authority.

Sophie identified improved physical outcomes from her use of water:

> Yeah so I really wasn't there for very long, [pause] recovery wise, I felt like I recovered really well because of the [pause] pool for me as well you know as her, you know I didn't have stitches which she said, the midwife said that was really good…… Which helped my recover I think, ummm. [Sophie]

Sophie progressed this even further when foregrounding her experience with her first baby:

> It did help me cause I think birth, it does, it can [pause] mentally affect you I suppose you know it can make you feel if, if it's not quite what you think it's going to be and it had all gone really well up until the end really when I got out of the pool, lost the contractions and then all of that trauma happened with the placenta so that, this yeah it is yeah that's probably the word I'm looking for, it is a shock. Yes, yes definitely whereas this time everythink was just really, I mean it hurt, it hurt like hell! [Sophie]

Sophie's story here is reflective of 'disenfranchised grief' (Doka, 2001) a specific form of complicated grief experienced by individuals when faced with loss that cannot be openly acknowledged, publicly mourned, or socially supported. Due to the dominant biomedical narrative valuing the singular outcome of a live newborn as a successful birth, Sophie may have felt unable to seek or gain empathy from others due to the loss experienced when she was not able to have a waterbirth with her previous births.

Many of the women were keen to support the natural state of childbirth eager to promote waterbirth to other women.

> Yeah, it was really, really good, really good I a hundred percent would do that again! If I was gonna have another one, so 100% as I say I would recommend it to anyone that I speak to, definitely [Alice]

> I would be really upset if I couldn't have one, if there was somebody else in about this yesterday and I just [pause] I think it made my experience feel really, really special. I'm sure there all special but it made it feel special, really nice and like, not many people I've spoken to have had them [waterbirth's] and its quite nice that it's something that I've done and yeah I would be, I'd definitely be asking for it. [Polly]

Many of the women's stories were suggestive of resistance presenting an embodied perspective of birth in water yet they remained dominated by master narratives whereby birth is told from a medicalised perspective (Pollock, 1999). Das (2017) suggests that a significant role of birth narratives is the sense of empowerment that is shared from one woman to another. It is a clear the women were keen to encourage other women to embrace a philosophy of natural birthing in water by sharing their positive experiences as a form of empowerment. Within these elements of the stories the narratives constructed present how childbirth in water facilitated an emerging entity of self through the agency women attribute to their choice and achievement of waterbirth.

5.5 Agent Midwives: 'she trusted me to give birth a go!'

Many of the women in the study spoke to the empowering relationships that midwives fostered with them during labour and delivery. In this element of the narrative it supported evidence (Rush *et al,* 1996; Hall and Holloway, 1998) which has illustrated the positive impact both physically and emotionally when the woman experiences a continuous supportive presence of a midwife during labour. This empowering relationship enables women to maintain control of their birth, as voiced by Leonie:

> Definitely in the sense of she was very calm and very capable, "what do you want?" "that's what you want". Erm and then just left me to it, erm the only thing that I heard from her throughout was "I'm just checking the heartbeat" erm, and that was pretty much it……..but other than that I didn't hear anything else from her, which was nice, in a sense cause I did, I was sort of in my own little zone, erm, which I think is nicer than

> constantly being interfered with and constantly being told what to do, or [pause] having that business around you so you can't really focus on what you need to do, erm it was, she was just sort of in the background almost, I knew she was there but didn't know she was there if that makes sense? [Leonie]

This positive affirmation by the midwife gave Leonie the courage to negotiate the challenge of this intense experience. Interestingly, none of the women in this study knew the midwife who supported them during labour and birth yet still found an empowering relationship. Hope speaks to her midwife's ability to promote a sense of agency:

> She was amazing! Yeah she was brilliant erm, I can't remember her name but erm, she, she was brilliant, she was so supportive, er and she really, she really kind've empowered me, really made me feel like I was in control, like I knew what I was doing and you know really reassured me that I should be trusting my body and my instincts, erm which was really nice erm……and I think it had been a while since she had done a waterbirth, erm I don't think it was something she normally did erm so she found the whole experience quite nice as well….. [Hope]

The importance of support during labour has been well documented in several studies (Callister, 2004b). Continuous support has been identified as an important factor in women's perception of a positive birth experience with benefits including a reduction in the use of analgesia, greater satisfaction and a shortened duration of labour (Hodnett *et al*, 2007, 2009). Sophie referred to the confidence her midwife had in waterbirth which in turn fostered a sense that she was supported:

> ……..my midwife was really good she really helped, she was not nervous of the waterbirth experience……she stayed with me the whole time, which I didn't have that experience first time round and I think that really helped cause she [midwife], she really led me…… [Sophie]

There are no current studies which explore links between the midwife's belief and support of waterbirth and how this affects the woman's choice, although this appears worthy of further exploration in determining the influence of the dyad relationship in this context. The stories illustrate a lack of continuity of care for

the women which fail to support a national policy drive promoting its importance over the past two decades (DH, 2007; DH, 2004; DH, 1993). This did not appear significant in the stories the women told here and is therefore not reflective of the substantial body of literature which has long supported that women value continuity of carer (NHS England, 2015; de Jonge *et al*, 2014; McIntyre, 2012; Sandall *et al*, 2009; Page *et al*, 1999). Whilst this may have been due to the uncomplicated nature of waterbirth told in these women's stories, it suggests further research may be required in this area. What they did value reflects the findings from Morgan *et al's* (1998) study, whereby friendliness and support offered by midwives was considered most important. A recent Cochrane review (Bohren *et al*, 2017) supports this, identifying 'continuous support' in labour as a key factor in improving several outcomes for the woman and her baby. The support received from a midwife was particularly important to Nicole who recalled feeling violated during the birth of her first baby. Her story traces progression from the first and throughout her three births which, with the support of the midwife, fostered a sense of trust and competence:

> The midwife did not tell me what to do during this labour (third baby) she just told me to listen to my body which I did……..I did as she said and listened to what my body was telling me to do and the baby was born ……They were both positive experiences, and the third time round I felt like the midwife was trusting me to give birth by myself – it was almost like learning to ride a biked – she trusted me to give birth a go (without my stabilisers!) and I found that I was able to do it all by myself, even though it was difficult. [Nicole]

Nicole appeared to value sharing her birth story, providing the opportunity to fully understand the meaning she attributed to the midwife's support in her waterbirth, potentially serving to foster a sense of self-actualization for her as suggested by Callister (2004a).

5.6 Summary

The narrative presented in this chapter was co-constructed from the women's stories whereby waterbirth promoted the perception of the 'agent self'. Women spoke of the physical support afforded to them by water promoting feelings of a more 'natural birth' and a sense that this allowed their childbirth experience to

become de-medicalised. Their stories illustrated the importance of individual choice for waterbirth and defined empowered individuals when this choice was realised. This promoted feelings of autonomy and created an embodied sense of self. Relationally, most women spoke passionately of the continuous support experienced from the midwife during their waterbirth. This afforded the women perceptions of control enhancing feelings of autonomy and empowerment.

The next chapter will present the final key narrative from the findings of this study that of the 'connected' self which continues to be explored both in a relational and socio-cultural context of the women.

Chapter 6

Narratives of the 'Connected' Self

The previous chapters explored the narratives of the *visible self* and the *agent self*. This chapter seeks to understand the narrative constructed which voices women's perceptions of their *connected self*. This narrative of the connected self extends to a connection with her newborn; the woman and the water; the newborn and the water; the family and finally, connection with the midwife.

6.1 Connected self

Despite this being her first baby, the connected self was a key aspect of Sarah's story as she talks of being intensely connected to her body in labour and birth:

> I was just like "honestly she's coming"……..she was already out……..like cause I put my hand down and I was just like "what's that?" and I could feel like her hair, cause obviously she's got loads of hair…….and I was just like "O my god like her heads actually there" [Sarah]

This part of Sarah's story supports Akrich and Pasveer (2004) study exploring women's participation in the birth and physical delivery of their newborn. They suggested a new form of duality whereby the woman is in and out of her body: both actor and spectator (Akrich and Pasveer, 2004). Sarah personifies this concept of the dual self as her story progresses, illustrating that her choice to use water derived from her desire to be connected physically and emotionally to the process birth.

The multigravid women in the study who told stories reflecting a (dis)connected self, mainly did so in the context of their previous birth experiences rather than their most recent birth in water. Telling largely negative memories which they felt water would help them to actively resist this time. An excerpt from Nicole's story illustrates conflicting voices for her, that of anger: 'he didn't treat me with any sort of care'; fearful: 'I did not know how to cope' and even childlike in some of the language she uses to describe the actions of the male consultant closing with 'I did not like him one bit'. Overall this initial part of Nicole's story is recounted in a very passive voice indicating that she had clearly felt 'done to', even violated, at points during her first birth. This appeared to lead to the need for her to shut off her 'self', such was the level of her disconnection suggesting

the final few minutes of her first birth were so 'traumatic that I blanked them out' [Nicole].

Helena was the only participant to identify a disconnect when in the water, presenting as an intuitive perception that she would not be able to give birth in water. In my role as a midwife, this element of Helena's story is suggestive of characteristics associated with 'transition' in labour; progressing from the first into the second stage of labour. The change in the physical sensations experienced during this time will often initiate a 'fight or flight' response. To the woman and others this often appears uncharacteristic behaviour even 'irrational' potentially threatening her pre-birth identity as a rational self:

> Oh and then at one point I was like "get me out of the pool!" I was convinced "I can't give birth" I don't know why I changed my mind? And then I, they laid me on the floor and I was like "no, no, I need to get back into the pool" cause I knew it was like the best thing for me. [Helena]

As she tells this part of her story, Helena clearly recalls that she reached the decision to re-enter the pool herself, which is important, as adopting a more paternalistic approach to encourage her to remain in the pool initially would have removed Helena's ability to listen instinctively to her innate self. In turn, this may have led to a sense of detachment from her sense of self.

6.1.1 Connection with her newborn

Several of the women spoke to the connection they had with their baby at birth, which appeared to be specifically linked to the environment of water; the atmosphere this helped to create at birth; as well as perceived contentment on the part of the newborn. Elisha's story strongly reflected the description of a serene atmosphere and baby, which she clearly valued:

> I sat back and they brought her up onto my chest, it was just the most, most magical thing, it was just wonderful when she was perfect and…….it was, yeah, it was, it was incredible, it was, it was beautiful…[Elisha]

> She was just so calm and content so we just cuddled for ages [Elisha]

Elisha reflects awe in recounting how quiet her baby was. This sits in juxtaposition to the socio-cultural context most frequently offered by media

sources. In fiction, news stories and television documentaries the 'healthy' baby is captured as one who screams loudly and cries at birth. Such that it effects some women's own perceptions of the condition of their newborn when born in water, as in this excerpt from Helena's story where she recounted her surprise that her baby seemed so relaxed:

> He seemed fine, he didn't cry! I expected like a scream but he just, yeah, I think he seemed like calm [surprised] [Helena]

Alice also spoke of this:

> ….he was nice and alert, he was, you know he didn't really cry a lot, he was [pause] yeah he's hardly cried at all….. [Alice]

Ava particularly valued the autonomy that the water afforded her in being the first one to meet her newborn, even determining gender herself, frequently a role privileged to the midwife:

> Erm and yeah so obviously it was amazing in the fact from that perspective that I got to bring him up and also, I got to find out that he was a boy first, whereas the first time obviously I didn't because I was on my back so I was looking to my other half sort of going "what did we have?" [Ava]

6.2 Women connected to water

Several of the women referred to a connection explicitly with water which has previously been explored in research with women's childbirth practises in different cultures around the world (Jordan and Davis-Floyd, 1993; Garland, 2017). For many of the women this connection began earlier in life, well before pregnancy, as Alice and Ava voice a feeling that water had previously been associated with relaxation. Nicole referred explicitly to feelings of connectedness with water in labour. This began at home during labour with her second baby when she entered the bath to assist with the labour pains; she voiced a disconnection when removed from it:

> I then went into a bath. The water really helped me to relax, I felt in control and that I was coping with the pain. When it got to about 3pm I felt like I could do with some gas and air so we went to the hospital. I

> found that I was in a lot more pain out of the water than I was in the water, luckily the pool was free and so we were able to use it. I felt so relieved when I climbed into the pool. [Nicole]

For Elisha, this connection even extended to being close to, rather than in the water. Recounting the birth of her second baby she describes entering the pool room with the pool filled but due to a medical complication, she was unable to use it. Despite this she was able to remain in the room labouring next to the water telling:

> Maybe, maybe there was a psychological element, I mean like I said I did stand for a, quite a bit by the side of the pool and I was looking at the kind of ripples, the mood lighting on the water and although I wasn't in it, erm I was definitely enjoying that sensory experience and I could feel the heat of the water, erm so yeah, possibly actually it probably took my mind off it a bit and helped me to relax a little bit more and again feel that bit more in control…….[Elisha]

As this part of Elisha story continues she appeared to re-purpose her previous experience:

> Erm not while I was contracting but in the middle, in between contractions I remember just sort of trickling the water erm [pause] which added to that feeling of relaxation. So maybe yeah, maybe it did have a positive effect on us, hadn't thought of it that way. [pause] [Elisha]

Odent (1983) reported women's labours progressing rapidly just by anticipating and watching the pool fill; supported by Maude and Fourer (2007) who identify a central theme of *'getting to the water'* in their research. Elisha's story appears to support these concepts; telling of this birth (her third) in which she ultimately achieved the waterbirth she had desired in her previous births. Her tone was one of positivity as she recalled relief offered to her by the water, specifically in this part of her story:

> Yeah absolutely, absolutely. I definitely felt some relief in my contractions and they were on full force, you know ready to deliver. I definitely felt that sense of relief from being outside of the pool to being inside the pool. Erm and that had a huge bearing for me and I think had, had I not felt

> that way I probably would've just said "ooo I want to get out" but it was almost like an instant relief……. [Elisha]

Alice recounted a similar relief on entering the water in her story. Her labour progressed quickly and she soon felt the need to push; birthing her son in water shortly afterwards. Alice revisits this concept later in her story:

> ……..I'm upright and the pressure but I'd imagine there's a element of [sigh] relaxing cause I'm getting into the water, cause it was literally immediate, as soon as I literally kneeled down in the water they [waters] just went, soooo I think psychologically there is something there that makes you [pause] relax definitely.[Alice]

A significant element involved in the move of childbirth from a home to a hospital setting in the 1950s and 60s was coupled with the availability of other forms of pharmacological pain relief in labour. Currently there is a resurgence in studies exploring non-pharmacological methods of pain relief, including water (Adams *et al*, 2015; Chaillett *et al*, 2014; Sanders and Lamb, 2017). Historically however studies exploring this like the one by Simkin and Bolding (2004) are titled to suggest non-pharmacological methods of pain relief should seek to prevent 'suffering' due to labour pain. Whilst this is the right choice for many women, caution should be exercised in generalising that all women want this part of their labour experience to be removed. Studies identify when women are able to embrace the pain and give way to it, it has the potential to be an empowering experience (Dahlen *et al*, 2010; Callister *et al,* 2010; Howarth *et al,* 2011). Many of the women voiced feeling connected, that whilst the water did not take away the pain of the contractions it did alter their perception of the pain, particularly referencing the warmth of the water as part of Alice's story:

> …..it was all very relaxing, I could have just stayed in the water I was really chuffed with the temperature I didn't think it would be as warm as it was…. [Alice]

Despite this being Helena's first baby, she determines that it would not have been as 'nice' out of water:

> …….I would definitely say, between contractions it's nice, it's like, it's like soothin, it's almost calming, where I reckon on a bed it would have been completely different, it wouldn't have felt nice. [Helena]

Women's connection with water itself is a significant element of the key narrative of the connected self here. This connection was recalled by the women with warmth with a confidence and use of positive language and imagery. It is acknowledged here that most of the women in this study cite a positive connection with water prior to pregnancy which may have influenced their positive perception of waterbirth and may not be the same without this initial connection.

6.3 Newborns connected to water

Most of the women perceived a connection between their newborn and water due to the nature of the waterbirth. Sarah and Alice perceived this connection to water to their baby's love of baths, as did Sophie:

> ……the first bath she slept through it! She did, she slept through it cause we were like "O maybe this is because of the waterbirth as well?"…….. yeah loves it, even if you put her head back and put water on her hair fine! In the face, fine! Yeah! [Sophie]

In some of the stories this concept progressed in more depth as women generated links between the transfer of their baby from the fluid in utero into the water at birth:

> Her entry into the world was not in any way traumatic, I think the water helped make the transition a gentler experience for her. [Nicole]

Ava detailed this concept of the newborn connected to water comprehensively and had researched this in some depth, suggesting that this was a significant part of her story in the choice to birth in water:

> ……obviously the sort of, the research about the baby coming out and obviously being in its own environment and being less stressful for them because there's just less of that transition, or more of a transition I should say than that shock of "OK you're in a lovely watery, warm environment where everything's a bit echoey and then ALL OF A SUDDEN you're out

> and there's the screaming thing", albeit that it's you [laughs] but you know someone's screaming really loud and it's cold and there's air and you having to breathe and you know? Erm so yeah so obviously I read quite a bit about their transition and how it actually eases that because they are born into an environment they have already bin in for 9 months and then, although it's only a few seconds, you know it's barely a minute that they've got that transition of being able to fling their arms about but it's still being in water [Ava]

Hope also refers to reducing the impact of this initial transition for her baby, presenting herself as a 'good' mother who was doing the best for her baby:

> I wanted it as natural as possible erm and I guess I also thought there was something quite nice about being in water erm for the baby cause they're in water for nine months [laughs] and I guess in terms of initial transition um, it's got to be less traumatic for them because they're going from water into more water, erm so it's a lot more natural for them as well [Hope]

This connection identified by the women between the newborn and water advocates it as a central storyline within the narrative, requiring consideration. Instinctively the women verbalised the benefits of their baby being delivered into water as an 'easier transition', 'gentle' and 'more natural'. The perception was that this resulted in their baby being 'calm' and 'relaxed' at birth and these positive effects continued after birth with them remaining connected to water. This suggests these women were keen to construct a narrative of mothers doing the best for their baby by minimising the 'trauma' of their birth.

6.4 Connected families

Relational connection as a family was identified by some women in the study as of particular importance to them. Hope spoke of how water permitted her to maintain a sense of identity as a coherent self and promoted the maintenance of a stable relationship with her husband when the labour pain presented the potential for this to be disrupted:

> Erm [pause] I think he, he liked it because I obviously the I wasn't on any other kind of drugs erm and he really struggled with me being on the

> pethidine the first time round erm, because I think at the point I was completely on another planet and don't remember some of it, erm he said I was not myself erm, nothing like myself he said he'd never seen me like that and it really scared him erm, and he found it quite nice that I was, that I remained myself throughout and I was, I was still me and I was you know, I was in control and erm, managing everything a bit better I think, so I think he liked that aspect of it erm and [Hope]

Stories of their birth experience in water promoted the early establishment of a connected triad: the woman, her husband/partner and the newborn.

> When our baby was born the midwives pushed her through my legs and together we gently lifted her out of the water. She was so calm; she just looked around blinking at the light. It was perfect. [Nicole]

> I think probably because I was more alert and more with it, it felt like we were closer than when I was on the bed with [our first baby] erm, cause he was right at the side of the pool with me……. [Hope]

Sophie referred to this:

> I think it both amazed us really though the part that she [baby] didn't know she'd been born and she just came around cause even though the midwife told us I don't think you are prepared for that are you really? [Sophie]

Polly refers to her husband's role during the birth as meaningful in determining the sex of their baby first; historically a role attributed to the midwife:

> ……so my husband had to check and erm I was sure we were having a girl and he was sure we were having a boy and he was like it's a girl and we were both crying [laughs] [Polly]

In a meta-synthesis by Steen *et al* (2012) they found that whilst fathers felt as 'partner and parent', they experienced maternity care not as patient nor as visitor, situating them physically and emotionally in an interstitial and undefined space, promoting fear and exclusion. Women's stories in this study suggest a connected familial relationship that supports inclusion of partners as fathers at the birth.

6.5 Connected midwives

In reading for relationships in the context of this narrative, connection with midwives was a central storyline. Elisha illustrates this in her story telling of a more relaxed approach following the birth of her baby in water:

> …….they [staff/midwives] were just so laid back, they were so chilled, they just let us stay……they just were not bothered about rushing us and, and that felt really nice…….that felt really special and you feel like you're being cared for absolutely, absolutely yeah erm rather than just on that conveyor belt of pregnant women that have just delivered…..[Elisha]

The bio-medical model of birth promotes a competent midwife as one who is physically busy, offering reassurance to the woman through monitoring and doing. For the women however, this physical demand was not identified as significant, instead they placed value on the emotional connection, as in the quote from Ava's story:

> ……..like I said the midwives just, barely, apart from just to do the heartbeat just kind of left me completely to it. Erm, which in itself was nice…….I mean I remember with my first [baby] the midwife being very involved, she was there at this end and just, for the whole time, whereas this time it was much more…….and them knowing I didn't need them there as such, um and yeah and just kind of just going with and letting my body just do what it needed to do. [Ava]

Sophie voices a real connection with her midwife not due to pre-existing high levels of continuity as she had not previously met the midwife prior to labour. For Sophie it was the feeling that the midwife truly supported her wish to birth in water:

> ……..and like I say she [midwife] gave me the choice to have her on the bed or, but I wanted to get back in and she [midwife] wanted me to get back in as well, she was quite keen for me to have the baby erm in the pool, she seemed very confident, she you know, as a midwife that that's where I should be and that was good for me, I liked that. [Sophie]

In Anderson's (2010) study exploring women's perceptions of the midwife during the second stage of labour, she identified the midwife as critical in influencing

perceptions of birth experiences both positively or negatively. Her study found that women needed the midwife to be present but unobtrusive, as offering the security required for them to enter the disconnected state required to facilitate birth (Anderson, 2010).

6.6 Summary

This chapter explores the narrative of the 'connected' self by the women in their stories of waterbirth. The findings in this chapter speak to the changing expectations of women surrounding childbirth in modern society where for some, water is central. Similarly, they illustrate the changing role of the midwife, valued for their ability to connect as guardians of the woman's choice for water in turn fostering a greater emotional connection within their relationship.

To summarise, the findings of this study identify three key narratives situated within the women's stories of waterbirth, that of the 'visible' self, the 'agent' self and the 'connected' self. Fluctuations between and within each of the women's stories were explored through the exhaustive analysis of the data exploring the influences of relational and socio-cultural concepts presented by the women in their stories. This allowed for recognisable connections within and between them to become visible ultimately creating the three key narratives.

The next chapter will conclude this thesis by outlining the unique contribution to knowledge that has been made by undertaking this research and how it has developed new knowledge around the meaning women attribute to waterbirth.

Chapter 7

Conclusion and final reflections

This final chapter reviews the study and concludes by identifying its contribution to knowledge within the context of my aim and research question. I provide a summary of the main findings, identify salient elements of having used a narrative methodology and identify limitations of the study as well as reflecting on the research. Finally, I make recommendations for policy, practice, and further research.

This original study explored the stories of women who had birthed in water and presented how these were constructed to reflect transitions to motherhood and changes in identity. This ensured I addressed an objective central to the study to provide a means for the stories of the women who participated to be clearly embedded within the narratives which were co-constructed. This chapter will illustrate how the study answered my research question: What do women's stories of waterbirth reveal about a woman's self and social identity around birth?

7.1 Unique contribution to knowledge

The gap in knowledge identified in the existing literature provided a basis for this research exploring women's stories of waterbirth and how the findings of this study contribute to literature in this area. The aim was to generate new knowledge around waterbirth from the emic perspective of the woman exploring this within both socio-cultural and relational contexts. The findings from my study to contribute to maternity service provision for women choosing waterbirth and can be used to inform discussions surrounding waterbirth between the woman and her midwife. The rich data provided by the women's stories are situated at the centre of this study enabled through the narrative methodology adopted based within a feminist framework. This illuminated the meaning women attribute to waterbirth which extends beyond previous knowledge and should benefit women and their families in the future.

The findings illuminate through the women's stories how waterbirth can support a sense of the visible, the agent and the connected self for some women. This enabled them to maintain a secure identity at a time of disruption during labour,

birth and in the early weeks of motherhood. Within their story's women attributed significance and meaning to the woman-midwife relationship. Women valued these relationships at an emotional level in the midwife's support for choice and self-determination. All the women valued their relationship with the water which in turn fostered close relationships with their newborn and family.

The unique contribution of this research extends existing knowledge about waterbirth in the following ways:

It disputes the dominant biomedical narrative which currently positions women who choose waterbirth as 'deviant'. Countering this the women fostered perceptions of their selves as 'good' mothers due to their choice to birth in water. Intuitively they perceived this allowed them to maintain a secure sense of self and identity during and after birth which improved their own health and 'recovery' following childbirth. They also perceived waterbirth as an enhanced choice in promoting the wellbeing of their newborn as they felt that water offered a less stressful, more gentle transition at birth.

This research contributes to relocating childbirth from its long established medicalised and in turn private domain in the UK. Childbirth mainly occurs 'behind closed doors' in a hospital environment whereby only those such as pregnant women, midwives and obstetricians have access through their own participation. This seeks to isolate women from marginalised narratives such as those of waterbirth and promote continuation of the status quo. By sharing the stories of the women in this study and the narratives co-constructed, will raise the profile of waterbirth, childbirth, and motherhood within the public domain. It will offer women and others the opportunity to access positive childbirth narratives interpreted within a variety of socio-cultural contexts providing them with the chance to identify individually with the practise of waterbirth.

The findings of this research illuminate the meaning placed on waterbirth by the women through their stories. By exerting control in their choice, it increased their satisfaction and provided a more meaningful childbirth experience, which appeared to continue well beyond the birth itself. This concept of choice has long been recognised as a benchmark standard for women during pregnancy and childbirth but is often only achieved by the minority rather than the majority. Essentially woman's choice to birth in water enabled them to maintain a secure

sense of self and identity during and after childbirth as they transitioned into motherhood.

This work illustrates that women recognise waterbirth as representing 'difference' yet 'familiarity'. The women in the study identified with the concept of 'natural birth' but mobilised this within the familiar biomedical narrative of 'safety' due either to birthing in hospital or accepting advice from professionals. This extends our knowledge of women who chose waterbirth, historically a choice made in opposition to the status quo of medicalised birth. The women in this study offered a binary position, not identified previously, which situates waterbirth both within the paradigm of physiological birth and within the biomedical model of birth.

Finally, this work illuminates how the women in my study embraced waterbirth as a means to defy disembodiment from childbirth. When presented within a biomedical model of birth it will often seek to 'separate' a woman from her body, meaning she no longer has sole access to it and it frequently becomes a shared object. Waterbirth offered exclusivity for the woman to maintain control of her body, fostering self-determination in her choice to restrict or allow access to it by others including midwives.

7.2 Contributions to policy and practice

This research was designed as part of a professional doctorate and therefore a key aim was to make recommendations for practice. The aim of this study was to illustrate the meaning women attribute to waterbirth through their stories, to inform future developments in maternity services, support midwives in providing care and help women when considering their birth options in the future.

7.2.1 Midwifery practice

It is important to identify prevalent issues from within the stories told and narratives constructed to inform future implications for midwifery practice.

Focussing on the relational aspect of care, midwives should be encouraged to reflect on how to employ a range of strategies to foster a sense of empowerment for the woman during labour and birth. They need to be alert to the significance of a woman's socio-cultural view of childbirth when caring for her. A woman's past life, relational encounters and previous birth experiences (or not) will all

assist the midwife in understanding the decisions and choices that she makes, including a desire for waterbirth. Inevitably, continuity of carer appears the logical solution to this challenge, however this too is a practise yet to be realised to its full potential in maternity services and therefore cannot be deemed as the only approach. Equally the women in this study failed to cite their lack in carer continuity as a negative aspect in their story. Instead they valued the continuous nature of the support they received during labour and birth in water, as well as valuing an emotional connection with the midwife. The women's narratives shared in this study suggest that:

- Midwives are encouraged to continue to engage in professional development by reviewing research findings that foreground the woman's voice and reflect on how such findings can be incorporated in future practice.

- Student midwives should be encouraged to participate alongside midwives in the facilitation of waterbirths as a means of disseminating skills and knowledge in this area of practice.

- Midwives should continue to embed core NHS values in their practice those of care; compassion; competence; communication; courage; and commitment, as these were highly valued by the women in this study.

None of the women in this study spoke of midwives being unsupportive of waterbirth in this or previous labours. The majority spoke of the sense of agency midwives had fostered in their innate ability to know their own body and birth their baby without intervention. This suggests that despite most midwives in the UK practising within the current dominant biomedical model of birth, some are able to actively resist this. The women's narratives recalled midwives who modelled the norms and behaviours associated with supporting the physiology of birth. Whilst society promotes contractions, pain during labour and lack of pharmacological analgesia as a 'negative' aspect of childbirth that should be removed, the findings of this study contradict this. The findings of the study illustrate that some women positively value the opportunity to physically experience labour and birth and waterbirth enabled them to do so. Women suggested this enhanced their perception that they were providing the best start

for their newborn, promoted feelings of presence within their birth by offering a sense of embodiment and allowed for close connection with their newborn following birth. The findings would suggest that for some women waterbirth has the potential to enhance emotional wellbeing during a time of significant transition, both during and after childbirth. Therefore, recommendations would be that:

- Midwives should support women who actively choose to embrace the experience of pain during labour as a meaningful part of childbirth, recognising waterbirth may be a means in which this can be achieved.

- Midwives need to continue to provide individualised care for every woman during labour and birth. The women who experienced waterbirth in this study recalled and valued the emotional support midwives offered above more physical aspects of care provided.

7.2.2 Policy

In this study nine of the ten women chose to birth in water either in an Obstetric unit (OU) or an Alongside midwifery unit (AMU) with only one choosing homebirth. The majority acknowledged the security of being in hospital implying this was the right place to be "just in case". It appears that childbirth may now be so entrenched in Western master biomedical narratives that waterbirth will rarely occur in anywhere other than a hospital setting. If this pattern continues it will require maternity service providers to review birthing pool provision and facilities in these environments. There is a need to address the compromise recalled by some women in this study during their previous births whereby birthing pool provision did not meet demand. Government policy continues to refer to the need to provide women with choice surrounding their birth and increased provision in some areas will be needed to achieve this. It is therefore recommended that:

- UK NHS Trusts should be required to collect and submit statistics annually as to the number of women who labour in water and those who progress to a waterbirth. This will allow for the:

    - Office of National Statistics (ONS) to collate and publish national statistics accessible to all and allow for comparison and analysis in the future.
    - Reliable data to inform commissioners of maternity services and service providers, identifying funding needs to increase birthing pool provision according to both, national and local need.

- Nationally service providers across the UK should review the number of birthing pools available within each maternity unit. Combining this information with local figures of both, waterbirths and physiological delivery rates, could indicate whether pool provision is adequate currently.

- Incorporate the support of women who birth in water within the new Nursing and Midwifery Council (NMC) 'Standards of Proficiency for Midwives' (2020) as part of the central tenant for woman centred care nationally across the UK.

- Incorporate a mandatory requirement for student midwives to facilitate waterbirth as part of the new Nursing and Midwifery Council (NMC) Standards for Pre-registration Midwifery Programmes (2020). This would promote equity of student experience nationally across all BSc (Hons) Midwifery programmes delivered in the UK.

- To review articles 40-42 of the EU directive 2005/36/EC which outline standardised requirements for midwifery training across Europe. This would allow the opportunity to amend the directive to stipulate facilitation of a minimum number of waterbirths, standardising practice and promoting waterbirth at an international level.

The women in this study attributed heightened levels of birth satisfaction in their stories of waterbirth, identifying it as an empowering experience, which they felt, provided a close connection to their newborn. Midwifery practice has long acknowledged that pregnancy and early life lay the foundations for individual health both physically and mentally, well beyond the early years. The feto/child centric view supported in society can therefore be used to support waterbirth as

a meaningful choice for women in the future. Enhancing perceptions of their own physical and emotional wellbeing their stories of waterbirth strengthened a secure identity and sense of self for the women enabling some to address previous negative birth experiences. It is therefore recommended that:

- NHS England and other funding bodies support research which explores possible links between waterbirth and the long-term impact on health and wellbeing for the woman and child as part of the UK public health agenda.

- Policy makers should collaborate to ensure the findings taken from this study on waterbirth are considered and embedded in future maternity policy updates, revisions and development. Examples could include;
    - The review of the National Institute for Health and Care Excellence (NICE) 2014 guidelines on 'Intrapartum care for Healthy Women and Babies'.
    - NHS England's 'Better Births' campaign specifically exploring this within the element of physiological birth, as well as the implementation of the Maternity Transformation Programme (MTP).
    - Maternity service user groups such as the National Childbirth Trust (NCT) to publish study findings on their website to ensure women and their families have easy access to primary research surrounding waterbirth assisting with informed decision making.

7.3 Reflexivity - Making sense of the stories

Reflexively, my own experience of meeting the women, listening to, then reading and hearing each of their stories on numerous occasions was immensely meaningful and a true privilege. It offered me the opportunity to share in their personal stories of waterbirth, coming to know each woman within their individual relational and socio-cultural contexts during a private period of their life. I was cognisant of the uniqueness of each story.

The narrative inquiry methodology and technique of VCRM mobilised through use of the 'Listening Guide' for data analysis illuminated the meaning placed on childbirth in water by the women. Reading story after story, resonant storylines emerged running through each woman's account which were co-constructed ultimately into three key narratives of 'self', identified as those of: the 'agent

self', the 'visible self', and the 'connected self'. Integrally, the degree of divergence in and between the women's stories were embraced and presented within discussion of the key narratives. Fundamentally, the women's own perceptions and stories of waterbirth, are embedded in and woven throughout the construction of the three narratives. These narratives, in turn, illustrated the emergence of women who presented with a secure identity as they transitioned into motherhood.

7.4 Limitations of the research

Limitations of this research include that frequently cited in other studies when using a purposive approach to sampling, this approach will be seen by many as providing an illustrative rather than representative sample of women. Acknowledged for its potential for bias in over or under representation within the sample, the study presents a homogenous sample of pre-dominantly white women. Mothers who were unable to speak English were excluded from the research due to a lack of interpretation services. Exploring the experiences of mothers from different ethnic and cultural backgrounds may have revealed different cultural expectations of childbirth in water with the potential to influence the meaning attributed by women.

A further weakness may relate to the recruitment process. Whilst the method employed supported self-determination using posters and leaflets to disseminate information about the study including my contact details as the researcher, I was mindful this was based on the altruistic actions of colleagues. I recognise now I was possibly idealistic in wanting to focus my study in one area (AMU) and with one group (primigravid women) as a means to enhance the credibility of my findings by minimising the influence of exogenous features on my findings. I recognise reluctance on my own part to alter my recruitment strategy and that this contributed to the length of time taken to recruit the ten women. Reflexively I came to appreciate that including multigravida women in the study added another dimension to my findings in conjunction with the methodology adopted and the approach of VCRM used to analyse the stories, which may not otherwise have been made visible.

7.5 Future research

Whilst this research provided a platform for the ten women and their stories of waterbirth, there remain many voices unheard. Further research surrounding waterbirth is required using qualitative methodologies which focus on the emic view of the woman. By increasing the prevalence of such studies women will illuminate different meanings in their stories, in turn informing childbirth narratives within society. This study illustrated that there was growing provision of birthing pools within maternity units across the UK which may be followed by an increase in women using water for labour and/or birth over the coming years. It is therefore important that studies explore the meaning ascribed by women from different cultural and ethnic groups to offer a more holistic view of waterbirth. The aim should be to provide inclusivity for all women to choose waterbirth and by specifically exploring stories of women from Black and Minority Ethnic (BME) groups the aim would be to actively discourage marginalising their narratives within an ethnocentric society.

This study demonstrates the potential to enhance women's satisfaction with their birth experience when a waterbirth is favoured and achieved. For some multigravid women in this study waterbirth appeared to enable positive resolution regarding previous negative birth experiences. Future research should therefore explore the potential for waterbirth to offer long term health and well-being physically, mentally and emotionally for women.

The new and original contribution to knowledge generated by the findings in this study relate to waterbirth as a practice no longer viewed by women as 'alternative' in some way. Instead this study presents the duality of waterbirth both, within the context of 'physiological birth' whilst also residing simultaneously within mainstream biomedical models of childbirth in the UK. Beyond this, the study contributes to the development of waterbirth as a narrative no longer marginalised within traditional discourses surrounding childbirth.

7.6 Closing remarks

As a result of the study I propose that using water during childbirth assisted the women in constructing identities that remained true to their concept of self. This concept was viewed in the context of a 'good mother' by means of a 'natural

childbirth' and a subsequent strong emotional connection with their baby. Their choice to birth in water was not presented overtly by the women in this study as a conscious counter narrative to the biomedical narrative of childbirth. Rather the women repurposed their stories of waterbirth to present them as a 'better choice' for them and their baby supporting the concept of society's definition of a 'good mother' placing their baby's needs ahead of their own. Positive birth outcomes were attributed to their use of water in labour and birth, in turn allowing for a more assured sense of self. This perception of identity reinforced a secure identity of an autonomous decision maker transitioning into motherhood.

Reference List

Adams, J., Frawley, J., Steel, A., Broom, A., Sibbritt, D., (2015) Use of pharmacological and non-pharmacological labour pain management techniques and their relationship to maternal and infant birth outcomes: Examination of a nationally representative sample of 1835 pregnant women. *Midwifery,* **31** (4): 458-463.

Akrich, M. and Pasveer, B., (2004) Embodiment and disembodiment in childbirth narratives, *Body and Society*, **10** (2–3): 63–84.

Allan, J., (2004) Mother blaming: a covert practice in therapeutic intervention. *Australian Social Work*, **57** (1): 57-70.

Alderdice, F, Renfrew, M, Marchant, S, Ashurst, H, Hughes, P, Berridge, G, and Garcia, J., (1995) Labour and birth in water in England and Wales. *British Medical Journal,* **310** (6983): 837,

American Association of Birth Centres (AABC) (2014) *Position Statement: Immersion in Water during Labor and Birth.* AABC

American College of Nurse-Midwives (ACNM) (2014) *Position Statement: Hydrotherapy during Labour and Birth.* Available at: http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000286/Hydrotherapy-During-Labor-and-Birth-April-2014.pdf Accessed 25th July 2016.

American College of Obstetricians and Gynecologists (ACOG) and American Academy of Paediatrics (AAP) (2014) *Committee Opinion Number 594, Reaffirmed 2016: Immersion in Water During Labor and Delivery. p 1- 4.* ACOG and AAP: Washington DC.

Anderson, T., (2010) Feeling safe enough to let go: The relationship between a woman and her midwife during the second stage of labour. In Kirkham, M., (ed) *The Midwife-Mother Relationship.* 2nd edition. Palgrave MacMillan: Basingstoke, Hampshire.

Andrews, M, Squire, C, and Tamboukou, M., (2008) *Doing Narrative Research*. 2nd edition. Sage: London.

Annandale, E, C., (1988) 'How midwives accomplish natural birth: Managing risk and balancing expectations'. *Social Problems*, **35** (2): 95-110.

Atkinson, P., and Silverman, D., (1997) Kundera's Immortality: The interview society and the invention of the self. *Qualitative Inquiry,* **3** (3): 304-325.

Ayers, S., Eagle, A., Waring, H., (2006) The effects of childbirth-related post-traumatic stress disorder on women and their relationships: A qualitative study. *Psychology, Health and Medicine,* **11** (4): 389-398.

Beauchamp, T, L, and Childress, J, F., (2009) *Principles of Biomedical Ethics.* Oxford University Press: London.

Beech, B, A, L., (1996) Water birth unplugged: Proceedings from the first International Water Birth Conference. In: Beech, B, A, L (ed) *International Water Birth Conference*; 1995. Books for Midwives Press: London.

Beck, C. T., (2004) Birth trauma: In the eye of the beholder. *Nursing Research*, **53** (1): 28-35.

Beck, C., (2002a) Postpartum depression: a meta-synthesis. *Qualitative Health Research,* **12** (4): 453-472.

Beck, C., (2002b) Mothering multiples: a meta-synthesis of qualitative research. *Maternal and Child Nursing,* **27** (4): 214-221.

Beck, C, T., (1992) The lived experience of postpartum depression: a phenomenological study. *Nurse Researcher,* **41** (3); 166-170.

Beech B, and Phipps B. (2004) Normal birth: women's stories*:* In: Downe, S., (Ed.) *Normal childbirth, evidence and debate.* Churchill Livingstone: London.

Beech, B, A, L., (1996) Water birth unplugged: Proceedings from the first International Water Birth Conference. In: Beech, B, A, L (ed) *International Water Birth Conference*; 1995. Books for Midwives Press: London.

Benoit, C, Zadoroznyi, M, Hallgrimsdottir, H, Treloar, H, and Taylor, K., (2010) Medical dominance and Neoliberalism in maternal care provision. *Canada and Austraia Social Science and Medicine,* **71** (3):475-481.

Berg, B., (1998) *Qualitative Research methods for the social sciences.* 3rd edition. USA: Allyn and Bacon.

Berg, M., Lundgren, I., Hermansson, E., Wahlberg, V., (1996) Women's experiences of the encounter with the midwife during childbirth. *Midwifery,* **12** (1): 11-15.

Bergum, V., (1997) *A child on her mind: The experience of becoming a mother*. Westport, CT: Bergin and Garvey.

Birch, M., and Miller, T., (2000) Inviting intimacy: The interview as therapeutic opportunity. *International Journal of Social Research Methodology,* **3** (3): 189-202.

Birthplace in England Collaborative Group (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: The Birthplace in England national prospective cohort study. *British Medical Journal* **343** (d7400): 1-13. Available at: https://www.bmj.com/content/bmj/343/bmj.d7400.full.pdf

Bloor, M, and Wood, F., (2006) *Keywords in Qualitative Methods: A vocabulary of research concepts.* Sage Publications Ltd: London.

Bohren, M, A., Hofmyer, G, J., Sakala, C., Fukuzawa, R, K., Cuthbert, A., (2017) Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews* 2017, Issue **7**. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub6.

Bowling, A., (2014) *Research Methods in Health: Investigating Health and Health Services.* 4th ed. Open University Press: Berkshire, Engalnd.

Bovbjerg, M, L., Cheyney, M., and Everson, C., (2016) Maternal and Newborn outcomes Following Waterbirth: The Midwives Alliance of North America Statistics Project, 2004 to 2009 Cohort. *Journal of Midwifery and Women's Health,* **61** (1): 11 – 20.

Brooks, L., (2011) *Story Engineering: Character Development, Story Concept, Scene Construction.* Writer's Digest: Ohio.

Brown, J., and Addington-Hall, J., (2008) How people with motor neurone disease talk about living with their illness: a narrative study. *Journal of Advanced Nursing,* **62** (2): 200-208.

Brown, L, M, and Gilligan, C., (1992) *Meeting at the Crossroads: Women's Psychology and Girls Development.* Harvard University Press: Cambridge, MA.

Browning, C, A., (2000) Using music during childbirth. *Birth,* **27** (4): 272-276.

Burns, E, E., (2014) *Intrapartum birthing pool use in the UK.* PhD, Oxford Brookes University. Available at: https://ethos.bl.uk/ProcessOrderDetailsDirect.do?documentId=3&thesisTitle=Intrapartum+birthing+pool+use+in+the+UK&eprintId=741019

Burns, E, E., Boulton, M, G., Cluett, E., Cornelius, V, R., Smith, L, A., (2012) Characteristics, interventions, and outcomes of women who used a birthing pool: A prospective observational study. *Birth,* **39** (3): 192-202.

Burns, E, E, and Greenish, K., (1993) Water birth. Pooling information. *Nursing Times,* **89** (8): 47-49.

Byrne, V., Egan, J., Mac Neela, P, Sarma, K., (2017) What about me? The loss of self through the experience of traumatic birth. *Midwifery,* **51**: 1-11.

Byrne, A., Canavan, J., and Millar, M., (2009) Participatory research and the voice-centred relational method of data analysis: is it worth it? *International Journal of Social Research Methodology*, **12** (1): 67-77.

Cahill, H, A., (2001) Male appropriation and medicalization of childbirth: an historical analysis. *Journal of Advanced Nursing,* **33** (3): 334-342.

Callister, l, C., Corbett, C., Reed, S., Tomao, C., and Thornton, K, G., (2010) Giving birth: the voices of Ecuadorian women. *Journal of Perinatal and Neonatal Nursing*, **24** (2): 146-154.

Callister, L, C., (2004a) Making Meaning: Women's birth narratives. *JOGNN,* **33** (4): 508-518.

Callister, L, C., (2004b) Promoting positive birth experiences. *Journal of Obstetrics and Neonatal Nursing,* **33** (4): 484.

Callister, L. C. (1995) Cultural meanings of childbirth. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, **24**(4): 327-331.

Care Quality Commission (CQC) (2015) *2015 Survey of Women's Experiences of Maternity Care: Statistical Release.* CQC: London. Available at: http://www.cqc.org.uk/sites/default/files/20151215_mat15_statistical_release.pdf

Care Quality Commission (CQC) (2010) *Women's experiences of maternity care in England: Key findings from the 2010 NHS trust survey.* CQC: London. Available at: http://www.cqc.org.uk/sites/default/files/media/documents/20101201_mat10_briefing_final_for_publication_201101072550.pdf

Carpenter, L and Weston, L., (2012) Neonatal respiratory consequences from water birth. *Journal of Paediatrics and Child Health,* **48** (5): 419 – 423.

Chadwick. R, J., (2014) Bodies Talk: On the challenges of hearing childbirth counter-stories. p44-63: In McKenzie-Mohr. S., and Lafrance. M.N., (eds) *Women Voicing Resistance: Discursive and Narrative Explorations.*

Chadwick, R, and Foster, D., (2012) Technologies of gender and childbirth choices: Home birth, elective caesarean and white femininities in South Africa. *Feminism and Psychology,* **23**(3): 317-338.

Chaichian, S., Akhlaghi, A., Rousta, F., Safavi, M., (2009) Experience of waterbirth delivery in Iran. *Archive Iran Medical,* **12** (): 468-471.

Chaillet, N., Belaid, L., Crochetière, C., Roy, L., Gagné, G, P., Moutquin, J, M., Rossignol, M., Dugas, M., Wassef, M., Bonapace, J., (2014) Nonpharmacologic Approaches for Pain Management During Labor Compared with Usual Care: A Meta-Analysis. *Birth,* **41** (2): 122-137.

Chapman, V., and Charles, C., (2009) *The Midwives Labour and Birth Handbook.* 2nd edition. Wiley-Blackwell: Chichester.

Chase, S, E., (2005) Narrative Inquiry: Multiple Lenses, Approaches, Voices. In: Denzin, N, K, and Lincoln, Y, S., (Eds.) *The Sage handbook of qualitative research* (pp. 651-679). Thousand Oaks, CA: Sage Publications Ltd.

Charmaz, K., (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.

Chief Nursing Officers (2010) *Midwifery 2020: Delivering expectations 2010.* DH: London.

Choi, P, Henshaw, C, Baker, S, Tree, J., (2005) Supermum, superwife, supereverything: performing femininity in the transition to motherhood. *Journal of Reproductive and Infant Psychology,* **23** (2): 167-180.

Chrisler, J, C, and Johnston-Robledo, I., (2017) *Woman's Embodied Self: Feminist Perspectives on Identity and Image.* American Psychological Association: USA.

Clandinin, D, J., (2007) *Handbook of narrative inquiry: Mapping a methodology.* California: Sage Publications.

Clandinin, D, J., and Connelly, F, M., (2000) *Narrative inquiry: experience a story in qualitative research.* San Francisco: Jossey-Bass Publishers.

Clemmens, D., (2003) Adolescent motherhood: a meta-synthesis of qualitative studies. *American Journal of Maternal and Child Nursing,* **28** (2): 93-99.

Clews, C., (2013a) Normal birth and its meaning: a discussion paper. *Evidence Based Midwifery,* **11** (1): 16-20.

Clews, C., (2013b) *An Audit Evaluation project of women's use of water during labour and birth at one local NHS Foundation Trust.* **Unpublished** August 2013, University of Northampton.

Cluett, E.R., and Burns, E., (2009) *Immersion in water in labour and birth.* Cochrane Database of Systematic Reviews 2009, Issue 2, Art No: CD000111. p 1 – 101.

Cluett, E, and Bluff, R., (eds) (2006) *Principles and Practice of Research in Midwifery*. 2nd Edition. Elsevier: London.

Connelly, F, M., and Clandinin, D, J., (1990) Stories of experience and narrative inquiry. *Education Research,* **19** (5): 2-14.

Conrad, P., (1992) Medicalization and Social Control. *Annual Review of Sociology,* **18**: 209-232.

Conrad, P., (1975) The discovery of hyperkinesis. *Social Problems*, **12**, (1): 12–21.

Cook, K, and Loomis, C., (2012) The impact of choice and control on women's childbirth experiences. *The Journal of Perinatal Education,* **21** (3): 158-168.

Cortes, E., Basra, R., and Kelleher, C, J., (2011) Waterbirth and pelvic floor injury: a retrospective study and postal survey using ICIQ modular long from questionnaires. *European Journal of Obstetrics & Gynecology and Reproductive Biology,* **155** (1): 27 – 30.

Cotterill, P., and Letherby, G., (1993) Weaving stories: Personal auto/biography in feminist research. *Sociology,* **27** (1): 67-79.

Coxon, K., Sandall, J. and Fulop, N., (2014) To what extent are women free to choose where to give birth? How discourses of risk, blame and responsibility influence birth place decisions. *Health, Risk and Society,* **16**(1):5-67.

Creswell, J, W., (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Crossley, M., (2007) Childbirth, complications and the illusion of 'choice': a case study. *Feminism and Psychology*, **17** (4): 543–63.

Dahlen, H.G., Dowling, H., Tracy, M., Schmied, V., and Tracy, S., (2013) Maternal and perinatal outcomes amongst low risk women giving birth in water compared to six birth positions on land. A descriptive cross-sectional study in a birth centre over 12 years. *Midwifery,* **29** (7): 759-764.

Dahlen, H, G., Barclay, L, M., Homer, C., (2010) Processing the first birth: journeying into 'motherland'. *Journal of Clinical Nursing,* **19** (13-14): 1977-1985.

Darra, S, and Murphy, F., (2016) Coping and help in birth: An investigation into normal childbirth as described by new mothers and their attending midwives. *Midwifery,* **40**: 18-25.

Das. R., (2017) Speaking About Birth: Visible and Silenced Narratives in Online Discussions of Childbirth. *Social Media and Society,* **3** (4): 1-11.

Data Protection Act (1998) The Stationery Office: London.

Da Silva, F.M., De Oliveira, S.M., and Nobre, M.R., (2009) A randomised controlled trial evaluating the effect of immersion bath on labour pain. *Midwifery,* **25** (3): 286 – 294.

Davis, M, W., (2012) Water births and the research required to assess the benefits versus the harms. *Journal of Paediatrics and Child Health,* **48** (9): 726 – 729.

Davis-Floyd, R, M., Khammarnia, M., and Eslahi, M., (2015) A comparison of mothers' quality of life after normal vaginal, caesarean, and water birth deliveries. *IJCBNM,* **3** (3): 198 – 204.

Davis D, L., and Walker, K., (2010) Re-discovering the material body in midwifery through the exploration of theories of embodiment. *Midwifery,* **26** (4): 457-462.

Davis-Floyd, R., Barclay, L., Tritten, J., and Daviss, B, A., (2009) *Birth models that work.* University of California Press: Berkley, US.

Davis-Floyd, R., (2001) The technocratic, humanistic and holistic paradigms of childbirth. *International Journal of Gynaecology and Obstetrics,* **75** (supplement 1): S5 – S23.

Davis-Floyd, R, and Sargent, C., (eds) (1997) *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*. Berkeley: University of California Press.

Davis-Floyd, R., (1994) The technocratic body: American childbirth as cultural expression. *Social Science and Medicine,* **38** (8): 1125-1140.

Davis-Floyd, R., (1992) *Birth as an American Rite of Passage.* California Press: USA.

Davis-Floyd, R., (1987) The technological model of birth. *Journal of American Folklore.* **100** (398): 479-495.

Davis-Floyd, R. and Davies, E., (1996) Intuition as Authoritative Knowledge in Midwifery and Homebirth. *Medical Anthropology Quarterly,* **10** (2): 237-269.

De Jonge, A., Stuijt, R., Eijke, I., and Westerman, M, J., (2014) Continuity of care: what matters to women when they are referred from primary to secondary

care during labour? A qualitative interview study in the Netherlands. *BMC Pregnancy Childbirth,* **14** (1): 103.

Demirel, G., Celik, I, H., Erdeve, O., and Dilmen, U., (2013) Neonatal respiratory consequences from water birth in a tertiary centre. *Journal of Paediatric Child Health,* **49** (1): E105 – 106.

Denzin, N, and Lincoln, Y., (Ed.) (2005) *The Sage Handbook of Qualitative Research.* 3rd ed. London: Sage Publications.

Denzin, T., Norma, K. & Lincoln, Y., (2003) *Strategies of Qualitative inquiry. Second edition.* Thousand Oaks, CA: Sage.

Department of Health (2015) *NHS Constitution: the NHS belongs to is all.* Available at: *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf*

Department of Health (2007) *Maternity Matters: choice, access and continuity of care in a safe service*. Department of Health, Partnerships for Children, Families and Maternity, London.

Department of Health, (2005) *Research Governance Framework for Health and Social Care, Department of Health*. England, London.

Department of Health, (2004) *National Service Framework for Children, Young People and Maternity Services. Standard 11. Maternity Services*. Department of Health, London.

Department of Health, (1993) *Changing Childbirth*. Department of Health HMSO, London.

Department of Health (1970) *The Peel report*. HMSO: London

Doka, K, J., (Ed) (2001) *Disenfranchised Grief: New Directions, Challenges, and Strategies for Practice.* Lexington Books: USA.

Doniec-Ulman, I, Kokot, F, Wambach, G, Drab, M., (1987) Water immersion-induced endocrine alterations in women with EPH gestosis. *Clinical Nephrology,* **28** (2): 51 -55.

Downe, S. and McCourt, C., (2008) From being to becoming: reconstructing childbirth knowledges. In Downe, S. (ed.) *Normal Childbirth; Evidence and Debate*. London: Churchill Livingstone.

Downe, S., (ed) (2004) *Normal Childbirth: evidence and debate.* London*:* Churchill Livingstone Elsevier.

Earle, S., and Hadley, R., (2018) Men's views and experiences of infant feeding: A qualitative systematic review. *Maternal and Child Nutrition,* **14** (3): article e12586.

Eberhard, J, Stein, S, and Geissbuehler, V., (2005) Experience of pain and analgesia with water and land births. *Journal of Psychosomatic Obstetrics and Gynaecology,* **26** (2): 127-133.

Eckert, K., Turnbull, D., and MacLennan, A., (2001) Immersion in water in the first stage of labor: a randomised controlled trial. *Birth,* **28** (2): 84 – 93.

Edwards, R, and Holland, J., (2013) *What is Qualitative Interviewing?* Bloomsbury: London.

Ehrenreich, B., and English, D., (1973) *Complaints and Disorders*. London: Writers and Readers Cooperative

Ehrenreich, B., and English, D., (1972) *Witches, Midwives and Nurses*. New York: Feminist Press.

Elliott, J., (2005) *Using Narrative in Social Research.* Sage: London.

Elliot, R., Fisher, C.T. & Rennie, D.L., (1999) Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, **38**: 215–229.

Embry, M., (1805) Observations sur un accouchement termine dans le bain. *Les Annales de la Societe de Medicine Pratique de Montpelier.* **53**:185 -191.

Emmel, N., (2013). *Sampling and choosing cases in qualitative research: A realist approach*. London: Sage.

Enkin, M., Keirse, M., Neilson, J., Crowther, C., Duley, L, and Hodnett, E., (2000) *A guide to effective care in pregnancy and childbirth.* New York: Oxford University Press.

Fahy, K., Foureur, M. and Hastie, C., (Eds) (2008) *Birth Territory and Midwifery Guardianship*. Elsevier, Edinburgh.

Fairclough, N., (2001) *Analysing Discourse: Textual Analysis for Social Research.* Routledge: London.

Fairtlough, A, C., (2007) Adapting the voice-centred relational method of data analysis: reading trainees' accounts of their learning on a pilot programme for practitioners working with parents. *Learning in Health and Social Care,* **6** (1): 2-13.

Farley, C., and Widmann, C., (2001) The value of birth stories. *International Journal of Childbirth Education,* **16** (3): 22-25.

Fine, M., (1992) *Disruptive voices: The possibilities of feminist research*. Ann Arbor: The University of Michigan Press

Forster, D, L., McLachlan, H, L., Davey, MA., Biro, M, A., Farrell, T., Gold, L., Flood, M., Shafiei, T., and Waldenström, U., (2016) Continuity of care by a primary midwife (caseload midwifery) increases women's satisfaction with antenatal, intrapartum and postpartum care: results from the COSMOS randomised controlled trial. *BMC Pregnancy and Childbirth,* **16** (28): 1-13.

Frank, A. W., (2000) The standpoint of storyteller. *Qualitative Health Research*, **10** (3): 354-365.

Frank, A, W., (1998) Just listening: Narrative and deep illness. *Families, Systems and Health,* **16** (3): 197-212.

Frith, L., and Draper, H., (Ed) (2004) *Ethics and Midwifery: Issues in Contemporary.* (2nd ed) Books for Midwives: London.

Frost, J., (2007) Older women and early miscarriage: leaky bodies and boundaries. In: Kirkham, M., (Ed) *Exploring the Dirty Side of Women's Health.* Routledge: Oxford.

Garland, D., (2017) *Revisiting Waterbirth: An Attitude to Care.* 2nd edition. Palgrave MacMillan: London.

Garland, D., (2006) Waterbirth- an international overview: Diane Garland, a freelance UK-based midwife lecturer, spoke at the ICM Brisbane Congress and

now gives an update on the practice of waterbirth around the world. *International Midwifery*, **19** (2): 24.

Garland, D, and Jones, K., (1997) Waterbirth: updating the evidence. *British Journal of Midwifery,* **5**(6): 368-73.

Garland, D, and Jones, K., (1994) Waterbirth, first stage immersion or non-immersion? *British Journal of Midwifery*, **2**(3):113–20.

Gaskin, I, M., (2003) *Ina May's Guide to Childbirth.* London: Vermillion.

Gayiti, M, R., Li, X, Y, Zulifeiya, A, K, Huan, Y, and Zhao, T, N., (2015) Comparison of the effects of water and traditional delivery on birthing women and newborns. *European Review for Medical and Pharmacological Sciences,* **19** (9): 1554-1558.

Ghasemi, M, Tara, F, and Ashraf, H., (2013) Maternal-fetal and neonatal complications of water-birth compared with conventional delivery. *Iran Journal of Obstetrics, Gynecology and Infertility,* **16**: 9-15.

Gibbins, J., and Thomson, A, J., (2001) Women's expectations and experiences of childbirth. *Midwifery,* **17** (4): 302-313.

Giddens, A., (1991) *Modernity and Self-identity: Self and identity in late modern age.* Cambridge, UK: Polity Press.

Gilbert, R, E., and Tookey, P, A., (1999) Perinatal mortality and morbidity among babies delivered in water: surveillance study and postal survey. *British Medical Journal,* **319** (7208): 183-7.

Gilligan, C., Weinberg, R, S, M., and Bertsch, T., (2006) On the Listening Guide: A voice centred relational method. In Hesse-Bibers, S., and Leavy, P., (eds) *Emergent methods in social research.* Pp 253- 272. Thousand Oaks, CA: Sage Publications.

Gilligan, C., (1993) *In a Different Voice: Psychological Theory and Women's Development.* (2nd edition). Cambridge, MA.: Harvard University Press.

Gilligan, C., (1982) *In a different voice; Psychological theory and women's development*. Cambridge, MA: Harvard University Press.

Giorgi, A., (1997) The Theory, Practice, and Evaluation of Phenomenological Method as a Qualitative Research Procedure. *Journal of Phenomenological Psychology,* **28** (2): 235-260.

Goer, H., Leslie, M, S., and Ramano, A., (2007) Step 6: Does not routinely employ practices, procedures unsupported by scientific evidence. *The Journal of Perinatal Education,* **16** (supplement 1): 32S – 64S.

Goodman, P., Mackey, M, C., and Tavakoli, A, S., (2004) Factors related to childbirth satisfaction. *Journal of Advanced Nursing,* **46** (2): 212-219.

Gould, D., (2000) Normal labour: a concept analysis. *Journal of Advanced Nursing,* **31** (2): 418-427.

Graham, H, and Oakley, A., (1986) 'Ideologies of reproduction'. In: Currer, C, and Stacey, M., (eds) *Concepts of health and illness and disease: A comparative perspective*. Leamington Spa: Berg.

Grbich, C., (2007) *Qualitative Data Analysis: An Introduction.* 2nd edition. Sage Publications: London.

Green, B., (2013) "Narrative inquiry and nursing research", *Qualitative Research Journal*, **13** (1): 62-71.

Green, J, and Thorogood, N., (2009) *Qualitative Methods for Health Research.* 2nd ed. Sage Publications: London.

Green, J, M., and Baston, H, A., (2003) Feeling in control during labor: Concepts, correlates and consequences. *Birth,* **30** (4): 235-247.

Green, J, M., (1999) Commentary: What is this thing called "control"? *Birth*, **26** (1): 51–52.

Green, J. M., Coupland, V. A., and Kitzinger, J. V., (1990) Expectations, experiences and psychological outcomes of childbirth: A prospective study of 825 women. *Birth,* **17** (1): 15-24.

Guest, G, Bunce, A, and Johnson, L., (2006) How many interviews are enough? An experiment with data saturation and variability. *Field Methods,* **18** (1): 59-82.

Gutterman, T, C., (2015) Descriptions of Sampling Practices within Five Approaches to Qualitative Research in Education and the Health Sciences. *Qualitative Social Research,* **16** (2): 1-23.

Hall, S, M., and Holloway, I, M., (1998) Staying in control: women's experience of labour in water. *Midwifery,* **14** (1): 30-36.

Hallgren, A., Kihlgre, M., Norberg, A., and Forslin, L., (1995) Women's perceptions of childbirth and childbirth education before and after education and birth. *Midwifery,* **11** (): 130-137.

Harding, S., (1992) `The Instability of the Analytical Categories of Feminist Theory'. In Crowley, H, and Himmelweit, S., (eds*) Knowing Women: Feminism and Knowledge*, pp. 338-354. Cambridge: Polity Press.

Harding, S., (1991) *Whose Science? Whose Knowledge? Thinking from Women's Lives.* Cornell University Press: New York.

Harding, S., (1987) (ed.) *Feminism and Methodology.* Milton Keynes: Open University Press.

Harding, S., (1986) *The Science Question in Feminism.* Ithaca, NY: Cornell University Press.

Harper, B., (2014) Birth, Bath, and Beyond: The Science and Safety of Water Immersion During Labor and Birth. *The Journal of Perinatal Education,* **23** (3): 124 – 134.

Hauck, Y., Rivers, C., and Doherty, K., (2008) Women's experiences of using a Snoezelen room during labour in Western Australia. *Midwifery*, **24**(4): 460-470.

Haydon, G., and van der Riet, P., (2017) Narrative Inquiry: A relational research methodology suitable to explore narratives of health and illness. *Nordic Journal of Nursing Research,* **37** (2): 85-89.

Healthcare Commission (HCC) (2008) *Towards Better Births: A review of Maternity Services in England.* Commission for Healthcare Audit and Inspection: London. Available at:

http://webarchive.nationalarchives.gov.uk/20110504142248/http://www.cqc.org.uk/_db/_documents/Towards_better_births_200807221338.pdf

Heidegger, M., (1927/2011). *Being and Time* (Macquarrie, J, and Robinson, E.,). New York, NY: Harper & Row.

Henderson, J., Burns, E, E., Regalia, A, L., Casarico, G., Boulton, M, G., and Smith, L, A., (2014) Labouring women who used a birthing pool in obstetric units in Italy: prospective observational study. *BMC Pregnancy and Childbirth,* **14** (17): 1 – 7.

Hendry, P, M., (2007) The future of narrative. *Qualitative Inquiry*, **13** (4): 487-498.

Henley-Einion, A., (2003) Chapter 11: The medicalisation of childbirth. In: Squire, C., (ed) (2003) *The Social Context of Birth.* Radcliffe Medical Press Ltd: Oxon.

Herman, D., (1995) *Universal Grammar and Narrative Form.* London: Duke University Press.

Hermanowicz, J, C., (2002) 'The great interview: 25 strategies for studying people in bed.' *Qualitative Sociology,* **25**: 479-99.

Hewer, N, Boschma, G, and Hall, W, A., (2009) Elective caesarean section as a transformative technological process: players, power and context. *Journal of Advanced Nursing,* **65**(8): 1762-71.

Hewett, J., (2007) Ethical components of researcher researched relationships in qualitative interviewing. *Qualitative Health Research,* **17** (8)**:** 1149-1159.

Heyman, B., (2009) Reflecting on a meta-synthesis of qualitative papers concerned with pregnant women's decision-making about prenatal screening for Down syndrome: A commentary on Reid, Sinclair, Barr, Dobbs and Crealey. *Social Science and Medicine,* **69** (11): 1574-1576.

Hinchman, L, P, and Hinchman, S, K., (1997) *Memory, Identity, Community: The Idea of Narrative in the Human Sciences.* New York Press: USA.

Hodnett, E, D., Downe, S., Walsh, D., and Weston, J., (2010) Alternative versus conventional institutional settings for birth. *Cochrane Database Systematic Review,* (9):CD000012. doi: 10.1002/14651858.CD000012.pub3.

Hodnett, E, D., Stremler, R., and Weston, J, A., (2009) Re-conceptualizing the hospital labor room: the place (Pregnant and Laboring in an Ambient Clinical Environment) pilot trial. *Birth* **36**(2):159-66

Hodnett, E. D., Gates, S., Hofmeyr, G. J., and Sakala, C., (2007) Continuous support for women during childbirth. Cochrane Database Systematic Reviews. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub2.

Holloway, W., (2016) Feminism, psychology and becoming a mother. *Feminism and Psychology,* **26** (2): 137-152.

Holloway, I, and Wheeler, S., (2015) *Qualitative Research in Nursing and Healthcare.* 3rd edition. Wiley Blackwell: West Sussex.

Holloway, W, and Jefferson, T., (2000) *Doing Qualitative Research Differently: Free Association, Narrative and the Interview Method.* Sage: London.

Holloway, I., and Freshwater, D., (2007) *Narrative Research in Nursing* Oxford: Blackwell Publishing.

Hosseini, S, E, Bagheri, M, Honarparvaran, N., (2013) Investigating the effect of music on labor pain and progress in the active stage of first labor. *European Review for Medical and Pharmacological Sciences,* **17**: 1479-1487.

Houghton, G., Bedwell, C., Forsey, M., and Baker, L., and Lavender, T., (2008) Factors influencing choice in birth place – an exploration of the views of women, their partners and professionals. *Evidence Based Midwifery,* **6** (2): 59-64.

Howarth, A, M., Swain, N., and Treharne, G, J., (2011) Taking personal responsibility for well-being increases birth satisfaction of first time mothers. *Journal of Health Psychology,* **16** (8): 1221-1230.

Hundleby, C., (1997) Where Standpoint Stands Now. *Journal of Women Politics and Policy,* **18** (3): 25-43.

Husserl, E. (1964). *The idea of phenomenology*. The Hague: Martinus Nijhof.

Illich, I., (1975) *Medical Nemesis*. London: Marion Boyars.

Jackson, D., and Mannix, J., (2004) Giving voice to the burden of blame: A feminist study of mothers' experiences of mother blaming. *International Journal of Nursing Practice,* **10** (4): 150-158.

Jafari, E., Mohebbi, P., Mazloomzadeh, S., (2017) Factors related to women's childbirth satisfaction in physiologic and routine childbirth groups. *Iran Journal of Nurse Midwifery Research,* **22** (3): 219-224.

Johnson, P., (1996) Birth under water: To breathe or not to breathe. *British Journal of Obstetrics and Gynecology,* **103** (3): 202 – 208.

Jordon, J., (1997) *Women's growth in diversity*. New York, NY: Guilford Press.

Jordan, B., and Davis-Floyd, R., (1993) *Birth in Four Cultures: a crosscultural investigation of childbirth in Yucatan, Holland, Sweden and the US.* 4th edition. Illinois: Waveland

Kaiser, K., (2009) Protecting respondent confidentiality in qualitative research. *Qualitative Health Research,* **19** (11): 1632-1641.

Kavosi, Z., Keshtkaran, A., Setodehzadeh, F., Kasraeian, M, Khammarnia, M, Eslahi, M., (2015) A comparison of mothers' quality of life after normal vaginal, caesarean, and water birth deliveries. *International Journal of Community Based Nursing and Midwifery,* **3** (3): 198-204.

Kay, L, Downe, S, Thomson, G, Finlayson, G., (2017) "Engaging with birth stories in pregnancy: a hermeneutic phenomenological study of women's experiences across two generations." *BMC Pregnancy and Childbirth,* **17** (1): 283.

Kennedy, H, P, Shannon, M, T, Chuahorm, U, and Kravetz, M, K, (2004) The landscape of caring for women: a narrative study of midwifery practice. *Journal of Midwifery and Women's Health,* **49** (1): 14-23.

Kirkham, M., (Ed) (2007) *Exploring the Dirty Side of Birth.* Routledge: London.

Kirkham, M., (1999) The culture of midwifery in the National Health Service in England. *Journal of Advanced Nursing,* **30** (3): 732-739.

Kitzinger, S., (2005) *The Politics of Birth*. London: Elsevier.

Kitzinger, S., (1993) Water wizard: Igor Charkovsky and his quest for super babies. *MIDIRS Midwifery Digest,* **13**: 379 -380.

Kitzinger, S., (1988) *The Midwife Challenge.* London: Pandora.

Kleiman, S., (2004) Phenomenology: to wonder and search for meanings. *Nurse Researcher,* **11** (4): 7-19.

Knight, M, Nair, M, Tuffnell, D, Shakespeare, J, Kenyon, S, Kurinczuk, J, J., (Eds.) (2017) *Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15*. MBRRACE-UK: Oxford.

Koch, T., (1998) Story telling: Is it really research? *Journal of Advanced Nursing*, **28** (6): 1182-1190.

Kolivand, M., Almasi, A., and Heydarpour, S., (2014) Comparison between the outcomes of water birth and normal vaginal delivery. *Journal of Midwifery and Reproductive Health,* **2** (4): 220 – 226.

Kralik, K, and van Loon, A., (2008) *Community Nursing in Australia.* Blackwell Publishing: Oxford, UK.

Kvale, S., (2007) *Doing Interviews.* Sage Publications: Thousand Oaks, California.

Kress, G., (1989) *Linguistic Processes in Sociocultural Practice.* Oxford: Oxford University Press.

Labov, W., (1982) Building on empirical foundations. In: Lehmann, W and Malkiel, Y., (eds.) *Perspectives on Historical Linguistics*. Amsterdam/Philadelphia: John Benjamins.

Labov, W, and Waletzky, J., (1967) Oral versions of personal experience. In: Helm, J., (Ed) *Essays on the Verbal and Visual Arts.* Seattle, WA: University of Washington Press.

Laney, E, K., Hall, M, E, L., Anderson, T, L., Willingham, M., (2015) Becoming a Mother: The Influence of Motherhood on Women's Identity Development, *Identity: An International Journal of Theory and Research*, **15** (2): 126-145.

Langellier, K, M, and Peterson, E, E., (2004) *Storytelling in Daily Life: Performing Narrative.* Philadelphia: Temple University Press.

Lankshear, G., Ettore, E., and Mason, D., (2005) Decision-making, uncertainty and risk: exploring the complexity of work process in NHS delivery suites health. *Risk and Society,* **7** (4): 361-377.

Leap, N, and Hunter, B., (2016) *Supporting Women for Labour and Birth: A thoughtful guide.* Routledge: Oxon.

Leboyer, F., (1975) *Birth Without Violence.* London: Mandarin.

Leder, D., (1990) *The Absent Body.* The University of Chicago Press Books: Chicago, USA.

Lee, A, S, M., and Kirkman, M., (2008) Disciplinary Discourses: Rates of Caesarean Section Explained by Medicines, Midwifery and Feminism. *Health Care for Women International,* **29** (5): 448 – 467.

Lee R., (1993) *Doing Research on Sensitive Topics*. Thousand Oakes, CA: Sage.

Letherby, G., (2005) 'Body lore and laws'. *Sociology of Health and Illness,* **27** (4): 546 -547.

Letherby, G., (2003) *Feminist Research in Theory and Practice***.** Open university Press, Buckingham.

Lieblich, A, Tuval-Mashiach, R, Zilber, T., (1998) *Narrative Research: Reading, Analysis and Interpretation.* Sage: London.

Lim, K, M, X., Tong, P, S, Y., and Chong, Y, S., (2016) A comparative study between the pioneer cohort of waterbirths and conventional vaginal deliveries in an obstetrician-led unit in Singapore. *Taiwanese Journal of Obstetrics and Gynecology,* **55** (3): 363-367.

Longhurst, R., (2000) 'Corporegraphies' of Pregnancy: 'Bikini Babes'. *Environment and Planning D Society and Space,* **18** (4): 453-472.

Lothian, J, A., (2004) Do Not Disturb: the importance of privacy during labour. *The Journal of Perinatal Education,* **13** (3): 4-6.

Lukasse, M., Rowe, R., Townend, J., Knight, M., and Hollowell, J., (2014) Immersion in water for pain relief and the risk of intrapartum transfer among low risk nulliparous women: secondary analysis of the Birthplace national prospective cohort study. *BMC Pregnancy and Childbirth,* **14** (60): 1-12.

Lundgren, I, and Dahlberg, K., (1998) Women's experience of pain during childbirth. *Midwifery,* **14** (2): 105-110.

Mammas, I.N., and Thiagarajan, P., (2009) Water aspiration syndrome at birth – a report of two cases. *Journal of Maternal Fetal and Neonatal Medicine,* **22** (4): 365-367.

Marsh, C, A, Browne, J, Taylor, J, and Davis, D., (2017) A researcher's journey: Exploring a sensitive topic with a vulnerable woman. *Women and Birth,* **30** (1): 63-69.

Martell, L, K., (2001) Heading toward the new normal: A contemporary postpartum experience. *Journal of Obstetric, Gynecologic and Neonatal Nursing,* **30** (5): 496-506.

Martin, K, A., (2003) Giving birth like a girl. *Gender and Society,* **17** (1): 54-72.

Martin, E., (1987) *The Woman in the Body: A cultural analysis of reproduction.* Boston, MA: Beacon Press.

Mason, M., (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 11(3), Art. 8, http://nbn-resolving.de/urn:nbn:de:0114-fqs100387 [Accessed: May 1, 2015].

Maternity Care Working Party (2007) *Making Normal Birth a Reality*. NCT/RCM/ RCOG: London.

Maude, R.M., and Foureur, M.J., (2007) It's beyond water: stories of women's experience of using water for labour and birth. *Women Birth,* **20** (1): 17 – 24.

Mauther, N, S., and Doucet, A., (2003) Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology,* **37** (3): 413-431.

Mauthner, N, S., (2002) *The Darkest Days of My Life: Stories of Postpartum Depression.* Harvard University Press: Cambridge Massachusetts.

Mauthner, N., and Doucet, A. (1998). Reflections on a voice-centred relational method: Analysing maternal and domestic voices. In: Ribbens, J., and Edwards, R., (Eds.), *Feminist dilemmas in qualitative research* (pp. 119-146). London: Sage Publications Ltd.

Mauthner, N., (1994) *Postnatal Depression: a relational perspective.* (Doctoral thesis), University of Cambridge.

MacLellan, J., (2015) Healing identity by telling birth stories on the internet. *British Journal of Midwifery,* **23** (7): 180-185.

McAdams, D. P. (2003). Identity and the life story. In: Fivush, R, and Haden, C, A., (Eds.) *Autobiographical memory and the construction of a narrative self: Developmental and cultural perspectives* (pp. 187-207). Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers.

McCosker, H, Barnard, A, and Gerber R., (2001) Undertaking sensitive research: issues and strategies for meeting the safety needs of all participants. *Forum Qualitative Social Research* **2**(1): 1-14.

McIntyre, M., (2012) Safety of non-medically led primary maternity care models: a critical review of the international literature. *Australian Health Review,* **36** (2): 140–147.

Menakaya, U., Albayati, S., Vella, E., Fenwick, J., and Angstetra, D., (2013) A retrospective comparison of water birth and conventional vaginal birth among women deemed to be low risk in a secondary level hospital in Australia. *Women and Birth,* **26** (2): 114 – 118.

Mercer, R, T., (2004) Becoming a mother versus maternal role attainment. *Journal of Nursing Scholarship*, **36** (3): 226-232.

Merriam, S, B., (2009). *Qualitative research: A guide to design and implementation*. San Francisco, CA: John Wiley.

Meyer, S, L., Weible, C, M., and Woeber, K., (2010) Perceptions and Practice of Waterbirth: A Survey of Georgia Midwives. *Journal of Midwifery and Women's Health,* **55** (1): 55 – 59.

Mies, M., (1983) Towards a methodology for feminist research. In Bowles, G and Klein, R., (Eds.) *Theories of women's studies* (pp.117-140). London: Routledge and Kegan Paul.

Miller, T., (2007) "Is this what motherhood is all about?" Weaving experiences and discourse through transition to first-time motherhood. *Gender and Society,* **21** (3): 337-358.

Miller, T., (2005*) Making sense of motherhood: a narrative approach*. Cambridge University Press: Cambridge.

Miller, T., (2000) Losing the plot: narrative construction and longitudinal childbirth research. *Qualitative Health Research,* **10** (3): 309-323.

Mills, M, S., and Stirrat, G, M., (1996) Water immersion and water birth. *Current Obstetrics and Gynaecology,* **6** (1): 35–39.

Mishler, E, G., (1995) Models of narrative analysis: A typology. *Journal of Narrative & Life History,* **5** (2): 87-123.

Mishler, E, G., (1986) *Research Listening: Context and narrative. Cambridge, MA: Harvard University Press.*

Mollamahmutoğlu, L, Moraloğlu, Ö, Özyer, S, Akin Su, F, Karayalçin, R, Hançerlioğlu, N, Uzunlar, Ö, Dilmen, U., (2012) The effects of immersion in water on labor, birth and newborn and comparison with epidural analgesia and conventional vaginal delivery. *Journal of the Turkish-German Gynecological Association,* **13** (1): 45-49.

Montgomery, E., Pope, C., Rogers, J., (2015) A feminist narrative study of the maternity care experiences of women who were sexually abused in childhood. *Midwifery,* **31** (1): 54-60.

Morgan M, Fenwick N, McKenzie C, Wolfe C. (1998) Quality of midwifery-led care: assessing the effect of different models of continuity for women's satisfaction. *Quality in Health Care* **7** (2): 77-82.

Morse, J, M., (1994). Designing funded qualitative research. In Norman K., Denzin & Yvonna S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 220-235). Thousand Oaks, CA: Sage.

Munro, J, and Spiby, H., (2010) 'The nature and use of evidence in midwifery'. In Spiby, H., (Ed.) *Evidence Based Midwifery: Applications in Context.* Chichester: Wiley Blackwell.

National Institute for Health and Care Excellence (2014) *Intrapartum care for healthy women and their babies.* Clinical guidelines. NICE: London. Available at: https://www.nice.org.uk/guidance/cg190/resources/intrapartum-care-for-healthy-women-and-babies-35109866447557

National Institute for Health and Care Excellence (2011) *Caesarean section. Clinical guideline CG132*. NICE: London. Available at: guidance.nice.org.uk/CG132/Guidance/pdf/English

National Institute for Health Research (NIHR) (2016) *Good Clinical Practice (GCP) Reference Guide.* NIHR Clinical Research Network: Leeds.

Nelson, A, M., (2003) Transition to motherhood. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, **32**(4): 465-477

Newburn, M., and Singh, D., (2003) *Creating a better birth environment: Women's views about the design and facilities in Maternity units: A National Survey.* An Audit Toolkit. NCT: London.

NHS England (2017) *Next steps on the NHS Five Year Forward View.* NHS England: London.

NHS England, (2015) *Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for maternity care: National Maternity Review*. NHS England, London.

Nicholls, S., Hauck, Y, L., Bayes, S., and Butt, J., (2016) Exploring midwives' perception of confidence around facilitating water birth in Western Australia: A qualitative descriptive study. *Midwifery,* **33**: 73 – 81.

Nicholls, L., and Webb, C., (2006) What makes a good midwife? Implications for Midwifery Practice. *Evidence Based Midwifery,* **4** (2): 65-70.

Nicolson, P., (1998) *Post-Natal Depression: Psychology, Science and the Transition to Motherhood.* Routledge: London.

Nieuwenhuijze, M, J., de Jonge, A., Korstjens, I., and Lagro-Janssen, A, L, M., (2016) Influence on birthing positions affects women's sense of control in second stage of labour. *Midwifery,* **29** (11): e107-114.

Nightingale, C., (1994) Waterbirth in practice. *Modern Midwife,* **4** (1): 15-19.

Nilsson, C., and Lundgren, I., (2009) Women's lived experience of fear of childbirth. *Midwifery,* **25** (2): e1 – e9.

Nikodem, C., Hofmeyr, G, J., Nolte, A, G, W., and de Jager, M., (1995) *The effects of water on birth: a randomised controlled trial. Proceedings of the 14th Conference in Priorities in Perinatal Care in South Africa 1995;* p163 – 166.

Norhayati, M, N., Surianti, S., and Nik Hazlina, N, H., (2015) Metasynthesis: Experiences of women with severe maternal morbidity and their perception of the quality of health care. *PLoS One,* **10** (7): e0130452.

Nursing and Midwifery Council (2015) *The Code.* NMC: London.

Nutter, E., Meyer, S., and Shaw-Battista, J., (2014) Waterbirth: An integrative analysis of peer-reviewed literature. *Journal of Midwifery and Women's Health*, **59** (3):286–319.

Oakley, A., (2015) Interviewing women again: Power, time and the gift. *Sociology,* **50** (1): 195-213. 1-19

Oakley, A., (1993) *Essays on Women, Medicine and Health.* Edinburgh: Edinburgh University Press

Oakley, A. (1984) *The Captured Womb: A History of the Medical Care of Pregnant Women*. Oxford: Basil Blackwell.

Oakley, A., (1980) *Women Confined: Towards a Sociology of Childbirth*. Oxford: Martin Robertson.

Oakley, A., (1979). *Becoming a mother*. Oxford: Martin Robertson.

Odent, M., (1995) Birth under water: sink or swim (letter). *British Journal of Obstetrics and Gynecology (BJOG),* **102** (1): 81 – 82.

Odent, M., (1992) *The Nature of Birth and Breastfeeding.* Westport CT: Greenwood Publishing.

Odent, M., (1987) The fetus ejection reflex. *Birth,* **14** (2): 104-105.

Odent, M., (1984) *Birth reborn*. New York: Pantheon Books

Odent, M., (1983) Birth under water. *Lancet,* **2** (8365-66): 1476 – 1477.

Office of National Statistics (2017) *Birth characteristics in England and Wales: 2016 (Statistical Release).* ONS Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthcharacteristicsinenglandandwales/2016

Olde, E., van der Hart, O., Kleber, R., van Son, M., (2006) Posttraumatic Stress following childbirth: a review. *Clinical Psychology Review,* **26** (1): 1-16

O'Connell, S., Richley, A., Williams, B., (2012) Northampton homebirth team. *Practising Midwife,* **15** (10): 19-20.

O'Reilly, M, and Parker, N., (2012) "Unsatisfactory saturation": A critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research*, **13**(2): 190-197.

O'Sullivan, S., (ed.) (1987) *Women's Health: A Spare Rib Reader.* Pandora Press: NY.

Otigbah, C, M., Dhanjal, M, K., Harmsworth, G., and Chard, T., (2000) A retrospective comparison of water births and conventional vaginal deliveries. *European Journal of Obstetrics & Gynecology and Reproductive Biology,* **91** (1): 15 – 20.

Page, L., McCourt, C., Beake, S., Hewison, J., Vail, A., (1999) Clinical interventions and outcomes of one-to-one midwifery practice. *Journal of Public Health,* **21** (3): 243–248.

Pagano, E., De Rota, B., Ferrando, A., Petrinco, M., Merletti, M., Gregori, D., (2010) An economic evaluation of waterbirth: the cost-effectiveness of mother well-being, *Journal of Evaluation in Clinical Practice,* **16**: 916-919.

Paliadelis, P., and Cruickshank, M., (2008) Using a voice-centred relational method of data analysis in a feminist study exploring the working world of nursing unit managers. *Qualitative Health Research,* **18** (10): 1444-1453.

Patton, M., (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). Thousand Oaks, CA: Sage.

Pedroso, F., Riesgo, R., Gatiboni, T., and Rotta, N., (2012) The diving reflex in healthy infants in the first year of life. *Journal of Child Neurology,* **27** (2): 168 – 171.

Pinette, M.G., Wax, J., and Wilson, E., (2004) The risks of underwater birth. *American Journal of Obstetrics and Gynaecology,* **190** (5): 1211 – 1215.

Pitchforth, E, Van Teijlingen, E, Watson, V, Tucker, J, Kiger, A, Ireland, J, Farmer, J, Rennie, A, M, Gibb, S, Thomson, E, Ryan, M., (2009) "Choice" and place of delivery: a qualitative study of women in remote and rural Scotland. *Quality and Safety in Healthcare,* **18** (1): 42 -48.

Pitchforth, E, Watson, V, Tucker, J, Ryan, M, Van Teijlingen, E, Farmer, J, Ireland, J, Thomson, E, Kiger, A, and Bryers, H., (2008) Models of intrapartum care and women's trade-offs in remote rural Scotland: a mixed methods study. *British Journal of Obstetrics and Gynaecology,* **115** (5): 560-569.

Pitts, J. (1968) Social control: the concept. In Sills, D.L., (ed) *International Encyclopaedia of the Social Sciences*. New York: Macmillan.

Plint, E., and Davis, D., (2016) Sink or Swim: water immersion for labor and birth in a tertiary maternity unit in Australia. *International Journal of Childbirth,* **6** (4): 206-222.

Plummer, K., (1995) *Telling Sexual Stories: Power, Change, and Social Worlds.* Psychology Press: London.

Polkinghorne, D, E., (2007) Validity issues in narrative research. *Qualitative Inquiry,* **13** (4): 471-486.

Polkinghorne, D, E., (1989a) Phenomenological Research Methods. In: Valle, R, S (Ed.) *Existential-Phenomenological Perspectives in Psychology: Exploring the breadth of human experience* (pp. 41-60). New York, NY, US: Plenum Press.

Polkinghorne, D, E., (1989b) Narrative knowing and the human sciences. *American Journal of Sociology,* **95** (1): 258-260.

Pollock. D., (1999) *Telling Bodies, Performing Birth: Everyday Narratives of Childbirth.* Columbia University Press: USA.

Pope, C, and Mays, N., (2006) Synthesising Qualitative Research (Chap 13) In: Pope, C, and Mays, N., (Eds.) *Qualitative Research in Healthcare.* 3rd edition. Wiley: Oxford.

Potter, J., (1996) *Representing Reality: Discourse, Rhetoric and Social Construction.* Sage Publications: London.

Power, G, G., (1989) Biology of temperature: the mammalian fetus. *Journal of Developmental Physiology,* **12** (6): 295 – 302.

Price, B., (1995) Assessing altered body image. *Journal of Psychiatric and Mental Health Nursing,* **2** (3): 169-175.

Punch, K, F., (2005) *Introduction to Social Research – Quantitative and Qualitative Approaches*. London: Sage.

Quine, W, V, O., (1963) "Two Dogmas of Empiricism". In: *From a Logical Point of View.* New York: Harper and Row.

Ramazanoglu, C, and Holland, J., (2002) *Feminist Methodology: Challenges and Choices.* Sage Publications: London.

Redshaw M., Rowe R., Schroeder L., Puddicombe D., MacFarlane A., Newburn M., McCourt, C, Sandall, J, Silverton, J, and Marlow, N., (2011). *Mapping maternity care: The configuration of maternity care in England Birthplace in England research programme. Final report part 3*. NIHR Service Delivery and Organisation Programme, United Kingdom: HMSO. Available at: http://www.netscc.ac.uk/hsdr/files/project/SDO_FR3_08-1604-140_V04.pdf

Rees, C., (2011) *Introduction to Research for Midwives. 3rd ed*. Churchill Livingstone: London.

Ribbens, J., (1994) *Mothers and their Children: a feminist sociology of childrearing.* Sage: London.

Rich, A., (1979) *On Lies, Secrets and Silence.* W.W Norton Company: US.

Richmond, H., (2003) Women's experience of waterbirth. *Practising Midwife,* **6** (3): 26-31.

Riessman, C, K., (2008) *Narrative methods for human sciences.* Los Angeles: Sage Publications.

Riessman, C, K., (1993). *Narrative analysis*. Newbury Park, CA: Sage.

Riessman, C, K., (1983) Women and medicalization: a new perspective. *Social Policy,* **14** (1): 3-18.

Riley, T., and Hawe, P., (2005) Researching Practice: the methodological case for narrative inquiry. *Health Education Research,* **20** (2): 226-236.

Robertson, A., (2007) *The Midwife Companion: The Art of Support during Birth.* 2nd edition. Sydney: Birth International.

Ros, H, B., (2009) Effects of waterbirths and traditional bedbirths on outcomes for neonates*. Curationis,* **32** (2):46–52.

Rosales, S., Ortiz-Prado, E., Alarcón, D, Rosales, D., and Iturralde, A, l., (2017) A retrospective study of maternal and neonatal outcomes following conventional and waterbirth in Ecuador. *Global Journal of Health Science,* **9** (4): 42-49.

Rosevear, S, K., Fix, R., Marlow, N., and Stirrat, G, M., (1993) Birthing pools and the fetus. *Lancet,* **342** :1048 - 1049.

Ross-Davie, M, and Cheyne, H., (2014) *Intrapartum support: what do women want? A literature review. Evidence Based Midwifery*, **12**(2): 52-58.

Rosser, J., (1994) Is water birth safe? The facts behind the controversy. *MIDIRS Midwifery Digest,* **4** (1): 4 – 6.

Royal College of Midwives (2016) *State of Maternity Services Report 2016.* RCM: London, Available at: https://www.rcm.org.uk/sites/default/files/SoMS%20Report%202016_New%20Design_lowres.pdf

Royal College of Midwives (2012) *Evidence Based Guidelines for Midwifery-Led care in Labour: Immersion in Water for Labour and Birth.* RCM: London. Available at: https://www.rcm.org.uk/sites/default/files/Immersion%20in%20Water%20%20for%20Labour%20and%20Birth_0.pdf

Royal College of Obstetricians and Gynaecologists (RCOG)/The Royal College of Midwives (RCM) (2001) *Joint Statement no 1: Immersion in Water During Labour and Birth*. London: RCOG.

Royal College of Midwives (1994) *The Use of Water During Birth. Position Statement 1a*. Royal College of Midwives; London.

Rubin, R. (1967) Attainment of the maternal role. Part I: Processes. *Nursing Research*, **16**:237-245.

Ruddick, S., (1989) *Maternal Thinking: Towards a Politics of Peace.* Beacon Press: Boston, Massachusetts, USA.

Rudolfsdottier, A. G., (2000) I am not a patient I am not a child: the institutionalisation and experience of pregnancy. *Feminism and Psychology*, **10**: 337-350.

Rush, J, Burlock, S, Lambert, K, Loosely-Millman, M, Hutchison, B, Enkin, M., (1996) The effect of whirlpool baths in labor: a randomised, controlled trial. *Birth,* **23** (3): 136-143.

Russell, K., (2016) *Changing the culture on labour ward to increase midwives promotion of birthing pools: an action research study.* (Doctoral thesis) University of Nottingham.

Russell, K, Walsh, D, Scott, I, and McIntosh, T., (2014) Effecting change in midwives' waterbirth practice behaviours on labour ward: an action research study. *Midwifery,* **30** (3): e96-e101.

Sackett, D, L, Rosenberg, W,M, Gray, J,A, Haynes, R,B, and Richardson, W,S., (1996) Evidence based medicine: what it is and is not. *British Medical Journal,* **312** (7023): 71-72.

Sandall, J, Soltani, H, Gates, S, Shennan, A, Devane, D., (2016) Midwife-led continuity models of care compared with other models of care for women during pregnancy, birth and early parenting. *Cochrane Database of Systematic Reviews 2016,* **Issue 4,** Art. No: CD004667. DOI: 10.1002/14651858. CD004667.pub5.

Sandall, J., (2013) Birthplace in England Research – Implications of New Evidence. *Journal of Perinatal Education,* **22** (2): 77-82.

Sandall, J., Hatem, M, Devane, D, Soltani, H, and Gates, S., (2009) Discussions of findings from a Cochrane review of midwife-led versus other models of care for childbearing women: continuity, normality and safety. *Midwifery,* **25** (1): 8-15.

Sandelowski, M., (2006) 'Meta-jeopardy': the crisis of representation in qualitative metasythesis. *Nursing Outlook,* **54** (1): 10-16.

Sandelowski, M., (2004) Metasynthesis, metastudy, and metamadness. *Qualitative Health Research,* **14** (10): 1357-60.

Sandelowski, M, and Barroso, J., (2002) Reading qualitative studies. *International Journal of Qualitative Methods,* **1** (1): 1-47.

Sandelowski, M, Docherty, S, Emden, C., (1997) Qualitative metasynthesis: issues and techniques. *Research in Nursing and Health,* **20** (4): 365-371.

Sandelowski, M., (1991) Telling Stories: Narrative Approaches in Qualitative Research. *Nursing Scholarship,* **23** (3): 161-166.

Sanders, R, A, and Lamb, K., (2017) Non-pharmacological pain management strategies for labour: Maintaining a physiological outlook. *British Journal of Midwifery,* **25** (2): 78-85.

Sang, K., Al-Dajani, H., and Özbilgin, M., (2013) Frayed careers of migrant female professions in British Academia: An international perspective. *Gender, Work and Organization,* **20** (2): 158-171.

Savage, W., (2007) *Birth and Power: A Savage Enquiry Revisited.* Middlesex: University Press.

Savage, W., (1986) *A Savage Enquiry: Who controls childbirth?* London: Virago.

Sawyer, L, M., (1999) Engaged Mothering: The transition of motherhood for a group of African American women. *Journal of Transcultural Nursing,* **10** (1): 14-21.

Scammell, M, and Alaszewski, A., (2012) Fateful moments and the categorisation of risk: Midwifery practice and the ever-narrowing window of normality during childbirth. *Health, Risk and Society,* **14** (2): 207-221.

Scammell, M., (2011) The swan effect in midwifery talk and practice: a tension between normality and the language of risk. *Sociology of Health and Illness,* **33** (7): 987-1001.

Schafer, R., (2014) Umbilical cord avulsion in waterbirth. *Journal of Midwifery and Women's Health,* **59** (1): 91-94.

Scott, J, W., (1991) The evidence of experience. *Critical Inquiry,* **17** (4): 773-797.

Seidman, I., (1998) *Interviewing as Qualitative Research.* Teachers College Press: New York.

Shelton, N, and Johnson, S., (2006) "I think motherhood was a bit like a double-edged sword": the narratives of older mothers. *Journal of Community and Applied Psychology,* **16**: 316-330.

Silverman, D., (2011) Approaches to Discourse Analysis. In: Whetherell, M, Taylor, S, and Yates, S, J., (Eds) *Discourse Theory and Practice: A Reader.* Sage Publications: London.

Simkin, P, and Bolding, A., (2004) Update on nonpharmacological approaches to relieve pain labor pain and prevent suffering. *Journal of Midwifery and Women's Health,* **49** (6): 489-504.

Simkin, P., (1992) Just another day in a woman's life? Part II: Nature and consistency of women's long-term memories of their first birth experience. *Birth,* **19** (2): 64-81.

Simpson, K, R., (2013) Underwater birth. *Journal of Obstetric, Gynecologic and Neonatal Nursing,* **42** (5): 588-594.

Smith, J., Jaraman, M., & Osborn, M., (1999) Doing interpretative phenomenological analysis. In: Murray, M and Chamberlain, K., (Eds.), *Qualitative health psychology* (pp. 218–240). London: Sage.

Smith, J, A., (1994) Reconstructing selves: An analysis of discrepancies between women's contemporaneous and retrospective accounts of the transition to motherhood. *British Journal of Psychology,* **85** (3): 371-392.

Souza, J, P, Cecatti, J, G, Parpinelli, M, A, Krupa, F, Osis, M, J., (2009) An emerging "maternal near miss syndrome": Narratives of women who almost died during pregnancy and childbirth. *Birth,* **36** (2): 149-158.

Squire, C., (2003) *The social context of birth*. Abingdon: Radcliffe Medical.

Stanley, L, and Wise, S., (1993) *Breaking Out Again: feminist ontology and epistemology*. 2nd edition. Routledge: London.

Stanley, L, and Wise, S., (1990) Method, methodology and epistemology in feminist research processes. In Stanley, L., (Ed.) *Feminist praxis* (pp.20-60). London: Routledge.

Steen, M., Downe, S, Bamford, N, Edozien, L., (2012) Not-patient and not-visitor: a meta synthesis of fathers encounters with pregnancy, birth and maternity care. *Midwifery,* **28** (4): 362-371.

Steinberg, Z., (2005) Donning the mask of motherhood: A defensive strategy, a developmental search. *Studies in Gender and Sexuality,* **6** (2): 173-198.

Stephens, C., (2011) Narrative analysis in health psychology research: personal, dialogic and social stories of health. *Health Psychology Review,* **5** (1): 62-78.

Stewart, M., (2001) Whose evidence counts? An exploration of health professionals' perceptions of evidence-based practice, focusing on the maternity services. *Midwifery,* **17** (4): 279-288.

Stoppard, J.M., (2000). *Understanding Depression: Feminist Social Constructionist Approaches.* London: Routledge.

Stuckley, H, L., (2013) Three types of interviews: Qualitative research methods in social health. *Methodological Issues in Social Health and Diabetes Research,* **1** (2): 56-59.

Takehara, K, Noguchi, M, Shimane, T, Misago, C., (2014) A longitudinal study of women's memories of their childbirth experience at five years postpartum. *BMC Pregnancy and Childbirth,* **14**: 221.

Taylor, H, Kleine, I, Bewley, S, Loucaides, E, and Sutcliffe, A., (2016) Neonatal outcomes of waterbirth: a systematic review and meta-analysis. *Archive of Disease Child, Fetal and Neonatal Edition,* **0**: F1-F9.

Taylor-Gooby, P., (Ed.) (2000) *Risk, Trust and Welfare.* Palgrave MacMillan: UK.

Tew, M., (1995) *Safer childbirth: A critical history of maternity care* (2nd ed.). London: Chapman & Hall.

Torkamani, S, A, Kangani, F, and Janani, F., (2010) The effects of delivery in water on duration of delivery and pain compared with normal delivery. *Pakistan Journal of Medical Science,* **26** (3): 551-555.

Tracy, S, K, Hartz, D, L, Tracy, M, B, Allen, J, Forti, A, Hall, B, Lainchbury, A, Stapleton, H, Beckman, M, Bistis, A, Homer, C, Foureur, M, Welsh, A, Kildea, S., (2013) Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. *The Lancet,* **382** (9906): 1723-1732.

Trahar, S, M., (2013) *Contextualising Narrative Inquiry: Developing Methodological Approaches for Local Contexts.* Routledge: London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1994) *Position Statement on Waterbirths*. Annexe 1 to Registrar's letter 16/1994. UKCC; London: 1994.

Vanderlann, J, Hall, P, J, and Lewitt, M, J., (2018) Neonatal outcomes with water birth: A systematic review and meta-analysis. *Midwifery,* **59**: 27-38.

Van Manen, M., (1997) Researching the lived experience: Human science for an action sensitive pedagogy (2nd ed.). Ontario, Canada: Althouse Press.

Van Stenus, C, Boere-Boonekamp, M, Kerkhof, E, Need, A., (2017) Client satisfaction and transfers across care levels of women with uncomplicated pregnancies at the onset of labor. *Midwifery,* **48**: 11-17.

Varela, V, S, Santos., and Rodrigues, S., (2014) *Immersion and waterbirth: first Portuguese study.* ICM conference: Prague.

Veltman, L, and Doherty, D., (2013) Safety and underwater birth – what every risk manager should know. *Journal of Healthcare Risk Management,* **32** (4): 16-24.

Wagner, M., (1994) *Pursuing the Birth Machine: The search for appropriate technology*. Camperdown, NSW, Australia: ACE Graphics.

Walsh, D., (2012) *Evidence and Skills for Normal Labour and Birth: A Guide for Midwives*. Abingdon: Taylor & Francis Group.

Walsh, D., (2010) Childbirth embodiment: problematic aspects of current understandings. *Sociology of Health and Illness,* **32** (3): 486-501.

Walsh, D., (2007) A birth centre's encounters with discourses of childbirth: how resistance led to innovation. *Sociology of Health and Illness,* **29** (2): 216-232.

Walsh, D, and Downe, S., (2006) Appraising the quality of qualitative research. *Midwifery,* **22** (2): 108-119.

Walsh, D, and Downe, S., (2005) Meta-synthesis method for qualitative research: a literature review. *Journal of Advanced Nursing,* **50** (2): 204-211.

Walsh, M, and Wiggens, L., (2003) *Introduction to Research.* Nelson Thornes Ltd: UK.

Wang, C, C, and Geale, S, K., (2015) The power of story: Narrative inquiry as a methodology in nursing research. *International Journal of Nursing Sciences,* **2** (2): 195-198.

Waters, I., (2011) An ethnography of water birth and its representations on YouTube. *Inquires Journal,* **3** (6): 1-3.

Webb, C., (1992) The use of the first person in academic writing: objectivity, language and gatekeeping. *Journal of Advanced Nursing,* **17** (6): 747-752.

Webster, L and Mertova, P., (2007) Critical Event Narrative Inquiry in Higher Education Quality, *Quality Approaches in Higher Education,* **3** (2): 15-21.

Wengraf, T., (2001) *Qualitative research interviewing: biographic narrative and semi-structured method.* London: Sage Publications

Wenzel, L., and Jabbal, J., (2016) *User Feedback in Maternity Services.* Kings Fund: London. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/User_feedback_maternity_Kings_Fund_Oct_2016.pdf

Wetherell, M, Taylor, S, Yates, S, J., (2001) *Discourse as Data: A Guide for Analysis.* The Open University, Milton Keynes.

Wickham, S., (1999) Evidence-informed midwifery 1: what is evidence-informed midwifery? *Midwifery Today,* **Autumn**: 42–4.

Winterton, N., (1992) *Maternity Services: Second report of the House of Commons Health Committee (The Winterton Report)*. London: HMSO.

Woliver, L, R., (2002) *The Political Geographies of Pregnancy.* Champaign: University of Illinois Press.

Woodiwiss, J., Smith, K., Lockwood, K., (Eds.) (2017) *Feminist Narrative Research: Opportunities and Challenges.* UK: Palgrave Macmillan.

Woodward, J, L., (2011) *The Challenge of Conducting a Waterbirth Randomised Controlled Trial.* Thesis, Doctor of Philosophy: University of Birmingham.

Woodward, J, L., and Kelly, S, M., (2004) A pilot study for a randomised controlled trial of waterbirth versus landbirth. *British Journal of Obstetrics and Gynaecology,* **111** (6): 537-545.

Woodward, K., (2003) Representations of motherhood. In: Earle, S and Letherby, G (eds.) *Gender, identity and reproduction: social perspectives.* Basingstoke, UK: Palgrave Macmillan Ltd.

World Medical Association (WMA) (1964) Declaration of Helsinki. *British Medical Journal,* 1996, **313**. DOI: https://www.bmj.com/content/313/7070/1448.2

Wright, S, and Abdel-Latif, M,E., (2016) Case report of near neonatal drowning associated with underwater birth. *Case Reports in Perinatal Medicine,* **5** (2): 10.

Wu, C, J, and Chung, U, L., (2003) The decision-making experience of mothers selecting waterbirth. *Journal of Nursing Research,* **11** (4): 261-268.

Young, K, and Kruske, S., (2013) How valid are the common concerns raised against waterbirth? A focussed review of the literature. *Women and Birth,* **26** (2): 105-109.

Yuval-Davis, N., (2006) Belonging and the politics of belonging. *Patterns of Prejudice,* **40** (3): 197-214.

Zimmer, L., (2006) Qualitative meta-synthesis: A question of dialoguing with texts. *Journal of Advanced Nursing,* **53** (3): 311-318.

Zinn, J, O., (2008) Heading into the unknown: Everyday strategies for managing risk and uncertainty. **10** (5): 439-450.

Zola, I., (1972) Medicine as an institution of social control. *Sociological Review*, **20** (4): 487–504.

Appendices

Appendix 1

Summary of Empirical Studies

Women's Experiences of Waterbirth

Study reference	Aim	Participants	Method of data collection	Method of analysis	Recruitment, setting, context	Country
Waters (2011)	Aimed to understand the perspectives and experiences of women who chose to give birth in water and post their birth videos publicly on YouTube.	16 parents who had birthed in water and posted a live video of this on YouTube.	Skype audio semi-structured interviews	Thematic	Participants were contacted by the researcher with an invitation letter via their YouTube handle.	USA
Maude and Fourer (2007)	Aimed to give 'voice' to women's experiences of	5 women who had used water for labour and	Interviews	Thematic	Women were recruited from an urban region of New	New Zealand

	using water for labour and birth.	birth at home or in the hospital.			Zealand if they had experienced waterbirth at home or in hospital	
Wu and Chung (2003)	Aimed to explore the decision-making experience of mothers selecting waterbirth.	9 women who had given birth in water in one maternity unit in the past 12 months	Questionnaire Interviews	Giorgi's phenomenological method	Women were recruited if they had experienced waterbirth in one midwife-clinic	Taiwan
Richmond (2003)	Aimed to explore the experiences of women who had birthed in water.	189 women who had experienced waterbirth in one of five birthing centres	Survey questionnaire	Statistical and descriptive analysis	Women were sent a participant invitation letter if they had birthed in water on one of the five UK birthing centres used for the study.	United Kingdom

Midwives Experiences of Waterbirth

Study reference	Aim	Participants	Method of data collection	Method of analysis	Recruitment, setting, context	Country
Plint and Davis, 2016	Aimed to describe and compare attitudes and practices of midwives and obstetric doctors in a tertiary setting regarding water immersion for labour and birth in order to identify strategies to increase bath usage in the facility.	Convenience sample consisting of 62 midwives (49 birth suite and 13 continuity) and 13 obstetricians were recruited (total sample size 124 practitioners = 60% response rate).	Survey Questionnaire (combination of likert scales and open ended questions)	Statistical and descriptive analysis	Midwives and obstetric doctors employed by the tertiary unit were e-mailed a questionnaire and hard copies were available in the clinical areas.	Australia
Nicholls, Hauck, Bayes and Butt, 2016	Aimed to explore midwives' perception of becoming and being confident around	26 midwives	Interviews (16 midwives) Focus group (10 midwives)	Thematic	Registered midwives employed in one of four publicly funded maternity services offering waterbirth in	Western Australia

	facilitating waterbirth.				the metropolitan area of Perth.	
Russell, Walsh, Scott and McIntosh, 2014	Using Action Research it aimed to explore labour ward midwives' practice, knowledge, self-efficacy and levels of social support surrounding waterbirth.	62 midwives (Band 5, 6 and 7) working on the labour ward of one NHS Trust	Survey questionnaire	Statistical and descriptive analysis	All Band 5, 6, and 7 midwives working on the labour ward of one NHS Trust were sent a questionnaire via the internal post system and e-mail.	United Kingdom
Meyer, Weible and Woeber, 2010	Aimed to explore nurse-midwives' perceptions and practices of waterbirth	A convenience sample of 119 certified nurse-midwives (CNM) identified. 53 CNM's responded.	Survey questionnaire	Statistical and descriptive analysis	Members of the American College of Nurse Midwives (ACNM) was used to e-mail a quarter of current or recently active Certified Nurse Midwives (CNM) in Georgia. 45% response rate was achieved.	Georgia, USA

Appendix 2

Summary of thematic analysis

Labour and birth in water: Women's experiences

Analytical themes			
Study reference	Knowledge of waterbirth	Intuitive knowledge of physiological birth	Water, autonomy and control
Waters (2011)	*	*	*
Maude and Fourer (2007)	*	*	*
Wu and Chung, (2003)	*	*	*
Richmond (2003)	*		*

	Analytical themes		
Study Reference	Knowledge and experience of waterbirth	Professional and organisational culture	Confidence in skills
Nicholls, Hauck, Bayes, Butt (2016)	*	*	*
Plint and Davis (2016)	*	*	*
Russell, Walsh, Scott and McIntosh (2014)	*	*	*
Meyer, Weible and Woeber (2010)	*	*	*

Appendix 3

Participant Invitation Letter

Invitation Letter

Study title: Labour and Birth in Water: women's narratives

Invitation to Participate

I am a midwife, lecturer and student at the University of [redacted]. I am completing a Professional Doctorate programme and am currently undertaking an original research study funded by the University of [redacted]. I am conducting a study into the experiences of women who have experienced labour and given birth in water, waterbirth.

Study purpose and what is involved?

You are receiving this information because you have delivered your baby in water. I would really like to know of your experience of labouring and giving birth to your baby in water. You are therefore invited to be involved in this study which will involve one individual interview lasting no more than 90 minutes for which I can visit you in your home or I can arrange a room at the University of [redacted].

Risks and Inconveniences

There are no physical risks to you as a person; you do not have to take part. There may be a risk that due to the emotions you feel when sharing your experience that you may become distressed or upset. If this happens and you want to stop the interview this will be fine. If you feel you would like to discuss your birth experience further then I will be able to give you details of the debriefing service in the unit where you delivered your baby or direct you to the Birth Trauma Association website.

Once the interviews have been typed up I will give you a different name (pseudonym) and will not refer to you, by your real name, or to the NHS Trust maternity unit, at which you delivered your baby. I will use some direct quotations from your interview and although they will be annonymised, due to the small numbers of women who deliver their babies in water, you may be identified by

friends, family members or midwives who were involved in your care; therefore your complete anonymity cannot be guaranteed.

Benefits

Whilst there will be no direct benefit to you taking part in this study, the results I gain from this study will be used to inform future services and practice in supporting and conducting water births.

Costs

You will be reimbursed for any travel expenses (e.g. taxi fare) or parking costs if attending for an interview so that you are not inconvenienced.

Contact

If you are interested in this study or if you would like to find out more about the study, please get in touch with the principal investigator:

Claire Clews
[Insert e-mail address]

Appendix 4

Participant Information Sheet

Participant Information Sheet

Study title: **Labour and Birth in Water: women's narratives**

You are being invited to take part in an original research study which is part of my studies for a Professional Doctorate programme at the University [redacted]. Before you decide whether or not to take part, it is important that you understand why this study is being done and what it will involve. If, having read the following information, you are unclear about any aspect related to this study please feel free to speak direct to one of the University project team.

What is the purpose of the study?

This study is hoping to explore women's experiences of labouring and then giving birth to their babies in water. In choosing to be involved in the study you will provide me with some important information which in turn may help to inform future services and practice in supporting and conducting water births.

Why have we been chosen?

You have been asked to take part in the study because you laboured and delivered your baby in water at [name of NHS Trust] during the time in which I am conducting my research study.

Do we have to take part?

Taking part is entirely voluntary. If you do decide to take part you will be given this information sheet to keep and be asked to give your written consent. You will receive a copy of your signed consent form. If you decide to take part you are free to withdraw at any time without giving a reason. Any information or responses you may have already given will be destroyed.

What will my participation involve?

If you agree to be involved in the study this will mean you will be invited to take part in a single interview, any time before your baby reaches six months of age.

An interview will be tape-recorded and last for approximately 45 minutes up to a maximum of 90 minutes (one and a half hours) in length. I will ask you about your experience of giving birth in water and then you will be free to tell me your experience without interruptions. At the end of the interview I may ask you to clarify anything that I am not clear about. The interview can take place in your home (I will travel to you) or I can arrange a room at the University. If this is your preferred choice we will be able to provide a taxi if your require one, to collect and return you to and from your home or, if you are driving we will reimburse any car parking costs you may incur.

What are the possible benefits of taking part?

Whilst there will be no direct benefit to you taking part in this study, the results I gain from this study will be used to inform future services and practice in supporting and conducting water births.

What are the possible risks or disadvantages of taking part?

There are no physical risks to you as a person; you do not have to take part in this study. There may be a risk that due to the emotions you feel when sharing your experience that you may become distressed or upset. If this happens and you want to stop the interview, this will be fine. If you feel you would like to discuss your birth experience further then I will be able to give you details of the debriefing service at the [name of the NHS Trust] where you delivered your baby or direct you to the Birth Trauma Association website.

What if something goes wrong?

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact the Director of Studies [contact details] or supervisor [contact details] for the study.

As well as a research student with the University of [redacted], I am also a Midwife registered with the professional regulatory body called the Nursing and Midwifery Council. I am therefore duty bound to act in a professional manner at all times, including when undertaking research. This could therefore mean that if, during your interview about you labour and birth in water, you disclose poor clinical practice then I have a professional responsibility to report this to the

Head of Midwifery at [insert NHS Trust name]. I will also be able to provide you with information regarding how to use the formal complaints procedure at [insert NHS Trust name].

Will my taking part in this study be kept confidential?

All the interviews will be tape recorded on a digital recorder. Once I have finished the interview I will type up your story of labour and giving birth in water. Once I have done this I will erase the recording from the digital recorder and the record of the interview (transcription) will then be held on the main IT server at the University of [redacted].

Once the interviews have been typed up I will give you a different name (pseudonym) and will not refer to you, by your real name, or to the NHS Trust maternity unit, at which you delivered your baby. I will use some direct quotations directly from your interview and although they will be anonymised, due to the small numbers of women who deliver their babies in water, you may be identified by friends, family members or midwives who were involved in your care; therefore, your complete anonymity cannot be guaranteed.

Will we be informed of the results of the research study?

If you would like to receive a copy of the study summary this can be sent to you, please make the researcher aware of this when you are completing your consent form.

What will happen to the results of the study?

A final report and full results of the research study will be presented as part of my Professional Doctorate programme. It is expected that the results will be published in a peer-reviewed journal such as the British Journal of Midwifery so that midwives can learn from your experiences. The NHS Trust and Head of Midwifery at [insert NHS Trust name] where you delivered your baby will also receive a full copy and summary of the study at the end of the research. A summary of the study may also be sent to other interested organisation such as the local National Childbirth Trust (NCT).

Who is organising the study?

The University of [redacted] is organising this study.

Who is funding the research?

The University of [redacted] is funding this study.

Who has reviewed the study?

This study has been reviewed by the University Ethics Committee at the University of [redacted]. The study has also gained full ethical approval from the National Research Ethics Service (reference number: 15/EM/0068) and from the [insert NHS Trust name] research governance committee.

Contact for further information

Principal Investigator:

Claire Clews

Professional Doctorate Student

[Insert e-mail address and telephone number]

Thank you for considering taking part in this study.

Appendix 5

Ethics Committee Approval

NHS
Health Research Authority

NRES Committee East Midlands - Leicester
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Tel: 0115 883 9436

19 February 2015

Claire Clews
University of Northampton
Boughton Green Road
Northampton
NN2 7AL

Dear Ms Clews

Study title:	**How are women's stories of labour and birth in water constructed to reflect meaningful experiences of the journey into motherhood?**
REC reference:	**15/EM/0068**
IRAS project ID:	**153853**

Thank you for responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion, but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, nrescommittee.eastmidlands-leicester@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Appendix 6

CONSENT FORM

Project title: **Labour and birth in water: women's narratives.**

Principal Investigator: **Claire Clews**

This form should be read in conjunction with the participant information sheet provided.

Please read the following statements and **sign your initials in the box** to show that you have read and understood them and that you agree with them.

		Please initial box
1.	I confirm that I have read and understand the information sheet [insert date and version number] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2.	I understand that my involvement 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 the information I disclose will remain confidential but that relevant sections of my data collected during the study may be looked at by responsible individuals from the sponsor, from the regulatory authorities or from the NHS trust, where it is relevant to my taking part in this research. I give permission to these individuals to have access to my records.	
4.	My data will not be identifiable by anyone other than the research team and all reasonable steps will be taken to ensure that my personal information is kept confidential.	
5.	I understand that the interview I have agreed to will be audio recorded using a digital recording device and that once this has been transcribed this recording will be deleted and the written record will be kept on the main IT server at the University until 2020 (at which point they will be deleted).	

6.	I understand that that direct quotations from my interview will be used for publication purposes once the study has been completed. Whilst they will be anonymised, with use of a pseudonym, I may still be identified by friends, family and the midwives who cared for me during the birth.	

Please tick the box if you would like to receive a summary of the study and provide an e-mail contact below where this can be sent to once the study has been completed. ☐

E-mail address:……..

Participant's statement:

I agree to take part in the study.

_____	_____	_____
Your name	Date	Your signature

Researcher's statement

I confirm that I have explained the nature, purposes and possible effects of the research study to the person whose name is printed above. They agreed to take part by signing and dating above.

_____	_____	_____
Name of person taking consent	Date	Signature