

Full citation

Hallam, J., Howard, C., Locke, A. & Thomas, M. (2016). Communicating choice: an exploration of mothers' experiences of birth. *Journal of Reproductive and Infant Psychology*. 175-184. DOI: 10.1080/02646838.2015.1119260

Abstract

Birth is a significant life event for many women that can have profound, long lasting effects on how they see themselves as women and mothers. Within the literature the importance of control over the birth experience and the support that the birthing woman receives from midwives is stressed. This paper gives an in-depth insight into the ways in which communication between midwives and the birthing woman shape the birth experience. Six women who had recently given birth participated in one to one semi-structured interviews designed to explore the kinds of support they received before, during and after their birth. An inductive thematic analysis was employed in order to identify and explore key issues which ran throughout the interviews. Within the interviews the importance of being an active mother, someone who made decisions in relation to her labour, was stressed. The analysis explores the ways in which communication style and compassionate care either enabled or prevented women from adopting the position of 'active' mother. It is argued that a personal connection with midwives and clear and open communication which places the birthing woman in a position of control are key to positive birth experiences.

Keywords: *birth, active mother, qualitative methods*

Introduction

Women vividly remember their first birth experience with some suggesting that many years after the event their memory of it can shape how they see themselves as women and mothers (Simkin, 1992). The importance of supporting women and promoting a good birth experience is reflected in the growing academic interest in this area and health policy surrounding respectful, women centred care in childbirth (Cipolletta & Sperotto, 2012; NICE, 2010).

One of the key factors that effects women's perception of birth is the 'control' they feel over their birth experience (Kendall-Tackett, 2005). Control is a subjective experience but Green and Baston (2003) draw a distinction between the control the woman has over her body (internal) and the control she has over medical staff and decisions made in relation to her labour (external). Midwives play a pivotal role in shaping women's birth experiences and the support they offer can enable women to achieve external control (Gibbins & Thomson 2001; Larkin, Begley & Devane, 2012). Support, in this sense has been defined as "the presence of an empathetic person who offers advice, information, comfort measures, and other forms of tangible assistance to help a woman cope with the stress of labor and birth" (Hodnett et al., 2002, p. 1374). This highlights the importance of providing information *and* emotional support. MacKinnon, McIntyre and Quance (2003) reported the benefits of medical staff responding intuitively to the birthing woman and ensuring that she is actively involved in the decisions made during her labour. This means offering individualised care which supports the birthing woman's choices in relation to levels of medical intervention (Lundgen, 2005).

A need for individualised care and respect for the birthing woman's wishes requires highly developed interpersonal skills from midwives (Corbett & Callister, 2000). Such skills are central to establishing good relationships during the birthing experience. Midwives are often

remembered for offering support, encouragement and keeping the birthing woman informed (Hall & Holloway, 1998). As such, a supportive care environment which offers the birthing woman control is key to a positive birth experience (Knapp, 1996) and emotional well-being (Green & Batson, 2003).

The interaction between control and communication is neatly captured in Cipolletta and Sperotto's (2012) qualitative research which explored the hospital birth experiences of Italian women. These women reported that feelings of fear and pain were associated with a loss of internal control. For some women a trusting relationship with their midwife which involved following instructions and handing over external control was key to managing their labour and regaining overall control. However, it is important to note that this handover of external control was considered to be part of a collaborative relationship between the woman and her midwife based on a compassionate, human approach. Lack of a caring relationship, often aligned with their gynaecologists, was associated with negative birth experiences and feelings of passively following instructions.

In a UK context, the importance of women centred birth is reflected in the introduction of the 6 C's (Care, Compassion, Competence, Communication, Courage and Commitment) policy which is designed to encourage midwives to deliver "compassionate care" (Department of health, 2012). This combined with NICE (2010) guidelines which state that "Women should always be treated with kindness, respect and dignity. The views, beliefs and values of the woman in relation to her care and that of her baby should be sought and respected at all times" aims to move midwifery towards women centred care. Given the significance that childbirth has for many women, this paper uses qualitative methods to explore women's birthing experiences. A specific aim is to further explore how the relationships between women and midwives shape the maintenance of control during labour and the birth experience itself.

Methods

The data analysed in this paper are taken from a larger, ongoing community psychology project working with the Positive Birth Movement (PBM). The PBM is a community group established by Milli Hill in 2012 with the aim of informing women of their birth choices, sharing positive birth stories and offering support for women during and after their pregnancy. The group is a non-profit organisation and all pregnant women, mothers and birth professionals are invited to attend monthly meetings, guided by specific discussion topics, held in their local area free of charge. Meetings are led by facilitators who come from a wide range of backgrounds, some are trained doulas (women who offer support during pregnancy and birth) and midwives whereas others are women who are passionate about birth and want to offer support to women in their community. Currently, there are 170 groups within the UK and a number of groups worldwide. Each group receives centralised support from the PBM webpage and regional groups often set up their own social networking pages to advertise the group and share information.

Recruitment procedure and participant information

In line with a community psychology approach, which positions participants as experts, the first and second authors worked closely with a branch of the PBM and sought to bring about positive change by exploring women's birth experiences. After the project was approved by the University's Psychology Research Ethics Committee the coordinator of the chosen branch of the PBM (and the fourth author), was trained as a researcher by the first and second authors. The fourth author recruited participants by posting information about the project with an open invitation to participate on the PBM social networking forum. Six women expressed interest and participated in a semi-structured interview facilitated by the fourth author. During the interview the women discussed (i) their birth experiences in relation to

the support they received before, during and after the birth and (ii) how they came to join the PBM and their experiences of the group. The interviews were between an hour and two hours in length. All the interviews were transcribed verbatim after they were conducted. Transcription during the data collection process enabled the research team to monitor the data collected by reviewing the narratives that were emerging from the interviews. Adopting this approach allowed the research team to ensure a range of birth narratives were captured during data collection. Once a rich and diverse set of birth stories were collected, the research team were able to stop data collection as no new or novel narratives were emerging. As detailed below in Table one, many of the women had first encountered a hospital birth they felt unsatisfied with and this led them to give birth at home or in a birthing centre for their second pregnancy. There are two notable exceptions - Alison had two traumatic emergency caesareans and Teresa had a positive hospital birth. The diversity within the group and the women's ability to explore differing experiences resulted in rich birth narratives which enabled an exploration of differing approaches to birth.

Participant pseudonym	Age	Details of birth experience(s)	Involvement with the PBM
Sarah	32	5 year old child born vaginally in hospital 8 month infant born vaginally at home	Supported by the PBM through her second pregnancy
Harriette	39	4 year old child born with the aid of ventouse in hospital 16 week infant born in a birth pool in a birth centre	Supported by the PBM through her second pregnancy
Teresa	35	17 month infant born vaginally in hospital	Now pregnant with a second child and regularly attending PBM

			meetings
Jessica	25	4 year old child born vaginally in a birth centre 11 month infant born in a birth pool at home	Joined the PBM after the birth of her second baby
Vicky	32	3 year old child born with the aid of ventouse in hospital 18 month infant born vaginally at home	Supported by the PBM through her second pregnancy
Alison	33	4 year old child born by emergency caesarean section in hospital 17 month infant born by caesarean section	Joined the PBM after the birth of her second baby

Table one. A table to show participant information.

Analytic approach

The interviews were collected together to form a data corpus and analysed using thematic analysis. Thematic analysis aims to identify a “patterned response or meaning within the data set” which captures “something important about the data” (Braun & Clarke, 2006 p. 82).

The themes presented in the analysis were identified using an inductive, data driven approach in which the data corpus was approached without a specific hypothesis in mind (Frith & Gleeson, 2004). Themes were identified using the six stages of thematic analysis (Braun & Clarke, 2006). Initially, the first author read through the data corpus a number of times to identify codes (reoccurring issues within the interviews). Extracts from the interviews for each code were gathered together to establish their prevalence and at this point codes with limited evidence were discarded. Mind maps were then used to explore the relationships between the remaining codes and this lead to the identification of key themes

running throughout the data corpus. These themes were reviewed to ensure that they told a coherent story which fairly represented the birth narratives. Finally, extracts that best represented each theme were selected for close analysis. At this point the second, third and fourth authors reviewed the themes and analysis to ensure credibility.

Findings

Within the interviews the importance of being an active mother, someone who sought 'external' control and made decisions in relation to her labour, was stressed. The following analysis explores the ways in which communication occurred (summarised below) with health professionals during labour and the extent to which this enabled or prevented the birthing women to take the position of active mother.

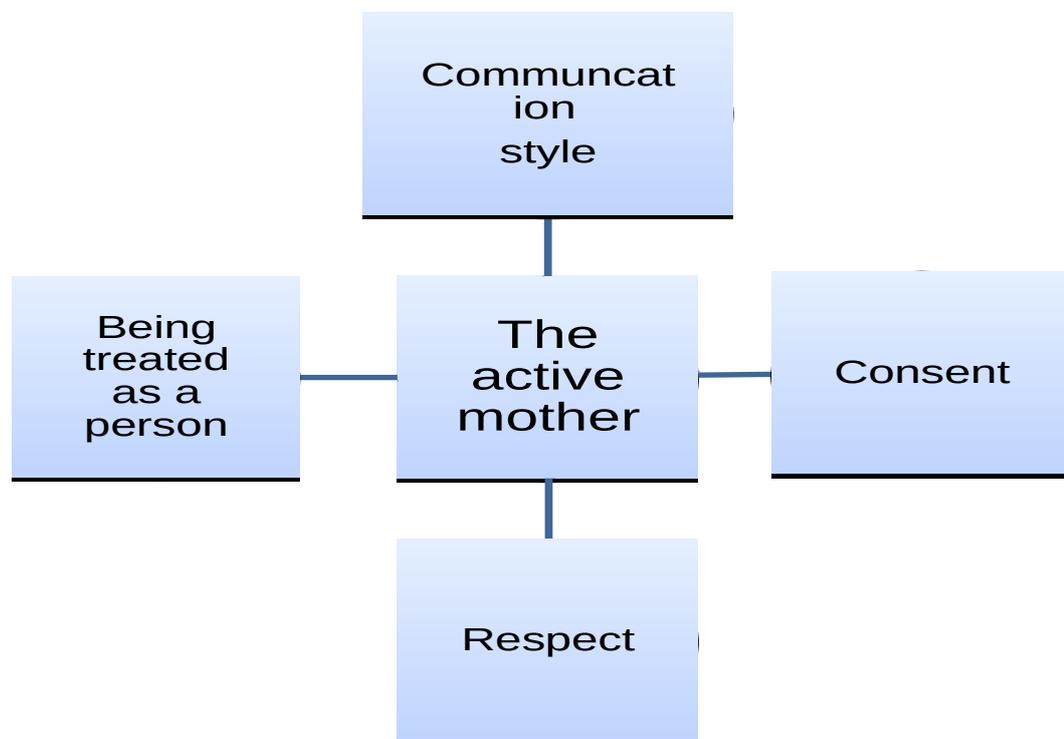


Diagram one: Pertinent issues explored the in the analysis.

Supporting the active mother

The ways in which communication occurred with the mother played an integral role in shaping the birth experience. Good practice was aligned with giving the woman choice and clearly explaining her options. This is explored below in Teresa's account which focuses on the importance of consent. Teresa was the only mother interviewed who had one child and this child was born through a vaginal delivery in hospital.

"They explained very well, they explained what they were doing erm, they always gave me a choice, they never did an internal without my permission erm, they never took Emma away from me without my permission erm, in fact they actually helped me with establishing breastfeeding, kind of like, can I touch you? Is that alright? They never just kind of man handled me, which I've heard of, so no, I'd say actually the level of service I got from the midwives was pretty high."

Teresa's account of a *pretty high level of service* highlights the importance of information, choice and consent. The first section of the quote presents a situation where Teresa was well informed about her choices and what was happening during her labour. The open and clear communication style adopted by midwives is aligned with high levels of external control as Teresa presents herself as someone who was able to play an active role in making key decisions. Repeated use of the word *permission* firmly places Teresa in a position of control in relation to what happened to her body and her baby. Furthermore, her suggestion that action was *never* taken without clear consent suggests that a respectful boundary between the midwives, mother and baby was consistently maintained. Further issues relating to consent that arose throughout the interviews will be returned to later on in the article but first we will further consider how the women linked their positive experiences in hospital to receiving support and compassion from health professionals. Given all of the current interest in midwife led care, birthing centres and home births, the next quote from Jessica that recounts a delivery in a birthing centre, also notes the importance of supportive communication in which a personal connection was established between mother and midwife.

“At the time I think I felt quite comforted by the fact that there were people there to take-over, to help me and they were really nice people, they kept saying really positive things, you know, they kept calling me a “super star” which makes me laugh now but it was really nice at the time because it felt like I was doing well and I was being supported and they were pleased and everything was going well.”

Jessica’s experience demonstrates the importance of receiving emotional support during labour. Midwives are referred to as *people* and this indicates that Jessica was able to relate to them as fellow human beings and not a faceless mass of health professionals. The positivity of the midwives and the support of being called a *super star* positions them as a team who showed an interest in Jessica’s birthing experience and offered her *comfort*.

For many of the women respect and support for their birthing choices was connected to a positive birth experience and enabled their constructions of being an ‘active mother’. The final two quotes in this section highlight the importance of respect. In the quote below, Sarah discusses her first birth which took place in hospital.

“We made a decision to come off all the monitors and go into the bathroom so I could refocus and get away from everything and she actually, although, I got the impression she didn’t 100% agree with what we were doing, she did spend a lot of time on her hands and knees in the bathroom with a hand held Doppler listening to Molly’s heartbeat because the consultants were saying that the heart beat was dropping and they wanted me to be on continuous monitoring. So she did support us in that way.”

Sarah discusses how continuous monitoring in a busy birthing environment was breaking the inward focus she needed to cope with the demands of her labour. Importantly, the midwife is positioned as a successful advocate as she found a way to support Sarah’s wishes without directly enforcing the consultant’s requirements upon her. Consequently, traditional patient/healthcare professional power relations were disrupted and Sarah was able to make important decisions relating to her birth.

The importance of the mother's wishes being respected and acted upon is documented in a quote from Teresa below.

"She says to me, 'have you got a birth plan?' I said, 'actually, I didn't write one on purpose because I felt that I'm very much a planner and quite organised and if it all went like against my birth plan then I'd be really disappointed with myself erm, and I think that would negatively affect my experience', so she said, 'fine, what do you want and don't want?' I said, 'what I don't want, I'd like to have a natural third stage, I don't really want any pain relief erm, and I want to deliver as naturally as possible plus I'd like to stay in here if possible', and obviously she said, 'fine, that's ok, we'll try and do that'. So I was like great."

Teresa constructs an empowering birth experience in which her requests were listened to and taken seriously by the midwife. Throughout the quote the midwife is positioned as someone who had good interpersonal skills and used these to quickly establish a bond of trust. The midwife accepts all of Teresa's requests without question *'we'll try and do that'*. Use of the word *we* is noteworthy as its inclusive function suggests that Teresa will be working closely with the midwife during her birth. This breaks down potential barriers between 'us' (the birthing mothers) and 'them' (healthcare professionals). Teresa is placed on an equal footing with the healthcare professionals and was able to play an active role in her birth experience.

This section of the analysis has explored the role that interactions with midwives and a personalised level of care have in shaping a positive birth experience. An open and informative communication style that built a trusting relationship was presented as central to facilitating the active mother. In addition to this the importance of emotional support and a personal connection between the birthing mother and midwife were also explored.

Restricting the active mother

Whilst we found examples of good communication that encourages the 'active' nature of the women during birth, we also had reports where this was not the case, as reflected elsewhere

in the literature (Rance, et al., 2013). Some women reported that they did not feel as though they were listened to or able to give consent during birth. In the quote below, Vicky discusses issues around consent during her first labour (ventouse, delivery in hospital).

“I was really, really struggling to cope because as I say the epidural didn’t work, the midwife didn’t believe me, that it wasn’t working. She started to get quite short with me, erm, finally managed to convince her that it wasn’t working and she turned up the drip erm, without my consent, I was asking for her to turn it off actually and she actually turned it up.”

Traditional patient/healthcare professional power relations are evident here and played a central role in action being taken without Vicky’s consent. Throughout this quote the midwife is presented as a healthcare professional whose medical knowledge over-rides the reported experience of the birthing mother. Vicky’s suggestion that *finally managed to convince* the midwife that her epidural was not working indicates that considerable work and effort was required to get her voice heard. This positions the midwife as an uncaring professional who undermined Vicky’s experience and placed her in a powerless position.

Vicky’s passive position is further reinforced when a drip was turned up *without consent*. The statement that the midwife *actually turned it up* constructs a sense of surprise that her wishes had not been respected. This highlights the importance of consent, if consent is not given then the birthing mother is denied control over her birth experience. This is pertinent as a lack of control is aligned with negative birth experiences and birth trauma (Kendall-Tackett, 2005). This lack of control and the absence of a supportive birthing advocate, who seeks to establish a personal connection with the birthing woman, is explored in the quote below from Harriette.

“The midwives when I was actually in labour, I just don’t feel were supportive at all. They were just, you know, doing their job and you might as well have been going in there with bunions and been under a general anaesthetic for the real, genuine heart to heart

engagement with you that they had. You know, nobody like held your hand or was just there for you in the way that you need, you know.”

The birthing experience is likened to a mundane medical procedure which did not reflect the life changing event Harriette was experiencing. Throughout the quote the midwives are positioned as uncaring professionals who did not offer emotional support in the form of *heart to heart engagement* or physical support in form of *holding* Harriette's *hand*. The suggestion that *nobody* offered the care *needed* constructs an extreme situation in which all the midwives present failed to provide a physical and emotional connection which she presents as an essential part of good care. Furthermore, in this section of the excerpt generic use of the term *you* widens out the importance of a supportive birth environment beyond Harriette's personal experience to all birthing women. The absence of a supportive birthing environment is used to construct a sense of disappointment and dissatisfaction.

The final quote from Alison (who had emergency caesareans in both her birth experiences) goes on to further explore the importance of support, respect and consent.

“Because I did think that is there was gonna be somebody supportive it would be a midwife. It would be one of them who would stand up for me or give me a voice, or let me speak, or do something but they, they were worse because they were the ones who just pinned me back down or shut me up with an oxygen mask on my face.”

Within the interviews there was a shared understanding that the midwife would act as the birthing mother's advocate during labour and ensure that her birth plan was honoured.

However, this was not always the case as Alison constructs a feeling of betrayal by contrasting the midwife's role as advocate and someone who would *stand up for me* with the care she received. Midwives are positioned as professionals who used physical force to control Alison. In addition to this an *oxygen mask* is likened to a gag which was used to *shut up* the birthing mother. Therefore, the midwives are positioned as professionals who sided

with the medical staff and actively worked against Alison and her wishes, thus ensuring that she had no control over her birth experience.

This section of the analysis has examined the importance of informed consent and the midwife adopting the position of the birthing mother's advocate. Midwives who did not listen to the birthing woman or gave her chance to get her voice heard were positioned as uncaring professionals who prevented the woman from taking an active role in their birth.

Discussion

Although this was a small scale study which relates to a specific group of women, the analysis has highlighted a number of important issues for further consideration. Within the analysis there was an exclusive focus on external control and maintaining this control was conceptualised as the key to a good birth experience. This is noteworthy as it contrasts with Cipolletta and Sperotto's (2012) findings which suggested that loss of internal control was an issue for birthing women and that for some women giving up external control was the gateway to a positive birth. Consequently, this analysis goes some way to examining the subjective experiences of control and how this concept is conceptualised across different cultural contexts. Furthermore, an in-depth exploration of women's experiences of control builds upon Green and Baston's (2003) questionnaire based research by examining how control manifests itself during the birthing process and how it can be facilitated and restricted.

When discussing external control the women emphasised the centrality of interpersonal communication. Successful communication was presented as being the foundation of consent and respect. This focus highlights the importance of power relationships during birth and the role that midwives have in creating a respectful birthing environment. As in Cipolletta and Sperotto's (2012) research the women positioned the midwives as being different from consultants. In positive birth accounts midwives were positioned as advocates whose open communication style which clearly presented birthing choices enabled a bond of trust to be

developed with the birthing mother. Within this collaborative relationship the midwife disrupted traditional patient/health professional power relationships and actively worked to ensure that the woman approached her birth from an empowered position in which her wishes, rather than consultant requests, were honoured. Failure to listen to the birthing mother reinstated traditional power relations and placed the midwife on the side of the consultants - this created a clear an 'us' and 'them' division where women were denied the opportunity to give informed consent and adopt the position of active mother.

The analysis also investigated the role that communication plays in providing emotional support and personalised care during labour. This analysis illustrated that emotional care also extended to being treated as a person during the birthing process. Birth was conceptualised as a special experience which required a personal connection to the midwives and medical staff present. Power also shaped the ways in which support was conceptualised as mothers reported that support for their birth choices was an essential part of compassionate care.

In conclusion, the focus on external control, emotional support and personalised care stressed the role that midwives' communication style plays in providing a compassionate and woman centred birth. It also highlighted the significance of the 6 C's policy and the potential impact this could have in reducing birth trauma. The analysis demonstrated the importance of "empathy, respect and dignity" (compassion), "the ability to understand an individual's health and social needs" (competence), "no decision about me without me" (communication) and "doing the right thing for the people we care for and to speak up when we have concerns" (courage) as outlined by the Department of health (2012). The experiences presented in this analysis illustrate how concepts integral to the 6 C's result midwives either getting it 'right' or 'wrong'.

Given the current financial pressures and staffing issues that are currently being placed on the NHS within the UK, there is a danger that compassionate care which implements the

6C's policy could be reduced leading to an increased number of negative birth experiences and possible trauma. This indicates that local midwifery services would benefit from having a meaningful dialogue with mothers about their birth experiences. Such communication could serve to reinforce the importance of interpersonal skills and the kinds of support that women find useful. Furthermore, this dialogue could inform training and professional development for midwives.

References

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.

Cipolletta, S., & Sperotto, A. (2012). From the hospital organization to the childbirth practice: Italian women's experiences. *Journal of Reproductive and Infant Psychology*, 30:3, pp3 26-336

Corbett, C.A. , & Callister, L.C. (2000).Nursing support during labor. *Clinical Nursing Research* 9, pp. 70–83.

Department of health (2012). Compassion in practice. Nursing, midwifery and care staff our vision and strategy. Retrieved from

<http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf>

Frith, H. & Gleeson, K. (2004). Clothing and embodiment: men managing body image and appearance. *Psychology of Men and Masculinity*, 5(1), 40-48.

Gibbins, J., & Thomson, A.M. (2001).Women's expectations and experiences of childbirth. *Midwifery* 17, pp.302–313.

Green, J.M., Baston, H.A. (2003). Feeling in control during labor: concepts, correlates, and consequences. *Birth* 30, pp. 235–247. Hall S.M., Holloway I.M., (1998). Staying in control: women's experiences of labour in water. *Midwifery* 14 pp. 30–36

Hodnett, E. (2002). Caregiver support for women during childbirth (Cochrane review). In *The Cochrane Library, Issue 2*. Oxford, UK: Update software.

Kendall-Tackett, K.A. (2005). Trauma associated with perinatal events: Birth experience, prematurity, and childbearing loss. In K.A. Kendall-Tackett (Ed.) *The handbook of women, stress and trauma* (pp. 53–74). New York: Taylor & Francis.

Knapp, L. (1996). Childbirth satisfaction: the effects of internality and perceived control. *Journal of Perinatal Education* 5, pp. 7–16.

Larkin, P., Begley, S., & Devan, D. (2012). 'Not enough people to look after you': An exploration of women's experiences of childbirth in the Republic of Ireland. *Midwifery*. 28 pp. 98–105

Lundgren, I. (2005). Swedish women's experience of childbirth 2 years after birth. *Midwifery* 21, pp. 346–354.

MacKinnon, K., McIntyre, M., Quance, M., (2003). The meaning of the nurse's presence during childbirth. *Journal of Obstetric Gynecological and Neonatal Nursing* 34, pp. 28–36.

NICE (2010). Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. *NICE guidelines [CG110]*. Retrieved from <https://www.nice.org.uk/guidance/cg110/chapter/Woman-centred-care>

Rance, S., McCourt, C., Rayment, J., Mackintosh, N., Carter, W., Watson, K. and Sandall, J. (2013). Women's safety alerts in maternity care: is speaking up enough?. *BMJ Quality and Safety*, doi: 10.1136/bmjqs-2012-001295

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 experiences. *Birth*, 19, pp. 64–81