FEELING LIKE A GENIUS:
ENHANCING WOMEN’S CHANGING EMBODIED SELF DURING FIRST CHILDBEARING

Submitted by
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STATEMENT OF ORIGINALITY

The thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to this copy of my thesis, when deposited in the University Library, being made available for loan and photocopying subject to the provisions of the Copyright Act 1968.

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SCHOLARSHIPS AND AWARDS RECEIVED DURING THIS RESEARCH

An Australian Postgraduate Award: Approximately $21,000 per annum was awarded in January 2002; following an extension it terminated in June 2005.

Australian Midwifery Scholarship Fund: $5500.00 awarded in August 2003 to support research. This award contributed to the cost of an audio-typist who transcribed interviews.

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PUBLICATIONS ARISING FROM THIS RESEARCH

Book

Book chapters


Refereed journals


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**Invited presentations**

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DEDICATION

Housewife Poet

There is a force
a power in me
compulsed to move expressively
in language
from my inner being

the senses tremble furiously
as mind unleashes catalysts
of enquiry and desire
to know itself.

And I,
this body dominated
by worldly commitments
must crush this spark
and shudder as I quench
the flame of my identity

And I,
this mind
modified to mediocrity
scream my cowardice
with shame

Anne Parratt

I dedicate this dissertation to my mother the Housewife Poet.
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ABSTRACT

Background
The traditional way of considering childbearing change has been to conceptualise the role of the woman as ‘becoming a mother’ and the role of the midwife in that view is to help the woman become a mother. Contemporary midwifery efforts aimed at empowering women toward positive birth experiences are based on incorrect or incomplete assumptions that limit the theory and practice of midwifery.

Question and aim
‘How does a woman’s embodied sense of self change during the childbearing period and what factors in the childbirth experience seem to be positively related to her improved sense of self’. The aim is to create theory about how to enhance women’s embodied self during childbearing.

Methodology
The research is explicitly feminist and post-structural. The fourteen primigravid participants planned normal birth in diverse settings. Personal narratives, survey research and grounded theorising guided data collection, analysis and theorising. Data was gathered via questionnaires and in-depth interviews at three time points, one antenatal and two postnatal.

Key findings
During childbearing, a woman’s sense of self is improved when she has an enhanced capacity to feel herself as an embodied whole and intrinsically powerful person. The concept ‘genius change’ represents a woman’s active and effortful use of intrinsic power. It also refers to a woman’s developing trust in her intrinsic power.

Midwifery factors that are unsupportive of a woman’s improved sense of self are termed ‘habitual practices’. These habitually undertaken practices undermine a woman’s sense of her own power and encourage reliance on her usual responses to change. ‘Empowering practices’ are positively related to a woman’s improved sense of self. These practices guide a woman to connect with and actualise her intrinsic power in new and previously unanticipated ways.

Significance
This research is significant for childbearing women because an enhanced sense of embodied self during first childbearing provides a strengthened foundation from which a woman can approach future changes in childbearing and throughout life.

The resultant theory is significant for midwifery practice and education because it makes explicit how a midwife can optimise a woman’s psychophysiological wellbeing in ways that uniquely suit the diverse requirements of each woman.
CHAPTER ONE: INTRODUCTION

The research reported in this dissertation considers women’s holistic wellbeing in terms of their embodied sense of self. It has been guided by the research question ‘How does a woman’s embodied sense of self change during the childbearing period and what factors in the childbirth experience seem to be positively related to an improved sense of self?’ This chapter provides an introductory framework and definition of key terms. Section 1.1 introduces the key terms and key theoretical ideas that have influenced this study. In section 1.2 the background context of the study is discussed. Currently known influences on women’s changing sense of embodied self in childbearing are described. Then, in section 1.3 I present an overview of my own background and a synopsis of my previous research featuring the pilot to this present project. Lastly, section 1.4 describes the project’s significance followed by a brief outline of the remaining chapters and appendices. A list of terms introduced in this chapter is included in table 1.1 (pp.28-29). For easy reference throughout the dissertation it is reprinted in appendix C.

1.1 KEY TERMS AND PERSPECTIVES

In this section I provide the key terms and perspectives that have variously influenced and arisen from the study. I developed the definitions as part of completing this project, including data analysis and theory development. Most of these definitions are consistent with the literature in a broad sense so I refer the reader to sections of the dissertation where relevant literature is discussed. Some definitions were developed as part of theory construction and where that is the case I refer the reader to the new theory which is contained in chapter six.

A person’s ‘embodied self’ is conceptualised in the dissertation as “an integrated whole body/soul/mind who is continually changing depending on the various contexts of existence”. This definition is part of the theory in chapter six and is outlined below. The terms ‘embodied self’, ‘sense of embodied self’ and ‘embodied sense of self’ are assumed to have the same meaning and I use them interchangeably throughout the dissertation.
An ‘improved sense of self’ is defined as “an enhanced capacity to feel oneself as an embodied whole and intrinsically powerful person”. This definition arose from the theorising in chapter five and six. A woman with an improved sense of self is more willing and able to release old ways of being and take on those that are new, thereby increasing her capacity to actualise her own intentions. Such a process can shift a woman’s awareness from what she thought was of value to a greater awareness of those aspects of her life which she later perceives as more valuable. In this dissertation an ‘enhanced sense of self’ is conceived to be equivalent to an ‘improved sense of self’.

As discussed in chapter six this dissertation reveals how a woman’s improved sense of self encompasses an increased capacity to optimise her ‘psychophysiological wellbeing’ relative to her in-the-moment situation. ‘Optimised psychophysiological wellbeing’ is defined as “the experience of mind, body and soul working seamlessly together in a way that is most advantageous to the embodied self”. The dissertation is concerned with how a woman can feel herself as having an enhanced sense of her embodied self while embracing the challenges that childbearing, mothering and life can bring.

1.1.1 ‘Embodied self’

The embodied self encompasses the person as a spiritual being, which deals with aspects of lived experience that are difficult to articulate. Concepts associated with defining embodied self as a spiritual being are briefly explored here. The philosophical framework that underpins these concepts is discussed in chapter two.

1.1.1.1 Spirit and soul

In this dissertation I define ‘spirituality’ as “the ways that people take to become aware of spirit and soul in their lives” (Kovel, 1991). I consider ‘spirit’ as the power that drives the world and the cosmos. Spirit is thus the animating energy of the embodied self. The power that is spirit is ethically neutral, paradoxical and not necessarily rational or irrational (Kovel, 1991). As such, spirit forms the nonrational milieu from which conscious existence arises. I define ‘nonrational’ as “the experientially real parts of living that are ungraspable by a purely rational perspective” (Kovel, 1991). A person’s own particular organic expression of nonrational spiritual power is defined as their ‘soul’ (Kovel, 1991). Soul is conceived as both the unifying power of the whole embodied self and the power that acts on parts of the self as the intrinsic starting-point of change. These concepts are further discussed in section 2.5.
Chapter One: Introduction

1.1.1.2 Intrinsic power

A person’s spirit and soul are expressed using power that is intrinsic to the embodied self. In this dissertation I consider a person’s ‘intrinsic power’ to be synonymous with their ‘spirit’ and ‘soul’. I define ‘intrinsic power’ as “a nonrational spontaneous power experienced in the current moment that influences future knowing, action and power in both subtle and not so subtle ways”. Intrinsic power forms part of the new theory contained in chapter six. Experienced in the immediacy of the here and now, intrinsic power is the force that animates the living body and embodies the self (Irigaray, 2001, 2002). The lived experience of body, mind and the world is fashioned through a person’s articulation with intrinsic power. While intrinsic power is expressed differently in different people, it is also a universal phenomenon indivisible from existence. As it is universal, intrinsic power has been assumed to be similar in all people. However, this research shows that the reality of intrinsic power’s moment-to-moment experience is one of diversity and uniqueness.

Throughout this dissertation intrinsic power is variously associated with, although not necessarily assumed to be the same as ‘inner knowledge’, ‘inner wisdom’, ‘inner meaning’, ‘intuition’, ‘bodily knowing/power’, ‘bodily capacity’, ‘inner strength’, ‘inner knowing/power’, ‘a woman’s own power’, her ‘capacity to take action’, or her ‘agency’. Other terms used to represent the uniquely experienced, embodied expressions of intrinsic power are ‘sexuality’, ‘instinct’, ‘love’, ‘creativity’ and ‘joy’. These manifestations of intrinsic power and use of the terms representing them are each contextually mediated by a person’s lived experience of the world and their body.

1.1.1.3 The living body

A phenomenological understanding of the living body sees it as perceptual, affective and holding knowing and power. The living body actively and reflexively inhabits time and space (Merleau-Ponty, 2002). My definition is consistent with this understanding, as discussed in section 2.3. I define ‘the living body’ as a “uniquely experienced, diverse biological organism that grounds existence of the self as an embodied being”. Prior to any conscious reflection on in-the-moment experience the body responsively grasps and internalises new sensations and patterns of behaviour as bodily knowing. For example, driving a car normally takes little or no conscious effort; the body just knows. Bodily knowing shapes current and future experiences directing how intrinsic power is
used from one moment to the next. Conscious awareness of the lived body, awareness of its nonrational decision-making capacity, awareness of intrinsic power, and the person’s in-the-moment experience all interact together creating dynamic change (Leder, 1990).

1.1.1.4 The power of ego and culture

‘Ego’ is defined as a “rational, reflective, self-defining, value-based power of the embodied self”; it is further discussed in section 2.4. Anchored by an often misrecognised self-image, ego reflexively interacts with and assesses itself and the world with the aim of keeping the self safe and maximising the self’s sense of cultural power (Lacan, 1977, 2002). Ego dichotomises and prioritises creating ‘either/or’ perspectives that shape desire, decision-making and action. These activities can lead a person to moderate their willing expression of intrinsic power. Egoic activities are inclined to ignore or demean nonrational experiential ways of knowing. Ego tends to assume that an absolute rational way of knowing is possible and slants its judgements toward its own assessments of safety (Lacan, 1977, 2002).

‘Culture’, in this dissertation, is defined as “the many and various contexts in which the embodied self exists” (Scott & Marshall, 2005). Such contexts may be broad, as with society and religion, or more specific, as with communities and particular situations that incorporate a person’s home, family and individual others. Power that is extrinsic to the embodied self arises from the varying contexts of culture. Ego interacts with extrinsic power to internalise and embody elements of culture perceived as powerful, such as behaviours and ideas that support culturally dominant ways of seeing the self (Lacan, 2002). The internalising process creates cultural power, security and self-definition through the misperception that these parts of culture are ‘owned’ by the person. With this illusionary sense of ownership the ego extends a person’s power into temporal and spatial contexts beyond the present in order to try to ensure security in multiple situations. However, the egoic maintenance of a culturally powerful sense of self often excludes perspectives of the self as embodied and changing.

1.1.1.5 Change and intention

I define ‘change’ of embodied self as “an experience of being or becoming different”. The lived experience of change is one of qualitative difference: between the past, present and/or future; between individuals; and between particular situations (Grosz,
As discussed throughout chapter two, change is continuous, nonlinear and multidimensional. The embodied experience of change may thus be perceived as a nonrational process that: folds back on itself; draws from a seemingly incongruent array of previous experiences; appears to end whilst actually continuing; or not appear to be occurring at all (Lacan, 1977, 2002; Merleau-Ponty, 2002). Hence, although the experience of change may be one of qualitative difference it may have similarities to previous experiences of change or to the experiences of other people in other situations. The way a person responds to a particular situation of change, such as labour pain, may fit the pattern of how that person has habitually responded to change in other situations throughout life (Lacan, 1977). Similar patterns of change have been identified within particular cultural groups, across cultural groups and at particular life stages (van Gennep, 1960). In this research similar patterns of change were evident between the overall experience of childbearing and the various phases, such as the experience of giving birth. I therefore came to consider the moment-to-moment process of change during childbirth as in some ways synonymous with the overall change process during childbearing.

Change experiences are mediated by culture and have temporal characteristics of which a person may or may not be aware (Grosz, 1995, 2004). A person may choose to respond to change using their intrinsic power as ‘intention’ (Irigaray, 2001). Intention is discussed further in section 2.5. I define ‘intention’ as “an intrinsic power that is actively used to shape the changing embodied self, rather than leaving it to be passively shaped by cultural power”. However, in responding to change the ego habitually accesses internalised behaviours in strategic ways that bolster cultural power, security and self-definition. These behaviours tend to disconnect the self from conscious awareness of the subtle nonrational choices available to the self from one moment to the next. Egoic responses to change prioritise linear, cause and effect perceptions that forfeit awareness of tangible in-the-moment experience (Lacan, 1977, 2002). Hence, during childbearing a woman may find herself consciously intending one thing, such as a natural birth, whilst her ego actually leads her toward more techno-medical culturally acceptable forms of birth. The manifestation of change as an improved sense of self is therefore not only an outcome but an ongoing practise. The ‘ongoing practise of an improved sense of self’ arose from the new theory introduced in chapter six. It is defined as “a continually made choice to negotiate a sense of embodied wholeness and
to use intrinsic power relative to in-the-moment bodily awareness and egoic assessments of security”.

1.1.1.6 Expanding perspectives
Dominant cultural understandings of the self, the body and change (discussed below) support the biases of the ego (Irigaray, 1993, 1996; Leder, 1990). These primarily dichotomised ‘either/or’ perspectives are limiting and thwart an enhanced sense of embodied self. By incorporating spiritual, nonrational concepts in the definition of embodied self, my understanding has been able to move beyond the limitations of culturally dominant definitions. When childbearing women incorporate spiritual, nonrational concepts into their self-understanding they can accept and benefit from including and valuing their own lived experience of contradictions, paradoxes and being able take ‘both/and’ perspectives. Having expanded perspectives frees a person to encompass both nonrational and rational forms of knowing, power and security in their practices of living. For example, rather than focusing purely on a desired childbirth outcome a woman may see that she can shape her intention by actively responding to the moment-to-moment changes of pregnancy and labour. By actively engaging in her experience of change a woman can begin to appreciate her own intrinsic power, be less reliant on extrinsic power, and open herself to new and yet to be experienced ways of being herself.

1.1.2 Study aim and approach
The research aimed to produce theory about how caregivers can most effectively work with women during the changes of childbearing so as to enhance, rather than diminish, a woman’s embodied sense of self. As issues of empowerment underlie a woman’s enhanced sense of embodied self, I chose a methodology from the critical research paradigm (Fahy & Harrison, 2005). The chosen methodology is explicitly feminist and post-structural. ‘Feminist research and theory’ is “the practice of identifying, understanding and changing intrapersonal and social factors that sustain women’s disempowerment” (Harrison & Fahy, 2005). ‘Post-structural research’ is a scientific process that “contests linguistic and socially constructed dichotomies, priorities and power imbalances aiming to reveal reality and truth as ever changing and driven by perspective” (Weedon, 1997). Feminist post-structural research values the reflexivity and accountability of the researcher, places personal experience at the centre of the
research, and respects diversity. Of particular concern in this study is the concept of ‘essentialism’ which refers to “the assumed existence of given attributes, fixed characteristics, and decontextualised functions in a person or group of people”, such as in all women (Grosz, 1995). Essentialism arises from narrow humanistic perspectives of the self (as outlined below) so it works to diminish diversity and limit the capacity for change.

‘Childbearing’ is an abstract term referring to the general period of a woman’s life in which she is giving birth to children (Trumble & Stevenson, 2002). For the purpose of this research I have more specifically defined ‘childbearing’ as “the period of time when women experience: becoming pregnant; being pregnant; giving birth; and the early months of parenting”. A woman’s experience of childbearing is entangled with that of her baby. The project has assumed that the baby, whether before or after birth, is also an actively changing and fully embodied being. ‘Birth’ is defined broadly as “the creation or release of new life” (Trumble & Stevenson, 2002). During childbearing a woman not only gives birth to her baby but to a new version of herself.

‘Childbirth’ is a concretely described term that refers to the act of giving birth (Trumble & Stevenson, 2002). In this study I define ‘childbirth’ as “the period of time that includes all stages of labour as well as birth of the baby and placenta”. In my analysis I acknowledged that each woman also brings embodied elements of herself and her culture to the childbirth experience. For methodological reasons discussed in chapter four, only women experiencing childbearing for the first time participated in the research. Hence, the context of the resultant theory is limited to women’s changing embodied self during first childbearing.

1.2 Background to the Study

The aim to produce theory means that the study’s focus needs to encompass how a woman’s lived experience of embodied sense of self is influenced by the power, knowledge and practices of caregivers. This ‘maternity care environment’ is defined as “the milieu of practices, power and knowledge that a woman is exposed to during maternity care provision in the childbearing period”. The broader cultural environment influences the maternity care environment as well as directly influencing how a woman experiences her changing embodied self. This section provides an overview of these
environments; the literature review will deal more fully with some of the studies cited here. Any woman’s experience will exist within a continuum of possible cultural and maternity care environments, but this section focuses primarily on one end of that scale. Although there are some examples of positive maternity care environments, I focus on the dominant cultural and maternity care environments that act to undermine a woman’s sense of embodied self during childbearing.

1.2.1 Maternity care environments and the embodied self

Maternity care environments that seem to enhance a woman’s sense of self follow a social model of health (Walsh, 2007; Walsh & Newburn, 2002a, 2002b). As chapter two identifies, these environments are organised to respect the contradictions and differences amongst childbearing women. Power and knowledge is shared through a partnership between midwife and woman (Guilliland & Pairman, 1995; Kennedy, Rousseau, & Low, 2003; McKay, 1991; Pairman & McAra-Couper, 2006). This partnership enables the promotion of a woman’s psychophysiological wellbeing through maintenance of her moment-to-moment sense of safety and control (Fahy & Parratt, 2006; Parratt & Fahy, 2004). Although they work in partnership with women, the midwives are autonomous within a legally defined scope of midwifery practice (Australian College of Midwives, 2008; Australian Nursing and Midwifery Council, 2006; World Health Organization, 1997). This autonomy means that, rather than being dictated to by hierarchical maternity care systems, midwives flexibly collaborate with maternity systems, other caregivers and with women (Daellenbach & Thorpe, 2007; Davis-Floyd, 2005; Gamble & Vernon, 2007; Reid, 2007a). These ‘autonomous midwifery practices’ are informed by research, inclusive of intuitive ways of knowing, and are individually determined through the woman/midwife partnership (Davis-Floyd, 2005; Kennedy & Shannon, 2004; Kennedy, Shannon, Chuahorm, & Kravetz, 2004; Walsh, 2006).

Childbirth in these maternity care environments is primarily considered ‘natural’ or ‘normal’. Women’s sense of self is enhanced in association with their positive sense of self-transformation and/or personal growth (Bergum, 1989; Parratt & Fahy, 2003; Rabuzzi, 1994; Vernon, 2006). The birth experiences are described as unique, powerful and life affirming (Bergum, 1989; Callister, 2004; Parratt & Fahy, 2003; Rabuzzi, 1994; Vernon, 2006). Such births may be physiologically ‘normal’ but they are not necessarily
considered socially ‘normal’. Generally, but not always, births in these maternity care environments occur in alternative settings such as home and birth centres where midwives known to the woman are holistically focused on her unique individuality (Davis-Floyd, 2001; Edwards, 2005; Frye, 1998; Walsh, 2007). In these environments midwives act as guardians of normal birth and only draw on technology in the service of the woman’s individual needs at the time (Fahy & Parratt, 2006; Kennedy & Shannon, 2004; Lundgren & Berg, 2007; Walsh & Newburn, 2002b).

The social model of caregiving respects the diversity of women and empowers each woman to experience the birth process in ways that are uniquely normal for her (Davis-Floyd & Davis, 1997; Downe & McCourt, 2004; Walsh, 2007). The embodied experience of change is valued as a passage through time in addition to the outcome or product of that change (Davis-Floyd, 1994; Simonds, 2002). During this process a woman’s sense of wholeness is subtly achieved by optimising her psychophysiology so that she connects with and uses her intrinsic power. In doing so the woman actualises her intention to have a baby, using her own power to give birth to both her baby and to her enhanced sense of self. However, most women in Australia, where this study is set, do not experience birth in these maternity care environments.

1.2.2 **The standard care paradigm**

I call the dominant maternity care environment the ‘standard care paradigm’. Here the word ‘paradigm’ means “a set of values, beliefs, assumptions and practices that are shared by a group of health care providers”. When giving care during childbirth the vast majority of midwives, nurses, and doctors in Australia work in hospitals and adhere to the values of this paradigm. Caregivers who are resistant to, but work within the paradigm, are still influenced and controlled by its values. Even the practices of midwives who work in alternative settings may be shaped by this paradigm (Edwards, 2005). The birth rate in alternative settings is, however, low. In 2004, the year after participants in this project were recruited, the homebirth rate was 0.2% while only 2.0% of births occurred in (hospital based) birth centres (Laws, Grayson, & Sullivan, 2006). Most Australian women therefore experience childbirth in hospital settings within the maternity care environment of the standard care paradigm.

The standard care paradigm is an obstetrically dominated techno-medical model that is structured to facilitate the physiological control of childbearing. Childbirth is primarily
treated as an illness or a potential medical crisis (Downe & McCourt, 2004). Caregiver practices tend to be organised in hierarchical, inflexible and fragmented ways. The organising principles are based on attempts to gain predictability, control, efficiency and calculability (Bennett, 1997; Davis-Floyd, 2001; Wagner, 1994). Structural order over the detail of childbearing experience is achieved through the management of time (Simonds, 2002). In this paradigm, women’s experience of change becomes limited to the surveillance of incremental achievements of duration, frequency and pace, in addition to milestones that depict the linear jump from past to future.

In the standard care paradigm the woman’s body and that of her baby are considered separate objects of care, with primary focus is on the baby’s body (Davis-Floyd, 2001). Women are expected to maintain their physical health for the benefit of the baby (Lupton, 1999). When problems arise, the woman or her body are considered the primary cause of malfunction (Davis-Floyd, 1992). Relational aspects of care may be included that, for example, respect patient decision-making and make room for compassion (Davis-Floyd, 2001). Ultimately, however, cultural and personal values are perceived as irrelevant to caregiver knowledge about childbearing (Cosans, 2001). Caregiver activities tend to be specifically orientated toward bodily function and productivity rather than toward the woman as an embodied being (Dykes, 2005; Goldberg, 2002). This physically oriented view is reflected in how some women see childbirth as divorced from personal meaning and/or spirituality (Davis-Floyd, 1994; Sered, 1991). The standard care paradigm’s focus on the physiological control of childbearing is also supported by the dominant cultural environment.

1.2.3 The dominant cultural environment

The underlying values of the standard care paradigm arise from the dominant cultural environment which is in turn sustained by the dominant cultural paradigm of humanism. ‘Humanism’ promotes the idealistic discourse of the self as stable, non-conflicted and rational (Harrison & Fahy, 2005). As discussed in chapter two, humanism arose from Enlightenment (17th and 18th centuries) Cartesian philosophy that conceptually divided the material body from the nonrational soul. The rational powers of the mind were then conceptually separated from the body; forming the so called mind/body split. The rational mind dichotomises each thought and places alternate options in opposition to each other and then deems them mutually exclusive and collectively exhaustive (Grosz,
1995). One part of the dichotomy is privileged over the other in ‘humanistic discourse’. Enlightenment philosophy used the rational/irrational dichotomy to argue that the only way the body could be perceived was as the irrational and powerless opposite of the rational and powerful mind. The soul, though disembodied by this philosophy, was similarly envisaged as the irrational opposite of the mind’s rationality. The body in humanistic discourse is perceived as an object that is passive and essentially the same for all people. A further assumption is that complete and value free facts can be known about the material body (Cosans, 2001).

Humanistic discourse has a symbiotic relationship with the dominant scientific paradigm of logico-empiricism. ‘Logico-empiricism’ assumes that single definitive truths are identifiable with the objective application of logical theory to empirical fact (Fahy & Harrison, 2005). The qualitative differences between people and situations are decontextualised by logico-empiricism which instead uses general theoretical principles formed from quantified cause and effect assessments of change. Theoretical frameworks produced by logico-empirical assumptions are reductionistic, causal and linear (Downe & McCourt, 2004; Enkin, Glouberman, Jadad, & Stern, 2006; Fahy & Harrison, 2005). One such framework that has a dominant influence on how the lived body is perceived is that of ‘technocratic practice’. These practices separate and analyse functioning aspects of life in such a way that dysfunction is perceived and technological treatment, such as that provided by the standard care paradigm, is presumed to be necessary (Davis-Floyd, 1992, 1994).

The values of logico-empiricism, technocratic practices and humanism have enabled significant advances in health care and improved some aspects of women’s childbearing experience. The values have also acted to perpetuate humanistic understandings about the self, the body and change. Assumptions that the human body changes in only preconceived physiological ways has meant that any deviation is seen in dysfunctional and/or problematic terms (Leder, 1990). The intrinsic power of women’s bodies is devalued and disempowered by these perceptions which in turn prompt reliance on power that is extrinsic to the embodied self. Humanistic discourses effectively create imperatives for childbearing women to be self-controlled, non-conflicted and rationally responsible selves (Lupton, 1999). This rationally responsible ‘self’ has evolved in Western society to have individual, privileged rights that may be asserted against the desires of others as well as the self’s own bodily sensations (Harrison & Fahy, 2005). In
the standard care paradigm it is often the individual rights of the baby that are asserted over the woman’s. A woman’s cultural power to assert her own privileged rights are moderated by how the dominant cultural environment views women in childbearing.

1.2.3.1 Humanism’s perspective on childbearing

Humanism’s perception of the sacredness of life takes precedence over other perceptions of women’s cultural power in childbearing (Balin, 1988). Motherhood is seen as the asexual but sacred state that produces new life; this perception contradicts the other dominant image of women as sexual and attractive (Chang, Chao, & Kenney, 2006; Earle, 2003; Young, 2005c). The dominant perceptions of childbearing women can also be contradictory for women who ordinarily derive cultural power from their professional life (Bailey, 2001; Reich, 2003). The unavoidable public definition of a woman as pregnant can challenge her to retain previous perceptions of cultural power in terms of professional identity and/or body image (Chang, et al., 2006; Earle, 2003; Reich, 2003). Some women eventually come to terms with these changes and use their public display of pregnancy to benefit their professional identity (Reich, 2003). Other women may be pragmatic about the temporary nature of their changed body image (Earle, 2003). However, for still other women contradictions between their body image as mother and their body image as woman can present an ongoing struggle (Chang, et al., 2006). Even after the birth these struggles can persist, diminishing a woman’s sense of cultural power such that she may socially isolate herself (Patel, Lee, Wheatcroft, Barnes, & Stein, 2005).

In humanistic terms, a woman’s cultural power in childbearing is perceived to revolve around her capacity to sacrifice herself to gestating, producing and nurturing her baby (Balin, 1988). Based on essentialist assumptions about women’s creative and nurturing power these cultural beliefs are often played out in apparently innocent social rituals (Balin, 1988). For example pregnant women can find strangers vacating seats or partners abstaining from sexual intercourse. Women often subscribe to and even expect these practices by sacrificing aspects of ordinary, non-childbearing life that do not match their perceptions of how a childbearing woman should be (Balin, 1988). Desire for the security of a family may also prompt self-sacrifice from women who, for example, tolerate insults from their partners (Bondas-Salonen, 1998). Other rituals
undertaken by a woman may be imposed by the social environment, such as those pertaining to hygiene, diet and health care (Balin, 1988).

Socially imposed rituals articulate with the standard care paradigm in the form of risk discourses (Lupton, 1999). Risk discourses work to enact the dominant cultural view that through prevention and management of pathology the standard care paradigm will produce the best possible childbearing outcome (Downe & McCourt, 2004). Risk awareness and the resultant desire to have wellbeing monitored are common concerns among pregnant women in Western society. Yet, a woman’s anxieties and fears about risk stem not from lived experience but from speculation about virtual risks (Possamai-Inesedy, 2006). Techno-medicine can provide a sense of security for some women but it also acts to confirm that there is indeed a potential risk (Possamai-Inesedy, 2006). Humanistic discourse prompts women to take action over potential risks or be blamed for the consequences. Through this sense of responsibility humanistic discourse motivates women to comply with recommended risk avoidance strategies. Paradoxically, cultural power in childbearing only appears available to women when they rescind that power and comply with dominant views. Some women do nonetheless assert their humanistically construed right to choose how they experience childbearing in the standard care paradigm.

1.2.3.1 The woman’s right to choose

Humanism creates its own internal dissonance between valuing the role of mother as the nurturer of new life and valuing an individual’s right to choose. A woman’s willingness to assert her right to choose how childbearing is experienced is also influenced by cultural power in more general terms, such as social class. Middle class women, for example, may feel they have the power to choose what type of birth they will have, whereas working class women, though given the same opportunities, may be more fatalistic (Zadoroznyj, 1999). Once women have given birth for the first time the discrepancy between social classes appears to fade. The birth experience itself then seems to act as a cultural resource for any woman to confidently negotiate their next birth experience (Zadoroznyj, 1999). Women also gain confidence in their decision-making through interaction with caregivers (Luyben & Fleming, 2005) and gathering information (Carolan, 2005a; Savage, 2006).
The extremes of possibility communicated within a woman’s cultural environment tend to provide the boundaries from which women make decisions about childbirth (Davis-Floyd, 1992). Such extremes of possibility not only articulate with risk discourses but with the imagined possibilities relayed by the extremes of birth settings. Women undertaking homebirth demonstrate that resisting the values of the standard care paradigm is possible (Davis-Floyd, 1992). At the other extreme, women choosing techno-medical birth illustrate the potential cultural power when dominant values are assimilated and used for personal advantage (Davis-Floyd, 1992). Women planning natural birth in hospital may therefore imagine that they are getting the best of both extremes (Davis-Floyd, 1992). However, humanistic values prioritise the control and rationalism of the mind over the spontaneity and unpredictability of the body even when women plan natural birth.

Women are urged to become fully informed antenatally in order to have the capacity for decision-making in labour and so feel in more control (Gibbins & Thomson, 2001). Women are also advised to keep their childbirth expectations realistic (Beaton & Gupton, 1990; Fenwick, Hauck, Downie, & Butt, 2005; Gibbins & Thomson, 2001; Savage, 2006). A realistic and flexible birth plan is part of this strategy (Savage, 2006; Shaw, 2002). However, expectations that are ‘realistic’ refer to women lowering their expectations to match the reality of the standard care paradigm (Hauck, Fenwick, Downie, & Butt, 2007). Admonitions of flexibility support that reality. Prior documentation of choice in a birth plan humanistically assumes the mind is absent once labour begins, prioritises body function and privileges caregivers’ observation/knowledge in a way that allows them to take over (Shaw, 2002). Humanistic discourse thus enables a woman to assert her right to choose whilst also socialising her to accept the maternity care environment of the standard care paradigm (Davis-Floyd, 1992; Hauck, et al., 2007). In addition, humanistic discourse deflects responsibility for the woman’s subsequent wellbeing away from caregivers in the standard care paradigm; if a woman does view her childbearing experience negatively the blame can only be perceived to lie with her for not remaining flexible enough (Shaw, 2002). Nonetheless many women do experience a diminished sense of self during childbearing, principally when accessing care from the standard care paradigm.
1.2.4 Manifestations of diminished sense of self

Diminished sense of self associated with childbearing has been extensively researched and is summarised here. A woman’s diminished sense of self may manifest as loneliness and anxiety (Cigoli, Gilli, & Saita, 2006), grief and alienation (Moyzakitis, 2004), guilt (Ward & Mitchell, 2004), fear (Melender, 2002), anger (Mozingo, Davis, Thomas, & Droopleman, 2002), stress (Ayers & Pickering, 2001) and/or depression (Kitamura, Shima, Sugawara, & Toda, 1996; R. L. Miller, Pallant, & Negri, 2006). Bodily experiences, such as changes in body shape and size (Chang, et al., 2006), fatigue (McVeigh, 1997), or sequelae from childbirth (S. Brown & Lumley, 1998) can contribute to a diminished sense of self as can alterations in cognition (De Groot, Vuurman, Hornstra, & Jolles, 2006) and memory (Henry & Rendell, 2007). Diminishing sensations may be isolated experiences at particular phases of childbearing; they may come and go, persist, or worsen throughout the period. The severity can be such that a woman may contemplate self-harm (Beck, 2002). Sensations can also compound creating negative effects on breastfeeding (Henderson, Evans, Straton, Priest, & Hagan, 2003), sexuality (DeJudicibus & McCabe, 2002), partners (Davey, Dziurawiec, & O’Brien-Malone, 2006), relationships (Ayers, Eagle, & Waring, 2006; Matthey, Barnett, Ungerer, & Waters, 2000), family dynamics (Tammentie, Åstedt-kurki, & Paavilainen, 2004) and parenting practices (McLearn, Minkovitz, Strobino, Marks, & Hou, 2006).

A prevalent characteristic of a woman’s diminished sense of self is the mismatch between her hopeful expectations and actual experience (Beck, 2002). Loss is the emotion that resonates most with women who experience this mismatch (Beck, 2002). Childbearing women struggle to redefine their sense of identity and to live up to their personal expectations (Edhborg, Friberg, Lundh, & Widström, 2005). Unfulfilled expectations include not only those associated with partner relationships and the realities of infant care but also with regard to the birth experience (Beck, 2002). Women predominantly expect childbirth to be a normal, non-medicalised experience (Fenwick, et al., 2005). In labour many women expect to be given explanations, be a part of decision-making and generally participate in the event. When these expectations are not fulfilled women can be left with a sense of betrayal that their caregivers did not meet their needs (Moyzakitis, 2004). The violation in trust when a woman’s expectations are
not met can result in a sense of powerlessness and fear which, after later reflection, may manifest as anger (Mozingo, et al., 2002).

Post-traumatic stress disorder is a recognised result of some experiences of childbirth. The manifestation of post-traumatic stress is significantly related to the degree of medical intervention, the quality of a woman’s interaction with caregivers, her feelings of powerlessness, and her perception of pain during the experience (Creedy, Shochet, & Horsfall, 2000; Olde, van der Hart, Kleber, & van Son, 2006; Soet, Brack, & DiIorio, 2003). In addition, operative births are associated with more postpartum morbidity (Borders, 2006) and a lower general health status (Lydon-Rochelle, Holt, & Martin, 2001).

1.2.5 How to prevent a diminished sense of self

The standard care paradigm’s humanistic values use a psychosocial approach to conceptualise diminished sense of self in childbearing as primarily a postnatal mental health problem. Much research has been conducted in an attempt to prevent and treat postnatal mental health problems in childbearing. Based on a psychosocial perspective a range of strategies to prevent postnatal depression have been trialled (Lumley & Austin, 2001). However, a meta-analysis showed that these strategies have not been effective (Lumley, Austin, & Mitchell, 2004). What is known is that parenting and childbirth classes as well as other forms of knowledge provision have, to some degree, allayed women’s antenatal fears (Melender, 2002). The early recognition of postpartum mental health problems and their early treatment is better than later treatment as the result of delayed recognition (Kowalenko, Barnett, Fowler, & Matthey, 2000). Obstetric intervention during childbirth, uncontrolled pain and poor communications have all been linked to postnatal mental health problems (Creedy, et al., 2000; Soet, et al., 2003). Furthermore, women who have unresolved issues surrounding unfulfilled childbirth expectations find the transition to mothering more difficult (Lesely Barclay, Everitt, Rogan, Schmied, & Wyllie, 1997; Kowalenko, et al., 2000).

1.2.5.1 Facilitating the transition to mother

Transition to motherhood theory purports to describe, explain and predict how a woman should become a happy mother. This theory underpins the way that midwives and maternity nurses have been trained to prevent mental health problems and identify them early if they do arise. In aiming to facilitate women’s transition to motherhood,
maternity nursing, primarily from the USA, has marked a psychosocial territory for itself within the standard care paradigm (Rubin, 1961a, 1961b, 1964, 1967a, 1968, 1984). Theory and research on transition to motherhood presents the transition as a linear, unidirectional process involving a series of psychosocial milestones that need to be achieved (Bibring, Dwyer, Huntington, & Valenstein, 1961; Leifer, 1977). In this view a woman reorientates her sense of self to take on the maternal identity. She does this by undertaking a series of developmental tasks and cognitive changes (Rubin, 1975, 1984). These tasks have been defined in terms of maternal role attainment (Mercer, 1985). Attaining this role is conceptualised as a cognitive process that is dependent on a woman’s ability to problem-solve, gather information, communicate effectively, project into the future, and establish nurturing relationships (Mercer, 1995). The woman’s lived experience of birth is de-emphasised as merely another milestone on the developmental path to what is really important: becoming a mother. Although the original research is now quite old, the linear transition to motherhood theory still shapes current understandings of a woman’s predicted and socially desired change during the childbearing year (Mercer, 2004, 2006). This theory is reflected in the current standard Australian midwifery basic text book (Pincombe, 2006).

In critiquing the conventional transition to motherhood theories I found they were all based on humanistic models of the self (such as the theory by Erikson, 1963; 1980/1959). These models purport to include bodily and/or behavioural change resulting in claims being made that the resultant theories were holistic (Mercer, 1995; Rubin, 1984). However, I argue that the humanistic values inherent in these models of the self actually reinforce the body/mind dichotomy. In my critique I identified that all the underlying research used a logico-empirical approach to data collection and analysis, although the process of transition to motherhood is clearly qualitative (Parratt & Fahy, under review). Reductive methods quantified and generalised the data. Analyses, are consistent with, and seem to be based upon, pre-existing assumptions and/or theoretical frameworks.

Humanist ideals prioritising rationalism and a future orientation that excludes an in-the-moment orientation are upheld in all the conventional theories of transition. The dominant, future focus shifts a woman’s social value and her own sense of self-worth toward the role of mother both as producer and nurturer of new social members. Rather than preventing women’s diminished sense of self, these conventional theories
strengthen essentialist concepts of a woman’s mothering role in society. Further, these theories serve to indoctrinate caregivers into believing that their role is to encourage the woman’s adoption of the pre-determined social role as mother. The theories all silence expressions of the self that are embodied, spiritual and/or sexual and hide moment-to-moment perceptions of change.

1.2.5.2 Empowering women towards a positive birth experience

Midwifery as a discipline is moving away from a focus on creating mothers for new babies toward a woman-centred focus where the woman feels empowered and confident. From the woman’s perspective, the birth experience forms an important part of her expectations during childbearing. To that end midwifery has taken on the role of supporting women’s empowerment by becoming guardians of normal birth in any setting (Downe, 2004b; Fahy & Parratt, 2006; Pairman, Pincombe, Thorogood, & Tracy, 2006; Parratt & Fahy, 2004; Thomson, 2000). The midwifery aim to empower women toward normal birth is in line with the discipline of midwifery’s own desire for empowerment from the regimes of the standard care paradigm (A. M. Brown, 2003).

When a woman has a positive expectation of birth, rather than some medically defined understanding of a ‘realistic’ expectation, then she is most likely to assess whatever birth experience she actually has in a positive light (Green, Coupland, & Kitzinger, 1990; Slade, MacPherson, Hume, & Maresh, 1993). Emotionally positive expectations enable a better appreciation of any negative aspects of the experience (Slade, et al., 1993). Concepts of control and power during childbirth are multidimensional and important to how a woman evaluates her experience (Green & Baston, 2003; Green, et al., 1990; VandeVusse, 1999). Women’s sense of control is significantly influenced by their physical setting (Hodnett, 1989). The capacity to control panic, rather than pain, and a woman’s comfort during labour are important to a satisfying experience (Green & Baston, 2003; Slade, et al., 1993). Quality woman/midwife relationships in labour mediate women’s sense of control and decrease their concern over unmet expectations (Green & Baston, 2003; Hauck, et al., 2007). Indeed, caregiver behaviours and attitudes have a powerful impact on labour pain and women’s subsequent sense of satisfaction (Hodnett, 2002). Of particular importance to women’s positive birth experience is the sense that they are being treated individually and with respect (Green & Baston, 2003).
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Research evidence has also provided an evidence-base for this ‘new’ midwifery (Page, 1993, 2003, 2000). ‘New’ practices are aimed at all midwives practising continuous one-to-one care during labour, giving woman centred care, and improving the midwife/woman relationship. Maternity systems have had a growing acceptance of this ‘new’ midwifery despite the prevailing hierarchy of the standard care paradigm (Brodie, 2005; Reibel, 2004; Victorian Health, 2004; World Health Organization, 1997). Supportive caregiver relationships and/or continued care from the same caregiver has been shown to reduce intervention in childbirth and increase women’s satisfaction (Gagnon, Meier, & Waghorn, 2007; Hodnett, Gates, Hofmeyr, & Sakala, 2003; Tarkka, Paunonen, & Laippala, 2000). However, the effective implementation of these new midwifery practices is infrequently realised, particularly in Australia (Gamble & Vernon, 2007; Homer, 2006; Reid, 2007b; Stephens, 2007; Warwick, 2001). Indeed, of women planning normal birth as many as three-quarters actually experience some form of medical intervention (Downe, McCormick, & Beech, 2001; Riley, Davey, & King, 2005; Tracy, Sullivan, Wang, Black, & Tracy, 2007). The rate of operative birth actually continues to rise. For example, in the ten year period to 2004 the Australian caesarean section rate rose over ten percent to 29.4% (Laws, et al., 2006). The most recent report, for 2006, measured the caesarean section rate at 30.8% (Laws & Hilder, 2008).

1.2.5.2.1 Challenges to the Empowering Women Strategy

Structural, organisational and relationship issues have been identified as impeding changes to midwifery practice (Brodie, 2005; Fleming, 1998b; B. Hunter, 2004; Kirkham, 1999; Kirkham & Stapleton, 2000; Seibold, Miller, & Hall, 1999; Shallow, 2001). At a fundamental level the barriers to change revolve around paradigmatic differences that block communication and understanding (Downe, 2004a). The midwifery practices that enhance a woman’s embodied self are non-liner and complex (Downe & McCourt, 2004). Yet, from the perspective of the standard care paradigm, complex process-based modes of practice do not reconcile with the linear, cause and effect modes that provide formal rationales for practice (Downe & McCourt, 2004; Enkin, et al., 2006).

The dominance of the standard care paradigm is such that evidence must be given in order to create practice change, yet habitually practised activities can remain merely on
the basis of maintaining the status quo (Stephens, 2007; van Teijlingen, Hundley, Rennie, Graham, & Fitzmaurice, 2003). Conversely, some practices are hastily changed, such as the prohibition on vaginal breech birth due to a misapprehended conceptualisation of safety (Bick, 2006; Glezerman, 2006; Hannah, et al., 2000). Then again, practices that may actually be experienced by women as beneficial, such as vaginal birth subsequent to caesarean section, are not fully implemented either through lack of evidence or through manipulation of the evidence (Goer, 2003). Dominant authorities variously use and ignore evidence according to their own interests (Fahy, 2002, 2007a; Goer, 2003). This manipulated evidence is then uncritically passed on to women by naïve journalists who depend on these ‘experts’ while claiming to give balanced information to the public (Curran, 1993; Fahy, 2007b; Hamer, 2007).

1.2.6 Concepts and assumptions that limit understanding

Dominant cultural and maternity care environments use concepts and make assumptions that limit understandings of childbearing and the embodied self. Dominant understandings that treat the childbearing woman’s body and mind as separate entities have no way of actively involving a woman in her process of embodied self change during childbearing. Perceptions of the sheer mental and physical effort involved in the childbirth process are also de-emphasised and lost (Davis-Floyd, 1992). Surrender, rather than activity, is prioritised in humanistic discourse, which is why women are called ‘patients’ even though they are neither sick nor dependent. Women, for example, may plan to ‘go with the flow’ of their bodies and surrender to the process of birth (Luyben & Fleming, 2005; Walsh, 2007). However, where humanistic discourse is dominant surrender to the process means surrender to the caregiver which prompts women to instead ‘go with the flow’ of the standard care paradigm (Fenwick, et al., 2005; Hauck, et al., 2007).

I acknowledge that the standard care paradigm is at times more fluid than the way it has been presented above (section 1.2.2). Some women may well have positive birth experiences within this paradigm. However, the standard care paradigm’s focus on preventing diminished sense of self fails to appreciate the value of enhancing women’s embodied self throughout the change process. As an outcome, normal birth is communicated using decontextualised rhetoric; medical intervention is the pathology to be avoided and normal birth is best. However, reducing the birth experience to either
normal or abnormal (or to low or high risk; or to natural or technological) can alter how women see their experience. Such an outlook can fuel women’s feelings of inadequacy and guilt if the intended normal birth doesn’t occur (Carolan & Hodnett, 2007; Lundgren & Berg, 2007). It can also act to marginalise the role of midwives or create division between midwives in differing settings (B. Hunter, 2004). In addition, the dichotomous outlook fails to make clear what exactly normal birth is, only that it is birth without intervention (Downe & McCourt, 2004). Healing these divisions and dichotomies is one outcome that I have attempted to achieve by completing this research.

The complex, holistic practices used by autonomous midwifery to enhance a woman’s sense of self are not effectively relayed using the language of the standard care paradigm. The standard care paradigm’s concepts do not reflect the contextual reality of lived experience for women or caregivers (Carolan & Hodnett, 2007; Crabtree, 2004; Enkin, et al., 2006; Fleming, 1998b). Nor do the concepts clarify how women and their caregivers can become aware of and actively facilitate the moment-to-moment experience of change. The practice of autonomous midwifery has traditionally been conveyed through oral storytelling and experiential learning (Davies, 2007; Fleming, 1998a, 1998b; Frye, 1998; Goldberg, 2003). Creative forms of expression such as fine art, poetry, music and dance have also been used to communicate its very experiential, sometimes spiritual, and often contradictory nature (Davies, 2007). Yet these approaches can serve to reinforce a science/art dichotomy and give no words that enable an understanding of how to bridge the standard approach. It is this mismatch between communicated understandings and contextual realities that has prompted my own search for greater understanding through this study.

1.3 PERSONAL INVOLVEMENT IN THE STUDY

My aim in this section is to give an honest account of how I as researcher, woman, midwife and mother have influenced the research project. For more than twenty years I practised as a midwife in rural Australia. Much of this practice was as an autonomous midwife working with women in their homes or occasionally in hospitals. I have a strong belief in women’s capacity, given the right circumstances, to give birth without medicalisation. This belief underscored my practice of midwifery. The belief has persisted despite my own three experiences of childbirth involving unexpected
medicalisation for varying reasons. Following these experiences I grieved that for some reason I was unable to draw on the power to give birth that I felt within me. My way of coming to some understanding about those experiences has been through research about childbirth from women’s perspectives.

1.3.1 My previous research

My research has primarily been prompted through observations within my clinical practice. Having noticed that childbearing could trigger memories of incest that then influenced the birth experience, I undertook research with women who were survivors of incest (Parratt, 1994). The women in that study linked their past abusive experiences to the experience of an altered conscious state during labour, which they perceived negatively. I found that other studies showed how a labouring woman could dissociate herself from currently experienced pain and/or trauma by altering her conscious state (Berg & Dahlberg, 1998; Kennedy & MacDonald, 2002). Yet, I observed from clinical practice that labouring in an altered state could also help women dissociate from the pain. When there was no current sense of trauma or history of abuse, women seemed to perceive the altered conscious state positively. For these women it appeared that the altered conscious state assisted them to give birth without drugs or other forms of intervention, potentially enhancing their psycho-spiritual growth and health. It was this observation that led me to research women’s sense of self during childbirth.

As a pilot to this current study, I undertook research that asked ‘What features of a woman's birth experience have a positive effect on her sense of self’ (Parratt, 2000). This pilot research was based on my opinion that if women felt control over the context of their labour and if they experienced natural birth without medication they would have an enhanced sense of self compared with women who did not experience birth in this way. Theorising about the self was guided by the now named Relational-Cultural Theory (Jordan, 1997b; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). Women’s sense of self was considered in terms of their self-worth, self-esteem, self-knowledge, self-efficacy, self-expression, agency, competence, gratification and power (not over but with others) (J. B. Miller, 1991a). A positive sense of self was defined as a feeling of connection with another involving mutual empathy and consequent empowerment as well as an inward sense of connection within the self (Parratt, 2000; Surrey, 1991b). This study supported the thesis that women who experience an autonomous midwifery
partnership during childbirth grow in self-awareness and self-confidence to a greater degree than those experiencing the standard medical model (Parratt, 2000; Parratt & Fahy, 2003). The pilot study is critiqued in chapter three.

1.3.2 The current research

My interest in women’s embodied self as a topic for research reflects my personal search for self-understanding. The embodied experience of undertaking the pilot research emphasised what I did not understand about my own embodied self. For this current research, in parallel with my exploration of philosophical and post-structural thought, I explored what embodiment meant to me. My daily practice of yoga, walking and meditation has been as important to this research as has my reading and writing. I have also made subtle shifts in the ways I relate to my partner, children, friends and colleagues. These shifts have led to a maturing of some relationships and the loss of others. These experiences of my changing embodied self have been instrumental to how this research was undertaken, including construction of the working definition of embodied self that occurred during early analysis. The working definition considered ‘embodied sense of self’ to encompass the steady sense of potential or actual wholeness experienced through living as relational beings in multiple changing contexts. This working definition guided me toward the post-structural definitions given at the beginning of this chapter.

My own changes, in addition to the changes of the participants, have been instrumental to theory development. As the research progressed I became increasingly aware that although I was using feminist methods my approach was still steeped in the dichotomies of humanistic discourse and the standard care paradigm. The process of transcending the dichotomies while simultaneously maintaining my post-structural feminist integrity created an increasingly more impartial perspective from which I could theorise. I had to challenge my own sacred ideas about natural/normal birth and face other challenges. For example, while I may have been sure in my embodied experience of what I meant by a particular concept, I found that my language also needed to be understood and accepted by others. Not only did I need words to transcend dichotomies, I also needed words that would simultaneously be true to the unique diversity inherent in the research participants, in me and in other women and caregivers. It was this process that allowed
me to undergo the personal changes to voice the otherness of intrinsic power and embodied wholeness in the theory and in this dissertation.

Although I have changed and healed during this research project, my passion has remained. I continue to be motivated by a sense of injustice that ordinary women who access standard maternity care are often scarred mentally and/or physically by their experience of childbirth. Regardless of intentions for natural/normal birth, I feel that all women deserve caregiving that optimises their psychophysiology, facilitates their sense of embodied wholeness and enables their potential to be intrinsically powerful. Hence, I have pursued this feminist post-structural project aiming to develop theory to enhance women’s embodied sense of self in childbearing.

1.4 STUDY SIGNIFICANCE

The standard care paradigm does not include theories that effectively act to enhance a woman’s embodied sense of self. Without such theories the education of caregivers and new practitioners cannot be facilitated in more holistic directions incorporating the contextual reality of each woman’s experience. Existing theories of the self in childbearing (for example, Raphael-Leff, 1994) do not theorise women as embodied selves. This project considers women as embodied spiritual beings whilst also considering the changing contexts of experience. By embracing the embodied complexity of the whole process of childbearing and the contextual reality of moment-to-moment change, the resultant theory is inclusive of even the most contradictory elements of women’s experience. In addition, as theorising occurred at the micro level of the individual woman and her caregivers the theory is not reliant on particular physical environments or institutional changes, although these may still be beneficial. The theory therefore brings a far more pragmatic understanding to the mainstream promotion of normal birth that has a potential relevance to women in any setting.

1.4.1 The theory and ‘genius birth’

The theory ‘Liberating intrinsic power’ is introduced in chapter six. This theory gives guidance about what maternity caregivers can do to help women have an enhanced sense of self before, during and after the birth. It is based on the understanding that caregivers as well as women are embodied selves. The theory proposes the use of the concept EMPOWERING PRACTICES and the sub-concept, genius change. Genius change
refers to a woman’s trust in her capacity to actively create new, previously unconceived, ways of being that optimise her psychophysiological wellbeing relative to her in-the-moment situation. **EMPOWERING PRACTICES** are the collection of practices that a woman’s caregivers can use to bring about those new, more optimal ways of being. As embodied selves both women and caregivers can also use **EMPOWERING PRACTICES** on themselves. When caregivers use **EMPOWERING PRACTICES** during any interaction with a woman, the woman is more likely to use **EMPOWERING PRACTICES** on herself and hence experience a *genius change*. During childbirth, if a woman’s caregivers are using **EMPOWERING PRACTICES**, a woman is presented with repeated opportunities to experience *genius change*. The repeated experience of *genius change* can reinforce a woman’s embodied sense of self-trust such that she has the courage to use her own power to give birth. As a result of this accumulated sense of embodied wholeness and intrinsic power, women can find the moment of birth an exceptionally powerful moment of *genius change*; I therefore call such a birth ‘*genius birth*’.

‘*Genius birth*’ and the theory are significant because they move away from the dichotomy of natural birth versus medical birth. The concept ‘*genius birth*’ is presented as a common goal for women and all maternity caregivers, particularly midwives. Unlike the terms ‘natural birth’ or ‘normal birth’, ‘*genius birth*’ does not represent the physiological process of childbirth, nor does it signify a woman’s lived experience of birth. What ‘*genius birth*’ does seek to represent is a woman’s active and effortful use of intrinsic power during childbirth. Through this use of intrinsic power the woman can come to realise that she is more powerful than she had previously imagined. It is this trusting articulation with intrinsic power that leads to a woman’s enhanced embodied self during childbearing. In coming to know and experience her intrinsic power through *genius change* and in particular, ‘*genius birth*’, a woman can feel not only joy and relief in the presence of her baby, but also in her own achievement; she may even feel like a genius for what she has done!

As will be demonstrated, implementation of **EMPOWERING PRACTICES** by caregivers has the potential to enable a woman’s enhanced embodied self during virtually any childbearing experience. If caregivers use **EMPOWERING PRACTICES** when interacting with a woman, that woman is more likely to gain an awareness of her intrinsic power to choose how she responds to change. These choices extend to both ordinary moment-to-moment experiences and extraordinary moments of peak experience represented by the
actual birth of a baby. **EMPOWERING PRACTICES** can guide a woman to actualise her intrinsic power to give birth in unique and personally meaningful ways. The increased trust in her intrinsic power then facilitates a woman’s sense of strength and confidence in other changing situations. Such effects can also impact on women’s ordinary day-to-day actions of living. When a woman uses **EMPOWERING PRACTICES** and experiences **genius change** she faces her life feeling stronger and more whole. Strong, healthy women are most able to facilitate the health of their baby and their family in addition to having a broad positive influence on society in general. Women’s experience of an enhanced sense of embodied self during first childbearing provides a strengthened foundation from which to approach future changes in childbearing and throughout life.

### 1.4.2 Dissertation outline

In this dissertation I am arguing that there *is* a better way to birth that is not determined by the singular desire to be a mother, or by societies’ determination to enable the production of ‘mothers’. Instead I argue that this better way is focused on women’s individual and very particular circumstances that are changing and developing from one moment to the next. In the chapters that follow I explain how the way through change is catalysed by women’s free access to and use of intrinsic power so that they experience a **genius change**. The chapters aim to substantiate the thesis that **during first childbearing a woman’s embodied sense of self is most likely to be enhanced, rather than diminished, when caregiver intentions and practices act to sustain her on a path toward genius change**.

Overall, this dissertation encompasses seven chapters with appendices and references. In appendix A ethical aspects of the research, a time line and examples of the research process that demonstrate my decision-making trail are presented. Appendix B is a published book of participants’ stories (Parratt, 2009); a complimentary copy is provided. In appendix C all the tables in the dissertation have been reprinted for easy reference. Chapter two presents a philosophical framework for the study. Perspectives on the self, embodiment and self-change are discussed. Chapter three reviews the childbearing research. The feminist post-structural methodology that shaped the research is outlined in chapter four. I also discuss the methods of personal narratives, survey research and grounded theorising that guided data collection, analysis and theorising.
Chapter One: Introduction

There are two results chapters. Chapter five focuses on the changes experienced by individual participants. These results show that when a woman uses her own power during labour and birth she is most likely to feel an improved sense of embodied self during childbearing. Chapter six then presents the theory and defines the theoretical concepts including *genius change* and *EMPOWERING PRACTICES*. In that chapter I use the concept of the ‘Change pathways’ to outline, using women’s words, the in-the-moment choices that can facilitate access to and use of intrinsic power. Chapter seven concludes by discussing the theory with regard to the philosophical and research literature. It contends that, when caregiver intentions and practices act to sustain a woman on a path toward *genius change* her embodied sense of self is most likely to be enhanced, rather than diminished, so that she, quite literally, enters motherhood feeling like a genius.
Table 1.1 Glossary of terms introduced in chapter one

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embodied self</td>
<td>An integrated whole body/soul/mind who is continually changing depending on the various contexts of existence. Encompasses the lived experiences of a person as a sexual, spiritual embodied being.</td>
</tr>
<tr>
<td>Improved sense of self</td>
<td>An enhanced capacity to feel oneself as an embodied whole and intrinsically powerful person. Encompasses an increased capacity to optimise psychophysiological wellbeing relative to in-the-moment situation.</td>
</tr>
<tr>
<td>Optimised psychophysiological wellbeing</td>
<td>The experience of mind, body and soul working seamlessly together in a way that is most advantageous to the embodied self.</td>
</tr>
<tr>
<td>Spirituality</td>
<td>The ways that people take to become aware of spirit and soul in their lives. Experience of spirituality is an expression of intrinsic power that is also shaped by cultural forms of power.</td>
</tr>
<tr>
<td>Spirit</td>
<td>The ethically neutral, paradoxical and not necessarily rational or irrational power that animates existence.</td>
</tr>
<tr>
<td>Soul</td>
<td>A person’s own particular organic expression of nonrational spiritual power that unifies the whole “embodied self” but also impacts on parts of the self as an intrinsic starting-point of change.</td>
</tr>
<tr>
<td>Nonrational</td>
<td>The experientially real parts of living that are ungraspable by a purely rational perspective. Cultural knowledges and individual egos may conceive the nonrational as irrational. Nonrational experiences can expand thinking from ‘either/or’ dichotomies into ‘both/and’ perspectives. Nonrational ‘both/and’ perspectives incorporate knowing and power that is nonrational as well as rational.</td>
</tr>
<tr>
<td>Intrinsic power</td>
<td>A nonrational spontaneous power experienced in the current moment that influences future knowing, action and power in both subtle and not so subtle ways. Animates the living body and expresses the diversity and uniqueness of a person’s spirit and soul. A universal phenomenon indivisible from the lived existence of the embodied self as a sexual, spiritual being.</td>
</tr>
<tr>
<td>The living body</td>
<td>A uniquely experienced, diverse biological organism that: grounds existence of the self as an embodied being; actively and reflexively inhabits time and space; holds both knowing and power; shapes and is shaped by its own and other’s knowing/power; and variously shifts in and out of a person’s conscious awareness.</td>
</tr>
<tr>
<td>Ego</td>
<td>A rational, reflective, self-defining, value-based power of embodied self. Ego dichotomises and prioritises creating ‘either/or’ perspectives that shape desires, decision-making and action as it interacts with itself and the world. Ego is most concerned with self-protection relative to the past, relative to culture, and relative to how the nonrational aspects of the self are expressed via intrinsic power. Extends a person’s power into temporal and spatial contexts beyond the present with the aim to ensure security in multiple future situations.</td>
</tr>
<tr>
<td>Culture</td>
<td>The many and various contexts in which the embodied self exists. These contexts may be misperceived as ‘owned’ by the ego so as to create a sense of cultural power, security and self-definition.</td>
</tr>
<tr>
<td>Change</td>
<td>An experience of being or becoming different.</td>
</tr>
</tbody>
</table>
### Table 1.1 (continued) Glossary of terms introduced in chapter one

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intention</td>
<td>An intrinsic power that is actively used to shape the changing embodied self, rather than leaving it to be passively shaped by cultural power.</td>
</tr>
<tr>
<td>Ongoing practice of improved sense of self</td>
<td>A continually made choice to negotiate a sense of embodied wholeness and to use intrinsic power relative to in-the-moment bodily awareness and egoic assessments of security.</td>
</tr>
<tr>
<td>Feminist research and theory</td>
<td>The practice of identifying, understanding and changing intrapersonal and social factors that sustain women’s disempowerment.</td>
</tr>
<tr>
<td>Post-structural research</td>
<td>Contests linguistic and socially constructed dichotomies, priorities and power imbalances aiming to reveal reality and truth as ever changing and driven by perspective.</td>
</tr>
<tr>
<td>Essentialism</td>
<td>The assumed existence of given attributes, fixed characteristics, and decontextualised functions in a person or group of people, which diminishes diversity and limits capacity for change.</td>
</tr>
<tr>
<td>Childbearing</td>
<td>The period of time when women are experiencing: becoming pregnant; being pregnant; giving birth; and when they are parenting their babies.</td>
</tr>
<tr>
<td>Birth</td>
<td>The creation or release of new life.</td>
</tr>
<tr>
<td>Childbirth</td>
<td>The period of time when women experience all stages of labour as well as birth of the baby and placenta.</td>
</tr>
<tr>
<td>Maternity care environment</td>
<td>The milieu of practices, power and knowledge that a woman is exposed to during maternity care provision.</td>
</tr>
<tr>
<td>Autonomous midwifery practice</td>
<td>Practised by midwives who are not dictated to but who work in flexible collaboration with maternity systems, other caregivers and with women. This practice is informed by research but individually determined by the woman and the midwife. Practice is holistically centred on the woman who is perceived as an integrated and autonomous whole intimately connected to her baby, her family and the contexts in which she is living her life.</td>
</tr>
<tr>
<td>Standard care paradigm</td>
<td>The dominant maternity care environment in which the vast majority of nurses, midwives, and doctors practice. A techno-medical model moderated by humanism but powered by logico-empiricism, technocratic practices and humanistic discourse.</td>
</tr>
<tr>
<td>Paradigm</td>
<td>A set of values, beliefs, assumptions and practices that are shared by a group of health care providers</td>
</tr>
<tr>
<td>Humanism</td>
<td>Promotes the idealistic discourse of a stable, non-conflicted, autonomous self who is rationally detached and has privileged rights that can be asserted against the desires of others.</td>
</tr>
<tr>
<td>Humanistic discourse</td>
<td>Idealised, judgemental and dichotomised forms of discourse that stabilise, universalise, and de-contextualise so as to create imperatives for people to be self-controlled, non-conflicted and rationally responsible selves who are primarily productive and socially valued.</td>
</tr>
<tr>
<td>Logico-empiricism</td>
<td>A methodological research paradigm that assumes single definitive truths can be found with the objective application of logical theory to empirical fact. Produces reductionistic, linear, cause and effect frameworks.</td>
</tr>
<tr>
<td>Technocratic practices</td>
<td>Practices that separate and analyse functioning aspects of life in such a way that dysfunction is perceived and technological treatment is presumed to be necessary.</td>
</tr>
</tbody>
</table>
2. **CHAPTER TWO- PHILOSOPHICAL FRAMEWORK**

2.1 **INTRODUCTION**

This chapter presents the key philosophical and theoretical literature that influenced my understanding of the changing embodied sense of self. It substantiates the way I defined ‘embodied self’ and spiritual being in chapter one. In addition it underlies, in concert with the data, the carefully defined theoretical concepts given in chapter six. The research question and aim, as stated in chapter one, broadly guided what literature I considered. The research methodology outlined in chapter four clarified my manner of studying the literature. The approach I have used to write this chapter and much of the dissertation has been to apply the iterative reflexive style proposed by Laurel Richardson (2000). Hence, whilst I started writing this chapter when the project commenced, I continued to develop and refine the chapter until the whole study was complete.

Initially I approached the philosophical literature with a broad focus on embodiment, the self and the change process. I read contemporary theories of embodiment (Crossley, 2001; Mol, 2002; Mol & Law, 2004; Shilling, 2005; Weiss & Haber, 1999), but rather than use these theories I chose to take the approach detailed below. My subsequent readings led me toward the understanding that a person’s sense of security influenced the degree to which she/he felt free to open the self to change. However, that simple statement belied the diverse complexity of changes that the childbearing women in this study experienced (as shown in chapter five and appendix B). The women’s changes were across multiple spatial dimensions: psychophysiological, social and spiritual. Changes also occurred across multiple temporal dimensions. For example, women changed from one moment to the next, they experienced an overall sense of change, and women’s perspectives of the past and future changed. Most importantly, women’s childbearing change was influenced by their perceptions of the baby’s security as well as their own personal security. My more refined focus was therefore on what philosophy could teach me about the ways a woman could freely open herself to the multiple dimensions of change whilst also maintaining her own and her baby’s embodied sense of being able to safely exist in, and interrelate with, the world.
The chapter begins by focusing on two feminist modes of seeing the embodied self and change. In the first section I highlight how effective relationships impact on sense of self and acknowledge the apparently contradictory nature of change. Section 2.3 discusses the embodied self from the perspective of phenomenological unity. Bodily movement through time and space is explored along with the body image. I identify how conscious body awareness can influence a person’s sense of being a unified self. In section 2.4 I use psychoanalytic and anthropological perspectives to explore how power can impact on a person’s process of change. The supposedly neutral positions of knowing relayed in these perspectives are identified to variously maintain humanistic understandings of the self and to sustain patriarchal power. Section 2.5 then considers perceptions of self that liberate power and enable an experiential sense of wholeness through practices that open the self to change. The chapter concludes that a woman’s capacity to experience herself as an embodied whole and intrinsically powerful person is variously enabled or disabled by the ordinary in-the-moment choices she makes during the change process.

2.2 TWO FEMINIST THEORIES

My philosophical exploration began with a focus on feminist modes of seeing the self. Relational-Cultural Theory informed my understanding about the self during the pilot study (as introduced in chapter one) so it was my starting point. At the same time, I considered the ‘ovarian’ (feminist word for ‘seminal’) theorising on embodiment by Iris Marion Young. Neither theory met the entire philosophical needs of the project. However, as I learnt more from the data and from my other philosophical readings I came to appreciate how these theories had a significant impact on the philosophical framework. This section outlines the two theories and discusses their significance to the project.

2.2.1 Relational-Cultural Theory

Relational-Cultural Theory is a psychological theory based primarily on the clinical practice of psychology. The theory’s relational focus is analogous with the concept of partnership as it is applied to midwifery (Guilliland & Pairman, 1995). Theoretical development was largely informed by feminist psychologist’s dissatisfaction with existing theories of the self, such as those of Freud (1930/1955) and Erikson (1963).
These masculine, modernist theories promoted a concept of the self as separate and autonomous. The growth of the self was argued to be increasingly self-sufficient and independent (Jordan, 1991c). This model did not suit women whose lives are inextricably linked to, and inter-dependent upon others. The work of feminist theorists such as Jean Baker Miller (1978) and Carol Gilligan (1982) led to a paradigm shift where women’s sense of self was viewed as having a more relational and contextual nature (Robb, 2006; Spencer, 2000). With this relational view of the self, the boundaries delineating the self from others came to be seen as changing and indistinct (Jordan, 1991c). Indeed, in Relational-Cultural Theory all of life activity is considered to occur within “a context of attentiveness and responsivity to the other as an intrinsic ongoing aspect of one’s own experience” (Surrey, 1991b, p.57). The theory is about far more than the value that women place on relationships (Jordan, 1991c). Judith Jordan explained that “the deepest sense” of a person’s being “is continuously formed in connection with others and is inextricably tied to relational movement” (p.141). Hence a woman’s sense of self in this theory is conceptualised in terms of her relative sense of connection with the ‘other’ to whom she is relating. The dynamics of this ‘relational movement’ is theorised to occur through a two-way mutually empathic process that can positively enhance the sense of self.

2.2.1.1 The mutually empathic process

Mutuality has been defined in Relational-Cultural Theory as the intersubjective appreciation and awareness of the fullness of experience for both the self and the ‘other’ in any relationship (Jordan, 1991b). Mutuality is considered to encompass and essentially act as the most favourable environment for empathy. Jordan identified how empathy has traditionally been seen as a basic emotive response to the ‘other’ that creates some loss of identity for the self (1991a). She claimed that empathy is profoundly more than merely being sympathetically affected with the same feeling as another. Within Relational-Cultural Theory empathy has been understood as a complex, interactive process using cognitive and emotional abilities (Jordan, 1991a; Jordan, Surrey, & Kaplan, 1991). Jordan referred to the work of psychoanalyst Heinz Kohut (1978) when she described empathy as basic to all human interaction. Kohut explained that empathy is an identification of “the self in the other”, the “accepting, confirming and understanding human echo” (pp.704-705).
The mutually empathic process is conceptualised as an oscillation between the testing out of an experience of the self with consideration of how the ‘other’ is in a relationship (Jordan, 1991a; Surrey, 1991b). During this oscillating process regard for the self is balanced with regard for the ‘other’ (Jordan, 1997b; Jordan, Kaplan, et al., 1991). According to the theory’s proponents, when this process is effectively used conflict and difference within a relationship can be expressed, accepted and worked through (Jordan, 1992; J. B. Miller & Stiver, 1998). The oscillating process has also been identified to occur within the self (Jordan, 1991a, 1991b; Surrey, 1991b). This inner self-empathic relationship, when effective, is purported to enable appreciation of the differing parts of the self, an appreciation of the self as a whole, and an appreciation of the self as a part of a larger whole (Jordan, 1991a, 1991b). Jordan claimed that mutually empathic relationships are intensely affirming to the self. Both the inner and outer oscillations of the mutually empathic process therefore impact on the self’s capacity to change and grow.

2.2.1.2 Positive self-growth

Positive self-growth according to Relational-Cultural Theory fosters an increase in relational capacity (J. B. Miller & Stiver, 1998). Through the interactive experience of the mutually empathic process a sense of the self as separate and disconnected is thought to dissolve into a sense of wholeness through connection with the ‘other’ (Jordan, 1991a). Effective mutually empathic connections promote growth by producing power and altering the way power is used. The word ‘power’ within Relational-Cultural Theory is used to mean “the capacity to produce change” rather than as a force that implies control or mastery over something (J. B. Miller, 1991b, p.198). In her later work Miller delineated the two forms of power as “power-to” and “power-over” (J. B. Miller, 2003, p.2). Rather than attempting to control change through ‘power-over’ others, mutually empathic connections are theorised to work with others enabling the ‘power-to’ change. Jordan asserted that mutually empathic connections enable change through providing a relational environment of “supported vulnerability” that could convey the sense that needs and wishes would be respected and not violated (1992, p.3). Those participating in such relationships could then feel safe enough and find enough courage to open themselves to change (Jordan, 2003).
According to Janet Surrey, effective mutually empathic connections promote self-growth through mutual empowerment (1991a). At least five mutually experienced elements to empowerment have been identified: “‘zest’, action, knowledge, worth and the desire for more connection” (J. B. Miller & Stiver, 1998, p.30). Miller and Irene Stiver explained the process of positive self-growth as follows (1998). They conceptualised ‘zest’ as the feeling of energy and vitality that increased with connection. This sensation of aliveness was then claimed to allow an in-the-moment action within the relationship that created change. For example, the mutually empathic connection may create an increase in courage and authenticity allowing emotions to be revealed; simultaneously the ‘other’ in the relationship may enact in-the-moment caring and concern. Through the activities of mutually empathic connection the relational participants are believed to gain more knowledge about the self and each other. In addition, the relational participants are thought to become more knowledgeable about the relationship itself. The process is then thought to promote a greater mutual feeling of connection and the wish for more connection. Miller and Stiver also claimed that, because of the mutuality of the interchange, both participants would have an increased sense of self worth and legitimacy.

2.2.1.3 A practice based theory: limitations
Relational-Cultural Theory is a practice based theory that is in synchrony with how autonomous midwifery (as defined in chapter one) is practised through a relationship with the woman (Guilliland & Pairman, 1995; Kirkham, 2000; Parratt, 2000). The theory provides a framework for how the sense of self changes within relationships. It does so by conceptualising relational movement and the oscillations of the mutually empathic process. This framework also shows how sense of self is enhanced and how relationships that foster such change can be sustained. Encompassed in the theory is a demonstration of how an enhanced sense of self stems from a relational environment where mutual empowerment is promoted. Additionally, the theory highlights the importance of considering the relational context from which empowerment emerges. Being based on practice, the theory itself comprises the movement and change of an embodied self, however it does not theorise embodiment. This limits the theory’s usefulness in this project as sometimes intense bodily changes accompany childbearing. Furthermore, the theory’s conceptualisation of the inner process of change is limited. In
the next section inner changes to the self are considered while particular focus is given to women’s experience of embodiment.

### 2.2.2 Embodied self in childbearing according to Young

Iris Marion Young began her theorising of women’s embodiment by reflecting on the possibilities and constraints inherent in being a girl (2005a, original 1980). She then shifted her focus toward the ordinary bodily experiences of women such as during pregnancy (2005b, original 1984) and breastfeeding (2005c, original 1990). Young saw women’s experience of embodied self during pregnancy as an immersion in “movement, growth and change” (2005b, p.54). Rather than being only future focused and ‘expectant’ as others see her, Young argued that a pregnant woman experienced herself actually as change, in addition to being the creative source of that change.

Young based her theorising on women’s diaries, literature and her own “phenomenological reflection” (p.46). She considered the existentialist theories of Merleau-Ponty (1968) and Straus (1969) in addition to referring to post-structuralist theories such as those of Lacan (1977, 2002) and Kristeva (1982). With these perspectives Young developed and critiqued the phenomenological concept of the self as pure unity. She instead portrayed the embodied self as not only whole and unified but in its lived experience also “a project … moving and often contradictory” (2005b, p.48).

Hence, in any lived experience of change there are inherent contradictions, such as that between the present and the future. Young outlined these kinds of contradictions in the context of childbearing.

#### 2.2.2.1 Inherent contradictions

In Young’s theorising, a woman’s previously held concepts and experiences of self-unity, wholeness and bodily integrity are challenged during childbearing (2005b). A woman can feel “decentred”, “split” or in some way alienated as a result of the ambiguous and contradictory nature of her changing embodied self (p.49). Young showed how a pregnant woman lives through contradiction during her in-between existence as neither one nor two bodies. During pregnancy, for instance: a woman’s bodily boundaries of what is inner and outer in relation to her sense of self are in flux; the image of her currently experienced body can become confused by the embodied image of herself as not pregnant; and the concreteness of her current bodily experience
can create a sense that she is imprisoned and cut off from her capacity to enact more transcendental, future plans.

The contradictory sensations of the changing embodied self may also be experienced during the postpartum. In Young’s essay about breastfeeding she identified how Western logic “defines an exclusive border between motherhood and sexuality” (2005c, p.85). With that logic a woman may either perceive herself to be a selfless nurturer or experience the pleasurable power of her sexuality, but not both. Young showed that the desires of women thereby become divided “in having to identify with one or other image of womanly power” (p.85). During the postpartum a woman’s breasts and her action of breastfeeding, in Young’s analysis, can challenge those pre-conceived boundaries of sexuality and nurture. The ambiguity and contradictions evoked by breastfeeding can therefore, like the experience of pregnancy, cause a woman to feel a disempowered sense of self as split or alienated.

2.2.2.2 A potentially powerful negotiation

Childbearing can be experienced as alienating and disempowering but it can also be experienced in powerful ways. Young claimed that a woman-centred conception of bodily experience is fluid and non-objectified (2005c). Citing Irigaray (1985a), Young observed how sexual desire is “flowing” “multiple”, “unlocatable” and “not identical” (2005c p.83). Thus, Young proposed that a woman may take pleasure in her mothering and allow breastfeeding to be celebrated as a “sexual interaction between the mother and the infant” (p.89). Similarly in pregnancy, while a sense of bodily “resistance” and entrapment may occur, Young insisted on the power of a pregnant woman to attend to her current physicality at the same time as using her body to accomplish her aims (2005b, p.51). Young called this approach a “double intentionality” (p.54). Young therefore argued that with this “double intentionality” women’s experience of embodied self becomes an ever changing on-going negotiation or “dialectic” between contradictory elements of her experience (p.54).

A woman’s diminished sense of embodied self arises, in Young’s assessment, from cultural practices that objectify and dichotomise women’s experience rather than support an on-going dialectic (2005b, 2005c). Young illustrated how encounters with obstetric care and its technologies may take the form of authoritarian one-way relationships. These one-way relationships objectify and devalue women’s embodied
experience. Such encounters “render the woman considerably more passive than she need be” (2005b, p.58). Young even made the observation that such encounters with obstetric care are still applicable to women’s 21st century experience of childbearing (2005d). Specific strategies to enhance a woman’s embodied sense of self were not given by Young. However, Young’s notion that embodied self change is a continual negotiation between inherent contradictions enabled her to identify how women’s experience of childbearing has the potential to be a powerful one.

2.2.2.3 The ‘both/and’ approach to change

Young’s theorising illustrated how the embodied experience of being a whole self includes the often contradictory and culturally shaped ideas of what or who that self may be. She showed how the experience of bodily change, such as pregnancy, brings to light those inherent contradictions. Young’s proposed fluid process of negotiation between the contradictory elements of self is analogous to the relational movements conceptualised in Relational-Cultural Theory. Young also theorised a potential power available to the woman who is able to successfully negotiate and live with the contradictory elements of her embodied experience. Similarly Relational-Cultural Theory conceptualised an experience of power when both the self and the other are actively respected through mutually empathic connections. Young’s theorising is far more descriptive than the practice based Relational-Cultural Theory, but exactly how the contradictory elements of embodied experience may be negotiated has not been made clear. Nonetheless, for the purpose of this project Young’s theorising extends that of Relational-Cultural Theory in terms of a woman’s inner experience of her changing embodied self.

The overall key point to be drawn from Young’s theorising is that a woman has the potential to experience childbearing powerfully when she perceives her embodied self as both whole and encompassing continually negotiated contradictory elements. These potentially powerful negotiations are most at odds with conventional understandings of childbearing transition that view women’s changing sense of self in unified linear terms. In chapter three alternative ways that research has conceptualised the changing embodied self in childbearing are discussed. Young maintained the post-structural ‘both/and’ position in her theorising by attempting to give both sides to the contradictory and often dichotomised elements of the changing embodied self. In doing
so she exposed herself to the criticism of not giving sufficient emphasis to one or other side of any dichotomy. For example, she has been critiqued for not taking adequate account of women’s anxiety, fear or ambivalence in pregnancy (Lupton, 1999); for not exploring the emerging embodied relationship between woman and unborn baby (Wynn, 2002); and more recently for portraying labour in inactive terms (Reiger & Dempsey, 2006). The next section of this chapter now considers the phenomenological unity that underlies Young’s theorising.

2.3 CONSIDERING THE EMBODIED WHOLE: PHENOMENOLOGICAL UNITY

In considering the embodied whole I focused predominantly on the work of French philosopher Maurice Merleau-Ponty (1908-1961). Merleau-Ponty was an early and major theorist of embodiment (1968, 2002). The body, to Merleau-Ponty, was conceptualised as perceptual, affective and holding its own bodily intelligence. He urged philosophy to “move on from knowledge of psychological and physiological facts” so that bodily animation could be recognised as “inherent” to “existence” (2002, p.102). Unity is characteristic of animation but Merleau-Ponty did not conceptualise it as an “amalgamation” of “mutually external terms” such as mind and body or subject and object (p.102). Instead he saw unity as a phenomenological process “enacted at every instant in the movement of existence” (p.102).

As a phenomenological process Merleau-Ponty conceptualised unity not as mind or matter but as “the flesh” (1968, p.139). His concept of ‘the flesh’ referred to a continually enacted potential mind/body/soul/world unity that was irreducible and fundamental to bodily experience. Hence Merleau-Ponty said that ‘the flesh’ spanned total bodily being and “that of the world” (p.148). Paradoxically though, Merleau-Ponty also said that ‘the flesh’ was the gap or “hiatus” between two entities in a relationship, such as between one moment and the next or between the heard voice and the uttered voice (p.148). Consequently ‘the flesh’ is a concept with relational qualities and with qualities associated with in-the-moment lived experience. I explain the latter, including a critique, first.
2.3.1 The lived unity of ‘the flesh’

The enacting of unity was not a passive movement to Merleau-Ponty. Rather than saying that the body is passively in time and in space, Merleau-Ponty claimed that the body actively “inhabits space and time” (2002, p.161). To him, the bodily habitation of space and time meant that “each instant” of a movement embraced the eventual “whole span” of that movement (p.162). In making this assertion Merleau-Ponty placed a single instance of in-the-moment experience prior to consciousness of that experience. This meant that phenomenological unity was pre-reflective, as it was not initially deduced through rational thought. Thus Merleau-Ponty claimed that the conscious notion of phenomenological unity could only be arrived at by resuming “contact with the sensory life” that is lived “from within” (p.255).

2.3.1.1 The invisible and the visible

To Merleau-Ponty the inner sensory life is the invisible “primordial layer” of “the flesh” where “both things and ideas come into being” (2002, p.255). He believed that what initially came into being was a pre-reflective bodily “grasping” of significance and understanding that he construed as habit (p.165). Merleau-Ponty perceived habit as the pre-reflective interpretation of a “shared meaning” (p.165). Creation of this shared meaning arose from the interaction of in-the-moment experience with previously internalised “attitudes and movements”, including their associated language, perceptions and tools (such as a walking stick or a car) (p.161). Merleau-Ponty argued that at each moment the bodily habitation of time and space was “performed afresh” so that at “all levels” of lived experience “new meaning” was continually being created (pp.162-9). However, in each new situation habit also provided the possibility of responding to the situation’s “certain general form” with a habitual “certain type” of solution (p.164). Habit therefore provided an experiential and invisible “interior possibility” (1968, p.151). This invisible possibility was then, to Merleau-Ponty, what rendered potential actions “visible” to embodied self through the body image (p.151).

Body image was theorised by Merleau-Ponty as a fluid system that was continually shaped by the embodied experience of particular situations (2002). As he conceived situations to be continually changing, the body image was considered as an “anchorage” from which to view a potential plan of action (p.167). The body knowing contained in habit gave an experience of “harmony” between what was aimed for and what was
given, “between the intention and the performance” (p.167). Hence Merleau-Ponty believed a person’s body image encompassed an embodied vision of the “system of present positions” that the body happened to be currently experiencing (p.163). He also believed it encompassed the vision of an “open system” of potential other “equivalent positions” formulated from habit (p.163). The invisible “power of habit”, to Merleau-Ponty, became transferred into a visionary power through the body image (p.167). Via the body image the embodied self found the power to “put forth” meanings “beyond itself” to create a whole new plan of experience and thought (p.146). The potential for action given by the body image thus produced the continually enacted potential mind/body/soul/world unity that was ‘the flesh’.

### 2.3.1.2 Prioritising the visible

Merleau-Ponty’s theorising of ‘the flesh’ in terms of envisaged potential meant that, to him, lived unity was never quite achievable. Phenomenological unity was instead transcendental and “always further on” (1968, p.217). It was this future focused perspective that Young was critiquing in her analysis of pregnant embodiment (2005b) (section 2.2). To Young, embodiment encompassed both an envisaged potential and the in-the-moment tangible experience of potential which became highlighted through pregnancy. To Luce Irigaray (1993) and Elizabeth Grosz (1994), Merleau-Ponty was blind to these more tangible elements of female bodily experience because he prioritised the visible.

Early in his theorising, Merleau-Ponty expressed a belief that “visual experience is truer than tactile experience” (2002, p.271-2 note 60). This belief is in line with the traditional patriarchal perception of vision as linked to knowledge and thus “superior to the other senses” (Grosz, 1994, p.97). In Irigaray’s critique “the tangible is, and remains primary” to the visible (1993, p.162). According to Irigaray, a person could “never see” the style or manner in which they touch or have been touched (p.161). For example, a “caress does not see itself” (p.161). Grosz underscores Irigaray’s critique by observing that the tangible is “the unseeable milieu of the visible” (1994, p.106). The tangible is “the source of visibility” and actually “precedes” distinctions such as those between “active and passive, and subject and object” (p.106). For a pregnant woman in particular, what she feels has a far greater importance than what she sees. When taking the traditional perspective of prioritising vision, anything less than vision is considered
as deficient or is passed over as less important. This bias went unacknowledged in Merleau-Ponty’s (1968) conceptualisation of ‘the flesh’ and was carried into his theorising of its relational qualities.

2.3.2 The fleshy unity of chiasmic relationships

The differing and paradoxical properties of ‘the flesh’ were maintained, in Merleau-Ponty’s theorising, through a chiasmic relationship called ‘the chiasm’ (1968, p.266). ‘Chiasm’ comes from the word “chiasma” meaning “an intercrossing” which in anatomy refers to the crossing of the two optic nerves (Trumble & Stevenson, 2002, p.392). To Merleau-Ponty a chiasmic relationship allowed parts of a whole to maintain their differences while crossing, doubling back, reversing and enfolding on/around each other. One way Merleau-Ponty explained the relationship was in terms of a “coiling over” of, for example, “the visible upon the seeing body” or the “tangible upon the touching body” (1968, p.146). Another example was of a person’s two hands touching: Merleau-Ponty discussed how each hand that was touching and being touched was different and separate, but each also worked as a fleshy unity through the process of their relationship. The chiasmic relationship was essentially Merleau-Ponty’s conceptualisation of what mediated the “style of being” that a person brought to lived experience (1968, p.139).

Feminist critique argues that Merleau-Ponty’s portrayal of the chiasmic relationship is unbalanced by his focus on the visible, even when his examples had no reference to vision (Grosz, 1994; Irigaray, 1993). For example, while the sensations involved in a person’s two hands touching are different and separate, Merleau-Ponty identified that one hand is always assumed to have primacy, and that when one hand is in control the other cannot be (1968). Hence, in this and his other examples, the “experiences never exactly overlap” and they “slip away” at the moment they are about to meet (p.148). It is because of this slippage that Merleau-Ponty said the phenomenological unity of “the flesh” is “always imminent and never realized in fact” (p.147). Grosz therefore considered Merleau-Ponty’s depiction of the enfolding, reversibility of the flesh to be “asymmetrical” (1994, p.102). Feminist theorising shows how more symmetry is possible.
2.3.2.1 A symmetrical chiasmic relationship

Irigaray (1993) explored how a symmetrical chiasmic relationship may occur. She drew from her understanding of female sexuality to suggest that a woman’s labial lips (and/or those of her mouth) form a more helpful metaphor for the enfolding chiasmic relationship of ‘the flesh’. To this carnal metaphor Irigaray added the usually hidden mucous as a lubricant in the relationship between differing parts of the body. Using this metaphor, during childbirth the appearance of the mucous as ‘the show’ can be considered to lubricate a woman’s awareness of the invisible opening process that is occurring. Irigaray explained that the mucous is the “most intimate interior” of the flesh, a “threshold of the passage from outside to inside, inside to outside and between” inside/outside, outside/inside (1993, p.170). Grosz identified that Irigaray’s metaphor added “simultaneity” to the experience of touch that made no presumption of dominance (1994, p.105). This “mutual and reciprocal” form of relating thus demonstrated ‘the flesh’ as encompassing a more symmetrical chiasmic relationship (p.105).

Both the feminist theories discussed in section 2.2 are supportive of the form of relating conceptualised in a symmetrical chiasmic relationship. In Relational-Cultural Theory this form of relating is a mutually empathic process that is empowering of the self, the other in the relationship, and the relationship itself (J. B. Miller & Stiver, 1998). In Young’s theorising it is the inner relationship of a woman perceiving her embodied self as both whole and encompassing continually negotiated contradictory elements (2005b). A symmetrical chiasmic relationship is also possible between a pregnant woman and her yet to be born baby.

2.3.2.2 The chiasmic ‘pre-infant’/woman relationship

Merleau-Ponty omitted theorising about foetal experience beyond perceiving that the birth was the point from which a visual life would begin. Nursing scholar Francine Wynn extended his theorising by considering the foetus as a “pre-infant” which “anticipates but does not necessitate the baby’s existence” (2002, p.8). Wynn used the prefix ‘pre’ in the phenomenological sense of pre-reflective, ‘pre-cognitive’ body knowing (p.6). In Wynn’s interpretation this sense of ‘pre’ was not “merely before in time” but also “a rich prefix” pointing to “irreducibility” (p.8). She argued that the “pure innateness” of the pre-infant is modified in-utero through a “chiasmic relating with its
mother and the world” (p.8). Indeed the woman is also changed through this relationship. Wynn claimed that both woman and pre-infant create new “perceptual and social-emotional structures” in relation to each other (p.12). This pre-infant/woman relationship is described by Wynn as the fleshy unity of a two-way reversible “intertwining” (p.11). Both woman and pre-infant are, for example, “moving” and “being moved”, “touching” and “being touched”, “feeling” and “being felt” in relation to the world around them and to each other (p.11).

The intertwining, overlapping of the chiasmic pre-infant/woman relationship is not a “grasping, controlling or owning” of either partner in the relationship, according to Wynn (2002, p.5). In this conceptualisation Wynn followed Merleau-Ponty’s idea of ‘chiasm’ as a ‘dispossession’ which is beyond or beneath intellectual grasps at ownership (1968, p.266). Wynn critiqued Young (2005b), maintaining that in Young’s theorising the pre-infant remained “at the level of a possession or object” (Wynn, 2002, p.9). According to Wynn this was because Young focused primarily on women’s self-conscious bodily experience and omitted the social and perceptive elements of the woman/pre-infant relationship. Young nonetheless exposed some of the heretofore hidden elements of women’s lived experience of pregnancy. In particular, Young highlighted how changes in a pregnant woman’s body awareness impacted on the ‘both/and’, chiasmic, nature of the relationship with herself.

2.3.3 A practical focus: body awareness

Merleau-Ponty’s theorising is descriptive and explanatory but does not clarify any practical ways in which improved sense of embodied self may occur. By conceptualising how conscious body awareness impacted on lived experience, medical doctor and philosopher Drew Leder made a more practical analysis of phenomenological unity (1990). Leder extended Merleau-Ponty’s work by analysing the lived experience of illness and health. The body was conceived as a “biological organism”, the “ground of personal identity” and a “social construct” (p.99). Leder theorised that “disruption and healing” took place “on all these levels” through “intricate chiasms of exchange” (p.99).

2.3.3.1 Conscious body awareness

A person’s conscious awareness of their body was noted by Leder to vary and in turn impact on their sense of unified self. Phenomenological unity was conceptualised by
Leder in terms of bodily presence and absence. He theorised the lived experience of bodily presence as a “highly paradoxical” concept that was characterized by absence and difference (1990, p.1). Body absence was conceptualised as a movement of body awareness to a more visceral inner depth. Leder identified that body absence arose from the “fundamental structure of embodiment” (p.105). His theorising was based on the understanding that although there is an innate source of vitality within the body, as described by Merleau-Ponty (1968), it is at a level to which the “conscious mind cannot follow” (Leder, 1990, p.173).

Leder considered that the “usual state” of lived experience was for embodied self “to be lost in the world” while at the same time the body disappeared from immediate awareness (1990, p.160). This was the ordinary state of body absence which, to Leder, was an example of “the body’s unproblematic unity with self” (p.103). Leder claimed that because “the normal and healthy body” largely disappeared in this way, conscious awareness of the lived body was “skewed toward times of dysfunction” (p.86). He showed that at times of body ‘dysfunction’, such as during pain or illness, conscious body awareness increased. Body awareness also increased, according to Leder, at times of “problematic operation” such as when physiological limits created a sense of thirst, depression created a sense of lethargy, or the sun’s glare caused a squint (p.85). “Marked shifts” in body awareness were also recognised to occur during particular phases of life and living, such as during youth and aging, and when pregnant or menstruating (p.89).

2.3.3.2 The alienation of ‘dys-appearance’

During periods of conscious body awareness Leder identified a different form of absence which he called “dys-appearance” (1990, p.84). This was an absence of the desired or “habitual” state of embodiment characterised by the usual unproblematic unity of body with self (p.89). ‘Dys-appearance’ thus occurred, according to Leder, when lived experience was accompanied by a sense of alienation often focused on the body. Citing Young (2005b), Leder recognised ‘dys-appearance’ during pregnancy. Women’s sensations of being decentred or split by the inherent contradictions of embodied self in pregnancy were, to him, an experience of ‘dys-appearance’. Like Young, Leder also critiqued the objectifying gaze of others and described how it caused a form of “social dys-appearance” (Leder, 1990, p.96).
The alienation of ‘dys-appearance’ was recognised as just one way to respond to conscious body awareness, but Leder believed it to be dominant in Western cultures. Leder showed how traces of the Enlightenment’s Cartesian philosophy that split rational thought from body experience were “deeply entrenched in our culture” (1990, p.5). He suggested that it was from the “very immediacy” of the ordinary lived experience of body absence that dualism arose and through which it was “continually sanctioned” (p.149). The cultural context therefore promoted, according to Leder, the “cognitive habits of dualism” making conscious body awareness one of alienating ‘dys-appearance’ (p.5). These habits are more specifically explored later in this chapter.

2.3.3.3 Phenomenological unity and being open to change

Leder also pointed out that there were ways in which a person may react to conscious body awareness while retaining their sense of unified self. He described a way of actively maintaining this unity through a chiasmic relationship with the self and the world. Leder expressed the “unifying principle” of phenomenological unity in terms of moral, aesthetic and spiritual modes of lived experience, that mutually resonated and intertwined to “form one body” with the world and personally (1990, p.161). Leder claimed that the phenomenological unity achieved through the practice of these modes of living could enable a person to more readily open themselves to change than is possible with a sense of ‘dys-appearance’.

The idea that embodied self could be open to change by forming one body through an entwined relationship of lived experiences has a clear resonance with Merleau-Ponty’s concept of ‘the flesh’ and ‘chiasm’. To Merleau-Ponty the envisaging potential of the body image was “open and limitless” (2002, p.171). However, Irigaray argued that the visible could also “totalize, enclose” and “give the illusion of a closed world” (1993, pp.174-5). According to Irigaray, emphasis on the visible had the potential to cancel out the sensory, creative “most powerful component” of “the flesh” by perpetuating a closed perspective that thwarted the changes of embodied self (Irigaray, 1993, p.175). Emphasis on the visible can also thwart a woman’s capacity to open herself to intimate and invisible aspects of the in-the-moment changes that occur at times such as during childbirth and sexual intercourse.

Leder’s analysis of conscious body awareness shows how a person’s body image may be enclosed and limited by an underlying cultural context of dualism. The resultant
alienating sensations of ‘dys-appearance’ are “immediate and privatized” (1990, p.99). This alienation, according to Leder, also plays a part in broader patterns of “social behaviour and power distribution” (p.99). His solution is a shift in focus away from dualism toward the unifying principle of phenomenological unity. With such a shift a sense of unified self can be experienced simultaneous to the paradoxical presence of the lived body. Leder therefore presents a ‘both/and’ solution much as Young does (section 2.2). Women’s lived experiences are by no means a focus of Leder’s theorising. Nonetheless his theorising does give a practical indication of how phenomenological unity can be experienced beyond Merleau-Ponty’s emphasis on the visual. Leder presented a strong analysis of the Enlightenment philosophies underpinning his claims. However, Leder made little analysis of the other ways power could impact on the sense of embodied self; this is the focus of the next section.

2.4 CONTROLLING POWERS: DESIRE, SECURITY AND CHANGE

Early in my study of philosophy I came to see that desire would be important to the understanding of embodied self and change. Desire is a form of power that directs a person’s action and influences their sense of wellbeing. According to the post-structural work of French psychoanalyst Jacques Lacan (1901-1981), underlying all desire is a desire to be secure (1977, 1991a, 1991b, 1992, 2002). Lacan symbolised security in the sense of containment and contentment believed to occur in-utero. “Residues” of the experiences of being contained within the security of “the maternal organism” were, to Lacan, retained by the newborn (2002, p.6). By this Lacan meant that for all people an embodied memory of past security remained in the form of a current sense of lack. It is therefore this sense of lack that forms the underlying desire to be secure. ‘Lack’ to Lacan is this powerful sensation of not being secure and whole. ‘Underlying desire’, on the other hand, is the power that is produced and held in the body as a result of sensing lack. These concepts along with those of ‘ego’, ‘drive’, ‘the real’ and ‘the unconscious’ (discussed below) are all forms of embodied power. The concepts are variously used by Lacan to relay how ‘embodied self” exists as the phenomenological unity of a body/self who rarely if ever sees, feels or conceptualises itself as a unity. Lacan thus theorised that changes to the self continue through life and are structured by the sense of lack and the concomitant desire to return to a state of secure wholeness.
2.4.1 **Underlying desire and the changing self**

The state of pure wholeness and security underlying all desire was called “the real” by Lacan (1977, p.167). ‘The real’ was not only a pre-linguistic and contained experiential state where all desires were continually met. To Lacan ‘the real’, was also a paradoxical state that was fearfully chaotic, boundless and distinguished “by its desexualisation” (p.167). He used the word ‘desexualisation’ to mean that ‘the real’ was a state of merger and sameness rather than one in which a relationship of difference was experienced. An experience of ‘the real’ has been closely associated to the concept of ‘little death’ colloquially known as orgasm, although, in Lacan’s theorising, it did not necessarily refer to the sexual act. Experiences of ‘the real’ encompass the orgasmic exquisite nature of pain and/or joy in such a way that it reflects the disruptive, undisciplined nature of a merger into pure sameness. Lacan considered this an experience beyond pleasure such that it was too painful, too awesome or too wonderful to be pinned down with words. Any extreme of experience is representative of ‘the real’ when the intensity blots out desire and a sense of self-definition.

The unconscious is not the same as ‘the real’, although Lacan aligned the chaotic and paradoxical elements of ‘the real’ with the unconscious. To Lacan the unconscious was the embodied “sum of the effects of speech” on a person (1977, p.126). He claimed that a person’s experiences of desire and their sense of lack were “inscribed” on the unconscious and then repeated in varying ways throughout life (p.153). Indeed, Lacan perceived the unconscious as “structured like a language” where symbols and meanings were continually shifting relative to desire (p.149). According to Lacan, underlying desire arises from and is shaped by the unconscious. The drive to fulfil desire also arises from the unconscious. However, it is via the ego that underlying desire is expressed as needs, demands or desires. The ego itself also evolves from the chaos of the unconscious to define and rationally order the changing self. Understanding the ego is therefore important to an understanding of how a childbearing woman’s embodied self changes.

2.4.1.1 **Imaginary power**

The ego is a form of power. The power forms through ego’s creation of an imaginary reference point from which the self can perceive itself as whole whilst interacting with the world. In considering how the ego developed, Lacan studied the function of body
image. His theorising was based on the suspicion that the “cerebral cortex functioned like a mirror” (1999, p.214). He theorised an ongoing process where what was outside of the self was reflected and integrated to “establish” a physical and psychological “relationship” between the person and their current “reality” (2002, p.6). Lacan observed that, since the self “is inside” the body, the self “knows” it “is a body”, but the self “never perceives it in a complete fashion” (1991a, p.176). Incomplete perceptions of the self and the world evoke a sense of lack reinforced by conflicting feelings and unmet desires. Lacan explained how such sensations prompt alienating experiences of “inner conflictual tension” and of being “fragmented” (2002, p.6 & 21). Alienation creates an “internal pressure” that “pushes” the person from a sense of “insufficiency” to one of “anticipation” involving a form of “spatial recognition” of how desires might be met (p.6).

According to Lacan, “as soon as” an object of desire is perceived a sense of ownership of that object develops (1977, p.81). On perception of the object the self then creates an image which Lacan theorised became misrecognised as belonging to or actually being part of the self. The sense of ownership can sometimes extend beyond ownership of the image to a perceived ownership of the actual object. The owned image may be another person, an actual thing or a preferred outcome. For the infant that image may be the maternal breast or the entire body of the mother/caregiver. For the pregnant woman the image may be of her plan for getting through labour and giving birth. By internalising an image of the desired object as part of the self, the ego, to Lacan, creates a secure “rigid” and whole self-image to take into the future (2002, p.6). This process of internalising images as part of the self is the ego’s imaginary power, but the ego also has a spoken power.

2.4.1.2 Spoken power

Lacan clarified that the security the self was “looking for” with the ego was “certainty” (1977, p.129). Egoic power enables this certain security not only through the imaginary self-image but through speech. By applying misrecognition back on the self, Lacan claimed that the ego objectified the self to create the spoken symbol ‘I’. To Lacan ‘I’ symbolised more than the simple desire to be recognised at the individual one-to-one relationship level. At the cultural level he believed that ‘I’ expressed the desire for recognition and certainty about the self’s place within culture. For Lacan linguistic
structure interrelated with cultural structure. To him the “power of naming” worked to sustain perception within cultures and to sustain how ego perceived itself, objects and people at the individual level (1991b, p.169). Speech moves the self beyond the “momentary” experience of an object to the misrecognition of the object as permanent and worthy of ownership (p.169). Through naming “a meaning” is conferred “on the functions of the individual” that makes “reality” more “concrete” which in turn makes a cultural level of security more possible (2002, p.49). For Lacan the ego’s spoken power was as powerful in silence as in sound. Language is iterated silently by conscious thought and marks the unconscious. Language is also powerful for the ego as it enables negotiation of desires with individual others and more generally within culture.

Ego uses two interconnected ways to negotiate desires with others. At the level of individual interaction Lacan explained that the self maintained the illusion of secure wholeness through compliance with the other person’s desires. At the cultural level the self complies with the cultural mores of the situation though may not necessarily comply at the individual level. Both ways express underlying desire. The expression of underlying desire, according to Lacan, is symbolically represented in language because language, in his view, was based on ‘lack’. Thus he said that “all speech calls for a response” and that “all demand” implies a “request for love” (2002, p.40 & 299). Lacan used the word ‘love’ here in the way that the ego misrecognises it to be synonymous with lasting wholeness and security. In effect ‘love’ in this context was an expression of “the desire for… desire”, meaning the desire to be loved by another and/or to be culturally accepted (p.188). Security is created by the ego’s spoken power to create a sense of “dependence”, for example, on the individual other’s ‘love’ or on cultural acceptance (p.188).

The dependencies created through ego’s spoken power concomitantly place “limits” on the self’s willingness, or drive, to change (1992, p.94). The body or its organs, for example, may be professed to function only according to certain limits although the body’s actual capacity may extend way beyond those limits. These limits, to Lacan, were “a kind of morality” constructed by the ego in its relations with individual others and with culture (1977, p.102). For example, limits are often constructed in the name of ‘safety’. Women interact with the standard paradigm of maternity care in their desire for ‘safety’. Such interaction constructs limits that can then cause women to doubt their body’s capacity to give birth making them more dependent on caregivers. The ego’s
spoken power can therefore designate limits of possibility that overshadow the body’s potential. Yet, to Lacan, although the ego exerts this moralising effect, in reality anything at all may be possible. These limits are however defensively nurtured by ego’s misrecognised spoken and imaginary powers.

2.4.1.3 Self-protective power
The self-protective power of ego aims to defend its misrecognised spoken and imaginary wholeness. According to Lacan it was through perception of the other person as different and therefore a potential “rival” that the self “grasps” itself “as ego” (1991a, p.176). The awareness of difference can occur at the individual or cultural level; for example, when the self’s love for another is rejected or when efforts to conform to culture go unrecognised. To Lacan that moment of realisation of difference is a moment of ego annihilation that reflects the self’s “own nothingness” relative to the ego’s perspective (1977, p.92). Lacan believed this moment was an experience of ‘the real’ and a reminder of the sense of lack. He argued that while an underlying desire for the secure wholeness of ‘the real’ may persist, the concomitant dissolution of the ego was far more terrifying. Lacan therefore conceptualised the ego as a self-protective power with the primary intention of defence.

Lacan’s conceptualisation of ego as a self-protective power was in line with Sigmund Freud (1856-1939) whom Lacan claimed to follow. One of the many ways their theorising differed was in what the ego was actually defending. To Freud the ego was a rational power that defended the self from the irrational drives of the unconscious (1962). The drives were conceptualised by Freud in terms of sexual power as a series of bodily impulses that the ego redirected from their pleasurable sexual goal toward one that was socially acceptable (1977). For Lacan, the rationality of the ego’s actions was relative to its imaginary, spoken and self-protective powers. Therefore Lacan theorised that the ego was defending itself against its own dissolution due to incursions from ‘the real’.

The ego acts to defend itself through interaction with ‘drive’. According to Lacan drive arises from the unconscious; it is the power used by the self to obtain the various objects of desire. Attaining an object of desire is the short term result of drive which gives a momentary experience of ‘the real’, but the sense of lack is theorised to quickly return along with ego power. An example is how the purchase of consumer goods does not
usually bring lasting contentment and the perceived need for other goods quickly returns. The action of drive thus appears to go against the self’s underlying desire for a more lasting sense of secure wholeness. Lacan made claims of an apparent “plasticity” to drive making it easily influenced by the ego’s self-protective power (1992, p.94). Hence, although the ego consciously directs drive, the ego also influences drive in ways that the self is unaware of. So while a person may consciously intend one thing the hidden protective power of ego may actually lead the person in another direction. For example, a person may dismiss their bodily sensations, or not even notice them. Additionally, the ego’s “paranoiac structure” might promote behaviours that are self-aggrandising through the use of arrogance and aggression, or self-sacrificing through the use of diminutive or submissive activities (2002, p.21). The disjunction between intention and action occurs, to Lacan, because ego’s self-protective power is aimed at its own imaginary and speaking power not at ‘the real’ of experiencing the self as an embodied whole. This is why a woman may find herself intending one thing, such as natural birth, whilst her ego actually leads her toward more techno-medical culturally acceptable forms of birth. Over time however, drive does force the ego into a situation of change.

2.4.1.4 Creative power

In the long term drive acts as a creative power. Drive does this by lifting the “screen” of the ego “fantasy” that “conceals” aspects of the self at the “primary” phenomenological level (1977, p.60). The ego’s fears, images and words may seem very real but they are merely reflections derived from experiential reality, they are not experiential reality itself. Lacan claimed “no language could ever speak the truth about truth” because the boundaries of truth are created by language (Bowie, 1991, p.119). Lacan maintained that the security and wholeness of underlying desire can only “emerge” as a “limitless love” in the experiential place of “the real”, which is “outside the limits” of language (1977, p.276). The unspeakable experience of truth cannot be pinned down from one moment to the next by rational words, imaginary reference points or the fears of the ego. Nonetheless the concept that the self may be something more than the images and words of the ego is often not recognised by the self. The long term function of drive is thus to reveal the reality of the self to the self.

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1 Lacan (1964-5) Seminar XII p.867-8 as translated by Bowie; I was unable to find an English version of this text.
However, the self may imagine itself as nothing without its ego. According to Lacan, drive in the long term is also a form of “death wish”, but he didn’t mean actual bodily death (2002, p.102). Lacan said “drive learns” through its repetitions that “by snatching at its object” it will not “be satisfied” (1977, p.167). By failing to achieve its objectives the self becomes aware that the wholeness guaranteed in the words and images of the ego is not real. The ego can then become revealed as “a hollow” or “void” (1977, p.180). This is ‘the real’ feared point of ego dissolution which may be perceived as a feeling of death. Nonetheless ego dissolution “later admits something new”, such as a changed ego, which at the time of the experience can seem “impossible” (p.167). Lacan calls this process “an inverted form of repetition” where the part of the ego involved with the particular repetitions of drive is forced to change (2002, p.100). Thus, in the long term the power of drive is “creationist”, both with a “will to destruction” and a “will to make a fresh start” (1992, p.212).

Creative power enables an overall change in the self that also encompasses many lesser experiences that successfully and unsuccessfully evoke self changes. A person’s drive is not about the things achieved or the things acquired. Nor is drive about maintenance of ego’s objectified ‘thing’ called ‘I’. Instead, drive is about nothing of value to the ego, or to a self who sees itself only as its ego. Drive’s “aim”, to Lacan, is actually about “the way taken” (1977, p.179). Rather than achieving desires, what is important in the overall process of change is whether the process successfully reveals more of the experiential reality of the self. Thus, it is the way the changing self is experienced that leads to ‘the real’ in-the-moment experience of wholeness and security, beyond the boundaries of language.

2.4.2 A partial rejection of humanism

Lacan’s theorising is a partial rejection of humanism, the dominant Western philosophy. For this reason his theorising underpins much of feminist psychoanalysis (Grosz, 1994). As outlined in the chapter one, humanism promotes the idealistic value of a non-conflicted, stable and autonomous self who is rationally disconnected. A key element of Lacan’s critique was focused on René Descartes’ (1596-1650) philosophy that the self was governed by reason (Lacan, 1977). According to Lacan, Descartes was “looking for certainty” (p.222). Descartes eventually achieved this certainty by using his rational
powers to argue for stable conceptual disconnections between soul and body, and between body and mind.

2.4.2.1 The power of disconnection

Descartes’ arguments for disconnection were based on his desire to undertake anatomical studies of dead bodies; an act that risked an accusation of heresy (Descartes, 1972; Spretnak, 1999). At issue was the Aristotelian concept of the embodied soul which encompassed a nonrational power unrelated to the intellect or reason (1984b, 1984c). By the 13th century the Christian theologian Thomas Aquinas (1224–1274) had re-developed that concept into a power perceived as a natural law grounded in the divine reasoning of his Christian God (I. Hunter, 2003). Natural law was used as a moral defence for the enormous power of religious authorities at the time. Descartes created the conceptual disconnection between body and soul by insisting that the body, as a corpse, was not animated by the soul but by yet to be discovered mechanisms (1972). In articulating this soul/body disconnection Descartes eventually engineered the split between religious authorities concerned with the spirit, and those who were to become the scientific medical authorities concerned with the body.

At the time the conceptual body/soul disconnection was resisted by philosophy and medicine (Conway, 1982; Wright, 1991). So Descartes conceptualised the body/mind disconnection (1956, 1996). To Descartes, the rational processes were so all powerful that he believed his theorising could not be faulted. Although the mind was not equivalent to Descartes’ “supremely perfect” deity, his rationality acquired a sense of omnipotence (Broadie, 2001; Descartes, 1996, p.32). In Descartes’ theorising pure rationality dictated that all was knowable one way or another, if one was rational enough. So Descartes personalised the arguments of his dissenters, criticising their rational capabilities. Descartes reasoned that the philosophers who disagreed could not have “distinguished with sufficient care the mind from the body” nor could they have thought with sufficient “attention” (1983, art XII & art XIII Part1). This was a form of rational dichotomous thinking that heralded the birth of the autonomous, rational individual known today (Mansfield, 2000).

Descartes’ disconnective theorising was powerful because it involved rational dichotomous thinking. As explained in chapter one, this powerful and often flawed form of thinking underpins humanistic discourse by privileging one of a pair of alternate
options over the other. Instead of recognising the ‘both/and’ perspective as nonrational (neither rational nor irrational), rational dichotomous thinking marks it as impossible and therefore opposite to rational, irrational. When using this form of thinking spirituality is perceived as abstract whereas the body is seen as concrete. As ‘abstract’ and ‘concrete’ are rationalised as opposites, spirituality and the body cannot rationally be perceived to occur together and all other options are rationalised as impossible. Likewise, mind and body are rationalised as opposites. They cannot be perceived together and the actions of the mind are valued over those of the body. Hence Descartes’ use of rational dichotomous thinking acted to maintain his conceptualised disconnections, including his flawed belief that the self was unchanging and purely governed by reason.

2.4.2.2 Soul/body unity: the power of potential

Lacan objected to both the pure rationality of Descartes and to the Cartesian concept that the body had no innate knowledge or power. He argued that Freud’s embodied network of sexual impulses had “caused the whole world to re-enter us” and re-establish the body as powerful (Lacan, 1992, pp.92-93). Lacan was also influenced by Aristotle’s (384–322 BC) philosophy which held none of the disconnective power of Descartes. For Aristotle soul/body “unity” was fundamental to the person as a living substance (1984c, p.412b). A person’s soul, to Aristotle, was divisible into “an infinity of parts” that each possessed a soul but were also inseparable from each other as well as the whole soul (1984c, p.432a). The “most primitive” and nonrational “power of soul” was found in “everything that grows and decays” (p.415a & 434a). Whereas the human soul also contained the rational power of the intellect which nonetheless still required a “body” as “a condition of its existence” (p.403a). Thus, the human soul was conceived as a unity of physiological, sensory and intellectual components that included aspects that influenced desire and empowered change.

Change, to Aristotle, was a linear process that occurred relative to the power of potential. The power of potential was the fundamental “principle” of the soul’s “own production”; it was essentially the “innate impulse to change” (1984d, p.192b). Aristotle claimed all forms of soul held potential but some were rationally able to act on themselves to change. Other forms of soul were “nonrational”, which meant, for Aristotle, that they contained potential but lacked the ability for self-reflexivity (1984b,
Nonrational potential was unity alone; a ‘both/and’ perspective did not figure in Aristotle’s theorising. Yet the concept of unity referred to the “actuality” of a “body having life potentially in it” (1984c, p.412a-b). Unity, nonrational potential, and lack were thus seen by Aristotle as the starting point or “originative” source of change and living which was literally and symbolically maternal (1984b, p.1046a). Similarly, the starting point of change was, for Lacan, a person’s “encounter” with the unity of “the real” (Lacan, 1977, p.52-3). The potential of both ‘the real’ and of nonrationality were conceptualised as an irreducible unity that to Lacan and Aristotle lacked the eventual outcome. What was actually lacking was Aristotle and Lacan’s own awareness of the incredible, nonrational ‘both/and’ potential of a pregnant woman, as disclosed in Young’s theorising (2005b) (section 2.2.2).

2.4.2.3 The power of lack

Lacan’s emphasis on lack is why his theorising can only give a partial rejection to humanism. By highlighting the concept of lack even within their own concept of supposedly irreducible unity both Lacan and Aristotle were ultimately endorsing the dominance of rationality; what they saw as lacking in unity was the imaginary and spoken power of the ego. Lacan also showed how the power of lack prompted the sense of deprivation and desire as well as arrogant, aggressive and self-sacrificing behaviours. These notions that the self has privileged rights that can be asserted against the desires of others is a feature of humanism’s stable autonomous self (Harrison & Fahy, 2005).

Lack is also an element in the rational dichotomous thinking underpinning humanistic discourse. Hence, although Lacan critiqued Descartes’ conceptualised disconnections, his theorising endorsed some of the humanistic values that arose from Cartesian philosophy.

While much of feminist psychoanalysis originated from Lacan’s theorising, feminists also find his focus on lack problematic. Lacan purposely used gender specific language to show differences in the power held by and influencing individuals. He variously symbolised the powerful positions of language and culture as the Phallus, Name-of-the-Father, or Law-of-the-Father. In contrast the symbolic mother was portrayed as lacking power in the sexually neutral position of ‘the real’. Irigaray described how Lacan himself “intentionally” took on the seductive and powerful position of the Phallus in his teaching role (2002, p.210). She identified how Lacan’s “delight” in not fully citing his
many philosophical sources added to this power (p.210). In Grosz’s analysis, from the outset of their theorising both Lacan and Freud adopted “only the boy’s point of view” (1994, p.59). As such the lack was, at its most basic, a reference to women’s lack of a penis and men’s fear of its loss. The female body’s lack in Lacan’s theory also acted to substantiate the male sexualised body and the supposedly neutral status of his knowledge (Grosz, 1995). Indeed, Grosz argued that Lacan’s theorising essentially demonstrated how “patriarchy is psychically produced” through the “constitution of women’s bodies as lacking” (1994, p.60). As this lack is inherent in humanism it also has an impact on how women are perceived to make social changes.

2.4.3 Making a social change

In Lacan’s theorising the desire for cultural security clearly had an impact on the change process. According to anthropologist Arnold van Gennep (1873-1957), the rites of passage are what provides that security while a person experiences the changes involved with social transition (1960). Life, to van Gennep, was cyclically patterned in a continual forward progression through periods of stability (no change) and periods of transition (rites of passage). He considered the rites of passage as the movements between different social positions or states. Expanding on this theory Victor Turner (1920-1983) identified that the movement is toward increasingly powerful social levels (1995).

2.4.3.1 Increasing social power

Social power in rites of passage theory refers to an individual’s increased value to society. For women this value is expressed in terms of their capacity to produce and nurture new members of society; by being a mother a woman demonstrates her social value. Women’s experience of pregnancy and birth was conceptualised by van Gennep to be their rite of passage from the socially construed position of young woman to that of mother (1960). Van Gennep also identified each physical experience of pregnancy as a rite of passage to a new socially enhanced version of mother. A woman’s rite of passage through childbearing is therefore, according to van Gennep and Turner’s theorising, a functional one, directing women toward the socially desired, elevated status of mother.

Van Gennep theorised three broad and often overlapping phases to rites of passage; “separation”, “liminality” and “incorporation” (van Gennep, 1960, p.11). As detailed
below, ‘liminality’ is the in-between phase where a person connects with their unconscious, with embodiment and with more spiritual elements of life. Van Gennep claimed that because of its complexity, rituals from all three phases form part of the overall liminal experience of childbearing. Similar to Lacan’s experiential state of ‘the real’, an experience of liminality is one of paradox that encompasses feeling powerless but also powerful. Turner called people experiencing this process “neophytes” because they were naïve and uncertain about their future new state (1972, p.342). Taking a linear pathway neophytes go through a separation from their prior social state to undertake liminal changes; they are then eventually incorporated back into society and their new social state.

### 2.4.3.2 Liminality: both powerful and powerless

According to Turner, during liminality neophytes are reflexively and progressively “ground down” by the inevitable elements of change, the most notable being those losses incurred in separation from their ordinary prior state (1972, p.342). In Turner’s theorising neophytes may resist and attempt to control the process but over time they acquiesce, moving deeper into the nonordinary liminal state in between social positions. Turner contends that neophytes are passive and malleable “to their instructors” and this passivity is “increased” by their “submission” to the “ordeal” (p.342). In succumbing to their powerlessness, neophytes were identified by Turner to turn inward and experience a “peculiar” sense of “unity” (p.341). This concept of unity is supported by Michel Odent who theorised about the physiology of altered conscious states in childbirth (1999). Many labouring women experience liminality as an altered conscious state. Odent claimed that in altered conscious states, the rational neocortex of the brain and the primal hypothalamus move toward a state of harmony (1999). In these more harmonious states the ordinary, relatively indiscriminate self-controls imposed by the neocortex are diminished. This allows the primal brain to optimally regulate the body’s complex hormonal balance. According to Odent the resultant effect can provide a sense of “being a part of a whole” that transcends space, time and other boundaries (p.66).

Liminality in Turner’s description was a spiritual experience. He noted that sometimes neophytes felt a “close connection” with “deity”, with “superhuman power”, or with what may be regarded as “the unbounded”, “the infinite” or “the limitless” (1972, p.340). According to Turner neophytes were eventually, reduced “to a uniform
condition” of openness and receptivity where they were “endowed with additional powers” (p.342-3). These powers of “arcane knowledge or gnosis” were felt by Turner to “change the inmost nature” of the individual (p.343). To him, this process was not a mere “acquisition of knowledge, but a change in being” (p.343). The neophyte “absorbed” these powers, but, Turner believed that these powers would not become “active” until the individual was incorporated back into society in their newly elevated more powerful state (p.343).

Turner identified that when liminality was more than a conceptual intention for spiritual renewal but “bound up” with inevitable “biological or meteorological rhythms”, as it is in childbearing, then rites of passage tend to “reach their maximal expression” (1972, p.338). Odent showed how “peak experiences” can occur, for example, in association with the high levels of endorphin production present in the extremes of pain and of pleasure (1999, p.75). He called these experiences “orgasmic” because their hormonal patterns reflect that of sexual ecstasy (p.64). Odent identified how the primal brain is “not repressed by cortical activity” during these altered conscious states (pp.75-6).

Liminality is thus a potentially vulnerable state which is why it is accompanied by ritual.

2.4.3.3 Ritual: containing liminal power

The concept of ‘ritual’, in rites of passage theory, is a culturally determined set of practices and symbolic representations of what has, should or will be practised by the person during their change process. Rituals act to variously protect, guide, separate and incorporate the changing person in relation to their culture. Turner identified ritual in opposition to ‘ceremony’ (1972). For Turner ceremony referred to practices related to stability whereas ritual referred to practices that create change (toward or away from stability). The role of both ritual and ceremony is to mediate between an individual’s actual experience and that individual’s conceptualisation of the experience. This mediation between actuality and conceptualisation thereby enables a person to positively integrate experiences into their embodied sense of self.

In van Gennep’s theorising the conceptual meanings symbolised by ritual are continually shifting and changing (1960). Part of the protective effect of ritual is its capacity to elevate aspects of life beyond the ordinary into an extraordinary sacred status. To van Gennep sacredness, as with ritual, is a relative state that he said is
“brought into play by the nature of particular situations” (p.12). For that reason van Gennep said ritual can “be interpreted in several ways, depending on whether it occurs within a complete system or in isolation, whether it is performed at one occasion or another” (p.166). Therefore, whether or not something or someone is seen as sacred, and whether or not a particular practice is considered a ritual, depends on what their situation is that particular moment.

The power and vulnerability induced through liminality are contained by ritual. Van Gennep identified that the process of social change could only occur through “disturbing the life of society and the individual” (1960, p.13). Ritual acts to limit that disturbance. To Turner, liminal individuals were “a paradox” and “a scandal” whose ambiguity threatened the clarity and structure of culture (1972, p.341). In Turner’s analysis liminal individuals were “nearly always” regarded as “polluting” to the members of society who had never been “initiated into the same state” (1972, p.340). This is why, Turner claimed, liminal individuals “have to be hidden” (p.341). So in order to protect both individuals and their social structure van Gennep reasoned, “it is the function of rites of passage” to “reduce” the “harmful effects” of transition through ritual (1960, p.13). It is through this paternalistic protective function that culture creates rituals.

2.4.4 ‘Neutral’ knowing hiding patriarchal power

Rites of passage theory clarifies and gives a broader perspective to how embodied self changes than does the complex and detailed analysis of Lacan’s theorising. However, the ideas expressed in both theories are brought from a fundamentally masculinist perspective. Van Gennep and Turner’s analysis of social power is linear and sees women’s status only in the essentialist terms of their reproductive capacity. Women’s rituals are considered by van Gennep and Turner. Yet, as the feminist theologian and researcher Jan Berry observed, their theorising “assumes a symmetry” between the male and female experiences (2006, p.276). This is an example, to Grosz, of how men take the role of supposedly “neutral knowers” that in turn renders women’s bodies as lacking and “neutral” (1995, p.38).

The desire to bring a feminist perspective to the supposedly ‘neutral’ position of knowledge generated by men can be problematic (Grosz, 1995). These ‘neutral’ knowledges reflect, according to Grosz, a “fundamentally patriarchal or phallocentric”
power (p.40). Adding, replacing, or discarding them for what Grosz saw as an “anti-theoretical, anti-intellectual reliance on experience or intuition” does not resolve the problem (p.40). When feminist theorists acknowledge their sexually particular position without full critique of their underlying purportedly neutral knowledges, they are at risk of presenting their ideas in essentialist terms (as defined in chapter one). Childbearing is inherently acknowledged as specific to women, so theories about childbearing are particularly vulnerable to essentialism. The theorising of psychoanalyst Joan Raphael-Leff is an example (1994, 2001). She rightly claimed that, whether in pregnancy, birth or the postpartum a woman’s “inner reality can be as real and influential as external reality, and overspill into it” (1994, p.vi). Childhood “impressions and identifications live on” in women’s “internal realities” according to Raphael-Leff, thereby influencing “perceptions of others in the external world” (p. 496). However, drawing from these claims, she then proposed a definitive and essentialist classification of how women approached change. In her theorising, while women do change during childbearing, the way they change is determined by her classifications; those designations, once given, appear unchanging. This categorisation reveals Raphael-Leff’s implicitly mainstream, humanistic approach to knowledge which is underpinned by patriarchal power. Raphael-Leff’s categories bind women to change in the particular ways she has defined and diminish their power as embodied selves.

Grosz identified that a “mainstream” approach considers women as “knowable objects” rather than as embodied beings who are “the subject of knowledges” (1995, p.39). To Grosz conceptualising “distinct processes” or “psychical states” are “abstractions” decontextualised from “current experience” and “the whole of one’s life history” as well as “disconnected from the flow of time” (2004, p.239). With this mainstream approach Irigaray claimed “living energy” becomes “sacrificed” to the disembodied and stable “truth” of patriarchal knowing (1996, p.99). Such situations are “beyond growth” because differences are “neutralised” and all people are expected to “become alike” (p.99). Patriarchal power masquerading as humanism hides what Grosz saw as the real “indeterminacy of identity” and the ongoing changes of “becoming” (2004, p.239). The next section considers the changing embodied self in ways that move beyond the ‘neutral’ knowing and patriarchal power of humanistic certainty and rationality.
2.5 EMBODIED SPIRITUAL BECOMING: PERCEPTIONS AND PRACTICES

My earliest understanding of the self as embodied stemmed from the dictionary definition of embodiment: embodiment was described as the bodily expression of spirit, as the “corporeal habitation of the soul” and as a unifying force (Trumble & Stevenson, 2002, p.811). This relationship between the concrete and abstract was, to me, what gave life to the body. The word embodiment therefore relayed spiritual and psychological as well as physiological and practical elements of life. I found that other critical post-structural theorists, such as Joel Kovel (1991), similarly perceived embodiment as expressing an abstract spiritual power in bodily form as well as being a site for the soul. Irigaray showed how this embodied spiritual power furnishes both the capability and the location from which change occurs, while the changing self in turn substantiates and maintains embodiment (1993, 1996, 2001). With this understanding I came to perceive change as a spiritual practice lived in the immediacy of the moment. I also perceived the embodied experience of change as a manifestation of the self in a state of continual becoming. The process of becoming, I found, was a process that flowed from how a person responded to what they perceived as different and/or challenging in their life.

2.5.1 Moving beyond ‘neutral’ knowing: perceptions of difference

In critiquing patriarchy’s supposed ‘neutral’ knowing Grosz argued that a “structural reorganization of positions of knowing” was needed (1995, p.40). She perceived that such a reorganisation should encompass not only the “pre-given ways of knowing” but also the effects that the knower had “on the kinds of object known” (p.40). Reorganisation of ways of knowing in this way presents many different perceptions of knowing. Irigaray focused on differences between knowers to critique not only patriarchal knowledge but also modes of communication in general (1993, 1996, 2001, 2002). For Irigaray, to speak “is rarely neutral”, and nor is to listen (2002, p.4). She recognised that “behaving” toward another person in a supposedly “ethical manner” in the name of the self’s own values was not an ethical position at all (2001, p.109). She believed a “reciprocal communication” that could “regulate and cultivate” power within and between people should be “a goal of spirituality” (1996, p.100). Spirituality in this sense did not mean “estranging” the self from the body and abandoning communication
in the aim for a transcendent form of becoming (p.40). This understanding of spirituality was instead one of embodiment.

### 2.5.1.1 Embodied spirituality: history, spirit and soul

An embodied perception of spirituality is given by socio-political theorist Kovel (1991). Kovel was concerned about the 20th century despiritualisation of secular societies because “the suppression of spirit has the ideological function of reinforcing the existing order.” (p.5). Spirit is fundamentally power according to Kovel. He considered spirit as vital, inspirational and able to act on “flesh and matter” to transform or give life (p.34). Kovel saw soul as the particular embodied manifestation of spirit at a particular time. Both spirit and soul were identified by Kovel as “nonrational” because they form “part of the universe which is real but beyond the power of the human intellect to grasp” (p.232). Kovel argued that what acted to limit spirit was how history was manifested amongst individuals and within culture. Cultural knowledges and individual egos may conceive the nonrational as irrational in their desire for stable and rational boundaries. However, Kovel said, although spirit and soul are “acted upon by history” and act “within history”, spirit also “stands outside history” (p.6). For this reason Kovel claimed that “all activity” had “some degree of spiritual potential” (p.198).

Embodied spiritual potential was, to Kovel, linked to the self’s “commitment” to “becoming” through practises of spirit (1991, p.108). Kovel’s references to spirit and soul were not meant to imply a single “objective truth” (p.108). Human spirit was conceived as “a practical wish to be free” that, from one moment to the next “has to be proven” (p.108). Spirituality was, to Kovel, a “conscious and goal-directed” practice aimed at releasing and experiencing “spirit and soul” (p.198). He theorised spirit to be released and experienced “in the motion” of a “dialectic” between selves and within each self (p.3). The actuality of the release and experience of spirit was dependent, to Kovel, on the self’s practise of differentiation rather than “splitting” (p.54). Splitting referred to an experiential form of rational dichotomous thinking where the self was perceived as dichotomously opposite, disconnected and separate from what is other than the self. In contrast, differentiation was a lived appreciated of the other as different and worthy of understanding.
2.5.1.2 Irreducible difference: the pathway to becoming

Difference in the form of irreducible difference has been a core element in Irigaray’s theorising. Irreducible difference refers to the impossibility of perceiving, in its entirety, what is ‘other’ than the self. ‘Other’ may refer to another time, place or person, a collection of others or the world itself. Irigaray explained how she, as a self, inhabits the world, “but the entirety of its truth is not mine”, it is a mystery (2001, p.8). She claimed that it is because the other is “not completely known”, that that other can “remain sensible and alive” to the self (p.8). One way Irigaray discussed irreversible difference was in terms of the relationship between woman and caregiver (2002). The main way she communicated the concept was through the irreducible difference between the sexes (1996, 2001, 2003).

In all the ways that irreversible difference may be discussed, Irigaray maintained that it involved the ethical practice of a “double dialectic” (1996, p.62). The double dialectic referred to two simultaneous and ongoing relationships of irreversible difference: a self/other relationship between different aspects of the self, and a self/other relationship external to the self. A further way of perceiving the double dialectic is in the irreversible difference between woman and baby who are at the same time unreservedly interconnected. This was shown in the theorising of Young (2005b) (section 2.2.2) and Wynn (2002) (section 2.3.2). The woman/baby double dialectic extends beyond pregnancy into the birth and the postpartum. Throughout childbearing the woman is giving birth both to herself and to her baby; similarly the baby is giving birth to itself and to its mother. They both give birth to their new relationship and to their joint and separate relationship with the world.

For women and men the recognition of difference as sexual difference is, according to Irigaray, “an immediate natural given” that is “a real and irreversible component of the universal” (1996, p.47). This is a lived difference “inscribed” biologically and in identity by women’s different “individual and to some extent collective history” (p.47). When recognition is given to this irreversible difference women’s power can be focused beyond reproduction to also accommodate “communication” and “growth” (p.99). With the recognition of self-growth the birth process can be seen to encompass a birth of the woman as well as a birth of the baby. The difference in a woman’s power can also become recognised in her relational power during communication, as shown in Relational-Cultural Theory (J. B. Miller & Stiver, 1998; Robb, 2006) (section 2.2.1).
The recognition of irreducible difference creates the power of being open to change. Irigaray argued that knowing “the fact of being half” of humanity leaves open the potential of becoming “whole” (1996, p.41). Whereas, “taking the whole” as the “point of departure” requires a forced denial of the whole, such as the sense of lack, for change to occur (p.41). Irigaray claimed that where “man and woman respect each other as those two halves of the universe” they also recognise that the other “cannot belong to them as their own property”, so each is able to retain their own self-integrity whilst also changing (p.51). The experience of recognising irreducible difference, to Irigaray “cannot be reduced to one hierarchy, one genealogy, one history”, nor can it be “weighed in terms of more or less” (p.105). Irigaray identified that each person is “in the process of becoming” and must define their self without “opposing” the different other in their process (p.27). Indeed, irreducible difference can construct no “absolute spirit” or “finality of being” because lived being is “always becoming” with “no end or final reckoning” (p.107).

2.5.1.3 Evolving difference: instinct, intellect and intuition

According to Grosz the endless differences manifested in and through life are what continually engender ‘becoming’ (2004). Drawing from evolutionary biology Grosz argued that it is because of the “degree of difference between individuals” that the grouping of individuals according to their similarities becomes possible (p.43). In her analysis of Henri Bergson’s (1859-1941) philosophy (1946, 1984) Grosz identified how the process of differentiation evolves in two alternate directions, quantitatively and qualitatively (2004). Quantitatively measurable difference is a process of the intellect. At its most basic the intellect is the “ability to choose”, to “discern a preference” and to “reframe a situation” using “external tools” (p.227). The intellect also has “innate knowledge” of spatial relationships (p.227). Intellect and ego appear very similar although the relationship is not discussed by Grosz. With quantitative difference Grosz found that time is conceptualised in linear terms and becomes hidden in ego’s spatial contemplation of “the nature of objects” (p.244).

Qualitative difference is, in contrast, the immeasurable difference of the unique particularity of events, places and living organisms both individually and collectively (Grosz, 2004). There may be many similarities between individuals who are each qualitatively different. Irreducible difference is an expression of the uniqueness of
qualitative difference. Qualitative difference emerges through “duration”; it evolves over time as the indivisible wholeness of an action whose particular characteristics “never occur again” even when an apparently similar action is repeated (p.183). Qualitative difference is enacted by instinct. Instinct acts on “unconscious or latent knowledge” orientated toward the individual’s survival (p.235). Grosz considered instinct as “a non-cognitive” bodily knowing and action (p.227). Instinct is enacted specific to the moment of time and the unique body that experiences the sensation.

Intellect and instinct are both ways of knowing and acting in response to difference. Intellect is rational and reflective. Instinct is nonrational and unreflective, or using Merleau-Ponty’s theorising (section 2.3.1), it is pre-reflective (2002). According to Grosz’s analysis, the knowing and actions of the intellect and instinct are also linked through the mediations of a third way of knowing, intuition (2004). Intuition takes a “reflective orientation”, both internally and externally, on the experiential whole (p.235). The knowing of intuition draws on the unreflective “inner directedness” of instinct (p.240). Intuition also draws on the intellect’s reflective and outwardly directed power that “divides the world according to the needs of action” (p.235). Grosz identified that, in comparison to intellect, intuition is “less self-invested” and does not “diminish the richness” of an object (p.235). Intuition seeks, “through patience” and a “provisional incomprehension”, the “precise forms of concept, method and representations” that suit the particular situation being experienced (p.237). Intuition is also, “thoroughly attuned to history”, to the “nuances of time” and the evolving particularities of qualitative difference (p.238). By considering the whole of a situation as it is experienced, intuition plays an important part in the practices of difference that enable becoming.

2.5.2 Practices of difference

Responding to difference is an ongoing practice throughout life, but a person does not necessarily respond in the same way all the time. An ever present influence is a person’s ego and intellect which maintain the potential to dichotomise and prioritise as well as to misrecognise. Also influential is the person’s cultural context and their response to that context. A person’s sense of cultural power tends to be measured by their capacity to conform, rather than to be different. As Irigaray noted, referring to herself, “the environment causes me to be like everyone else, to do as they do” (2001, p.39).
Through “passivity, through egoism” or through fear, Irigaray contends, she becomes “an anybody” so as to “find solidarity” with the crowd “rather than to affirm my singularity” (p.39). However, Irigaray explained, where a woman conforms passively with “a model of identity imposed upon her by anyone” that woman then “contributes to the erasure” of her own “spiritual reality” (1996, p.27). Passively conforming to the mores of the standard paradigm of maternity care can have similar results.

2.5.2.1 Conforming to culture

Conforming to culture is not necessarily a consciously chosen practice. A woman’s internalised understandings about herself and cultural power can, for example, impact on her capacity for experiencing embodiment and childbearing. Psychoanalyst Jane Van Buren perceived the capacity for embodiment to revolve around: a woman’s realisation that body and mind were linked; an awareness of herself as continually becoming; a sense of presence; and a willingness to give voice to inner aspects of herself (1996). The capacity for embodiment was a “female potency” that Van Buren linked to the cultural image of mother with power over life and death (p.434). Van Buren’s reference to the powerful image of mother drew on the psychoanalytic perspective that all women have had mothers, rather than the essentialist assumption that all women should be mothers. Van Buren illustrated how fears of this female potency could be internalised by families and by women. In Van Buren’s study, these fears impeded a woman’s capacity for embodiment, created barriers to her experience of change and compromised her bodily confidence to gestate and nurture her babies.

In the work of Jungian psychoanalyst Merete Leonhardt-Lupa the feminine aspect of women and men was “the shadow side” of culture that is kept at bay through the social sanction of “those who dare to express its teachings” (1995, p.56). Yet, Leonhardt-Lupa claimed that the place where women would find the power to mother was “deep inside their feminine selves” (p.56). The body “instinctively answers to the feminine self”, so to Leonhardt-Lupa “a woman’s body is her most important source of information about the feminine self” (p.103). But, in line with Van Buren’s analysis, Leonhardt-Lupa said this feminine “principle” was part of the “murky territories of our souls” which often becomes feared and perceived as “off-limits” by the self (p.55). A woman’s bodily knowledge was therefore “buried under deep layers of distrust” which has been nurtured, according to Leonhardt-Lupa, by Western culture’s disrespectful and
problematical approach to the female body (p.103). In both Leonhardt-Lupa and Van
Buren’s theorising internalised familial and cultural sanctions act to neutralise
difference and thwart women’s power to access their feminine self and to change.

2.5.2.2 Separating ‘other’: dirt, death and abjection

Women and their bodies are conceptualised as ‘other’ to patriarchy’s ‘neutral’ and
idealised humanistic version of self. Anthropologist Mary Douglas (1921-2007)
theorised how otherness becomes associated with ‘dirt’ (1994). To Douglas ‘dirt’ was
quite simply “matter out of place” (p.36). She believed ritual had evolved to produce
and maintain a “semblance of order” by separating ‘dirt’ and incorporating purity (p.4).
Ritual, in her analysis, revolved around positive/negative symbolism about purity and
pollution. The symbolism of purity/pollution overlays other concepts and exaggerates
their differences. Hence dichotomies such as “within and without”, “male and female”,
are variously associated with purity/pollution by being built into ritual and so into the
social structure (p.4). Young (section 2.2.2), for example, discussed how motherhood
and sexuality are dichotomised and separated in Western cultures (2005c). Embedded
concepts of purity/pollution serve to symbolically and sometimes actually separate what
is ‘other’ and different so as to preserve the stability and ‘neutral’ order of humanism.

What is ‘other’ and different is nonetheless never totally hidden. In the theorising of
feminist psychoanalyst Julia Kristeva, the idea of ‘dirt’ takes another form with the
concept of abjection (1982). To Kristeva the “abject” was death, waste, filth, or body
fluids, “what I thrust aside in order to live… death infecting life” (pp.3-4). To Kristeva
death or the confrontation with something symbolic of death was fundamental to an
experience of change. Like ‘dirt’, the abject is more than the literal ‘unclean’, it disturbs
system and order as Douglas (1994) theorised. However, Kristeva more specifically
identified that abjection “disturbs identity” as well (1982, p.4). Kristeva showed how
the abject symbolised experiences that can prompt ego annihilation, such as in the
realisation of “a hatred that smiles”, “a passion that uses the body for barter” or “a
friend who stabs you” (p.4). Abjection is thus an experience of ‘the real’ provoking, to
Kristeva, “a weight of meaninglessness” that “crushes me” (p.2). It is also an experience
of liminality that Kristeva considered “does not respect border, positions” or “rules”
(p.4). Women’s ongoing experience of the concepts of dirt, death and abjection are a
reason for the use of ritual.
2.5.2.3 Living with ‘otherness’: women’s rituals

Although Kristeva said the otherness of the abject can be kept “under control”, it never leaves (1982, p.11). Women’s menstruating bodies are a reminder of the abject. The sense of abjection can also come to the fore during childbearing where a woman may become aware of her own mortality and that of her baby. Through ritual, women are able to live with the ongoing ‘otherness’ of the abject as part of their ordinary lives. In a sense this continued practice of ritual is a necessity. Women in Western society, particularly childbearing women and mothers, are always liminal and never fully accepted and empowered in patriarchal society.

Women’s rituals do not necessarily take the strictly structured format that involves the physical separation from ordinary life described by van Gennep (1960) and Turner (1972) (section 2.4.3). Berry identified that more often women continue their ordinary lives at the same time as undertaking a “more internal” form of separation (2006, p.276). Alternatively, she found women may make a “clear differentiation” in terms of the space and time for ritual, but undertake the ritual in the home (p.281). Berry perceived this as a “blurring of boundaries” between the sacredness of ritual and the “profane” of ordinary domestic life (p.281). Berry also established that women had a conscious “inventiveness” with regard to the rituals they undertook, rather than seeing ritual as “fixed and stereotypical” (p.281). The more inventive forms of ritual are undertaken by women during birth at home (Klassen, 2001). Such rituals focus on familiarity and on individual uniqueness. For example, the familiar sights and sounds of home or the known face of her midwife create a sense of stability and comfort for the woman allowing her to experience the moment-to-moment changes of childbirth as special and unique.

Women’s rituals are considered “other” and “more marginal” than conventional ritual (Berry, 2006, p.287). Indeed Berry claimed that women’s rituals are not about maintaining the social structure. She argued instead that they are a unique and personal “enactment” of women’s lives (p.288). This enactment is “potentially subversive” and “resists” the cultural power of similarity and order promoted by patriarchy (p.288). Women’s ritual can be effective for a woman because it can cater to the unique reality of otherness that is part of lived experience.
2.5.2.4 Transcendence: a here and now bodily experience

Many aspects of childbearing mark the experience as different or transcendent to a woman’s ordinary life, yet childbearing is also an experientially very real part of life. Feminist Kathryn Rabuzzi was interested in the extraordinary and transcendent qualities of childbearing which she associated with self-transformation and personal growth (1994). Rabuzzi reframed the childbirth process as having erotic and pleasurable potential as well as being one of life’s most significant and sacred events. Her theorising was set within Rabuzzi’s gynaecocentric perspective which was aimed at empowering women through “the positive ramifications” of change (p.ix). This perspective was based on what she considered the feminine qualities of sacredness, such as depth, fluidity, interiority, earthiness and the whole fertility cycle.

Rabuzzi used her feminist perspective to place the transcendent qualities of childbearing in the natural earthly “this-worldly” realm (p.xiv). These transcendent qualities were illustrated with Rabuzzi’s own “here and now” experience of a nonordinary conscious state during childbirth in which she felt herself change. Rabuzzi had planned a technomedical birth but the epidural was delayed and she unintentionally experienced the awesome qualities of a natural birth. Describing the experience was a struggle for Rabuzzi; she said it was “on the other side of pain”, where the word “pain” was no longer “appropriate”, so she thought, “possibly ecstasy” would “do” to describe it (p.vii). Extending her ‘here and now’ analysis to women’s overall transition, Rabuzzi maintained that the key to self-transformation is community: “the community to which the childbearing woman belongs and the community that the midwife creates with her” (p.86). With the sense of belonging created by community a woman can feel secure at the same time as experiencing change.

2.5.2.5 Community: organised to respect difference

In my analysis, what is not made clear in Rabuzzi’s theorising is that the community to which she refers is a community organised to respect difference. Irigaray explains how some communities draw on ‘neutral’ knowing and create a “sort of abstract equal-to-all individual” where “individual responsibility is neglected or stifled” (1996, p.127). In contrast a community that respects the differences between “real persons” is “organised” according to the individuality of their lives (p.127). In the security of such a community a person can then “gather” their self “in” as being different “from the other”
and, according to Irigaray, use “trust” to experientially “restore the body to its integrity” (2001, p.13). Such a community also enables a “collective energy” to be “constantly modulated” through the intimacy of individual relationships (1996, p.127). For example, in a caregiver/woman relationship Irigaray saw how the carer had a role much like the broader community, “anchoring …knowledge” and acting as a “guarantor” that the irreducible differences between carer and woman were respected (2002, p.245).

A community that respects differences was considered in the scholarly theorising of Trudelle Thomas (2001). Thomas aimed to show how Christian communities could better support women during childbearing change. The whole period of “matrescence” was, to Thomas, a “time of power” as well as “a time when a woman can encounter new dimensions of self, relation, and God” (p.90). In an analogy with a seed breaking open to bring new life, Thomas said “a woman is issuing forth a new life in the form of a child, but also in the form of her own new identity” (p.94). Thomas recalled her own experience of not only “joy and euphoria” but also “deep brokenness, rage and confusion” (p.96). In doing so Thomas identified powerful positive and negative emotions as well as her “neediness” at this time (p.96). Thomas claimed that a unifying form of change could be empowered by women’s “willingness to make good choices” at this time (p.101). Such choices were made available, Thomas believed, with the security of “an interpretative framework” that is provided by “faith communities” (p.101).

The unifying form of change was portrayed by Thomas as a new sense of connectedness (2001). This connectedness was a state of “two-in-one-ness” that could shift perspective toward a “double-vision” enabling women to learn to combine “self-love” with “love-for-other” (2001, pp.99-100). The process Thomas described is similar to the chiasmic ‘pre-infant’/woman relationship proposed by Wynn (2002) (section 2.3.2). However, Thomas was referring to more than the woman/baby relationship; she was also referring to the woman’s general relationship to what is other. Hence, her theorising showed both how the intimate community of woman/baby may impact on change and how a broader community could also influence the process. This is an example of Irigaray’s “double dialectic” of self/other relations within the self occurring simultaneous to those that are external to the self (1996, p.62). Practices of difference in the childbearing context include the irreducible woman/baby difference and their utter interconnectedness, each as embodied spiritual beings. Additionally practices of difference involve recognition of
the irreducible difference between the woman and the individual others who each singularly and in community impact on her process of change. Ultimately, however, it is up to a woman to actively choose whether the practices she undertakes incorporate this ‘both/and’ approach to change.

2.5.3 Choosing the ‘both/and’ approach

Practices of difference that incorporate a ‘both/and’ approach move the self beyond ‘neutral’ self-knowing toward a perception of the self that encompasses uniquely embodied becoming. The ‘both/and’ approach identified by Young (section 2.2.2) showed how a woman can experience herself paradoxically as both whole and as having continually negotiated contradictory elements (2005b). Lacan (1977) and Irigaray (2001) both identified how conceptually “the whole can never be reached” (p.57). Yet from one experiential moment to the next a sense of wholeness is always possible by choosing to negotiate a ‘both/and’ approach to the embodied self and to what is other. Active and ongoing participation is necessary in such a negotiation because the rational powers of the ego habitually reject the nonrational and paradoxical ‘both/and’ concept as irrational. As Irigaray observed, each person “has to negotiate” the “varying degrees of freedom or confinement” perceived by their ego relative to ego’s misrecognitions (2002, p.7).

2.5.3.1 Negotiation: liberating intrinsic power

Negotiation of a ‘both/and’ approach with the ego occurs through and potentially results in the liberation of power that is intrinsic to the self. Kovel theorised this negotiation as between the ego and the intrinsic power of the soul (1991). He perceived the negotiation as a “struggle” that was reflected in culture (p.221). Ego, he said, was “defined by what it has” and became depleted and exhausted by giving (p.221). In contrast Kovel saw the nonrational nature of soul as an “openness to the other” that was “empowered by giving” (p.221). By being open to giving the soul could then, to Kovel, “inspire the self and fill it with the power of spirit” (p.221). Indeed in Kovel’s analysis love was this giving openness of soul. In this process the soul acted nonrationally, much like Grosz’s (2004) concept of intuition, to “reclaim a full notion of truth” that allowed “the particularity of each individual to come to the fore” (1991, pp.232-4). Embodied spirituality, to Kovel, therefore referred to the “conduct of life” where the self worked to
accept and understand the differentness of what was other and nonrational to the ego (p.65).

Irigaray perceived negotiation of the ‘both/and’ approach more generally through irreducible difference and the ‘double dialectic’ of the self/other relationship within the self and external to the self (1996). In Irigaray’s analysis the openness that liberates intrinsic power is “both prior to and beyond the closure of language” created by the ego (2002, p.245). The openness stems from “a state of tranquillity” that is “without… struggles” over ownership or the “lethal fusion” of a unity where difference is not simultaneously respected (p.245). This openness, to Irigaray, is a “harmony that lets the other be” (p.245). However, for Irigaray the “peacefulness” of this state does not mean “passivity” (2001, p.28). It is the active, conscious and effortful practice of respecting that which is different and other. Irigaray equates this practice with the discovery and cultivation of happiness. This happiness, in Irigaray’s analysis, is “the happiness” of “shared energy” and “the joy of a path that is taken together” (p.57). Whether referring to a joyful power shared between two people or the happiness of a power shared between different parts of the self, the liberation of this power requires being open to what is nonrational about the self, including instinct and intuition.

2.5.3.2 Being open to instinct and intuition

Grosz’s analysis of Bergson’s work identified that an individual’s response to difference presents a fundamental choice based on the two reflective forms of knowing: the intellect and the intuition (2004). In any one situation the intellect may choose to maintain attention only on particular parts of the whole in its rational bid for practical action. Or, the intellect may allow time to also attend to the whole via the nonrational ways of knowing given by the intuition. The choice for labouring women was not proposed in terms of the intuition by Odent (1999). He identified how intuition was a function of the right hemisphere of the neocortex, although it was “in touch” with the instincts of the “primitive brain” (p.73). Odent insisted that “the actual duality” should not be considered to be between left and right sides of the neocortex, but between the newer and the older brains (p.73). It is the function of the older primal structures which, according to Odent, has most impact on the actual birth process as it is from here that hormonal regulation of childbearing occurs. Odent therefore argued that women should
“give the intellect a rest” and allow the instinctual functions of the primal brain to take over (p.29).

Odent maintained that a woman’s active decision to allow herself to enter an altered conscious state would be health promoting; but, he claimed, it was unlikely unless she was labouring in conditions of privacy and security (1999). A woman’s environment is clearly important to her birth process. However, Odent’s encouragement to rest the intellect gives the impression that women should then passively succumb to the process. Odent’s approach effectively renders the woman passive to her environment and her instincts. No analysis of how intuition functions is made by Odent. Odent instead gave a rational dichotomous assessment of the intellect versus instinct. He did not propose how a woman may learn to be open to her instinct and intuition whilst also retaining some sense of active intellectual capacity. By enabling a woman to work with her intuition she may be able to both retain her intellect and allow her instinctual processes to unfold.

According to Grosz’ theorising (2004) a ‘both/and’ process such as this could only occur through the nonrational reflective knowing of intuition.

### 2.5.3.3 Including the nonrational: promoting psychophysiological coherence

When the intellect makes choices that encompass intuition and the more nonrational ways of knowing, then, in Grosz’ analysis, an expression of the self’s “own inner cohesion” is more likely (2004, p.239). The development of inner and outer coherence is salutogenic, meaning health promoting (Antonovsky, 1979, 1990). Salutogenesis is a term used to express the midwifery aim for health promotion during childbearing (Downe & McCourt, 2004). Salutogenic brain function has been identified by psychobiological researcher Donald Smith to have a key part in staying well in situations that are stressful (2002). This inner sense of coherence is enabled, according to Smith, by maintaining perceptions about life and relationships that are nonrational, as well as rational.

A person’s inner and outer sense of coherence enables optimal psychophysiology. To medical sociologist Aaron Antonovsky (1923-1994) nurturing the sense of coherence involved making cognitive and emotional sense of one’s situation which is conceptualised as comprehensibility and meaningfulness (1979). Coherence, to Antonovsky, is also nurtured by having a sense of being able to cope with other
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situations, conceptualised as manageability (1979). Coherence has been measured in terms of clarity of thought and emotional balance that have then been found to occur in association with more coherent heart rhythm patterns (McCraty, Atkinson, & Tomasino, 2001). Synchronicity between the physiological, emotional and cognitive systems has also been found to occur with coherence (McCraty, et al., 2001). Additionally, the experience of coherence and intuition have been found to be factors that impact positively on interpersonal interactions (McCraty, 2003; McCraty, Atkinson, & Bradley, 2004a, 2004b; McCraty, Bradley, & Tomasino, 2004; McCraty & Childre, 2003). Relational-Cultural Theory’s mutually empathic connection between self and other (section 2.2.1) supports interpersonal practices that are both rational and nonrational (Jordan, 1997b; Jordan, Kaplan, et al., 1991). Jordan showed how this process of relating with the other also leads to greater personal clarity and integration (1997a). Choosing to be open to the nonrational in relationships and through life in general is more likely to enable an understanding of the self as both whole and undertaking a continual process of becoming. Change is, however, an inner process that requires the self to also open to the in-the-moment experiential processes of the self.

2.5.3.4 The present and the past: shaping change

Change in sense of self is variously influenced by how a person interrelates with the past and the present. The present, according to Grosz, is a continuity that “spreads itself out” to “that future a moment ahead” for which it has prepared by “reactivating the past” (2004, p.251). Grosz observed that the present draws on those “most immediate and active forms” of the past, such as habit (p. 251). By drawing on more automatic behaviours the continuity of the present is preserved. Consciousness is diverted to the creation and maintenance of the ego’s self-investments. However, with the preservation of a stable and uncontested present much of the individual’s choice and personal power becomes directed toward attainment of future egoic desires. The present becomes a tool for the future where awareness of actual bodily experience is limited and a sense of being able to actively choose moment-to-moment thoughts and activities is diminished.

Behaviours undertaken in the present, whether consciously or automatically performed, do nonetheless become “the transformative effects of the future” according to Grosz (2004, p.251). The present also, in Grosz’s analysis, acts to consolidate those chosen aspects of the past giving the impression that the past is “fixed, inert, given, unalterable,
even if not knowable in its entirety” (p.254). Limitations on change experienced in the present may thus be perceived as created by the past. Yet, according to Grosz, the past is “inherently open to future rewritings” and always able to be animated “in different ways” (p.254). She believed that “the past grows and augments itself” during the present (p.250). Each experiential moment of the present becomes an embodied element of the past which then becomes a resource for future moments. Grosz considered this feature of the past a “virtual potential” capable of enriching each moment with currently un-envisaged possibilities (p. 250). Although, such possibilities may be perceived as nonrational and threatening to the ego, it is through a re-assessment of embodied past experience that the current moment’s “potential for being otherwise” arises (p.254).

The past can therefore be perceived, Grosz theorised, as a resource for “overcoming the present” and for “bringing about a future” (2004, p.257). Grosz did not mean “an immersion in the past for its own sake”, which is “debilitating” (p.257). She meant that planning and envisioning of the future should not “reduce the future to the present” as the ego has a tendency to do (p.261). “Creation of the new”, according to Grosz, comes about through both the lived experience of the present and a degree of “dissociation” from that present moment (p.261). To Grosz such dissociations “disrupt the continuity of the present” by creating fractures that waylay the automatic modes of “habit, recognition” and “understanding” (pp.251-2). These fractures draw consciousness into the present, enable reflection on in-the-moment experience, and bring different “resources of the past” to “bear on the present” (p.255). Thus, when the self brings a ‘both/and’ approach to the present, an awareness of its own embodied potential to change is made available.

2.5.3.5 Intention: shaping becoming

One way of achieving a ‘both/and’ approach to the present is through the practice of intention which can act to shape the future direction of a person’s life. “Intention” is, in Irigaray’s rendition, an intrinsic power that is actively used to shape becoming, rather than leaving it to be passively determined by experiences in “the exterior world” (2001, p.39). To Irigaray intention is an “interiority” that forms part of how irreducible difference is enacted (p.39). Within Eastern spirituality intention is a meditative practice that is used to position mind and body as well as to cultivate the spirit through the breath (Chen, 2004). Qigong and yoga are examples of Eastern disciplines where
intention is practised. Intention refers not only to a person’s overall aim for the future, but also the manner or way in which it is enacted. ‘Overall aim’ does not refer to a linear process of cause and effect. In the context of intention ‘overall aim’ expresses the direction of phenomenological, pre-reflective becoming; it refers to the complex and embodied direction in which a person’s moment-to-moment choices take the self. The degree of conscious participation in that overall aim will therefore depend on the degree to which a person consciously participates in moment-to-moment choice.

Intention involves an increase in a person’s awareness of even the smallest, most ordinary degrees of change and then acting on it mindfully according to Thich Nhat Hanh’s description of Zen practice (1995). To Hanh mindfulness promotes: a sense of whether or not choices and aims are free of manipulation by the ego or others; a decrease in materialist desires; and the implementation of unconditional love through forgiveness, trust and acceptance of the self and the world. These practices teach that any one perception of truth is not the only truth and that intention which is solely based on self-serving goals is not always the best for a person’s overall wellbeing. Irigaray is clearly cognisant of the Eastern spiritual understandings of intention in her theorising (2001, 2003; Irigaray & Pluhacek, 2002). She recognised that the power of intention does not take an egoic form that creates dichotomous relationships such as “light opposed to darkness, or knowledge opposed to ignorance” (p.110). Intention was instead, to her, a power that expresses a ‘both/and’ truth where “light” does not “give up mystery” but “illuminates without revealing” (p.110). The truth of intention, for Irigaray, was “never total, never authoritarian or dogmatic” but rather a “light always shared between two”, self and other, “irreducible to one another” (p.110).

The mindfulness of intention provides a means to bring consciousness back into the present moment. Intention disrupts the arrogant, aggressive, diminutive or submissive activities of the ego. The disruption of intention opens in-the-moment experience to a sense of intrinsic power. In-the-moment choices which were previously perceived as unavailable become revealed. The self’s own unique creative power starts to be expressed. Communities of self/other, both internal and external, begin to be organised in ways that value difference. Self/other trust is experienced that facilitates ‘both/and’ practices respecting the mystery or sense of unknown about the self, the other and the future. Intuition becomes used as a way to find “oneself in the unknown” and negotiate with its newness (Grosz, 2004, p.240). The disjunctions between desire and outcome are
less frequent, as are those between perception and experience. The overall future aim of intention begins to be fulfilled. Becoming is thus shaped through intention into an embodied spiritual practice that liberates intrinsic power and brings the potential of a sense of wholeness to each experiential moment. Hence it is through the mindfulness of in-the-moment experience and of intention that a woman can gain a sense of herself as an embodied whole and intrinsically powerful person.

2.6 CONCLUSION

This chapter has presented the key philosophical and theoretical literature that influenced my understanding of how the embodied self changes. Section 2.2 presented two feminist theories that introduced how the quality of relationships and a paradoxical ‘both/and’ approach could impact on the process of change. These two themes have been carried through the chapter. In section 2.3 the qualities connected with lived experience and the associated relational qualities were explored in the context of phenomenological unity and body awareness. Section 2.4 considered how power impacts on the changing embodied self as expressed through the ego, the power hidden within the self, and the power of others including culture. A partial rejection of humanistic understandings of the self was identified in some of the theorising examined. Yet I also recognised that underlying this rejection was an allegiance to patriarchal power. Section 2.5 aimed to move beyond patriarchal power in exploring the perceptions and practice of embodied spiritual becoming. Using the concepts of spirit, soul, instinct, intuition, intention and irreducible difference the ‘both/and’ approach to relationships and to the changing embodied self was detailed. The section showed how a woman’s capacity to experience herself as an embodied whole and intrinsically powerful person is variously enabled or disabled by the ordinary in-the-moment choices she makes during the change process. The next chapter now considers how that change process is represented in the childbearing literature.
3. **CHAPTER THREE- LITERATURE REVIEW**

3.1 **INTRODUCTION**

Relevant childbearing research literature is critically reviewed in this chapter. It assumes the reader is aware of my critique of humanism and logico-empiricism in the study background (section 1.2, pp.10-21). Search and decision-making strategies that guided the review are described in section 3.1.1. An outline of each study is provided in table 3.1 (pp.122-132) which is reprinted in appendix C for easy reference. The reader is advised to refer to the table when reading the text as duplication between text and table has been minimised. The order in which each study has been reviewed is replicated in the table.

The critical reviews in this chapter evolved through and were strengthened following data analysis and interpretation. My overall aim has been to identify those factors in a woman’s experience of childbearing that may contribute to an increased sense of herself as an embodied whole and intrinsically powerful person. The chapter subheadings represent my understanding of the main findings of the research being reviewed. In the text of each review I describe the study, focusing on those aspects that are largely consistent with my own findings. Each review ends with the heading ‘limitations relative to this dissertation’ where I identify in dot points how the study does not adequately address my research question.

The chapter is organised into three main sections according to what the literature revealed about how a woman’s embodied self changes in childbearing. Section 3.2 focuses on research that collectively depicts the breadth, depth and diversity of change that a childbearing woman may be exposed to, in addition to how she may respond. Section 3.3 recognises contradictions within a woman’s experience of change and explores the way she may negotiate those contradictions to her advantage. Section 3.4 explores activities of caregivers that have been reported to make change an empowering experience. Lastly in section 3.5, I consider how the literature strongly supports the notion of women being empowered through flexible interactions with caregivers, but conclude that none of literature adequately addresses my research question.
3.1.1 **Search and decision-making strategies**

The research question ‘How does a woman’s embodied sense of self change during the childbearing period and what factors in the childbirth experience seem to be positively related to an improved sense of self?’ has guided the search and decision-making strategies. The research aim, to produce theory on how caregivers can most effectively work with women during the changes of childbearing so as to enhance rather than diminish the woman’s embodied sense of self, was also used as a guide. In order to ensure that relevant medical, nursing, midwifery, psychological and social science literature was included specific searches were periodically undertaken. I searched used the following terms and their truncations: ‘embodiment’, ‘self’, ‘identity’, ‘subjectivity’, ‘body’, ‘soul’, ‘sacred’, ‘spirit’, ‘power’, ‘dynamic’, ‘intuition’, ‘change’, ‘altered’, ‘transition’ and ‘transformation’. These terms were combined with each other and with childbearing related terms of ‘pregnancy’, ‘prenatal’, ‘antenatal’, ‘childbirth’, ‘labour’, ‘birth’, ‘postpartum’, ‘postnatal’, ‘breastfeed/fed’. Medline, PsychINFO, Social Work Abstracts and CINAHL databases linked to the University of Newcastle library were used. Searches were limited to research reports written in English and published in refereed journals or academic books. I began these searches in 2002; the final full search was undertaken in May 2008.

Over eighty studies were seriously considered for inclusion in this chapter. In making decisions about what to include I prioritised research that specifically focused on embodiment and the self. I added one earlier item of research that had not been replicated in subsequent years (Bergum 1989). I then considered research centred on in-the-moment change, transition, and the paradoxes inherent in change. Research that revealed a woman’s use of her own power or her sense of wholeness and wellbeing was also taken into account. Finally, I included research that depicted women’s experience of childbirth in addition to the activities that successfully exposed what seemed to empower a woman to use her own power to give birth.

In line with the woman-focused nature of my research question, all the literature chosen for review incorporates data from women, although some of the research also includes data from other sources. Excluded studies were those that provided etic perspectives alone, such as quantitative studies or research that involved only midwives. Most included studies were published in the past 10 years. Older studies were included where
no subsequent research had covered the issue. Other older studies were excluded when subsequent research was more expansive or where such studies were part of a metasynthesis. With these strategies, I am confident that the thirty-nine studies included in this chapter are of most relevance to my feminist post-structural approach and to my aim to produce theory.

3.2 CHANGE: EXPANDING PERSPECTIVES

The focus of this section is on presenting some of the expanded perspectives on childbearing change that move beyond the conventional ‘transition to motherhood’ theories outlined in chapter one. The studies reviewed propose no decisive endpoints, tasks or phases so that no definitive path through the changes of childbearing is provided. The studies instead illustrate the varied ways that women experience change and the diverse interpretations made by researchers of those changes. The majority of studies do not give definitions of the embodied self; they nonetheless generally assume that women actively participate, to some degree, in their experience of childbearing. The studies collectively show how a woman’s perspectives on her embodied self and the world are variously expanded through her experience of childbearing change. In addition, some of the studies explore the ways a woman may respond to those expanding perspectives.

3.2.1 Articulating with humanistic values

Much of the research I considered for review showed how women’s experience of childbearing articulated implicitly or explicitly with dominant humanistic values. Idealised expectations, self-judgements and desires for certainty were expressed. In this section I review studies showing four ways that this articulation with humanism may be experienced by women.

3.2.1.1 Intellectualised responses

An intellectualised response to childbearing was identified by midwife Mary Carolan in a longitudinal narrative study with first-time pregnant women over 35 years (2004, 2005, 2007). By eight months postpartum none of these women displayed evidence of depression and most were “positive about their mothering roles”, but their journey to this point was not necessarily easy (2005a, p.782). Impending motherhood was perceived as an “adjunct” to work that involved active preparation, elaborate planning
Chapter three - Literature review

and gathering information (p.778). Participants believed that obtaining as much information as possible was necessary for making choices, undertaking tasks “properly” and ensuring their baby’s wellbeing (2005a, p.764). Yet, after the birth participants found that the actual experience of change was “fraught with anxieties and initial struggle” (2005a, p.782). “Self-abnegation” accompanied women’s desire to meet the baby’s needs (p.780). The women also experienced a difficult period of ambivalence where they “felt it was unreasonable and unnatural” that they were not “overjoyed” with their baby (2004, p.53).

In Carolan’s analysis, when participants had moved through the “turning point” of “giving in” to change they were able to self-reflectively identify the unhelpful aspects of the intellectual focus and shift their goals (2005a, p.774). Participants gained a “growing understanding” of the “individuality of mother-infant dyads”, realised there was “no one right way” to undertake infant care and that it was “okay to have negative feelings” (pp.774-6). An expanded perspective was made available to these women by releasing the self to change. According to Carolan, accompanying this change was each participant’s increased confidence to interpret available information in their own particular way. Carolan theorised that caregivers could facilitate this change through collaboration with women to give a more normalised and de-mystified framework for information interpretation (2007).

Limitations relative to this dissertation:
- no analysis of childbirth experience;
- omits embodied sensations from analysis;
- did not consider how caregivers may facilitate women to focus on feelings and bodily experiences;
- supports dominant humanistic understandings of the self.

3.2.1.2 Being novice, not expert

The humanistic discourse that prioritises expert knowledge and practices over that of novices was made explicit in grounded theory research with primiparous postpartum women by midwife Carol Wilkins (2006). Wilkins showed how a woman’s prior competencies are “thrown into confusion” by the “new skills” required in the postpartum; they moved from their prior state of general expertise in life to one of being a novice (2006, p.173). Participants expected that “nurturing skills” would “instinctively emerge” (p.174). These expectations went unfulfilled and the participants felt
inadequate and reliant on others. In addition, Wilkins identified that the women isolated themselves because they feared criticism and wished to avoid embarrassment. Yet, like Carolan’s (2005a) participants, the women in Wilkins’ study also felt acutely responsible and really wanted to “do it right” for their babies (2006, p.174).

In Wilkins’ analysis, eventually a sense of balance was recovered by participants as they became more confident at decision-making (2006). This “more intuitive and experienced way of mothering” was learnt through practise and support (p.178). Peer support gave women “permission” to “know little”, “make mistakes”, “share experiences” and “ask for help without fear of criticism” (2006, p.176). Women’s experience was also influenced by the “positive or negative effect” of “perceived expertise” (p.174). A negative effect reiterated the woman’s novice status in comparison to the expert’s skill. When participants had an established relationship with their midwife a positive effect of expertise was observed. In these situations Wilkins identified that midwives had an individualised focus so women “trusted and absorbed” their professional advice “more fully” (p.175). Wilkins’ results were strengthened by a subtle analysis that gave authentic expression to women’s lived experience. Her recommendation for a more individualised focus by caregivers is one that resonates throughout the childbearing period. Limitations relative to this dissertation:
- presented a somewhat simplistic and linear picture of role acquisition;
- did not critique dominant cultural discourses;
- only considered the postpartum.

3.2.1.2.1 Critiquing the dominant discourses

A longitudinal narrative study by sociologist Tina Miller did critique dominant cultural discourses and considered the whole of her participant’s first childbearing experience (1998, 2000, 2007). Miller did not specifically identify that a primigravid woman might perceive herself as a novice. However, Miller did find that giving authentic voice to feelings and experiences was deemed too risky for her participants. In pregnancy the techno-medical discourse induced in participants a “sense of the predictability of childbearing” (2000, p.316). Women also placed “faith” in the dominant discourses surrounding “ideas of nature”, “women’s ability to give birth naturally” and to be a good mother (2007, p.344). In this research each participant’s personal account of their
sense of self was, considered by Miller, to have been silenced to some degree by professional and/or lay discourses.

Miller identified the birth experience as “a discursive turning point” where women’s expectations about labour and/or mothering went unfulfilled (2007, p.354). The disconnection between expectations and experience created an intense sense of loss and failure for many of Miller’s participants. In the postpartum some participants had “literally lost the plot” of who they were (2000, p.322). Eventually each woman did become confident in “weaving together discourse and experience”, in perceiving herself as “the (relative) expert” on her child, and in challenging the stereotypes (2007, p.354). Yet, according to Miller it was only following months of mothering that these women were secure enough in their sense of self to follow their own path and give authentic expression to their experiences. Limitations relative to this dissertation:

- definition of ‘self’ limited to a woman’s expression of self relative to the discourses of others (Miller 2000);
- inner aspects of embodied self not conceptualised;
- did not consider why a woman may trust lay and professional discourses over her own or critique the ‘either/or’ discourses that compelled such a trust;
- proposed no alternative discourses and made no practical recommendations to enhance women’s experience.

3.2.1.3 Concerns for productivity

Humanistic values surrounding productivity can shape a woman’s experience even once a healthy baby has been produced. Fiona Dykes’ midwifery research in a postnatal hospital ward illustrated how concern for productivity was a dominant image during women’s early experience of breastfeeding (2005). According to Dykes, participants’ primary perception of breast milk was as a disembodied product of their bodies. Their main concern was in supplying this product to their babies. However, Dykes found that supply was compromised through mechanised understandings of the breastfeeding process, in addition to a lack of confidence and bodily trust. Worry about “coping” at home and on eventual return to “economically productive life” prompted some participants to place controls on breastfeeding involving use of bottles and/or artificial milk (p.2289). Dykes critiqued how midwives acted as “the producer of the product”, where the product is a breastfeeding woman and a “good baby” (pp.2285-2288). In
Dykes’ analysis of postnatal care should instead be focused on more embodied processes that emphasise woman/baby relationality. In that way the breastfeeding experience would be seen as just one part of a loving woman/baby connection. A strength of this research was its substantial cultural critique surrounding its focus on women’s bodies and embodiment. Limitations relative to this dissertation:
- did not go beyond breastfeeding in the early postpartum;
- did not consider women’s sense of self.

3.2.1.4 Struggles of self-definition
The humanistic value of a stable non-conflicted self is sharply contested by the embodied experience of childbearing. In a study of the embodied self in pregnancy and breastfeeding, midwife Virginia Schmied and sociologist Deborah Lupton found that women struggled to retain their usual boundaries of self-definition when relating to their babies (2001a, 2001b). Schmied and Lupton undertook a strong cultural critique where essentialising aspects of dominant discourses were identified. A woman’s embodied experience of pregnancy was identified as being fluid, ambiguous and surreal (2001a). Even participants who had a sense of the baby as separate from themselves expressed difficulty using words to express the “ambiguous and uncertain position of having another within oneself” (p.35). Later in pregnancy when the physicality of the experience was tangibly present, the experience was still too abstract for words.

Schmied and Lupton recognized the humanistic ideals of some participants in what they called a “masculinised ideal of the autonomous self” (p.38). Those participants with this ideal felt threatened by the ambiguous presence of their baby; they were distressed over lost pre-pregnancy identity and their diminished bodily control. In contrast, and consistent with feminist understandings, some women appeared to accept the more dynamic, dialectical and less definite version of the self. Schmied and Lupton found these women had a more fluid relationship with their babies; they spoke of their babies as “constant companions” existing “in harmony” with their “bodily rhythms and patterns” (2001a, pp.36-38).

Women’s embodied experience of breastfeeding, according to Schmied and Lupton, also encompassed the fluid sense of ambiguity and blurred boundaries that pregnancy did (2001b). For some participants breastfeeding involved pleasurable, intimate connection with their baby. However, Schmied and Lupton said that for the majority of
participants the ambiguity between embodied self and breastfed baby was distasteful and difficult to reconcile with their sense of self. These participants were keen to control their breastfeeding experience and restore previous boundaries of self-definition. Participants were, in addition, confronted by contradictions between their breastfeeding experience and the dominant discourses surrounding healthy babies and good mothers. For many participants expectations about breastfeeding and mothering went unfulfilled. As a result Schmied and Lupton found many of their participants felt a loss of self.

Limitations relative to this dissertation:
- spirit and intrinsic power were omitted from understandings of embodied self;
- no practical solutions are presented;
- relays no sense that a woman may use her own power to change her situation.

3.2.2 ‘Both/and’ discourses

One way a woman can change her situation is through the expanded perspective given with ‘both/and’ discourses. Schmied and Lupton (2001a, 2001b) presented a dichotomised understanding of childbearing experience which showed childbearing as pleasurable for a few women while for the majority it was not. However, in reviewing the literature I often found research that depicted women’s childbearing experiences as having both pleasurable and un-pleasurable aspects that were described using ‘both/and’ discourses.

3.2.2.1 A tapestry of joy and suffering

A ‘both/and’ discourse was evident in women’s ‘tapestry’ of joy as well as suffering proposed in the nursing study by Terese Bondas and Katie Eriksson (2001). In this study of the lived experience of pregnancy, endurable suffering was linked to health, personal growth and the relationship between caregiver and woman. The researchers conceived health as the activities associated with “doing, being and becoming” that move a person toward wholeness, integration and uniqueness (p.826). According to Bondas and Eriksson pregnancy challenged women to place their current experiences into terms relevant to their own and their (future) family’s health and suffering, in addition to the more existential framework of life and death. As such, the experience of pregnancy was conceived as either one of anxiety and worry or, through what Bondas and Eriksson called “family communion”, one of both joy and suffering that heralded the beginning of “major change” (p.831, 835). This study presented a philosophically
sound analysis of how women may choose to use ‘both/and’ discourses during pregnancy. Limitations relative to this dissertation:
- did not specifically conceptualise embodied self;
- did not go beyond the antenatal period.

3.2.2.2 Moving toward the unknown
In another study of change in pregnancy the challenge for women was that they were moving toward the unknown. This phenomenological midwifery research by Ingela Lundgren and Vivian Wahlberg relayed a sense that women meet the ongoing changes of their current situation while at the same time preparing for their unknown future (1999). Hence Lundgren and Wahlberg found that women feel happiness or joy at the same time as experiencing negative emotions or fear of miscarriage. To Lundgren and Wahlberg the wellbeing of women’s relationships, particularly with their partner and mother, were essential elements of the early months of change. Later in the pregnancy the women in this study felt curiosity simultaneously with a sense of hesitation about what their future may bring. However, preparation to meet the unknown was also identified as a frightening experience which Lundgren and Wahlberg proposed could be allayed through continuity of relationship with the same caregiver. This was a relatively simple study that nevertheless gave a similar ‘both/and’ message to the more philosophically sophisticated one by Bondas and Eriksson (2001). Women can experience both positive as well as negative aspects of change and this ‘both/and’ discourse is most easily sustained within the context of relationship with meaningful others. Limitations relative to this dissertation:
- presents participants with physiological information about change in pregnancy without critiquing how such information may influence a woman’s perception of her experience;
- embodied self is not conceptualised;
- only pregnancy is considered.

3.2.2.3 Maintaining identity
A study of primigravid women’s self-identity showed a ‘both/and’ discourse being enabled by their community-based midwives. This grounded theory research by sociologist Sarah Earle established how the woman/midwife relationship acted to maintain a woman’s self-identity (2000). This rigorously conducted study considered
that a woman’s self-identity was “based on self-reflection” (p.237). In Earle’s analysis a woman’s relationship with her midwife provided this reflexivity in two ways: through similarity and through difference. Earle claimed that during her first pregnancy a woman needs reassurance of her similarity to other women because the experiences are “unusual” relative to pre-pregnancy or her imagination (p.238). Midwives in this study enabled the sense of similarity by defining participants’ experience as normal. However, Earle also found that midwives nurtured women’s uniqueness by showing participants the ways in which they were different to others. The nurture of uniqueness enabled participants to “feel individuals” (p.239). Women in this study felt their sense of self was nurtured by being reassured of both their similarities and differences to other women. Earle identified that midwives used an authoritative form of knowing to assess women’s normality, but in order to nurture uniqueness the midwife and woman had to come to know each other through relationship. Limitations relative to this dissertation:

- definition of the self was limited to a self-reflective awareness relative to other people;
- inner elements of the self, embodiment and change were not considered;
- study focus was on women’s antenatal interaction with midwives.

3.2.2.4 Working out motherhood

In the postpartum another ‘both/and’ discourse has been identified. Using a grounded theory analysis midwives Frances Rogan, Lesley Barclay and colleagues presented a dynamic theory of change in motherhood (Lesely Barclay, et al., 1997; Rogan, Schmied, Barclay, Everitt, & Wyllie, 1997). These researchers theorised that women “work out” motherhood relative to the context of their experience of change. This context was associated with: the actions women take in response to their situation; which intervening actions were a help or a hindrance; and the consequences of their actions (Rogan, et al., 1997). The women in this study commonly felt alone, unready and drained. However, they were also identified to move through times of both attachment and loss according to three factors: baby behaviour, social support and previous experiences (Rogan, et al., 1997). The researchers claimed these factors could provide a broad framework from which maternity intervention might lessen the distressing aspects of becoming a mother, although how that may occur was not clarified. Nonetheless, the study did indicate how ‘both/and’ discourses are highly contextual and multidimensional. Limitations relative to this dissertation:
3.2.2.5 Being propelled into adulthood

A similar picture of both gains and losses was also presented in Carmel Seibold’s midwifery research with young single women both before and after birth (2004). Although women in this small qualitative study experienced challenges Seibold also found that they welcomed the changes. Seibold partially attributed this positive outlook to her participants’ perception that childbirth was propelling them into adulthood. Parental support, sympathetic caregivers and acceptance of pregnancy were also identified as influential. According to Seibold the women actively constructed their new identities as mothers at the same time as maintaining a “sense of who they were and their direction in life” (p.177). This ‘both/and’ discourse enabled the young participants to not only feel a continued sense of self through the change process but also move through change in a way that was far more expansive than toward motherhood alone. This small, rigorous study was strengthened by its understanding of identity construction as an ongoing, embodied experience that is influenced by culture but not solely determined by it. As such, an ongoing positive sense of identity was able to be conceived through the expanded perspective of a ‘both/and’ discourse.

Limitations relative to this dissertation:
- did not formally define the embodied self;
- gave only limited attention to the birth experience;
- did not take account of women’s experience of pregnancy.

3.2.3 A sense of continued self

One way that women respond to the expanding perspectives of childbearing is to seek to maintain a sense of continued self. A woman’s sense of continued self can bring a feeling of security and confidence. Such confidence can allow a woman to make her own choices and pursue her own unique path through change. Using ‘both/and’ discourses a woman may simultaneously maintain some sense of continued self whilst being challenged to change. However the challenges of change can make maintaining a
‘both/and’ discourse difficult. For some women a sense of continued self is instead maintained through their social identity and ‘either/or’ discourses.

3.2.3.1 Using a discourse of dualism

In longitudinal sociological research by Lucy Bailey women maintained a sense of continued self through a discourse of dualism (1999, 2001). To Bailey the changing self was a “refracted self” who glimpsed usually hidden elements of personality that inevitably became revealed through the “prism” of change (1999, p.339). The refracted self was a reflexive concept; continually developing and impacting on change. Participants used their refracted selves for “self-affirmation”, to “excuse” them from usual embodied practices, and to undertake practices perceived to control change (1999, pp.348-349). They repositioned themselves relative to different discourses so that they could develop a “real, though limited sense of agency” (p.351). The “discourse of dualism” between mind and body was used to “distance” participants’ bodily changes from their identity (2001, p.125). By using a dualistic ‘either/or’ discourse these women were able to “reject” that their bodily changes were “associated” with their “inner self” (p.125). The concept of ‘inner self’ was not explored further by Bailey; however, it was through this dualistic discourse that these women maintained a sense of continued self.

The physically inevitable elements of childbearing, according to Bailey, prompted participants to a greater appreciation of their bodies and to alter their bodily practices (1999, 2001). Women’s bodily practices became less subordinate to traditional concepts of motherhood which in turn empowered the women to enact what Bailey called a non-submissive form of caring practice. However, Bailey claimed that none of her participants underwent any “fundamental change in character”, although what exactly Bailey meant by “character” was not evident (1999, p.346). Childbearing was instead recognised to present women with the choice or “discursive opportunity” to actively construct lasting differences in their social identity and self-narrative (2001, p.126). Bailey’s research thus illustrated that women have no imperative to change, nor do they need to feel defined by how their body changes (1999, 2001). Limitations relative to this dissertation:

- defined embodied self as a social construction;
- how women could maintain a continued sense of self other than by a dualistic discourse unclear;
no analysis of the deeper more intrinsically experienced aspects of embodied self.

3.2.3.2 Introspectively experiencing self
A woman’s continued, introspective experience of self during motherhood was the focus of phenomenological nursing research by Gweneth Hartrick (1996, 1997). Hartrick considered the self as having “a multiplicity of parts” which were variously expressed or kept in the background (1996, p.323). Hartrick found that a woman’s conceptualisation of the “institution of motherhood” sometimes dictated which parts of herself were expressed or hidden (1996, p.323). In contrast, a woman’s “experience of motherhood” tended to reveal hidden aspects of self which had the potential to create conflict with other parts of herself (p.323). Hartrick primarily saw this as a conflict between “being authentic and being connected” (1997, p.270). With a sense of connection participants were found to gain cultural power, but this cultural power appeared to come at the expense of their inner power. According to Hartrick, when women prioritised connection over authenticity they also had an inner sense of vulnerability and aloneness which ultimately created more distance between themselves and others. Schmied and Lupton (2001b) inaccurately critiqued this authenticity; to them Hartrick was taking an essentialist perspective that promoted a single essential truth. However, Hartrick’s analysis was of each participant’s unique experiences that were each taken as a form of truth (1997). Hence, although Hartrick gave no formal definition of ‘authenticity’, it seems to mean ‘being true to in-the-moment experience’.

Hartrick found that when participants remained relatively unconscious of the authenticity/connection conflict they chose the security of being connected to others over being authentic to the self. Yet, participant’s discontent gradually drove them from this non-reflective state into what Hartrick called a more transitional “shadow” time where the “secure foundation of their lives” began to crumble (1997, p.271). To participants, while this was a struggling period of loss and devastation they still saw this period of change as a positive restructuring of their sense of self. This ‘both/and’ discourse of gain despite extensive loss seemed to enable a continued sense of self. In what Hartrick called a “reauthoring process” the women in her study progressively came to trust, nurture, and be more aware of new and differing aspects of themselves which they then brought together as a connected whole (p.272). Hartrick’s analysis gave
a scholarly picture of women’s introspective process of change during their lived experience of being mothers. Limitations relative to this dissertation:

- did not encompass an analysis of change during pregnancy and birth;
- omitted caregiver’s impact on change.

### 3.2.3.3 Connecting to others in ordinary ways

A woman can have a sense of continued self whilst in labour by maintaining her ordinary behaviours toward others. A sociological study by Karin Martin claimed that women ordinarily connected with others through a pattern of selfless interactions which were maintained even in labour (2003). Martin’s focus was on internalised behaviours that caused labouring women to interact in selfless, nice, polite and caring ways. According to Martin this abnegation of self caused participants to: be mute about their needs; shift energy towards other people and away from themselves; and to have more difficulties at birth. Participants were also found to defer to other people’s observation of their experience rather than attend to their own bodily experience. Furthermore, when these selfless behaviours were not undertaken, Martin identified that participants would apologise and discipline themselves by considering themselves as bad or misbehaving.

Martin’s study illustrated how essentialist humanistic discourses of niceness and being ‘good’ had been embodied by women and were enacted in labour (2003). In addition, the study showed how women participated in maintaining these discourses. Participants’ selfless interactions conformed to dominant humanistic discourses that prioritised their sense of connection with others above their own sense of self. By making this choice these women maintained a sense of continued self in culturally defined terms. However, by maintaining these selfless interactions the participants were also identified to be less powerful during labour.

This study was limited in a number of ways. Martin claimed that participant interactions were gendered, but she did not provide evidence from her own data to show that they were (2003). Martin then claimed that these selfless interactions were normal for women in general, when her data merely indicated that they were normal for this group of women. Additionally, Martin did not define what healthy interactions were or how they may occur, which resulted in her impaired analysis of the three participants whose interactions were not selfless. With no understanding of healthy interactions Martin was
unable to propose alternative ways that women may connect with others, feel a sense of continued self, or be powerful in labour. **Limitations relative to this dissertation:**

- embodied self change was not conceptualised;
- did not critique the influence of the ways caregivers relate to women;
- the sole focus was on childbirth.

### 3.2.3.4 Being powerless from pain

During the childbirth experience a woman’s ordinary ways of maintaining her continued sense of self are often challenged and rendered powerless by labour pain. Women felt powerless when experiencing the pain of prolonged labour in a qualitative nursing study by Astrid Nystedt and colleagues (Nystedt, Högberg, & Lundman, 2006). This study undertook a simple, though rigorous thematic analysis. Participants had considered themselves healthy until labour began. However, Nystedt and colleagues found that labour was not an experience of health for these women, but one of loss. Participants became caught up with fear in addition to intractable pain. The embodied experience of fear was described as one of "deep horror and panic" that the participants associated with thoughts of death (p.63). Participants felt that not only their sense of self but their bodily integrity was under "threat" (p.63). Exhaustion and loss of control also made these women feel dependent on caregivers which then reinforced the participant’s sense of powerlessness. **Limitations relative to this dissertation:**

- embodied self was not defined and the concept of ego dissolution (as discussed in chapter two) was not considered as an explanation for participant’s sense of impending death;
- critiques of maternity care environments or of humanistic discourses were not made so that the only pathway open to these women appeared to be dependence on caregivers;
- specific ways to assist women to maintain a sense of continued self and feel powerful were not considered.

### 3.2.3.5 Managing childbirth related fear

The way a woman manages childbirth related fear can enable her to maintain a sense of continued self through childbirth. The very embodied nature of intense fear in a group of twenty women who had given birth at least once was considered in qualitative research by Carola Eriksson and colleagues (C. Eriksson, Jansson, & Hamberg, 2006).
This study found that intense fear could manifest as a mental state, a bodily state or as “an intertwined feeling of troublesome thoughts and embodied sensations” (p.242). Eriksson and colleagues identified that in controlling their fears some of the women evaded the thoughts and situations associated with the fear which gave them some sense of self protection. However, Eriksson and colleagues did not classify participants as fear “evaders”, fear “processors” or “help seekers” (p.247). Instead, the researchers identified that participants proactively managed their fears by choosing the approach that most suited their needs at the time.

No matter how participants in this research experienced their fear or how it was managed, the women also judged their fears according to their self perceptions and perceptions of social norms (C. Eriksson, et al., 2006). These women then had difficulties expressing their fear and considered themselves “different and inferior” because of their fears (p.247). The interest and understanding of their midwife was identified as a “crucial necessity” for women to be able to express their fear (p.245). This rigorous study exposed how a woman can actively participate in managing her fear and it provided a beginning understanding of how caregivers can facilitate that process.

Limitations relative to this dissertation:
- embodied self was not specifically conceptualised;
- only provided an analysis of one aspect (fear) of the embodied experience of self in childbearing.

3.2.3.6 Struggling with life

Maintenance of a sense of continued self appears to be absent from the perceptions of women with postpartum depression. An all-encompassing sense of loss, in addition to the sense of disconnection between expectations and reality, are both prevalent characteristics in Cheryl Beck’s metasynthesis of 18 qualitative studies of postnatal depression (2002). According to Beck women’s sense of disconnection involved a whole series of unfulfilled expectations including those associated with birth, partner relationships and the realities of infant care. Beck claimed that the discourses from which women formed expectations were “destructive myths” that permeate culture (p.458). In Beck’s metasynthesis women with unfulfilled expectations experienced guilt, blame, feelings of isolation and sometimes contemplated self-harm. In addition, she found that women had a pervasive sense of self loss that included loss of cultural
power as well as losses related to sexuality, body image, intellectual capacity and personal space.

In a more recent grounded theory study of women’s depressed mood postpartum Maigun Edhborg and colleagues confirmed much of Beck’s analysis (Edhborg, et al., 2005). The women in this study “struggled with life” in their attempts to redefine their identity and to live up to their expectations of being a good mother (p.263). Participants considered themselves lonely and powerless because they felt separated from the “fast-paced” and culturally powerful “masculine world” (p.265). The key to explaining women’s depressed mood postpartum, according to Edhborg and colleagues, was their experience of change and loss of expectations, identity and space (2005). But loss and change were also characteristics of non-depressed women in the postpartum, as identified in by Rogan et al (1997) and Barclay et al (1997). Edhborg and colleagues therefore hypothesised that the difference between depressed and non-depressed women “might be their strength” in how they responded to change after the birth (2005, p.265). The researchers do not, however, explore the relative capacity for depressed women to hold ‘both/and’ discourses and therefore maintain a sense of continued self. In both Beck and Edhborg et al’s studies the limitations relative to this dissertation were:
- the influence of humanistic discourse was not considered;
- ‘self’ was only defined in terms of social identity;
- only provided an analysis of one aspect (depression) of the embodied experience of self in childbearing.

3.2.4 The transforming potential of childbirth

When expanded perspectives are inclusive of the lived experience of birth, childbirth can have a transforming potential. A characteristic of conventional theories of transition was to de-emphasise childbirth as merely another milestone in a woman’s childbearing experience. Yet the embodied intensity of the childbirth experience can, for some women, make childbirth itself the focal point of change. Such an experience exposes the actual birth process as a relevant and important event in the lives of many women.

3.2.4.1 Trust and the bodily experience of labour pain

The potential for transformation in childbirth was linked to a woman’s bodily experience of labour pain in another midwifery study by Lundgren with Karin Dahlberg (1998). Lundgren and Dahlberg’s phenomenological analysis showed that women
handled their pain by trusting in themselves and in their body as well as by trusting their midwives and partners. Self-trust was illustrated by these women using terms such as “listening” to their body and “hiding” in their bodies in what appeared to be a deeply altered conscious state (p.107). In Lundgren and Dahlberg’s analysis the essential element for women to experience labour pain as transforming and meaningful was a woman’s capacity “to be her own body” in a unified, non-objectified way (p.109). Lundgren and Dahlberg identified that women’s awareness of their changing state was what gave the experience of pain “a positive meaning” (p.108). This positive meaning was also associated to an inner more spiritual meaning related to life purpose.

The importance of women’s self and bodily trust was also identified in further research by Lundgren, this time with women two years after their birth experience (2005). Lundgren’s analysis highlighted that it was the inevitability of women’s situation during labour that led to their sense of being changed and also to a sense of empowerment. Participants’ overall sense of wellbeing about birth meant that these women were unconcerned that their expectations were not the same as their experiences. In this study women identified that they chose an active course through labour that encompassed many paradoxical elements such as: being in control and losing control; feeling helpless as well as being empowered; and passively “going with the flow” in addition to more actively “taking command of oneself” (p.348). The contradictory ‘both/and’ position was therefore shown to be a feature of how women experienced their power in childbirth as well as antenatally and postnatally.

These studies provide a valuable perspective on women’s lived experience of childbirth (Lundgren, 2005; Lundgren & Dahlberg, 1998). The phenomenological analysis is well supported by the data. However, the reliability of results was diminished, as both studies only undertook single interviews and member checking was not performed. Limitations relative to this dissertation in these two studies were:
- embodied self is not specifically conceptualised;
- cultural influences on a labouring woman are not analysed.

3.2.4.2 An experience of power

Women’s experience of power in birth is strongly portrayed in a small qualititative study of homebirth by midwife Ingela Sjöblom, psychologist Berit Nordström and nurse Anna-Karin Edberg (2006). In their phenomenological analysis a woman’s “self-
determination” was “naturally embedded” in being at home (p.352). Participants felt an authority over their place of birth which enabled them to give their whole focus to the birth experience “without any distractions” (p.350). They contrasted this birth place with the hospital environment which was considered as “consuming energy and taking the focus away from the labour” (p.354). At home participants created an overall secure “frame” for their experience as an “inner space” and as a space shared with midwives and family (p.353).

To Sjöblom et al, participant’s “inner space” was where a woman was “present with herself”; could focus inwards; follow “the signs of her body” and trust “the process” (2006, p.353). In the inner space, woman and baby were found to “co-operate and communicate during the whole process and are coalesced” until the birth (p.353). Participants “quietly” listened “inwards” and perceived “feelings of the baby” in addition to being aware of the mutuality of their experiences (p.351). Together woman and baby created the coalescence in such a way that the participant’s power or “faith in one’s own competence” was enabled (p.350). However this faith, in Sjöblom and colleagues’ theorising, was more than coalescing with baby, it was a coalescing of mind and body too. Coalescing was a consciously undertaken process of coming to know the baby and an ongoing fluctuating practice of nonrational knowing of self and other at an embodied level.

Member checking was not undertaken in this study. However, all researchers with their differing perspectives participated in analysis and themes were well supported by quotes from the data. Adding to the study’s credibility was the dual phenomenological-hermeneutic mode of analysis that allowed firstly for a naïve reading of the data, followed by the more structured, thematic analysis. Unfortunately the researchers used phrases such as “master the situation” and “control of the body” that dominated and overrode the ‘both/and’ inclusiveness of the coalescing process they described (2006, p.350). As further discussed below, negotiation of ‘both/and’ experiences of contradiction appears to prompt the sensation of power during childbirth. Limitations relative to this dissertation:

- specific conceptualisation of embodied self not given;
- no analysis of cultural influences on labouring women.
3.2.4.3 Being vulnerable to socialisation

The intensely powerful, transforming potential of childbirth also makes it a time when a woman is vulnerable to socialisation. Two anthropological studies by Robbie Davis-Floyd focused on how a woman’s values were shaped by childbirth (1992, 1994). In Davis-Floyd’s first study most participants planning natural birth in hospital actually had highly techno-medical births (1992). Only nine participants were distressed by this outcome. Ten participants perceived that techno-medicine was “at their service” and used it to maintain a “degree of control” over their birth experience (p.217). This perception of technology “strengthened” these women’s “sense of themselves” in relation to dominant cultural values (p.219). The remaining 42 women rationalised that the “medical interventions they experienced were justified, appropriate and necessary” (p.220). They “internalised” their “inadequacy as birth-givers” (p.227). Davis-Floyd claimed that this was not a long term trauma because many of the women’s beliefs were based on values confirmed by their techno-medical birth experiences. Hence, women’s complacency about their unfulfilled plans was because they had been socialised before and during their experience to accept the underlying values of the standard care paradigm (outlined in chapter one).

In Davis-Floyd’s second study she drew on data from successful professional women plus four successful women classed as non-professionals (1994). These four non-professional women planned homebirth. The majority of the professional women planned techno-medical births in hospital, but four of these professional women chose homebirth. In pregnancy the non-professional participants saw themselves as a self/body unit and felt that letting go of personal controls was a valuable approach to life and birth. In contrast, all the professional participants desired to be in control and expressed “feelings that body and self are separate” (p.1133). Their sense of mind/body separation not only prioritised their rational processes but also created the perception that bodily processes were or should be controlled. According to Davis-Floyd, these feelings of separation were reinforced for the professional women who gave birth in hospital. These participants saw the body as a “vehicle, a tool for the self” and techno-medicine was simply a mechanism to control bodily experience (p.1130). What was most important to these women was being intellectually aware so that they could then be actively responsible and capable of rational decision-making.
In contrast, Davis-Floyd found that values of conceptual mind/body integration were emphasised and the body’s uncontrollability was accepted by participants experiencing homebirth (1994). The four professional participants who had desired bodily control and expressed a sense of mind/body separation prior to the birth “somehow” sensed that these values were “inconsistent” with lived experience and homebirth philosophies (p.1133). According to Davis-Floyd, these women changed as they experienced the contradictions of their lived reality. These four participants came to perceive a sense of the “organic interconnectedness” of their self in relation to their body (p.1133). By planning and achieving homebirth participants allowed themselves to be socialised according to the non-dominant values of natural birth at home.

In Davis-Floyd’s research childbirth was conceptualised as “a rite of passage” that held “tremendous cognitive significance” for women (1992, p.305). This perspective enabled the research to emphasise the influence that childbirth could have on women’s experience of childbearing change. Hence, the research was able to highlight the very vulnerable, liminal position that women are in during childbearing as well as the transforming potential of childbirth. Limitations relative to this dissertation:
- the body and the self were not defined but were considered according to each participant’s own “conceptions of body and self” (1994, p.1128);
- analysis centred on the cognitive rather than embodied significance of childbearing change;
- analysis did not include planned homebirths that were not achieved, or planned techno-medical births that were natural.

3.2.5 **Depth, complexity and the fluidity of time**

The expanding perspectives of women’s changing embodied self encompass depth, complexity and the fluid dimensions of time. This very contextual “enlarged view of experience” was taken in the phenomenological research of the whole childbearing period by nurse Vangie Bergum (1989, p.113). Bergum used the concept of the “hermeneutic circle” to relay the fluid complexity of time (p.113). This concept incorporates the idea that while parts of a phenomenon make up its whole, understandings of that whole inform understandings of its parts and vice versa. Bergum described “thematic moments” that formed the parts of each participant’s whole period of change and could also contain a sense of their whole experience of becoming (p.113).
Through this approach Bergum illustrated the complexity of women’s whole experience but also the complex depth of labour and birth as a valuable part of that experience.

Bergum’s analysis relayed the nonlinear aspects of participant’s lived experience (1989). She found significant aspects of the present were enveloped by the past while new experiences could “reach back” to change understanding of earlier experience (p.36). Bergum explained that “a woman’s knowledge” of transformation was “a process that deepens her understanding of what she already knows”, enabling her to become what she “already is” (p.55). In addition, Bergum conveyed a repetitious element to time when she explored how her participants acquired an “increasing depth of understanding” as they “again and again” faced previous themes of their life experience (p.113). Labour pain was similarly conceived not as “static and unchanging” but “dynamic”, “moving” and warranting a response (p.70). Pain, to Bergum, was enduring as well as something to be endured because while immersed in pain time itself appeared to stop, to go on forever or to just be irrelevant. The way participants experienced pain at any particular moment was associated with the way they held themselves in relation to the pain. Bergum found that a woman’s past experiences and her future intentions influenced how she held herself and experienced pain as well as the choices she made while having that experience.

3.2.5.1 Choice as an embodied experience

Bergum’s contention was that women’s use of their own power in giving birth and experiencing change is a responsible choice (1989). Choice, to Bergum, was not the purely rational one that limited humanistic understandings of self would suggest. Decision-making and responsibility were shown to also be mediated by bodily, spatial, temporal and communally shared activities as well. Participants, for example, undertook daily activities whilst also “being aware” of the “unique experience” of their “body as being with child” (p.56). In labour participants felt contractions and movements “with an immediacy and certainty” that “no one” could “share” (p.89). Such sensations provided an embodied, experiential form of knowing that impacted on how participants made decisions and took responsibility. While acknowledging that it “is easy for a woman to lose touch with or doubt her own experience” and “to accept objective knowledge as more correct”, Bergum demonstrated that women did have these nonrational forms of knowing available to them (p.89).
How a woman should maintain a connection with nonrational forms of knowing was not made clear in Bergum’s analysis. Bergum nonetheless maintained that even during participants’ most painful and vulnerable moments of change nonrational modes of knowing were available and able to facilitate responsibility and decision-making. Periods of vulnerability were not, to Bergum “a sign of weakness” but indicated participant’s increasing need for “relationship with others” (1989, p.155). Childbearing was therefore found by Bergum to also be a community responsibility. However, Bergum still claimed that ultimate responsibility for change was with the woman herself. The apparently unending intensity and exhaustion of labour pain induced in some participants a state of “passive suffering”, but Bergum insisted that a woman could free herself from that state through “active relaxation” (p.70). Each participant had a choice to “accept and take hold” of “autonomy and personal power” in birth, or to be “at the mercy of the environment or the doctor, alienated from her body and subject to fearful thoughts and imaginings” (p.69). A woman who actively responded was, according to Bergum, more likely to experience a sense of “integration and wholeness” for both herself and her baby (p.155).

Bergum exposed the “layers of complexity” in women’s private, inner experiences of change in addition to the more public, cultural reality of their lives (1989, p.151). The “awesome, mysterious, spiritual dimension” was relayed through participants’ embodied experience of “the actual maternal blood and pain” inherent in a woman’s relationship with her child, particularly during childbirth (p.139). The intimate and sexual nature of childbirth was also depicted by Bergum. By moving beyond limited humanistic understandings of the self, Bergum’s research revealed that childbirth was a deep, complex and potentially powerful event which could then articulate positively with a woman’s whole experience of change in childbearing. Limitations relative to this dissertation:

- no deep analysis of women as reflexive, socially constructed selves who make decisions amidst diverse powerful and not so powerful discourses;
- analysis did not extend to specific and useful recommendations for practice.

3.2.6 **Summary**

This section has reviewed a diverse array of studies giving perspectives on childbearing change that are more expansive than those presented in the conventional “transition to
motherhood’ theories. Some of the studies purposely focused on only a portion of a woman’s experience of change while other studies claimed to consider transition as a whole but omitted key elements. For example Bailey (1999, 2001) and Miller (1998, 2000, 2007) omitted an analysis of intrinsically experienced aspects of embodied self. Of all the research reviewed in this section Bergum’s (1989) broad descriptive analysis has presented the most expansive perspective on a woman’s changing embodied self. However, Bergum made no detailed analysis of cultural influences on change. None of the research systematically developed an holistic understanding of what practices could help a woman feel better or worse about herself during childbearing change. The next section more specifically considers how women may make active responses to the contradictions of change in ways that they believe will be personally beneficial.

### 3.3 NEGOTIATING THE CONTRADICTIONS OF CHANGE

A woman’s negotiation of the contradictions made apparent through her experience of change can impact on her sense of self. Various forms of contradiction become highlighted through the childbearing experience. For example, a woman may become aware of contradiction between her beliefs and the values promoted in medical and lay discourses, or she may see contradiction between her expectations and experience. Women often have to negotiate contradictions in order to make decisions, to actively respond to situations, and to make meaning of experiences. The studies I review in this section consider how a woman undertakes such negotiation during childbearing.

#### 3.3.1 A complex and highly contextualised activity

Negotiating with contradictory powers, such as the norms of society and medicine, is a complex and “highly contextualised” activity, according to Robin Root and Carole Browner’s anthropological research (2001, p.203). This research considered women’s choices and consequent “practices of the pregnant self” as they negotiated the “physical, social and psychological changes” of childbearing (p.218). In Root and Browner’s theorising, practices of the pregnant self were embodied and encompassed both a woman’s agency and her capacity to be socialised. During pregnancy participants were exposed to multiple social and techno-medical norms that gave differing advice on whatever aspect of experience was of concern. Each participant acted to “make relevant” these “diverse streams of knowledge” in a way that was “appropriate to her
pregnancy needs” (p.207). Root and Browner identified that each woman variously referred to: her bodily knowledge; the differing knowledges conveyed by professional and lay discourses; as well as her “own ethics” or self understanding (p.207). A woman would then make choices according to the power she attributed to each of these knowledges. Each woman thus individualised her prenatal practices by making choices according to her own particular context.

According to Root and Browner, entangled in each woman’s particular context, was the relative degree of importance each woman attributed to her particular understanding of the discourses of ‘good’ and ‘bad’ mothering (2001). The particular practices participants undertook with regard to a particular aspect of pregnancy occurred across a spectrum of compliance/resistance to techno-medical norms. This spectrum was related to each participant’s varying beliefs in techno-medicine’s scientific and moral claims about whether or not a particular practice was appropriate. For example, a woman might choose to “privilege” techno-medical “know-how” about diet, alcohol consumption or exercise and totally comply with the relevant norms (p.208). Participants also minimally complied, partially resisted or openly resisted the medicalised norms. Some participants resisted a particular medicalised norm but complied with norms from another source, such as their mother or the internet. In such circumstances these women considered the particular social norms “virtually analogous” to the medicalised norm in question (p.212). In this way women could retain a moral sense of themselves as ‘good’ and compliant without actually undertaking the medically recommended practice.

In Root and Browner’s research women’s ways of coming to know about themselves and their pregnancies was in a continual state of flux (2001). Root and Browner maintained that, “despite the homogenizing potential” of techno-medicine “an ever-present and potent, individual agency” endured in women’s accounts of pregnancy (p. 218). Participants would “strategically, if unwittingly, conjure and solicit a biomedical logic” to validate their bodily knowledge (p.202). Yet participants also actively sought out “non-biomedical sources of experience and knowledge” to both justify “their resistance to biomedical norms and/or” to help them to make “better sense of their pregnancies” (p.203). This research therefore showed that although pregnant women may in some ways be socialised to conform to social and/or medical norms, they also have the agency to actively negotiate and make their own decisions.

Limitations relative to this dissertation:
omitted analysis of impact that impending childbirth may have on decision-making;
- no analysis of how risk discourses may influence women’s agency in decision-making;
- did not consider how women’s decision-making impacts on their overall experience of childbearing.

3.3.2 Retaining responsibility for decision-making

In two studies of how homebirth risk was negotiated, women chose homebirth because they wished to retain responsibility for decision-making (Lindgren, Hildingsson, & Rådestad, 2006; Viisainen, 2000). In Kirsi Viisainen’s anthropological study participants’ decision-making was shaped by perceived risks of pregnancy and birth, by iatrogenic medical risks, and by the implicit moral risks of going against authorities (2000). Participants, some of whom were health professionals, felt a “deep mistrust of the system” and were aware that a degree of social coercion was sometimes used to gain compliance with medical recommendations (p.810). However, participants also wished to ensure safety and access prenatal screening. When gaining this access some participants were found to conceal their homebirth plans to avoid being stigmatised by hospital-based prenatal caregivers.

According to Viisainen, participants used the ambiguity of medical knowledge and risk in addition to their individual screening results to downplay their personal risks during homebirth (2000). For their final decisions, however, participants drew on “intuitive knowledge” in combination with the knowing generated from past experience, particularly if an actual risk had been detected (p.802). By drawing on intuition during decision-making the participants gained the courage to go “against the norms of the system” and make choices relevant to their particular situation (p.803). Participant’s use of intuition was highly dependent on the context of their individual situation. They conceived “intuition” as a “natural” resource that enabled them to take responsibility rather than blindly follow the rationality of techno-medicine or any other ideology (p.803). Presumably intuition’s experiential basis was what made intuition “natural”, although that was not made clear by Viisainen. Viisainen’s theorising was well supported by the data and she illustrated the very embodied way that intuition may be used to negotiate experiences of contradiction. Limitations relative to this dissertation:
- no detailed analysis of intuition or other intrinsically experienced aspects of self;
women’s changing embodied self not conceptualised.

In midwife Helena Lindgren and colleagues’ phenomenological study participants acknowledged that complications could occur at home and hospital (2006). This was a small but rigorous exploratory study. Participants carefully weighed up the relative risks of each. Amongst the strategies that participants used to assess risk were: physical preparation; trust in their bodily capacity; confidence in their midwife; and confidence in the woman/partner relationship. Participants counterbalanced their perceptions of risk by combining these strategies with a trust in their intuition. This intuitive trust was found to be central to their decision-making. Lindgren and colleagues conceptualised intuition as “an opposite pole to the intellectual process” although the processes appeared to occur simultaneously (p.19). According to Lindgren and colleagues intuition was a medium through which woman and baby could communicate. This communication then enabled participants to trust that they would intuitively know if/when there was a problem requiring a change in their decision-making. The implications and success of this decision-making was not, however considered.

**Limitations relative to this dissertation:**

- intuition was conceived naively and the embodied nature of intuition was not considered;
- women’s changing embodied self not conceptualised;
- no consideration of moral influences on decision-making;
- no discussion of highly contextual way risk is negotiated.

### 3.3.3 Feeling power through paradox

Post-structural research about religion and homebirth by Pamela Klassen, a feminist academic, found that women created feelings of power through negotiation of paradoxical elements of their experience (2001). Participant’s experiences of power were, to Klassen, profoundly entangled in personal concepts of spirituality and procreation. Many participants used “spirituality” to imply an “embodied connection with a supernatural power” which was perceived to be available universally “to anyone who made the effort” (p.73). Faith in this embodied connection was recognised to mediate how participants experienced and interpreted labour pain.

According to Klassen, participants variously endured, surmounted and even exulted in the sensations associated with labour pain (2001). Although experiencing labour pain
was not necessarily pleasant or easy, all participants gave it a “generally positive interpretation” (p.206). In Klassen’s feminist analysis this overall positivity posed “some difficult questions” surrounding “unnecessary martyrdom”, the “spiritualising of suffering” and essentialised perspectives (p.206). Klassen nonetheless identified that the variety of meanings created by women about their pain were socially located and relative to the various ways each woman perceived control. For many participants the pain experience became an expression of the woman’s own power in resistance to medicalisation. This was “visionary pain” to Klassen because it had “political undertones” that presented “rival constructions of reality” and re-valued women’s power (p.211). Some participant’s expressions of power during labour were thus linked to the politicised meanings that woman and/or others had already given to childbirth.

Klassen identified that the experience of visionary pain crossed “between ecstasy and agony” (2001, p.211). The linking of childbirth joy with pain enabled some participants to perceive labour pain as purposeful such that the pain seemed “dulled” or “dispersed” (p.178). To Klassen the contradiction of the pain/joy paradox was an expression of what some women experienced as an intimate link between labour pain and the joy of meeting their baby. One of the reasons that participants chose to experience the pain of unmedicated birth at home was the anticipated joy of the baby whom they wished to protect from medication. Klassen found participants’ negotiation of pain and joy in this way produced power in the sense that the women “acted as agents responsible for the care” of their babies (p.182). Thus, the feelings of power created by negotiating contradictions were embodied into practices that expressed a woman’s sense of responsibility for her baby.

Amongst Klassen’s participants the lived experience of physically contradictory sensations such as “pleasure, pain, sexuality, and relief” seemed to have “powerfully transformative” possibilities (2001, p.193). For example, Klassen claimed “the bodily rigors” of labour “opened” women “up to connection with children, friends, midwives, spiritual powers, or husbands” (p.196). This connectivity could in turn produce further, more social, contradictions in a woman’s need to both focus on herself and to connect with her baby, partner and/or midwife. Participants’ on-going negotiation of these contradictions produced a “ritual of intensification” where the pain and social relationships emphasised and intensified women’s self concepts as both lover and mother (p.85). Overall, the research showed that by negotiating to both embrace change
and surrender to change, a woman can experience her own power during childbirth. For this to happen Klassen found that participants needed to be themselves at birth which “required being at home, not the hospital” (p.100). Limitations relative to this dissertation were the omission of:

- what midwives could do to facilitate a woman to ‘be herself’ in settings other than home;
- specific midwifery practices that could enable empowerment.

### 3.3.4 Finding meaning in natural birth dilemmas

Meaning is also created by negotiating the contradictions of natural childbirth according to research by Paaige Turner (2002, 2004). Turner, a feminist academic working in the area of organisational communication made an auto-ethnographic analysis of her first pregnancy and birth experience within a freestanding birth centre (2002). This analysis underpinned Turner’s ethnographic research of midwifery practice within that same birth centre (2004). Turner used narrative and reflexive introspection to consider the self and the activities surrounding birth. The self was initially discussed in dichotomous terms of the “modernist” versus “postmodernist” self (p.653). The modernist self, in Turner’s analysis, had the values of humanism (as outlined in table 1.1, pp.28-29). The postmodernist self allowed for a multiplicity of selves, the fragmentation of lived experience and the partiality of truth. By negotiating the contradictory dilemmas within her own natural childbirth Turner moved beyond the dichotomous ‘either/or’ perspective of self to a more inclusive ‘both/and’ understanding.

Turner identified a number of contradictions within her own natural birth experience (2002). For example, Turner wanted a natural birth but also wanted the sense of certainty that ultrasound could give to her perceived capacity to have that natural birth. In another example Turner found herself evaluating her natural birth experience using the safety model of techno-medicine because the actuality of her experience did not match with how she had previously conceptualised natural birth to be. Turner similarly observed her midwives addressing a midwifery issue in biomedical terms rather than in terms of practices specific to the natural birth model of midwifery. In negotiating these and other contradictions Turner reflexively identified her own inclination toward a modernist stance that sought the consistency of non-conflicted thoughts and beliefs. Through self-reflection Turner eventually came to perceive herself post-structurally as a
single “speaking subject” who at the same time had “multiple” postmodern concepts of self that included her modernistic self (p.665). This introspective focus enabled a perception of her birth story not as depicting “the experience exactly as lived” but as a negotiated meaning of the “multiple representations of self” relevant to “time and contexts” (p.656).

Turner also found a postmodern multiplicity in her analysis of midwives practices in the birth centre (2004). She identified how midwives negotiated the dilemmas of natural birth by being “the keepers of alternative birth ideologies” at the same time as using “more traditional practices should the situation require” (p.659). In Turner’s theorising the negotiation of “contradiction and inconsistency” as well as “paradoxes and double binds” are not “problems to be solved” but “moments” when “meaning” becomes created (p.648). She maintained that when “the relationship between opposites” are negotiated instead of “dismissing one or the other”, then an expanded understanding of the self and the world is possible (2002, p.655). Hence in her auto-ethnographic analysis Turner established that what was natural about her natural birth was the tension between the contradictions, because these contradictions could allow room for diversity.

By considering aspects of life “natural”, Turner claimed, women can consider diversity as well as certainty and maintain an “illusion of coherence” (p.665). A complete analysis of what Turner meant by the “illusion of coherence” is not given. However, Turner did relay how she gained an embodied sense of coherence in the context of her own natural birth. Turner acknowledged that she did not intellectually “know” whether she had had a natural birth, but experientially she knew that her feelings of pride and strength could “count as natural” (p.666). By negotiating the perceived contradictions in her experience Turner created an individualised meaning of what natural birth meant to her. Turner’s research illustrated how meanings change according to the individuality of person’s embodied experience, whether that person is a midwife or labouring woman.

Limitations relative to this dissertation:
- did not encompass particular midwifery practices that could facilitate a woman’s experience of changes;
- made no analysis of overall experience of change.
3.3.5 Knowing about childbirth

A woman’s subsequent experiences of power and meaning are variously influenced by the ways of knowing she initially negotiates. The ways women know about childbirth during and after their first pregnancy were explored in a phenomenological nursing study by Jane Savage (2006). The study was small but rigorous with themes well supported by data. Participants were found to access numerous professional and lay sources of knowing about birth. The more intrinsically based ways of knowing such as “intuition” and “inner wisdom” were also considered (p.14). According to Savage, intuition was an experience of the lived body that presented a way of understanding the “uncertainty” of “ever changing reality” and could form a basis “for learning and decision-making” (p.18). Participants expected to have intuition available as part of the embodied naturalness of childbirth, yet in the reality of their pre and perinatal experience they were only aware of extrinsic modes of knowing. They found the concept of intuition “disquieting” and several “denied having any inner wisdom at all” (pp.13, 18). Even after giving birth participants were “unaware of any substantial, trustworthy intuition” with regard to childbirth (p.21). Savage suggested that the dearth of intuition was because it was “repressed with a high degree of success” (p.21). A woman’s birth environment and her caregiver relationships were acknowledged to play a part in this repression.

To Savage, the degree of empowerment participants gained from knowing about birth was influenced by the support available in their environment (2006). Their relationships also mediated participants’ ways of knowing. Participants had no wish to portray their own knowledge as greater than their caregivers as they believed that doing so might “jeopardize” relationships or care (p.18). Although participants became quite dependent on their own mother’s knowledge, they also believed family, friends, and caregivers withheld and otherwise controlled their access to knowledge. Participants were resentful about this control but passive about challenging practices that contradicted the knowledge that they did have. These passive responses were due to fear which Savage claimed “prohibits active participation in discourse” (p.21). Even when participants accessed formal childbirth education an undercurrent of fear remained. In contrast, birth stories were a desirable resource that helped participants to “explain the unknown”, “lessen fear” and feel some control over childbirth (p.17). Most participants were nonetheless found to “lower their personal expectations” and their sense of
“responsibility” over the birth in order to ensure they “achieved a positive, safe birth” (p.19). This research reveals how a woman’s capacity to negotiate contradictory ways of knowing is rendered passive by her fears. Limitations relative to this dissertation:
- little analysis of the unsupportive environments and relationships that appeared to reinforce a woman’s fear;
- women’s changing embodied self not conceptualised;
- no new recommendations for practice were made;
- encouraged “realistic” and “flexible” birth plans that support the underlying values of the standard care paradigm (2006, p.21).

3.3.6 Summary
This section has explored the varying ways that women can actively respond to the contradictions of change. Root and Browner (2001) showed that women do have the agency to make their own decisions. Women planning homebirth were found to use this agency to negotiate moral and medically conceived risks and to encompass intuition in their decision-making (Viisainen 2000). In examining women’s experience of homebirth Klassen (2001) claimed that feelings of power were actually created through a woman’s negotiation of contradiction. To Turner (2002, 2004) it was meaning that was created by negotiation. Each of these studies showed how women may act to positively influence their experience of change. However Savage’s study (2006) illustrated that, although women may strive to gain knowledge and smooth their way through change, their fear and/or environment can thwart their negotiating capacity. None of these studies showed what caregivers could effectively do to enhance a women’s embodied sense of self during change. Practices that have the potential to be empowering are the focus of the next section.

3.4 Making Change Empowering
Caregivers can have a profound influence on how a woman responds to and experiences her changing sense of self in childbearing. Chapter one outlined the ways that the standard care paradigm could diminish women’s sense of self such that they become reliant on the techno-medical care during childbearing. In this section I use the literature to explore caregiver activities, mainly of midwives during childbirth, which appear to
enhance a woman’s sense of embodied self. These studies primarily highlight activities that support a woman’s feelings of being empowered during her experience of change.

3.4.1 The milieu of partnership

Women felt empowered in the presence of midwives with whom they could form a partnership in the pilot study outlined in chapter one (Parratt, 2000, 2002; Parratt & Fahy, 2003, 2004). The study defined a positive sense of self as a mutually empathic and empowering feeling of connection occurring extrinsically with other people and intrinsically with the self (Parratt, 2000; Surrey, 1991b). My analysis found that a woman’s sense of self could be positively influenced by her internal response to the bodily sensations of labour (Parratt, 2000; Parratt & Fahy, 2003). A supportive external milieu enabled a positive internal response by creating a birth space in which the woman felt safe enough to release herself to change (Parratt, 2000; Parratt & Fahy, 2004).

The process of internal release was described as an oscillation between relinquishing mind control and releasing bodily self-controls which gradually altered a woman’s conscious state (Parratt, 2000; Parratt & Fahy, 2003). Natural birth, in this analysis, occurred through participants’ continued oscillating release of mind and body control which in turn prompted an ever-deepening surrender to bodily sensations. However, the process was easily disturbed by the external environment and by how each participant adapted to challenge (Parratt, 2000; Parratt & Fahy, 2003). Participants were challenged by: their own responses that reinstated bodily control; fearful/anxious responses that increased cognition; spontaneous occurrences like ruptured membranes; labour’s increasing intensity; and, the necessity to endure (2000). After the birth a further challenge presented itself in some participants’ need to attend to the bodily cues of third stage labour in addition to being with the baby. The participants who experienced labour within the milieu of a midwifery partnership were more able to adapt to these challenges.

This was a small pilot study that dichotomised caregiver practices and used a dichotomised perspective to show the oscillating negotiations of body/mind surrender (Parratt, 2000, 2002; Parratt & Fahy, 2003, 2004). I argued that participants were empowered through their surrender to the process of labour. However I also found that a
degree of personal discipline was required for a woman to undertake the oscillating release of body/mind control. Limitations relative to this dissertation:
- did not include a post-structural critique of studies relevant to birth and the self;
- no consideration of embodiment;
- in hindsight I believe I was overly influenced by Odent’s rational dichotomous assessment of the intellect versus instinct (1999). To some degree I perceived an altered conscious state as a mode of mind/body separation that allowed the body to get on with the business of birth without interference from the mind. As discussed in section 2.5.3 this perspective is not consistent with post-structural ‘both/and’ understandings of how the embodied self changes.

3.4.2 Being active and retaining agency

Sociological research by Madeleine Akrich and Bernike Pasveer (2004) examined caregiver activities that enabled a woman to retain a sense of her agency and be active during labour. This research drew from a diverse range of women’s birth narratives. Each participant was considered an embodied self who each also experienced a sense of duality between the agency of her embodied self and the power manifested by her “body-in-labour” (p.66). These two “active entities” were not pre-defined and stable but produced and recomposed throughout labour where they “merged and separated” in differing ways (p.74). Connection between a participant’s agency and bodily power was variously mediated by her sensations and awareness such that she felt empowered to be active. Akrich and Pasveer found that both disembodying and embodying labour activities could be empowering.

Embodying activities, according to Akrich and Pasveer, occurred in response to a participant’s dissociation from the ways her agency was ordinarily used, often because of the intense bodily power of painful contractions (2004). Some participants undertook alternate activities to re-embody their agency. For example, participants used activities that “strongly engaged” their bodies, such as squeezing their partner’s hand, rocking or focusing on breathing (p.72). Participants who were unable to maintain these re-embodifying activities felt alienated and disempowered. Caregivers were identified to respond with embodying activities to “establish and maintain” the duality of the woman’s relationship between her embodied self and her bodily power (p.78). Some of these embodied activities supported participants’ actions to “re-embody” the self, such
as woman/caregiver breathing together (p.72). Other embodying activities were highly techno-medical such as an epidural. Epidural was considered as an embodying activity because it enabled a woman to resume contact with the ordinary agency of her embodied self.

Akrich and Pasveer did recognise that, although a participant’s experience of epidural brought agency into the foreground of awareness, an epidural also dissociated her from sensations of bodily power (2004). For one participant this experience was as disempowering as the pain itself. Some participants also felt a degree of dissociation from sensations of bodily power because their “internal sensations” were generally “ambiguous” (p.68). In response to dissociation, women as well as caregivers were found to undertake “objectifying” or disembodying activities (p.69). Objectification was “a form of disembodiment” that provided the clarity of a conceptual awareness which, instead of sensation, mediated the interaction between bodily power and agency (p.76). Participants were identified to enter labour with a prior objectified understanding of their uterus as the “active element” of bodily power which to a degree defied “voluntary control” (p.69). Hence Akrich and Pasveer claimed that participants “easily accepted” the objectification of “medical action” (p.76). Participants also undertook objectification themselves.

Disembodying activities, in Akrich and Pasveer’s analysis, used an object or gesture to separate a woman’s sensory perception of bodily power from her conceptualisation of that power (2004). One participant, for example, had a bath to “test” her “own perceptions” of whether her contractions were intense enough to go into hospital (p.69). Disembodying activities were found to “requalify” a woman’s perception of her body, constituting it “as an acting entity” (p.68). In one example, the “thickness” of the cervix measured by a midwife’s fingers showed how the body could resist “the woman’s will” for labour to progress (p.70). More complex interventions, such as the electronic monitor “disregarded” the participant’s sensations but provided a visual concept of bodily power (p.75). Objectification did not necessarily better enable participants’ sensory awareness of bodily power. However, gaining objective confirmation of sensations did enable some participants to be active and adapt to their changing bodily power during labour.
Akrich and Pasveer made a nuanced analysis of caregiver practices that empowered participant’s changing embodied self in labour (2004). Their non-dichotomised approach found embodying and disembodying activities in all the narratives, regardless of caregiver profession and regardless of birth place. Limitations relative to this dissertation:

- aligned childbirth with disease states, considered women as patients and perceived all types of caregiving as forms of medical practice;
- no analysis of how disembodying activities distort concepts of bodily power and in-the-moment experience;
- failed to consider particular caregiver activities that may optimise women’s overall wellbeing and enhance their sense of self.

3.4.3 Instruments of care

Research by midwife Holly Kennedy and colleagues has identified central aspects of midwifery practice that appear to differentiate it from obstetric care and clearly link it with positive outcomes including a woman’s sense of empowerment (Kennedy, 2004; Kennedy & Shannon, 2004; Kennedy, Shannon, Chuahorm, & Kravetz, 2004). A metasynthesis of Kennedy’s earlier work along with four other studies of midwifery practice showed how midwives “strategically” use themselves as “instruments” of care (Kennedy, et al., 2003, p.207). This metasynthesis highlighted how both the midwife and woman were unique individuals who formed an alliance where the woman acted “as a partner” in her care (p.207). An important element of this relationship was the environment of “normalcy” created by the midwife (p.210).

In Kennedy’s later research midwives “individualised their care” in purposeful ways “geared toward” knowing the woman “as a unique person” (Kennedy, et al., 2004, p.17). This process involved “a realistic and honest reflection with the woman about the current situation” and included the validation of her fears (p.17). The mutuality and respect of the woman/midwife relationship formed the basis from which the midwife acted to “orchestrate an environment of care” that met each woman’s individual needs (p.18). Integral to this process was the “physical act of being with woman” including a “belief and trust” in the woman’s “strength”, “knowledge” and “instincts” (Kennedy & Shannon, 2004, p.557). As an instrument of care the midwife became a “conduit” who “harmoniously” negotiated the best possible environment for each woman (Kennedy, et
In doing so the midwife aimed to optimise the woman’s health in any “given situation” and to enable a birth experience that was “respectful and empowering” (Kennedy, 2004, p.509).

According to Kennedy et al the dynamic, “complex” and “intricate” nature of midwifery practice produced specific, measurable outcomes in terms of a woman’s feelings of safety, achievement, empowerment and transformation (2004, p.20). The credibility of this research is underscored by its congruence with other studies of midwifery practice and with Kennedy’s earlier research (Kennedy, 2004; Kennedy, et al., 2003).

**Limitations relative to this dissertation** were:
- the study sampled only “exemplary midwives” which Kennedy et al identified as problematically creating an “artificial dichotomy” within midwifery (2004, p.21);
- women’s dissatisfaction with care was not analysed;
- concepts of the self, embodiment and change were not specifically considered.

### 3.4.4 A relationship of two unique persons

The uniqueness of both people in the woman/midwife relationship was captured in Marie Berg’s secondary analysis of her three previous phenomenological studies (2005). Berg explored midwifery activities that supported women in their experience of high risk childbearing. A “dignity-protective relationship” was established as part of the midwifery model of “genuine caring” that Berg devised (p.14). In her analysis mutuality was not necessarily symmetrical as it “always includes a meeting of two unique persons” (p.17). A midwife’s “deep-rooted”, “integrated”, “embodied knowledge” enabled the individual nature of the relationship (p.14). Embodied knowledge, according to Berg, included theoretical, practical, intuitive and reflective forms of knowing in addition a midwife’s “genuineness” toward her/himself (p.14). Midwives were found to undertake a “balancing of the natural and medical perspectives” (p.15). This balancing process involved supporting a woman to experience childbearing as normally as possible while also being open to the woman’s genuine individuality.

To Berg, the term “genuine” reflected the characteristics of authenticity, truth, naturalness, validity, and ingeniousness that she theorised were part of an ideal caring relationship between two individuals (2005). For the midwife genuineness was the “openness and knowledge of self” which Berg considered important to the development of embodied knowing (p.18). For the woman “genuine” referred to her individuality and
her access to the “intrinsic power” which Berg maintained existed within motherhood (p.17). However, the voice of women is poorly represented in this study. The majority of the data comes from midwives and the data from women does not stand alone to support Berg’s ideas. Although Berg claims that empowerment is part of the ideal caring relationship, the actual ways a midwife may enable a woman’s sense of empowerment in high risk situations is not made clear.

Women’s words are better represented in another secondary analysis that included Berg’s three original studies and five other studies (Lundgren & Berg, 2007). In this second study the differing perspectives of woman and midwife interacting together in both high-risk and normal situations were revealed. Lundgren and Berg used pairs of concepts to depict the woman’s perspective and the midwife’s response to that aspect of experience. For example, the lonely nature of a woman’s experience of ambivalence and fear was found to be met by the midwife’s presence as “an anchored companion” (p.224). A woman’s surrender to her experience was similarly identified as met by the midwife being “open and pliable” to her “uniqueness” (p.222). Trust, mutuality and support for a woman’s sense of meaning were also a recognised part of the woman/midwife relationship.

Both these studies show how the interpersonal dimensions of the woman/midwife relationship might unfold during childbearing (Berg, 2005; Lundgren & Berg, 2007).

Limitations relative to this dissertation:
- did not detail specific ways relationships are empowering or how they may impact on a woman’s sense of self;
- no critique of the cultural elements of childbearing;
- omitted analysis of how aspects of the environment can influence the woman, the midwife or their modes of relating.

3.4.5 Embodied relating in institutionalised environments

The embodied nature of woman/caregiver relating was considered in the institutionalised environment of standard hospital care in a feminist phenomenological study by perinatal nurse Lisa Goldberg (2005, 2008). Goldberg revealed disembodying caregiver activities that involved an averted gaze, and/or included statements that “reduced” the woman’s experience to “generalities” (2005, p.407). In these situations caregivers became disengaged from relating with the woman and closed to “the
particulars and context” of her experience (p.407). Women were diminished and disempowered by these experiences. Goldberg also showed how women sometimes worked “against themselves” forgetting, denying and/or “negating the power of their own bodies” (2008, p.79). In addition, women were found to disengage themselves from relating with caregivers (2005). Nonetheless, despite the institutional setting, some caregivers were found to “leave the busyness behind” and make the birth room “a vital space where relationships could nourish all those involved” (p.405).

According to Goldberg the “experiential practices” of caregivers, undertaken as part of an embodied relationship, could allay a woman’s feelings of vulnerability, foster her self-trust and nurture her sense of empowerment during childbirth (2005, p.402). Such practices included a sense of reverence enacted through an attentive gaze, the creation of humour or the embodied detail of listening, touching, smiling or being still. These practices valued “women as individual selves” (p.404). In addition, caregivers were found to situate “the facts” of a woman’s situation “in the context” of her life (2008, p.77). This practice made the “situation more real” for each woman and ensured that “she was not jettisoned from her own bodily knowledge” (p.77).

Goldberg recommended that caregivers embrace an “understanding of the body as lived” (2008, p.80). To do this, Goldberg advised caregivers to recognise their own dominance in a situation and allow themselves to “exist” as an embodied being who, like the woman, is “in a place of vulnerability” (p.78). Limitations relative to this dissertation were:

- a full post-structural analysis was not undertaken. For example, Goldberg judged a high risk woman’s aim for a homebirth as a “misplaced” self-trust without seeing how perceptions of self-trust and safety may change, particularly if appropriately nurtured by caregivers (2008, p.80);
- missed the post-structural understanding that wholeness for women as well as caregivers is a continually negotiated process.

3.4.6 **Enacting decision-making: midwife autonomy**

The influence of midwifery autonomy on women’s homebirth decision-making and eventual home or hospital birth was explored in research by childbirth educator Nadine Edwards (2005). All participants in this post-structural feminist study were women who had planned homebirth. According to Edwards, women’s “beliefs and lifestyle” were
manifested in the “ethical decision-making” they used to “negotiate safety” for themselves and their loved ones (p.255). Despite the non-institutionalised environment of home, many of Edwards’ “well informed and assertive” participants had difficulty enacting their “deeply held” and “ethical beliefs” (p.255). Although participants “described diverse needs for control in their lives”, they also wished to “avoid being controlled” during childbirth (pp.224-5). To give birth these women needed “stability, safety, and the freedom to be themselves” in an environment that kept distractions “to a minimum” (pp.224-5). They also needed to “simultaneously” let go as well as concentrate in an “active passivity” that necessitated a sense of safety (p.230).

Participants used the term “relaxed” to express their desire to be “released” from control and to “free” their “minds, bodies and spirits to the power of birth within them” (pp.226-7). However, Edwards found that whether or not participants found “their own power” to give birth “depended on how empowered their midwives were” (p.227). It was the midwife’s relative degree of autonomy and skill that most influenced participant outcomes.

To Edwards, the sense of empowerment was entwined in a woman’s experiences of safety, autonomy and integrity (2005). Autonomy was not meant in terms of a humanistic self existing separate from others, but in post-structural terms of a woman negotiating the freedom to be herself whilst simultaneously maintaining relational connections with others. Integrity was dependant on a participant’s ability to “fulfil”, as much as possible, her “own meanings of birth” (p.255). Nonetheless, participants experienced “uneasy compromises” that variously negated their sense of integrity, autonomy and safety (p.17). These compromises were, to Edwards, associated with midwifery practices that reflected obstetric ideology and revealed a lack of “low-tech” skills for facilitating normal birth (p.257). Edwards argued that “for women to be more autonomous, they must be attended by autonomous midwives”, which requires the development of a midwife’s “self-awareness” (p.256). Then, claimed Edwards, midwives could “develop their knowledge and skills to make birth safer while at the same time enhancing women’s self-esteem” (p.17). This research embraced the paradoxical nature of women’s childbearing experience; it noted that autonomous midwifery is “one of the main bridges” between a woman’s simultaneous experiences of vulnerability and power during childbirth (p.260).

Limitations relative to this dissertation:
lacked the structure of a theory to communicate how midwives can act to implement the paradox of a ‘both/and’ approach.

3.4.7 Holding circles of interpersonal support

In a study exploring the paradoxes in sociological and physiological understandings of childbirth, sociologist Kerreen Reiger and educator Rhea Dempsey conceptualised birth as an active, intensely creative practice with the potential for mediation by interpersonal support (2006). To Reiger and Dempsey childbirth involved interplays between bodily experience and internalised aspects of culture that for each woman inevitably generated “their own particular crisis of confidence” (p.370). Such a crisis was associated with, for example, fear, endurance and/or pain. The actual “doing of birth” was identified as “a process of actively surrendering” that also required “agency in managing contractions, moving the body and responding” (p.368). This agency was recognised as devalued within medical discourse and contemporary culture. For example expressions of sympathy, concern, or anxiety directed toward a labouring woman were found to “reiterate” and “enact” a perception that “women can’t do it any more” (p.371). Reiger and Dempsey claimed that individual and cultural confidence in women’s childbirth capacity has been diminished by contemporary interpersonal and institutional practices.

According to Reiger and Dempsey cultural messages about the difficulties in birth can be mediated through the social support provided by a “holding circle” of caregivers and other birth attendants (2006, p.370). ‘Holding circle’ referred to “the embodied capacity of others to hold and contain the woman’s fear” such that it could be “transformed” into the “physiological response” of giving birth (p.370). Reiger and Dempsey’s research drew from childbearing women as well as from athletes and performers who experienced similar forms of “creative and peak physical effort” (p.369). Participants’ supportive interpersonal relationships shaped the “possibility of moving” past whatever particular crisis of confidence each experienced (p.370). The “holding circle” offered more than encouraging words or a “superficial level of emotional support” (p.371). It “often” had “a visceral quality” that Reiger and Dempsey believed created “a network of energy” and an “embodied exchange” of “oxytocins” (p.371). They maintained that the intimacy and strength of the “human connection” of a holding circle was “vital in the unfolding of women’s agency in birthing” (pp.370-1).
In this research holding circles of interpersonal support were found to sustain “self-direction” and maintain “confidence” in participants’ “capacity to accomplish the task” (Reiger & Dempsey, 2006, p.369). For childbearing women, “trusted midwives” were “critical to their capacity to birth physiologically” (p.371). The active, intensely creative practice of childbirth occurred at both a “collective and individual level” (p.369). Creating a holding circle involved “intense effort in which each person participates” (p.371). The holding circle provided a “solid sense of support to lean into” and a “perception of worth” at the interpersonal level that sustained the circle itself (p.370). Nonetheless “greater demands” were placed on “the capacity” of the holding circle in situations where women’s agency during childbirth was devalued (p.370). This research has shown how caregivers can collectively work with the woman to make childbirth an empowering experience.

Limitations relative to this dissertation:
- researchers speak in terms of women actively “performing” birth which has connotations of being watched (p.369);
- a woman’s need for privacy was not specifically acknowledged;
- did not consider how holding circles may impact on a woman’s overall childbearing experience.

3.4.8 Nesting and matrescence
The concept of a holding circle is reflected in the function of free-standing birth centres as shown in an ethnographic study by midwife Denis Walsh (2006). Walsh found that both women and caregivers undertook ‘nesting’ activities that impacted on a woman’s journey through childbearing change or ‘matrescence’. Nesting was conceived as “a drive to prepare the baby’s immediate environment” that encompassed aspects of physical, cultural, social and psychological safety (p.231). In what Walsh called “vicarious nesting” the birth centre staff were identified to “constantly” adapt, make-over and maintain the birth space in a “continuous activity” of “preparing for a baby” (p.233). This vicarious nesting also included the unconditional welcoming of women, family, “chosen birth partners” and staff to the birth centre (p.234). Walsh observed the importance of “environmental, organisational and emotional ambience” to women which shifted the concept of safety “beyond mortality and morbidity statistics” (pp.231-2). The “ownership or control” of the birth space was theorised as “pivotal” to a woman’s “expression of nesting” because descriptions of the birth centre revolved around “home-like metaphors” (pp.235-6). Indeed the women in this study seemed to
perceive physical safety as more likely to occur in environments that embraced “a homely, familial setting and social model of care” (p. 235). Walsh did recognise that “notions of home and family” could also be “places of abuse” and emphasised the importance of making “contextual meanings” explicit (p.237).

Although nesting has traditionally been understood to be “grounded in instinct” Walsh identified that women’s responses actually involved intuition (2006, p.232). Intuition was also observed in how caregivers nurtured women’s environment and responded to each woman’s individual situation. Midwives undertook “non-verbal, empathic actions” that arose from “fairly immediate insight and awareness”, often with “no obvious logical or rational analysis guiding them” (p.236). To Walsh, these midwifery actions “seemed to tap into a protective, nurturing reservoir” that he called “matrescent” (p.236). This caregiving “made space” for “relational and emotional work” that wove a nuanced and “delicate path between listening, talking, showing, observing and leaving alone” (pp.237-8).

In this research matrescence was “an attitude as much as an attribute of care” that “permeated birth-centre relationships generally” (Walsh, 2006, p.238). Matrescence was aligned by Walsh to the “mothering” dimensions of care (p.235). As recipients of that care women: expressed feelings of “comfort and protection”; experienced sensations of “being cherished and being loved”; and, were “pampered and made to feel special” (pp.234-7). In Walsh’s analysis nesting coaxed a woman “towards the right space and place to give birth” and matrescence facilitated her “becoming mother journey” (p.238). In doing so it showed how caregivers can act to be with women to make their experience of change an empowering one. Limitations relative to this dissertation:
- the embodied self, enhanced sense of self and empowerment were not specifically conceptualised.

3.4.9 Summary
This section explored the capacity of caregivers to have an active and sometimes profound influence on women’s experience of change. Akrich and Pasveer (2004) illustrated how caregivers and women themselves appear to act in complex, non-dichotomous ways in order to maintain a woman’s sense of agency. Most of the studies highlighted the individualised manner in which midwives worked to meet women’s changing needs. The woman/midwife relationship was consistently identified as being
influential over whether or not a woman may feel empowered in her experience of change. Also found to impact on this experience was the midwife’s skill and autonomy in being physically present and in tune with the woman as an embodied being. However, none of the studies specifically considered women’s enhanced sense of embodied self throughout childbearing, nor were any fully conceptualised theories proposed.

3.5 **CONCLUSION**

In this chapter I firstly made a broad review of literature about women’s experience of childbearing change. Then in section 3.3 I more specifically considered how a woman may negotiate her way through change in ways that she perceives to be most advantageous. Lastly, in section 3.4 I focused on caregiver activities that can make the women’s change experience empowering. In completing the final version of this chapter in October 2009 I conclude that the literature makes a very strong claim that women are empowered through interaction with caregivers who adjust their practices to suit the changing needs of each woman. What the literature does not address in its entirety, is the holistic embodied experience of women experiencing childbearing change and the factors affecting that. Some research (for example Bergum, 1989) holistically considered the embodied and changing complexity of the self, but did not develop holistic understandings of practice. Other research (for example Walsh, 2006), developed an holistic understanding of practice but did not conceptualise the depth and complexity of the changing embodied self. Hence, this literature review demonstrates that the research that I planned has not been conducted before. The next chapter considers the methodology used to conduct this research and to theorise how to enhance a woman’s embodied self in childbearing.
### Table 3.1 Study outlines

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<th>Author/year</th>
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<th>Theory base</th>
<th>Participants</th>
<th>Method/analysis</th>
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</table>
b) ‘Doing it properly’  
c) Health literacy needs | Midwifery; nursing; feminist; narrative inquiry. | 22 primigravid women >35 years attending tertiary hospital.  
15 midwives/ maternal child health nurses associated with same hospital. | 3 in-depth interviews (3rd trimester, 2nd week postpartum, 6-8 months postpartum). 3 focus groups each with 5 caregivers. Qualitative thematic analysis of first mothering experience. |
| Wilkins (2006) | Support needs of first-time mothers | Midwifery; conventional theories of maternal role attainment; feminist sociological theories. | 8 primiparous women following normal birth attending either consultant obstetric units or midwife-led centres. | In-depth interviews 6 weeks after birth. Grounded theory analysis (Strauss & Corbin, 1990) of postpartum care that empowered and facilitated women’s emotional adjustment. |
| Miller (1998, 2000, 2007) | a) Shifting layers of professional, lay and personal narratives  
b) Losing the plot  
c) Weaving Experiences and Discourse | Sociology; self as narrative construction. | 17 primigravid women. | 3 semi-structured interviews (3rd trimester, 6-8 weeks postpartum, 8-9 months postpartum). One end of study questionnaire. Narrative analysis of childbearing experience. |
### Table 3.1 (continued) Study outlines

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<tbody>
<tr>
<td>Schmied &amp; Lupton</td>
<td>a)Body images of pregnancy</td>
<td>Feminist; sociological; post-structural.</td>
<td>25 primigravid women and their heterosexual partners.</td>
<td>Separate semi-structured interviews at end of pregnancy and at 8 points after the birth up to 3 years. Phenomenological and discourse analysis of: a)Pregnancy interview for how women verbalise the sensations and meanings of pregnancy; b)Postnatal interviews to 6 months for the centrality of breastfeeding in women’s experience of motherhood.</td>
</tr>
<tr>
<td></td>
<td>b)Breastfeeding and maternal subjectivity</td>
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<tr>
<td>Bondas &amp; K. Eriksson</td>
<td>Women’s lived experiences of pregnancy</td>
<td>Psychological phenomenology (Colaizzi, 1978); ontological health model (K. Eriksson, 1997).</td>
<td>40 pregnant women.</td>
<td>Dialogical interviews: early and late pregnancy, after the birth. 9 women also interviewed at 3 weeks, 3 months and 2 years after the birth. Phenomenological analysis of lived pregnancy experience.</td>
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<tbody>
<tr>
<td>Barclay et al (1997)</td>
<td>a)Becoming a mother b)A new theory of early motherhood</td>
<td>Midwifery; feminist; sociology.</td>
<td>55 primiparous women up to 4½ months postpartum.</td>
<td>Single open ended discussions in one of nine focus groups. Grounded theory analysis.</td>
</tr>
<tr>
<td>Rogan et al (1997)</td>
<td>Young women's experiences of pregnancy and identity</td>
<td>Feminist; midwifery; grounded theory.</td>
<td>5 primigravid women aged 17-23.</td>
<td>Diary entries, and semi-structured pre &amp; post birth interviews, telephone interview 6 months postpartum. Thematic analysis.</td>
</tr>
<tr>
<td>Hartrick (1996; 1997); Martin (2003)</td>
<td>a)The experience of self for women who are mothers b)Women who are mothers</td>
<td>Self-in-relation theory, interpretive phenomenology; feminist.</td>
<td>7 introspective women already mothers (children aged 3-16 years).</td>
<td>2 in-depth interviews; 1 focus group discussion. Thematic analysis of introspective experience of self as mother.</td>
</tr>
<tr>
<td>Martin (2003)</td>
<td>Giving birth like a girl</td>
<td>Feminist; sociology, technologies of power (Foucault, 1979a), relational self (Gilligan, 1982).</td>
<td>26 primiparous women. Births: 7 caesarean, 1 forceps, 18 vaginal (15 hospital, 2 home, 1 birth centre).</td>
<td>Semi-structured interviews within 3 months postpartum. Analysis according to women’s fulfilment of normal gendered obligations.</td>
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### Table 3.1 (continued) Study outlines

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<th>Participants</th>
<th>Method/analysis</th>
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<tbody>
<tr>
<td>Nystedt et al (2006)</td>
<td>Experiences of prolonged labour</td>
<td>Nursing and midwifery.</td>
<td>10 primiparous women who experienced prolonged labour with assisted vaginal or caesarean delivery in past 3 months.</td>
<td>Single semi-structured interviews narrating women’s experience. Thematic content analysis for manifest content and underlying meaning of text.</td>
</tr>
<tr>
<td>Beck (2002)</td>
<td>Postpartum Depression: A Metasynthesis</td>
<td>Nursing; psychology; sociology.</td>
<td>309 women who were mothers in 18 studies: 6 phenomenological; 4 general descriptive; 2 ethnographic; 2 grounded theory; 1 case study.</td>
<td>Studies chosen for qualitative design and focus on postpartum depression. Analysis according to Noblit and Hare’s (1988) seven phased approach to synthesizing qualitative studies.</td>
</tr>
<tr>
<td>Edhborg et al (2005)</td>
<td>Narratives from women with postpartum depression</td>
<td>Nursing; feminist; sociology.</td>
<td>22 women showing signs of depression (≥10 on EPDS) selected from 224 women who completed the Edinburgh Postnatal Depression Scale at two months postpartum.</td>
<td>Unstructured, probing interviews approximately 80 days postpartum. Grounded theory analysis (Strauss &amp; Corbin, 1990) of experiences of early postpartum.</td>
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Table 3.1 (continued) Study outlines

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<tr>
<td>(1998)</td>
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<tr>
<td>Sjöblom et al (2006)</td>
<td>Experiences of home birth</td>
<td>Midwifery; hermeneutics; phenomenology.</td>
<td>12 women: at least one homebirth in past 10 years (3 had first birth at home).</td>
<td>Open interviews ‘performed as narratives’. Analysis of birth experience.</td>
</tr>
<tr>
<td>Davis-Floyd (1992)</td>
<td>Birth as an American Rite of Passage</td>
<td>Feminist; anthropology; rites of passage theory.</td>
<td>100 women: 6 homebirth, 94 hospital birth. Plans &amp; outcomes: 18 planned techno-medical (all pleased); 82 planned natural (21 pleased to achieve, 52 didn’t achieve but pleased, 9 seriously disturbed at not achieving).</td>
<td>Pregnancy and postpartum interviews; interviews with a selection of caregivers. Inductive analysis of hospital’s technocratic values, participant’s initial values and final conceptual assessment of birth experience.</td>
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### Table 3.1 (continued) Study outlines

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<th>Participants</th>
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<tbody>
<tr>
<td>Davis-Floyd (1994)</td>
<td>The technocratic body</td>
<td>Feminist; anthropology; technocratic mythology (Reynolds, 1964).</td>
<td>32 professional women choosing hospital birth; 4 professional women choosing homebirth; 4 non-professional women choosing homebirth. All equally affluent &amp; middle-class &amp; giving birth in chosen birth place.</td>
<td>Interviews focusing on physical changes of pregnancy, symbolic aspects of motherhood in relation to women’s conceptions of body and self. Analysis of childbearing experience in relation to technocratic model.</td>
</tr>
<tr>
<td>Bergum (1989)</td>
<td>Woman to Mother</td>
<td>Nursing; hermeneutic phenomenology (Van Manen, 1984).</td>
<td>6 primigravid women intensively followed from mid-pregnancy to ‘some months’ postpartum. 17 other women participated in one or more interview.</td>
<td>Conversational interviews. Analysis of lived experience of childbearing.</td>
</tr>
<tr>
<td>Root &amp; Browner (2001)</td>
<td>Practices of the pregnant self</td>
<td>Medical anthropology; public health; ‘care of the self’ (Foucault, 1979b); post-Foucauldian theories (Haraway, 1991).</td>
<td>158 pregnant women from diverse backgrounds.</td>
<td>Antenatal interviews; observation of first clinic visit; observation of prenatal education classes for 40 participants. Analysis of women’s practices in pregnancy across the spectrum of compliance and resistance to prenatal norms.</td>
</tr>
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Table 3.1 (continued) Study outlines

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<th>Participants</th>
<th>Method/analysis</th>
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<tbody>
<tr>
<td>Viisainen (2000)</td>
<td>The moral dangers of homebirth</td>
<td>Public health; feminist; medical anthropology.</td>
<td>21 women and 12 partners who planned homebirth (8 primiparous; 13 multiparous). 17 achieved homebirth, 2 transferred in 3rd stage. 3 women &amp; 2 partners were health professionals.</td>
<td>Single semi-structured interviews 2 weeks to 3 years postpartum; couples interviewed together; 3 women interviewed during pregnancy. Qualitative analysis for perceptions of risk and strategies used to deal with risk.</td>
</tr>
<tr>
<td>Klassen (2001)</td>
<td>Religion and Homebirth in America</td>
<td>Feminist; post-structural; scholarly understanding of religion and spirituality.</td>
<td>45 women planned homebirth with and without religious affiliations.</td>
<td>Single interviews after birth. Two women were interviewed twice. 4 midwives also interviewed. Analysis of tension surrounding symbolic meanings of birth and sense of agency women derive from such meanings.</td>
</tr>
<tr>
<td>Author/year</td>
<td>Short Title</td>
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<td>Participants</td>
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<tr>
<td>Turner (2002, 2004)</td>
<td>a)Is Childbirth With Midwives Natural? b)Mainstreaming alternative medicine</td>
<td>Feminist postmodern ethnography; organisational communication; modernist and postmodernist concepts of self.</td>
<td>a)Author’s childbearing experience in freestanding birth centre subsequent to researching midwifery practices in that centre. b)Single North American birth centre. 7 women employed as midwives within that centre.</td>
<td>a)Introspective investigation of contrasting aspects of self in the context of planning and experiencing natural childbirth. b)Interviews, document review, site visits and participant observation of meetings and appointments; focus on the discursive practices that contribute to understanding how midwives ‘do’ midwifery. Embodied interpretive interactionist analysis of contradictions and problems in practising midwifery.</td>
</tr>
<tr>
<td>Savage (2006)</td>
<td>The lived experience of knowing in childbirth</td>
<td>Nursing; childbirth education; feminist; hermeneutic phenomenology (Van Manen, 1990).</td>
<td>9 primigravid women planning hospital births, 3 had prenatal midwifery care. 4 births prior to the second interview: 2 women prematurely and 2 women induced for nonmedical reasons.</td>
<td>Voluntary journaling by participants; interviews in 2nd/3rd trimester; follow-up interviews in 3rd trimester or postpartum. Analysis of women’s lived experience of knowing about birth.</td>
</tr>
</tbody>
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### Table 3.1 (continued) Study outlines

| Author/year       | Short Title                                                                 | Theory base                                                                 | Participants                                                                 | Method/analysis                                                                 |
|-------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Parratt (2000)    | a) Trusting enough to be out of control                                      | Midwifery; feminist constructivism; self according to Relational-cultural Theory (J. B. Miller, 1991a). |
                      | c) Creating a 'safe' place for birth                                        | 6 women: 5 primiparous, 1 multiparous. Birth & outcome: 3 assisted vaginal in hospital (2 felt positive; 1 felt negative); 4 homebirths (all felt positive). |
|                   | SECTION 3.4                                                                  |                                                                            |                                                                             | Single probing, in-depth interviews 2-8 months postpartum; single telephone interviews. Validation through two mail outs. |
|                   |                                                                              |                                                                            |                                                                             | Thematic analysis of features within the birth experience positively influencing sense of self. |
|                   |                                                                              |                                                                            |                                                                             | Analysis of different forms of agency mediated by birth experience, by caregivers and by technology. |
### Table 3.1 (continued) Study outlines

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<th>Method/analysis</th>
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<tbody>
<tr>
<td>Kennedy et al (2004)</td>
<td>a) The landscape of caring</td>
<td>Midwifery</td>
<td>11 midwives and 4 women who had participated in Delphi study of exemplary midwifery practice (Kennedy, 2000); 3 newly recruited midwives.</td>
<td>Interviews focused on scenarios describing midwifery practice or care experience. a) Narrative analysis of central processes of care and links between processes of care and short/long term outcomes. b) Analytic focus on preserving ‘normalcy’ c) Results of narrative analysis compared with previous Delphi study.</td>
</tr>
<tr>
<td>Kennedy (2004)</td>
<td>c) Enhancing Delphi research</td>
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<tr>
<td>Berg (2005)</td>
<td>A model for childbearing women at high risk</td>
<td>Midwifery; phenomenology</td>
<td>3 phenomenological studies about experiences of high risk caregiving (participants: 16 primiparous and 8 multiparous women; 10 midwives).</td>
<td>Secondary analysis of original interviews and thematic results for essential elements in ideal caring of women at high risk.</td>
</tr>
<tr>
<td>Lundgren &amp; Berg (2007)</td>
<td>Central concepts in midwife/woman relationship</td>
<td>Midwifery; phenomenology</td>
<td>Data from eight phenomenological studies; seven interview-based and one using diaries. (participants: 77 women; 19 midwives).</td>
<td>Secondary analysis of original qualitative data for components central to midwife/woman relationship in normal and high-risk childbearing.</td>
</tr>
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Table 3.1 (continued) Study outlines

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<th>Participants</th>
<th>Method/analysis</th>
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<tbody>
<tr>
<td>Goldberg (2005, 2008)</td>
<td>a) Introductory engagement</td>
<td>Perinatal nursing; interpretive feminist phenomenology.</td>
<td>8 women recruited in pregnancy; 8 perinatal nurses working in childbirth.</td>
<td>Participant observation, conversational interviews two weeks postpartum, follow-up phone calls; researcher’s reflective journaling. Thematic analysis of experiential activities fostered by the nurse/woman relationship.</td>
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<td>b) Embodied trust</td>
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<tr>
<td>Edwards (2005)</td>
<td>Experiences of planning homebirth</td>
<td>Birth activism; feminist emancipatory research.</td>
<td>30 women planning homebirths, 13 primigravid; 7 transferred to hospital; 3 had caesarean sections.</td>
<td>In-depth open-ended interviews: twice in pregnancy, twice postpartum. Analysis of how women move through childbirth with integrity, dignity and control despite uneasy compromises and varying degrees of distress.</td>
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<tr>
<td>Reiger &amp; Dempsey (2006)</td>
<td>Performing birth in a culture of fear</td>
<td>Sociology; feminist theories of embodiment; neuro-physiological patterning of the body.</td>
<td>4 groups of women; 12 actors/athletes working intensively with their bodies.</td>
<td>Focus groups in postpartum; single interviews with actors/athletes. Qualitative analysis according to the ‘biopsychocultural’ framework of birth as an embodied activity.</td>
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4. CHAPTER 4- METHODOLOGY

4.1 INTRODUCTION

I developed the research methodology described herein to enable me to meet the project’s aim to produce theory about childbearing change. A theory is defined as an orderly way of structuring knowledge so as to describe, explain and predict phenomena, events and activities (Bryar, 1995; Scott & Marshall, 2005). When I began this research a definition of embodied self was not fully developed. I therefore designed data collection methods using the pilot study definition of ‘sense of self’, as summarised in chapter one. Notably, embodiment was absent from this definition. As my study progressed the definition of sense of self also developed into an interim, working definition that encompassed embodiment. Finally, the definition of ‘embodied sense of self’ as shown in table 1.1 (pp.28-29) was arrived at when theory development was nearly complete.

The first section of this chapter outlines the feminist, post-structural methodological principles guiding this study. I then describe and defend the research design of personal narratives, survey research and grounded theorising which resulted in the theory presented in chapter six. In section 4.3, participant recruitment, the study setting and ethical issues are described. The methods of data collection are examined in section 4.4. This section explains how data was collected at three times points via questionnaires and interviews. In addition, the section outlines the extensive process of data validation. Section 4.5 details the methods of data analysis, interpretation and theorising. It clarifies how the questionnaires were interpreted, how the participants’ individual stories were constructed and the methods of theory creation. Lastly, section 4.6 concludes by considering the overall quality of the research. Tables 4.1-4.9 supplement the text and are reprinted in appendix C for easy reference.

4.2 FEMINIST POST-STRUCTURAL METHODOLOGY

The methodology for this study is explicitly feminist. Feminism is the practice of identifying, understanding and changing the intrapersonal and social factors that sustain women’s disempowerment (Harrison & Fahy, 2005). This definition is consistent with my understanding of feminism based on wide reading (Harding, 1986; Reinharz, 1992;
Stanley & Wise, 1993). Post-structural methodology is defined here as specifically challenging linguistic and socially constructed dichotomies, priorities and power imbalances revealing reality and truth to be ever changing and driven by perspective (Fine, 1992; Gavey, 1989; Harrison & Fahy, 2005; Stanley & Wise, 1993; Weedon, 1997). Merger of post-structural methodology with feminism, despite contradictions, can be beneficial when the researcher uses post-structural ideas as tools to produce knowledge that has empowering potential (Fahy, 2000; Gannon & Davies, 2007; Olesen, 2005). Fifteen principles form the feminist post-structural methodological framework for this study.

4.2.1 A framework of methodological principles

1. The concerns of women and their ordinary day to day experiences are at the centre of the research (Fonow & Cook, 1991; Harding, 1986; Kirsch, 1999; Reinharz, 1992; Stanley & Wise, 1993; Young, 2000).

2. Reality and truth are perceived to be driven by perspective and are ever changing (Alcoff, 1997; Harrison & Fahy, 2005; Olesen, 2005; Stanley & Wise, 1993).

3. Research practices should reflect the diverse and changing complexity of the problem being researched rather than any particular form of orthodoxy (Jayaratne & Stewart, 1991; Kirsch, 1999; Olesen, 2005; Reinharz, 1992; Weedon, 1997).

4. Ethical issues are at the forefront of and entwined with the particular research practices undertaken (Irigaray, 1993; Kirsch, 1999; Olesen, 2005; Ribbens & Edwards, 1998; Young, 2000).

5. The goal of the research is to produce knowledge that contributes to women’s lives by being useful to the women themselves (Acker, Barry, & Esseveld, 1991; Fonow & Cook, 1991; Harrison & Fahy, 2005; Kirsch, 1999; Mies, 1991).


7. Theory that aims to address changes in women’s experience must encompass both the underlying materiality of their existence in addition to the competing
power relations that they variously negotiate (Grosz, 1994; Irigaray, 1996, 2003; Weedon, 1997; Young, 2000).

8. Research practices and outcomes must honour the diversity of thought and experience amongst women (Reinharz, 1992; Stanley & Wise, 1993; Weedon, 1997).

9. Power imbalances inherent within language and lived experience are recognised and explicitly critiqued (Acker, et al., 1991; Grosz, 1995; Nash, 1994; Reinharz & Kulick, 2007).

10. Gaps, silences, exclusions and erasures in women’s embodied experience and the representation of that experience are explicitly acknowledged and investigated (Belenky, Clinchy, Goldberger, & Tarule, 1997; DeVault & Gross, 2007; Fine, 1992; Fine & Weis, 2005; Reinharz & Kulick, 2007).

11. The researcher/woman relationship is respected as a central element of the research process; trust is not abused and appropriate boundaries are negotiated (DeVault & Gross, 2007; Etherington, 2004; Harrison & Fahy, 2005; Kirsch, 1999; Olesen, 2005; Reinharz, 1992; Ribbens & Edwards, 1998).

12. An honest accountability of how the researcher’s values influence the research project and the participants is included (Etherington, 2004; Harding, 1986; Kirsch, 1999; Stanley & Wise, 1993).


14. Both researcher and women are acknowledged to be diverse, complex and contradictory spiritual beings who are variously changed by the research experience (Clements, 2004; Clements, Ettling, Jenett, & Shields, 1994; Gavey, 1989; Irigaray, 2001, 2002; Irigaray & Pluhacek, 2002; Oakley, 1974; Stanley & Wise, 1993).

15. Feminist post-structural methodology embraces complexity and contradiction in addition to disrupting the status quo (Fine, 1992; Gavey, 1989).
This methodology is most appropriate for my study because it offers new ways of theorising about change during childbearing. These 15 principles have been honoured in all aspects of the design and conduct of the research.

### 4.2.2 Research design

This project is a prospective, longitudinal study. Three major research designs were used: 1) personal narratives research, 2) survey research, and 3) grounded theorising.

#### 4.2.2.1 Personal narratives

Personal narratives are a particularly appropriate design for the longitudinal study of change during childbearing and mothering (Hartrick, 1996, 1997; T. Miller, 1998, 2000). Narrative design has an enormous potential to provide a complete picture of any health issue (Boykin & Schoenhofer, 1991; Emden, 1998a; W. Miller & Crabtree, 2005; Sandelowski, 1991; Stevens, 1993). A narrative is a story set in time and has a beginning, middle and end. Although some researchers differentiate between narrative and story (Emden, 1998b; McCance, McKenna, & Boore, 2001), in this study I use the terms interchangeably.

A personal narrative design supports the researcher in an ethical approach to a deep exploration of a sensitive area. Narrative construction is an active process that is essentially a mode of self analysis (Stanley, 1992; Stivers, 1993). Through narrative construction, a woman can come to know herself more fully. Constructing one’s story can help restore feelings of wholeness and continuity when life events have challenged meanings and values (Ellis & Bochner, 2000, p.744; Polkinghorne, 1988). During the process the researcher’s potentially powerful role during data collection and analysis can be acknowledged (Stivers, 1993). In this project I aimed to create a communication context which was unconstrained, as far as possible, by socially and/or linguistically contrived power imbalances (Allen, Allman, & Powers, 1991). Three in-depth interviews were undertaken with each participant, as detailed in section 4.4.

There are a number of advantages to using personal narrative design (Daiute & Lightfoot, 2004; Emden, 1998a, 1998b; Kirkman, 2002; McAdams, 1997; Polkinghorne, 1988, 1995). The key advantages for this study are that personal narrative methodology:
places the experiences of individual women at the centre of the research (Daiute & Lightfoot, 2004; Stanley, 1992; Stivers, 1993);

- invites a woman to tell a story where she can represent herself in terms of meaning (Carolan, 2005b; Kirkman, 2002; Stanley, 1992);

- facilitates the exploration of the woman’s embodied activities that occurred while constructing that meaning (Carolan, 2005b; Kirkman, 2002; Stanley, 1992);

- reveals a woman’s sense of self with the story (McAdams, 1997; Polkinghorne, 1988);

- represents the woman as a self-conscious self who takes ownership of her own experience (McAdams, 1997; Polkinghorne, 1988);

- facilitates the woman’s perceptions of her past and present and as integrated experiences (McAdams, 1997; Polkinghorne, 1988; Sandelowski, 1991);

- validates the meanings that are created and that will guide future actions (McAdams, 1997; Polkinghorne, 1988; Sandelowski, 1991);

- brings to light the contextual reality of power and perspective in shaping women’s experience (Daiute & Lightfoot, 2004; Stanley, 1992; Stivers, 1993);

- facilitates deep exploration by respectfully negotiating with each woman through questioning and probing (Fahy & Harrison, 2005);

- enables meanings to be both individually and intersubjectively constructed (Fahy & Harrison, 2005);

- demonstrates ethical respect for women’s own voice by using her in narrative which is produced (Emden, 1998b); and,

- can include other forms of data such as survey data (Kirkman, 2002; Polkinghorne, 1995).

During the research individual stories were constructed. A narrative analysis formed part of the initial process of theory creation. Narrative analysis included a cross-case analysis and incorporated a consideration of each woman’s survey results (Emden, 1998b; McCance, et al., 2001; Polkinghorne, 1995). Analysis is described at section 4.5.

### 4.2.2.2 Survey research

Survey research design was used to measure changes in individual women across their childbearing experience. Following consultation with Professor Christina Lee from the Australian Longitudinal Study on Women’s Health a conscious decision was made to
incorporate surveys into the research design. Combining surveys with personal narrative design is acknowledged as unusual due to the limited participant numbers; however no cross-case quantitative analysis was undertaken. The use of a quantitative method of data collection in addition to qualitative interviews is consistent with feminist post-structural research because “good survey research incorporates the same principles inherent in a feminist methodology” (Miner-Rubino, Jayaratne, & Konik, 2007, p.206). The simultaneous use of quantitative methods in a qualitatively driven project triangulates and strengthens the design, analysis and interpretation of findings (Morse & Richards, 2003). The qualitative and quantitative arms of this study met at the research question providing quantitative data that strengthened the qualitative data. Overall triangulation of the design using survey research strengthened the whole research project as shown in the findings chapter.

Questionnaires were in two parts. Part one gathered demographics and detail about participant experience. Part two collected psychometric data using standardised tools. Selection of each tool was guided by Professor Lee. Each of five tools measured concepts relating to the body and to ‘sense of self’ as it was initially defined. The concepts were: concern about body shape (Body Shape Questionnaire); optimism (Life Orientation Test); perceived control over health (control dimension of Health Related Hardiness Scale); self-esteem (Rosenberg Self-Esteem Scale); and depression (Edinburgh Postnatal Depression Scale). The questionnaires, the concepts measured, and the psychometric tools are described in section 4.4.

The main benefit of survey research was that any change from previous answers was immediately obvious to the researcher; women’s responses thus acted as a prompt to more detailed discussions during interviews. Survey research was also of benefit to the participants. Potential participants had an early opportunity to view the questionnaire. They could decline to participate if they considered the questions too confronting. Once she agreed to participate a woman could approach the interviews with some idea of the depth of questioning that would be involved.

4.2.2.3 Grounded theorising

Grounded theorising design provided a framework from which theory construction could occur. I am not referring to the traditionally conceived grounded theory by Glaser and Strauss (1967) which was further elaborated by Strauss and Corbin (1990). Feminist
researchers have rightly criticised that traditional grounded theory as being too rigid, too hierarchical and too positivistic (Charmaz, 2000, 2005; Clarke, 2007; Keddy, Sims, & Stern, 1996; Kushner & Morrow, 2003). I understand grounded theorising more generally as a methodology that produces concepts from empirically generated data and links those concepts together into a theoretical explanation (Atkinson & Delamont, 2005; Clarke, 2007). Grounded theorising has been used in feminist research, in social justice research, and in postmodern research (Charmaz, 2005; Clarke, 2007; Kushner & Morrow, 2003). It is an inherently feminist design that can encompass the embodied reality of lived experience (Clarke, 2007). Grounded theorising may include a deconstructive form of analysis that highlights its value as a post-structural methodology (Clarke, 2007).

Grounded theorising in this research refers to theorising that is primarily grounded in the data (Charmaz, 1995, 2000; Clarke, 2007; Glaser, 2002; Glaser & Strauss, 1967). Purposive sampling was done to ensure the participants were all women able to provide information relevant to development of this particular theory (Charmaz, 1995, 2000; Morse & Richards, 2003). The sampling process is detailed in section 4.3. Data gathering and data analysis were centred on the aim to create theory; they occurred concurrently so that tentative theorising could be developed and deepened through discussion with the women (Charmaz, 1995, 2000; Morse & Richards, 2003). Validation of emerging ideas with participants formed a major part of participant/researcher interaction, as explained in sections 4.4 and 4.5. When etic concepts were absolutely consistent with data they were used to inform the developing theory (Charmaz, 1995, 2000; Keddy, et al., 1996). A constant comparison of emerging concepts included a process of abductive reasoning as explained in section 4.5 (Atkinson & Delamont, 2005; Clarke, 2007; Emden, 1998b; Glaser, 2002; Levin-Rozalis, 2004).

4.2.3 Myself as researcher

As a feminist qualitative researcher I have consciously reflected on my own role as the primary ‘instrument’ for gathering and analysing data (Clements, 2004; Clements, et al., 1994; Etherington, 2004; Keddy, et al., 1996; Morse & Richards, 2003). I brought my whole self to work on this project (Etherington, 2004). My experience of the changing nature of the research mirrored the complexities, contradictions and puzzles of my life.
(Birch, 1998). I learnt about my own changing embodied self as I learnt from the participants. At times I felt lost in the data or had sensations of angst and confusion as I waded through the many paradoxes I found. Daily walks and yoga provided some peace and facilitated theoretical insights.

Insights about the research emerged in a spontaneous embodied way. I avoided reliance on very structured techniques such as data coding and the documentation of my every thought (Cutcliffe, 2003; Kushner & Morrow, 2003; May, 1994). When insights arose I would write notes on scraps of paper or make voice recordings; these now form part of the audit trail that link my insights to the data. Ideas were often clarified through discussions with my supervisor which were recorded. These discussions, along with many reflective emails, are part of that data trail. Additionally, I articulated ideas in presentations to colleagues and papers for publication. The dialogue and feedback received during presentations and from submitting papers also enhanced my insights.

The process of abstracting new and often unexpected insights from the data led to the eventual conceptualisation of the theory (Morse & Richards, 2003). Theorising was a thoroughly embodied process that required “incubation” so it evolved over time (Cutcliffe, 2003; Etherington, 2004, p.257; May, 1994). I maintained a high level of practical engagement with the data, which meant I routinely checked insights against data and included data in the audit trail. As similar insights repeatedly arose and fitted well with the data I became more trusting of those insights and they evolved into concepts. The concepts that appear in the theory are thus thoroughly grounded in the data as shown in chapters five and six.

4.3 PARTICIPANTS, SETTING AND ETHICAL ISSUES

The research project formally commenced when ethical approval was granted in November 2002 by the Human Research Ethics Committee of The University of Newcastle. Further ethical approval was gained from the Bendigo Health Care Group in February 2003. As the research progressed, variations to the research process required minor amendments to these approvals. These approvals and amendments are outlined in appendix A1. Also in that appendix are examples of relevant documentation I used to undertake the research in an ethical manner.
4.3.1 Recruitment

Recruitment began following ethical approval (see appendix A1). The aim in recruitment, in line with best practice in qualitative research, was to select participants who would be able to provide the qualitative depth required to appropriately answer the research question (Morse & Richards, 2003; Patton, 1990). It was important to ensure that the participant group included women who were accessing midwifery-led care and women accessing standard medically-led care. Medically-led care was defined as standard medical care; either public or private. Midwifery-led care was defined as care from a known midwife. In this study women accessing midwifery-led care were those who engaged an autonomous midwife as their primary caregiver throughout childbearing.

Initially recruitment was undertaken through networking with autonomous midwives and other caregivers. Once ethical clearance was granted recruitment was also undertaken through the public hospital antenatal clinic. Caregivers were asked to distribute the invitation to participate (appendix A1). Potential participants were invited to contact the researcher so their privacy during recruitment was protected. Those women who chose to contact me were given further information during any ensuing conversation. Further contact was only instigated after ensuring the potential participant wished to be sent the first mail out which included the first questionnaire, Information Statement and Consent Form.

Eight women were recruited via autonomous midwives, six planned homebirth and two planned to use public hospital birth centres. Rates of response from women planning standard care were very low. The cut off date for recruitment was extended twice. Reasons for the low response rate were assumed to be: concurrent recruitment for other studies; the required high level of personal involvement; and the sensitive nature of the research. Recruitment stopped at a total number of fourteen participants: eight having midwifery-led care and six having medically-led care.

4.3.2 Participants and setting

The target population were women in the latter months of their first pregnancy who were planning to have what they considered to be a normal birth. ‘Normal’ in this context excluded any planned surgical or interventionist birth but was otherwise determined by the woman. Women experiencing first childbearing were targeted
because of the acknowledged influence of first labour on women’s subsequent labours (Paterson & Saunders, 1991). Multigravid women were excluded to limit the already complex and lengthy research project. A cut off date for the woman’s ‘expected due date’ limited time lines. The target population was further defined as women who lived in: metropolitan Melbourne, provincial Bendigo, or its semi-rural surrounds.

Over a twelve month period potential participants were being asked to fill in three two-part questionnaires and participate in three audio-recorded interviews approximately two to three weeks after returning each questionnaire. Questionnaires were to be mailed to participants’ home addresses. Interviews were to last up to two hours and be undertaken in their own homes or in a quiet private place of participant choice where their babies were welcome. Participants were also being given the opportunity to check and correct interview transcripts, resultant stories and outcomes of the research. As a token of appreciation a book voucher valued at $15.00 was to be offered at completion of the study. Participants were also offered a copy of their own story of how they changed during their experience of childbearing.

Practicalities of participant selection included confirming that the women were over 18, English speaking and that they anticipated being able to participate in the entire project. The women needed to be prepared to discuss bodily and emotional aspects of themselves, in depth, with the researcher. The target group were acknowledged as likely to define themselves as women who valued exploring and receiving a narrative of themselves surrounding the birth of their first child. The research did not target women with an intellectual or mental impairment, those highly dependent on medical care, or Aboriginal and Torres Strait Islander individuals or communities. It was possible that a member of a specific cultural, ethnic or indigenous group would agree to participate in this study, and while appropriate processes were in place in case they did, none were recruited.

4.3.3 Consent, confidentiality and anonymity

Women’s informed consent to participate was obtained as outlined in the consent and information forms (appendix A1). Obtaining consent and providing information were undertaken in line with the National Health and Medical Research Council guidelines for ethical research (National Health and Medical Research Council, 1999, 2001). The maintenance of confidentiality and anonymity was continually monitored throughout
this research. Audio-tapes of interviews and identifying records were kept secure as detailed in the Information Statement. The audio typist signed a Promise of Confidentiality (appendix A1). Women chose pseudonyms for themselves, their partners and babies. Names of midwives, doctors, institutions and those of others involved were also altered. Women were reminded to preserve their anonymity by not talking of their participation. When each woman’s narrative was being finalised I reiterated the ways the narratives would be shared with others. At this time each participant’s option to either withhold or alter sensitive sections of the narrative was discussed and variously enabled. One participant chose to withhold a segment of her pre-pregnant experience and minor amendments were made by other participants.

4.3.4 **Incorporating change: some dilemmas**

Incorporating change in the research processes and as part of the research question created some dilemmas. While participants were given the opportunity to check, correct and alter their narratives, they were also reminded that the research was about how they were changing. During narrative construction (detailed in section 4.5) participants were encouraged not to alter aspects of their story that may indicate such change. Alterations undertaken to respect participant privacy and preserve anonymity were carefully made in contextual ways that did not compromise the research focus on the changing embodied self.

Ethical research practice also required working with unforseen changes. The possibility of unexpected events related to participants’ childbearing experience were identified at the outset. Protocols were in place should a participant experience, for example, the death or disablement of her baby. Changes in participant’s feelings of wellbeing during interviews were responded to at the time through positive reflections and active listening. I had the ability to direct women to counselling, support and information services, but such referrals were never required. One participant did feel distress following her first interview; she felt she had revealed too much of herself and considered withdrawing. We clarified misunderstandings during a telephone conversation; she was reminded of the control she had over the content of her narrative and of her right to withdraw. Over time her concerns dissipated and she chose to remain a participant.
The edicts of informed consent created a dilemma as prior knowledge of the research practices was not available: these practices evolved over time. Precise details about the validation of this research did not become apparent until data collection was nearly complete. Participants were asked to validate their narratives, validation extended the length of their third interviews, and participants were asked to validate the ideas arising from analysis. Furthermore, study timelines were lengthened due to delays in recruitment, delays in gaining ethical approval for amendments and by the time-consuming nature of story construction. Nurturing an honest and respectful interaction between myself and each woman was crucial to their continued participation.

Another way that change was incorporated into this project was in the evolution of the research design. The study commenced recruitment according to a two group design but this grouping was not maintained. Although women’s initial placement in the midwifery-led or the medically-led group can still be identified, the differences between the two groups quickly blurred. As data collection proceeded it became clear that the two-group design was not relevant to women’s changing embodied self; it was therefore abandoned.

### 4.4 METHODS OF DATA COLLECTION

In this section I outline the modes and timing of interaction between participant and researcher. I describe the questionnaires and detail the probing in-depth interviews. Lastly I explain the methods of validation.

#### 4.4.1 Mode and timing of participant/researcher interaction

Participant/researcher interaction occurred for three primary reasons: to administer questionnaires; to undertake interviews; and for the purpose of validation. The points of interaction, including their timing relative to the participants, are outlined in table 4.1 (p.146). Appendix A2 provides a more detailed picture of the research timing relative to data collection, analysis and theorising. The project was designed around three set time points: ‘AN1’ soon after recruitment in the latter half of the participant’s pregnancy (28-38 weeks gestation); ‘PN1’ at 3-4 months after the birth; and ‘PN2’ at 7-8 months postpartum. These time points assumed women’s memory of childbirth events was reliable, as it has been shown to be maintained even years after the event (Fowles, 1998; Githens, Glass, Sloan, & Entman, 1993; Hewson & Bennett, 1987; Lundgren, 2005;
Niven, 1988; Simkin, 1992). However, women’s evaluation of their birth experience is also known to change according to the quality of their overall experience as well as in relation to the particularities of labour pain (Kabeyama & Miyoshi, 2001; Niven & Brodie, 1996; Niven & Murphy-Black, 2000; Waldenström, 2003, 2004). Hence the third time point was felt necessary so as to highlight change in women’s evaluation of the birth in addition to further changes in their embodied self.

The main modes of interaction with participants were face to face during interviews, and by mail. In addition, two women completed their third interviews via telephone. A sample letter is included in appendix A3. These letters listed the content of that mail out, explained in detail what the participant needed to do with that content (for example: fill out questionnaire; prepare for interview; undertake validation) and clarified what I would do. Where the return of a questionnaire or validation was required I made follow-up telephone calls seven to twelve days after the mail out. These phone calls also served to make appointments for the interviews. If questionnaire/validation return was delayed a further two telephone reminders were made. In one instance a participant had mislaid the questionnaire and filled it out immediately prior to her third interview. On another occasion, after three telephone reminders for the fourth validation, a participant declined to respond. Infrequently follow-up was undertaken via email. On a minimal number of occasions participants contacted the researcher via email, for example one participant sent a brief email about the birth of her second baby (see postscript of Jasmin’s story appendix B).

In addition to the three set time points formal contact with participants was made at three other times. Participants were notified of a delay in the mail out of the third validation which included the draft of their stories. This delay meant that validation occurred approximately two years after the baby’s birth. A fourth validation was then undertaken some months later. This mail out also included a consent form for retention of contact details (in appendix A1) so that participants could be invited to be part of future longitudinal research; ten women gave this consent. The final contact with participants was made by mail approximately three years after recruitment.
Table 4.1: Mode and timing of participant/researcher interaction

<table>
<thead>
<tr>
<th>REASON FOR INTERACTION</th>
<th>MODE</th>
<th>TIMING (approx.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionnaire 1: Antenatal questionnaire</td>
<td>Mail, telephone follow-up</td>
<td>28-35 weeks pregnant</td>
</tr>
<tr>
<td>Consent form, Information sheet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview 1: Antenatal interview</td>
<td>Face to face</td>
<td>31-38 weeks pregnant</td>
</tr>
<tr>
<td>Validation 1: First interview transcript</td>
<td>Mail, telephone follow-up</td>
<td>4-8 weeks postpartum</td>
</tr>
<tr>
<td>Antenatal narrative draft</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questionnaire 2: First postnatal questionnaire</td>
<td>Mail, telephone follow-up</td>
<td>11-13 weeks postpartum</td>
</tr>
<tr>
<td>(TIME POINT PN1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview 2: First postnatal interview</td>
<td>Face to face</td>
<td>13-16 weeks postpartum</td>
</tr>
<tr>
<td>Validation 2: Second interview transcript</td>
<td>Mail, telephone follow-up</td>
<td>21-31 weeks postpartum</td>
</tr>
<tr>
<td>Antenatal narrative draft</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questionnaire 3: Second postnatal questionnaire</td>
<td>Mail, with telephone follow-up</td>
<td>6-7 months postpartum</td>
</tr>
<tr>
<td>(TIME POINT PN2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview 3: Second postnatal interview*</td>
<td>Face to face*</td>
<td>7-10&lt;sup&gt;§&lt;/sup&gt; months postpartum</td>
</tr>
<tr>
<td>Notification of delay</td>
<td>Mail</td>
<td></td>
</tr>
<tr>
<td>Validation 3: Whole narrative draft</td>
<td>Mail, telephone follow-up including</td>
<td>24 – 30 months postpartum</td>
</tr>
<tr>
<td>Whole narrative draft in colour</td>
<td>clarification of anonymity in final</td>
<td></td>
</tr>
<tr>
<td>Early ideas from research (Validation A1 and</td>
<td>draft of narrative</td>
<td></td>
</tr>
<tr>
<td>A2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Validation 4: Final story</td>
<td>Mail, telephone follow-up</td>
<td>27-36 months postpartum</td>
</tr>
<tr>
<td>Booklet of all stories, comment sheet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permission to retain name and address*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early ideas from research (Validation A3 or a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>copy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Later ideas from research (Validation B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notification of study completion, provision</td>
<td>Mail</td>
<td>29-38 months postpartum</td>
</tr>
<tr>
<td>of book voucher</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**KEY:** *Due to its length, three women chose to undertake the third interview in two parts. Part two for one woman was face to face and for two women part two was by telephone; #Not included for the two women recruited via hospital antenatal clinic; §One participant was unavailable until 10 months postpartum*
4.4.2 Questionnaires

The questionnaires were used to measure changes in individual women across their childbearing experience. They were in two parts. Part one was different at the three time points (AN1, PN1, PN2). Part two was identical at each time point. A copy of part two and each version of part one are included in appendix A4.

4.4.2.1 Part one

Part one provided an introduction to the participant at that particular time point. This introduction facilitated preparation for the forthcoming interview. In particular, a question (question 15 in AN1) about the degree to which the participant was willing to speak about their sensuality/sexuality guided that segment of the interview. This question was repeated at the third (PN2) time point. Each version of part one was as follows:

**Time point AN1:** part one surveyed pregnancy experience, birth plans and demographic details. Questions were compiled specifically for this research.

**Time point PN1:** part one surveyed the birth experience and current postnatal experience. Questions 1–16, 31 & 32 were compiled specifically for the research whereas questions 17–30 were sourced from doctoral research on postnatal depression (Lloyd, 1998).

**Time point PN2:** part one surveyed current postnatal experience. Questions were a repeat of the postnatal questions administered at PN1 (questions 17-32 in PN1).

All three versions of part one were trialled prior to use and peer reviewed.

4.4.2.2 Part two

Part two consisted of five standardised quantitative tools:

- Life Orientation Test, revised version (Scheier & Carver, 1985; Scheier, Carver, & Bridges, 1994);
- Health Related Hardiness Scale, control dimension (Pollock, 1986; Pollock & Duffy, 1990);
- Rosenberg Self-Esteem Scale (Rosenberg, 1965);
Body Shape Questionnaire, 8-item version (Cooper, Taylor, Cooper, & Fairburn, 1987; Evans & Dolan, 1993);

Each tool was well validated, relatively short and simple to use by non-experts in the topic. Professor Christina Lee from the Australian Longitudinal Study on Women’s Health (ALSWH) guided selection. The chosen tools were deemed relevant to my research question and most able to triangulate with the qualitative data. Each tool measures a concept of ‘sense of self’, as it was initially defined. The five tools respectively measured the concepts of optimism, control over health, self-esteem, body shape concern, and depression. The tools and respective concepts are discussed below.

4.4.2.2.1 **Life Orientation Test (revised version)**

The Life Orientation Test (LOT) measures a person’s general expectation of outcomes in a wide variety of areas including physical and emotional health (Scheier & Carver, 1985). It assumes that optimism is a stable personality characteristic influencing how people regulate actions according to expectation of outcome (Scheier & Carver, 1985). Optimism is defined as a person’s inclination to think that good rather than bad experiences will occur in life (Scheier & Carver, 1985). Although similar to self-efficacy, optimism focuses on outcome expectancy rather than expectation of efficacy (Scheier & Carver, 1987). Optimism is construed as a general tendency rather than applied to a specific task or action (Scheier & Carver, 1987). As a positive personal characteristic optimism appears to contribute to a person’s well-being (N. E. Smith, Young, & Lee, 2004). Thus changes in the LOT indicate changes in the degree of optimism a person holds over the outcome of future events.

An 8-item version of the LOT was extensively tested, including a factor analysis, internal consistency and test-retest reliability, plus convergent and discriminant validation with a number of scales, all showing very promising results (Scheier & Carver, 1985). The current 6-item scale removed two items to give a more exclusive focus on good outcomes rather than bad (Scheier, et al., 1994). This revised version is the most widely used measure of optimism (N. E. Smith, et al., 2004). It is currently included in the ALSWH (Women's Health Australia, 2001). The scale’s psychometric properties are reasonable, it has good retest reliability, internal consistency and
convergent and discriminant validity as well as moderate internal reliability (Scheier & Carver, 1987; Scheier, et al., 1994; N. E. Smith, et al., 2004).

4.4.2.2 Health-Related Hardiness Scale (control dimension)

The Health-Related Hardiness Scale (HRHS) was developed by Susan Pollock from an earlier scale measuring hardiness (Jennings & Staggers, 1994; Pollock, 1986). Hardiness is conceived as a personality characteristic that positively mediates the negative effects of stress (Kobasa, 1979; Pollock & Duffy, 1990). There have been two revisions of the HRHS since its initial appearance in the early 1980s (Jennings & Staggers, 1994; Pollock, 1986). The HRHS originally focussed on the chronically ill; it consisted of three dimensions: commitment, challenge and control. In line with contemporary hardiness theory each dimension was respectively related to an absence of alienation, threat and powerlessness (Jennings & Staggers, 1994; Kobasa, Maddi, Puceetti, & Zola, 1985; Pollock, 1986). Since then, the definitions of the three dimensions have altered, and hardiness is presently defined in positive terms rather than as an absence of alienation (Pollock & Duffy, 1990).

The perceived control dimension chosen for this study measures changes in a person’s sense of confidence when appraising and interpreting their health. Perceived control is a subjective element of personal control that also includes objective control (Steptoe, 1989). In contrast to the actual control inherent in a setting or situation, perceived control is defined as a belief in the ability to influence one’s own behaviour, internal states and environment and/or to manipulate how events occur (Wallston, 1989). As a belief, perceived control is understood to vary within individuals over time and between individuals (Wallston, 1989). The HRHS dimension of control is defined as a “sense of mastery or self-confidence needed to appropriately appraise and interpret health stressors” (Pollock & Duffy, 1990, p.219). This definition assumes that not all health related stress is preventable; it also encompasses responses to stress and actions that are health promoting.

The HRHS is now recognised to be useful in health related research with well adults (Pollock, 1989). Psychometric testing has been meticulously adhered to and the scale has been rigorously assessed for validity (Jennings & Staggers, 1994). The 14-item HRHS control dimension has been used in the ALSWH (Women's Health Australia, 2001). Along with optimism the control dimension of hardiness seems to positively
contribute to a person’s well-being (N. E. Smith, et al., 2004). The ALSWH added a fifteenth question at the end of the HRHS: ‘I feel I am independent enough to do the things I want to do’. This question was inadvertently retained in the version used in this project (see appendix A4) but was scored separately.

4.4.2.2.3 Rosenberg Self-Esteem Scale

The Rosenberg Self-Esteem Scale (RSES) measures the hypothetical construct of global self-regard, which is more relevant to self-esteem than a specific self-esteem measure (Rosenberg, 1965; Rosenberg, Schooler, Schoenbach, & Rosenberg, 1995). The definition of self-esteem can be broad ranging and difficult to articulate (Mruk, 1999; Wylie, 1974). Whether focusing on self-respect, feelings, cognition or behaviour, each definition of self-esteem both reveals and conceals, creating a “problem of perspectivity” (Mruk, 1999 p.9). Rosenberg defines self-esteem in terms of a person’s positive or negative attitude to the self (1965). This definition encompasses the more global feelings of self-worth and self-respect while also avoiding any sense of superiority.

This scale was developed from Rosenberg’s sociological perspective (1965). It encompasses the assumption that the self is a social construction and that self-values arise from socio-cultural processes (Mruk, 1999; Rosenberg, 1965). It has good face validity and satisfactory internal reliability as indicated by the Reproducibility and Scalability coefficients (Rosenberg, 1979; Wylie, 1974). Extensive factor analysis has been done and there is suitable evidence of convergent and discriminant validity (Silber & Tippett, 1965; Wylie, 1974). This scale is frequently used to assess self-esteem, including self-esteem in pregnant and postpartum women (B. Cox & Smith, 1982; Fisher, Astbury, & Smith, 1997; Hall, Kotch, Browne, & Rayens, 1996; Kamysheva, Skouteris, Wertheim, Paxton, & Milgrom, 2008; Kim, Hur, Kim, Oh, & Shin, 2008; Logsdon & Usui, 2001; Ritter, Hobfoll, Cameron, Lavin, & Hulsizer, 2000).

4.4.2.2.4 Body Shape Questionnaire (8-item version)

The Body Shape Questionnaire (BSQ) measures causes and consequences of body shape concern (Cooper, et al., 1987). Body shape concern is defined as a disturbance of body image that includes an overestimation of body size; it is known to vary markedly in intensity within the community as well as clinically (Cooper, et al., 1987). The BSQ items came from interviews with young women on experiences of ‘feeling fat’; further
development and testing occurred with large groups of women including a small group with a diagnosed eating disorder (Cooper, et al., 1987). The BSQ measures the extent of psychopathology; it is not a means of case detection (Cooper, et al., 1987). For this project, participants’ individual score results provided an indication of the degree to which each woman was concerned about her body shape and how that concern changed over childbearing.

The BSQ has excellent psychometric properties: discriminant and concurrent validity is evident; internal consistency and test-retest reliability is also satisfactory (Cooper, et al., 1987; Evans & Dolan, 1993; Rosen, Jones, Ramirez, & Waxman, 1996). The BSQ has been used extensively in body image research including research with healthy women, including those who are pregnant (Fox & Yamaguchi, 1997; Hetherington & Burnett, 1994; Lautenbacher, et al., 1992; Winzelberg, et al., 1998; Zabinski, et al., 2001). The original version had 34 items, but, given the BSQ’s uni-dimensional nature, shorter versions have been proposed when the main focus of investigation is not body disparagement (Evans & Dolan, 1993). Comparison of the shorter versions with the full BSQ can easily be achieved. The second of Evans and Dolan’s 8-item versions has been recommended following convergent and discriminant validation; it is used in this project (1993).

4.4.2.2.5  Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) screens postpartum women for depression (J. Cox, et al., 1987). ‘Postnatal depression’ is a non-psychotic depression that takes its name from its postpartum occurrence (J. Cox, Murray, & Chapman, 1993; Watson, Elliott, Rugg, & Brough, 1984). It is recognized when some of the following symptoms interfere with a woman’s customary routines: concentration and memory problems, appetite changes, sadness, unexplained tearfulness, guilt, amotivation, hopelessness, numbness, decreased confidence, self-depreciation, anxiety, irritability, anger and inability to feel pleasure (Cooper & Murray, 1995; O'Hara, Zekoski, Philipps, & Wright, 1990). The symptoms are usually characterised by standardised diagnostic criteria; it is the ‘Research Diagnostic Criteria’ taken from ‘s’s Standardised Psychiatric Interview’ that were used to define depression when the Edinburgh Postnatal Depression Scale was developed (J. Cox, et al., 1987).
Chapter four- Methodology

Development of the EPDS involved a detailed analysis of other scales of well-being and the construction of new items (J. Cox, et al., 1987). Some items were initially adapted from the Irritability, Depression and Anxiety Scale (Snaith, Constantopoulos, Jardine, & McGuffin, 1978) and the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983). Extensive piloting of the initial tool with postpartum women evaluated its detection of postnatal depression and checked its acceptability to health workers and women. The resultant tool was validated and modified further to increase its specificity (J. Cox, et al., 1987).

The EPDS is widely used throughout the world and has successfully been used with pregnant women (L. Barclay & Lloyd, 1994; Boyce, Stubbs, & Todd, 1993; Green & Murray, 1994; Lloyd, 1998; Murray & Cox, 1990; O'Hara, 1994; Pop, Komproe, & van Son, 1992). When used as a screening tool the EPDS is most satisfactory, but problems are evident when it is used as a diagnostic tool or as a measurement of treatment outcome (Lloyd, 1998). The scale has good criterion validity and content validity as well as moderate test-retest reliability (Astbury, Brown, Lumley, & Small, 1994; J. Cox, et al., 1987; Lloyd, 1998; Pop, et al., 1992). The ability of the scale to test additional constructs associated with postpartum women’s health behaviour and well-being has been demonstrated by good construct validity, including predictive construct validity (Lloyd, 1998).

4.4.3 Interviews

The three probing in-depth interviews aimed to build a story of who the participant was at that time point. Each interview enabled me to write about that woman’s in-the-moment bodily experience as well as incorporate her past experiences and future expectations in the story. The focus at each interview was as follows:

**Time point AN1**: on the woman’s embodied experience of pregnancy and her current sense of self.

**Time point PN1**: on the woman’s embodied experience of childbirth and her current experience of the postpartum.

**Time point PN2**: on the woman’s current sense of self and how she perceived her embodied self to have changed subsequent to her childbirth experience.
4.4.3.1 Interview structure

Interviews were semi-structured around plans (included in appendix A5). In the pilot research (Parratt, 2000) I used a single main question aimed at inducing a narrative followed by probing open-ended questions intended to gain deeper understanding (Wengraf, 2001). This strategy successfully gained detail about women’s childbirth experience and associated feelings but little data was gathered about current sense of self until specific questions about the self were asked. Hence for this present project questions specific to current sense of self, change, embodiment and the childbearing experience were carefully planned.

During each interview the pre-planned format was broadly followed although question order was varied. Subsequent interviews also included discussions validating early theorising, previous interviews and stories. On arrival rapport was built through pleasantries and sharing, consent was revisited, progress of the research reviewed and participant’s willingness for audio recording re-confirmed. I usually began by discussing the questionnaire and verifying participant answers. Reviewing part one, for example, allowed clarification of what model of care the participant was receiving. Reviewing part two generally centred on responses to specific questions that were either very different to that participant’s previous responses or differed relative to the way the scale was interpreted (discussed in section 4.5). Discussing these answers often elicited a deeper exploration of the concept being assessed. For example, exploration of one woman’s answer to the final question of the LOT resulted in a detailed discussion about her life philosophy which is reflected in her final story (see Gina’s story, paragraph 1, appendix B).

4.4.3.1.1 The questions

Questions about current sense of self were broadly derived from my theoretical understanding of Relational Cultural Theory (as outlined in chapter two). However, theoretical questions were recognised as being less likely to gain an effective response (Wengraf, 2001). Some questions were therefore reworded from those that were successful in the pilot study. These questions, for example, focused on how each woman looked after and expressed herself, and her ability and confidence to do things. Theorising from the pilot study also suggested some questions, such as one about responses to bodily cues. A trial interview about current sense of self was undertaken
with a volunteer. This trial showed that women were likely to be comfortable with these questions and established that the questions were effective at eliciting personal narrative.

The inclusion of questions about abusive situations, including domestic violence, arose from the link between past sexual abuse and childbirth identified in previous research (Parratt, 1994). For example, a question was asked about being forced to have sex or see unwanted sexual things. Due to the sensitivity of this issue these questions were left until the third interview when participant/researcher rapport was likely to be greatest. These questions were derived from those used in a ‘wellbeing in pregnancy’ consultancy for the New South Wales Health Department (Private communication, Maggie Haertsch, August 2003).

Some of the planned questions were devised so as to specifically induce narrative. For example, participants were asked to talk of their most memorable antenatal visit and to tell the story of their labour experience. Narrative about the self was encouraged by asking the participant to speak of a time when she felt good about herself and then to relay another story of when she felt really bad. A further question asking her to tell of a time when she was particularly moved by life also produced narrative. This request is an example of a theoretically derived question (based on spirituality) that was rephrased so as to be non-theoretical.

4.4.3.1.2  Follow-up questions

Follow-up questions generally aimed to give greater depth and breadth to women’s narrative. The second interview plan, included prompts to ensure specific aspects of the birth experience and the associated physical and emotional feelings were discussed. Many of the follow-up questions were particular to each woman. Follow-up questions probed for underlying explanations, identified the chronology of events and feelings, and added clarity and detail to specific aspects of the narrative (Wengraf, 2001). Questions asking for more detail were commonly directed toward the embodied sensations and experiences. For example, during one interview I probed the bodily sensations associated with feeling good and the sensations linked to knowing that a particular course of action was the right action (see example, appendix A6). Success of the probing aspect of any interview was reliant on the quality of participant/researcher interaction during that interview and the preparation undertaken prior to the interview.
4.4.3.2 Participant/researcher preparation

Participant preparation focused on building rapport through honesty about what was required and openness about myself as researcher. The first contact with participants, the invitation to participate, contained my photograph and a brief outline of myself personally and professionally. When a woman and I communicated on the telephone I endeavoured to be welcoming, respectful and interested in her contribution to the study. The cover letters with each questionnaire reflected this stance and provided specific details about the forthcoming interview. These letters also detailed ways in which women themselves could, if they chose, prepare for the interview (see appendix A3). Women were, for example, guided to use sensory prompts to help remember experiences and feelings. They were also asked to prepare by thinking of particular aspects of their childbearing experience in addition to contemplating an awesome, exhilarating moment in their lives.

My personal preparation for the interview was to spend time centring myself on the research purpose and on what the participants could teach me. I did not enter the interview as an experienced midwife or as a knowledgeable researcher but as a person who was keen to learn. I considered that I could not know the particularities of the experience that the women would relay – it was each woman who was the expert at this. Similarly, I could not fully know the embodied sensations and meanings that the women attached to their experiences. I nurtured a state of openness where I hoped to respectfully expose what was currently unknown to me, and to negotiate how to record what I found in terms that the participant was happy with. Doing this enabled me to focus on the woman’s experience as she saw it, rather than my interpretation of it. This focused perspective was further enabled in subsequent interviews through reflection and critique of my performance at previous interviews. Furthermore, I prepared for each later interview by carefully reviewing that participant’s previous transcripts and stories. My capacity to focus fully on the woman’s experience was also achieved through pragmatic aspects of interview preparation. For example, I ensured ahead of time that the interview environment was most likely to be peaceful and private and that the audio recorder would function.
4.4.3.3 Researcher conduct during interviews

During interviews I actively listened to participants using eye contact and body language. At times I would repeat a participant’s statement in an attempt to understand her meaning, at other times I used verbal and bodily cues to do this (Minichiello, 1990). This was a “fully engaged practice” that involved not only absorbing information but processing it too (DeVault & Gross, 2007, p.182). I frequently gave non-directional responses to maintain participant control of the direction and flow of her story. Rarely would I take notes as they detracted from being fully engaged. Instead I would mentally hold ideas for further questioning until the right moment in the interview. I was aware of developing a form of “double attention” where I attended to the women’s words simultaneous to managing the interview content and direction (Wengraf, 2001, p.194). I had no desire to rush through the interview until I fully understood the experience the woman was conveying (Wengraf, 2001). My focus was on the ongoing negotiation of meaning by attending to participant answers and the follow-up questions (Fahy & Harrison, 2005).

Care was taken to ensure that all the questions, whether planned or unplanned, were worded in a style and language that participants would wish to respond to (Wengraf, 2001). I preceded the more personal probes with a reminder of the participant’s right to not answer if so desired. Although I undertook probing with a particular theoretical purpose, I aimed to avoid biased or leading questions. Likewise, most questions that I posed were open and not closed. In all contact with participants I endeavoured to nurture genuineness in my style of communication. This style was supportive of the creative and spontaneous way that I approached follow-up questioning. It was also forgiving of errors I made, such as asking closed or leading questions. My technique improved through active reflection while repeatedly listening to each interview during its transcription.

4.4.3.4 Interview transcription

Producing an interview transcript was the first stage in constructing a personal narrative. Transcribing was undertaken firstly by an audio-typist and then by myself. Following each interview a copy of the audio-tape was forwarded to the typist; this same typist remained throughout the project. The resultant raw transcripts were quite difficult to read and contained a number of misheard words and phrases. Through repeated careful
listening to the recordings, in addition to having had the experience of actually being at
the interview, I produced a transcript that the participants could validate.

Transcripts prepared for validation used various fonts and brackets to differentiate who
was speaking and what occurred during the interview in addition to what was done with
the transcript. A ‘key’ detailing these strategies preceded the transcript. These same
strategies were used in constructing story drafts. Shown in one typeface (Tahoma) were
notes relevant to the interview and details directly observed during the interview such as
the participant’s body language, emotions and distractions. Where these notes occurred
in the body of the transcript they were placed in square brackets [ ]. The women’s actual
words as heard on the audio-tape were bolded (Times New Roman). Where changes or
additions were made words were bracketed [ ] and un-bolded except when pseudonyms
were inserted. Lastly, my speech during the interview was un-bolded and prefixed with
‘J:’. Each transcript was given some introductory context. Appendix A6 includes a
segment of interview transcript prepared for validation.

4.4.4 Validation

Participant validation of the data and of the emerging theory formed a major part of
participant/researcher interaction. Through the validation process the data was refined
and at times resulted in new data. Formal confirmation of interviews, stories and/or
theorising was sought at the validation points as shown in table 4.1. Formal validation
of emerging theoretical ideas is discussed in section 4.5. Discussions aimed at validation
occurred during the interviews, occasionally using email, and infrequently via brief
telephone conversations. Prior to the third interview such discussions were focused
entirely on the data already generated by the particular participant being interviewed. At
the third interview a far more extensive validation was undertaken.

4.4.4.1 Validating emerging concepts and insights

The third interview included validation of emerging concepts and insights. This final
interview focused on how the participant’s embodied sense of self had changed or was
still changing relative to her childbirth experience. In order to grasp that change a clear
and validated picture of embodied self prior to and during the birth was necessary. In
addition, the comparison of each participant’s experience of embodied self with each
other participant meant confirming that a common language was being used. For
example, a number of women used the word ‘grounded’ to describe their embodied feelings. The validation process enabled me to determine what each woman meant by this word and how their use of the word related to other words participants commonly used to describe feelings such as ‘security’, ‘comfort’, ‘trust’ and ‘centred’. Validation of emerging concepts and insights followed initial analysis of individual participant’s questionnaires, interviews and resultant antenatal and first postnatal stories. This extensive process of preparation formed the beginning of theorising (described in section 4.5).

4.4.4.2 Formal validation of interviews and stories

Formal validation involved mailing out documentation to participants. Validations one and two focused on confirmation of the respective interview transcripts and the stories that were constructed from them. In order to ease the validation process I used a highlighter pen to direct the women to particular segments that I hoped they would verify. Such segments were sometimes related to the audio recording quality or to the need to confirm implied meanings found during story construction. Story construction was itself a form of analysis (described in section 4.5). The responses provided by women were sometimes quite extensive; one woman added two pages of notes. These responses both contributed to and refined that participant’s narrative.

At the third validation point a decision was made to mail two different drafts of the entire narrative and not the transcript of interview three. One copy of the draft narrative was in plain black type while the other used colour to show the origin of different parts of the narrative including the words from the third interview (see example, appendix A6). Participants were asked to confirm that the meanings within their narrative were correct. Additionally I requested that women consider how comfortable they felt with this final version of their narrative, including the way their privacy was being protected; some women responded with minor alterations. During our follow-up telephone call I also invited each woman to insert an addendum about their current life to their story; seven women chose to do this. At the fourth validation point each woman was given a bound copy of their final validated story in addition to a booklet of all participants’ stories. The women were invited to comment on these stories relative to their own experience; six women gave broad generalised feedback.
4.5 METHODS OF DATA ANALYSIS, INTERPRETATION AND THEORISING

Data analysis, interpretation and theorising were an on-going and intermixed process throughout this research project. Appendix A2 outlines timing of the analysis and theorising relative to the data collection and the whole study. In this section I describe questionnaire interpretation, narrative construction and how the grounded theory presented in chapter six was created.

4.5.1 Questionnaire interpretation

The questionnaires provided an objective assessment of the changing embodied self. A within-case analysis of results was conducted to augment the qualitative data from the interview. No cross-case statistical analysis was undertaken because the small number of participants would have made such an analysis scientifically invalid. Participant responses were assessed according to whether or not they had changed over the three time points and the degree to which this change had occurred. Much of part one (outlined in section 4.4.2.1) merely provided demographic detail as shown in the sample results table given in Appendix A7. However, some part one questions did enable comparison across time points. For example, assessments of sexuality and partner relationships occurred antenatally and twice postnatally. Additionally, questions about bodily wellbeing and baby relationships were comparable across the two postnatal time points. Changes indicated through these assessments were explored with the women and are reflected in their stories; they are discussed in chapter five.

Interpretation of part two (outlined in section 4.4.2.2) was made through comparison over the three time points in addition to being assessed relative to the tool itself. Each tool incorporated guidance on numerically rating answers to individual questions and then summing those answers into a final score. Individual answers could thus be assessed according to the rating and then discussed during interviews (as outlined in section 4.4). To enable interpretation of the summed final score a specific range of responses were determined to be high, for example, relative to the concept being measured by the tool. In some cases, such as the Edinburgh Postnatal Depression Scale, this range had already been determined during the scale’s development. Psychometric tool scoring and interpretation is summarised in table 4.2 (pp.160-161). One participant’s results and associated discussion is provided in Appendix A8 as an
## Table 4.2: Psychometric tool interpretation

<table>
<thead>
<tr>
<th>TOOL</th>
<th>PURPOSE</th>
<th>DESCRIPTION</th>
<th>INTERPRETATION</th>
</tr>
</thead>
</table>
| **Life Orientation Test (revised version)**  
(Scheier & Carver, 1985; Scheier, et al., 1994) | Measures change in degree of optimism held over the outcome of future events. | 6 items, 5 response options scored from 0-4 with negatively worded items scored in reverse order to positively worded items. | When summed a higher score indicates greater optimism with a score range of 0-24.  
A mean of 15.6 (SD 3.5) was demonstrated in a cohort of older women indicating a range of 12.1–19.1 (N. E. Smith, et al., 2004). | **In this study** positively and negatively worded items were scored separately and then summed. A range of 14-19 was understood to be moderate optimism; above 19 was called ‘high’, below 14 was called ‘low’.

| Health-Related Hardiness Scale (control dimension)  
(Pollock, 1986; Pollock & Duffy, 1990) | Measures change in sense of confidence in appraising and interpreting of own health. | 14 items, 6 response options scored from 1-6 with negatively worded items scored in reverse order to positively worded items. | The range of scores, when summed, is 14-84; higher scores indicate greater hardiness.  
In a cohort of older women the mean was 29.6 (SD 6.1) for the summed positively worded items (range 23.5-35.7) and 27.1 (SD 6.0) for those worded negatively (range 21.1-33.1) (N. E. Smith, et al., 2004). The summed mean was therefore 56.7 and the range 44.6-68.8. | **In this study** positively and negatively worded items were scored separately and then summed. Scores above 64 were considered to indicate a high level of self-confidence over health and a range of 45-64 was called ‘moderate’.

| Rosenberg Self-Esteem Scale  
(Rosenberg, 1965) | Measures change in positive and negative attitude to the self. | 10 items, 4 response options scored from 1-4 for negative items and 4-1 for positive items. | The range of scores is from 10-40, higher scores indicating higher self-esteem.  
A mean of 32.78 (SD 4.87) was found in a sample of Australian women in the second trimester of pregnancy (Kamysheva, et al., 2008) indicating a range of 27.91-37.65. | **In this study** positive and negative items were scored separately and then summed. A range of 21-29 was considered moderate self-esteem, whereas above 29 was called ‘high’ and below 21, ‘low’.

~ 160 ~
Table 4.2 (continued): Psychometric tool interpretation

<table>
<thead>
<tr>
<th>TOOL</th>
<th>PURPOSE</th>
<th>DESCRIPTION</th>
<th>INTERPRETATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body Shape Questionnaire</strong></td>
<td>Measures change in body shape</td>
<td>8 items, 6 response options scored from 'never' (1 point) to 'always' (6 points).</td>
<td>When summed total scores multiplied by four to enable comparison with full scale (Evans &amp; Dolan, 1993). Range of scores is 32-192 with higher score meaning greater body shape concern. A mean of 109.0 (SD 21.2) for women who were ‘concerned’ about body weight and shape made the range 87.8-130.2, while the mean of the ‘unconcerned’ group was 55.9 (SD = 14.4) with range the 41.5-70.3 (Cooper, et al., 1987). In this study a summed score over 87 indicated concern whereas under 70 indicated definite unconcern. A range of 70-87 was considered to indicate slight concern.</td>
</tr>
<tr>
<td><strong>Edinburgh Postnatal Depression Scale</strong></td>
<td>Measures change in depressed</td>
<td>10 items, 4 response options scored from 0-3.</td>
<td>The summed range of scores is 0-30 with higher scores indicating less well-being and greater likelihood of depression. A threshold of 10 has been suggested as an indicator for possible depression (J. Cox, et al., 1987) and 12.5 was recognised as the cut-off for women with probable major depression (Boyce, Hickie, &amp; Parker, 1991). In this study a summed score of 10 was seen to indicate depressive feelings and above 12.5 probable depression.</td>
</tr>
<tr>
<td>(J. Cox, et al., 1987)</td>
<td>feelings.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

example of how part two results were interpreted. Chapter five summarises these interpretations and considers their consistency with participant stories. This process is in line with the triangulation of the data.

4.5.2 Narrative construction

The purpose of narrative construction was to elucidate each woman’s perspective of how her embodied self changed in childbearing and the factors in the childbirth experience that were related to her improved sense of self. The procedure for creating the stories was adapted from the eight-step guide used by Carolyn Emeden (1998b). Emeden called this process “combing the data” so that “no key meanings” were “lost”
The story construction process aimed, as Emden did, to use the participants’ “own words almost exclusively” (1998b, p.36). However, I also aimed to make the story easily readable and understandable. Table 4.3 (p.163) lists the steps I took in constructing each participant’s final story.

The narratives were constructed as a “temporal gestalt” where the meaning of each story component came from its reciprocal links with the other story parts and the whole story (Polkinghorne, 1995, p.18). Each woman’s final story was built from her validated antenatal story, her validated first postnatal story and the third transcript. Each paragraph of the antenatal story and each paragraph of the first postnatal story was built from their respective transcripts made ready for validation. These transcripts in turn came from the raw transcripts. An example of this process is given in appendix A6: an extract from Dawn’s first interview transcript is followed to her antenatal story draft and then to the relevant portion of her final story draft. Extracts of colour drafts of two other final stories are also given in Appendix A6. The complete stories are in Appendix B and are summarised in chapter five.

4.5.3 Theory creation

The outcome of this research has been a situation-producing theory (Dickhoff & James, 1968; Peterson & Bredow, 2004). This theory describes, explains and predicts how women and health professionals can produce a situation where childbearing women experience changes in ways that enhance their embodied self (chapter six). The theory is comprised of concepts which I define as symbolic representations of abstract ideas about things, phenomena and/or actions (Peterson & Bredow, 2004; Walker & Avant, 2005). The concepts are linked in systematic and meaningful ways by propositional statements so as to form the theory (Fawcett, 2000; Walker & Avant, 2005). This section presents the interconnected methods used to create the theory. My grounded theorising process involved three phases:

- **an initial phase** of analysis where the core process of changing embodied self was identified;
- **a clarifying phase** where provisional frameworks were established and ideas were validated; and
- **a refining phase** that created and refined the theory.
Table 4.3: Steps in construction of each participant’s final story

1. Using a commercial standard word processor create a new document and insert antenatal transcript made ready for validation
2. Familiarise with content by reading and rereading
3. Delete all interviewer questions, observations and notes, bold remaining text
4. Separate blocks of text into phrases, sentences or sentence groups that pertain to key elements being relayed by woman
5. Group similar key elements of text together
6. Reread
7. Further separate elements of text that detract from the key element in each phrase, sentence or sentence group
8. Delete words redundant to the key messages being relayed by woman
9. Use an un-bold font to prudently add or alter words:
   – to ensure story is in appropriate tense (for example change ‘had’ to ‘have’)
   – to protect privacy (for example alter name of midwife)
   – to make sense of the story (add words, for example ‘that’ or ‘from’)
   – to give context (such as when original transcript showed the woman agreeing and expanding on a question or statement but not repeating the relevant words of the topic)
10. Except for pseudonyms, enclose added or altered words in square brackets [ ]
11. Ensure women’s words are differentiated from added/altered words by being in bold font
12. Check original interview transcript to ensure the text still portrays the meaning intended by the participant
13. Keep at least two pages of the document on screen at any time to simultaneously maintain focus on the page of text being worked on
   – skim through the whole narrative as it emerges
14. Repeat steps 4 to 13 until key elements chronologically and logically portray the overall purpose of the story from that particular woman’s perspective.
15. Use highlight pen on added/altered text segments with ambiguous meaning for particular attention during validation (see section 4.4.4.2)
16. Seek formal validation, make additions/deletions where necessary
17. Once validated remove square brackets and bold all story text to signify its verification by the woman. This is the antenatal portion of the story
18. Repeat steps 1 to 17 with the first postnatal transcript so as to produce the birth and early postnatal portion of the story
19. Create another new document and insert the third interview transcript preceded by the validated antenatal story and the validated birth/postnatal story.
20. Differentiate the words of the antenatal story and the words of the birth/postnatal story from each other and from the transcript using different coloured fonts.
21. Repeat steps 2 to 16
22. Once validated change all text to black, un-bold font and remove square brackets.
23. Add addendum and postscript as appropriate
24. Add chronological headings and brief introduction
4.5.3.1 Analysis

Analysis began with the first interview and continued until the theory was complete. Three interconnected forms of analysis were undertaken (Daiute & Lightfoot, 2004). I undertook an analysis of:

- the individual and general meanings used by the participants to describe their experience of changing embodied self;
- how cultural powers, including those internalised by women, impacted on their understandings and experiences; and
- the embodied practices that influenced how the participants had and were currently changing.

Analysis involved close scrutiny of the data. I focused on the meaning of specific words used by the women, on perceptions of their hoped for or actual experiences and on the detail of embodied experience. The questions I asked of the data were centred on particular scenarios. These scenarios, such as the experience of being in an altered conscious state during labour, were either specific to the participant or common to some or all participants. Example questions are in table 4.4 (below).

**Table 4.4: Sample questions asked of the data**

<table>
<thead>
<tr>
<th>For a particular scenario:</th>
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<tbody>
<tr>
<td>What processes were involved in this scenario?</td>
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<tr>
<td>Under what conditions did the scenario occur?</td>
</tr>
<tr>
<td>What were its consequences?</td>
</tr>
<tr>
<td>How did the woman’s relationship with herself, her partner, baby, and/or caregivers impact on this scenario?</td>
</tr>
<tr>
<td>What perspectives did the woman bring to her experience?</td>
</tr>
<tr>
<td>In what ways did her future expectations and her current and past experiences have an influence?</td>
</tr>
<tr>
<td>How might this scenario impact on her future experiences?</td>
</tr>
<tr>
<td>What are the similarities and differences between this scenario and other scenarios in this woman’s story and in the other participants’ stories?</td>
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</table>

During the analytic process I constructed numerous tentative explanations for what I saw in the data. I used these tentative explanations to compose probing questions specific to the particular participant whose story I was focused on. These probing questions were used in the participant’s third interview. I carried forward the more
salient of these questions to consider during the analysis of the next participant’s stories. My provisional theorising therefore evolved according to the stories I was analysing and the previous participants’ responses during interview. The order in which I considered the stories matched the third interview order (as shown in appendix A2). Three provisional themes arose from this analysis. These broad themes of ‘security’, ‘knowing’ and ‘potential’ were the beginning from which understanding about the changing embodied self started to arise. In table 4.5 (below) extracts of data and a selection of the related probing questions illustrate the provisional theme of security.

**Table 4.5: The provisional theme of ‘security’**

<table>
<thead>
<tr>
<th>Data extracts:</th>
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<tbody>
<tr>
<td><em>Normally I’d barrel through crowds, big and strong. But I feel vulnerable, like I have to protect my belly. I don’t feel as centred as I have been.</em></td>
</tr>
<tr>
<td>(Gina’s AN1 story)</td>
</tr>
<tr>
<td><em>It was quite a long labour … I felt really safe and very comfortable … I was really present with the baby … It was a grounding thing for me, helping me be patient and in the moment</em></td>
</tr>
<tr>
<td>(Elizabeth’s PN1 story)</td>
</tr>
<tr>
<td><strong>Sample probing questions:</strong></td>
</tr>
<tr>
<td>What does ‘comfort’ mean to you?</td>
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<tr>
<td>What do you mean by grounded/centred? Is it something within you?</td>
</tr>
<tr>
<td>How is feeling centred different to feeling grounded?</td>
</tr>
<tr>
<td>Did you become more grounded/centred as the labour progressed? In what ways?</td>
</tr>
<tr>
<td>Were you feeling grounded/centred when you had the placenta?</td>
</tr>
<tr>
<td>How did the blood [in third stage] affect your feelings of being grounded/centred/secure/comfortable?</td>
</tr>
<tr>
<td>Has feeling grounded in labour changed you now?</td>
</tr>
</tbody>
</table>

The tentative explanations were clarified and re-clarified according to specific participant responses and searches across my whole database. In these searches I considered how explanations found in one story may or may not link with those in other stories. The tentative explanations were further clarified into paradoxes reflecting the many contradictions I found both within women’s stories and between the stories; the paradoxes are shown with examples in table 4.6 (p.166). My overall focus during this analysis was to find the path through the contradictions by identifying the core process of changing embodied self leading to women’s enhanced sense of self.
Table 4.6: Three paradoxes with examples

<table>
<thead>
<tr>
<th>Paradox 1: Women have hopes and desires, they make plans, and they have expectations yet they also need to remain aware that other outcomes are possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants Jane and Elisabeth both planned and achieved home birth but they had differing approaches. Jane said she was not “flexible” in her mind “about what the outcome would be”. She did not believe that that “level of expectation” was too much given the “constant objection and fear” that other people expressed about her decision. (Appendix B, p.37) Elisabeth said that thinking about labour caused “too much anticipation” which she said could give her “a bit of trouble” if it did not “work out that way”. So she did not think “too much” about labour and was prepared “to accept whatever” happened. (Appendix B, p.46)</td>
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<tr>
<th>Paradox 2: During the changes of childbearing women need to be prepared to be both out of control and controlled enough to achieve their goals</th>
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<tr>
<td>During labour Gina let herself “be out of control” while she “completely let go to a higher power”. Yet she says she was also “consciously aware” of pushing as a “physical activity” that she had to “get in there and do”. (Appendix B, pp.209, 211) In the postpartum Lisa discussed the unpredictability of baby care and how she had to come to terms with there being “no rules”. Yet both Lisa and her baby also benefitted once some degree of “routine” was established. (Appendix B, p.451)</td>
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<thead>
<tr>
<th>Paradox 3: Pain, fear and/or tiredness can disintegrate women’s sense of wholeness yet to most effectively use their power women need to bring their whole self to the experience of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michelle deferred pregnancy for many years due to fear of childbirth. She stayed “away from babies” because she did not want to be pressured by others. As time passed she began to “want a baby more than the fear”. Then she felt far more capable at experiencing childbearing because it was her own decision and not made through pressure from others (Appendix B, p. 363). For Celeste pushing was “rawer” and “even more painful” than first stage. She was “getting so tired” that she tried pushing when the urge was not there. However, pushing without fully engaging with her body “didn’t work”. Pushing was only effective “when the urge was there” (Appendix B, pp.305-6).</td>
</tr>
</tbody>
</table>

4.5.3.2 Identifying the core process of changing embodied self

Identifying the core process of changing embodied self was a lengthy process that involved inductive, deductive and abductive reasoning (Danermark, Ekstrom, Jakobsen, & Karlsson, 2002; Levin-Rozalis, 2000, 2004; Peirce, 1955). Inductive reasoning was used to detect similarities and differences in the data. Deductive reasoning was used to consider how existing theories may or may not apply to this data. Abductive reasoning
was used to reflect on the process of inductive and deductive reasoning. Abductive reasoning also supported intuitive insights by continually posing questions of the data and examining for fit. Through abductive reasoning tentative explanations that were heretofore un-thought of and often surprising were produced. Ongoing reflection provided a means to determine which tentative explanations to discard, to modify, or to take seriously (Levin-Rozalis, 2000, 2004). This was a non-linear process that was complex and multilayered (Emden, 1998b; Levin-Rozalis, 2000, 2004; Polkinghorne, 1995).

I was searching for the core process that ‘fit’ the diverse nature of each participant’s story in addition to bringing meaning and order to the collection of stories (Morse & Singleton, 2001; Polkinghorne, 1995). A theory’s ‘fit’ refers to its ability to explain a phenomena in such a way that key elements are incorporated and make sense (Morse & Singleton, 2001; Peterson & Bredow, 2004; Walker & Avant, 2005). I undertook recursive back and forth movements both from the data to the emerging ideas as well as from the various parts of the data to their collective whole (Polkinghorne, 1995). As a process of detection the procedure also required a reflexive wariness of following false trails laid by the desire to achieve a particular outcome (Zizek, 1991). The oscillation to and from data prevented the imposition of preconceived ideas and ensured that emerging ideas were thoroughly grounded in data (Emden, 1998b). Gradually the core process became more defined and this initial phase of analysis shifted into the clarifying phase where I began to establish provisional frameworks.

4.5.3.3 Establishing provisional frameworks

The process of establishing provisional frameworks began with the need to establish a framework to interpret the core process of changing embodied self. My ongoing philosophical readings, as outlined in chapter two, underpinned this process. The process primarily drew from the data coding I undertook at varying periods during analysis. I aimed to keep the codes active and specific to the research question and I variously categorised the codes. Some of this analytic coding was done by hand with highlighter pens and notation. I also coded using the highlight function of my word processing package. Most coding was done using the computer program NVivo (QSR International Pty Ltd Version 2.0.163, 2002) which was developed to assist researchers undertake grounded theory (Richards, 1999). NVivo was useful for devising varying
ways to structure and organise the codes. I also regularly used NVivo to assist with searching and retrieving portions of the data during my ongoing reflective process. However, I found that coding in general and NVivo in particular was too structured for the embodied and post-structural way in which I undertook theory creation (described in section 4.5.3.5).

Very early in the process of analysis two provisional frameworks were evident within the data: the experiential and the relational. The experiential framework focused on participant’s in-the-moment experience. Development of the relational framework then arose from the need to consider women’s reflexive relations with themselves and others. Examples from these two provisional frameworks, including propositional statements are given in table 4.7 (below). Eventually, however, a more post-structural framework was required to achieve fit with the complexity and contradiction within the data. This framework focused on how women and caregivers could intentionally direct childbearing practices toward enhancing a woman’s changing embodied self. This third

**Table 4.7: Sample provisional frameworks**

<table>
<thead>
<tr>
<th><strong>Experiential framework</strong>: evolved from participant’s descriptions of in-the-moment experiences both in labour and at other times. These often intense bodily experiences involved an inward focus and release of ideals and expectations; they appeared to direct participants to new or different ways of being.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Story example</strong>: During labour Dawn felt “a strength and a power as well as the pain” by “focusing deeply inside” which helped her to “go with it” in “a primal response that gradually built with the pain” (appendix B, p.108).</td>
</tr>
<tr>
<td><strong>Example propositional statement</strong>: ‘Shifting awareness toward inner self will better enable a woman to release herself to the process of change’.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Relational framework</strong>: based on the observation that participant’s ordinary sense of security was challenged when faced with unknown, different or unexpected aspects of themselves, their situation or other people. Differing forms of connections/relations were identified as empowering or disempowering.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Story example</strong>: Gina said she “had the best team a girl could have” at her birth. She “felt so unconditionally loved” and “able to be who I needed to be because they were there especially for me” which was “really affirming because that meant that I was normal” (appendix B, pp.214-5).</td>
</tr>
<tr>
<td><strong>Example propositional statement</strong>: ‘Feeling a sense of connection between elements of the self and between the self and others generates a sense of security, power and wholeness’</td>
</tr>
</tbody>
</table>
provisional framework encompassed the other two frameworks to become the post-structural theory presented in chapter six. The experiential and relational frameworks evolved into the meta-concept of ‘The embodied self’ and the intentional aspect became the ‘Change pathways’. Prior to this evolution into theory another key element of the clarifying phase was undertaken; my more salient ideas were validated with participants.

4.5.3.4 Validating ideas

Validation of the provisional frameworks was undertaken by devising theorised statements for women to respond to. Two different lists of statements were included with the mail outs at validation 3 and validation 4 (table 4.1). I called the first list Validation A ‘Early ideas from the research’ and the second list Validation B ‘Later ideas from the research’. Three versions of Validation A (‘A1’, ‘A2’ and ‘A3’) were developed over a 12 month period. Development of Validation B occurred in the latter half of this period. Refinement of statements in Validation B and development of further theoretical statements for participant validation was curtailed by study time lines. Participants either responded to Validation A1, A3 and B, or Validation A2 and B. One participant declined to respond to Validation A1, and one to Validation B. Appendix A2, table A2.3 shows which women participated and when.

The statements were centred on experience of self rather than experiences specific to childbirth; they arose from the ongoing reflective process, the process of establishing the provisional frameworks, and participant responses to the earlier statement versions. The purpose of Validation A statements was to confirm how each woman understood their embodied self and how they saw themselves changing. Three definitions arising from Validation A prefaced Validation B. These definitions were:

- ‘The outer sense of me is that part of me that relates to the outside world. I can explain myself in terms of words or images referring to what is outside of me such as who is in my life, the past, present and future happenings in my life and the various roles I take on’.
- ‘My outside environment includes things, situations and people’.
- ‘The inner sense of me arises from a felt sensation deep within my body that results in a compulsion to act in a certain way or the knowing of something without actually thinking’.
The statements in Validation B were more specifically focused on factors about how relations within the self and between the self and others had an impact on participant’s experience of self. Participants were asked to circle ‘agree’ or ‘disagree’ or to indicate neutrality about a statement by striking both out. Where varying options were given participants were invited to respond to all, some or none. Comments were welcomed and a number of participants qualified their answers in ways that assisted the evolution of future statements. Sample statements are given in table 4.8 (below).

**Table 4.8: Sample statements validating ideas**

<table>
<thead>
<tr>
<th>Validation A:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. This statement remained unchanged in each version of Validation A and was affirmed by all participants:</td>
<td></td>
</tr>
<tr>
<td><em>I am both the same person as I was before pregnancy but also a different person.</em></td>
<td></td>
</tr>
<tr>
<td>2. The following version A1 statement was affirmed by the majority of participants but as the other statements evolved, it was clarified.</td>
<td></td>
</tr>
<tr>
<td>Version A1:</td>
<td></td>
</tr>
<tr>
<td><em>My feeling of wholeness begins to break down if I have a sense of disconnection from others.</em></td>
<td></td>
</tr>
<tr>
<td>Version A3:</td>
<td></td>
</tr>
<tr>
<td><em>When I have a feeling of connection to what I value outside of myself, whether my environment and/or people, I am aware of an increased sense of inner wholeness.</em></td>
<td></td>
</tr>
<tr>
<td>3. Two participants disagreed with the following version A1 statement. In the A3 version all participants were able to affirm at least one of the options:</td>
<td></td>
</tr>
<tr>
<td>Version A1:</td>
<td></td>
</tr>
<tr>
<td><em>When faced with new and/or overwhelming challenges I sometimes perceive the part of myself that is the same, that inner sense of me, as weakened, vulnerable and/or lost.</em></td>
<td></td>
</tr>
<tr>
<td>Version A3:</td>
<td></td>
</tr>
<tr>
<td><em>When faced with new and/or overwhelming challenges I perceive:</em></td>
<td></td>
</tr>
<tr>
<td>a. <em>that inner sense of me as weakened, vulnerable and/or lost in both the short and long term</em></td>
<td></td>
</tr>
<tr>
<td>b. <em>that inner sense of me as weakened, vulnerable and/or lost in the short term while in the long term I sense the return of my inner strength</em></td>
<td></td>
</tr>
<tr>
<td>c. <em>that inner sense of me as strong in both the short and the long term</em></td>
<td></td>
</tr>
</tbody>
</table>

**Validation B:**

All but three participants affirmed this statement:

*As a human being I feel known by another human being when I am acknowledged as having at least some basic similarities to that person;*

One participant was neutral about this statements while the remaining participants were affirming:

*I also feel known by another person when that person respects that there are parts of me that are unknown or different to him/her.*
There were limitations to this form of decontextualised validation (Morse, 1998). If, for example, a woman had never experienced what was referred to in the statement then she was more likely to disagree with the statement. This problem was partially resolved in the latter versions by separating statements into sub-statements that could encompass the diversity of experience relative to that statement (see table 4.8). Disagreement with a statement was therefore not necessarily interpreted to mean that the statement was wrong. Women’s responses to the statements enabled me to confirm that the language I was using in the provisional frameworks matched with participants’ understanding. My thinking about the provisional frameworks was clarified by this validation process; it opened my mind to the final, very creative phase where concepts were brought together and refined into the actual theory.

### 4.5.3.5 Bringing the concepts together

The defining period in theory creation was when I brought the concepts together into meaningful table on a single page. The process encompassed periods of intense focus on the emerging concepts, on their meanings, and on the theory as a whole. Concepts and sub-concepts were primarily derived from the methods detailed above and as a result of my own self-reflection. The embodied process of abstraction from the data into concepts was also the process that identified the interrelationships between concepts. The particular words I used were critical but so too was where I placed those words. I felt myself creating the theory much as a potter shapes clay, although my process involved not only my hands but the mental contemplation and physical activity encompassed in many hours of walking. I used my bodily sensations of wholeness to gauge whether a particular collection of concepts was accurately representing the data. I also used my knowledge of psychoanalysis, as well as nonrational techniques such as Tarot cards and yoga, to question and re-question my own underlying motivations for what words I was using and where I was placing them. My reflexive capacity was also enabled through general discussions about self change and embodiment with other people, in particular my partner and my primary supervisor. The interrelationship and meanings of concepts in the theory were expressed through their positioning. Two sample theory tables, in table 4.9 (p.172), illustrate the relationship between concepts and descriptors.
Table 4.9: Sample theory tables
4.5.3.6 Refining concepts and meanings

Concepts and meanings underwent a lengthy period of refinement following initial construction of the theory table. My own capacity to fully explain the post-structural and spiritual elements of the theory was initially quite limited. I had an embodied knowledge of what I meant, yet my articulation of that meaning was poor. Bringing my internalised meanings into words required many more hours with the data and with philosophical texts, as well as multiple attempts at communication of the theory to others. I often used the thesaurus or dictionary (Trumble & Stevenson, 2002) to choose which word to represent a concept. Using the dictionary enabled me to ensure that my intended conceptual meaning was aligned with the meaning relayed to other people.

As I began to articulate my conceptual meanings more clearly I made alterations in the theory table, but I also resisted making some changes. For example, my initial preference was to encompass intrinsic power into the concept ‘embodied truth’ and to symbolise its nonrational character in the empty space below (table 4.9). Over time I realised that ‘embodied knowing’ represented the data far more accurately but I retained the empty space. Further time elapsed before I was prepared to add the words ‘intrinsic power’ to that space. Use of the single theory table in this format was eventually discarded; however, the concept ‘Intrinsic power’ remains central to the theory as described in chapter six.

A large part of refining the theory involved ensuring that other people could understand it. I gave presentations using portions of the theory and I published papers using some of the concepts; these are listed at the front of the dissertation (pp.ii-iii). This process refined how I was communicating the theory and at times prompted changes to the concepts and sub-concepts. For example, the concept ‘spiritual practices’ was altered to ‘empowering practices’ as it was felt to be more immediately understandable by midwives and not so open to misinterpretation. In another example, the sub-concept ‘instinctive birth’ was discarded following its misinterpretation as essentialist by a group of theorists. I eventually renamed the sub-concept ‘genius change’ but it was this early criticism that prompted me to conceptualise ‘genius birth’. Since then the concept ‘genius birth’ and the theory in general has been positively received by midwives and women.
4.6 RESEARCH QUALITY

In appraising the overall quality of this research I have drawn from criteria used in a study considering the quality and significance of Australian midwifery research (Fahy, 2005). Please refer to Appendix A9 for a list of this criteria. These criteria derive from and are consistent with the recommendations from a number of major authorities in qualitative methodology (Joanna Briggs Institute, 2004; Morse, 1999a, 1999b, 2004; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Morse & Singleton, 2001; Taylor, 2002). The criteria are also consistent with criteria proposed in a more recent appraisal of qualitative research (Walsh & Downe, 2006).

The study’s strengths lie in its rigorous methodology which commenced with the production of a clear and specific research question. The research question, the research aim and key terms are clearly defined in chapter one. The research question and aim has linked the study to other knowledge via the philosophical framework in chapter two and the critical literature review in chapter three. Methodological links to the research question have been made throughout the study facilitating congruence of the research design, recruitment, data collection and the analytic methods.

Strategies to support the rigor of the research were built into the methodology (Morse, et al., 2002). Methods were adjusted according to how the research was proceeding; they have been described and justified in this chapter. On-going adjustments to the methods were enabled and did occur at the micro-level of participant/researcher interaction during interviews as well as at the more macro-level of how theorising was validated. Researcher responsiveness to the evolving research methods was facilitated by the feminist post-structural framework. This framework also created the boundaries that enabled the study to be conducted ethically; it was also approved by the relevant authorities.

The logic of sampling, as made explicit in this chapter, meant relevant data was gathered that could answer the research question. Given the limits of doing a primarily unfunded\(^2\) PhD in rural Victoria, a demographically diverse group of women was recruited, as shown in table 5.1 in chapter five. This group was representative of the target population of women planning what they understood as a normal birth for their

\(^2\) Scholarships and awards received during the research project are listed at the beginning of the dissertation.
first baby. Purposive sampling meant that the group included women planning midwifery led home birth as well as medically led hospital birth. These women made a diverse array of plans for childbirth and they experienced change over the childbearing period in diverse ways. This diversity enabled data to be collected from women for whom the birth experience had great meaning in their lives as well as from women to whom childbirth was merely the way to become a mother. Alternative view points were specifically canvassed during the probing interviews and the methods of theorising purposely worked to honour the varying contradictions within the data.

Methods for checking validity of the data and theoretical interpretations were appropriate to the research and have been explicitly outlined in section ‘4.4.4 Validation’ and section ‘4.5.3.4 Validation of ideas’. The chapter has specified how the theoretical concepts are grounded in the data. Chapter six further substantiates the grounded nature of the theory: theoretical concepts are defined and each is illustrated with the data. The approach taken throughout this research project has been a reflexive one, aimed at making it clear how I, as the researcher, have participated and influenced the process and its outcomes. My own views were identified in chapter one. These views were appropriately bracketed at times during the research, such as during interviews. Verification during the theorising was enabled by my open and self-questioning stance. The verification process was also facilitated by my experienced and reflexive primary supervisor. In varying ways and at various stages of the design, analysis and reporting, all my supervisors contributed to the adequacy of this research.

Feed-back from maternity care clinicians and theorists has confirmed the plausibility of the theory. The theory as described in chapter six contributes new knowledge to maternity care-giving that is also of relevance to childbearing women. Significance of the theory has been outlined in the introductory chapter and is further discussed in chapter seven. The theory could be safely transferred to other similar Anglo-Saxon Australian women planning normal birth in any setting. Although general aspects of the theory such as ‘embodied self’ theoretically apply to all people, until further research is undertaken the theory should only cautiously be applied to other contexts.
4.7 CONCLUSION

In conclusion, in this chapter I have given a framework of the methodological principles and explained the research design used in this study. The study setting, participants and ethical issues have been outlined. I have elucidated the methods of data collection, analysis and theorising in addition to discussing the research quality. Overall, the chapter has detailed a creative and ethical process of theory generation that challenges assumptions, respects the contextual diversity of all the data, and considers the opinions of those to whom the final theory is to be directed. The chapters that follow show how the procedures outlined in this chapter were used to create that theory.
5. **CHAPTER 5- RESULTS: INDIVIDUAL CHANGES**

5.1 **INTRODUCTION**

This chapter contains summaries of the research findings focused on the individual participant’s experience of their changing embodied self. Pseudonyms are used to represent participants, their partners and their babies. The summaries are variously paraphrased from the full, validated, stories that are contained in appendix B. Brief, direct quotes are contained in “double quotation marks” and page numbers refer to the full stories in appendix B (Parratt, 2009). The summaries are also informed by the questionnaire results. Tables 5.1-5.10 within the chapter provide summaries of the women’s experiences and questionnaire results. The tables are reprinted in appendix C for easy reference. Participants are listed in the same order in each table; this order matches that of the stories in appendix B, but this ordering is not followed when participants are discussed in the text.

The chapter is structured around my research question: ‘How does a woman’s embodied sense of self change during the childbearing period and what factors in the childbirth experience seem to be positively related to an improved sense of self?’ In section 5.2 the participants are introduced according to their planned birth place. Their individual summaries contain salient features of each participant’s story including past details, current experiences and future concerns. Section 5.3 compares some of the similarities and differences of the participants as a group; it includes the psychometric results. In section 5.4 I consider the limitations of psychometric assessment and discuss participant’s improved sense of self. I conclude that all participants identified ways in which their embodied self improved during childbearing, but it was those participants who had used their own power to labour and give birth that were most empowered by change.

5.2 **PARTICIPANTS’ EXPERIENCES OF CHILDBEARING**

When they joined the study the fourteen participants were aged between 21 and 38. They were all in the latter months of their first pregnancy. Over the study period participants remained generally healthy and each woman continued in a de-facto or married relationship with her male partner. None of the women were of a specific ethnic
or indigenous group, thus English was their first language. The women did, however, have a varied social profile as table 5.1 (p.179) illustrates. Their stories are summarised below, including some questionnaire responses. The three part summaries are told from three different perspectives relative to participants’ interviews. The first part is where the women are currently pregnant. Part two looks back on the birth from the perspective of the first postnatal interview at 3-4 months postpartum. The third part gives an overview of the postpartum experience from both the 3-4 month and the 7-8 month interviews. The fourteen summaries are grouped according to where the women planned to give birth. Each group of summaries is introduced by a comparative outline of the women’s antenatal experience, drawn from survey results.

5.2.1 Six women planned homebirth

Jane, Elizabeth, Louise, Jasmin, Gina and Maree planned to give birth at home. All six women employed private midwives and had antenatal visits with these midwives. Jane’s midwifery visits were followed by visits with a doctor who was also to attend the birth. Five of the six women had visits with a second midwife who was to act as a back-up caregiver during the birth. Louise was unaware of the availability of any other private midwives; she had the majority of her antenatal care with her usual doctor and no back-up midwife. Of the six women only Louise went to hospital based childbirth education classes whereas the other women attended private classes. All these six women planned to have other female friends and/or family present at the birth. Maree differed from the thirteen other participants by planning that her partner would not attend the birth.

5.2.1.1 Jane

During pregnancy

Jane and Martin underwent a stressful but maturing re-evaluation of their relationship “a long time ago” (p.10). Jane’s view was that those bad times had to be experienced in order to have the “good times” (p.10). The relationship was described as currently “very open” and Jane expressed a sense of ease about it (p.10). Jane saw herself as usually fit and active. She was highly optimistic, had high self-esteem and no body shape concerns or depressive feelings. Jane had a moderate degree of self-confidence about her capacity to control her health.
## Table 5.1: Introducing participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Highest education</th>
<th>Occupation</th>
<th>Current paid employ</th>
<th>Household</th>
<th>Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane</td>
<td>31</td>
<td>Uni degree</td>
<td>Restaurant supervisor</td>
<td>Maternity leave</td>
<td>Partner (Martin)</td>
<td>Own home in rural area</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>28</td>
<td>Cert/dip</td>
<td>Massage therapist</td>
<td>No</td>
<td>Partner (Bob)</td>
<td>A rental house in an outer suburb, later moved to share house with another couple</td>
</tr>
<tr>
<td>Louise</td>
<td>29</td>
<td>Year 10</td>
<td>Sales representative</td>
<td>Maternity leave</td>
<td>Partner (Stephen)</td>
<td>Renovating their provincial city home</td>
</tr>
<tr>
<td>Dawn</td>
<td>30</td>
<td>Cert/dip</td>
<td>Administrative assistant</td>
<td>Maternity leave</td>
<td>Partner (David)</td>
<td>Own home in outer suburbs</td>
</tr>
<tr>
<td>Leanne</td>
<td>35</td>
<td>Uni degree</td>
<td>Manager, clinician in rehabilitation</td>
<td>Full-time</td>
<td>Partner (John)</td>
<td>Own home in outer suburbs</td>
</tr>
<tr>
<td>Jasmin</td>
<td>30</td>
<td>Higher uni</td>
<td>IT Consultant</td>
<td>Full-time</td>
<td>Partner (John)</td>
<td>An inner city house</td>
</tr>
<tr>
<td>Gina</td>
<td>24</td>
<td>Higher uni</td>
<td>Midwife</td>
<td>Part-time, just resigned</td>
<td>Partner (Riley) &amp; Gina’s mother</td>
<td>Gina’s mother’s home in outer suburbs</td>
</tr>
<tr>
<td>Maree</td>
<td>29</td>
<td>Uni degree</td>
<td>Volunteer support work</td>
<td>No</td>
<td>Partner (Peter) &amp; his daughter aged 8</td>
<td>First in an inner city unit (part of a Christian household) then moved to a country property within a year of birth</td>
</tr>
<tr>
<td>Patricia</td>
<td>21</td>
<td>Year 10</td>
<td>Factory worker</td>
<td>Full-time</td>
<td>Partner (James)</td>
<td>Initially rented a unit, then a house and later moved in with James’ mother in a provincial city</td>
</tr>
<tr>
<td>Celeste</td>
<td>31</td>
<td>Uni degree</td>
<td>Welfare worker</td>
<td>Full-time</td>
<td>Partner (Henry)</td>
<td>Own home in provincial city</td>
</tr>
<tr>
<td>Emily</td>
<td>38</td>
<td>Higher uni</td>
<td>Midwife; works in administration</td>
<td>Full-time</td>
<td>Partner (Graeme)</td>
<td>Own home in rural area (commute to the city for work)</td>
</tr>
<tr>
<td>Michelle</td>
<td>30</td>
<td>Year 10</td>
<td>Office clerk</td>
<td>Part-time</td>
<td>Partner (Brett)</td>
<td>Renovating their provincial city home</td>
</tr>
<tr>
<td>Helen</td>
<td>28</td>
<td>Uni degree</td>
<td>Welfare Worker</td>
<td>Maternity leave</td>
<td>Partner (Bob)</td>
<td>Renovating their provincial city home</td>
</tr>
<tr>
<td>Lisa</td>
<td>29</td>
<td>Higher uni</td>
<td>Accountant</td>
<td>Full-time</td>
<td>Partner (John)</td>
<td>Own home in a provincial city</td>
</tr>
</tbody>
</table>

**KEY:** 1 At first antenatal interview; IT = information technology; uni = university; cert/dip = certificate or diploma
Since she became pregnant Jane had not completely attended to her needs; she pressured herself to do what she “normally” would do (p.10). However, she had also learnt the “subtle vulnerability” of her body; Jane and Martin stopped having sex for fear of harming their baby (p.12). Despite the sense of uncertainty that pregnancy brought, Jane felt joy and fulfilment. She identified pregnancy as her most meaningful life experience so far. To Jane, care and relationship were more important than money. Jane expressed strong negative views on how mainstream medicine treats human beings. She believed that the bond between mother and child could easily be damaged through neglect or lack of respect. Jane’s mother and sister followed “the norm” of childbearing but Jane chose a homebirth like her sister-in-law (p.13). Jane has got to know and trust her midwives; however the differing routines of her backup midwife created a sense of insecurity for her. She felt a little nervous about the impending birth because the classes were very intense, so she focused on what she envisaged as the wonderful feelings at the moment of birth.

Looking back on the birth
Labour began for Jane as she awoke from an erotic dream that ended in ruptured membranes. She spent early labour weeding the garden and walking the driveway. When it got to the point where Jane couldn’t respond anymore Martin became a “bit panicked” and called the midwives (p.17). In established labour Jane moved deeply inside herself where her “hormones took over” (p.18). When the contractions were quick and intense she moved into the bath. She saw nothing negative about this stage of labour but transition was “just horrible” (p.20). Jane was frightened by the personal effort and sense of responsibility that came with the urge to push. Eventually her midwives recognised Jane’s attempts to resist pushing. They negotiated in such a way that her confidence and capability returned. Jane pushed her baby, Heidi, into Martin’s waiting arms and the moments afterwards were “intensely packed” emotionally (p.24). Jane did not want to interrupt the “marvellous family time” afterwards by pushing out her placenta, but she remembered it was important (p.25). When the placenta did come out she was “relieved” she didn’t feel pain (p.25).

In the postpartum
Jane was still getting used to how different her body felt. Her sexuality was less superficial and she felt her relationship with Martin had deepened. She had let go of
wanting her body to be a “certain way” and was less self absorbed (p.31). Jane intuitively knew Heidi’s slow weight gain while being breastfed was “her own way”, but she had to “justify” it to “mainstream health practitioners” (p.27). In providing for Heidi Jane aimed for the middle ground where she considered her own wellbeing along with Heidi’s. Jane felt passionate about birth being positive for others and made a video of her labour available for teaching purposes. As time passed Jane considered returning to work but she found her mothering role more meaningful and resigned from her old job.

5.2.1.2 Elizabeth

During pregnancy
Elizabeth had undertaken some intense meditative practices and was spiritually self-aware. She had also learnt about herself from past experiences of disempowering abusive relationships. In her current relationship Elizabeth felt she and Bob communicated well. Their relationship went through a re-evaluation period in its early stages. Elizabeth considered herself a very sensual person. She nurtured herself by being still and listening to her bodily responses in order to judge her emotional wellbeing. Her self-esteem was high and she displayed no concern over body shape or feelings of depression.

Elizabeth was very optimistic and felt immense gratitude for her good fortune in life. She tried to “just trust” rather than anticipate too much and her body felt strong and healthy (p.40). To Elizabeth hospitals were “impersonal” (p.46). She had a high level of confidence in her capacity to control her health and she felt responsible to her baby for giving birth as naturally as possible Elizabeth said she was pretty confident about labour and imagined pain in relation to past experiences of food poisoning. Nonetheless, she acknowledged that anything was possible. She has tried to be prepared for the “best or the worst” and “accept whatever happens” (p.46).

Looking back on the birth
Elizabeth said nothing when she experienced her first contraction. She wanted to “make sure what was happening” (p.48). As the contractions continued she felt really safe and comfortable labouring at home with Bob, her mother and friends. It took twenty hours of intense contractions before her cervix was half way dilated. At that point her midwife ruptured her membranes and the contractions become even more intense. After twelve
more hours Elizabeth was ready to push. Once she did start pushing baby Allan was born within forty minutes. The whole process was very grounding for Elizabeth, so although it was “so painful, so horrible” she says she stayed “totally focused” on what she was doing and it was “never a negative experience” (p.53). Afterwards though, Elizabeth felt upset because she was too exhausted to push the placenta out without the help of an oxytocic.

**In the postpartum**

Elizabeth was in awe of her body, feeling that she was ‘inhabiting’ it; in charge but not in control of its function (p.61). She enjoyed her milk-producing, menstruating body and noted now menstruation was less painful. Elizabeth’s relationship with Bob had deepened, and whilst her libido was lower she was enjoying sex more. Her baby’s sleeping had become more problematic throughout the postpartum. Hence, tiredness continued to be a major issue and Elizabeth did not feel as fit as usual. With regard to study and work she felt less organised and had “many unfinished things on the go” (p.60).

### 5.2.1.3 Louise

**During pregnancy**

Louise’s first marriage was very insecure and resulted in a traumatic break-up that made her change her life around. She felt secure in her current marriage to Stephen; her passion was renovating their home. Louise’s parents were very giving but also very controlling. She vividly remembered an uncle attempting to “force” himself on her at age 9 but never told her parents (p.65). Louise gained little pleasure from touch and was not very sensual or sexual, although Stephen’s response to her touch made her feel good.

According to the psychometric scales Louise had possible depressed feelings and slight body shape concern. She was moderately optimistic, had moderate self-esteem and had a moderate sense of self-confidence over health issues. Louise was self-critical when things went wrong and sometimes she sought attention by being “sooky” (p.65). Since being pregnant Louise has laughed less because her alcohol consumption has decreased. She has avoided thinking too much about the unknown of her baby’s future. Louise felt scared of out of control situations where “something” could go wrong (p.73). A visit to her doctor made her feel very insecure about her baby’s wellbeing so she purchased a
Doppler machine which she regularly used for reassurance. Louise thought a lot about how she would like her childbirth experience to be and she remained sure that it was bearable pain. She planned a water birth but her doctor was unsupportive. She learnt about homebirth from her chiropractor but had no choice of midwife. During the antepartum Louise’s respect for her midwife lessened because her midwife revealed so much about herself.

Looking back on the birth

Louise knew early labour may go on for a while so she paid little attention to the contractions that occurred during her family Christmas celebrations. Even after her midwife visited and confirmed it was labour Louise really didn’t believe it was labour. Only once her membranes ruptured did she believe it was “really happening” (p.75). Between the intense contractions she would remember “it’s only 24 hours of your life” and “you can bear it” (p.76). She hated having her midwife or Stephen fussing over her. Louise developed no real urge to push and worried about pushing too early, her midwife had to “teach” her (p.78). Then Louise internalised, felt herself energised and dropped into an altered conscious state. But when her midwife said “I can see the head” Louise felt frightened (p.78). Suddenly she was “outside” herself (p.78). She switched into being a detached observer and watched herself give birth to baby Flynn. This outer body experience was not as positive for Louise as the internalised one. She felt disconnected from the birth experience and her son. Sitting outside on a bed pan she smoked her first cigarette in months and relaxed while the placenta was born.

In the postpartum

Louise found the initial postpartum quite unpleasant because her midwife arrived unannounced and was not as understanding as she would have liked. Breastfeeding was unexpectedly painful and stressful. Her baby lost weight, was unsettled and fed continually. The situation only improved once Louise started him on formula and she returned to work part time. By 8 months Louise had weaned but she was “constantly worrying” about Flynn (p.91). Louise had major problems with exhaustion, weight gain and “constant” illnesses (p.89). She was finally diagnosed with Hashimoto’s Thyroiditis and successfully treated. Louise felt “bad” about being less sensual since the birth, but Stephen was “becoming more understanding” (p.95).

3 Hashimoto’s Thyroiditis is an autoimmune inflammatory condition that causes the thyroid to become underactive.
5.2.1.4 Jasmin

**During pregnancy**
Jasmin left home at 15, putting herself through high school and university; she was a well travelled independent woman with high self-esteem. She had no concern over body shape. Having always been bigger than average Jasmin learnt at a young age that being happy with herself and comfortable in her “own skin” was most important to feeling sensual (p.161). She did, however, recognise that in the past she fell into passive “victim” roles with men and felt fortunate that nothing untoward happened (pp.159-60).

Jasmin used anger and violence to protect herself in relationships until she realised she was behaving like her estranged father. Counselling enabled her to find other ways of relating. Jasmin felt little patience for people who “wallow” in things like depression and were not prepared to change; she herself displayed no depressive feelings (p.162).

Jasmin was highly optimistic, yet she despaired of finding the “right life partner”, until she met John (p.161). They married within 5 months and she became pregnant 18 months later. Her relationship with John restored Jasmin’s faith in the “notion of love”, though in many ways they were still getting to know each other (p.162). She felt very safe in this relationship and was less interested in shopping as often as she used to.

Time, to Jasmin, “moved from now to whenever” and she felt more relaxed (p.164). Pregnancy made Jasmin feel more complete and mature. Jasmin was highly confident about health matters. As she held little faith in the medical profession she educated herself and employed a private midwife. Jasmin found it challenging to stop working and relinquish “control of looking after me”; she also worried about her mothering capabilities (p.164). Jasmin had no fear of birth and expected labour to be short. By imaging the pain in relation to food poisoning she imagined her brain would “switch off” and trusted that nature would “kick in” (pp.167-8).

**Looking back on the birth**
Jasmin expected labour to start early but she was 41 weeks when it began. From the first early morning contraction she was “whooping up the event” as if she was holding a party for her attendants (p.169). Contractions eventually became more intense overnight when her membranes ruptured. In the morning she moved into the birth pool as her midwife felt it was “action stations” (p.170). An examination indicated Jasmin’s cervix was 8cm dilated. During contractions Jasmin used her midwife to gain focus, but that midwife became ill with food poisoning. To Jasmin, no one else could help and she felt
fear and panic. By midafternoon it seemed that something was “not going to plan” (p.172). Another examination showed only 3cm dilatation. Jasmin was transferred to hospital for epidural and Syntocinon augmentation. Her cervix did not dilate; possibly due to past diathermy scarring. Jasmin “felt complete disbelief” once she was at the point of needing a caesarean (p.176). Although baby Molly was healthy Jasmin was only able to hold her finger because “she was all wrapped up” (p.177). After the birth John was sent home and Jasmin spent a difficult night in hospital. Within 20 hours of the birth they were all home together and then “things started to go more” as she had “planned” (p.178).

In the postpartum

During the postpartum Jasmin grieved her lost birth plan and the lack of skin to skin contact with Molly. She loved breastfeeding and became “completely lost in the Molly world for many months” (p.185). On the outside Jasmin did not feel as attractive as before but her sexuality had shifted in intensity so that touch with John was more pleasurable. Life for Jasmin was busy and full of financial uncertainty, but Molly was “what life’s really about” so she was looking for a more family friendly job (p.186).

5.2.1.5 Gina

During pregnancy

Gina saw herself as insightful about her own feelings. She believed that people were created equally. While it might seem that one person had more than others, Gina’s view was that “digging deeper” usually revealed other things were lacking (p.193). To Gina there was no certainty in life because ultimately there was an “element of control” that was “out of your hands” (p.193). Hence, she displayed only a moderate level of optimism and only moderate confidence over her capacity to control her health. In the past she had experiences that led her to question her self-trust and belief system; while this was a “hard lesson” she was stronger for it (p.196). Nonetheless, Gina tried to be in control as much as she could be and had a self-protective element to her personality that did not trust people at face value. Her self-esteem was high and she had no evidence of depressed feelings.

Gina believed wellness was about keeping her “heart and soul happy” so that she could keep her body well (p.193). She had no body shape concerns, was very fit and drew power from physical exertion. However, she stopped cycling because her changed
bodily boundaries made her feel vulnerable and protective of herself and her baby. Feeling connected with the earth and her environment was also important to Gina. She planned to give birth at her mother’s home which was the home she grew up in. Her views on childbirth were very different from the midwives with whom she worked, but rather than be directed by other people Gina was determined to plan her birth as she chose. She also found it difficult to meet the expectations of Riley’s parents and this was made more challenging as her mother-in-law was dying of cancer. Gina’s focus was on herself as a person and not on her baby at all costs. Although she arranged a homebirth she did not expect it to be easy. She aimed to protect herself from taking things for granted by being stoic. Gina did worry a little about the possible intensity of labour but made “peace” with her lack of control over the situation (p.196).

Looking back on the birth
Soon after Gina’s labour started Riley had an asthma attack and labour just turned off. This experience reminded Gina that her sense of feeling safe was important. Labour began again a week later and she enjoyed being looked after by Riley, her mum and a midwifery student. She felt herself become “really primal” and time lost all meaning (p.208). Her own midwife was unavailable but another midwife arrived and to Gina that meant she really was in labour. As the intensity increased Gina felt her mind “totally shut off” (p.210). Yet by connecting with her mother Gina was also able to be focused to push and not be lost in the pain. The whole of labour felt like a letting go. Gina was also aware that pushing was physically hard work that she just “had to get in there and do” (p.211). When baby Vicki was born into Riley’s waiting arms Gina felt “amazed” by all Vicki’s potential (p.212). Gina wasn’t looking forward to the placenta and she did not enjoy the feeling when it was born.

In the postpartum
After the birth Gina wanted to “hit the ground running” and attended uni within the first week (p.217). Although she did modify this approach she had no regrets and eventually juggled work and study with mothering. Gina saw herself as very changed from the birth and from mothering, but in many ways she did not look at things “much differently” (p.227). The death of her mother-in-law and financial concerns strained Gina’s maturing marital relationship. Breastfeeding was harder than expected and Gina experienced oversupply problems and thrush. Her body was “a bit saggier”, but she saw
such body image concerns as superficial and over time Gina’s pre-birth feelings of sensuality returned (p.220).

5.2.1.6 Maree

During pregnancy
Maree was part of a Christian household of eight adults who undertook local voluntary work. They were beneficiaries of a bequest that allowed them to move onto a country property which they did within a year of Maree giving birth. As a practising Christian Maree saw that she was not in control of what she had in life. She felt blessed that she eventually became pregnant and considered herself lucky to have the opportunity to be connected with the land. Maree was moderately optimistic and had a moderate sense of control over her health. Her self-esteem was high. Maree was confident of making unconventional decisions but shied away from potential conflict. In the past Maree had “bad” sexual experiences where her wishes were not listened to (p.232). The expressions of love and closeness in her marriage were quite different. She felt very comfortable and relaxed in her relationship with Peter and experienced touch as a “mutual thing” that was good to both give and receive (p.233). Maree had no concerns with her body shape and no indication of depression.

Pregnancy taught Maree how much control her body had. There were times where she felt a failure for being inactive and so tired. Such feelings passed quickly when she was able to talk to others about her situation. Maree was often uncomfortable, nauseated and regularly vomited, but because people said she was small the discomfort was also an affirmation that her baby was healthy. She planned a home birth in order to maintain her spiritual integrity and access one-to-one midwifery. Peter was not going to attend the birth as they each saw birth as a place for women. Maree imagined labour pain in relation to past experiences of illness. She thought she would want touch but knew she would have to accept it without trying to return it. Maree was excited about the birth and considered it a physical challenge much like the marathon bike rides she did in the past.

Looking back on the birth
A week before her due date Maree started trickling meconium stained liquor. She transferred to hospital for oxytocic induction. Maree’s first response was not disappointment at the transfer from home, but excitement that her baby would come
soon. It was some hours before her body started to respond to the induction but when it
did it was “quite full on” (p.241). Maree got into a rhythm of “letting go” during the
“full on” contractions and stayed “centred” by making low outward sounds (p.243). She
focused on the image of her husband at home “cheering” her on; she found his belief in
her very empowering (p.244). Though she couldn’t use the shower Maree negotiated
with the hospital staff to have half an hour of monitoring and half an hour of showering.
Maree found the uncaring manner of one obstetrician very distressing but her private
midwife ensured he would not return. The hospital midwives also protected Maree by
keeping her in the shower when that obstetrician returned. Maree’s female friends were
very supportive but her midwife kept cautiously stressing that labour might be long, and
intervention necessary. Nonetheless after only six hours Maree began to push but the
birth was complicated by shoulder dystocia. Baby Patrick was nearly five kilograms and
had Apgar scores of 3 then 8. His resuscitation seemed to take “a long time” (p.249).
Although Maree prayed aloud, she was calm and never thought he would not “survive”,
but the staff convinced Maree to let her baby go to Special Care Nursery (p.249).

In the postpartum
Maree really began to miss her baby as the perineal suturing finished. She insisted on
being taken to the nursery where she got to “really hold him” (p.251). The staff gave no
clear explanation for her baby’s continued presence in the nursery but it took seven
hours before Maree was allowed to take Patrick out. The panicked reactions and
manipulative behaviours of hospital staff caused Maree to become distrustful of them;
she cautiously returned home with her baby that evening. Maree heard how her support
people found the birth quite frightening and became concerned that she had traumatised
them. This concern was resolved when Maree’s private midwife held a joint debriefing
session. Maree felt supported by her midwife to breastfeed and look after herself “in as
natural a way as possible” (p.253). Initially Maree described her identity as quite caught
up in being a mother. She gradually broadened her focus beyond mothering alone and
came to enjoy the feelings of being independent. Maree continued to be amazed at how
well her body functioned, but was aware that she had to work harder at pelvic floor
exercises and at staying fit. Now Maree experienced a deepened sexual relationship
with Peter and she felt highly sensual.
5.2.2 Three women planned birth in a birth centre

Dawn, Leanne and Emily planned to give birth in a public hospital birth centre. Dawn and Leanne each employed a private midwife to attend during the birth. Their private midwife also provided the majority of their antenatal care. They had additional antenatal visits with various birth centre midwives and attended the hospital childbirth education classes as well as private classes. Emily, a midwife, attended no childbirth education classes but did do yoga and antenatal water classes. She saw her usual doctor and the birth centre midwives for antenatal care.

5.2.2.1 Dawn

During pregnancy

Dawn’s psychometric results showed she was moderately optimistic, highly self-confident about her health and had moderate self-esteem. Dawn grew up without a father and had learnt from her mother’s relationship mistakes. On one occasion she had to protect her younger sister from her abusive step-father. Dawn always chose partners very carefully because she refused to be with anyone who was constricting. She found that it took courage to stop bottling up her emotions in her relationship with David. Dawn never felt sexy or hugely attractive. She was quite self-conscious of and concerned about her body shape; she would like to be slimmer. She loved giving and receiving massages and hugs.

In the past Dawn had counselling for depression. She blamed herself for every failure and once even felt suicidal. She still had “bad days” but did not necessarily expect bad things to happen to her (p.98). Now, if things kept going wrong she looked at her approach to life because “sometimes a person’s attitude can cause things to go wrong” (p.101). She did, however, need people’s responses to know if she had done a good job. In pregnancy she was actively being positive, felt much better about herself and used tapestry to shut her “crazy mind off” (p.98). Dawn disliked the system of medical control in hospitals. In her view, hospitals and doctors were counted on for a lot that was unnecessary. Labour was natural, Dawn believed, so she wanted no intervention unless it was really needed. Her confidence was “shattered” though, by an obstetrician who threw doubt on her capacity to grow her baby and give birth (p.104). She wanted to have her baby at home but negative family pressure and David’s discomfort led her to compromise with a private midwife and birth centre. Dawn was concerned about her
complacency surrounding childbirth and thought she would have to “talk to someone” in the event of the “worst case scenario”, a caesarean (p.106).

**Looking back on the birth**

Dawn laboured at home until her membranes ruptured at seven centimetres dilatation. She knew that if she wanted to do it her way she would “have to do it” and not the “machines and medicine” (p.107). By focusing “deeply inside” for every contraction she felt “a strength and a power” as well as the pain (p.108). When she arrived at the birth centre with David and her private midwife Dawn had a strong pushing urge, but dilatation was still seven centimetres. She kept her eyes closed so she could “control the pushing” at the same time as “continuing to feel the pain as an empowering pain” (pp.109-10). After five hours there was no change in dilatation and meconium had appeared in the liquor. She transferred to the labour ward where Dawn had an epidural and oxytocics. Dawn no longer felt “grounded” and as she tried to stay calm the tears started; she felt “defeated” (pp.110-11). Seven hours later she was fully dilated but too exhausted to do without the epidural. She “wasn’t getting anywhere” pushing and was taken to theatre for a forceps delivery (p.112). The forceps were unsuccessful and her mind went blank when a caesarean was mentioned. She felt “crushed” and was a “blubbering mess” (p.113). She was grateful though, that the labour was finally over and she could meet baby Alex.

**In the postpartum**

Dawn hated her stay in hospital. She was encouraged to rush breastfeeding because Alex required phototherapy. After four days they went home. Dawn recovered well physically and attempted to maintain her positive mental focus. She felt unprepared for the high level of attachment and dependence involved in breastfeeding so she weaned after three weeks. Three months later Dawn still felt guilt about weaning and had sleepless, tense nights thinking about her birth experience. Her fears focused on not being like her own mother. Six months on Dawn was hospitalised with severe postnatal depression. Until this hospitalisation Dawn felt she needed someone to be a mother to her and felt resentful of Alex. Now Dawn was more accepting of her mother and forgiving of herself. She was, however, still angry at the antenatal obstetrician who threw doubt on her abilities to grow and birth her baby. Dawn was starting to feel an overwhelming love for Alex and she cuddled with David a lot more, although she still said ‘no’ to sex.
5.2.2.2 Leanne

**During pregnancy**

Leanne saw herself as lucky to have been encouraged by her parents to be anything she wanted, which meant she was independent by the age of twenty-one. Leanne believed that although fate and luck played a part in life, a lot could be controlled, so she chose a positive approach to life. Describing herself as a “pretty cruisy” personality, Leanne was tolerant of variations in lifestyle and enjoyed today rather than tomorrow (p.132).

Leanne’s psychometric results indicated no concerns with her body shape or with depressive feelings. She had high self-esteem and was a highly optimistic woman who was very confident with regard to her health. Her “inner core” had stood her in good stead through hard times, particularly when she and John went through a serious re-evaluation of their relationship (p.132). Leanne was emotionally expressive and saw her sexuality as built around her need to communicate. She recognised that there were health consequences to being “wound up” over life events so did yoga to change her stress responses (p.130).

Becoming pregnant affirmed to Leanne that her way of life was a healthy one. But she was concerned that family and friends often said she was small. Recently she spent a day “howling” over her weight and the forthcoming life changes, now she felt much better (p.136). Leanne planned to give birth at a birth centre and employed a private midwife who reinforced that anything was possible. Her midwife took a significant role in steering Leanne through a “middle ground” between the natural and the medical models (p.135). Though she was not currently feeling scared, Leanne anticipated that she may do so once labour began. The presence of her midwife would allow her to stay home in early labour until it was time to go to the birth centre.

**Looking back on the birth**

Having reached her due date Leanne had the feeling that something may happen soon. Early the next morning she had a show, but she knew it could still be days. Contractions soon started and quickly got longer, stronger and closer. Once she acknowledged it was labour she felt “a letting go” (p.138). Leanne was consumed with the contractions; it was a very “in body experience” (p.139). She channelled the pain out of her body by focusing on using sound during expiration. When the contractions moved to another level of intensity she felt a bit panicky and knew she had to rush to the birth centre. There was no time to ring her private midwife. She felt calmer once in the car although
the desire to push was strong. Paperwork was meant to be done but her “bellowing in
the reception area” convinced the administrators that she “needed to go right now”
(p.140). As she stepped out of the elevator and heard the voices of midwives she felt
herself “melting another layer” (p.141). Once in their company Leanne felt safe enough
to start pushing. Baby Rose was soon born into John’s arms. The speed of Leanne’s
labour was overwhelming; in comparison giving birth to the placenta was easy.

In the postpartum

After one night at the birth centre Leanne felt confident enough to return home. She
enjoyed “letting the experiences unfold” at home, but as “things were new and
changing” Leanne also appreciated the reassurance of her visiting midwives (p.145).
Leanne savoured the time she had to focus on parenting. Eventually she resumed work
and found she was not nearly as ‘busy in the head’ as she used to be. Seven months after
Rose’s birth Leanne was pregnant. Breastfeeding became painful and the tiredness and
nausea of pregnancy combined with parenting and work were challenging. Leanne
experienced a brief period of “flatness” as she grieved for the two months of indulgence
she had expected before getting pregnant again (p.153). Leanne’s sense of feeling “trim
and healthy” had also been eroded by the tiredness (p.151). John helped her feel like
herself again and she was actually quite pleased to have become pregnant without
having to think about it.

5.2.2.3 Emily

During pregnancy

Emily liked to be organised and in control but she also acknowledged that, whether
through “luck or fate or divine intervention”, she did not have control over “everything”
(p.318). She was actually pleased that total control was impossible because she would
be “really anxious with so much responsibility” (p.318). Nonetheless, Emily was sure
about the things she believed she could control and did everything to make them
happen. She was moderately optimistic, had high self-esteem and was moderately self-
confident about controlling her health. Her sense of self came from her heart so Emily’s
responses arose from feelings. She was touch orientated and did yoga and meditation.
Her sense of intuition about a situation came from both her own body and the other
person’s body language. When she was not dealing well with something Emily became
aware of her bodily responses and had to remember to listen to herself. Emily currently
had no depressed feelings but she had been through unhealthy periods where she had linked her identity to doing things for people. This unhealthy perspective would result in her looking after the other person’s needs rather than her own. When she was a teenager she was manipulated into sex and the associated guilt, as a Catholic, felt terrible. She had been in other relationships where she felt she was inauthentic to herself. Emily felt safe with Graeme, although sometimes the relationship was stressful which made her feel reflective and sad.

For Emily pregnancy created a powerful feeling of graduating into womanhood. She now thought of life in terms of stages and not just “success marks” (p.322). Emily nurtured herself by shifting her focus toward connections with people and the “wholeness of life” (p.323). Her friends were very practical, reasonable and grounding for her. Now she was pregnant Emily had a slight concern about her body shape because going up three bra sizes was “difficult to deal with from a practical perspective” (p.319). While Emily considered the birth important, her philosophy of parenting was more so. But Emily knew the reality of how midwives and hospitals work so she was cautious. Rather than choosing a local hospital, Emily chose a birth centre in the city because of their philosophy of practice. The midwives had been very inclusive of Graeme so she felt she had made the right choice.

**Looking back on the birth**

Emily found it challenging that labour did not start until 42 weeks. Her “midwives” and doctor’s faith” combined with her own “faith in myself” got her through (p.331). When labour did start her liquor was stained with meconium so she was transferred from the birth centre. In the labour ward Emily felt trapped, “quite defensive” and unable to trust the labour ward midwife (p.333). Emily agreed to have labour augmented but also negotiated to have a birth centre midwife. Emily’s steady progress through labour combined with a trusting relationship with this midwife enabled her to feel more secure and less trapped. The contractions were “hard going” in transition (p.338). But Emily also found it “refreshing” that she could still think (p.338). She trusted her body to tell her what was happening but she had no sense of “total surrender” to the process, what she did do was to go “down” into herself (p.339). When she became aware that the birth was complicated with shoulder dystocia, Emily realised no one else could effectively help. She focused thoroughly on opening up her pelvis. As baby Sarah was born Emily’s primary sensation was a sense of relief that she had “done it” and Sara was
“OK” (p.342). Sarah’s breathing was fast but settled when she was cuddled. Emily was grateful that the doctor was “open” to the positive effect of touch and did not insist on Sarah’s transfer to the nursery (pp.342-3). Emily felt a “time pressure” to have the placenta out so she agreed to an oxytocic injection (p.343). The new family was then able to go back to the birth centre for two nights before going home.

**In the postpartum**

Associating her choices with feminism Emily approached the postpartum by choosing to do anything she wanted relative to Sarah’s needs. But by the end of 6 weeks she was tired, had experienced endometritis and nipple thrush. Now she saw that women need nurture after giving birth and she had more empathy for women “juggling their lives around children” (p.348). Emily’s post birth experience was marred by her mother’s death and a rift with her family. She felt depressed and “emotionally numb” at times which in turn created stress that impacted other areas such as her return to work (p.344). The past month of antidepressant treatment enabled Emily to find a sense of security and self-trust as she sorted through her changing sense of self. Although her libido was low and she felt more dependent on Graeme than in the past, Emily felt her body had taught her much by going through birth.

**5.2.3 Five women planned birth in hospital**

Patricia, Celeste, Michelle, Helen and Lisa focused their plans for childbirth on hospital. They all lived in provincial cities and had access to one large public hospital or one private hospital. Lisa had private health insurance and was able to go to a private hospital. Her sole caregiver was her private obstetrician although she did attend the hospital’s antenatal classes given by midwives. Helen also hoped to attend the private hospital and chose an obstetrician who employed a midwife to give antenatal care. Having commenced this plan of care Helen found her insurance didn’t cover obstetrics. She changed to the public hospital and chose to have her remaining antenatal care through their midwives clinic. Celeste and Michelle also attended the public hospital and both had the opportunity to have most of their antenatal visits with midwives. Patricia had the majority of her antenatal care with her usual doctor. She was already in the public hospital with ruptured membranes when she had her first interview. Helen, Celeste and Michelle each attended the public hospital childbirth classes. Patricia attended no childbirth education sessions.
5.2.3.1 Patricia

During pregnancy
Patricia was not afraid to be expressive but did not consider herself creative. Her psychometric scores indicated she did not feel depressed. She had high self-esteem and was confident about her capacity to control her health. Although her scores indicated moderate optimism, Patricia tended not to expect the best so as to not get her hopes up. A previous relationship was with a fitness instructor who was mentally abusive and made her feel “fat” although she wasn’t (p.268). She had no current concern over her body shape. Her first kiss with James was like a “comfort zone” that was “right” and changed her life completely “what with the baby” (p.269). Their relationship was very open and she felt good when she made James feel good. She decided to stop having sexual intercourse for fear of her baby and was very scared of sex after the birth. Patricia sometimes felt unhappy and lonely because her family and many of her friends live some hours away; she knew she needed other people as well as James.

Patricia’s first three antenatal months were very stressful because of pressure from her family to have the pregnancy terminated. Although her family said they loved her she felt a “sick feeling” of being different and that her baby would not be accepted (p.270). When she “stood tall” and said “no” Patricia began to feel accepted (p.270). She said that now, “everyone is really happy” with the decision she made (p.270). Since being pregnant Patricia felt really “grown up”, but being in hospital with ruptured membranes since 34 weeks left her feeling bored, frustrated and worried about what had happened (p.273). Patricia still hoped to have a normal birth although she knew little about the process. She did not deal with pain “too well” and therefore worried what people would say because she may “make an idiot” of herself by swearing too much or yelling (p.275). Patricia was looking forward to labour, though, because at the end was the baby; she dreamt of doing the whole “movie thing” of cuddling her baby straight away (p.275).

Looking back on the birth
Patricia began leaking fluid at 34 weeks so she expected to go into labour early. Each week of waiting in hospital she “psyched” herself up for the pain with the promise of a baby (p.276). Patricia went through a number of unsuccessful and very disappointing inductions between 37 weeks and 39 weeks. She felt “useless” that she “couldn’t deliver this baby”; she wanted her body to “do it” but “it wouldn’t” (p. 276). This created a
“kind of anger” toward herself (p.276). After one failed induction she was sent home where she felt like she would “have this thing” in her forever (p.278). During the last induction Patricia feared for her baby’s safety to such a degree that she requested a caesarean. Although the hospital staff agreed with her decision, the obstetrician did not so she had to be very insistent. To Patricia the process of having a caesarean was frightening and quite embarrassing. As baby Leigh was placed on her chest she felt the “overwhelming love” she had dreamt of (p.281). Four days later she was at last home with her baby.

In the postpartum
Patricia loved breastfeeding although she believed Leigh was not getting enough milk because he awoke two hourly and wanted to be held. Her maternal and child health nurse insisted she continue, but Patricia did not like being told “what to do” and weaned (p.285). There were some days where Patricia felt “yuck” about her body, but she thought, “I’ve had a baby, I’ve got that excuse” (pp.285-6). She did regain some body confidence and enjoyed cuddling with James, though still did not feel “100% sensual” (p.290). Patricia still worried about what people thought and really just wanted to feel accepted. Rather than returning to factory work Patricia would like to do something different but was too frightened to try because she was “one of those people that start things and never finish them” (p.288). She did think she must be doing “something right” as Leigh was learning many different things (p.289). Patricia was very tired and that became compounded with worry if Leigh was “a little bit sick” (p.287). When reflecting on the birth Patricia’s sense of disappointment sometimes returned; she did not want a caesarean, but ultimately her baby was more important.

5.2.3.2 Celeste
During pregnancy
A year ago Celeste and Henry broke up and Celeste was evicted from the house she rented. At the time everything felt “crumbled”, “black” and bad for her (p.293). But Celeste made some changes and picked herself up again. She underwent a lot of growth in a short period: she purchased a house, got back with Henry, and became pregnant. Celeste now felt quite secure and comfortable with Henry whereas in other relationships she had felt forced to have sex. Around strangers Celeste was not good at expressing emotions. She became self-critical when her emotions were negative but Celeste had
high self-esteem, was moderately optimistic and highly confident with regard to her health. She was unconcerned about her body shape and had no depressive feelings. Seeing her extended family brought happiness and made her feel “real” (p.293). Such happy feelings were part of the meaning she saw in life; she said other meaningful parts of life included sadness and death.

Since becoming pregnant Celeste was aware of her existence revolving around “substantial stuff like making a meal” (p.295). She had been getting in touch with her body and tried to listen to herself. But she was still pretty shy about “the whole naked thing” (p.293). Her focus was on having a healthy body and feeling mentally good about herself. Following a recommendation from her doctor Celeste attended the hospital’s midwives clinic. She was surprised to learn that a doctor may not be at the birth. Celeste liked the idea of only having midwives because they were “specialists in natural birth” (p.297). Her only fear was that the baby was not born alive; listening to the heart beat was reassuring. Celeste had read thoroughly about birth and wanted to be active during labour. Although she was taking care not to be idealistic about the process she was looking forward to labour and meeting her baby.

Looking back on the birth
Celeste had five hours of early labour contractions at home and left for hospital when she felt she “needed” to be where she was going to have the baby (p.299). Once she arrived labour didn’t stop as she had feared. Celeste relaxed into “knowing” that she was in labour and would not have to relocate again (p.299). She felt safe in hospital but she did not find it a comfortable place to be. The pain of labour was a shock to Celeste and yelling helped her to let go. She found the increasing pain was easier to manage with the midwives who were prepared to remain focused on her rather than on merely saying encouraging words. Henry’s consistent presence also enabled Celeste to feel secure. She maintained her determination through the exhaustion and pain but when the midwife offered to rupture her membranes Celeste agreed. “Instantly everything changed”; she felt her “body letting go and the baby coming” (p.305). The medical staff were watching the clock but the midwife kept them out and “told a little fib” about dilation (p.305). Celeste remained focused on pushing and after 20 minutes baby Max was born. She barely remembered the needle that brought on the placenta but found the placenta “good” to look at (p.306). The new family went home after two days spent altogether in a double-bed room.
In the postpartum

In the months after the birth Celeste felt quite challenged by the “whole mum thing” (p.312). She reflected on the first two months as being a time of “absolute confusion” about who she was (p.317). Now she saw herself as more mature and womanly. Rather than being busy socially and with work, she was a lot more “domesticated” (p.311). Some stories and events left Celeste feeling “so much more compassion” than she did before Max’s birth (p.316). She also felt “older” physically, more achy and less fit (p.314). Her pride in her looks was reduced, although she was more comfortable generally and sexually with Henry; their relationship was now deeper and less stressful. Celeste was not so concerned with the things people said and believed that she would concentrate on her job far better. Underneath her tiredness and body image concerns she did feel “stronger and more confident” as a result of her birth experience (p.311).

5.2.3.3 Michelle

During pregnancy

Although Michelle was not very outgoing she was confident at work and had quite definite ideas. She was also confident with regard to control over her health. For the past five years Michelle has taken antidepressants for minor depression. Her mother and sister also had depression. Michelle’s psychometric results were indicative of her depressive feelings; she had only moderate self-esteem. Plenty of people had made Michelle feel bad about herself; she felt unsure of what people thought of her and was quite self-conscious. Michelle had a tendency to give “too much” to friendships and could date her initial seesawing emotions from the manipulatory behaviour of a close friend (p.362). Michelle had slight concern over her body shape, but her body image had never been “great” and Brett was the only person she allowed to touch her (p.358). She was moderately optimistic: while she may expect the best she tended not to think too far ahead so as to avoid stress. Brett was good at snapping her out of feeling stressed; their relationship was very strong and close. He had a chronic stomach illness that caused him to “throw up” when stressed; Michelle was quite protective of him (pp.366-7).

Fear of childbirth had stopped Michelle from having children earlier. Michelle was frightened by forceps and the lack of privacy horrified her. She heard an imitation of the sounds of labour and felt physically sick. Her hope was that she did not scream in
labour. By deliberately reading little about birth she avoided thinking about it and limited her stress. She found out about water birth from the internet and hoped to have one in order to avoid an episiotomy. Despite her fears Michelle was pretty amazed by her body’s capability. She had been reassured by the hospital’s midwives that regardless of her knowledge her body would know what to do. Michelle reasoned that millions of women go through labour, plus she would get a baby out of it; she thought that she could put up with anything for a day, and drugs were always available.

Looking back on the birth
Michelle finished work at 37 weeks with the expectation of having three weeks off in which to “get organised” before the birth (p.365). One day later her membranes ruptured. She was not pleased. Brett became sick as soon as she told him so she drove herself to the hospital. Although she had no contractions Michelle was not allowed home. After some delays she was admitted and expected to be induced in two days. That night she continued to wake with feelings of discomfort. This was not how she imaged contractions to be and the staff told her to stay in bed and rest. Although Michelle became progressively more uncomfortable she kept silently dealing with it. Morning came and a midwife sat with her reminding Michelle that it was only early labour. Soon Michelle got to a point where she could no longer stop herself from making pushing sounds. The midwife was “horrified” and “quickly” transferred her to labour ward (p.373). Once Michelle knew how far along she was, her pain and sense of panic diminished. Brett arrived and mopped her brow. She focused on her body, on what was happening and on the midwives. While her brain “sort of” stood back and watched she felt her muscles push down deep inside her body as she made strange involuntary sounds (p.375). “Apparently” the doctors were ready to “do something” as Michelle was “taking a while”, but the midwives asked them to wait (p.377). Finally, Michelle felt relief from the pain as baby Dawn was born. The placenta came quickly and that felt good too. She felt energised when she later she walked from the labour ward back to her room.

In the postpartum
Michelle returned to work within a week because “they needed me”, but that was a “bad move” (p.381). She had to “learn how to say no” to work despite her financial difficulties (p.390). Breastfeeding was a challenge with continued nipple pain and supply problems, but Michelle was determined to persevere. She also had no choice but
to be responsible and deal with the stress of Dawn needing an inguinal hernia repair. There was little time to get depressed, although Michelle did have mood swings and at times she missed taking her antidepressants. When she was depressed she tended to feel a “build up of inner anger” about herself, her partner, and at “things” not going the way she wanted them to be (p.392). Michelle was less self-conscious and a little more confident with her body. She continued to feel pain on intercourse so avoided close physical contact with Brett. Although they communicated in other ways, not having that intimate contact made Michelle feel more alone and upset. They were, however, “closer in a different way because of Dawn” (p.387).

5.2.3.4 Helen

During pregnancy

Helen’s psychometric results showed moderate confidence about controlling her health, high self esteem and no depressed feelings. Helen identified herself as highly self aware but severely lacking in self acceptance. The present was full of doubt and impossibility to Helen, whereas the past showed her who she was, what she had accomplished and how she had overcome situations. Self-analysis was one of her coping strategies. She could be hot tempered and quite harsh. Yet her fear of rejection and need for attention meant she would create situations that gave reinforcement; sometimes it was even good to be sick. Helen saw that she was really the only person that stopped her from making decisions. While she might want to be a better person she was not motivated to actually do anything to change. Nonetheless, Helen looked for beauty in the everyday aspects of life. She was moderately optimistic and purposefully created positivity within herself as well as her relationships so as to feel accepted. Security had been her most important life focus and it was upper most in her choice of Bob as partner. Helen did not consider herself a sexual person and found cuddling with Bob in front of the TV most nurturing. To Helen, Bob was quite sensitive. Her hope was that they would satisfactorily redefine their relationship after the birth so that he would still feel special.

Helen would naturally take an average size in clothing but she had never been able to control her size and was now an extra, extra large size. Pregnancy was somewhat liberating and Helen felt really positive about her body image although her psychometric results still indicated concern. She had “gone off” touch quite a bit lately because “everybody” seemed to pat her which made her feel like an object (p.403).
Chapter five - Results: Individual changes

Helen felt empowered and capable since becoming pregnant; it had also taught her that if she had a positive attitude she could handle things well. She was not particularly concerned about labour as it was “too surreal” and she believed she had little say over it (p.407). As a Catholic though, she saw that God would not give her anything she couldn’t handle. She knew the body was amazing and she approached labour with a firm belief that her body could do it. Though she respected doctors as people, Helen did not necessarily respect them as doctors. She was less argumentative with midwives and respected their knowledge more because it felt “natural” (p.404). She did not want to labour in a room full of strangers so she attended the midwives clinic and hoped for a natural birth.

Looking back on the birth
Helen’s “earthmother” birth did not eventuate because her blood pressure rose and she had an induction (p.411). Although the medicalised environment was depressing she turned it into her own space through nurturing interaction with all who entered her hospital room. This strategy helped Helen feel more in control of the people around her, most of whom were unknown to her. She used visualisation and a mantra of “this too shall pass” which blocked out the world around her so she could manage the pain (p.411). Although nothing took the pain away she continued to expect the pain to be worse than it was. Helen did not feel supported by the hospital staff to actually labour without intervention. Every time they offered an epidural she felt a challenge to her power. After 11 hours, feeling exhausted and wondering if she really could keep going she succumbed to the offers of an epidural. After the epidural Helen’s cervical dilatation increased quickly and following a sleep she was told to start pushing. She found her bodily signals to push became confused by the mental directions coming from the staff. Helen felt vulnerable to and anxious about her caregivers’ focus on time. With determination Helen resisted the caesarean most of the staff thought she should have. She managed to give birth to baby Grace with the assistance of forceps. Soon after, she felt the “slippery sensation” of the placenta’s birth (p.420).

In the postpartum
Helen’s baby was jaundiced on day three and spent a day having phototherapy in the special care nursery. Although Helen understood intellectually that she did not cause this jaundice, she retained a sense of blame about it. Once home Helen felt “positive” and saw “everything as a challenge”, but she became exhausted and questioned her
abilities (p.421). A visit from a nurse reassured Helen that she was “doing everything right” and was just “a little premature” in “saying it’s not working” (p.421). Helen’s body image had returned to the low pre-pregnancy level that reflected the dislike she had of her body. She also had continued problems with her episiotomy and required treatment for a fissure. Her relationship with Bob had not needed redefinition as she feared and they were learning to be parents together. Sex was still not a big part of their relationship but touch was very special. Helen’s changing roles confused her confidence in who she was and what she wanted. She was also stressed by the closure of Bob’s business, his depression and her return to work. Helen felt “really resentful” that the crèche had not been particularly supportive of her breastfeeding (p.428).

5.2.3.5 Lisa

During pregnancy

Lisa saw herself as a “planner” rather than a spur of the moment person (p.432). She did not consider herself very creative but was good at expressing herself, particularly through touch. To her, touch could create a caring connection that made Lisa feel good about herself and gave “real warmth” to people (p.432). The worst feeling Lisa ever had was when her sister committed suicide two years ago. She had had many happy feelings too; Lisa felt overwhelmed with happiness during her wedding ceremony. Now seven years later her relationship with John was good and Lisa felt secure. Listening to the baby’s heart beat together was amazing and brought them even closer. Lisa tried to respond to her body and “do the right thing by it” (p.431). She felt fortunate to have inherited healthy genes. She was confident about looking after her health, had high self-esteem and was optimistic. Lisa had no depressive feelings but had a slight concern about her body shape. Usually she did a 1.2km sea swim each year, but not this year. It was a revelation to her that she had to slow down her physical activities.

Lisa was pleased with her changing shape and felt “sort of special” that she was able to be pregnant (p.436). She found it “unnerving” when people looked down at her belly to check her out (p.435). Lisa had chosen her obstetrician and hospital on recommendations from work mates. Her obstetrician was disappointingly impersonal but Lisa was pleasantly surprised to find the hospital birth room was not a sterile environment but more like a motel room. She had no specific plans for the birth and had done little preparation for labour except attending antenatal classes which she found
quite repetitive. Childbirth and the pain did not really worry Lisa, although she might want pain relief. She was happy for midwives “to deliver” and they told her they would allow her to “go with the flow” and make the decisions (pp.437-8). Lisa’s main concern was coping with the length of labour, but she was not worried for herself, her main hope was to perform well enough that the baby had a good birth. She was apprehensive about not knowing what to expect with the labour. Lisa also worried about whether parenting would come naturally as she had no experience with babies.

Looking back on the birth
After a show Lisa checked with the hospital who told her labour might be weeks away yet. She had a feeling that something would happen soon and felt nervous. When her membranes ruptured that evening she was sure it was the real thing and was relieved that the hospital said to come in. In hospital Lisa only had minor contractions. She was given an IV and antibiotics. Her baby was monitored and there was some concern through the night over heart rate fluctuations, though that passed. Lisa was woken early and walked the corridors hoping to move the baby’s head deeper into her pelvis. She found the waiting around very frustrating. Lisa counted this period as part of labour. She was very concerned about the impact of a long labour on her baby’s wellbeing, but she didn’t talk to a midwife about her fears. That afternoon she had an x-ray indicating her pelvis was “fine” (p.442). At last her contractions really got started and many of Lisa’s concerns disappeared. Following four hours of established labour, and with a single dose of Pethidine, Lisa was pushing. She “listened” to her body and to her midwives because she wanted to do “anything” to help it along (p.444). After two hours Lisa was worn out and the baby seemed stuck. It was a struggle to not push while she waited to go into theatre. In that time the baby turned. Until she had the spinal block Lisa felt in a haze, but once it was in the pain went and she sort of “became a normal person again” (p.445). She was determined to have her baby born in the final hour left of that day. With the assistance of an episiotomy, a suction cap and one push Lisa did it and baby Rachael was born. Her placenta had to be manually removed but eventually Lisa, Rachel and John were altogether in her room. That night Rachel slept in the nursery so Lisa could sleep.

In the postpartum
In hospital Lisa and Rachel were gradually left “more alone” by the midwives (p.447). When Lisa returned home it “really hit” that now she had to make decisions herself and
could not just “buzz” for advice (p.447). Breastfeeding was “pretty challenging” but eventually she did it “without it hurting” (p.448). Regular lunches with her “mum’s group” had stopped feelings of being “confined” at home and gave Lisa “more courage to feed” in public (p.452). Lisa found that all her reading had led to expectations rather than helping her to know what was “right”, but she came to realise that parenting was so unpredictable that there “really are no rules” (pp.448, 451). Gradually Lisa got to know Rachael and gained more confidence. Now Lisa saw that she was more “laid back”, flexible and able to go “with the flow” (pp.452, 455). Lisa’s body had returned to “the original” and was all healed (p.454). Her relationship with John had matured and she was now doing some work from home.

5.2.4 Summary

In this section I have introduced the fourteen participants and outlined their experiences in childbearing. Their summaries have given some past detail, identified current experiences and considered future concerns. The women’s antenatal responses to the psychometric scales were also included. These summaries make clear some of the ways that the participants are quite different from each other. I have, however, grouped the summaries according to similarities in their birth plans. In the following section I collectively consider some similarities and differences in the women’s labour, birth and postpartum experiences.

5.3 The Participants as a Group

Participant story and questionnaire results are collectively compared in this section. An overview of each participant’s labour and birth experience is presented in table 5.2. In this table their planned place of birth is compared with their actual birth place and the mode in which it occurred. Summaries of participant’s general postpartum experiences are in tables 5.3-5.6 and their psychometric responses are in tables 5.7-5.8. These tables include each participant’s mode of birth, but show no distinct association across the participant group between birth mode and subsequent postpartum experiences. The tables do, however, indicate the diverse ways that participants experienced change during childbearing.
5.3.1 Labour and birth

For eleven of the participants labour began naturally (see table 5.2, p.206). Lisa, Patricia and Michelle had pre-labour ruptured membranes and antibiotics. Lisa and Michelle came into labour naturally whereas Patricia had repeated unsuccessful inductions. Maree and Helen had labour more successfully induced. Six women considered their labours to be more than 24 hours; of these women Lisa actually only experienced contractions for six hours. Two of those women (Elisabeth and Louise) remained at home whereas Helen, Dawn and Jasmin had epidurals. Dawn and Jasmin, as well as Emily, had labour augmented intravenously. Meconium liquor prompted Maree, Emily and Dawn to transfer to hospital. Jasmin transferred from home because labour was not progressing. In contrast, Leanne’s labour progressed so quickly she was lucky to make it to the birth centre.

Four participants (Jane, Gina, Elizabeth and Louise) gave birth at home. Leanne was the sole participant who had her baby in a birth centre. In hospital Celeste, Michelle, Maree and Emily had births without intervention. Maree and Emily’s unassisted births were complicated by shoulder dystocia. Two women had assisted deliveries; Helen had forceps and Lisa had a vacuum extraction. Dawn experienced an attempted forceps delivery prior to having a caesarean section. Jasmin and Patricia also had caesarean sections. Of all the participants only Lisa haemorrhaged and required a manual removal of her placenta. All the babies born to participants were healthy although three had short admissions to the nursery for transient jaundice.

5.3.2 Postpartum: general

In the postpartum constant tiredness was of concern to all participants at some stage and most participants also worried about their physical fitness (see table 5.3, p.207). Gina, Lisa, Jane, and Leanne were the only women who did not identify feelings of being overweight as an issue. On the Body Shape Questionnaire (BSQ) four participants registered increased body image concerns. In addition, the antenatal body image concerns of Helen and Dawn persisted into the postpartum. Late in the postpartum eight women had problems with lack of sexual desire and/or loss of sexual enjoyment (see table 5.4, p.208). Two of these women (Patricia and Michelle) were also experiencing pain with sexual intercourse. At their interviews Jane, Elizabeth, Celeste and Emily related this lack of desire to tiredness. The extent to which women enjoyed their own
## Table 5.2: Labour and birth experiences

<table>
<thead>
<tr>
<th>Name</th>
<th>Planned Place</th>
<th>Actual Place</th>
<th>Labour length</th>
<th>Labour comment</th>
<th>Birth</th>
<th>Third stage management</th>
<th>Perineal damage</th>
<th>Birth/baby comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane</td>
<td>Home</td>
<td>home</td>
<td>6-12 hours</td>
<td>Initially lacked the will to push</td>
<td>vaginal</td>
<td>expectant</td>
<td>tear</td>
<td></td>
</tr>
<tr>
<td>Elizabeth</td>
<td>Home</td>
<td>home</td>
<td>&gt; 24 hours</td>
<td>ARM</td>
<td>vaginal</td>
<td>active</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Louise</td>
<td>Home</td>
<td>home</td>
<td>&gt; 24 hours</td>
<td>Nitrous oxide/oxygen gas used</td>
<td>vaginal</td>
<td>expectant</td>
<td>tear</td>
<td></td>
</tr>
<tr>
<td>Dawn</td>
<td>BC</td>
<td>hospital</td>
<td>&gt; 24 hours</td>
<td>No progress beyond 7cm and meconium liquor; restrict to bed; Monitor; IV, epidural</td>
<td>CS</td>
<td>during CS</td>
<td>?</td>
<td>Unsuccessful forceps in theatre</td>
</tr>
<tr>
<td>Leanne</td>
<td>BC</td>
<td>BC</td>
<td>&lt; 6 hrs</td>
<td>Quick labour, no time to ring PM</td>
<td>vaginal</td>
<td>active</td>
<td>tear</td>
<td></td>
</tr>
<tr>
<td>Jasmin</td>
<td>Home</td>
<td>hospital</td>
<td>&gt; 24 hours</td>
<td>Lengthy early labour and little progress; monitor; restrict to bed; IV; epidural</td>
<td>CS</td>
<td>during CS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gina</td>
<td>Home</td>
<td>home</td>
<td>6-12 hours</td>
<td>Booked PM unavailable, other PM for labour/birth</td>
<td>vaginal</td>
<td>expectant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maree</td>
<td>Home</td>
<td>hospital</td>
<td>&lt; 6 hrs</td>
<td>Pre-labour MR and meconium liquor; monitor; IV; TENS</td>
<td>vaginal</td>
<td>? active</td>
<td>episiotomy</td>
<td>Shoulder dystocia; babe to SC nursery for 7 hours</td>
</tr>
<tr>
<td>Patricia</td>
<td>Hospital</td>
<td>hospital</td>
<td>&lt; 6 hrs</td>
<td>Pre-labour MR 34 weeks, bed rest, antibiotics, three attempted inductions; monitor, Prostin, IV, labour never established</td>
<td>CS</td>
<td>during CS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Celeste</td>
<td>Hospital</td>
<td>hospital</td>
<td>12-18 hours</td>
<td>Monitor; ARM</td>
<td>vaginal</td>
<td>active</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emily</td>
<td>BC</td>
<td>hospital</td>
<td>6-12 hours</td>
<td>Meconium liquor during labour, monitor, IV; TENS</td>
<td>vaginal</td>
<td>active</td>
<td>episiotomy</td>
<td>Shoulder dystocia</td>
</tr>
<tr>
<td>Michelle</td>
<td>Hospital</td>
<td>hospital</td>
<td>6-12 hours</td>
<td>Pre-labour MR at 37 weeks, 20 hours before labour established, antibiotics</td>
<td>vaginal</td>
<td>? active</td>
<td>tear</td>
<td></td>
</tr>
<tr>
<td>Helen</td>
<td>Hospital</td>
<td>hospital</td>
<td>&gt; 24 hours</td>
<td>Induction for hypertension; restrict to bed; Monitor; Prostin, IV; epidural</td>
<td>assisted</td>
<td>vaginal</td>
<td>active</td>
<td>Forceps; babe to SC nursery for jaundice day 3</td>
</tr>
<tr>
<td>Lisa</td>
<td>hospital</td>
<td>hospital</td>
<td>&gt; 24 hours</td>
<td>MR 18 hours before labour established, antibiotics, X-ray, monitor, pethidine, &gt; 2 hours pushing</td>
<td>assisted</td>
<td>vaginal</td>
<td>manual removal</td>
<td>episiotomy; Vacuum extraction; spinal block; haemorrhage</td>
</tr>
</tbody>
</table>

**KEY:** BC = Birth Centre; > greater than; < = less than; ARM = artificial rupture of membranes; MR = membranes ruptured spontaneously; PM = private midwife; IV = intravenous oxytocic; CS = caesarean section; SC = special care; TENS = Transcutaneous electrical nerve stimulation; ? = unknown/unconfirmed
Table 5.3: Bodily experiences

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth</th>
<th>Constantly tired</th>
<th>▼condition and/or ▼exercise</th>
<th>Feeling overweight</th>
<th>Body shape concern</th>
<th>Other issues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PN1</td>
<td>PN2</td>
<td>PN1</td>
<td>PN2</td>
<td>overall change</td>
</tr>
<tr>
<td>Jane</td>
<td>Vaginal</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>none</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>Vaginal</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>none</td>
</tr>
<tr>
<td>Louise</td>
<td>Vaginal</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>raised</td>
</tr>
<tr>
<td>Dawn</td>
<td>caesarean</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Leanne</td>
<td>Vaginal</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>none</td>
</tr>
<tr>
<td>Jasmin</td>
<td>caesarean</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>raised</td>
</tr>
<tr>
<td>Gina</td>
<td>Vaginal</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>raised</td>
</tr>
<tr>
<td>Maree</td>
<td>vaginal – s/d</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>slight</td>
</tr>
<tr>
<td>Patricia</td>
<td>caesarean</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>only at PN1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Celeste</td>
<td>Vaginal</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
<td>raised</td>
</tr>
<tr>
<td>Emily</td>
<td>vaginal – s/d</td>
<td>✓</td>
<td>✓</td>
<td>✓✓</td>
<td>✓✓</td>
<td>lowered</td>
</tr>
<tr>
<td>Michelle</td>
<td>Vaginal</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
<td>raised</td>
</tr>
<tr>
<td>Helen</td>
<td>vaginal – ass</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lisa</td>
<td>vaginal – ass</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
<td>lowered</td>
</tr>
</tbody>
</table>

KEY: s/d = shoulder dystocia; ass = assisted; ▼condition = feeling out of condition; ▼exercise = not getting enough exercise; PN1= 3-4 months; PN2 = 7-8 months; ✓ = mild/moderate problem; ✔ ✔ major problem; 1Body Shape Questionnaire (8 item version); 2 concern about tummy, breast and/or stretch marks
Table 5.4: Experiences relating to sexuality

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth</th>
<th>Perineal damage Problems</th>
<th>Dyspareunia</th>
<th>Loss of sexual enjoyment</th>
<th>Lack of sexual desire</th>
<th>Experience of self as sensual / sexual level at PN2</th>
<th>Getting along with partner level at PN2</th>
<th>change</th>
<th>change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jane</td>
<td>vaginal</td>
<td>tear</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Elizabeth</td>
<td>vaginal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Louise</td>
<td>vaginal</td>
<td>tear</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dawn</td>
<td>caesarean</td>
<td>?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Leanne</td>
<td>vaginal</td>
<td>tear</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Jasmin</td>
<td>caesarean</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Gina</td>
<td>vaginal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maree</td>
<td>vaginal – s/d episiotomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patricia</td>
<td>caesarean</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Celeste</td>
<td>vaginal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emily</td>
<td>vaginal – s/d episiotomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michelle</td>
<td>vaginal</td>
<td>tear</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helen</td>
<td>vaginal - ass episiotomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lisa</td>
<td>vaginal - ass episiotomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**KEY:** s/d = shoulder dystocia; ass = assisted; ? = unknown/unconfirmed; PN1= 3-4 months; PN2 = 7-8 months; ✓ = mild/moderate problem; ✓✓ major problem
bodies sensually and/or sexually was exceedingly variable and not clearly related to their type of birth or perineal trauma. At the later time point only Gina and Maree experienced themselves as ‘greatly’ sensual; this was an increase for Maree but for Gina it was a resumption of her pre-birth feelings. Elizabeth, Jasmin and Leanne experienced a reduction in their previously high level of sensuality.

The babies were all considered by their mothers to be generally contented and settled. Nonetheless, the majority of participants felt that their baby’s sleep behaviour presented a mild to moderate problem later in the postpartum. Crying was problematic to Jane, Elizabeth, Helen and Leanne at 4 months; it persisted to 8 months for Leanne, whereas Patricia, Emily and Michelle found crying a mild to moderate problem at 8 months. Partners were identified as providing assistance most of the time. Only Celeste acknowledged that her partner helped infrequently, nonetheless she was one of the participants who were very satisfied with the assistance provided by others, who, in her case, were extended family. At 4 months Lisa was the only participant to be clearly dissatisfied with assistance available from others but this had improved by 8 months.

Two women, Leanne and Jasmin, were clearly dissatisfied at 8 months, primarily because extended family were not as available as they would have liked. All the participants initiated breastfeeding and many experienced some challenges, such as nipple thrush and/or pain (see table 5.5, p.210). Three women weaned during the study period. Patricia believed she had low supply. Louise and Dawn both felt that despite their antenatal education, the reality of breastfeeding was not what they expected.

Participants generally maintained a sense of being independent enough to do what they wanted to do during the whole childbearing period (see table 5.6, p.211). Nonetheless, half the participants experienced some decrease in their overall sense of independence, for five women it was unchanged while Jane and Gina felt more independent. Each participant’s sense of being independent enough to do what she desired did not necessarily follow through to a sense of satisfaction in her current situation. Most participants would have preferred not to return to work. Others found that in returning to work their interest had shifted more toward home than work. For some women, related financial concerns were pressuring them to work. Some participants resisted the financial incentives to return to work (e.g. Jane and Dawn), others negotiated a way to work at home (e.g. Lisa), or they worked for considerably less hours (e.g. Michelle).
Table 5.5: Breastfeeding experiences

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth</th>
<th>Breastfeeding / problems</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-4 months</td>
<td>7-8 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jane</td>
<td>vaginal</td>
<td>✓ no problems ✓ no problems</td>
<td>Baby’s slow weight gain.</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>vaginal</td>
<td>✓ mastitis ✓ no problems</td>
<td>Being run down related to mastitis.</td>
</tr>
<tr>
<td>Louise</td>
<td>vaginal</td>
<td>One feed each evening weaned</td>
<td>Baby’s weight loss, green stools, long frequent feeds, presumed low supply. Felt useless and ill informed by parenting classes.</td>
</tr>
<tr>
<td>Dawn</td>
<td>caesarean</td>
<td>Weaned at 3 weeks weaned</td>
<td>Encouraged to rush initial feeds due to phototherapy. Felt unprepared for emotional and physical demands, despite preparation classes.</td>
</tr>
<tr>
<td>Leanne</td>
<td>vaginal</td>
<td>✓ no problems ✓ nipple pain</td>
<td>Very tender nipples due to baby’s biting and being pregnant again.</td>
</tr>
<tr>
<td>Jasmin</td>
<td>caesarean</td>
<td>✓ no problems ✓ no problems</td>
<td>Breastfed immediately after caesarean. Loves breastfeeding.</td>
</tr>
<tr>
<td>Gina</td>
<td>vaginal</td>
<td>✓ thrush ✓ no problems</td>
<td>A lot harder than expected. Initial oversupply problems, later thrush.</td>
</tr>
<tr>
<td>Maree</td>
<td>vaginal – s/d</td>
<td>✓ no problems ✓ no problems</td>
<td>Had to insist on being taken to give first feed in Special Care Nursery.</td>
</tr>
<tr>
<td>Patricia</td>
<td>caesarean</td>
<td>Weaned at 3 months weaned</td>
<td>Loved breastfeeding but frequent feeds, presumed low supply.</td>
</tr>
<tr>
<td>Celeste</td>
<td>vaginal</td>
<td>✓ no problems ✓ no problems</td>
<td>Cracked nipples in hospital.</td>
</tr>
<tr>
<td>Emily</td>
<td>vaginal – s/d</td>
<td>✓ no problems ✓ no problems</td>
<td>Just ‘knew’ she could breastfeed.</td>
</tr>
<tr>
<td>Michelle</td>
<td>vaginal</td>
<td>✓ nipple trauma, pain thrush, mastitis ✓ pain, low supply</td>
<td>Cracked nipples in hospital. Continued nipple pain and use of nipple shield.</td>
</tr>
<tr>
<td>Helen</td>
<td>vaginal - ass</td>
<td>✓ needed reassurance ✓ low supply</td>
<td>Contradictory advice unhelpful. Crèche was unsupportive.</td>
</tr>
<tr>
<td>Lisa</td>
<td>vaginal - ass</td>
<td>✓ no problems ✓ no problems</td>
<td>Contradictory advice unhelpful.</td>
</tr>
</tbody>
</table>

KEY: s/d = shoulder dystocia; ass = assisted; ✓ = fully breastfed
Table 5.6: Experiences relating to independence and work

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth</th>
<th>Change in sense of independence</th>
<th>Satisfaction with current home/work situation</th>
<th>Related financial concerns</th>
<th>PN2 Non-parenting work</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane</td>
<td>vaginal</td>
<td>slight increase</td>
<td>satisfied (PN2 state)</td>
<td>less</td>
<td>✓</td>
<td>Mothering role more meaningful so chose to resign from old job.</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>vaginal</td>
<td>slight decrease</td>
<td>satisfied</td>
<td>less</td>
<td>✓</td>
<td>Setting up a massage business.</td>
</tr>
<tr>
<td>Louise</td>
<td>vaginal</td>
<td>none</td>
<td>very satisfied</td>
<td>more</td>
<td>✓</td>
<td>Chose to return to work early in postpartum but parenting is main focus.</td>
</tr>
<tr>
<td>Dawn</td>
<td>caesarean</td>
<td>none</td>
<td>very satisfied</td>
<td>more</td>
<td></td>
<td>Mothering is harder and more rewarding than paid work but Dawn feels some guilt about not working. Applied to do part time nursing course.</td>
</tr>
<tr>
<td>Leanne</td>
<td>vaginal</td>
<td>slight decrease</td>
<td>satisfied</td>
<td>less</td>
<td>✓</td>
<td>Savoured time focused on parenting. Feels fragmented working at home.</td>
</tr>
<tr>
<td>Jasmin</td>
<td>caesarean</td>
<td>none</td>
<td>dissatisfied</td>
<td>less</td>
<td>✓</td>
<td>job search</td>
</tr>
<tr>
<td>Gina</td>
<td>vaginal</td>
<td>increased</td>
<td>very satisfied</td>
<td>more</td>
<td>✓</td>
<td>Loves mothering and would rather delay return to work but sees positives.</td>
</tr>
<tr>
<td>Maree</td>
<td>vaginal – s/d</td>
<td>slight decrease</td>
<td>very satisfied</td>
<td>none</td>
<td>✓</td>
<td>Weaves and knits items for sale but focused on home-making.</td>
</tr>
<tr>
<td>Patricia</td>
<td>caesarean</td>
<td>none</td>
<td>dissatisfied</td>
<td>less</td>
<td>✓</td>
<td>Does night duty factory work opposite shift to partner, would like to do a different job. Would love to be at home with baby and do some study.</td>
</tr>
<tr>
<td>Celeste</td>
<td>vaginal</td>
<td>slight decrease</td>
<td>satisfied</td>
<td>none</td>
<td>study</td>
<td>To start back at full time work in 6 weeks. Knows baby will be fine.</td>
</tr>
<tr>
<td>Emily</td>
<td>vaginal – s/d</td>
<td>slight decrease</td>
<td>satisfied</td>
<td>less</td>
<td></td>
<td>Works long hours but no longer works weekends. Very tired.</td>
</tr>
<tr>
<td>Michelle</td>
<td>vaginal</td>
<td>none</td>
<td>satisfied</td>
<td>more</td>
<td>✓</td>
<td>Has learnt to say ‘no’ to work. Only works half a day because focus is on parenting and childcare is too expensive.</td>
</tr>
<tr>
<td>Helen</td>
<td>vaginal - ass</td>
<td>slight decrease</td>
<td>split: satisfied</td>
<td>dissatisfied</td>
<td>less</td>
<td>Initially thought about home when at work and was very tired once at home. Now enjoys job more but finds it difficult being divided between work/home. Feels guilt at leaving baby in childcare.</td>
</tr>
<tr>
<td>Lisa</td>
<td>vaginal - ass</td>
<td>decrease</td>
<td>very satisfied</td>
<td>none</td>
<td>✓</td>
<td>Soon to return to work place 3days/week. She is sure she will cope well.</td>
</tr>
</tbody>
</table>

**KEY:** s/d = shoulder dystocia; ass = assisted; PN2 = 7-8 months; ✓ = yes
Elizabeth, Leanne, Michelle, Helen, Patricia and Emily finding the balance between work and home was noted as difficult. Emily in particular found it exceedingly tiring and questioned whether that tiredness led to depressed feelings.

### 5.3.3 Postpartum: depressed feelings and self-esteem

At least half of the participants experienced some degree of depressed feelings at some point in their childbearing experience. As outlined in table 5.7 (p.213) the Edinburgh Postnatal Depression Scale (EPDS) indicated probable depression for Michelle (antenatally and late in postpartum) and Helen (early in postpartum). EPDS results also indicated that Louise, Patricia, Celeste and Emily experienced depressed feelings. Elizabeth, Leanne, Gina, Maree and Lisa had EPDS scores that were just below those indicative of depressed feelings but that were high compared to their scores at other time points. Their stories substantiated that they did have a degree of sadness, worry, self-blame and/or difficulty coping even though they may not have collectively called them depressive feelings. Michelle’s probable depression was symptomatic of the depression she had had for 5 years. She missed doses of her medication antenatally and again later in the postpartum. At four months postpartum the therapeutic benefit of her medication was evident. Postnatally Helen experienced a return of her pre-pregnancy body image concerns, tiredness and high financial stress. She had high levels of self-blame, some sadness and worries as well as problems coping at times in the postpartum. Emily’s depressive feelings were prompted by the death of her mother but the antidepressant treatment was effective. Dawn had a history of depression before pregnancy. In the postpartum she put up a façade of positivity, but inside she felt no such positive feelings. At 6 months she was hospitalised for severe postnatal depression.

Participant’s self-esteem seemed to be variously associated with their depressive feelings (see table 5.7). At 8 months the self-esteem of five participants (Louise, Dawn, Emily Michelle and Helen) was at a moderate level and the remaining nine women had high self-esteem. The Rosenberg Self-esteem Scale (RSES) indicated an overall decrease in Helen and Emily’s self-esteem whereas for seven women a slight increase was evident that did not register in terms of overall change. This slight increase was possibly indicative of a return to pre-pregnancy levels subsequent to successfully weathering the challenges of the antenatal, childbirth and early postnatal periods. For Gina, this was also the reason for a rise in her optimism and her answers to the Health
### Table 5.7: Depressed feelings and self-esteem

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth</th>
<th>Depressed feelings (EPDS)(^1)</th>
<th>Self-esteem (RSES)(^2)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>AN1</td>
<td>PN1</td>
<td>PN2</td>
</tr>
<tr>
<td>Jane</td>
<td>vaginal</td>
<td>not indicated</td>
<td>high</td>
<td>none</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>vaginal</td>
<td>not indicated</td>
<td>high</td>
<td>none</td>
</tr>
<tr>
<td>Louise</td>
<td>vaginal</td>
<td>possible</td>
<td>not indicated</td>
<td>possible</td>
</tr>
<tr>
<td>Dawn</td>
<td>caesarean</td>
<td>not indicated</td>
<td>not indicated *</td>
<td>moderate</td>
</tr>
<tr>
<td>Leanne</td>
<td>vaginal</td>
<td>not indicated</td>
<td>high</td>
<td>none</td>
</tr>
<tr>
<td>Jasmin</td>
<td>caesarean</td>
<td>not indicated</td>
<td>high</td>
<td>none</td>
</tr>
<tr>
<td>Gina</td>
<td>vaginal</td>
<td>not indicated</td>
<td>high</td>
<td>none</td>
</tr>
<tr>
<td>Maree</td>
<td>vaginal - s/d</td>
<td>not indicated</td>
<td>high</td>
<td>none</td>
</tr>
<tr>
<td>Patricia</td>
<td>caesarean</td>
<td>not indicated</td>
<td>possible</td>
<td>high</td>
</tr>
<tr>
<td>Celeste</td>
<td>vaginal</td>
<td>not indicated</td>
<td>possible</td>
<td>high</td>
</tr>
<tr>
<td>Emily</td>
<td>vaginal - s/d</td>
<td>not indicated</td>
<td>possible</td>
<td>moderate</td>
</tr>
<tr>
<td>Michelle</td>
<td>vaginal</td>
<td>probable *</td>
<td>not indicated*</td>
<td>probable *</td>
</tr>
<tr>
<td>Helen</td>
<td>vaginal - ass</td>
<td>not indicated</td>
<td>probable</td>
<td>possible</td>
</tr>
<tr>
<td>Lisa</td>
<td>vaginal - ass</td>
<td>not indicated</td>
<td>high</td>
<td>none</td>
</tr>
</tbody>
</table>

RSES highest at PN1 associated with > sense of achievement at birth.

EPDS scores rose at PN1 & PN2. Moved house at PN2 & very tired.

EPDS at PN1 high but not indicative of depressed feelings. RSES lower at PN1 due to > tiredness and body shape concerns.

At AN1 past depression improved. At PN2: PND diagnosed & treated.

>EPDS at AN1 -a challenging week; >EPDS at PN2 -pregnant again.

Maintained grief over birth experience through PN1 and PN2.

<EPDS & slight >RSES at PN1 & PN2 consistent with < AN1 worries.

EPDS high at AN1 -nausea, vomiting & concern for baby; at PN1 >self-blame associated with concern for friends present at birth.

>EPDS - tiredness, worries about baby and disappointment over ability to give birth; >RSES - pride in achievements.

>EPDS at PN1 - emotional challenge in becoming mother; at PN2 - concern for world issues & a quickly resolved argument with partner.

Emily’s mother died PN1. Treatment helping her sort out sense of self.

5 years depression treatment, often forgot medication at AN1 & PN2.

>EPDS & <RSES reflect >body shape concerns, >tiredness, >financial stressors.

>EPDS at PN1 -baby’s unpredictability & worries for baby.

**KEY:** s/d = shoulder dystocia; ass = assisted; * = on antidepressants; > = increase; < = decrease; PND = postnatal depression; 1Edinburgh Postnatal Depression Scale (EPDS); 2Rosenberg Self-esteem Scale (RSES); AN1 = third trimester time point; PN1= 3-4 months; PN2 = 7-8 months
Related Hardiness Scale (HRHS). Elizabeth had a slightly reduced postpartum self-esteem which may have been linked to being overtired; tiredness also influenced her EPDS answers. Following Dawn’s treatment for depression, her self-esteem decreased to antenatal levels reflecting an increased honesty about herself. In line with Helen’s EPDS scores, her substantial drop from high antenatal self-esteem was consistent with the return of her body image concerns in addition to other life pressures.

Both Celeste and Patricia had increased depressed feelings but high self-esteem. Celeste’s raised EPDS scores at 8 months were based on a single brief incident with her partner which was resolved within hours. She also had a sense of worry and even fear about world issues such as terrorism. These feelings did not impact on her self-esteem. Patricia’s high self-esteem increased over the childbearing period due to pride in her achievements. However, Patricia’s EPDS score at 8 months postpartum indicated depressed feelings which she associated with worry about her baby and disappointment over her ability during childbirth. These factors possibly contributed to a more marked drop in Patricia’s optimism than the very mild drop experienced by Celeste.

5.3.4 Postpartum: optimism and confidence to control health

Participant scores in the Life Orientation Test (LOT) at 8 months postpartum indicated that half the women were highly optimistic, six were moderately so and that Patricia’s optimism was low (see table 5.8, p.215). Gina, Maree and Lisa’s optimism increased to a high level as their pregnancy and birth worries diminished; Helen’s optimism rose slightly for the same reason. Reduced childbirth and baby related concerns also influenced these participant’s Health Related Hardiness Scale (HRHS) scores; Gina’s score was slightly increased whereas Maree, Lisa and Helen’s increase was marked. A similar pattern was evident for the three participants whose optimism decreased; they showed a diminished confidence to control their health. Patricia’s lowered scores reflected her increasingly negative assessment of her capacity to experience situations the way she would like to. Disappointment about the birth, tiredness and worry also diminished her sense of confidence in situations. Emily’s tiredness and grief similarly influenced her optimism and her HRHS scores but not to the degree that either indicated an overall change.
Table 5.8: Changes in optimism and confidence to control health

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth</th>
<th>Optimism (LOT)¹</th>
<th>Confidence to control health (HRHS)²</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PN2 level</td>
<td>change</td>
<td>PN2 level</td>
</tr>
<tr>
<td>Jane</td>
<td>vaginal</td>
<td>high</td>
<td>none</td>
<td>moderate</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>vaginal</td>
<td>high</td>
<td>none</td>
<td>moderate</td>
</tr>
<tr>
<td>Louise</td>
<td>vaginal</td>
<td>moderate</td>
<td>decrease</td>
<td>moderate</td>
</tr>
<tr>
<td>Dawn</td>
<td>caesarean</td>
<td>moderate</td>
<td>decrease</td>
<td>moderate</td>
</tr>
<tr>
<td>Leanne</td>
<td>vaginal</td>
<td>high</td>
<td>none</td>
<td>high</td>
</tr>
<tr>
<td>Jasmin</td>
<td>caesarean</td>
<td>high</td>
<td>none</td>
<td>high</td>
</tr>
<tr>
<td>Gina</td>
<td>vaginal</td>
<td>high</td>
<td>increase</td>
<td>moderate</td>
</tr>
<tr>
<td>Maree</td>
<td>vaginal - s/d</td>
<td>high</td>
<td>increase</td>
<td>high</td>
</tr>
<tr>
<td>Patricia</td>
<td>caesarean</td>
<td>low</td>
<td>decrease</td>
<td>moderate</td>
</tr>
<tr>
<td>Celeste</td>
<td>vaginal</td>
<td>moderate</td>
<td>none</td>
<td>moderate</td>
</tr>
<tr>
<td>Emily</td>
<td>vaginal - s/d</td>
<td>moderate</td>
<td>none</td>
<td>moderate</td>
</tr>
<tr>
<td>Michelle</td>
<td>vaginal</td>
<td>moderate</td>
<td>none</td>
<td>high</td>
</tr>
<tr>
<td>Helen</td>
<td>vaginal - ass</td>
<td>moderate</td>
<td>none</td>
<td>high</td>
</tr>
<tr>
<td>Lisa</td>
<td>vaginal - ass</td>
<td>high</td>
<td>increase</td>
<td>high</td>
</tr>
</tbody>
</table>

KEY: s/d = shoulder dystocia; ass = assisted; AN1 = third trimester; PN1= 3-4 months; PN2 = 7-8 months; > = increase; < = decrease; 1Life Orientation Test (revised version) (LOT); 2Health Related Hardiness scale (control dimension) (HRHS)
An increasing awareness of the uncertainties of life and of bodily function was a factor in the decreased HRHS results of Elizabeth and Celeste as well as the slight decrease in Jasmin’s result. Jasmin’s self-confidence to control health nonetheless remained at a high level despite disappointments about her birth experience. For Dawn the decrease in HRHS was consistent with her difficult birth experience and diagnosis of postnatal depression. Her lowered HRHS, in tandem with her decreased LOT, was also illustrative of her increased self-honesty at this time. Louise’s postnatal health challenges and fears for her family’s health impacted on her sense of optimism and confidence to control health. This diminished confidence in health matters was illustrated by Louise’s decision not to have a home birth for any subsequent pregnancies. Other women (Leanne, Maree, Michelle and Helen) expressed a philosophical awareness of not being fully in control of their health although their HRHS results were high, implying that these women did have the confidence to control their health. In contrast, moderate scores in the HRHS theoretically indicated a lesser degree of confidence to control health, however some such women (Emily, Gina, Elizabeth, and Celeste) also demonstrated a high capacity to undertake activities that positively influenced their health.

5.3.5 **Summary**

In this section I have used participants’ stories and questionnaire responses to examine labour, birth and postpartum experiences across the group. The diversity of women’s experience and the individual ways in which women respond to change are what stand out most. The childbearing period appeared to challenge each participant in various ways to varying degrees which also diversely influenced their psychometric responses. While for the majority of participants the psychometric scales demonstrated at least one area in which the participant had changed, no change was shown for Jasmin, Leanne and Jane, who each had very different birth experiences. The details from their stories do however show how all participants identified that they had changed in some way during childbearing.

5.4 **DISCUSSIONS ABOUT CHANGE**

This section discusses the ways in which participants recognised that they had changed as a result of their childbearing experiences. Firstly I discuss the strengths and
limitations of using psychometric scales to measure childbearing change. Then I draw from participants’ stories to summarise how they perceived their embodied self had improved during childbearing. In doing so I consider how participant’s childbirth experience influenced that change.

5.4.1 Limitations in psychometric assessments

The process of reporting on participant’s experiences of change revealed limitations in the use of psychometric assessments. The dissertation focus is on participant experiences and feelings as relayed in their stories. These stories have been thoroughly validated with each woman (as detailed in chapter four) and are taken as true. The psychometric scales were rigorously constructed and have provided a valuable supplement to those stories. However, the scales were derived from generalised estimates of change experiences by people in a variety of contexts. These scales do not have the specificity of the stories. I have therefore assumed that disjunctions between story and psychometric results are due to the questionnaire being insensitive or inappropriate to the changes being examined in the specific context of pregnancy, birth and postpartum. As outlined in table 4.2 (pp.160-161) I used a pre-determined range of scores (such as high/moderate/low) to assess individual psychometric responses. For some scales this pre-determined range seemed to arbitrarily acknowledge some women’s changes and not others. For example, Louise’s response to the HRHS dropped 13 points but remained at a ‘moderate’ level throughout, therefore registering as ‘no change’ in table 5.8. In contrast, Lisa’s HRHS score increased by only 3 points to show change from a moderate to high level. I attempted to remedy this problem in the comment sections of tables 5.7-5.8. This example shows that both the degree of change and change in itself cannot be captured by a psychometric test alone.

5.4.1.1 Congruence between psychometric results and story

Most of the psychometric results did broadly fit with women’s stories, but this congruence was still dependent on interpretation. For example, my initial response to Jane’s moderate antenatal HRHS score and her antenatal interview was to perceive her caution and insecurity as a diminished self-confidence that I thought may impede her capacity to give birth. When Jane did give birth as planned at home, I considered this an incorrect interpretation. However, on further analysis I found that Jane did experience an intense challenge to her confidence and willingness to take responsibility during the
second stage. The skill of her midwives guided her back to a return of her confidence and capability which is indicated in her slightly raised HRHS and RSES at PN1.

Table 5.9 (p.219) summarises how specific psychometric results were incongruent with some of the stories. Dawn had marked depression that was not indicated by the EPDS. Emily and Helen had EPDS results indicative of depression but they categorically denied that the presence of such feelings meant that they should be considered depressed. Furthermore, the EPDS was unable to indicate if women were more or less capable of drawing on a sense of inner wellbeing to moderate the depressive feelings (such as was done by Leanne and Celeste). The HRHS also demonstrated problems of congruence with women’s stories. Emily specifically criticised the HRHS as confusing. As a midwife she was well aware of her capacity to make healthy choices that would impact on her own and her baby’s wellbeing. Her story showed how she actively made those choices and how they impacted on her childbearing outcomes. This high level of control over her health was not reflected in the HRHS because philosophically Emily also saw that she did not have control over everything, which, to her was a healthy approach. The HRHS also did not differentiate the subtle influence of inner strength in enabling a woman’s self-confidence to control her health (such as for Jane and Maree). Furthermore, self-confidence may be measured as high in the more general context of the scale yet it may not be demonstrated in a specific context such as childbirth preparation (for example Lisa and Patricia).

The stories relay a far greater subtlety to women’s experience of change than the psychometric scores. All of Dawn’s results at the first postnatal time point were fabricated to match the degree of positivity that she thought she should have. Hence the scales indicated a false level of positivity for Dawn. None of the scales registered Jasmin’s upset and grief over her birth experience, perhaps due to Jasmin’s very resilient personality. For other women the psychometric scales missed the more subtle positive aspects of childbearing experience that were evident in their stories (such as Louise and Michelle). As this project aims toward enhancing the positive aspects of change rather than merely treating the negative ones, a greater focus has been given to the subtlety of each woman’s individual assessment of change. By considering the positive aspects of change, each participant’s perspectives on her improved sense of self have been revealed.
Table 5.9: Congruence between psychometric results and story

<table>
<thead>
<tr>
<th>Name</th>
<th>Optimism(^1)</th>
<th>Confidence to control health(^2)</th>
<th>Self-esteem(^3)</th>
<th>Body shape(^4)</th>
<th>Depressed feelings(^5)</th>
<th>General assessment / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>HRHS ≠ Jane’s inner strength.</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>HRHS ≠ Elizabeth’s demonstrated high confidence in health.</td>
</tr>
<tr>
<td>Louise</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Good fit but ≠ positive aspects of Louise’s change.</td>
</tr>
<tr>
<td>Dawn</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Dawn’s PN1 answers fabricated, were other women’s?</td>
</tr>
<tr>
<td>Leanne</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>EPDS ≠ Leanne’s underlying inner sense of wellbeing.</td>
</tr>
<tr>
<td>Jasmin</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>≠ Jasmin’s upset over birth.</td>
</tr>
<tr>
<td>Gina</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>HRHS ≠ Gina’s demonstrated high confidence in health.</td>
</tr>
<tr>
<td>Maree</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>HRHS ≠ Maree’s inner strength.</td>
</tr>
<tr>
<td>Patricia</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Good fit with story; HRHS ≠ Patricia’s low initiative over childbirth plans.</td>
</tr>
<tr>
<td>Celeste</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>EPDS ≠ Celeste’s underlying sense of wellbeing at PN2.</td>
</tr>
<tr>
<td>Emily</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>HRHS ≠ Emily’s demonstrated high confidence in health; depression at PN1 denied by Emily.</td>
</tr>
<tr>
<td>Michelle</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Good fit but ≠ positive aspects of Michelle’s change.</td>
</tr>
<tr>
<td>Helen</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
<td>Depression at PN1 denied by Helen.</td>
</tr>
<tr>
<td>Lisa</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>HRHS ≠ Lisa’s low initiative over childbirth plans.</td>
</tr>
</tbody>
</table>

KEY: AN1 = third trimester; PN1 = 3-4 months; PN2 = 7-8 months; ✓ = congruence with story; ✗ = discrepancy with story; ≠ = ‘not representative of’; \(^1\) Life Orientation Test (revised version) (LOT); \(^2\) Health Related Hardiness scale (control dimension) (HRHS); \(^3\) Rosenberg Self-esteem Scale (RSES); \(^4\) Body Shape Questionnaire (8 item version) (BSQ); \(^5\) Edinburgh Postnatal Depression Scale (EPDS)
5.4.2 **Perspectives on improved embodied self**

Participant’s perspectives on their sense of improved embodied self were focused on the influence of childbearing generally and on the impact of childbirth more specifically. Each woman’s discussions of change often involved ‘both/and’ contradictions that relayed that, as Jasmin said, she was “still the same person underneath” (p.178). The process was a rite of passage to some women. For example, Lisa claimed, “my life is back to normal although at a different stage” (p.454). Other women saw the change as an expansion rather than a return to normal; Michelle stated “it’s like I’ve moved to a different level and see things differently to before” (p.392). This expanded perspective, when directed toward the self, meant to Leanne that she was more “multifaceted” (p.157) and that Jasmin felt a “bit more complex” (p.181). There were also distinct changes identified by some women. Patricia recognised a matured sense of responsibility that had given her life some “direction” (p.287). Elizabeth considered she was now “not as weepy and fiery” but “pretty placid” (p.58). Similarly Louise felt she was “much softer” as “things” no longer had “to be perfect” (p.87). Maree described herself as “more relaxed” and “content” (p.258), while Gina said she was a “far milder person” who checked the “small stuff” less (pp.218, 225). Both Gina and Jasmin recognised a diminished interest in buying things or going out all the time. Elizabeth said that, “rather than striving for happiness” she was happier “to just be” (p.63). This sentiment was echoed by Jane’s contentment “with what we’ve got” which she expressed as a “fullness where there’s no aching for anything” (p.33). The sense of contentment arose both from each participant’s achievements and from feelings for their baby.

5.4.2.1 **Feelings for baby**

All participants experienced a positive sense of having changed when they discussed feelings for their babies. Participants gave a diverse range of descriptions that reflected the difficulty that many had in using words to express the intensity of their emotion. For example, Jane used the idea of “circles of beautiful energy” (p.25), Gina likened the sensation to orgasm, but “not in any way sexual” (p.213), and Emily used breastfeeding to describe how she felt both connected and separate from her baby. A sense of identification with their baby was encompassed in some women’s feelings. To Jasmin her feelings were “beyond joy” when she perceived her baby both as different yet also
Chapter five: Results: Individual changes

familiar (pp.176-7). Recognition of Helen’s baby as her own came when she watched her mother with her daughter. Dawn’s emotions were focused on a protective sense of ownership that “he was mine” (p.114). The sense that their baby was a separate person was at the forefront of the feelings expressed by Elizabeth, Celeste, Emily and Michelle. Leanne described a feeling of awe over the presence of her baby and Celeste felt slightly intimidated by her son.

A number of women used the word ‘love’ to describe what they did or did not feel for their baby. Helen was somewhat confused by the mismatch between her expectations and experience, she said “I love what I’ve got, I feel like I’m enjoying her, but it’s not what I expected” (p.428). For Patricia love was used to describe the overwhelming feeling she had hoped for, but she also sought confirmation from others that her baby was “cute” enough to love (p.282). Elizabeth’s reference to feeling love was prefaced by her mind thinking how she loved her baby. Gina skirted the idea of love, recognising that it was because she herself felt loved that she had the potential to love her baby.

Participant’s feelings of love developed and changed over time. Jane talked of having learnt the “varying degrees of love” from her daughter and “discovered that love knows no bounds”, that it is “just endless” (p.33). Lisa and Michelle noted that the feelings of love came over a period of days. Lisa’s love grew from when she “noticed” her baby’s “own little smell”, but she “had to learn” to “be patient and not worry” about spending time touching and playing with her daughter (pp.447, 454). For Louise and Maree the sense of love developed over many weeks. When her son was born Louise felt nothing initially, he was like “an alien” (p.79). She believed there was “something was wrong” because she did not have the expected “overwhelming” sense of love, but over the ensuing weeks love did grow (pp.81-2). Maree expressed an initial “amazement” centred on her son’s health at his birth (p.250). She explained how the weeks that followed were focused on meeting her baby’s needs, it was once he showed “a bit of a personality” and was less dependent on her that she was overwhelmed by love (p.265).

Each participant’s feelings for her baby were a product of her own particular sense of being and becoming a mother. The sensations of being/becoming were entwined and sometimes inseparable from the woman’s experience of love for baby and love for self as mother. However, whatever way the sensations manifested they were definitively unique to each woman at the time in which they were experienced. This variety in how
a woman may respond to her baby does not fit with the standard theory of transition to motherhood (outlined in chapter one), nor does it align with the dominant social expectation of immediate overwhelming love (as Louise found). The women’s honesty in expressing such unconventional feelings must be acknowledged and was enabled by the honest and respectful participant/researcher relationship.

5.4.2.2 Changes in relationship

For many participants feelings for their baby positively added to the feelings they had for their partner. Lisa said childbearing had “matured our feelings of connection to each other” (p.453) and Elizabeth felt she and her partner were “more committed to each other now” (p.63). Celeste’s feelings had become “much more substantial and solid” which included an increased sense of sexual comfort (p.314). Other women identified a greater depth to their sexual relationship: for Maree it was more open; Jane felt it had “more beauty” (p.28); and Jasmin considered that sex had become “quite spiritual” because they now knew their “potential to create” (p.185). Louise, Michelle and Leanne recognised that their respective partner’s admiration during the birth had, as Leanne put it, resulted “in another level” to their relationship (p.149).

Most women also identified greater challenges within their relationship, often due to financial stress or parenting issues; these challenges dominated how Gina discussed her relationship. Relationships were also changed by the reduction or absence of sexual intercourse. Dawn said this was “an issue” but not a problem because she and her partner were open with each other (p.124). Helen claimed sex was not after all a big part of her marriage. Even though Patricia said “sex isn’t everything” she also expressed concern for how she and her partner were relating (p.284). Similarly Michelle’s continued dyspareunia made it feel like she and her partner had “become more distant” because although they communicate in other ways “sex is the most intimate” (p.387). Michelle did, however, also recognise that a greater, different sense of relational closeness had developed as a result of childbearing.

All participants experienced some change in how they related to other people, childbearing women and children in particular. For some women this change merely reflected their altered social circle in the early postpartum months. Maree and Emily developed an increased awareness of the need to nurture communities. Others remarked that an increased tolerance, flexibility and forgiveness variously accompanied this
change. These characteristics were sometimes directed toward the self, as for Gina, Louise and Dawn, which in turn influenced their relations with others. Celeste, Louise and Lisa found that their feelings of compassion were at times quite intense.

For many of the participants the increased sense of being open to the feelings of others often included a greater sense of connection with other women. Leanne, for example, would catch herself “smiling at women and children” in ways she had not done in the past (pp.157-8). Louise called the sense of connection a “special bond” (p.88) and Jane considered it “a kind of respect” (p.38). For Jane, Louise and Michelle, this connection was manifested in a desire to share what they had experienced and/or learnt. Louise, for example, was keen to share how childbirth and parenting “really is” because “in reality it’s not like what people or books say you should be feeling or doing, it’s about how it is” (p.92). Interestingly none of the women noted that they had become any less tolerant or compassionate of other people, although Jane found her newly found sense of connection to women did diminish when they had more medicalised opinions about childbirth.

5.4.2.3 Change as a process of learning

The sense of having changed was often spoken of in terms of what participants had themselves learnt. Having approached her birth with a high degree of self-confidence, Jasmin said she had “learnt about humility” and the many uncertainties of life (p.182). In healing from postnatal depression Dawn “learnt to forgive” herself, became “more honest” and readjusted her sense of responsibility (p.122). Louise also identified she had to “learn” responsibility as she said it “really didn’t come naturally to me” (p.82). Patricia, Elizabeth and Jasmin found that they had learnt more patience. Jane became better at managing her time and Elizabeth identified that she was able to “concentrate on things more easily” (p.63).

Some participants seemed particularly aware that their experience of change was a manifestation of what they were learning. Michelle thought that “something new” could be learnt “from everything” (p.359) and Elizabeth believed that the reason she had the experiences she had was because she “needed to learn from them” (p.42). This sentiment was echoed by Jasmin who reflected that her birth experience was “the challenge I needed to grow and change” (p.190). Emily considered that parenting was “a bit like birthing” and was confident she would “learn along the way” as she did.
during labour (p.357). However, while Helen identified that she learnt from her experiences, she said “having that knowledge doesn’t necessarily motivate me to change” (p.425). Hence, while Helen knew that for her next birth she would like to have a known midwife, she was not prepared to make the changes that would give her the “responsibility and control” involved in employing a private midwife (p.430).

All participants learnt in some way from their particular experience of childbirth. Maree learnt to be “quite a bit more realistic about birth” because “things can still go wrong”, even in hospital (p.263). Louise’s learning was expressed in a change of plan for her second birth experience. Her initial choice of homebirth had been “all about me”, but, having learnt about responsibility and experienced the love of her baby, she planned a hospital birth next time (p.96). Table 5.10 (p.225) summarises each participant’s birth experience relative to their original plan, their future births plans and whether or not their second plan was achieved. Most remarkable of those achievements was that of Jasmin. Jasmin had been “learning from everything” that had happened to her and through perseverance eventually achieved the desired homebirth of her second baby (p.189).

5.4.2.4 A sense of achievement and confidence

The experience of improved embodied self relative to a woman’s initial experience of childbearing was expressed by the majority of participants in terms of a sense of achievement. There were many instances where participants did not attain their desired goal, those women who had assisted childbirth, for example. However, when asked about positive aspects of change, each woman was also able to identify a situation in which they had achieved something. Patricia was proud of her capacity to get “back into shape”, to “be a mum, work and still have a life” (p.290). Lisa was pleased to attain her aim of a healthy baby. Like other participants, Lisa was keen to explain that she did not mean she was “being better than anybody else” (p.457). Other women expressed pride in their experience of childbirth. Michelle was “very proud” of how she “dealt with it” (p.384) and Helen felt “impressed” with her body and herself (p.422). Leanne was pleased to have “actually felt, without pain relief, every minute of the whole physical experience” (p.157). The sense of achievement for Emily was not “about the best way to give birth” but about being “privileged” to have “had that feeling” and to “still feel excited and energised by it” (p.356).
### Table 5.10: Birth plans and achievements

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth</th>
<th>Experience relative to plans</th>
<th>Same general plan next birth?</th>
<th>Second birth relative to plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane</td>
<td>vaginal</td>
<td>✓ Initial lack of will to push</td>
<td>Yes, at home with same midwives</td>
<td>Not known</td>
</tr>
<tr>
<td>Louise</td>
<td>vaginal</td>
<td>✓ Longer</td>
<td>Yes but will get fitter &amp; healthier for quicker recovery</td>
<td>Not known</td>
</tr>
<tr>
<td>Dawn</td>
<td>caesarean</td>
<td>✗ Medicalised, ended in caesarean</td>
<td>Yes, natural birth: more determination, less surety</td>
<td>✗ Caesarean much like last time</td>
</tr>
<tr>
<td>Leanne</td>
<td>vaginal</td>
<td>✓ Quicker; own midwife not present</td>
<td>Yes, birth centre, no private midwife</td>
<td>✓ Birth centre, no problems</td>
</tr>
<tr>
<td>Jasmin</td>
<td>caesarean</td>
<td>✗ Medicalised, ended in caesarean</td>
<td>Yes, different midwife, a lot more self preparation, very determined.</td>
<td>✓ Home, no problems</td>
</tr>
<tr>
<td>Gina</td>
<td>vaginal</td>
<td>✓ A “bit put out” that own midwife did not attend (p.220)</td>
<td>Yes, different midwife, more financial preparation</td>
<td>Not known</td>
</tr>
<tr>
<td>Maree</td>
<td>vaginal - s/d</td>
<td>✗ Intervention in labour; shoulder dystocia at birth</td>
<td>Birth Centre (BC) of local (country) hospital. Only women present.</td>
<td>✗ Transferred to hospital care in pregnancy; ✓ BC midwife in labour – no problems</td>
</tr>
<tr>
<td>Patricia</td>
<td>caesarean</td>
<td>✗ Medicalised, ended in caesarean but not as bad as expected</td>
<td>Yes, “definitely” like to “do it naturally”, won’t be as scared of a caesarean next time (p.289)</td>
<td>Not known</td>
</tr>
<tr>
<td>Celeste</td>
<td>vaginal</td>
<td>✓ More painful</td>
<td>yes</td>
<td>✓ Just as painful, no problems</td>
</tr>
<tr>
<td>Emily</td>
<td>vaginal - s/d</td>
<td>✗ Intervention in labour; shoulder dystocia at birth</td>
<td>yes</td>
<td>✓ Got pregnant once off antidepressants. No problems during or after birth.</td>
</tr>
<tr>
<td>Michelle</td>
<td>vaginal</td>
<td>✗ Too soon, completely different</td>
<td>yes</td>
<td>Not known</td>
</tr>
<tr>
<td>Helen</td>
<td>vaginal - ass</td>
<td>✗ Intervention in labour; unplanned forceps</td>
<td>A private midwife would involve too much responsibility for Helen so would like midwives clinic and a private hospital.</td>
<td>Not known</td>
</tr>
<tr>
<td>Lisa</td>
<td>vaginal - ass</td>
<td>✗ Too long, ended in vacuum extraction</td>
<td>Yes, may change obstetricians</td>
<td>Not known</td>
</tr>
</tbody>
</table>

**KEY:** s/d = shoulder dystocia; ass = assisted; ACS=altered conscious state; ✓ = as planned; ✗ = Not as planned
The sense of achievement, for some participants, appeared to have an impact on their general self-confidence. Elizabeth and Michelle found that they worried less. Celeste, Maree and Louise were less sensitive about what they believed other people thought or said about them. To Louise this meant she no longer had to “pretend” she was a “particular sort of person” (p.87). Jasmin had gained confidence from the “conscious decisions” she had made surrounding childbirth which in turn impacted on most areas of her life (p.184). Maree found she was more confident at solving her problems alone and Celeste noted she had become “more confident at making decisions” (p.313). Celeste explained that since labour had put her “in a position of having to express my emotions, I’m more willing to say what I think” (p.313).

All participants found their confidence increased in some way over the childbearing period, particularly in the context of parenting. In some contexts participants also identified a reduced sense of confidence. For example, Jane, Jasmin and Leanne each felt somewhat less confident when they first considered returning to work. In contrast, Gina’s birth experience increased her confidence regarding work because she felt that by achieving a homebirth her body had “proven itself”, which as a midwife, reinforced her “faith in other women’s bodies” (p.218). Gina did not, however, apply that confidence to her own future birth experiences because, she said, “I’m not ready to have another baby yet” (p.228). Michelle, on the other hand, was clear that her experience of birth prompted “more confidence” about future birth experiences (p.393). For many participants, the more powerful aspects of their sense of achievement and confidence were generated by how they had actually experienced childbirth.

5.4.2.5 Being empowered by childbirth

Some sense of empowerment relative to childbirth was relayed by most of the participants. Each participant’s degree of empowerment appeared to be related to how personally powerful that woman felt during her actual birth experience. Lisa explained that the tiredness and pain of labour meant she did not feel empowered in childbirth “at all” (p.455). She maintained that parenting was “the big issue” because labour is “over so quickly, in time the pain diminishes and you forget” (p.455). In contrast, both Jane and Gina recognised that the initial emphasis they gave to childbirth did diminish, but they also found that their sense of being empowered by childbirth remained.
For a number of participants their sense of trust influenced feelings of power during childbirth. Michelle identified the one thing that helped her through labour was the knowledge that her body would know what it needed to do. Helen remembered the sense of power in knowing and having faith in her body which, since the birth, had reinforced for her "the importance and power of having a positive attitude" in life (p.422). Emily’s memory of power in labour was described as an extension of trust beyond the physical realm; this experience has resulted in her becoming better at trusting herself to be present in-the-moment. The actuality of Gina’s birth experience affirmed for her the antenatal trust she had in her birthing ability. It was this trust that created the “link between the birth and now” which Gina explained in terms of her current sense of “being grounded” and generally confident (p.229).

The process of being inwardly centred during labour was identified by some participants as important to their experience of being empowered. Becoming inwardly centred enabled an altered conscious state. Hence, to Maree “being centred in labour was quite a spiritual experience” which in turn strengthened her inner self (p.265). Celeste said that the experience “added” to her “sense of security”, to her “centeredness in general” and to inner self-knowledge (p.317). Leanne found that childbirth was similarly affirming of her inner self in a way that she said would be with her “forever” (p.157). Dawn recognised that her experience of being inwardly centred during labour created a “helpful sense of self reliance” that helped her to “know” that within herself she had “the innate resources to cope to the best of my ability with whatever comes along” (p.128).

No participants identified that they were disempowered by being inwardly centred. However, whether or not a woman became inwardly centred was closely related to the participant’s response to pain and its intensity. Gina pointed out that her altered conscious state was “a reaction to the pain” and she went “as deeply inside” herself as she needed to be “according to the pain” (p.209). Furthermore, the quality of the altered conscious state was dependent on the labour environment. This was vividly illustrated by Louise who had a positive, deeply internalised experience until her midwife said “I can see the head” and her altered conscious state changed into an out-of-body experience (p.78). Although this dissociative experience had a negative impact on Louise’s early postpartum, she was able to reflect positively on her overall experience. Childbirth showed Louise how she could “go into” herself and “concentrate” on what
Chapter five - Results: Individual changes

she was doing (p.86). This experience enabled Louise to perceive herself as “a bit invincible” with a far stronger will power than she thought she had (p.95).

Participants who did experience some sense of being empowered by childbirth seemed to readily transfer their resultant empowerment to contexts other than birth. Maree specified that the increased awareness of her inner strength had given her confidence in unrelated situations that were unchosen or unpleasant. Emily perceived the power of birth as similar to the power she associated with breastfeeding; she considered that her awareness of this power was a “huge strength” that will get her “through life” (p.357). Elizabeth similarly spoke in terms of birth being “absolutely amazing” making her feel capable of doing “just about anything” (p.58). She believed that “going through labour prepares you for those harder parts” of parenting “to come” (p.58). Jane said she “learnt from labour what” her “will” could do and that had “subtly changed” her; she explained that “knowing what I physically and emotionally can endure changes my approach on a lot of things” (p.38). When women’s experience of labour and birth prompts them to use their own power, the resultant sense of empowerment can then positively impact on a woman’s overall improved sense of embodied self.

5.4.3 Summary

In this section I have shown that there are limitations to using psychometric scales to measure change associated with childbearing. I have argued that such scales should only act to supplement women’s stories as it is through stories that the subtleties of change experiences are revealed. Participants’ stories reveal how a woman’s feelings for her baby develop in diverse and individual ways but that these feelings have an influence on her experience of childbearing change. Changes in partner relationships and relations with others can also impact on how a woman perceives herself. Participants identified that change was often a learnt process which included learning about the self and about childbirth. From this process participants variously gained a sense of achievement and confidence which was most powerfully generated when they perceived their actual childbirth experience as empowering.

5.4 Conclusion

In this chapter I have presented the research findings focused on each participant’s experience of their changing embodied self. In section 5.2 I introduced the fourteen
participants according to their planned birth place and presented summaries of each of their stories. I considered the participants as a group in section 5.3, commenting on similarities and differences between their labour, birth and postpartum experiences. Lastly, in section 5.4 I discussed the relative merits of how I had assessed change associated with childbearing and then considered the nuances of participants’ own perspectives on their improved embodied self. In aiming to answer the research question, ‘How does a woman’s embodied sense of self change during the childbearing period and what factors in the childbirth experience seem to be positively related to an improved sense of self?’, I found that women experienced positive as well as negative changes. Negative changes included: sequelae from the birth; disappointment about unplanned birth experiences; breastfeeding problems; a diminished sense of independence; postpartum tiredness and depression; work and financial difficulties; parenting challenges; and, relationship readjustments. Positive changes included: an altered outlook on life; deepened sexuality and maturing of relationship with partner; love for baby and self; increased inner strength, awareness and centeredness; greater connection with other women; a sense of pride and achievement; and, raised confidence in the self, in bodily capacity, and in giving birth.

These findings indicate that any woman can experience an improved sense of embodied self as a result of childbearing generally and childbirth more specifically. Embodied self change that is most empowering occurs when a woman employs her confidence and capability ‘in-the-moment’, she draws from an inner sense of trust and becomes inwardly centred during labour and birth. This process of change is positively facilitated by these factors. A woman’s improved embodied self is then manifested by an increased awareness of and capacity to use her inner strength. This has the consequence that a woman who experiences a sense of improved embodied self feels more confident in dealing with other challenging life circumstances. I therefore conclude that when a woman uses her own power during labour and birth she is most likely to feel an improved sense of embodied self during and after childbearing.
6. **CHAPTER SIX- OVERALL RESULTS: THE THEORY**

6.1 **INTRODUCTION**

In this chapter I report the overall theoretical results of the research. I fulfil the research aim to produce theory about how caregivers can most effectively work with women during the changes of childbearing so as to enhance, rather than diminish, a woman’s embodied sense of self. In addition, I answer the research question ‘How does a woman’s embodied sense of self change during the childbearing period and what factors in the childbirth experience seem to be positively related to an improved sense of self?’ Chapter one defined ‘improved sense of self’ as “an enhanced capacity to feel oneself as an embodied whole and intrinsically powerful person”. Chapter five demonstrated that a woman is most likely to feel an improved sense of embodied self when she uses her own power during childbirth. This chapter now presents the theory which applies to the whole of a woman’s first childbearing experience. In particular, the theory establishes the factors that appear to enable a woman to use her own power during childbirth. I have called this theory ‘Liberating intrinsic power’.

A theory consists of a collection of theoretical constructs that are linked in systematically meaningful ways, as outlined in chapter four. The theory ‘Liberating intrinsic power’ is structured by three meta-concepts: ‘The embodied self’, ‘Intrinsic power’ and the ‘Change pathways’ (see table 6.1). Under these come concepts and sub-concepts as shown in table 6.2.

Guidelines for reading the chapter:

- I distinguish between the theoretical constructs using single quotation marks for the ‘Meta-concepts’ and different fonts for the concepts and the sub-concepts for the remainder of the dissertation
- I assume the reader is aware of the terms associated with defining embodied self as a spiritual being outlined in section 1.1.1 and listed in table 1.1 (pp.28-29).
- Tables 6.1-6.6 within the chapter are reprinted in appendix C; they supplement the text and should be read when referred to in the text.
I use extracts from the participants’ stories in appendix B; all page numbers refer to that appendix (Parratt, 2009). Direct quotes are enclosed in “double quotation marks” or placed in:
Separate paragraphs of Arial font.
In the longer story extracts I indicate deleted words with ‘…’ and words I have added with [square brackets].
I also use italics when quoting some of the statements that validated my emerging ideas (as described in section 4.5.3.4).

The chapter starts by explaining the theoretical constructs in section 6.2. In section 6.3 I describe what a woman can do to optimise her psychophysiological wellbeing and experience genius change during childbirth. Then, in section 6.4, I consider the way in which caregiver practices may enhance a woman’s embodied sense of self. The factors that seem most influential over how a woman experiences her changing embodied self are accountability, decision-making and the way power is used. I conclude, using the language of my theory that, when a woman’s caregiver practises honest accountability, undertakes contextual decision-making and uses integrative power during each woman/caregiver interaction, the woman is more likely to feel an improved sense of embodied self.

6.2 THE THEORY: ‘LIBERATING INTRINSIC POWER’
Definitions of the three meta-concepts (‘The embodied self’, ‘Intrinsic power’ and the ‘Change pathways’) comprising the theory are given in table 6.1 (p.232). These meta-concepts explain how change occurs for a person according to their particular situation.
‘Situation’ is defined as the state of affairs or set of circumstances relevant to the person immediately prior to, during and soon after the particular aspect of change being considered (Trumble & Stevenson, 2002). The meta-concepts describe a person’s subtle in-the-moment changes, changes over short and long periods of time, and changes across varying situations.

‘Intrinsic power’ is central to the theory because with an awareness of ‘Intrinsic power’ the self can actively use that power and feel intrinsically whole and powerful. ‘Intrinsic power’ is part of ‘The embodied self’. Intrinsic power cannot be divided into sub-concepts. The ‘Change pathways’ can be used to describe how woman interacts with
Table 6.1 Theory outline: the meta-concepts

**THE EMBODIED SELF**:  
- is defined as an integrated whole body/soul/mind who is continually changing depending on the various contexts of existence;  
- describes existence in the experiential moment including temporal awareness and capacity to act relative to the past or future;  
- describes the relational qualities of ‘ego’ as it responds to intrinsic and extrinsic power in creating a sense of security;  
- manifests, uses and knows intrinsic power;  
- continuously interacts in complex ways that are indivisible from the whole except in a theoretical context.

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Sub-concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMBODIED BEING</td>
<td>Being whole</td>
</tr>
<tr>
<td></td>
<td>Being fragmented</td>
</tr>
<tr>
<td>EMBODIED KNOWING</td>
<td>Spiritual knowing</td>
</tr>
<tr>
<td></td>
<td>Egoic knowing</td>
</tr>
<tr>
<td>EMBODIED POTENTIAL</td>
<td>Creative action</td>
</tr>
<tr>
<td></td>
<td>Conformist action</td>
</tr>
<tr>
<td>AWARENESS</td>
<td>Integrated strength</td>
</tr>
<tr>
<td></td>
<td>Qualified strength</td>
</tr>
<tr>
<td>INTEGRITY</td>
<td>Nonrational truth</td>
</tr>
<tr>
<td></td>
<td>Rational truth</td>
</tr>
<tr>
<td>TRUST</td>
<td>Genius change</td>
</tr>
<tr>
<td></td>
<td>Forced change</td>
</tr>
</tbody>
</table>

**Intrinsic power:**  
- describes the nonrational spontaneous power experienced in the current moment that influences future knowing, action and power in subtle and not so subtle ways;  
- is an energy that animates ‘The embodied self’;  
- is indivisible from ‘The embodied self’;  
- cannot be further divided into concepts or sub-concepts.

**CHANGE PATHWAYS:**  
- describe choices of ‘The embodied self’ that impact on security, knowing and power of the self and other selves;  
- comprise two concepts and six sub-concepts;  
- are a collection of actions that set ‘The embodied self’ on pathways that are self-enhancing or self-diminishing;  
- are a collection of actions that set other embodied selves on pathways that are self-enhancing or self-diminishing.

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Enhanced sense of embodied self is catalysed by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPowering PRACTICES</td>
<td>Honest accountability</td>
</tr>
<tr>
<td></td>
<td>Contextual decision-making</td>
</tr>
<tr>
<td></td>
<td>Integrative power</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-concepts</th>
<th>Diminishing sense of embodied self is catalysed by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HABITual PRACTICES</td>
<td>Vested accountability</td>
</tr>
<tr>
<td></td>
<td>Abstract decision-making</td>
</tr>
<tr>
<td></td>
<td>Disintegrative power</td>
</tr>
</tbody>
</table>
herself, how a woman and caregiver interact with each other. The way a person
interacts with other people and their environment in turn impacts on their interaction
with ‘Intrinsic power’. Hence, the ‘Change pathways’ can describe what caregivers can
themselves do to facilitate a woman’s interaction with her ‘Intrinsic power’.

6.2.1 The theoretical model

A model of the theory is provided in table 6.2 (p.234). All the concepts and sub-
concepts interrelate with each other; thus there are no solid divisional lines. Dots and
dashes are used sparingly. ‘Intrinsic power’ and ‘The embodied self’ are centrally
placed because they are the core of the theory. The ‘Change pathways’ are on the outer
dge of the model as they represent the more extrinsic elements. Those concepts most
influential in enhancing the embodied sense of self are shown on the left side of the
model, whereas those toward the right are those concepts that are associated with a
diminishing sense of self. Changes to the self occur from inside and outside ‘The
embodied self. The ‘Change pathways’, ‘The embodied self’ and ‘Intrinsic power’ are
contained within the line of dashes ‘- - - -’. The core concepts (EMBODIED BEING,
EMBODIED KNOWING and EMBODIED POTENTIAL) are separated from the two columns
of egoic concepts (AWARENESS, INTEGRITY and TRUST) by fine dotted lines ‘........’. The
different ways that the concepts change through time are represented differently as
described in the two following sections.

6.2.1.1 Change shown in the horizontal plane

In the horizontal plane change occurs in small steps in either direction within the
particular situation. The contents of the zigzag ‘........’ boxes make explicit the temporal
changes in the horizontal plane. The central zigzag box represents the pre-reflective
existence in the experiential moment. I define the ‘experiential moment’ as the
qualitative experience of a period of time prior to conscious reflection upon that
experience. In-the-moment thoughts/feelings, embodied elements of the past and
aspects of the present that impact on the future are all present simultaneously in each
‘experiential moment’. The particular current experiential moment passes when the
qualities of the experience have changed and/or when purposeful, conscious reflection
on that moment begins.
Table 6.2 Theoretical model: ‘Liberating intrinsic power’

<table>
<thead>
<tr>
<th>CHANGE PATHWAYS</th>
<th>THE EMBODIED SELF</th>
<th>HABITUAL PRACTICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choices available in any particular situation:</td>
<td>Intrinsic power</td>
<td>Choice in each interaction</td>
</tr>
<tr>
<td>● self interacting with self; ● self interacting with environment and other selves; ● environment and other selves interacting with self</td>
<td></td>
<td>Short/long term responses and influences</td>
</tr>
</tbody>
</table>

**EMPOWERING PRACTICES**
Choice in each interaction

<table>
<thead>
<tr>
<th>Relational qualities of the ego</th>
<th>Relational qualities of the ego</th>
<th>Short/long term responses and influences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhancement</td>
<td>Diminishment</td>
<td></td>
</tr>
</tbody>
</table>

**AWARENESS**

- Honest accountability
- Contextual decision-making
- Integrative power

**INTEGRITY**

- Integrated strength
- Nonrational truth
- Genius change

**TRUST**

- Spiritual knowing
- Egoic knowing
- Creative action
- Conformist action

**EMBODIED BEING**

- Being whole
- Being fragmented

**EMBODIED KNOWING**

- Integrative power

**EMBODIED POTENTIAL**

- Forced change

**Enhancing embodied self**

- Repetition within & between varying change contexts: moment-to-moment; interactions; and situations

**Diminishing embodied self**

- ‘The embodied self’ increasingly learns from repetitions in more diverse contexts so that embodied awareness of ‘Intrinsic power’ increases and ‘Intrinsic power’ is more actively used

- ‘The embodied self’ minimally learns from repetitions and resists learning in some contexts so that embodied awareness of ‘Intrinsic power’ does not increase and extrinsic/egoic power is most actively used
Chapter six - Overall results: The theory

The outer two zigzag boxes show interactions between the egoic concepts and the choices that are available in the ‘Change pathways’. The egoic concepts can be thought of as an influence on the experiential moment and a response to that moment. These responses/influences are primarily spontaneous; they may be so pre-reflectively reactionary that no ‘choice’ is really made and instead habitual patterns of coping are used.

The concepts of the ‘Change pathways’ (concerning accountability, decision-making and the use of power) describe longer term influences/responses as either consciously or habitually made choices. Concepts in the ‘Change pathways’ mutually interact with the egoic concepts to influence each experiential moment. Under the influence of the ego and the ‘Change pathways’, the choices of ‘The embodied self’ may be conscious and contrived to maximise egoic security and control. Alternatively, the choices of ‘The embodied self’ may enable the ego to become increasingly conscious of and trusting in ‘Intrinsic Power’ as a way to achieve security and empowerment. The concepts of the ‘Change pathways’ also represent the specific outcomes of the choices that ‘The embodied self’ makes. For example a person may choose to practise honest accountability and in doing so they become, at the time, honestly accountable.

6.2.1.2 Change shown in the vertical plane

In the vertical plane change occurs in a downward direction. Thus, change in AWARENESS precedes a change in INTEGRITY. Change in this plane occurs at variable rates. For example, the rate at which the core concepts change in relation to each other may be so rapid as to appear simultaneous, whereas in the ‘Change pathways’ change can be so slow that there can appear to be no choice available. The vertical plane also represents the ongoing, repetitious nature of change. The repetitions occur from one moment to the next. They occur within specific interactions and in different interactions in different contexts. In the model the vertical waving lines (at the bottom) are used to highlight this type of repetitive change. The left side of the model shows that there is potential for ‘The embodied self’ to learn and change in creative and powerful ways which lead to an enhance sense of self. The right side of the model depicts how not learning means maintaining habitual and self-limiting practices which actually lead to a diminished sense of self. In the sections below I now draw on data from the participants to support my concepts.
6.2.2 ‘Intrinsic power’

The concept ‘Intrinsic power’ represents the nonrational, intrinsically sited sense of self knowing, security and power. Many of the participants made specific reference to this inner sensation. Dawn said she gets a “warm fuzzy feeling inside” that helps her feel “strong and confident” (p.125). She explained “it is an intuitive feeling, not in my head but in my body around the heart area, and it instinctively makes me want to hug myself” (p.125). Celeste saw that her “inner strength” enabled a sense of trust and security when relating with her partner (p.294). Of labour Gina said “I didn’t expect to feel that much energy inside me”; she was especially impressed by the power available during the urge to push (p.214). Jasmin chose her midwife because she believed the midwife had an “inner core of strength” for which Jasmin felt respect (p.166). Leanne encapsulated ‘Intrinsic power’ in her personal philosophy:

I’m not a religious person but I have a belief in a universal energy that we’re all part of, that’s my spirituality. I nurture the whole by looking after me; maintaining my life spirit includes a philosophy of caring for my body physically, spiritually and psychologically (p.129).

Many of the statements confirmed by participants in Validation A3 focused on both the concept of ‘Intrinsic power’ and its relevance to the women. For example:

- Since experiencing the challenges of pregnancy, birth and parenting I am more aware of the potential power I have inside of me;
- I can explain myself in terms of how I feel inside my body at any particular moment of time; and,
- The inner sense of me and the outer feeling of connection I have with others are both related to my sense of security.

Participants’ agreement with the presence of ‘Intrinsic power’ was contrasted with, but simultaneous to, their agreement with the presence of the ego-based outer sense of self. The participants all agreed that:

- I can explain myself in terms of the words or images referring to outside of myself such as who is in my life, the past, present and future happenings in my life and the various roles I take on.

In their stories some women specifically identified the differences between inner and outer in order to explain how they had changed. Louise, for example, said “before I had Flynn … the way I… changed was more on the outside … since having Flynn I feel really safe, secure, happy and fulfilled on the inside” (p.90).
‘Intrinsic power’ can provide a sense of continuity when outer elements of the self are changing. Leanne maintained that the power of her “inner core” was what helped her through a difficult period in her marriage (p.132). Jasmin evoked this sense of continuity in saying she felt “a big bubble of happiness and... really calm, like coming home” the very first time she met her future husband (p.161). Some sense of ‘Intrinsic power’ can also facilitate a woman’s process of change when it is coming from within. Maree described what she did during a contraction:

All the way through I would sing a low note and visualise a downward movement of him and an outward sound for me. I felt... vibration... down the centre of my body... It was the type of centring where the vibration of the note is far more powerful than all of that chaos going on around me like the pain and my friends talking me through the contractions (pp.243-4).

In validation A3 all participants agreed that:

- *The power inside of me... assists me to face... new challenges.*

However, not all participants drew on ‘Intrinsic power’ during labour, nor did they necessarily draw on it at other times of challenge. In this study ‘Intrinsic power’ often provided a sense of continuity for the women, yet ‘Intrinsic power’ is always changing relative to each experience. The particularities of each woman’s situation sometimes led to a sense of insecurity and/or confusion about her sense of self as well as a loss of confidence in her ‘Intrinsic power’. Furthermore, a woman’s response to her experiences impacted on how she perceived the situation, herself and her ‘Intrinsic power’. The sections that follow explore those responses; firstly, a woman’s pre-reflective experience of the current moment is examined.

### 6.2.3 ‘The embodied self’: core concepts

The concepts that constitute the core of ‘The embodied self’ are **EMBODIED BEING**, **EMBODIED KNOWING** and **EMBODIED POTENTIAL**. They and their sub-concepts are defined in table 6.3 (p.238). Each concept coexists simultaneously as part of a person’s qualitative experience of the experiential moment. Change continues to subtly occur in the experiential moment, so each concept expresses a different temporal aspect of the self in that experiential moment. In addition, each concept interacts with ‘Intrinsic power’ so as to portray knowing, security and power from different perspectives.
## Table 6.3 ‘The embodied self’: core concepts

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Definition</th>
<th>Sub-concepts</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMBODIED BEING</strong></td>
<td>The experience of existing in the experiential moment, actualising ‘Intrinsic power’ as it interacts with and enables body, mind and soul to exist.</td>
<td><em>Being whole</em></td>
<td>The activity of immersion in embodied existence, where a sense of inner and outer balance is experienced and a sense of loss or lack is absent.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Being fragmented</em></td>
<td>The activity of immersion in thought, where a sense of fragmentation is experienced and/or a sense of loss or lack is felt.</td>
</tr>
<tr>
<td><strong>EMBODIED KNOWING</strong></td>
<td>The experience of knowing in the experiential moment. Knowing may be conscious and/or unconscious. It may be holistic or limited to cognitive or automatic repetition of previous patterns of behaviour.</td>
<td><em>Spiritual knowing</em></td>
<td>Embodied knowing which is spontaneous, free flowing and sometimes paradoxical. The self is experienced as a unique body/mind/soul in the immediacy of the here and now. Includes ‘Intrinsic power’ which provides the courage for recognising and responding to the uniqueness of the experiential moment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Egoic knowing</em></td>
<td>Embodied knowing according to previous learning which the ego applies (consciously or unconsciously) to the experiential moment. Security and power are drawn primarily from extrinsic sources that deny the uniqueness inherent in the experiential moment.</td>
</tr>
<tr>
<td><strong>EMBODIED POTENTIAL</strong></td>
<td>The possibility and latent ‘Intrinsic power’ embodied in the current experiential moment which can impact on subsequent experiential moments.</td>
<td><em>Creative action</em></td>
<td>The potential to create new actions. Similarities and differences are experienced with neutrality allowing ‘Intrinsic power’ the comparative freedom to integrate body/mind/soul with the activity to be experienced in the next moment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Conformist action</em></td>
<td>The potential to undertake conformist actions. Similarities and differences are experienced defensively causing a comparative reliance on egoic/extrinsic power. ‘Intrinsic power’ is experientially ignored.</td>
</tr>
</tbody>
</table>
6.2.3.1 Embodied being

EMBODIED BEING describes the way in which ‘The embodied self’ exists in the experiential moment. In EMBODIED BEING ‘Intrinsic power’ is being actualised to animate body, mind and soul at that moment. The concept has two sub-concepts: being whole and being fragmented which variously impact on a person’s sense of security.

**Being whole** is an in-the-moment sensation of body/mind/soul balance where there is no sense of loss or lack. The perception of being whole can feel as if change has stopped and time has stood still. For example, Jane’s description of her altered conscious state during labour:

I started to go into the zone when the contractions became closer together and more intense... I had the feeling that all that existed was this pain and me, nothing else. When they became really intense I had that feeling that death could come and it didn’t matter. It was very much just being alive in that moment and dealing with each second as it came, there was no feeling of future or past (p.18).

**Being fragmented** is an in-the-moment sensation of imbalance where imagination, thoughts, worries and desires dominate. Being fragmented is often the first sensation during a situation of change, because the unknown future can evoke fear. When Lisa’s membranes ruptured she “felt a bit scared and excited” because, to her “this was the real thing now”, then speaking to the hospital “eased” her “nervousness” and the sense of being fragmented passed (pp.239-40). Louise on the other hand had an intense experience of being fragmented toward the end of labour:

[My midwife] said ‘I can see the head’ and I was suddenly outside of myself imagining the baby’s head coming out; that was the part I’d been scared of. I didn’t really feel like I was going through it anymore, I seemed to totally let go and click into watching myself do it... I was an observer looking from the outside and detached from the whole giving birth experience as well as from the baby (pp.78-9).

Whether or not a woman is experiencing herself as being whole or being fragmented, during the experiential moment, she is also expressing her own particular version of EMBODYED KNOWING.
6.2.3.2 Embodied knowing

**EMBODIED KNOWING** describes the current embodied expression of self in the experiential moment. Self-expression is drawn from past experience and from what is known of the experiential moment. **EMBODIED KNOWING** conceptualises how the self manages what is already known about itself relative to the experiential moment.

Security is variously drawn from internalised elements of past experience (such as values, habits and intentions) and from ‘Intrinsic power’. Power in the experiential moment is physically manifested according to this **EMBODIED KNOWING**. The two sub-concepts of **EMBODIED KNOWING** are spiritual knowing and egoic knowing.

**Spiritual knowing** embraces change. **Spiritual knowing** enables the self to be expressed uniquely according to the needs of the moment in a way that may be described as peaceful and/or energising. Connection and integration are characteristics of **spiritual knowing** because ‘Intrinsic power’ provides the courage to face whatever is different, unpalatable or unknown. As Emily progressed through labour she embodied **spiritual knowing**:

> Once I’d got to 5 cm I became really secure within myself... I had been quite vulnerable to whichever midwife was on but now I knew I was doing this and nobody else, it didn't really matter who my midwife was... I might have been on the delivery unit's whiteboard as one of those crazy birth centre women, but I knew I could do it now (p.337)

**Egoic knowing** resists change so that self-expression is based on previously perceived expectations, beliefs and habits. ‘Intrinsic power’ is diminished or may seem unavailable with **egoic knowing**. For example, Dawn’s focus on particular ways of knowing led her to inauthentic expressions of self that lasted until she was diagnosed with postnatal depression:

> I dislike hospitals and... put little spins on it to try and stay positive... I felt like I had to be strong because it was so clinical and I didn’t have any privacy to let my feelings out, inside I wanted to be a blubbing mess... [Once home] I kept telling everybody I was OK and on the outside I coped well but... inside I was tearing to pieces (pp.115, 121-2).

While a woman may express herself according to **spiritual knowing** or **egoic knowing** in any experiential moment, in doing so she is simultaneously also influencing her potential for future action.
6.2.3.3 Embodied potential

EMBODIED POTENTIAL conceptualises the possibility and latent ‘Intrinsic power’ that are inherent in the experiential moment. EMBODIED POTENTIAL is the manifestation of the self’s sense of security. The two sub-concepts of EMBODIED POTENTIAL are creative action and conformist action.

Creative action is the potential to create new actions through an embodied openness to difference and change. The potential in creative action comes from an intrinsic sense of security, power and freedom shifting to produce the experientially ‘right’ conditions for the situation. The ‘Intrinsic power’ inherent in creative action can provide the security to keep going in times of challenge, as Celeste found in labour:

I knew the pain was something that had to happen, I saw it as a necessity and accepted it on a very deep level but at the time I felt no appreciation of it and looked at it neither pessimistically nor optimistically. It was just what I had to do. I had a sense that it was inevitable, this baby was going to be born. But it was so painful I also had to evoke a sort of bravery or courage to get through it (p.300).

Conformist action conveys the potential to undertake actions that are limited by embodied expectations and defensive values that resist change. Conformist action does not necessarily mean action that conforms socially. Conformist action is potentially disintegrative to the self and may cause disconnections with others. Louise said:

Because I was scared there was something wrong [with my baby in pregnancy] I had almost detached myself from him just in case there was, but that meant when I actually had him I couldn’t believe I had a baby. (p.91)

Patricia’s fear also led her toward conformist action during one of her attempted labour inductions:

Watching the heart rate drop scared me a lot... The feeling inside me was that something was wrong with my baby. I was terrified; all I wanted was a happy baby.... I just didn’t feel safe... My obstetrician wanted me to keep the induction going... I ended up talking to another doctor... I [said]... ‘I want to have a caesarean’ ...she thought I was doing the right thing (p.279)

A woman’s EMBODIED POTENTIAL for creative action or conformist action is also shaped by the way her ego responds to change.
6.2.4 ‘The embodied self’: egoic concepts

The ego, as defined in chapter one, is most concerned with self-protection relative to culture and relative to how the nonrational aspects of the self are expressed via ‘Intrinsic power’. The egoic concepts of ‘The embodied self’ are AWARENESS, INTEGRITY and TRUST. They and their sub-concepts are defined in table 6.4 (p.243). These concepts collectively represent the qualities of the ego. AWARENESS, INTEGRITY and TRUST depict qualities that influence change and impact on multiple, often simultaneously occurring, interactions. Each egoic quality is relevant to aspects of the situation that are extrinsic and intrinsic to the self. These egoic concepts are reactive and often controlling. They influence the subtle changes in the experiential moment and in the broader situation of change. The egoic concepts may be themselves changed by the experiential moment and by the situation. Interaction also occurs between the egoic concepts and the ‘Change pathways’. In addition, the egoic concepts interact with each other.

6.2.4.1 Awareness

The concept AWARENESS describes ego’s relative receptiveness to the possibility that ‘Intrinsic power’ is an available resource. Ego derives strength relative to its AWARENESS of ‘Intrinsic power’. The pair of sub-concepts representing AWARENESS are integrated strength and qualified strength; they describe where and how the ego derives strength and security during change.

With integrated strength ego draws security, knowing and power from the experiential moment as well as from extrinsic means. Emily was clear that it was an integrated strength and not just her ego that got her through labour:

My ego was there very strongly... But if I were motivated by ego alone [pushing] wouldn’t have felt authentic to me and I wouldn’t have been able to sustain it.

‘Intrinsic power’ and extrinsic power are used simultaneously in integrated strength, as Helen explained:

My feeling of inner power [during labour] was intrinsic whereas my feeling of control was more extrinsically influenced by those around me and the situation I was in so I could feel powerful and not necessarily in control at the same time. I felt like I could cope when I felt powerful, and cope even better when I felt powerful and in control... I had never been in that situation before [so] I
wasn't always sure I wanted to be in control... I felt comfortable with... [the staff] having... control, as long as I got to keep the power (p.413).

Table 6.4 ‘The embodied self’: egoic concepts

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Definition</th>
<th>Sub-concepts</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AWARENESS</td>
<td>Describes how ego derives strength relative to awareness of extrinsic and ‘Intrinsic power’.</td>
<td>Integrated strength</td>
<td>Strength arises from practises of awareness that integrate extrinsic and ‘Intrinsic power’. Strength also comes from the sense of security provided by this ‘both/and’ awareness.</td>
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<tr>
<td></td>
<td></td>
<td>Qualified strength</td>
<td>Strength is bounded by ego’s qualified judgments enabling only a pragmatic awareness of ‘Intrinsic power’. Strength may also come from the ‘either/or’ perspective of an ideal future.</td>
</tr>
<tr>
<td>INTEGRITY</td>
<td>Describes the truth of ego’s expression of ‘The embodied self’ relative to the situation and to ‘Intrinsic power’.</td>
<td>Nonrational truth</td>
<td>Ego’s assessments of the situation include the nonrational value of unique expressions of self. Vitality is perceived as unconditional and outcomes are accepted as uncertain.</td>
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<tr>
<td></td>
<td></td>
<td>Rational truth</td>
<td>Ego’s assessments of the situation are rationally limited to expressions of self that are deemed ‘normal’. Vitality is perceived as conditional on normality and certain outcomes are sought.</td>
</tr>
<tr>
<td>TRUST</td>
<td>Describes how ego changes through its relative capacity to trust ‘Intrinsic power’.</td>
<td>Genius change</td>
<td>Ego has the courage to use ‘Intrinsic power’ and absolutely releases itself according to the needs of the situation. Integrity is preserved and what was previously perceived as impossible becomes an experiential reality.</td>
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<tr>
<td></td>
<td></td>
<td>Forced change</td>
<td>Ego only relatively releases itself to the needs of the situation. Egoic/extrinsic power is primarily used to force change. Ownership of previous perceptions of impossibility is preserved.</td>
</tr>
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</table>
Qualified strength is where power is drawn from extrinsic means or from the qualifications of the ego; ‘Intrinsic power’ is ignored or difficult to access. Helen did not always ‘keep the power’ she described above. She used a qualified strength when she was pushing:

They said ‘push into your bottom’... I just did the funny face and they'd go, ‘good girl’... I wasn’t fully pushing right down through my whole body; I was just keeping them happy. I got confused between the physical and the mental. I was concentrating on the words the medical professionals were saying and that distracted me from my natural urges (pp.416-7).

In concert with a woman’s use of integrated strength or qualified strength the ego also assesses, responds to and influences how ‘The embodied self’ changes according to INTEGRITY.

6.2.4.2 Integrity
The concept INTEGRITY describes the congruity between ego expressions of the self, the current experience of ‘Intrinsic power’ and the broader situation of change. INTEGRITY expresses how the ego assesses the unknown, hidden, unexpected, different and changing elements of experience. INTEGRITY is thus an expression of the ego’s perception of truth at any particular experiential moment. The concept has two sub-concepts nonrational truth and rational truth.

Nonrational truth encompasses a ‘both/and’ perspective on the self and the situation that is inclusive of rational forms of truth. Nonrational truth allows for uncertainty, accepts the unknown and perceives the changeability of the self and the situation.

Leanne made her plans for labour using nonrational truth:
I certainly don’t want to be presumptuous and appear as though I’ve got it all sorted. I wonder how I’ll know that I’m in labour... I have confidence that things will go according to the best plan for whatever is unfolding on the day... What lies ahead is unknown but very positive... I have made common sense attempts to be ready for what is ahead. I’m not too fussed about things, life can go up and down and I’ll just cruise along, so that gives me a quiet sense of control without actually having any rigidity (p.137).

Rational truth presents a rational ‘either/or’ understanding of self and the situation that is based on imagined expectations of normality and desires for certainty. In assessing the experiential moment rational truth excludes nonrational forms of truth. Lisa, for example, used rational truth:
I’d heard stories about long labours and the baby coming out with brain damage. I wanted to get on with it and make sure she was OK… around 7pm… I was 4cm. In the back of my mind… I was thinking I’m not going to let it go another 24 hours. I asked for some pain relief… I just wanted some help… pain relief was there and I needed it! I was given Pethidine... [Later] they gave me the spinal block. I’m so glad they did... I... became a normal person again. I thought... I want this baby born today after all this, but it was 11 o’clock so I only had an hour... in the theatre... one of the girls had to feel my stomach for contractions and tell me when to push... soon it was going to be over. The doctor gave me an episiotomy, put the suction cap on... just one push and she was out (pp.441, 443, 445).

A woman’s **nonrational truth** or **rational truth** is also influenced by the way in which her ego approaches **TRUST**.

### 6.2.4.3 Trust

The concept **TRUST** is an expression of how the ego changes relative to its assessment of safety. **TRUST** describes how prepared the ego is to welcome change, let go to ‘Intrinsic power’ and believe in the capacity of ‘The embodied self’ to survive the situation. The two sub-concepts of **TRUST** are **genius change** and **forced change**.

With **genius change** the ego welcomes change and releases itself to the needs of the situation. Elizabeth explained the process antenatally:

> You get through these things, even though you think you’re going to die. It’s really not a physical death; it’s more a death of what you’re holding on to, of your ego. Childbirth will be a really intense experience and there are going to be times when I think I’m going to die but I know deep down I can handle it, I’ll be fine (p.47).

‘Intrinsic power’ is used during **genius change** so that what was previously thought to be impossible is achieved, as Jane described:

> As the head crowned, I was determined and completely let go. It felt impossible, everything was stretching. It’s the intensity of it and it’s the imagined impossibility of it, like a sick joke. Then the head was there, unbelievable, amazing (p.24).

With **forced change** the ego does not fully welcome change and only partially releases itself to the needs of the situation. During a **forced change** trust is placed in the ego and directed extrinsically without reference to ‘Intrinsic power’. Egoic and/or extrinsic power instead works to compel change in certain ways. Celeste attempted a **forced change** during pushing:
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The urge to push felt like a grunt, a deep, deep feeling that I didn’t really have control over... I tried to consciously control it once, because I was getting so tired I pushed when the urge wasn’t there, but that didn’t work it only worked when the urge was there (pp.305-6).

Louise’s experience of dissociation at the end of second stage (section 6.2.3.1) was also an experience of forced change. The intensity of Louise’s fear and lack of trust, in combination with the inevitability of change (the impending birth), forced her ego to protect itself by utterly dissociating from the situation. Louise’s body meanwhile continued with the birth process whilst the she was “outside” of herself (p.78).

As a woman experiences more or less TRUST in her situation, her active use of ‘Intrinsic power’ changes. Her experience of the moment also changes in subtle and not so subtle ways. In addition, subtle adjustments occur with AWARENESS and INTEGRITY that then further impact on TRUST and the woman’s experience of the situation. Collectively the egoic concepts of ‘The embodied self’ and the core concepts describe how in-the-moment and short term changes are continually taking place relative to a woman’s ‘Intrinsic power’. These changes primarily occur spontaneously and seemingly without choice. The next section, the ‘Change pathways’, now considers how a woman may choose to consciously adjust the ways that she changes.

6.2.5 ‘Change pathways’

The ‘Change pathways’ describe the choices that ‘The embodied self’ can make to influence how change is experienced by the self and others. The ‘Change pathways’ also describe the choices made by other embodied selves; these choices can in turn influence how ‘The embodied self’ experiences change. Self-enhancing pathways are described using the concept EMPOWERING PRACTICES. Self-diminishing pathways are described using the concept HABITUAL PRACTICES. EMPOWERING PRACTICES and HABITUAL PRACTICES are each defined with their sub-concepts in table 6.5 (p.247).

Table 6.5 shows three forms of practice that make up each of the pathways. Practices pertaining to accountability, decision-making and the use of power impact on each interaction during any particular situation of change.
### Table 6.5 ‘Change pathways’: concepts

<table>
<thead>
<tr>
<th><strong>CHANGE PATHWAYS</strong></th>
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<tbody>
<tr>
<td>Choices available in any particular situation relative to:</td>
<td></td>
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<tr>
<td>- self interacting with self;</td>
<td></td>
</tr>
<tr>
<td>- self interacting with environment and other selves;</td>
<td></td>
</tr>
<tr>
<td>- environment and other selves interacting with self.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>EMPOWERING PRACTICES</strong></th>
<th><strong>HABITUAL PRACTICES</strong></th>
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</thead>
<tbody>
<tr>
<td>A group of activities that are qualitatively congruent with the in-the-moment situation and liberate ‘Intrinsic power’ enabling ‘The embodied self’ to sense itself as an embodied whole and intrinsically powerful person.</td>
<td>A group of activities based on assumptions qualitatively inappropriate to the in-the-moment situation which dominate and/or ignore ‘Intrinsic power’ undermining ‘The embodied self’ as an embodied whole and intrinsically powerful person.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Accountability in each interaction</strong></th>
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<tbody>
<tr>
<td>Practices concerned with how the situation is understood.</td>
<td></td>
</tr>
<tr>
<td><strong>Honest accountability</strong></td>
<td><strong>Vested accountability</strong></td>
</tr>
<tr>
<td>A practise where the situation of change is impartially assessed; underlying rationales for action are explicitly recognised as rational and nonrational; and in-the-moment experiences are taken into account.</td>
<td>A practise where the situation of change is assessed in prejudiced ways; underlying rationales for action are unclear, unsought or ignored; and in-the-moment experiences are overlooked.</td>
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<table>
<thead>
<tr>
<th><strong>Decision-making in each interaction</strong></th>
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<tbody>
<tr>
<td>Practices concerned with how the situation’s decisions are made.</td>
<td></td>
</tr>
<tr>
<td><strong>Contextual decision-making</strong></td>
<td><strong>Abstract decision-making</strong></td>
</tr>
<tr>
<td>A ‘both/and’ practise that places the uniqueness of ‘The embodied self’ and the particularities of the current situation into the centre of decision-making; decisions are made relative to each individual situation as it unfolds, the nonrational possibilities in a situation are respected.</td>
<td>An ‘either/or’ practise that uses a rational approach ignoring the uniqueness of ‘The embodied self’ and the current situation; decisions are made relative to particular ways of knowing, the nonrational possibilities in a situation are considered disparagingly.</td>
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<table>
<thead>
<tr>
<th><strong>Use of power in each interaction</strong></th>
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<tbody>
<tr>
<td>Practices concerned with how power is used in the situation.</td>
<td></td>
</tr>
<tr>
<td><strong>Integrative power</strong></td>
<td><strong>Disintegrative power</strong></td>
</tr>
<tr>
<td>A practise where extrinsic and egoic powers work co-operatively with ‘Intrinsic power’ to enable unique responses that optimise intrinsic security and release ‘The embodied self’ to change. The use of <em>integrative power</em> provides clarity of overall intention so that power is directed to the wellbeing of the whole ‘embodied self’ according to its current situation rather than to ego alone.</td>
<td>A practise where extrinsic or ego driven forms of power exclude individual differences and promote reliance on extrinsic forms of security; ‘The embodied self’ only relatively releases to change, and ‘Intrinsic power’ is effectively unavailable. The use of <em>disintegrative power</em> fragments intention and maintains the dominance of self-protective ego actions.</td>
</tr>
</tbody>
</table>
6.2.5.1 Empowering practices

EMPOWERING PRACTICES are purposefully chosen according to the unique needs of ‘The embodied self’ and the particular situation of change. The three sub-concepts of EMPOWERING PRACTICES are: honest accountability, contextual decision-making and integrative power. These sub-concepts can be clearly articulated but, as they take a ‘both/and’ perspective, they are not in practice mutually exclusive.

Honest accountability is a practice that non-judgementally acknowledges biases or excuses and makes underlying rationales for action explicit. Dawn showed honest accountability in how she understood what was happening for her during contractions:
I was focusing deeply inside myself, not to escape but to help me go with it, a primal response that gradually built with the pain. Everything was about me labouring, about what was happening down in the uterus because that was where all the power was. There was no fear, I just didn’t care about anything else, I wasn’t even aware of my partner holding my hand or the rest of my body (p.108).

Contextual decision-making is a practice that places the unique embodied self and the particular aspects of the situation at the centre of decision-making. Only rational process and knowledge that is contextually appropriate to the particular self experiencing the particular situation are included. Contextual decision-making was practised by Patricia when she was being pressured by loved ones to terminate her pregnancy:
The first 3 months of this pregnancy were probably the worst time of my life... I had all these emotions running through my head at that time... I was confused... I thought [mum] was turning against me... it gave me a... sick feeling... I stood tall and said ‘no’. I think people started to accept me and the baby because I was so sure of what I was doing. I didn't have any doubt about the decision that I was making (pp.269-70)

Integrative power is a practice where extrinsic and egoic powers work co-operatively with ‘Intrinsic power’ so as to optimise the experience of change. When Emily realised she had shoulder dystocia she made a choice to use integrative power:
I never went through the pictures of shoulder dystocia in my mind... It was like my body interpreted what it meant to have shoulder dystocia... I never went through the ‘what ifs’ of possible damage or disablement; I wasn’t even focused on making her safe. In those few seconds I realised no one else could help me... there were three people pulling on her head... I didn’t see any of that, my body was totally focused on opening up (p.342).
For practices to remain empowering the **EMPOWERING PRACTICES** must be continually adjusted to suit those changes. However, when the situation changes often more **HABITUAL PRACTICES** are at least initially undertaken.

### 6.2.5.2 Habitual practices

**HABITUAL PRACTICES** are activities that are routinely undertaken or rationalised as necessary. These practices primarily take an ‘either/or’ perspective that minimises awareness of the experiential moment and diminishes the capacity to individualise responses to change. **HABITUAL PRACTICES** draw from egoic and extrinsic resources that limit the free flow of ‘Intrinsic power’ knowing and security. The concept’s three sub-concepts are **vested accountability**, **abstract decision-making** and **disintegrative power**.

**Vested accountability** is a practice where the biases underlying rationales for action are ignored, unacknowledged or difficult to articulate. Leanne was eventually able to articulate why her **vested accountability** negatively coloured how she experienced being pregnant for the second time:

I spent my day wondering what would make me smile and feel excited, I couldn’t think of anything… it worried me that I couldn’t and [that] compounded the situation. I felt like howling and couldn’t articulate why… Much of my flatness has been about that superficial layer of self dealing with things… I had conditioned myself to think I’d have… time out for me [before getting pregnant again]. I was really looking forward to a little sense of indulgence like having, wearing sexy lingerie and doing a few girly things (p.153).

**Abstract decision-making** is a practice where decision-making prioritises rational considerations above those of the uniquely changing embodied self. Louise’s decision-making regarding her second birth was an **abstract decision**:

Being at home was such a good thing but it was all about me, how confident I was feeling and how I wanted to labour. Next time it will be about the baby and it doesn’t matter what they do to me as long as the baby’s healthy. It is a sacrifice but I have a totally different feeling for the next baby… I’m scared of having the next baby at home and I know it’s going to be in hospital (p.96).

**Disintegrative power** is a practice that fragments experience by using dominant extrinsic ego-based forms of power to drive action. Dawn started using **disintegrative power**, when she was transferred out of the birth centre:
I didn’t feel grounded anymore. I tried but wasn’t able to stay very calm... I felt defeated. I was so tired and disappointed I half wondered why I’d tried in the first place... I was mentally uncomfortable because I didn’t want to be there. But I accepted it because by then I just wanted him to be born... The epidural was put in... [7 hours later] I got fully dilated... I let the epidural start to wear off but I’d had such a big break and lost that inside focus that the contractions came back feeling twice as strong and so fast they were almost an assault. I was too tired and couldn’t cope with that at all so I kept the epidural going (p.110-2).

Dawn’s use of disintegrative power, maintained her HABITUAL PRACTICES. The choice to use EMPOWERING PRACTICES is often hidden by HABITUAL PRACTICES. Becoming more aware of this choice is a characteristic of an enhanced embodied self.

6.2.6 Discussion: characteristics of the changing embodied self

The theory ‘Liberating intrinsic power’ describes how a person’s embodied sense of self changes relative to their active awareness and use of ‘Intrinsic power’. The embodied sensations that arise from ‘Intrinsic power’ shape a person’s in-the-moment experience, their self-knowing, and their potential for change in any situation. ‘Intrinsic power’ also reflexively interacts with a person’s egoic qualities. The egoic qualities thus impact on: a person’s willingness to draw strength from ‘Intrinsic power’; on their inclusion of nonrational perspectives; and, on their feelings of being secure enough to welcome change. A person can actively participate in their process of change by choosing practices that, according to the ‘Change pathways’ are more or less mindful of ‘Intrinsic power’. EMPOWERING PRACTICES are mindful of ‘Intrinsic power’ and enhance ‘The embodied self’. Those that involve HABITUAL PRACTICES ignore or demean ‘Intrinsic power’ and are diminishing to ‘The embodied self’.

By using EMPOWERING PRACTICES a woman can incorporate ‘Intrinsic power’ into her change situation. The factors that appear to have most impact on how she then experiences her changing embodied self are accountability, decision-making and the use of power. When a woman actively uses her ‘Intrinsic power’ and integrates it into her situation of change, she is more likely to have an experience where mind, body and soul work seamlessly together in ways that are most advantageous to the embodied self. In this state of optimised psychophysiological wellbeing she can feel a sense of her
embodied self as whole and intrinsically powerful. This state is so self-enhancing that negotiation of an improved sense of self is more likely to become an ongoing practice.

The characteristics of an enhancing embodied self and those of a diminishing embodied self as found in this research are listed in table 6.6 (p. 252). Change is an ongoing process and enhancing ‘The embodied self’ through EMPOWERING PRACTICES is necessarily a continued process. The characteristics of the enhancing embodied self indicate that the process can become easier, as shown in table 6.6. Nonetheless, while EMPOWERING PRACTICES may become easier to undertake, they cannot become habitual because some sense of the conscious capacity to choose relative to the particularities of the situation must always remain. The next section explores the various ways that women experience an improved sense of self by using EMPOWERING PRACTICES during childbirth.

6.3 TOWARD AN IMPROVED SENSE OF SELF DURING CHILDBIRTH

In this section I present five different scenarios from stories in Appendix B. These scenarios were chosen to illustrate women’s experience of moving toward an improved sense of embodied self during childbirth. I also include interpretive comments that relate each scenario to the theoretical concepts. In these commentaries I use the sub-concepts of ‘The embodied self’ to variously discuss how each woman changes. I also consider the ‘Change pathways’, showing how women’s accountability, decision-making and the use of power are factors influencing improved sense of self during the birth experience. For the remainder of this dissertation I differentiate the ‘Change pathways’ sub-concepts from ‘The embodied self’ sub-concepts by underlining them. For clarity I have rearranged portions of some scenarios to give a more chronological picture of the particular situation of change being considered. The subheadings name each scenario with my understanding of the main change situation for each woman. HABITUAL PRACTICES dominate the first extract from Jasmin. For each of the other women integrative power is variously used in a way that returns them to a pathway of EMPOWERING PRACTICES.
Table 6.6 ‘The embodied self’: characteristics of change

<table>
<thead>
<tr>
<th>Enhancing embodied self</th>
<th>Diminishing embodied self</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Being whole, spiritual knowing</strong> and <strong>creative action</strong> are increasingly a part of</td>
<td><strong>Being fragmented, egoic knowing</strong> and <strong>conformist action</strong> are maintained as a part of</td>
</tr>
<tr>
<td>in-the-moment experience</td>
<td>in-the-moment experience</td>
</tr>
<tr>
<td>Qualities of <strong>integrated strength, nonrational truth</strong> and <strong>genius change</strong> are</td>
<td>Qualities of <strong>qualified strength, rational truth</strong> and <strong>forced change</strong> continue to be</td>
</tr>
<tr>
<td>increasingly demonstrated by the ego</td>
<td>demonstrated by the ego</td>
</tr>
<tr>
<td>Awareness of capacity to choose practices during any change context is increased</td>
<td>Maintains sense of having no choice during change situations</td>
</tr>
<tr>
<td>Increasingly chooses <strong>EMPOWERING PRACTICES</strong></td>
<td>Maintains <strong>HABITUAL PRACTICES</strong></td>
</tr>
<tr>
<td>Increasingly welcomes change and maintains values appropriate to the in-the-moment</td>
<td>Continues to resist change and defend values regardless of how appropriate they are</td>
</tr>
<tr>
<td>situation</td>
<td>to the in-the-moment situation</td>
</tr>
<tr>
<td>Is increasingly more mindful of ‘Intrinsic power’</td>
<td>Continues to dominate or ignore ‘Intrinsic power’</td>
</tr>
<tr>
<td>Increasingly draws on ‘Intrinsic power’</td>
<td>Continues to draw from extrinsic/egoic sources of power</td>
</tr>
<tr>
<td>Increasingly accepts paradoxical (‘both/and’) perspectives</td>
<td>Increasingly rejects paradoxical (‘both/and’) perspectives</td>
</tr>
<tr>
<td>Increasingly questions either/or perspectives</td>
<td>Increasingly accepts either/or perspectives</td>
</tr>
<tr>
<td>Sense of security is becoming steadier during situations of change</td>
<td>Sense of security is erratically experienced during situations of change</td>
</tr>
<tr>
<td>Increasingly has a sense of embodied wholeness during situations of change</td>
<td>Continues to have a sense of fragmentation during situations of change</td>
</tr>
<tr>
<td>Demonstrates increasing capacity to optimise psychophysiological wellbeing relative</td>
<td>Demonstrates little apparent capacity to optimise psychophysiological wellbeing relative</td>
</tr>
<tr>
<td>to in-the-moment situation</td>
<td>to in-the-moment situation</td>
</tr>
<tr>
<td>Intention/action are increasingly congruent</td>
<td>Intention/action are frequently incongruent</td>
</tr>
<tr>
<td>Love increasingly feels unconditional</td>
<td>Love continues to feel conditional</td>
</tr>
<tr>
<td>Increasingly feels intrinsically powerful</td>
<td>Increasingly feels intrinsically powerless</td>
</tr>
<tr>
<td>Self is increasingly defined in diverse &amp; multidimensional ways</td>
<td>Self primarily defined in terms of social identity</td>
</tr>
</tbody>
</table>
6.3.1 Planning a certain way - Jasmin

Antenatally Jasmin told of how she planned for her homebirth to go a certain way:
If I’ve got a place to go and everything around me that I need, [labour] will be a really positive experience. The only thing I can do is control the environment… I’ve set myself up really well with support people and two midwives… I’ve prepared a room specifically… She is being born in her own room in water… My friend Hannah… did a lot of preparation for a natural birth but had a Caesar… she didn’t have access to the same level of information about birth as I have (pp.167-168).

Jasmin practised vested accountability to understand her situation and accessed a qualified strength to gain security about the birth. She demonstrated no awareness of her ‘Intrinsic power’ or the in-the-moment sensations that motivated her. Jasmin’s abstract decision-making provided a rational truth that she experienced as egoic knowing of being certain about where her baby would be born. Jasmin was so sure of this that she used disintegrative power to explain why her friend did not do what Jasmin was certain she would do, thus expressing her potential as conformist action.

Jasmin did begin labour at home:
I was mentally prepared for letting go… I trusted that the people I needed were in the room and because those supports were around me I was able to give up… control. But Mae [my midwife] became quite ill… and was often out of the room. I couldn’t focus during contractions without her. I became scared when I knew a contraction was coming; then the fear developed into… panic… In between contractions I’d have my eyes on Mae whenever she moved… [my second midwife] was trying to help but… she just wasn’t Mae. My husband tried holding me but I didn’t want a bar of that… The minute Mae put her hand on my forehead it was all right, I could do it. I just needed that soothing voice, I was really clinging and in between I was apologising… [After Mae left and I knew labour was not going to plan] I was panicking, screaming and completely out of control. I didn’t have Mae holding my hand, the pool, or that peaceful, everything’s going to be all right feeling. I was in free fall; I had no surety [my baby] was going to be born at home. I didn't know what was going to happen (pp.170-3).

Jasmin continued to practise vested accountability and again accessed qualified strength to enable her to let go. But when those strengths were removed she was left to experience being fragmented. Without being aware that she was undertaking abstract decision-making she experienced the fearful reality of her egoic knowing. With egoic
knowing no one and nothing else would do, she had to have her midwife and the birth had to go according to her plan. Practising disintegrative power Jasmin invested all her energy in this plan which led to the forced change of a hospital transfer.

Of the transfer to hospital Jasmin said:
Hospital wasn’t the big demon that I thought it was going to be... [my second midwife] was with me and I felt quite safe... [but] I still believed I was going to have... a natural birth although I wasn’t quite sure how... I felt in control of the decisions I’d made about my care, but what felt out of my hands was the outcome. It was all so hard and out of control. I really feel like I sold myself to the devil... A doctor pressured me saying ‘has anyone talked about caesarean’... I was buying time for Mae to tell me I wouldn’t need to talk about it; I thought there would be another card in the bag...I had felt completely in control beforehand, it was terrible to have it go so far from the plan I thought I could guarantee myself the best outcome by surrounding myself with the right tools: I studied, did all the possible preparation, and employed my own midwives. I put so much effort into having it go a certain way (pp.174-6,180).

Jasmin made few adjustments to her HABITUAL PRACTICES once in hospital. In practising vested accountability Jasmin denied the lived reality of her in-the-moment experience, maintained her experience of being fragmented and still accessed qualified strength from her midwife. Her abstract decision-making led Jasmin to continue resisting change and keep the experiential security of her egoic knowing. Practising disintegrative power to maintain the illusions of her ego Jasmin experienced a forced change because, try as she might, she could not force her birth to go the certain way she planned.

6.3.2 Worrying about whether labour will start - Emily

Emily planned to use a birth centre; as her pregnancy crept toward 42 weeks her caregivers gave supportive advice:
I really believed that I would go into labour... the whole team of hospital midwives had real faith in me. They suggested things to help me get into labour and said I could ring any time. Even though I had plenty of knowledge, just knowing they were there was reassuring (p.329).

Emily initially practised integrative power and trusted her capacity to go into labour. She used honest accountability to assess her situation, drew an integrated strength from her own belief and from her midwives.
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However labour did not start:

As I got more overdue I worried that maybe I was being crazy waiting… I found it very easy to
default to that rational part of me… I [even] initiated a conversation about Caesars… but I was…
encouraged to be patient (pp.329-330).

Emily shifted to a vested accountability and her worries created an experience of being
fragmented. She practised abstract decision-making and expressed a rational truth.
However, her caregivers used EMPOWERING PRACTICES to encourage her to be patient.

Nonetheless Emily continued to have concerns:
I’d been through conversations with myself about why my baby’s head was still high… I worried I
had talked my body into being overdue because I’d worked until late in pregnancy and nothing
was ready… By this point my doubts and fears were so real … I began to question why I was
waiting… I had to stand back and ask myself who ‘I’ was in the experience and I tried to let my
body be (p.330).

Emily used disintegrative power on herself; she tried to force change and shifted her
potential to conformist action. She again practised vested accountability and
experienced being fragmented as she worried over causation. Expressing herself in this
way was a practise of abstract decision-making and an experience of her egoic
knowing. But rather than persisting on this path she reverted back to using integrative
power and the other EMPOWERING PRACTICES, again welcoming genius change. By
looking inside herself she increased her awareness of in-the-moment bodily experience
so she resumed experiencing being whole, her spiritual knowing and creative action.

However, Emily was further challenged:
When I was 11 days over I felt petrified because I hadn’t had any foetal movements for 3 hours, I
thought maybe I’d gone too far and should get induced. I knew if I had been going to a different
hospital I’d have been induced that day. I contemplated going to have the heart beat done, but
part of me asked what running to someone else was going to achieve. I realised I had to accept
whatever was going to come from this, that my body would tell me what was coming. I’d either
have more movements or I wouldn’t…I didn’t leave home; I just squatted outside in the garden,
calming my mind and feeling acceptance of my body. The midwives and doctor’s faith in me got
me up to that point and then faith in myself got me the next three days …the day before I was due
to start Prostin, my membranes ruptured (pp.330-331).
Once again Emily responded to challenge with **HABITUAL PRACTICES** and expressed the fears of her **egoic knowing**. She contemplated practising **vested accountability** and accessing **qualified strength**. However, Emily instead chose to practise **honest accountability** as she listened to her body as well as her questions as they arose. She undertook **contextual decision-making**, drew on a **nonrational truth** and took courage in the experience of her **spiritual knowing**. Thus Emily actively used **integrative power** to enable a **genius change** in herself that allowed her to patiently wait for labour to begin unaided.

### 6.3.3 Losing the rhythm: starting to push - Maree

Maree planned a homebirth but transferred to hospital with meconium stained liquor and no labour. During her oxytocic induction she responded rhythmically to contractions:

> Often I almost forgot the image of hospital while I focused on my husband at home feeling pleased and cheering me on… Contractions were fairly full on but didn’t take over my body; I felt quite controlled and got into a rhythm of focused letting go… I never really went off into another space although as the contractions increased and got more difficult I needed to put more energy into being centred and focused so I would talk less…Every time a contraction started I would take a big breath in and focus really deeply… I felt… the sensation of actually centring internally…The repetitive stuff and familiar things strengthened my centeredness (pp.243-4).

In understanding her situation Maree practised **honest accountability** and continually accessed an **integrated strength**, partially from the positive image of her husband but primarily from within herself. During each contraction she practised **contextual decision-making**, expressed her **nonrational truth** and experienced the **spiritual knowing** of being utterly centred. By using **integrative power** to maintain her focus she remained open to **genius change** and the potential of **creative action** despite the distractions within her environment.

However, things began to change for Maree:

> I seemed to lose the rhythm and couldn’t get centred any more… my body was pushing… I still had a long way to go so I felt I must need to do a pooh and sat on the toilet for 3 or 4 contractions. That’s when I lost control. The contractions were coming too quickly to be able to think… [My midwife] was giving me all the advice about interventions I could end up with but I wasn’t really being given the option to not take them… Hearing what she said made me doubt
whether I could physically go on without intervention... I was getting quite upset because I couldn't get back to that centred feeling and it was even more painful (pp.246-7).

Maree was secure with the rhythm of her centred feelings, but when they were lost she practised vested accountability and experienced being fragmented. The HABITUAL PRACTICES of her midwife prompted her to use abstract decision-making: Emily searched for a rational truth and entered egoic knowing as she wished to resume that centred focus. Emily practised disintegrative power when she doubted her capacity and had a forced change that limited her potential to conformist action.

Then the situation changed again:
It really felt like something needed to come out... I was standing up and as the pain came I'd bend over and lift a leg up to try to cope with it...I was fully dilated... [I sat on] a birth stool... and suddenly... I didn't feel another contraction... [just] that pushing feeling (pp.247-8).

Maree reverted again to her practise of honest accountability as she listened to her body with integrated strength. She undertook contextual decision-making in responding to the pain and began a different experience of the spiritual knowing. She thus used her integrative power to open herself to the genius change of pushing which eventually led to her baby’s birth.

6.3.4 Sharing responsibility and letting go - Jane
Jane laboured at home, but was shocked by the responsibility that came with the urge to push:
Then the urge to push started... In first stage I wasn't thinking about what I was doing but now I was conscious of what was happening... [it was] a very different feeling... I [had] thought... the baby would just slip out on its own. When I realised that it wasn't going to I felt really scared. In my mind this baby was huge and it was just bizarre to think it was going to get down this canal. I thought 'nothing I'm doing is going to get this baby out'. I was shocked by what was expected of me compared to what I'd just gone through (p.20).

In first stage Jane had been immersed in being whole and her spiritual knowing but with the lucidity of pushing she shifted to HABITUAL PRACTICES. Jane practised vested accountability to understand the sensations of second stage. She accessed her qualified strength and experienced being fragmented. She undertook abstract decision-making which meant that as she thought about what was required to push she constructed a
**rational truth** and experienced **egoic knowing**. Jane used **disintegrative power** to reject change and make claims of impossibility so she experienced potential as **conformist action**.

Jane reflected that:

It was in my control to push but I was scared to do it... I didn't have the... confidence, the belief and even the desire to do it. It was the lowest point for me; if I had been in the situation where a caesarean was offered that was the point where I would have said ‘yes’... I couldn’t see how it was possible for me to push her out. I was focusing on those really negative outcomes, and that wasn’t allowing any positive thought...I used what little will I did have to slow down that natural urge to push...I was fighting against it, tensing up and resisting the push (p.21)

Her practise of **vested accountability** meant Jane was prepared to defer to a **qualified strength** rather than honestly respond to the lived reality of her in-the-moment experience. Jane’s **abstract decision-making** limited her self-expression to the **rational truth** of her **egoic knowing**. She continued to use **disintegrative power** to force change and resist pushing

Changing the situation in anyway seemed too compromising for Jane:

...I was too caught up to ask for help... the fear, the lack of confidence, the negative focus and all that impossibility in my head was getting in the way...I confessed to [my partner] that I was really scared. I could see he was really anxious; he tried to be supportive but with every contraction I was saying 'I can't do it'. I chose him because, rather than make me face the fear; I knew he would agree with my beliefs that I couldn’t do it...I was hiding my fear because telling the midwives would have meant doing what I thought was impossible (pp.21-2)

Jane was so determined in her use of **disintegrative power** and experience of **conformist action** that she avoided the midwives. Practising **vested accountability** she instead accessed **qualified strength** from her partner who strengthened her sense of being fragmented. By continuing to undertake **abstract decision-making** Jane was able to retain the illusions of her **rational truth** and **egoic knowing**.

The situation did eventually change:

But [my midwife]...figured out what was going on eventually... [she] said ‘why are you resisting each contraction’ and that's when I said I was scared. I felt an enormous responsibility to get the baby out. By guiding me through it [she] took a bit of that responsibility away... even though it was still up to me, [my midwife] was ultimately responsible for getting me through it by talking to
me... Their belief that I could do it made me do it, it brought me into the present, stopped me from being all flighty and worried. It took me out of my head and into my body to what I had to do... It was a big relief to stop resisting and finally begin to let go (pp.22-3)

The use of **EMPOWERING PRACTICES** by Jane’s midwife enabled Jane to reassess her situation using **honest accountability**. She was then able to use an **integrated strength** to have a sense of **being whole** and in-the-moment again. This in turn allowed Jane to undertake more **contextual decision-making** and accept a **nonrational truth** about herself based on the **spiritual knowing** of her bodily experience. Her own and her midwife’s practise of **integrative power** gave Jane the courage to trust enough to let go to **genius change** and be experientially open to the potential of **creative action**.

### 6.3.5 Actually doing it - Gina

Gina also laboured at home; she explored the differences between first and second stage labour:

The whole labour felt like a letting go, but pushing didn’t. I was consciously aware of it as a physical activity, something that I had to get in there and do, so to some degree I had to come out of that animalistic letting go phase. I felt that I needed to take control of it but at the same time I knew I had no control either way. Pushing was mostly involuntary but I needed that voluntary mind set (p.211).

Gina’s practise of **honest accountability** was evident in her awareness of the differences between first and second stage labour. She undertook **contextual decision-making**, accepted the contradictions of a **nonrational truth**, and continued to experience **spiritual knowing**. By using **integrative power** Gina was able to open herself to a **genius change** from first to second stage and to approach pushing with **creative action**.

Gina explained:

I was thinking ‘you’re the only one who can do this’ but I said ‘I can’t do this’ and my support people would answer ‘yes you can’. I didn’t really believe them but I wasn’t feeling negative. Not believing them provoked and challenged me and I like challenge. By saying ‘I can’t do it’ I was building up my impetus to do it and that actually made me feel better. I wasn’t trying to delude myself; I knew I had to do it (p.211)

Gina’s use of **integrative power** meant she did take **creative action**. Her **honest accountability** of the situation enabled her to draw on an **integrated strength** in ways
that were very particular to her own assessment of in-the-moment experience. She practised *contextual decision-making* which involved expressing herself in ways that only Gina knew could work. This process was in turn sustained through her continued practise of *integrative power* enabling her to welcome *genius change*.

Gina continued:

I was in tune with the physicality of the baby. I wasn’t in tune with her as a soul. I was very aware of her head coming down my vagina. I needed to reach down and feel her head again; I felt 20 cents worth at my perineum. I couldn’t believe I was going to get a head out of there, it felt impossible. I felt stretched to capacity; like I was going to split apart. I made peace with that fear pretty quickly by thinking ‘oh well, I might not have an intact perineum’… I wasn’t really ever fearful, it was more about my confidence… Knowing that I had to do it was what took me from seeing it as impossible to actually doing it. (pp.211-2)

As her sensations changed Gina briefly practised *vested accountability* and had a sense of *being fragmented*. That was a moment of *abstract decision-making* for Gina where she used a *rational truth* and experienced the *egoic knowing* of impossibility. Yet she pulled herself together by practising *integrative power*, shifting back into an experience of *creative action*, *being whole* and *spiritual knowing*. She then actualised her potential for *genius change* and gave birth to her baby using her own power.

### 6.3.6 Discussion: empowering practices and genius change

This section has considered five scenarios that formed a small part of five participants’ stories of childbirth. Jasmin’s scenario was solely one of HABITUAL PRACTICES whereas the four other scenarios illustrated how the women shifted between HABITUAL PRACTICES and EMPOWERING PRACTICES. In each scenario the shift to HABITUAL PRACTICES occurred as the change situation became more challenging. However, for Maree the challenge was made worse by her midwife’s HABITUAL PRACTICES. In contrast, Jane only resumed her pathway of EMPOWERING PRACTICES with the help of her midwife. Interestingly, despite the challenges they were experiencing, Emily, Maree and Gina each resumed EMPOWERING PRACTICES of their own volition. Furthermore, they each also experienced *genius change* more than once.

I highlight *genius change* as ‘The embodied self’ sub-concept that is most indicative of an improved sense of self. I do this because *genius change* is the quality most closely...
associated with a woman’s potential for creative action; in particular, her potential to be a whole and intrinsically powerful person in any situation. Theoretically then, genius change indicates an increased likelihood of a woman being able to resume a pathway of EMPOWERING PRACTICES. Although, like the other egoic sub-concepts, genius change acts as a relatively spontaneous ego response, the ego also learns from the quality it represents, namely TRUST. In learning, the ego internalises the quality, and uses it in other interactions and situations of change. Chapter five considered how longer term learning had an impact on women’s improved sense of self. When I examined the participant’s stories, all the women had experienced genius change in contexts other than childbearing. It is possible that the women who had more experiences of genius change were able to resume EMPOWERING PRACTICES with more ease during childbirth; however, that was not clear from the stories. Emily and Gina were themselves midwives who therefore had a far greater awareness of change situations during childbirth than the other participants; this meant their practise of honest accountability was in some ways different. Nonetheless, as their scenarios both illustrated, what was most important to their genius change was not professional knowledge, but their awareness of and capacity to tap into their own knowing and ‘Intrinsic power’ relevant to their experience at the time.

Short term learning from experiences of genius change clearly does have an impact on a woman’s capacity to shift from HABITUAL PRACTICES to EMPOWERING PRACTICES during childbirth. This was illustrated in Emily’s scenario of waiting for labour. In this scenario Emily repeatedly oscillated between HABITUAL PRACTICES and EMPOWERING PRACTICES, each time returning to genius change. During the process Emily learnt about her ‘Intrinsic power’ and learnt a deeply embodied sense of self-trust that enabled her to maintain her integrity whilst changing. Later in her story Emily reflected that what she had learnt while waiting for labour “was a real asset” during labour (p.338).

Collectively, all the scenarios indicate how a woman is presented with repeated opportunities to experience genius change during childbirth. These opportunities were clearer to the participants when their caregivers also used EMPOWERING PRACTICES. When Emily, Maree, Jane and Gina’s stories were considered, they each experienced many increments of genius change during their whole childbirth experience. This repeated experience of genius change reinforced the women’s embodied sense of self-trust such that each woman had the courage to use her own power to give birth. In
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Jane’s scenario this was only possible because of the EMPOWERING PRACTICES of her midwife. The result of this accumulated sense of embodied wholeness and ‘Intrinsic power’ was that the moment of birth was an exceptionally powerful moment of genius change. I call such a birth ‘genius birth’. ‘Genius birth’ represents a woman’s active and effortful use of ‘Intrinsic power’ during childbirth. As shown in chapter five, it is this active participation and use of her own power during labour and birth that makes a woman most likely to feel an improved sense of embodied self during childbearing in general.

Elizabeth, Leanne, Celeste and Michelle’s stories also indicate that they experienced ‘genius birth’. Each of these women variously used EMPOWERING PRACTICES and developed some degree of trusting articulation with their ‘Intrinsic power’ through genius change. In contrast, I consider that Jasmin, Dawn, Helen, Lisa, Patricia and Louise experienced ‘forced birth’, because their active participation was limited through experiences of forced change. Nonetheless, genius change was, at times, part of the labour experience for some of these women, such as Dawn. At other times during childbearing genius change was experienced to some degree by all the women; for example, Jasmine could be said to have had an experience of ‘genius breastfeeding’ and Lisa an experience of ‘genius parenting’. This fits with chapter five’s identification that, during childbearing in general, all the participants experienced an improved sense of self in some way. Of the women who experienced ‘forced birth’ Jasmin’s story was most remarkable. Although she experienced forced changes during her plan to experience birth a certain way (as shown above), her whole story indicated that she learnt from those forced changes and eventually shifted toward a ‘Change pathway’ that was empowering. The following section now considers how the EMPOWERING PRACTICES of caregivers can influence a woman’s sense of self.

6.4 CAREGIVERS ENHANCING WOMEN’S SENSE OF SELF

The theory ‘Liberating intrinsic power’ is based on the understanding that caregivers are themselves embodied selves who variously interact with their own ‘Intrinsic power’ and with the ‘Intrinsic power’ of the women with whom they provide care. Caregivers are thus in a position where the ‘Change pathways’ that they choose to take can influence their professional choices. These choices can then impact on how they interrelate with a childbearing woman. In this section I firstly outline how caregivers may actively choose...
to use EMPOWERING PRACTICES. I then consider how caregivers use HABITUAL PRACTICES. These practices each pertain to the caregiver’s accountability, decision-making and use of power in each woman/caregiver interaction (table 6.5). Lastly I discuss how the EMPOWERING PRACTICES form reflexive maps for caregivers’ moment-to-moment professional choices. A caregiver who chooses to undertake EMPOWERING PRACTICES provides individualised care that enables a woman to experience genius changes and increase her likelihood of having a ‘genius birth’. As the research on which this theory is based did not include the embodied sensations of caregivers, the focus here is only on woman/caregiver interactions as told by women. However, the theory itself does enable some conclusions to be drawn about each embodied self participating in each interaction.

6.4.1 Empowering practices

EMPOWERING PRACTICES are a collection of activities that are purposefully chosen by the caregiver to match the particular aspects of a woman’s in-the-moment situation in ways that can enhance her embodied wholeness and ‘Intrinsic power’. With the simultaneous practice of honest accountability, contextual decision-making and integrative power, as defined in table 6.5, a caregiver can positively influence a woman’s embodied self. These practices can challenge a woman to actualise her ‘Intrinsic power’ in new and previously unanticipated ways such as was done by the midwife in Jane’s scenario above (section 6.3.4).

Foremost in positively influencing a woman’s embodied self is a caregiver’s mindfulness of how her/his own values and desires influence each woman/caregiver interaction. This honest accountability of the self underpins the caregiver’s capacity to understand the woman’s in-the-moment situation in impartial ways. Elizabeth found this characteristic in her friend as well as her midwife:

My friend Mandy... was really humble and didn’t try to put her own stuff on me. She was awesome like my midwife, supportive and really tuned into what I needed. She didn’t talk much; she was just there, not intrusive (p.51).

The practice of honest accountability in this interaction meant contextual decision-making was made. The friend’s nonintrusive presence was an example of integrative power as it enabled Elizabeth to focus inwardly on her whole embodied self.
Honest accountability also involves the caregiver’s honest communication of her/his rationales for action so that the woman can transparently see her situation and respond accordingly. Dawn explained her situation:

My midwife and the Birth Centre [midwives]... were really thoughtful and I was included in every process; I was told what they’d like to do and asked what I’d like to do… The labour ward was stark, hot and sticky and I was mentally uncomfortable because I didn’t want to be there… I had my private midwife with me the whole time … the vaginal examinations became quite traumatic because they were done by strangers … my midwife … held my hand giving the ordeal a personal touch because she knew who I was (pp.110-1).

Initially all Dawn’s caregivers practised honest accountability and undertook contextual decision-making that enabled Dawn to herself undertake EMPOWERING PRACTICES. When her situation changed and Dawn’s sense of empowerment diminished, her midwife undertook contextual decision-making and used integrative power. This midwife’s EMPOWERING PRACTICES then anchored Dawn to an in-the-moment sense of being known and whole despite what was happening to her.

A woman’s sense of self-knowing and wholeness is promoted through the caregiver practise of contextual decision-making which respects the nonrational possibilities in any situation. A caregiver’s use of contextual decision-making draws on knowledge and rational processes that are appropriate to the particular woman in her particular situation. Hence, contextual decision-making places the unique woman and her context at the centre of decision-making so that the woman is encouraged to draw from her own ‘Intrinsic power’. In Gina’s experience her midwife’s contextual decision-making meant the decision of what to do was left to Gina:

I tried to turn off my rational mind as much as possible. I asked her, ‘can I get into the birth pool now?’ She said ‘there’s no such thing as the right time, you just get in whenever you want’. That wasn’t the answer I wanted. I decided that I’d done all right thus far... I might as well give it a go (p.208).

Honest accountability underpinned the midwife’s respect for Gina and allowed the midwife to undertake contextual decision-making. In drawing on both her own power of trust in Gina and Gina’s power the midwife practised integrative power. The midwife’s actions prompted Gina to drawn from the awareness and knowing of past instances of genius change which gave her the confidence for her own contextual decision-making that led to other experiences of genius change.
A caregiver who uses **integrative power** also necessarily trusts her/his own ‘Intrinsic power’. This self-trust is evident in the behaviours a caregiver takes when interacting with a labouring woman, as described by Celeste:

The night duty midwife … gave … encouragement but she didn’t give me much recognition or assistance as I screamed in pain… The day time midwives … changed everything, they were so caring everyone else paled in comparison … as I screamed in pain, [my midwife] would grab my hand, look me in the eye and say ‘it’s OK love, you’re doing really well’. As soon as she did that the pain of the contractions changed and was almost halved… it felt like she was there for me all day (p.302)

Celeste’s first midwife used **HABITUAL PRACTICES** and resisted bringing more of herself to the interaction, so she did not fully engage with Celeste. The second midwife had an approach based on **honest accountability** that allowed her to remain present as an embodied self interacting with Celeste; she was therefore able to undertake **contextual decision-making** related to Celeste’s in-the-moment experience. This midwife’s practice of **integrative power** demonstrated her own self-trust through her preparedness to be open, make eye contact and become known to Celeste. These **EMPOWERING PRACTICES** prompted a **genius change** that allowed Celeste to more confidently approach contractions.

Practising **integrative power** is an effortful process for both caregiver and woman as each must use their own power and continually integrate it to the needs of the experiential moment in the best possible way. Gina explained:

It blew me away what really hard work [the birth] was… I don’t feel just lucky [with the outcome]… we worked damn hard and planned for every contingency to give it every possible opportunity to go right. I had the best team a girl could have. I felt so unconditionally loved… shown to me in the kindness of their words and their looks; they were all non-judgmental. They treated me normally, in a way they ignored me; they were quite happy for me to parade around naked or to fulfil my requests. I felt that I was able to be who I needed to be because they were there especially for me; to me that’s love… each of them contributed to the radiation of this amazing, positive energy; words can’t do it justice. (pp.212, 214-5).

Gina and her caregivers consistently used **EMPOWERING PRACTICES** enabling Gina’s frequent experience of **genius change**. Gina interpreted the sensations surrounding **integrative power** in terms of love. The combined effort led to Gina’s experience of ‘**genius birth**’.

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The practice of *integrative power* can also involve integration with other extrinsic powers, such as technology, to the best possible advantage of the woman as an embodied whole and intrinsically powerful self. Emily observed of her birth experience:

I was [initially] really frightened of the Syntocinon and quite defensive... I ended up agreeing to the Syntocinon but I said I wanted a midwife from the Birth Centre... the Birth Centre midwife demonstrated she could work with both me and the technology... I didn’t know whether I would have enough will or confidence to not be undermined by technology and I feared succumbing to it further once I was confined in that hospital room. But instead I was able to work with technology and still get what I wanted... I’m grateful for that team approach (pp.333-5, 346).

Emily experienced a *genius change* with regard to her attitude about technology. Her Birth Centre midwife practised *honest accountability*, undertook *contextual decision-making* and used *integrative power*. Thus Emily and her midwife worked together with the technology to enable the best possible circumstances for Emily to effortfully use her own power and experience a ‘*genius birth*’. This integrative focus was not, however, how Emily initially experienced her labour as her first midwife used the *disintegrative power* of *HABITUAL PRACTICES*.

### 6.4.2 Habitual practices

*HABITUAL PRACTICES* are caregiver activities that are incongruent with the in-the-moment needs of the woman as an embodied whole and intrinsically powerful person. These practices can limit a woman’s potential for *genius change* and an improved sense of self. When caregivers practise *vested accountability, abstract decision-making* and *disintegrative power*, as defined in table 6.5, a woman’s sense of ‘Intrinsic power’ is undermined and a reliance on her own habitual responses to change is encouraged.

*HABITUAL PRACTICES* may be routinely undertaken or they may have been carefully thought through. In Maree’s scenario above (6.3.3) her midwife was practising *vested accountability*. As Maree noted:

[My midwife] was concerned that induction can hit pretty hard and I had planned to have no drugs... at the time she came across as very negative, it was almost like she’d convinced herself that was how it was going to end up... she’d had a lot of transfers. She was probably more disappointed for her than me... I think she was caring for me too. I wanted to give it my best shot but I understood that maybe what she said was reality. I just would have preferred her to mention the interventions as they came up (p.241)
Maree’s midwife had clearly thought through the particularities of Maree’s situation creating a *vested accountability* on which she based *abstract decision-making* about the in-the-moment situation. The midwife used *disintegrative power* on herself and Maree to focus on preparing for future possibilities which meant that, at that time, she was distanced from Maree’s current experiential moment.

Caregivers practising *vested accountability* may also assess and respond to situations in egocentric or organisation-centric ways without presenting clear rationales for action.

Maree experienced this routine practice of *vested accountability* from an obstetrician: [The obstetrician] gave the impression that I could keep trying if I wanted but I’d probably have to have a caesarean because I was three centimetres dilated but the head was still quite high. He suggested monitoring the baby by the scalp and I said I didn’t want that. At first he said it was necessary but eventually he admitted it was not really. [My midwife] would have given me the information so that I could make a decision... he was only interested in telling me his opinion without helping me understand what it meant (p.242)

In this interaction the obstetrician practised *vested accountability* as an expert who assumed little needed to be known about Maree, he therefore undertook *abstract decision-making*. He also used *disintegrative power* by providing only biased knowledge which was not enough for Maree to make informed decisions. His admission that monitoring was not really necessary was a *forced change* toward having some understanding of Maree’s perspective. Maree was confused by this interaction and underwent her own *forced change* that focused on worrying about and avoiding any future interaction with that doctor.

During the practice of *vested accountability* caregiver personal boundaries may not match the needs of the woman. Louise found her homebirth midwife disclosed aspects of herself inappropriately:

She [has] revealed so much about her life that I [have] lost a bit of respect for her. I feel that I know more about her than she does about my pregnancy (pp.70-1).

In practising *vested accountability* this midwife still ignored aspects of Louise’s in-the-moment experience, as was particularly evident in the postpartum:

[My midwife] would rock up at any time without warning, she’d say ‘let’s go in that room, pull your pants down and show me’. I just had a tiny tear that healed with no problems but she was
checking for days afterwards. I got taken away from family and friends and I felt really violated (p.81).

The midwife took little account of Louise’s in-the-moment experience so abstract decision-making was based on the midwife’s routines. Due to this approach the midwife used disintegrative power which physically separated Louise from her loved ones and initiated a sense of violation. The potential in Louise’s in-the-moment experience was limited to conformist action that significantly contributed to her negative postpartum experience.

When the unique situation of the individual woman is ignored by caregivers, abstract decision-making follows. Such decisions take an ‘either/or’ rational approach that fragments and prompts reliance on extrinsic power. Underlying the HABITUAL PRACTICES of one of Helen’s midwives was abstract decision-making:

I’d actually met [this midwife] socially and she’d been really nice but now she was quite surly, judgemental and really medical… [she] had been rostered to another… woman… that… gave birth quickly, I sensed her resentment [at being with me]. That was not my problem yet she told me about it… I felt guilty that she didn’t have the easier night… maybe she would have been nicer to us if she had… she should have been less selfish… [she] never looked at me like [she was] connecting with me as a person (p.414).

This midwife’s abstract decision-making led her to assume that, as Helen was being induced and had already laboured for some time, she would not have an easy normal birth. On that basis the midwife then practised vested accountability, drew on the extrinsic power of medical knowledge to undertake further abstract decision-making and used disintegrative power. Rather than the midwife changing to suit Helen’s situation, the midwife’s HABITUAL PRACTICES instead led Helen to a forced change of feeling guilty. This guilt suited the midwife’s situation as then Helen was more likely to take conformist action and comply with the midwife’s abstract decision-making.

A caregiver’s practise of abstract decision-making can mean that professional decision-making is avoided and referred to others. In this interaction with Michelle the midwife relied on the extrinsic power of the doctor to make a decision:

I asked the midwife for pain relief but she said it was only the start of labour. The doctor had been asked to check me but wouldn’t be there for another hour. It really scared me… because I thought it would get 50 times worse and I would not be able to cope… Eventually I did start groaning very quietly, I couldn’t help it… I started pushing. The midwife was absolutely horrified... if I was right at
the start of labour I shouldn’t be pushing... She seemed to freak out... She didn’t bother to ask the doctors; she... took me quickly to the labour ward (pp.372-3).

Michelle’s midwife was practising *vested accountability* when she assumed Michelle was in early labour, her *abstract decision-making* was based on that assumption. The midwife practised *disintegrative power*, expecting Michelle to conform to the usual behaviour of a woman in early labour. When her midwife realised that Michelle was actually pushing the midwife experienced a *forced change* that required a decision related to in-the-moment experience. As a result of the midwife’s *HABITUAL PRACTICES* Michelle experienced *being fragmented* and *egoic knowing* as she questioned her capacity to draw on her own power during labour.

Caregivers can gain a sense of security from practising *disintegrative power* as it can be used to confirm rational beliefs and exclude the contradictory, nonrational aspects of a woman/caregiver interaction. Emily observed how this practise by her first caregiver impacted on her own sense of security:

The … midwife [spent] a lot of time looking at the monitor. … I felt insecure with her … She would ask whether I was comfortable but … if I [said] ‘I’m uncomfortable’ or ‘I don’t feel right’ she would assume I was only referring to my physical experience and suggest changing positions. I was never asked whether I was nervous or frightened, my physical state was generally seen as a proxy for my emotional state because the midwife didn’t know me. Yet I couldn’t feel comfortable physically unless I was comfortable emotionally (p.333)

This midwife’s practise of *vested accountability* meant she knew little of Emily’s in-the-moment experience. Her *abstract decision-making* was centred on the rational information that the monitor provided and the perspective that the person ‘Emily’ was just a physical body. By using *disintegrative power* the midwife maintained this blinkered perspective. With *disintegrative power* the midwife could resist bringing more of herself to the interaction and come to know more of Emily. In doing so the midwife diminished Emily’s sense of embodied self and reinforced her sense of discomfort. The midwife was not apparently aware of the effect that her practises had on Emily, nor that she could have chosen practises would more effectively enhance Emily’s in-the-moment experience.
6.4.3 **Discussion: reflexive maps for individualised caregiving**

Caregivers who undertake *EMPOWERING PRACTICES* appear to hold a sense of their own embodied self as whole and intrinsically powerful. That sense of self also appears to be reflected in how these caregivers perceive women. Such caregivers use their own power to undertake incremental *genius changes* in practice. These are changes that match their own in-the-moment practices with the woman’s in-the-moment experience in the most effective way. Rather than the woman having to change to suit the midwife’s situation, the midwife changes to suit the woman. Hence, the details of caregiver activities that are actually undertaken during *EMPOWERING PRACTICES* are utterly individual to the time, the situation and the people who are involved. This individualised caregiving increases a woman’s potential for *genius change* and thus for having a ‘*genius birth*’. The practices of *honest accountability, contextual decision-making* and *integrative power* form reflexive maps for caregivers’ moment-to-moment professional choices that enable this individualised caregiving.

6.4.3.1 **Integrative power**

By using *integrative power* caregivers draw on whatever resources are available to *both* maintain a woman’s embodied sense of wholeness and simultaneously enable her to use her own power. Sometimes this ‘both/and’ practice means stepping away and making no decisions, as Gina’s midwife did. It may mean challenging the woman to face her fears as Jane’s midwife did. At other times it can mean drawing from technology or other people to assist, as in Emily’s story.

The practice of *integrative power* always involves a caregiver’s use of her/his own power. This use of power may occur in quite subtle ways, such as the eye contact of Celeste’s midwife or the hand contact of Dawn’s midwife. Using *integrative power* may also be time consuming and effortful for the caregiver, but the sensations can be so powerful to the woman that she may associate the practises with feeling loved as Gina did. Caregivers must additionally direct *integrative power* toward maintaining their own sense of embodied wholeness because reverting to *HABITUAL PRACTICES* in new, different or stressful situations is always possible. For example, when considering her second labour Jasmin identified that she would expect midwives to look after their own needs, such as sleeping, and to meet Jasmin’s needs. By directing *integrative power*
toward their own sense of self, as well as the woman, the caregiver can remain open to genius change and nurture her/his own potential for creative action.

6.4.3.2 Honest accountability

When practising honest accountability a caregiver is receptive to the possibility that her/his own ‘Intrinsic power’ is an available resource at any time, providing the caregiver with a sense of being whole. A caregiver’s practise of honest accountability also includes an awareness that a woman will have ‘Intrinsic power’ available to her. Hence in practising honest accountability a caregiver can have the humility to acknowledge that the woman will have access to information about herself that the caregiver does not have. Jane’s midwife, in section 6.3.4, demonstrated this when she asked Jane why she was resisting pushing. The practice of honest accountability also enables a caregiver to honestly consider her/his own embodied wellbeing. Jasmin’s midwife did not do this; her experience appeared to be one of being fragmented. She was “tired from being at a birth the previous night”, experienced the forced change of being ill during Jasmin’s labour, and then she prematurely left Jasmin for another birth that she missed anyway (p.188). Jasmin attributed no blame, because “people make mistakes”; however, this midwife’s lack of accountability for her own wellbeing contributed to Jasmin’s experience of forced change and ‘forced birth’ (p.188).

By practising honest accountability a caregiver is able to put limitations around her/his own knowledge, assumptions, values and desires that are inappropriate to the situation. The midwives of Elizabeth and Leanne did this quite effectively whereas those of Louise and Helen did not. With honest accountability limitations can also be placed around professional and institution based assessments and routines. Maree’s midwife showed a variable capacity to do this. She was aware that Maree’s baby was potentially very large and that induction could be challenging. This midwife omitted to limit that knowledge to the most appropriate moment so that during much of Maree’s first stage she used HABITUAL PRACTICES. However, once Maree was fully dilated the midwife practised honest accountability. As Maree observed, “that was the point where [my midwife] took me seriously and went into the role I needed her to be in” (p.247). Despite the panic of the hospital staff and the malfunctioning equipment, this midwife then used her EMPOWERING PRACTICES to help Maree past shoulder dystocia so that she had a ‘genius birth’ of her 4920gm baby.
6.4.3.3 Contextual decision-making

A caregiver’s practise of contextual decision-making places the woman as an embodied whole and intrinsically powerful person at the centre of decision-making. During contextual decision-making knowledge and rational processes are therefore individualised according to the woman, her situation and her in-the-moment experience. This means that a caregiver may draw on the nonrational truth of her/his own ‘Intrinsic power’ but in doing so the nonrational truth of the woman’s own knowing must also be accommodated. This was, for example, evident in the practise of Gina, Celeste and Dawn’s midwives. Contextual decision-making also means drawing on extrinsic resources in different or innovative ways according to the needs of the woman at the time. For example, midwives did this with Maree in second stage and with Dawn and Emily.

The practise of contextual decision-making respects a woman’s differences as well as the nonrational possibilities in her unfolding situation. Underlying such a respect are the caregiver's own decisions about her/his embodied self in relationship with the particular woman. For the caregiver this practise is an expression of the balanced knowing of her/his own spiritual knowing. Contextual decision-making will thus be non-judgemental and resist the biases given through labelling. In deciding to bestow a label the caregiver shifts her/his expression of self to egoic knowing. Then decisions become more abstract as the caregiver defers to the rationalised assumptions that are associated with the label; as Emily observed “once you get labelled you start to get less care” (p.334). For example, Helen’s final midwife labelled Helen as having a techno-medical birth and she made ‘either/or’ decisions relative to her assumptions about techno-medical versus normal birth. By placing her assumptions about the birth outcome at the forefront of her decision-making this midwife significantly contributed to Helen’s experiences of forced change and her eventual ‘forced birth’. In contrast, Emily’s and Maree’s experience of using techno-medicine indicated that when the individualised caregiving of EMPOWERING PRACTICES are used genius change and even ‘genius birth’ are possibilities.

6.5 CONCLUSION

In this chapter I have reported on the overall theoretical results of the research. Section 6.2 described the theory ‘Liberating intrinsic power’, explained the theoretical
constructs and outlined their systematic links to each other. In section 6.3 I presented five scenarios from participants’ experiences of childbirth and used the theory to discuss the factors that influenced their improved sense of self. Then section 6.4 focused on the individualised ways that caregivers can act to enhance a woman’s embodied self. Using the theory I described how a childbearing woman’s embodied sense of self changes relative to her active awareness and use of ‘Intrinsic power’. The mindful EMPOWERING PRACTICES were contrasted with the HABITUAL PRACTICES that ignore or demean ‘Intrinsic power’. The factors appearing to have most influence over how a woman may experience change, particularly during childbirth, were identified as accountability, decision-making and the use of power. I presented those factors that were positively related to an improved sense of self as the EMPOWERING PRACTICES.

The chapter has shown how genius change is the egoic quality most representative of a woman’s potential to be a whole and intrinsically powerful person in any situation. The liberation of ‘Intrinsic power’ through EMPOWERING PRACTICES was identified as an experience of genius change. In my interpretation, the repeated experience of genius change can reinforce a woman’s embodied sense of self-trust such that she can find the courage to use her own power to give birth. The moment of birth, if ‘Intrinsic power’ is actively and effortfully used, is an exceptionally powerful moment of genius change which I have called ‘genius birth’. In contrast I have conceived ‘forced birth’ as when a woman’s active participation as an embodied whole and intrinsically powerful self was limited through experiences of forced change.

I have found that caregivers using EMPOWERING PRACTICES draw on their own power to undertake incremental genius changes in practice. These genius changes are what individualise caregiver practices and match them with a woman’s particular in-the-moment experience in the most effective, self-enhancing way. The EMPOWERING PRACTICES of honest accountability, contextual decision-making and integrative power form reflexive maps that can guide professional choices and individualise caregiving. These practises are what enable a woman to experience genius changes and increase her likelihood of having a ‘genius birth’. I therefore conclude that, when a woman’s caregiver practises honest accountability, undertakes contextual decision-making and uses integrative power during each woman/caregiver interaction, the woman is more likely to feel an enhanced sense of embodied self.
7. CHAPTER 7- DISCUSSION AND CONCLUSIONS

7.1 INTRODUCTION

This dissertation answers the research question ‘How does a woman’s embodied sense of self change during the childbearing period and what factors in the childbirth experience seem to be positively related to an improved sense of self?’ The research evolved from my concern that ordinary women who access standard maternity care are often scarred mentally and/or physically by their experience of childbirth. In chapter one I outlined how midwifery practices that follow a social model of health and appear to enhance a woman’s embodied self are not effectively implemented in the standard care paradigm. Dominant cultural and maternity care environments use concepts and make assumptions that limit understandings of change, childbearing and the embodied self. The standard transition to mother theories have not been effective in preventing women’s diminished sense of self. These standard theories indoctrinate caregivers into believing that their role is to facilitate women’s adoption of the pre-determined social role of mother. All women deserve caregiving that optimises their psychophysiology by facilitating their sense of embodied wholeness and enabling their potential to be intrinsically powerful. In this dissertation I have met my initial aim which was to produce a theory about how caregivers can most effectively work with women during the changes of childbearing to enhance, rather than diminish, a woman’s embodied sense of self.

The key philosophical and theoretical literature underpinning the theory was presented in chapter two. That chapter concluded that a woman’s capacity to experience herself as an embodied whole and intrinsically powerful person is variously enabled or disabled by the ordinary in-the-moment choices she makes during the change process. The childbearing research literature in chapter three made a very strong claim that women are empowered through interaction with caregivers who adjust their practices to suit the changing needs of each woman. The literature did not, however, entirely address the research question guiding this study. The research methodology involved a feminist post-structural approach that was explained in chapter four. The methodology was a rigorous, creative and ethical process of theory generation that respected the contextual diversity of all the women and incorporated ideas from the literature. The final theory
was only completed after validation with the women from whose experiences the theory was generated. Chapters five and six then provided each woman’s individual results and the broader theoretical answers to the research question.

Collectively the chapters of this dissertation substantiate the thesis that during first childbearing a woman’s embodied sense of self is most likely to be enhanced, rather than diminished, when caregiver intentions and practices act to sustain her on a path toward genius change. In this concluding chapter I draw from all the previous chapters to support this thesis. In section 7.2 (below) I discuss the theory ‘Liberating intrinsic power’ in relation to the literature presented in the earlier chapters and experiences of the study participants. Then in section 7.3 I provide a conclusion that considers the study’s strengths, its limitations and presents recommendations. I contend that when the practices of a woman’s caregiver act to sustain her on a path toward genius change she is more likely to use her own power to experience a ‘genius birth’ and to enter motherhood feeling like a genius.

7.2 DISCUSSION

In this section I discuss key aspects of the research that are consistent with and support the theory ‘Liberating intrinsic power’. I review the philosophical literature from chapter two that focused on the influence that power, in particular ‘Intrinsic power’, has on how ‘The embodied self’ changes. I consider what the research from chapter three communicated about women’s power when the changes of childbearing are experienced. Then I revisit the results from chapter five to reflect on how the participant’s used their own power during change and experienced an enhanced embodied self. Lastly I summarise the theory from chapter six to outline the factors related to an improved embodied self and how caregivers can most effectively work with women during childbearing to empower genius change.

7.2.1 The philosophical framework

The power inherent in the embodied self, which I have called ‘Intrinsic power’, is a bodily intelligence that acts to animate existence (Aristotle, 1984a; Merleau-Ponty, 2002). This is a nonrational form of bodily knowing and power which is experientially ‘pre-reflective’ (Merleau-Ponty, 2002). From one moment to the next the embodied self, prior to any thinking or conceptualising, assesses and responds to differences within
situations, internalising those assessments/responses as habits (Merleau-Ponty, 2002). Internalised habits are used by the ego to promote security and defend against its own dissolution during periods of change (Lacan, 1977, 2002). While the embodied self can approach each moment anew, it frequently acts pre-reflectively based on habit or instinct (Grosz, 2004; Merleau-Ponty, 2002). Habits are often triggered when a new situation is perceived in a limited way to be very similar to a previous situation. In this study a woman’s typical ways of responding to unknown situations often predicted that she would behave in these typical ways during childbearing. A nonrational ‘Intrinsic power’ is also available to the woman; this power is intuitively aware of the experiential whole of a situation and enables a more holistic ‘both/and’ response (Grosz, 2004). However, the intellect (Grosz, 2004) and the ego (Lacan, 1977, 2002) are extrinsically directed rational powers that reflect on only parts of the whole in an ‘either/or’ approach. Social rituals and internalised habits sanctioned by the ego are used to maintain cultural security, create certainty and resist awareness of ‘Intrinsic power’ and moment-to-moment change (Irigaray, 2001; Lacan, 1977, 2002; Leonhardt-Lupa, 1995; V. W. Turner, 1972; Van Buren, 1996; van Gennep, 1960).

7.2.1.1 ‘The embodied self’ and change

‘The embodied self’ as theorised in chapter two, is often contradictory and in a continual state of change (Grosz, 2004; Irigaray, 1993, 1996, 2001; Kovel, 1991; Young, 2005). Change is engendered through the self’s relationship with what is perceived as different or ‘other’ than the self, including other people (Grosz, 2004; Irigaray, 1993, 1996, 2001, 2002; Jordan, 1997b; Kovel, 1991; Lacan, 2002; Young, 2005). Anything ‘other’ or threatening to the ego’s estimation of the self at the time can be perceived as different (Irigaray, 1996, 2001; Lacan, 1977; Leder, 1990). ‘Intrinsic power’ may be perceived as different and a threat to the ego as it is an unbiased, ever changing ‘both/and’ force (Grosz, 2004; Irigaray, 1993, 1996, 2001; Young, 2005). The power of being open to change and other differences occurs when the ego recognises and respects the difference of ‘Intrinsic power’; this ‘both/and’ approach serves the interests of the holistic self (Irigaray, 1996). However, egoic and extrinsic powers using ‘either/or’ reductionistic thinking generally resist change (Grosz, 2004; Irigaray, 1993, 1996, 2001; Kovel, 1991; Leder, 1990; Young, 2005). ‘Either/or’ reductionistic thinking is a judgemental form of knowing that ignores the uniquely lived, ever changing nature
Chapter seven - Discussion and conclusions

7.2.1.2 Choosing to be mindful of ‘Intrinsic power’


7.2.1.3 Having a sense of wholeness whilst changing

In chapter two being mindful was theorised to enhance ‘The embodied self’ by allowing for a sense of wholeness simultaneous to an appreciation of change (Hanh, 1995; Irigaray, 1996, 2001, 2003; Kovel, 1991; Leder, 1990). When ‘The embodied self’ is dominated by the ego, whether in self-aggrandising or self-diminishing ways, a sense of fragmentation is more likely during change (Irigaray, 1996, 2001; Lacan, 2002; Young, 2005). Change becomes perceived in the ‘either/or’ terms of lack versus desired gains (Lacan, 1977, 2002). With the ego dominating choice, responses to change tend to draw on internalised habits that the ego perceives to be the safest (and often quickest) way to attain desires (Grosz, 2004; Lacan, 1977, 2002). Alternative responses are rationalised as impossible and even misperceived as life threatening (Lacan, 1977, 2002). In contrast, being intentionally mindful disrupts ‘either/or’ intellectual pursuits and brings consciousness into the current moment (Grosz, 2004). By being mindful the whole of
the self and the situation can be taken into account rather than a singular focus on loss or gain (Grosz, 2004; Hanh, 1995; Irigaray, 1996, 2001, 2003; Kovel, 1991; Leder, 1990). In such a state ‘The embodied self’ becomes open to new change responses that had previously been considered impossible (Grosz, 2004; Irigaray, 1996; Kovel, 1991). An empowering sense of inner and outer coherence can then develop which optimises psychophysiological wellbeing (Antonovsky, 1979, 1990; Grosz, 2004).

**7.2.1.4 Being empowered through interaction with others**

Chapter two described how during any interaction each person affects the ‘other’ in the relationship, whether or not they are aware of it (Grosz, 1995; Irigaray, 2001, 2002; J. B. Miller & Stiver, 1998). The ego habitually relates by assuming its primacy and using supposedly neutral forms of knowing that judgementally demean or ignore what is ‘other’ than the self (Grosz, 1995, 2004; Irigaray, 1993, 2002). However, relating toward another person in the name of the self’s own supposedly neutral values is not an ethical practice (Irigaray, 1993, 2001, 2002). A ‘both/and’ approach to relating integrates whoever is perceived as ‘other’ without subsuming their differences into a single neutral way of knowing (Grosz, 2004; Irigaray, 1996, 2001, 2002; Young, 2005). With a ‘both/and’ approach women are considered embodied beings who are repositories of their own knowledge and power; a woman is not merely the passive recipient of caregiver practices (Grosz, 1995). This ‘both/and’ approach is a spiritual practice that both regulates and cultivates power between people and within people (Irigaray, 1996, 2001, 2002).

In chapter two the ‘both/and’ approach was acknowledged to empower change through mutually empathic connections with others instead of by power over others (J. B. Miller, 1991b, 2003). In such a woman/caregiver interaction the carer has a role that anchors knowledge and guarantees that the uniqueness of both caregiver and woman are each respected, thereby nurturing a sense of self-trust and trust in each other (Irigaray, 1996, 2001, 2002). Interacting in this way is mutually empowering as it increases the sense of self worth and legitimacy of both people (J. B. Miller & Stiver, 1998; Surrey, 1991a). Interactions such as this can be supported by the collective energy of a broader community that respects the unique knowing of each individual (Irigaray, 1996, 2001; Rabuzzi, 1994; Thomas, 2001). Ultimately, however, it is up to each person, woman and caregiver, to intentionally choose whether the practices they undertake incorporate

7.2.2 The research literature

As illustrated in chapter three, a woman’s experience of childbearing change is highly contextual and often contradictory (Lesely Barclay, et al., 1997; Bergum, 1989; Edwards, 2005; Klassen, 2001; Root & Browner, 2001; P. K. Turner, 2002). The change experience can be a difficult, distressing and lengthy process that often involves inauthentic expressions of self (Carolan, 2005a; Hartrick, 1996, 1997; Martin, 2003; T. Miller, 2007; Wilkins, 2006). A woman’s sense that she is a novice facing an unknown future can create fear and diminish her feelings of power relative to how she perceives the power of others (Davis-Floyd, 1992; Goldberg, 2005, 2008; T. Miller, 2007; Wilkins, 2006). Her change experience is often shaped by the woman’s own intellectualised responses, ‘either/or’ perceptions of herself, and desires to conform to cultural expectations (Beck, 2002; Carolan, 2005a; Dykes, 2005; Hartrick, 1996, 1997; T. Miller, 2000, 2007; Wilkins, 2006). A woman’s responses to change are also shaped by the sense of physical, cultural, social and psychological safety she holds for herself and her baby (Edwards, 2005; Parratt & Fahy, 2004; Reiger & Dempsey, 2006; Walsh, 2006). Some women minimise their distress by using ‘both/and’ approach as described above (Lesely Barclay, et al., 1997; Bondas & Eriksson, 2001; Klassen, 2001; Lundgren & Wahlberg, 1999; Rogan, et al., 1997; Seibold, 2004). Other women appear to resist change by attempting to retain their prior social identity and their usual habits, which is evident when women use ‘either/or’ discourses (Bailey, 1999, 2001; Beck, 2002; Davis-Floyd, 1994; Dykes, 2005; Edhborg, et al., 2005; C. Eriksson, et al., 2006; Lindgren, et al., 2006; Martin, 2003; Nystedt, et al., 2006).

7.2.2.1 Women influencing how they change

Chapter three identified that some women negotiate the contradictions of the change process more actively than others (Bergum, 1989; Klassen, 1998; Lindgren, et al., 2006; Viisainen, 2000). Considered in terms of individual agency or as intuition, ‘Intrinsic power’ has an impact on decision-making before and during the birth (Bergum, 1989; Klassen, 2001; Lindgren, et al., 2006; Root & Browner, 2001; Viisainen, 2000; Walsh, 2006). However, some women seem unable to access intrinsic ways of knowing during childbirth (Savage, 2006). Other women have a sense of being utterly powerless due to
pain and/or loss of cultural power (Beck, 2002; Edhborg, et al., 2005; Nystedt, et al., 2006). A woman’s physical environment, including her relationship with caregivers, has an important influence on whether she expresses her own power in spontaneous and individual ways (Edwards, 2005; Klassen, 2001; Parratt, 2000; Sjöblom, et al., 2006; Walsh, 2006). In supportive environments a woman can uniquely respond to childbearing challenges by listening to her body and her baby, patiently accepting the reality of her experience and actively relaxing (Bergum, 1989; Edwards, 2005; Lindgren, et al., 2006; Lundgren, 2005; Lundgren & Dahlberg, 1998; Sjöblom, et al., 2006; Viisainen, 2000). When a woman feels powerful enough to give unique expression to herself in this way, she becomes aware of contextual, nonrational elements of her experience and is able to include them in meaning-making and decision-making (Edwards, 2005; Klassen, 2001; P. K. Turner, 2002; Viisainen, 2000; Walsh, 2006).

As shown in chapter three a woman can feel better about her experience of change when she actively negotiates aspects of her experience (Klassen, 2001; Lindgren, et al., 2006; Sjöblom, et al., 2006; P. K. Turner, 2002; Viisainen, 2000). During labour this negotiation is a moment-to-moment activity that requires a woman to both open herself to change and use her own power to resume that stance when it is challenged (Akrich & Pasveer, 2004; Klassen, 2001; Parratt, 2000; Parratt & Fahy, 2003). The most empowering and least alienating activities are those that permit a woman to remain connected to her bodily sensations at the same time as retaining an awareness of her own power to adapt to those sensations (Akrich & Pasveer, 2004). The practices of caregivers can individually and collectively guide a woman to undertake these empowering activities (Edwards, 2005; Goldberg, 2005, 2008; Kennedy, et al., 2004; Parratt, 2000; Reiger & Dempsey, 2006; Walsh, 2006).

7.2.2.2 Empowering woman/caregiver interactions

Chapter three consistently identified that the woman/caregiver relationship is influential over whether a woman feels empowered during her change experience (Edwards, 2005; Kennedy, et al., 2004; Lundgren & Berg, 2007; Parratt, 2000; Reiger & Dempsey, 2006; Walsh, 2006). As childbearing novices women are willing to trust their caregivers as well as the discourses of non-professionals (Davis-Floyd, 1992; T. Miller, 2000, 2007; Root & Browner, 2001; Savage, 2006; Schmied & Lupton, 2001b). However, dominant
humanistic and childbearing discourses that resist change seem to silence a woman’s authentic in-the-moment expressions of embodied self, including her sense that she has the ‘Intrinsic power’ to act (Edwards, 2005; Goldberg, 2005, 2008; T. Miller, 2000, 2007; Reiger & Dempsey, 2006; Savage, 2006). A sense of moral responsibility can motivate the woman to comply with caregiver recommendations or she may even feel coerced into doing so (Davis-Floyd, 1992; Root & Browner, 2001; Viisainen, 2000). Fear can prompt compliance and create dependency on caregivers (Nystedt, et al., 2006; Savage, 2006). A woman may also passively comply because she does not wish to jeopardize the caregiver relationship or her care (Martin, 2003; Savage, 2006).

Furthermore, compromises in a woman’s normal birth plans are associated with a lack of caregiver skills to facilitate normal birth and midwifery practices that mirror obstetric ideology (Edwards, 2005). Other disempowering caregiver practices include: disengaging from the woman/caregiver interaction; ignoring the particularities of the woman’s individual context; and, reinforcing the woman’s novice status in comparison to the caregiver’s ‘expert’ skill (Dykes, 2005; Goldberg, 2005, 2008; Wilkins, 2006).

In chapter three empowering caregiver practices were shown to involve an ongoing and nuanced negotiation that creates the best possible, normalised and subjectively safe environment for each woman (Kennedy, et al., 2003; Parratt, 2000; Walsh, 2006; Wilkins, 2006). The most empowering woman/caregiver interactions are those that mutually respect the unique personal situation of both woman and caregiver (Berg, 2005; Kennedy, et al., 2003; Walsh, 2006). A caregiver’s personal sense of being empowered enough to act autonomously, rather than to conform to dominant norms, is an important underlying characteristic of these practices (Edwards, 2005). Caregivers must be actively self-aware of biases and inequalities during interactions, including their own vulnerabilities (Berg, 2005; Edwards, 2005; Goldberg, 2008). Rational and nonrational processes are used by caregivers to negotiate the contradictions between standard maternity care practices, practices promoting normal physiological birth and each woman’s particular situation (Berg, 2005; Kennedy, et al., 2004; Lundgren & Berg, 2007; P. K. Turner, 2004; Walsh, 2006). The caregiver’s skill and autonomy in being physically present and in tune with the woman also positively impacts on her experience (Edwards, 2005; Goldberg, 2005; Kennedy & Shannon, 2004; Lundgren & Berg, 2007). When actively and effortlessly present to a woman as an embodied being the caregiver repeatedly takes the time and space to learn about her life context and
currently lived experience (Edwards, 2005; Goldberg, 2005, 2008; Kennedy, et al., 2004; Walsh, 2006). Caregivers can then mediate disempowering cultural messages, coordinate social support and create interpersonal relationships that contain a woman’s fear (Reiger & Dempsey, 2006). Empowering practices allay a woman’s feelings of vulnerability, foster her self-trust and nurture her sense of empowerment (Goldberg, 2005). A woman may then feel empowered enough to negotiate her own unique responses to in-the-moment experience whilst simultaneously fulfilling, as much as possible, her own intentions in childbearing (Edwards, 2005).

### 7.2.3 What the women experienced

Chapter five summarised the fourteen participants’ stories and their questionnaire responses. These summaries illustrate the complex variety of each woman’s situation. The breadth and depth of individual life experience is brought into the childbearing period by each woman. In pregnancy each woman constructs a diverse range of expectations, concerns, hopes and fears about her forthcoming experience. Previous experiences impact on her attitudes to pregnancy, her plans for birth and her approach to parenting. Prior experiences also influence how the woman sees herself and how she changes. Furthermore, a woman’s in-the-moment experience of change is dependent on the detail of her particular situation at the time. In the postpartum, coming to terms with change is at the forefront of experience as she gets to know her baby, learns to meet her baby’s needs, readjusts relations with her partner, heals from the birth experience and looks after her own wellbeing. The various elements of a woman’s wellbeing are important to her self-perception and her function in the postpartum. However, results of the psychometric scales often overlook subtle positive and negative aspects of a woman’s experience that are evident in her story. In this study broad comparisons between each woman’s experiences reveal no distinct association between birth mode and subsequent postpartum experience. Instead, the individual ways in which each woman responds to change stand out as the most influential factor on the experience of overall childbearing change.

#### 7.2.3.1 Feelings of enhanced embodied self

The results in chapter five confirmed that a woman can feel that her sense of self is enhanced in some way over the childbearing period. However, although a woman may feel she has changed, she is also likely to feel that in many ways she is unchanged. For
some women the change involves an expanded, more complex, sense of self. For others it can encompass an increased tolerance and compassion for other people. Some women are particularly aware that their experience of change is a manifestation of what they are learning. Women can experience positive as well as negative changes. Negative changes include: sequelae from the birth; disappointment about unplanned birth experiences; breastfeeding problems; a diminished sense of independence; postpartum tiredness and depression; work and financial difficulties; parenting challenges; and, relationship readjustments. Positive changes include: an altered outlook on life; deepened sexuality and maturing of relationship with partner; love for baby and self; increased inner strength, awareness and centeredness; greater connection with other women; a sense of pride and achievement; and, raised confidence in the self, in bodily capacity, and in giving birth. A woman is most likely to consider her change experience positive when she refers to her baby, although loving feelings for her baby change and develop over time. Loving feelings are often entwined and sometimes inseparable from the woman’s developing love of self as mother. Whatever way a woman’s feelings of childbearing change are manifested they are definitively unique to each woman at the time in which they are experienced.

Chapter five found that a woman’s feelings of enhanced embodied self also stem from her capacity to achieve her plans in some way and to accommodate her experience when those plans are not as intended. Feelings of achievement have a positive impact on self-confidence. Although a woman may not attain her goal of normal birth, she is likely to be able to perceive at least one other positive area of achievement if asked. A woman’s confidence is particularly likely to increase in the context of parenting. For many women, the more powerful aspects of their sense of achievement and confidence are generated during childbirth. The characteristic that has most impact on enhanced embodied self is how the woman uses her own power. By using her own power, a woman can gain a sense of her ‘Intrinsic power’. A woman’s effortful use of her own power during childbirth is clearly linked to a sense of empowerment during the birth. Women who feel most empowered by childbirth enter labour with a sense of self-trust, become inwardly centred in some way and variously allow themselves to alter their conscious state during the most challenging parts of the experience. Furthermore, a woman’s use of her own power is clearly influenced by the ways her caregivers respond at the time. Some women are later able to transfer a sense of being empowered to
contexts other than birth. It is this capacity to utilise past experiences of feeling whole and powerful during other situations of change that is most enhancing to a woman’s current sense of embodied self.

7.2.3.2 Woman/caregiver interactions influencing embodied self

Chapter five showed how childbearing women interact with a range of caregivers in addition to their primary antepartum caregivers. Women frequently consider their midwife the primary caregiver during labour even if they are not involved in antepartum care. Negative woman/caregiver interactions can have a detrimental influence on a woman’s childbearing experience. Responses by a woman’s midwife and/or her doctor can be a source of insecure feelings for the woman. The woman may feel a lack of respect from her obstetrician or she may feel trapped and unable to trust a midwife who agrees with all that the doctors say. Hospital staff can prompt a woman to feel unsupported to labour without intervention; if their behaviours are panicked and manipulative it may cause a sense of distrust such that the woman discharges herself early. Caregivers can also omit practices that could otherwise have improved the woman’s experience. For example, hospital staff may agree with a woman’s wish for a caesarean but not work to allay her in-the-moment fears.

The summaries in chapter five also indicated how woman/caregiver interactions positively influence participants’ childbearing experience. Antenatally a woman’s midwife may steer her through the middle ground between natural and medical childbirth models. A doctor’s attentive and positive responses when the baby’s heart beat is heard for the first time are likely to be appreciated by the woman. A labouring woman is likely to find that midwives who remain focused on her rather than merely uttering encouraging words make pain easier to manage. When a woman’s midwife is in continuous attendance during labour the midwife can undertake activities that protect the woman from the disempowering practices of other caregivers. The development of trusting woman/midwife relationships enables the woman to feel more secure. In this research empowering woman/caregiver interactions had a substantial positive influence on each woman’s birth experience and their sense of embodied self.

7.2.4 The theory ‘Liberating intrinsic power’

‘Intrinsic power’ is central to the theory in chapter six (table 6.2). In line with the philosophical literature of chapter two, chapter six describes ‘Intrinsic power’ as
diversely related to a woman’s sense of self knowing, security and power. Chapter six also recognises the inherent changeability of ‘Intrinsic power’ relative to the particular in-the-moment situation of ‘The embodied self’. As an inner sensation, some women contrast ‘Intrinsic power’ with their ego-based outer sense of self. A woman’s ‘Intrinsic power’ can provide a sense of continuity when outer elements of the self change; it can act as a resource during the change process. However, in some situations a woman may experience insecurity and/or confusion about her ‘Intrinsic power’ and her sense of self in general. In chapter three such responses were associated with pain and diminished cultural power. Chapter two explained these responses as resistance to or absence of ‘Intrinsic power’ relative to extrinsic power and the ego. The theory in chapter six describes how a person may interact with her/his ‘Intrinsic power’ using the concepts and sub-concepts of ‘The embodied self’ and the ‘Change pathways’.

7.2.4.1 ‘The embodied self’ influencing the change experience

All the chapters have iterated that ‘The embodied self’ can itself influence how change is experienced. Chapter two made clear that ‘The embodied self’ assesses and responds to situations without prior reflection. In chapter six the core concepts of ‘The embodied self’ depict that pre-reflective process. These core concepts describe how ‘The embodied self’ is pre-reflectively ‘being’ in-the-moment and pre-reflectively ‘knowing’ in-the-moment. In addition, the core concepts describe how pre-reflective being and knowing influence the future potential of ‘The embodied self’ in that same moment.

Chapter two also showed how the ego has an ever present influence on ‘The embodied self’. In chapter six the egoic concepts of ‘The embodied self’ portray that influence, which is often automatically undertaken according to internalised habit. The egoic concepts express how the ego interacts with ‘Intrinsic power’, extrinsic power and ‘The embodied self’ as a whole. These concepts explain:

- how ego derives strength relative to its awareness of ‘Intrinsic power’;
- the congruity of egoic ‘truth’ with the experience of ‘The embodied self’;
- and, ego’s preparedness to change relative to its sense of safety.

By being mindful of ‘Intrinsic power’ chapter two promoted the concept of choosing to take a ‘both/and’ approach to change that allows for the contradictory nature of ‘The embodied self’. Chapter three showed the ways some women might take such an approach. The results of chapter five illustrated how, in taking that approach women
may use their own power. In chapter six the ‘Change pathways’ signify assessments and responses to situations that are more or less mindfully undertaken. These pathways consider the factors that have seemed most influential on ‘The embodied self’ in any situation, namely how ‘The embodied self’:

- accounts for itself;
- makes decisions; and
- uses power.

Of these activities, the HABITUAL PRACTICES represent those that are less mindful of ‘Intrinsic power’ whereas EMPOWERING PRACTICES represent activities that are mindful of ‘Intrinsic power’. ‘Change pathways’ where EMPOWERING PRACTICES are actively chosen are thus theorised to liberate ‘Intrinsic power’ and be potentially enhancing of ‘The embodied self’.

7.2.4.2 Maintaining ‘Empowering practices’ during change

As supported by the philosophy in chapter two, chapter six claimed that by using EMPOWERING PRACTICES a woman is more likely to optimise her psychophysiological wellbeing. However, during periods of intense challenge (such as labour) a woman may revert to using HABITUAL PRACTICES. This was underscored in chapter three’s observation that the experiential newness of a situation can present a fearsome challenge to the woman’s confidence. Nonetheless, chapter six demonstrated how some women can, of their own volition, shift from HABITUAL PRACTICES to the more mindful EMPOWERING PRACTICES through the repeated experience of genius change. During genius change a woman trusts herself and her situation enough to both actively use her own power and release herself to the uncertainty of change. A repeatedly reinforced sense of self-trust provides the foundation from which a woman can find the courage to use her own power; she is then more likely to achieve her intentions. At the moment of birth this accumulated sense of embodied wholeness and ‘Intrinsic power’ can mean that a woman effortfully uses her own power to experience an exceptionally powerful moment of genius change called ‘genius birth’. In contrast, a ‘forced birth’ may be experienced by a woman whose active participation in childbirth is limited through experiences of forced change. During forced change egoic and/or extrinsic power compels change in certain ways, often confirming previous perceptions of impossibility. With forced change a woman’s actions become less creative and more conformist,
diminishing her capacity to achieve her intentions and optimise her psychophysiological wellbeing relative to in-the-moment situations.

7.2.4.3 Caregivers using ‘Empowering practices’

Chapter six found that a woman is more likely to experience the limitations of *forced change* when her caregivers use *HABITUAL PRACTICES*. In line with chapter two’s philosophy, chapter six recognised that each woman/caregiver interaction involves the caregiver relating inwardly toward her/his self and outwardly toward the woman. The woman similarly relates outwardly toward the caregiver and inwardly toward herself. A caregiver undertaking *HABITUAL PRACTICES* variously ignores the inward/outward relational aspects of an interaction. *HABITUAL PRACTICES* are reflected in the disempowering practices identified in chapter three. *HABITUAL PRACTICES* also underlie the negative interactions found in chapter five. In contrast, chapter six argues that when caregivers use *EMPOWERING PRACTICES*, a woman is more likely to also use them.

The philosophy of chapter two supports the claim in chapter six that a caregiver may at any point in an interaction intentionally choose to use *EMPOWERING PRACTICES*. The particular details of a caregiver’s *EMPOWERING PRACTICES* are utterly individual to the time, the situation and the people who are involved. The literature in chapter three and the individual results in chapter five corroborate this theorising. As shown in chapter six, by undertaking *EMPOWERING PRACTICES* the caregiver is embodying an intention to enhance rather than diminish a woman’s embodied self. In the context of childbirth a caregiver’s intention toward enhancing the woman’s embodied self equates with the intention that she experience ‘genius birth’. With an intention to undertake *EMPOWERING PRACTICES*, the caregiver uses her/his own power to make incremental *genius changes* in practice. These *genius changes* in practice respect the woman’s own intentions and optimise her in-the-moment psychophysiological wellbeing. A caregiver’s *EMPOWERING PRACTICES* present the woman with repeated opportunities to know, trust, consciously experience and use her ‘Intrinsic power’ according to her in-the-moment experience. By using *EMPOWERING PRACTICES* the caregiver repeatedly demonstrates ‘Change pathways’ where a woman can liberate her ‘Intrinsic power’ and potentially sustain her experience of *genius change*. Hence, caregivers can most effectively work with women to enhance their embodied self by using *EMPOWERING PRACTICES*. The discussion undertaken in this chapter has shown that the philosophical
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literature from chapter two, the research literature from chapter three and the women’s words from chapter five are consistent with and support this theory.

7.3 CONCLUSIONS

In this dissertation I have answered the research question and fulfilled the research aim by presenting the theory ‘Liberating intrinsic power’. This theory explains how caregivers can most effectively work to enhance, rather than diminish, a childbearing woman’s embodied sense of self. I have shown that during the childbearing period a woman’s embodied self changes in diverse and unique ways. Those changes occur across psychophysiological, social and spiritual dimensions; they also occur moment-to-moment, in the short and in the long term. These results belie the traditional way of conceiving childbearing change as the woman taking on a role of ‘becoming a mother’. The results also challenge the view that the role of the caregiver is to help the woman become a mother. I argue that more effective caregiving is focused on women’s individual and very particular circumstances that are changing and developing from one moment to the next. The ‘in-the-moment’ experience of self-trust, inner centeredness, confidence and capability during childbirth are factors that seem to have a positive influence on a woman’s subsequent embodied self, as shown in chapter five. In chapter six the factors that influence how a woman experiences her changing embodied self over the whole of the childbearing experience are identified as accountability, decision-making and the way power is used. In the language of my theory, the factors positively related to a woman’s improved sense of self are the EMPOWERING PRACTICES of honest accountability, contextual decision-making and integrative power.

7.3.1 Strengths

The study’s strengths lie in its rigorous methodology. The qualitatively driven study design, analysis and interpretation were strengthened by the inclusion of quantitative survey research methods. As discussed in chapter four, strategies to support the rigor of the research were built into the methodology and adjusted according to how the research was proceeding. The feminist post-structural framework facilitated my responsiveness to these evolving research methods, the emerging results and my critique of the literature. This framework further strengthened the study by promoting my conscious reflection on my role as the primary ‘instrument’ for gathering the data and undertaking
analysis and theorising. The iterative process ensured that the research was conducted ethically and that the changing needs of each participant were respected. An extensive validation process also provided strength to the study.

A substantial strength is the study’s grounding in the embodied reality of participant’s lived experience as told in their stories (Parratt, 2009). These stories represent each woman’s perspectives on their changing embodied self as experienced within the diverse and often disempowering contexts of childbearing. This diversity has meant that the theorising has captured the embodied uniqueness of any individual woman’s experience of change. The theory then communicates those modes of change in concepts that are clear to both women and caregivers. Further strengths of the theory are its capacity to challenge assumptions and reveal that choices are available to anyone (woman or caregiver), at any time, in any context.

7.3.2 Limitations
The study was limited to Anglo-Saxon Australian women in their first pregnancy planning normal birth in a variety of settings. The theory may safely be transferred to a similar population of women. Although this was a longitudinal study it did not purposefully gather data beyond a year after the women’s first birth. Furthermore while some participants did have a second childbearing experience before the study was completed, those subsequent birth experiences were not included in the data. Until further research is undertaken the theory should only cautiously be applied to other contexts.

General aspects of the theory such as ‘embodied self’ theoretically apply to all people. For that reason the theory is applied to the caregivers in each woman/caregiver interaction. The study did not however include data from caregivers or significant others (such as partners and mothers) involved in a woman’s childbearing experience. Although beyond the scope of this particular project, the research and the theory itself could have been strengthened if separate interviews with caregivers and significant others were also undertaken.

7.3.3 Implications and recommendations
This study and the resultant theory have implications for women, midwives and all maternity caregivers in addition to maternity service managers, educators and
researchers. For women, the study is significant because it makes clear that when a woman actively uses her own power she is more likely to feel better about herself than when she does not. The theory reveals the ways in which childbearing women can actively engage with their experience of change. By using **EMPOWERING PRACTICES** a woman can expand her perspectives to encompass both nonrational and rational forms of knowing, power and security. In doing so she can learn to appreciate her own ‘Intrinsic power’ during the changes of childbearing, be less reliant on extrinsic power, and open herself to new, yet to be experienced ways of being herself. The resultant sense of being whole and powerful provides a strengthened foundation from which a woman can approach future changes in childbearing and throughout life. I therefore recommend that women nurture their own capacity for **EMPOWERING PRACTICES** before during and after childbearing. Furthermore, I strongly recommend that all caregivers facilitate a woman’s use of **EMPOWERING PRACTICES** by themselves using these practices.

The study is significant to caregivers because it contributes new knowledge to maternity caregiving. This project has highlighted the subtle nuances of a woman’s experience of change. Perspectives on a woman’s improved sense of self have been revealed by considering the positive aspects of that change experience rather than aiming to merely treat the negative ones. The theory presents a structure from which to communicate how caregivers can act to implement the contradictions of a ‘both/and’ approach to caregiving. This theoretical structure articulates how to provide care that is more individually focused on the changing and very particular needs of any woman. In particular, the theory is significant to midwifery practice and education. The theory clearly identifies how a midwife’s **honest accountability** will impact on her/his capacity to be ‘with woman’, it shows how a midwife’s **contextual decision-making** can impact on a woman’s embodied experience of herself, and it demonstrates how a midwife’s **integrative power** empowers the woman to be actively involved in her own experience. Thus the theory makes explicit how a midwife can optimise a woman’s psychophysiological wellbeing in ways that uniquely suit the diverse requirements of each woman. I therefore recommend that:

- midwives and all caregivers make choices that incorporate **EMPOWERING PRACTICES**;
Chapter seven - Discussion and conclusions

- maternity educators include an understanding and application of EMPOWERING PRACTICES in their curriculums; and,
- maternity service managers facilitate caregivers’ use of EMPOWERING PRACTICES by themselves using these practices.

The study is significant to researchers of women’s health and maternity caregiving. The theory itself has a significant potential to be applied in diverse circumstances by any person to enable their own and others’ enhanced embodied self; it could, for example, be applied to a woman’s experience of menopause. In the context of childbearing I recommend that future research be undertaken on:
- the changing embodied self of both the woman and her caregiver;
- the changing embodied self of both the woman and her partner;
- a woman’s changing embodied self during first and subsequent childbearing experiences;
- a woman’s changing embodied self in relation to her intention and practice of breastfeeding;
- the application of EMPOWERING PRACTICES by caregivers and the subsequent use of EMPOWERING PRACTICES by women;
- a woman’s experience of genius change in the antepartum and during labour and her subsequent experience of ‘genius birth’.

7.3.4 Conclusion

In conclusion this research has depicted the diverse complexity of changes that a woman may experience during childbearing. It has explained how a caregiver who undertakes her/his own genius changes while practising can direct their intentions toward the best possible, uniquely normal ‘genius birth’ for the woman. Furthermore, the research has shown that when a woman is able to actively and effortfully participate in her experience, the resultant genius change in herself can mean she quite literally feels like a genius. This dissertation therefore contends that, during first childbearing a woman’s embodied sense of self is most likely to be enhanced, rather than diminished, when caregiver intentions and practices act to sustain her on a path toward ‘genius change’.
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APPENDIX A1: ETHICAL PROCESSES AND DOCUMENTATION

A1.1 ETHICS APPROVAL - NEWCASTLE

Certificate of Approval
for a research project involving humans

Applicant:
Chief Investigator/Project Supervisor:
(First name as indicated in application)
Professor Kathleen Fathy

Other Investigators:
Ms Jennifer Poerat
Professor Christina Lee

Project Title:
Childbirth: its influence on women’s embedded sense of self

In approving this project, the Human Research Ethics Committee (HREC) is of the opinion that the project complies with the provisions contained in the National Statement on Ethical Conduct in Research Involving Human, 1999, and the requirements within this University relating to human research.

Details of Approval

HREC Approval No: H.436-1002
Date of Approval: 16 October 2002
Approval valid for: 3 years
Progress reports due: Annually

Comments or conditions:

Approved with comments.

[a] Amendment to Information Sheet (Attachment 14).
The researcher should carefully separate her role as researcher and that of counsellor in order to avoid a conflict of interest. On page 2 of the Information Sheet the researcher states that she can provide immediate counselling. This should be modified to indicate that she will provide support and information regarding counselling/support services and resources.

[b] Amendment to Consent Form (Attachment 15).
The request to provide details of a third party contact must be optional. This to be made clear at that section of the Consent Form, eg use a heading of Optional Information as well as stating it in the text.

13 November 2002
Amended documents received. Approval confirmed.

Signed: ____________________________
Ms Susan O’Connor
Secretary to the Committee

(Signatures removed to protect privacy)
Appendix A1: Ethical processes and documentation

A1.2 Ethics Approval - Bendigo

Thursday, 27 February 2003

Ms Jenni Parratt
PhD candidate, University of Newcastle
Post Office Box Mandurang,
Mandurang, Victoria, 3551

Dear Ms Parratt

Re: Study Title: Childbirth and Women’s Embodied Sense of Self

HREC Reference Number: 3/2003

I am pleased to advise you that the Human Research Ethics Committee of the Bendigo Health Care Group has approved the above project.

The project has been approved for the period 27/2/2003 to 13/5/2005.

Would you please note that the following standard conditions apply:

a. **Limit of Approval**: approval is limited strictly to the research proposal as submitted in your application.
   
   In addition, approval by the HREC does not guarantee that an individual HHC unit or service will agree to provide resources or support to your research. Such assistance will need to be negotiated separately.

b. **Variation to Project**: any subsequent variations or modifications you might wish to make to your project must be notified formally to the committee for further consideration and approval. If the committee considers that the proposed changes are significant, you may be required to submit a new application for approval of the revised project.

c. **Incidents of Adverse Effects**: researchers must report immediately to the committee anything which might affect the ethical acceptance of the protocol including adverse effects on subjects or unforeseen events that might affect continued ethical acceptability of the project.

Consider the following:

- **Progress Reporting**: please be aware that the Human Research Ethics Committee requires all researchers to submit a report on each of their projects yearly, or at the conclusion of the project if it continues for less than a year. Failure to submit a progress report may mean approval for this project will lapse. The first progress report for this project is due on 27/2/2004.

- **Auditing**: all projects may be subject to audit by members of the committee.

If you have any further queries on these matters, or require additional information, please contact me on 5454 6419, or e-mail: m.o'connor@bendigohealth.org.au. Human Research Ethics Committee information and ethics documentation is now available on the Bendigo Health Care Group intranet (local access only) at http://bhcweb/Committees/Human_Research_Ethics/Details.html.

Please quote the HREC reference number and the title of the project in any future correspondence.

On behalf of the committee, I wish you well in your research.

Yours Sincerely,

Michael O’Cleireacain
Secretary
Human Research Ethics Committee
Bendigo Health Care Group

(Signatures removed to protect privacy)
A1.3 AMENDMENTS AND EXTENSIONS

<table>
<thead>
<tr>
<th>REASON FOR VARIATION</th>
<th>DATE &amp; PLACE APPROVAL GRANTED</th>
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</thead>
<tbody>
<tr>
<td>Extension of recruitment to antenatal clinic, extend due date of participant group to June &amp; amendments to documentation</td>
<td>Newcastle March 2003</td>
</tr>
<tr>
<td>Extend due date of participant group to June &amp; amendments to documentation</td>
<td>Bendigo April 2003</td>
</tr>
<tr>
<td>Extend due date of participant group to September &amp; amendments to documentation</td>
<td>Newcastle June 2003</td>
</tr>
<tr>
<td>Extend due date of participant group to September &amp; amendments to documentation</td>
<td>Bendigo June 2003</td>
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<tr>
<td>Request to create a register of future potential research subjects, alteration to cover letters, final letter and form ‘Permission to retain contact details’</td>
<td>Newcastle November 2004</td>
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<tr>
<td>Alteration to cover letters &amp; final letter (request to create a register of future potential research subjects NOT granted)</td>
<td>Bendigo February 2004</td>
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<tr>
<td>Alteration to cover letters &amp; final letter</td>
<td>Newcastle February 2005</td>
</tr>
<tr>
<td>Extension of ethics approval to end February 2006</td>
<td>Bendigo March 2005</td>
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<tr>
<td>Request for different cover letters &amp; final letter for two participants recruited via BHCG</td>
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<td>Request to exclude the two participants recruited via BHCG from proposed register of future potential research subjects</td>
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A1.4 SAMPLE COVER LETTER TO HEALTH CARE PROVIDERS

[LETTERHEAD]

• [DATE]

[RECIPIENTS NAME & ADDRESS]

Dear …,

Re: Distribution of invitations to participate in research

As a part of my doctoral studies I am undertaking research into how women feel about themselves and their bodies during childbirth, my supervisor is Dr Kathleen Fahy. The attached Information Statement provides details about this research including the University of Newcastle’s Human Research Ethics Committee approval number and information about the researchers.

I write to request that you distribute the enclosed invitations to participate in this research to women in your practice. The women targeted to participate in this study are those who:

– are pregnant for the first time
– have due dates on or before 20th April 2003
– are planning to have what they consider to be a normal birth.

I will telephone in one week to confirm if this is possible. Many thanks for considering this request.

Kind regards,

Jenny Parratt
A1.5 Invitation to Participate

October 2002

Hello,

I am Jenny Parratt. I am a midwife researcher working on my PhD through the University of Newcastle with Dr Kathleen Fahy. I live and work in the Bendigo area with my partner and our three children. I have recently retired from my clinical midwifery practice where I attended women through their pregnancy, birth and afterwards in their homes and sometimes in hospital.

Are you interested in participating in a research study over the next 12 months?

The study is about how women feel about themselves and their bodies during pregnancy and childbirth. The title of the study is: Childbirth: its influences on women’s embodied sense of self.

I am interested in understanding in what ways your experience of childbirth influences how you feel about yourself. As a midwife who has read widely and previously researched in this area, I believe that what happens to women in their pregnancies and births have a profound affect on how they feel about themselves. This, I believe, links with postnatal distress and postnatal depression if women’s experiences are not positive. Conversely if their experiences are positive I believe that they will have a much more harmonious early postnatal period with their baby. This is the area that I want to explore so that health care professionals can be given information about how best to help women have positive experiences.

Participation in the research will involve filling out some questionnaires and having three interviews with me over a twelve month period. The first questionnaire and interview will be sometime between 6 and 8 months of pregnancy. The study is focused on women having their first baby who are planning what they consider to be a normal birth, and have due dates on or before 20th April 2003.

I will be undertaking this project with women who live in the Bendigo area as well as with those living in and around Melbourne. I would like to begin interviews as soon as possible so if you are interested or have a question, please give me your name and phone number and I will contact you within the next 2 weeks. I am happy to hear from you by telephone, mail or email (details above), or you may prefer to tear off the slip below and give it to the person who gave you this form.

...X.......................................................................................................................

To Jenny Parratt, PO Mandurang 3551
Telephone: 0409393073

Yes, I am interested in knowing more about and possibly participating in your study into childbirth and how women feel about themselves.

Name:.................................................. Telephone number:.............................

What is the best time of day to contact you?........................................................................

The University of Newcastle
Appendix A1: Ethical processes and documentation

A1.6 INFORMATION STATEMENT

Information Statement for the Research Project:
Childbirth: its influences on women's embodied sense of self.
Version 4, 13th May 2003

Research Team:
- Professor Kathleen Fahy, Professor of Midwifery and Head School of Nursing
  and Midwifery, The University of Newcastle.
- Jenny Parratt, PhD Student, School of Nursing and Midwifery, The University of
  Newcastle.
- Professor Christina Lee, Director Research Centre for Gender and Health, The
  University of Newcastle.

Thank you for your interest in this research project. This information sheet is a formal
invitation to you. It contains information about what will be involved if you decide to
participate. Jenny Parratt is conducting the research as part of her Doctorate of
Philosophy. Professor Kathleen Fahy from the School of Nursing and Midwifery at
the University of Newcastle is supervising her.

Way is the research being done?
The way women experience pregnancy and childbirth may influence how they feel
about themselves and their bodies. Previous research has shown that a medical
approach to childbirth sometimes decreases women’s self-esteem. This in turn may
have an affect on how the woman copes after the baby is born.

The research aims to answer two questions: Firstly, how does a woman’s sense of
herself change during the childbirth period. Secondly, what factors in the childbirth
experience result in an improved sense of self? The purpose of the project is to guide
maternity care providers, particularly midwives, on how to work with women during
the childbirth year in ways that improve their sense of self. In this way, women’s
wellbeing in the early mothering period will hopefully be enhanced.

Who can participate in the research?
Women who: - are pregnant with their first baby,
 - have due dates on or before 30th September 2003
 - are planning what they consider to be a normal birth,
are being invited to participate in this study. If your birth experience does not go as
planned you can still participate in the study.

What choice do you have?
Participation in this research is entirely your choice. Only those people who give their
informed consent will be included in the project. Your decision about participating
will not disadvantage you in any way. It will not affect your maternity care.
Appendix A1: Ethical processes and documentation

You may withdraw from the project at any time without giving a reason. The researchers may withdraw a participant for two reasons. Firstly, if it is considered in the participant’s best interest. Secondly, if it is appropriate to do so for another reason. The researchers will explain why withdrawal is necessary. They will also advise you about any follow-up procedures or alternative arrangements as appropriate.

What would you be asked to do?

If you agree to participate, you will be asked to:

- Fill in three 2-part questionnaires that will take approximately 20 minutes each. The first questionnaire is to be completed once you consent to participate. The other two questionnaires will be sent to you at about three months and six months after your baby is due to be born. You will find that many of the questions in these three questionnaires are the same. This is because the study is looking at changes over time.

- Participate in three interviews occurring about two to three weeks after you return each questionnaire. Interview length will vary but will last no more than one and a half hours. The researcher will be available for a total of two hours to answer any questions you may have. Interviews will be in private, in your home or a quiet place of your choice, and it is fine if your baby is with you.

The three interviews will focus on the following issues:

a. Before-birth: your feelings about yourself, your body and your pregnancy.

b. First after-birth (about 4 months after your baby’s birth): your experience of childbirth and your feelings at the time.

c. Second after-birth (about 7 months after your baby’s birth): your feelings about yourself and your childbirth experience now.

- You will be given an opportunity to check and correct the interview transcript. These will be sent a few weeks after each interview. Jenny Parratt will then write about your experiences using your own words from the interviews. This will be organised like a story. You will be given the opportunity to check and correct this story. The outcome of this research for you will be your story. This will be the story of your childbirth experience and how your sense of self changed during that time. The amount of time you will need to put into this research should be considered now. It should form part of your decision about whether you will participate or not.

- You will also be given an opportunity to comment on the whole study toward the end of the research. The amount of time, if any, you spend on this will be up to you.

- As a token of appreciation of your time and sharing we will give you a book voucher valued at $15.00 when the study has finished. You will also receive a copy of your story and the whole research report.

What are the risks and benefits of participating?

Participation in this study will present no threat to your physical welfare. Uncomfortable feelings of distress over the recall of events and recall of feelings are possible risks of participation. Distress over recall of your experience of childbirth is another possible risk of participation. The researcher can provide support and

Jenny Parratt, PhD candidate; University of Newcastle
Information Statement, Version 4, 13/05/2003;
information regarding counselling/support services and resources if you do become distressed.

The opportunity to discuss how you feel about yourself and your feelings surrounding this important life event is an expected benefit of participation. This research has the potential to open your mind to greater self-understanding. You will gain a copy of your final story that may eventually be shared with your child.

**How will your privacy be protected?**

A promise is given of maintaining your privacy, confidentiality and anonymity. The following steps will be taken to honour this promise:

- The interviews will be audio taped, if you agree, but you can turn the tape off at any time. You will be discouraged from mentioning proper names during the audio-recorded interviews.
- Audio-tapes will be stored in a locked cabinet in my home while not in use. An audio typist familiar with the process of confidentiality will transcribe these tapes. He/She will be asked to sign a Promise of Confidentiality. You have the right to decide to withhold sections of the transcript from the study.
- You will be invited to choose a pseudonym for yourself and important others. Within written records and computer files all names, including those of health care providers and other non-essential information, will be altered.
- On completion of the study all computer files will be transferred to and stored on a compact disc. This will be stored with the paper records and audio-tapes in a locked cabinet in the School of Nursing and Midwifery at the University of Newcastle for a period of five years. Only the researchers and authorised administrative staff will have access to this data. All names, addresses and consent forms will be secured and separated from records.
- The researchers will not use the information provided for any purpose other than that for which it is given. This includes not giving anyone, other than those identified to the participants, access to the information.

**How will the information collected be used?**

The data will be presented in a research report by Jenny Parratt. Results from this study will also be presented at conferences and published in scientific journals. In these reports individual participants will only be identified by their pseudonym. Every effort will be made to disguise any information in this study that could possibly identify you, your family and any health care providers. Sections of the study will be withheld from publication if there are any details that, despite being disguised, are still identifying. Where these details are essential to the end result of the study they will only be available at the researcher’s discretion and according to ethical values.

**What do you need to do to participate?**

- Please read this Information Statement. Be sure you understand its contents before you consent to participate. Please contact the researcher, Jenny Parratt, if there is anything you do not understand, or if you have any questions.
Appendix A1: Ethical processes and documentation

If you would like to participate please follow the instructions in the covering letter. This includes filling out and signing the consent form. Filling out the first questionnaire. Then returning both in the stamped addressed envelope provided.

You will receive a telephone call approximately one week after receiving this Information Statement. Another telephone call will be made a few days after you have mailed the consent form and questionnaire.

Further information
Further information is available from:
Jenny Parratt
PO Mandurang 3551
03 54395607,
or, if no answer: 0409393073.
email: jnparratt@bigpond.com

Kathleen Fahy
School of Nursing & Midwifery,
The University of Newcastle,
Callaghan, NSW 2308
02 492 15965
email: Kathleen.Fahy@newcastle.edu.au

Thank you for considering this invitation,

Yours sincerely,

Kathleen Fahy
Head of School
Nursing and Midwifery

Jenny Parratt
PhD Student
Nursing and Midwifery

Complaints about this research
This project has been approved by the University of Newcastle’s Human Research Ethics Committee, Approval No. H-436-1002

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2304. Telephone 02-49216333, email Human-Ethics@newcastle.edu.au.

Or

The Research Officer, Secretary Human Research Ethics Committee, Collaborative Health Education and Research Centre, Bendigo Health Care Group, P.O. Box 126, Bendigo, Victoria, 3552, Telephone: (03) 5454 6419

Jenny Parratt, PhD candidate; University of Newcastle
Information Statement, Version 4, 13/05/2003;
Appendix A1: Ethical processes and documentation

A1.7 CONSENT FORM

Consent Form for the Research Project:
Childbirth: its influences on women’s embodied sense of self.
Version 3, 11th January 2003

Research Team:
- Jenny Parratt, PhD Student, School of Nursing and Midwifery, The University of Newcastle.
- Professor Kathleen Fahy, Professor of Midwifery and Head School of Nursing and Midwifery, The University of Newcastle.
- Professor Christina Lee, Director Research Centre for Gender and Health, The University of Newcastle.

I agree to participate in the above research project and give my consent freely. I understand that the project will be conducted as described in the Information Statement. I have kept a copy of the Information Statement. I understand I can withdraw from the project at any time. I do not have to give any reason for withdrawing.

I consent to:
- filling in three 2-part questionnaires. One now, and the other two about three months and six months after my baby is due to be born.
- participating in three interviews. Each will occur about two to three weeks after I return the questionnaires.
- checking and correcting material from the interviews some weeks after each interview.

I understand that:
- my personal information will remain confidential to the researchers.
- the interviews will be audio-taped but that I can turn off the recording at any time. I will be able to review the interview transcripts and edit or delete my contribution.

I have had the opportunity to have my questions answered to my satisfaction.

Name (please print):..........................................................

Signature: ............................................ Date:..................

Address:.............................................................................

Postcode: ............ Home phone: ..................

Optional Information
This study will occur over a long period of time. The researchers would like to provide you with final details about the research once it has concluded. To help us keep in touch, please provide details of a parent, a relative or friend who will be able to help in contacting you. Providing this information is optional.

Name: ................................................ Relationship to you: ..............

Address:.............................................................................

Postcode: ............ Home phone: ..................

Jenny Parratt, PhD candidate; University of Newcastle,
A1.8 Promise of Confidentiality

[LETTERHEAD]

- Promise of Confidentiality for the Research Project: Childbirth: its influences on women’s embodied sense of self.

Research Team:
- Jenny Parratt, PhD Student, School of Nursing and Midwifery, The University of Newcastle.
- Professor Kathleen Fahy, Professor of Midwifery and Head School of Nursing and Midwifery, The University of Newcastle.
- Professor Christina Lee, Director Research Centre for Gender and Health, The University of Newcastle.

I, ……………………………………………………………., am aware of the importance of maintaining the confidentiality of the information that may be revealed to me during transcription of the interviews from the above research project conducted by Jenny Parratt. I am aware that during these transcriptions I may be privy to information about individuals that, if publicly revealed may be harmful to the participants themselves or their families. I realise that by signing this document, I promise not to reveal any of the information contained in any of these interviews to any other person. I am aware that if I am distressed or concerned in anyway by the content of these transcriptions I am able to contact Jenny Parratt (on 0354395607 or if no answer on 0409393073) to discuss these issues.

Signed: …………………………………………………

Date:……………………………………..
A1.9 PERMISSION TO RETAIN NAME AND ADDRESS

[LETTERHEAD]

Promise of Confidentiality for the Research Project:
Childbirth: its influences on women’s embodied sense of self.

Research Team:
- Jenny Parratt, PhD Student, School of Nursing and Midwifery, The University of Newcastle.
- Professor Kathleen Fahy, Professor of Midwifery and Head School of Nursing and Midwifery, The University of Newcastle.
- Professor Christina Lee, Director Research Centre for Gender and Health, The University of Newcastle.

I, ……………………………………………………, am aware of the importance of maintaining the confidentiality of the information that may be revealed to me during transcription of the interviews from the above research project conducted by Jenny Parratt. I am aware that during these transcriptions I may be privy to information about individuals that, if publicly revealed may be harmful to the participants themselves or their families. I realise that by signing this document, I promise not to reveal any of the information contained in any of these interviews to any other person. I am aware that if I am distressed or concerned in anyway by the content of these transcriptions I am able to contact Jenny Parratt (on 0354395607 or if no answer on 0409393073) to discuss these issues.

Signed: …………………………………………

Date:………………………………..
### Appendix A2: Timelines

#### A2.1 Timeline of Data Collection, Analysis and Theorising

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<tr>
<td>DATA COLLECTION &amp; INDIVIDUAL STORY CONSTRUCTION</td>
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<td>Exploration of literature, preparation for data collection</td>
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## A2.2 Order of Interviews and Initial Analysis

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<th>Validation A2</th>
<th>Validation A3</th>
<th>Validation B</th>
</tr>
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<tr>
<td>Jane</td>
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<tr>
<td>Elizabeth*</td>
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<td>Louise</td>
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<tr>
<td>Dawn</td>
<td>✅</td>
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<tr>
<td>Leanne</td>
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<tr>
<td>Jasmine</td>
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<tr>
<td>Gina</td>
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<td>Maree</td>
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<td>Patricia</td>
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<tr>
<td>Celeste</td>
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<td>Emily</td>
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<td>Michelle</td>
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<td>Helen#</td>
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<td>Lisa</td>
<td></td>
<td>✅</td>
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</tr>
</tbody>
</table>

* Elizabeth declined to answer Validation A3 and chose not to answer the Validation B statements either.

# Helen only responded to Validation A3 and B statements
Appendix A3: Sample cover letter

APPENDIX A3: SAMPLE COVER LETTER

[LETTERHEAD]

• [DATE]

Dear …,

Thank you for your continued participation in this study about women’s embodied sense of self during childbirth. This is the mail out of your second questionnaire.

Included in this mail out are the following items:

– Part 1 and Part 2 of the second questionnaire
– A stamped and addressed return envelope.
– A new version of the Information Sheet.

The new version of the Information Sheet:

– This is enclosed for your records. The Information Sheet has been rewritten in plain language and page 3 clarifies data storage procedures after completion of the study.

What you need to do with this package:

– Fill out the questionnaire – as before, remember there are no wrong answers only what is right for you; you may like to have a break between parts one and two. You will notice that many of the questions are the same as those in the first questionnaire this is due to the study’s focus on changes over a period of time.
– Place the completed questionnaire, parts 1 and 2, in the return envelope and mail to me as soon as possible.

What I will do:

– I will telephone approximately one week after I mail this package to you as a reminder to do the questionnaire.
– Once I have received the questionnaire I will telephone again to make a time for our second interview.

Our second interview:

– Will begin in a similar way to the first interview.
– You will be asked if you have any other feedback about the first interview, or the draft of the first part of the story.
– We will use the questionnaire and start from general feelings you have about yourself.
– We will focus on your birth experience and how you felt during labour and childbirth.
– Remember, please use general terms (like ‘the public hospital’) rather than people’s real names or the names of organisations.

How to prepare for our second interview:

• Think back to what it really felt like for you at your labour and when your baby was born. Choose a part of your labour or birth experience such as your first contraction, the moment of birth or when you first touched your baby. It is OK if you had a caesarean birth, just chose one part of that. You may like to use these sensory prompts to help you remember the experience, think of:
  – the sounds you heard
  – the things that you said and that were said to you
  – the smells you smelt
  – people/things you touched or that touched you
  – particular things that you looked or stared at.

~ 332 ~
Observe how you felt then and how you feel now when you think about this part of the labour or birth. Observe whether your body reacts in any way to these emotions. You may like to repeat this with other specific aspects of your experience or with your experience as a whole. Don’t worry if you have trouble doing this, I will help you at the interview.

- Using the sensory prompts above, contemplate the times (if any) when you felt out of control during labour or the birth and the times when you really let go. Reflect on how you felt at these times and also what your physical response was at the time. Consider how returning to these feelings makes you feel now.
- Think about touch during your birth experience, when you received touch and also when you may have given touch. Contemplate how you feel about being touched and giving touch now.
- Think about the moment of your baby’s birth, consider your physical and emotional feelings at this time and the meaning this event has brought to your life.

You are welcome to contact me with any questions or concerns either at home on 0354395607 or if no answer on 0409393073 (you can leave a message on this number).

I’m looking forward to seeing you again and to meeting your baby,

Kind Regards
Jenny Parratt
APPENDIX A4: QUESTIONNAIRES

A4.1 QUESTIONNAIRE PART ONE: ANTENATAL

QUESTIONNAIRE Part 1(Antenatal):

Today's date: ........................................ Your name/study ID: ........................................

Please fill in today's date and complete this questionnaire by writing your answer in the appropriate area or by marking an 'X' in the box beside your answer. You are not restricted to the answers included here, if desired, please write as much as you would like. You will have the opportunity to talk to me about the content of this questionnaire at our interview.

1. When is your due date?

   [ ] day [ ] mth [ ] yr

2. Which type of health worker provides most of your antenatal care? (Please mark only one.)

   [ ] Private midwife
   [ ] Private obstetrician
   [ ] Your usual General Practitioner
   [ ] A General Practitioner you go to specifically because you are pregnant
   [ ] Hospital midwife
   [ ] Hospital doctor
   [ ] Other (please specify) ........................................

3. At some antenatal visits, have you received care from a different health worker of the same type, instead of your usual health worker of this type? (Please consider your 'usual health worker' as the person with whom you have visited most often.)

   [ ] Yes
   [ ] No (please go to question 5)

4. How many different health care workers of the same type have you had visits with? (other than with your usual health care worker)

   [ ] 1 other health care workers
   [ ] 2 different health care workers
   [ ] 3 different health care workers
   [ ] 4 or more different health care workers
5. How many antenatal visits have you had with your usual health care worker?
   - 1-2 visits
   - 3-4 visits
   - 5-8 visits
   - More than 8 visits

6. How long do you spend with this health care provider during an average visit?
   - Less than 15 minutes
   - 15 minutes to just under 30 minutes
   - 30 minutes to 60 minutes
   - More than an hour

7. Who else has provided antenatal care to you? (Please mark as many as applicable.)
   - The same type of health provider marked in question 2, but a different person
   - Private midwife
   - Private obstetrician
   - General Practitioner
   - Hospital midwife
   - Hospital doctor
   - Other (please specify) ........................................
   - No one else has provided antenatal care to me (please go to question 10)

8. How many visits in total have you had with this/these health care provider(s)?
   - 1-2 visits
   - 3-4 visits
   - 5-8 visits
   - More than 8 visits

9. How long did these visits last, on average?
   - Less than 15 minutes
   - 15 minutes to just under 30 minutes
   - 30 minutes to 60 minutes
   - More than an hour.

Jenny Parrott, PhD student; University of Newcastle; First questionnaire Part One, Page 2
10. How are you preparing for childbirth and parenting? (Please mark as many as applicable.)
   - Attending hospital based childbirth and parenting classes
   - Attending private childbirth and parenting classes
   - Having private visits with health care provider
   - Attending church based parenting classes
   - Attending support group meetings
   - Reading books
   - Watching videos
   - Talking to family/friends
   - Other (please specify) ...............................................

11. Where do you plan to have your baby?
   - Private hospital
   - Public hospital
   - Private Birth Centre
   - Public Birth Centre
   - Home

12. Which health care provider(s) do you plan to have with you when your baby is born? (Please mark as many as applicable)
   - Private midwife
   - Private obstetrician
   - General Practitioner
   - Hospital midwife
   - Hospital doctor
   - Other (please specify) ...............................................

13. Who do you plan to have with you when your baby is born? (Please mark as many as applicable)
   - Partner/husband
   - Sister or mother
   - Friend
   - Other (please specify relationship not name) ..........................
14. To what extent do you experience yourself as a sensual, sexual person who enjoys your body?

☐ Greatly
☐ Moderately
☐ Minimally
☐ Not at all
☐ I don’t want to answer

15. Would you be willing to speak further about yourself and the topic of sensuality / sexuality during our next interview?

☐ No
☐ Possibly
☐ Yes

16. How well do you think you and your partner/husband are getting along?

☐ Very well
☐ Fairly well
☐ Not at all
☐ I don’t have a partner/husband

17. What is your current marital status?

☐ Never married
☐ Now married
☐ Living together/defacto
☐ Separated but not divorced
☐ Divorced
☐ Widowed

18. What is your birth date?

   [ ] [ ] [ ]

   [ ] [ ] [ ] [ ] [ ]

   day month year

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Jenny Parrott, PhD student; University of Newcastle; First questionnaire Part One, Page 4
Appendix A4: Questionnaires

19. What is the highest level of education you have completed?
   - No formal qualifications
   - Year 10 or equivalent (e.g., School Certificate)
   - Year 12 or equivalent (e.g., Higher School Certificate)
   - Trade/apprenticeship (e.g., hairdresser, chef)
   - Certificate/diploma (e.g., child care, technician)
   - University degree
   - Higher university degree (e.g., Grad Dip, Masters, PhD)

20. What is the highest educational level of your father/stepfather (or other main male caregiver) while you were growing up?
   - No formal qualifications
   - Year 10 or equivalent (e.g., School Certificate)
   - Year 12 or equivalent (e.g., Higher School Certificate)
   - Trade/apprenticeship (e.g., hairdresser, chef)
   - Certificate/diploma (e.g., child care, technician)
   - University degree
   - Higher university degree (e.g., Grad Dip, Masters, PhD)

21. What is the highest educational level of your mother/stepmother (or other main female caregiver) while you were growing up?
   - No formal qualifications
   - Year 10 or equivalent (e.g., School Certificate)
   - Year 12 or equivalent (e.g., Higher School Certificate)
   - Trade/apprenticeship (e.g., hairdresser, chef)
   - Certificate/diploma (e.g., child care, technician)
   - University degree
   - Higher university degree (e.g., Grad Dip, Masters, PhD)

22. What is (or was) your father/stepfather’s main occupation? (Or other main male caregiver while you were growing up)?

   ..........................................................
23. What is (or was) your mother/stepmother’s main occupation? (Or other main female caregiver while you were growing up)?


24. Are you working in paid employment at present?
   - □ Yes, full-time
   - □ Yes, part-time
   - □ No, on maternity leave
   - □ No

25. What is (or was) your main occupation?


26. How satisfied are you with your current role of either staying at home or being at work?
   - □ Very satisfied
   - □ Satisfied
   - □ Unsatisfied
   - □ Very satisfied

27. Please indicate what income bracket your household is in (before-tax income)?
   - □ No income
   - □ $1 - $299 per week ($1 - $6,239 annually)
   - □ $300 - $699 per week ($6,240 - $25,999 annually)
   - □ $700 - $1499 per week ($37,000 - $77,999 annually)
   - □ $1500 or more per week ($78,000 or more annually)
   - □ I don't want to answer

You have completed Part One, thank you!
Maybe you would like to have a break before moving on to Part Two.
A4.2 QUESTIONNAIRE PART ONE: FIRST POSTNATAL

QUESTIONNAIRE Part 1 (First Postnatal)

Today's date: ........................................ Your name/study ID: ........................................

This is the second of the three surveys making up this research project. As this project is looking at your responses over time, some questions are the same as in the previous survey. Please fill in today's date and complete this questionnaire by writing your answer in the appropriate area or by marking an 'X' in the box beside/under your answer. You are not restricted to the answers included here, if desired, please write as much as you would like. You will have the opportunity to talk to me about the content of this questionnaire at our interview.

1. On what date was your baby born?  
   
   day  month  yr

2. Did you come into labour naturally?  
   □ Yes (please go to question 4)  
   □ No

3. If not, how was your labour started? (Please mark as many as applicable)  
   □ A drip (intravenous line)  
   □ Vaginal gel (Frostin)  
   □ Membrane rupture  
   □ Other (please specify) ........................................

4. Where did you have your baby?  
   □ Private hospital  
   □ Public hospital  
   □ Private Birth Centre  
   □ Public Birth Centre  
   □ Home

Jenny Parrett, PhD student; University of Newcastle; Second questionnaire Part One, Page 1
5. How long was your labour?
   - Less than 6 hours
   - 6 hours – just under 12 hours
   - 12 hours – just under 18 hours
   - 18 hours – 24 hours
   - Greater than 24 hours

6. How long did you labour in the hospital/birth centre (or with the midwife present if a homebirth)?
   - Less than 6 hours
   - 6 hours – just under 12 hours
   - 12 hours – just under 18 hours
   - 18 hours – 24 hours
   - Greater than 24 hours

7. Did you experience any of the following during labour? (Please mark as many as applicable)
   - Monitoring of baby with belts across your abdomen
   - Monitoring with an electrode put on the baby’s scalp
   - Being restricted to bed
   - Rupture of membranes
   - A drip (intravenous line)

8. Did you use any of the following during labour? (Please mark as many as applicable)
   - Hot packs
   - Water (shower, bath)
   - Nitrous oxide and oxygen gas
   - TENS machine
   - Pethidine
   - Epidural
   - General anaesthetic
   - Other (please specify) ........................
Appendix A4: Questionnaires

9. During childbirth did you experience any of the following? (Please mark as many as applicable)
   - Forceps
   - Ventouse suction (suction cup on baby’s head to assist birth - vacuum)
   - Episiotomy
   - Tear
   - Caesarean Section
   - An injection to deliver the placenta
   - An operation to remove the placenta (usually undertaken in an operating theater)
   - Excessive blood loss requiring a blood transfusion

10. Which health care person do you consider was the primary caregiver during labour and birth? (Please mark only one)
    - Private midwife
    - Private obstetrician
    - Your usual General Practitioner
    - Another General Practitioner
    - Hospital midwife
    - Hospital doctor
    - Other (please specify) .........................

11. Had you met this person prior to going into labour?
   - No, never
   - Yes once during pregnancy
   - Yes, met 2-4 times during pregnancy
   - Yes, more than 4 times during pregnancy
   - Other (please specify) .........................

Jenny Parrott, PhD student; University of Newcastle; Second questionnaire Part One. Page 3
12. Did this person attend you continuously during labour and the birth?
   □ Yes except for short breaks
   □ Yes, all except the beginning of labour
   □ Yes, all except the birth
   □ No, this person was present for less than 1/2 the labour
   □ No, this person was present for less than 1/4 the labour
   □ No, this person visited a number of times during the labour
   □ No, this person visited during the labour and was present for the birth
   □ Other (please specify) ........................................

13. Which other health care provider(s) attended you during labour and birth? (Please mark as many as applicable)
   □ Private midwife
   □ Private obstetrician
   □ Your usual General Practitioner
   □ A General Practitioner you have been to specifically because you are pregnant
   □ Hospital midwife
   □ Hospital doctor
   □ Other (please specify) ..............................
   □ No other health care provider (please go to question 15).

14. Had you met this person/these people prior to going into labour?
   □ No, never
   □ Yes once during pregnancy
   □ Yes, met 2-4 times during pregnancy
   □ Yes, more than 4 times during pregnancy
   □ Other (please specify) .................................

15. Who else was with you during labour? (Please mark as many as applicable)
   □ Partner/husband
   □ Sister or mother
   □ Friend
   □ Other (please specify relationship not name) .................................
   □ No one else

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Jenny Parrott, PhD student, University of Newcastle; Second questionnaire Part One. Page 4
16. Who else was with you during the birth? (Please mark as many as applicable)
   - Partner/husband
   - Sister or mother
   - Friend
   - Other (please specify relationship not name)
   - No one else

17. In the past 4 weeks, have any of the following aspects of your own physical well-being been a problem for you?

<table>
<thead>
<tr>
<th></th>
<th>No problem</th>
<th>Mild / moderate problem</th>
<th>Major problem</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling overweight</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Feeling out of condition</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Feeling constantly tired</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Worrying about my diet</td>
<td></td>
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<tr>
<td>Being accident prone</td>
<td></td>
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<tr>
<td>Not getting enough exercise</td>
<td></td>
<td></td>
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<tr>
<td>Incontinence or leakage of urine</td>
<td></td>
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<tr>
<td>Stretch marks</td>
<td></td>
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<tr>
<td>Varicose veins</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concern about shape/size of breasts</td>
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</tr>
<tr>
<td>Concern about shape/size of tummy</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Problems resulting from Caesarean</td>
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<tr>
<td>Problems resulting from an episiotomy or tear</td>
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<tr>
<td>Loss of sexual enjoyment</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Pain with sexual intercourse</td>
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<tr>
<td>Lack of sexual desire</td>
<td></td>
<td></td>
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<tr>
<td>Pain with breastfeeding</td>
<td></td>
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</tbody>
</table>
18. Have there been any other aspects of your own physical well-being that have been a problem for you in the past 4 weeks? (please specify)

19. Which of the following health care providers or services have you consulted in the past 4 weeks? Please indicate how many times you have used this provider or service for your own health and how many times you have used it for your baby’s health. (If you haven’t used a particular provider or service at all, put 00 in the box.)

<table>
<thead>
<tr>
<th>Provider/Service</th>
<th>Number of Times for Own Health in Past 4 weeks</th>
<th>Number of Times for Baby’s Health in Past 4 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your usual GP</td>
<td></td>
<td></td>
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<tr>
<td>Another GP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatrician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Another specialist doctor (please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital outpatient</td>
<td></td>
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<tr>
<td>Hospital inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse at chemist shop</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning Association</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal &amp; Child Health nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australian Breastfeeding Association</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table continued, please turn to page 7
### Appendix A4: Questionnaires

<table>
<thead>
<tr>
<th>Provider/Service</th>
<th>Number of Times for Own Health in Past 4 weeks</th>
<th>Number of Times for Baby’s Health in Past 4 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage Counselor</td>
<td></td>
<td></td>
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<tr>
<td>Social Worker or Welfare Officer</td>
<td></td>
<td></td>
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<tr>
<td>Drug or Alcohol Counselor</td>
<td></td>
<td></td>
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<tr>
<td>A self-help group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietician</td>
<td></td>
<td></td>
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<tr>
<td>District, Home or Community Nurse</td>
<td></td>
<td></td>
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<tr>
<td>Alternative health provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e.g., Chiropractor, Chiropodist, Osteopath, Naturopath, Hypnotherapist, Herbalist, Acupuncturist, Masseur etc.)</td>
<td></td>
<td></td>
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<tr>
<td>Other (please specify)</td>
<td></td>
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</tbody>
</table>

20. Have you taken any prescription medication in the past seven days?
   - [ ] Yes
   - [ ] No (please go to question 24)

21. For how long have you been taking this medication?
   - [ ] Less than 1 week
   - [ ] Between 1 week and 4 weeks
   - [ ] Between 1 month and 6 months
   - [ ] Longer than 6 months

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*Jenny Parrett, PhD student; University of Newcastle; Second questionnaire Part One, Page 7*
22. Who prescribed this medication for you?

☐ Your usual GP
☐ Another GP
☐ Psychiatrist
☐ Another specialist doctor
☐ Hospital doctor
☐ Other (please specify) ..............................................................

23. What is the main reason you are taking the medication?

☐ Bad nerves:
☐ Sadness
☐ Depression
☐ Anxiety
☐ Stress
☐ Sleep problems
☐ Infection
☐ Other (please specify) ..............................................................

24. In the past 7 days have you had problems with any of the following aspects of your baby’s behaviour?

<table>
<thead>
<tr>
<th></th>
<th>No problem</th>
<th>Mild/moderate problem</th>
<th>Major problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Crying</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Feeding / eating</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

25. Overall, how would you describe your baby in terms of being contented or settled?

☐ Very contented/settled
☐ Contented/settled
☐ Discontented/unsettled
☐ Very discontented/unsettled
26. How satisfied are you with your current role of either staying at home or being at work?

☐ Very satisfied
☐ Satisfied
☐ Unsatisfied
☐ Very unsatisfied

27. How well do you think you and your partner/husband are getting along?

☐ Very well
☐ Fairly well
☐ Not at all
☐ I don’t have a partner/husband

28. Does your partner/husband help with the care of the baby and household chores?

☐ Most of the time
☐ Sometimes
☐ Not very often
☐ Not at all
☐ I don’t have a partner/husband

29. How satisfied are you with the amount of help you received from others in caring for your baby?

☐ Very satisfied
☐ Satisfied
☐ Unsatisfied
☐ Very unsatisfied

30. In the past 4 weeks have you had an accident of any type, which was bad enough to make you cut-down on your usual activities for at least one day?

☐ Yes
☐ No
31. To what extent do you experience yourself as a sensual, sexual person who enjoys your body?
   □ Greatly
   □ Moderately
   □ Minimally
   □ Not at all
   □ I don’t want to answer

32. Would you be willing to speak further about yourself and the topic of sensuality / sexuality during our next interview?
   □ No
   □ Possibly
   □ Yes

Thank you for completing Part One, maybe you would like to have a break before moving on to Part Two.
A4.3 QUESTIONNAIRE PART ONE: SECOND POSTNATAL

<table>
<thead>
<tr>
<th>Question</th>
<th>No problem</th>
<th>Mild/moderate problem</th>
<th>Major problem</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling overweight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling out of condition</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Feeling constantly tired</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Worrying about my diet</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Being accident prone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not getting enough exercise</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Incontinence or leakage of urine</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Stretch marks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicose veins</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concern about shape/size of breasts</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Concern about shape/size of tummy</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Problems resulting from Caesarean</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Table continued, please turn to page 2

Jenny Perrett, PhD student; University of Newcastle; Third questionnaire Part One, Page 1
### Appendix A4: Questionnaires

<table>
<thead>
<tr>
<th>Problem</th>
<th>No problem</th>
<th>Mild/moderate problem</th>
<th>Major problem</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems resulting from an episiotomy or tear</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of sexual enjoyment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain with sexual intercourse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of sexual desire</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain with breastfeeding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Have there been any other aspects of your own physical well-being that have been a problem for you in the past 4 weeks? (please specify)

3. Which of the following health care providers or services have you consulted in the past 4 weeks? Please indicate how many times you have used this provider or service for your own health and how many times you have used it for your baby’s health. (If you haven’t used a particular provider or service at all, put 00 in the box.)

<table>
<thead>
<tr>
<th>Provider/Service</th>
<th>Number of Times for Own Health in Past 4 weeks</th>
<th>Number of Times for Baby’s Health in Past 4 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your usual GP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Another GP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatrician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Another specialist doctor (please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table continued, please turn to page 3

Jenny Parrett, PhD student, University of Newcastle; Third questionnaire Part One, Page 2
### Appendix A4: Questionnaires

<table>
<thead>
<tr>
<th>Provider/Service</th>
<th>Number of Times for Own Health in Past 4 weeks</th>
<th>Number of Times for Baby’s Health in Past 4 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse at chemist shop</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning Association</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal &amp; Child Health nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australian Breastfeeding Association</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage counselor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social worker or welfare officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug or alcohol counselor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A self-help group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District, Home or Community Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternative health provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(eg Chiropractor, Chiropodist, Osteopath, Naturopath, Hypnotherapist, Herbalist, Acupuncturist, Masseur etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Jenny Parratt, PhD student; University of Newcastle; Third questionnaire Part One, Page 3
4. Have you taken any prescription medication in the past seven days?
   - Yes
   - No (please go to question 8)

5. For how long have you been taking this medication?
   - Less than 1 week
   - Between 1 week and 4 weeks
   - Between 1 month and 6 months
   - Longer than 6 months

6. Who prescribed this medication for you?
   - Your usual GP
   - Another GP
   - Psychiatrist
   - Another specialist doctor
   - Hospital doctor
   - Other (please specify) ..........................................................

7. What is the main reason you are taking the medication?
   - Bad nerves
   - Sadness
   - Depression
   - Anxiety
   - Stress
   - Sleep problems
   - Infection
   - Other (please specify) ..........................................................
8. In the past 7 days have you had problems with any of the following aspects of your baby’s behaviour?

<table>
<thead>
<tr>
<th>No problem</th>
<th>Mild / moderate problem</th>
<th>Major problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding / eating</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. Overall, how would you describe your baby in terms of being contented or settled?

- Very contented/settled
- Contented/settled
- Discontented/unsettled
- Very discontented/unsettled

10. How satisfied are you with your current role of either staying at home or being at work?

- Very satisfied
- Satisfied
- Unsatisfied
- Very unsatisfied

11. How well do you think you and your partner/husband are getting along?

- Very well
- Fairly well
- Not at all
- I don’t have a partner/husband

12. Does your partner/husband help with the care of the baby and household chores?

- Most of the time
- Sometimes
- Not very often
- Not at all
- I don’t have a partner/husband

Jenny Burnett, PhD student; University of Newcastle; Third questionnaire Part One, Page 5
13. How satisfied are you with the amount of help you received from others in caring for your baby?
   □ Very satisfied
   □ Satisfied
   □ Unsatisfied
   □ Very unsatisfied

14. In the past 4 weeks have you had an accident, of any type, which was bad enough to make you cut-down on your usual activities for at least one day?
   □ Yes
   □ No

15. To what extent do you experience yourself as a sensual, sexual person who enjoys your body?
   □ Greatly
   □ Moderately
   □ Minimally
   □ Not at all
   □ I don’t want to answer

16. Would you be willing to speak further about yourself and the topic of sensuality / sexuality during our next interview?
   □ No
   □ Possibly
   □ Yes

Thank you for completing Part One, maybe you would like to have a break before moving on to Part Two.
**QUESTIONNAIRE Part 2:**

Today’s date: ....................................... Your name/study ID: ..........................

Please fill in today’s date and complete Part 2 of this questionnaire by marking an ‘X’ in the box beside or under your answer. As in Part One, you are not restricted to the answers included here; if desired, please write as much as you would like. You will have the opportunity to talk to me about these issues during our interviews.

1. Thinking about your current approach to life, please indicate how much you think each statement describes you:
   (mark one on each line)

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   a) In uncertain times, I usually expect the best
   b) If something can go wrong for me, it will
   c) I’m always optimistic about my future
   d) I hardly ever expect things to go my way
   e) I rarely count on good things happening to me
   f) Overall, I expect more good things to happen to me than bad

Jenny Parrett, PhD student; University of Newcastle; Questionnaire Part Two, Page 1
2. Please indicate how much you agree with each statement. (Mark one on each line)

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>I can avoid illness if I take care of myself.</td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Slightly disagree</td>
<td>Slightly agree</td>
<td>Agree</td>
</tr>
<tr>
<td>b)</td>
<td>Luck plays a big part in determining how soon I will recover from an illness.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>c)</td>
<td>I am in control of my health.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>d)</td>
<td>My good health is largely a matter of good fortune.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>e)</td>
<td>No matter what I do, I am likely to get sick.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f)</td>
<td>The main thing which affects my health is what I do myself.</td>
<td></td>
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</tr>
<tr>
<td>g)</td>
<td>Setting goals for health is realistic.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>h)</td>
<td>Most things that affect my health happen to me by accident.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i)</td>
<td>If I get sick, it is my own behaviour that determines how soon I will get well.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j)</td>
<td>I will stay healthy if it's meant to be.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k)</td>
<td>No matter what I do, if I am going to get sick, I will get sick.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l)</td>
<td>If I take the right actions, I can stay healthy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>m)</td>
<td>I can be as healthy as I want to be.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n)</td>
<td>I have little influence over my health.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o)</td>
<td>I feel I am independent enough to do the things I want to do.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Please indicate how much you agree with each statement dealing with your general feelings about yourself (mark one on each line):

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) On the whole, I am satisfied with myself.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b) At times I think I am no good at all.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c) I feel that I have a number of good qualities.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>d) I am able to do things as well as most other people</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>e) I feel I do not have much to be proud of.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>f) I certainly feel useless at times.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>g) I feel that I'm a person of worth, at least on an equal plane with others.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>h) I wish I could have more respect for myself.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>i) All in all, I am inclined to feel that I am a failure.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>j) I take a positive attitude toward myself.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
4. Please indicate how have you been feeling about your body over the past four weeks (mark one on each line):

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Have you worried about your flesh not being firm enough?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
<tr>
<td>b) Has eating even a small amount of food made you feel fat?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Have you avoided wearing clothes which make you particularly aware of the shape of your body?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>d) Have you felt ashamed of you body?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Has worry about your shape made you diet?</td>
<td></td>
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</tr>
<tr>
<td>f) Have you felt happiest about your shape when you stomach has been empty (e.g. in the morning)?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>g) Have you felt that it is not fair that other women are thinner than you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) Have you worried about your flesh being dimply?</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
5. The following statements ask about your general feelings of well-being. Please choose the answer which comes closest to how you have felt in the past 7 days, not just how you feel today.

a) I have been able to laugh and see the funny side of things.
   [ ] As much as I always could
   [ ] Not quite so much now
   [ ] Definitely not so much now
   [ ] Not at all

d) I have been anxious or worried for no good reason.
   [ ] No, not at all
   [ ] Hardly ever
   [ ] Yes, sometimes
   [ ] Yes, very often

b) I have looked forward with enjoyment to things.
   [ ] As much as I ever did
   [ ] Rather less than I used to
   [ ] Definitely less than I used to
   [ ] Hardly at all

c) I have blamed myself unnecessarily when things went wrong.
   [ ] Yes, most of the time
   [ ] Yes, some of the time
   [ ] Not very often
   [ ] No, never

e) I have felt scared or panicky for no very good reason.
   [ ] Yes, quite a lot
   [ ] Yes, sometimes
   [ ] No, not much
   [ ] No, not at all

f) Things have been getting on top of me.
   [ ] Yes, most of the time I haven't been able to cope at all
   [ ] Yes, sometimes I haven't been coping as well as usual
   [ ] No, most of the time I have coped quite well
   [ ] No, I have been coping as well as ever
g) I have been so unhappy that I have had difficulty sleeping.
   □ Yes, most of the time
   □ Yes, sometimes
   □ Not very often
   □ No, not at all

h) I have felt sad or miserable.
   □ Yes, most of the time
   □ Yes, quite often
   □ Not very often
   □ No, not at all

i) I have been so unhappy that I have been crying.
   □ Yes, most of the time
   □ Yes, quite often
   □ Only occasionally
   □ No, never

j) The thought of harming myself has occurred to me.
   □ Yes, quite often
   □ Sometimes
   □ Hardly ever
   □ Never

Please check you have answered all the questions.
Thank you for agreeing to participate in this research project.
Please return the questionnaire as soon as possible.
APPENDIX A5: INTERVIEW PLANS

A5.1 PLAN FOR FIRST INTERVIEW (ANTENATAL)

PLAN for FIRST INTERVIEW (Antenatal interview)

Introduction
- Introductions and sharing.
- Explanation about research, answering questions.
- Review consent, audio taping and choice of pseudonym.
- About this particular interview, its purpose:
  The purpose of this interview is for you and I to build a story of who you are now, that is, to enable me to write, narrate, how you feel about yourself in your body at this point in time.
  Please answer each question in whatever way that feels right to you. There are no right or wrong answers. If you don't want to answer a particular question, just say so.
- Invite questions and comment about the questionnaire.
- General discussion about how the pregnancy is with reference to Part 1 of the questionnaire.

Outline of questions about current sense of self
Discussion prompted by questions in Part 1 of the questionnaire. Expand on these questions depending on individual participant responses, for example:
1. Please explain how you look after/nurture yourself.
2. Please explain how you express yourself creatively.
3. In what ways do you express your emotions?
4. To what degree do you have the ability and the confidence to take action and to do the things you want to do? Please give an example.
5. Please think of a time, recently or in the past, where you felt really good about yourself. Describe to me what was happening at that time and tell me what you thought and how you felt.
6. Now recall a time when you felt really bad about yourself, possibly right now or in the past. Please describe this for me and explain the feelings and thoughts that you had at that time.
7. What do you do to recover from these bad feelings so you feel good again?
8. Please think of a time that your body gives you and how you respond to them, for example, hunger, thirst, or headache. Describe a recent experience that you have had in responding to your body.
9. Please tell me about a time when you have felt particularly moved by life – an awesome, exhilarating moment. (Some possible examples are: when you watch a spectacular sunset, when a child hugs you, when you first fell in love, when walking in a rain forest.) How did you feel emotionally and physically at this moment? How do moments like this one bring meaning to your life?
10. Think of a time when you have given touch (massage, stroking, hugging), how did it make you feel when you were doing this?
11. Think of a time when you were receiving touch (massage, stroking, hugging), please tell me about how this made you feel.

12. If the woman has indicated her willingness to expand on Question 14 from Part One of the questionnaire: In the questionnaire you marked that you may be willing to expand on the question about yourself as a sensual, sexual person who enjoys your body. I do not wish to invade your privacy, however if you are comfortable expanding, in general terms, on the ways that you do or don’t feel yourself to be a sensual, sexual woman I would like you to.

Outline of questions about experience of pregnancy:
Questions concerned with the woman’s relationship with her health provider:
1. Please tell me about your most memorable antenatal visit.
2. How did the experience of this visit make you feel?
3. When you tell this story and return to your feelings during the visit, are you aware of any physical sensations occurring now or at the time?

Questions concerned with embodiment and the experience of pregnancy:
4. Think of a time when you have been feeling your pregnant belly and at the same time your baby has been moving. Please describe these sensations. How do these sensations make you feel?
5. What has the experience of being pregnant taught you about your body and about how you see yourself?
6. How do you feel about other people’s reactions to your pregnant belly? Do you respond physically to their reactions?
7. Please tell me about how you are looking after yourself and your baby at the moment.
8. How does being pregnant and preparing for childbirth make you feel as a woman? How is this different to your feelings about yourself before you were pregnant?
9. How do you expect to recognise when you are in labour and when childbirth is imminent?

Questions concerned with the plans for childbirth:
10. Describe how you feel, physically and emotionally when you think about labour and birth.
11. Please tell me about your hopes and fears with regard to your labour and giving birth.

ADDITIONAL QUESTIONS:
- What led you to choose the type of birth that you have chosen to plan for?
- Did you have any difficulties in obtaining this, i.e. finding a doctor or a midwife?
A5.2 PLAN FOR SECOND INTERVIEW (FIRST POSTNATAL)

PLAN for SECOND INTERVIEW (First postnatal interview)

Introduction
- General pleasantries and sharing.
- General explanation about how research is progressing, answering questions.
- Review of consent and audio taping.
- Seek further validation of previous interviews.
- Reminder about interview purpose:
  The purpose of this interview is for you and I to build a story of who you are now, that is, to enable me to write, narrate, how you feel about yourself in your body at this point in time.
  Please answer each question in whatever way that feels right to you. There are no right or wrong answers. If you don’t want to answer a particular question, just say so.
- Invite questions and comments about the questionnaire.
- General discussion about life postpartum with reference to Part 1 of the questionnaire.

Outline of questions about embodied experience of childbirth
1. Please tell me the story of your experience of labour and birth. Prompt for descriptions of the experience and of the associated feelings (physical/emotional) about the:
   - first contraction
   - increase in pain/frequency of contractions
   - membrane rupture
   - urge to push
   - actually pushing
   - being out of control
   - ‘letting go’
   - birth of baby
   - first touch of baby
   - placental birth
   - physical environment of labour/birth
   - being touched and spoken to
   - actions/behaviour of attendants during labour/birth
2. When you tell this story and return to your feelings during labour and birth, are you aware of any emotional or physical sensations occurring now?
3. What feelings are provoked when you consider how similar or different your labour and birth experience was from your expectations?
4. How do you feel about your body now you have experienced childbirth?
5. How do the problematic aspects of your physical well-being listed in part one of the questionnaire impinge on your feelings about yourself?
6. What has the experience of childbirth taught you about how you see yourself?
7. In what ways do you recognise you have changed as a result of your particular experience of childbirth?
8. How does your experience of childbirth make you feel as a woman?

Jenny Forrest, PhD candidate, University of Newcastle  
Second interview plan 1
PLAN for THIRD INTERVIEW (Second postnatal interview)

Introduction
- General pleasantries and sharing.
- General explanation about how research is progressing, answering questions.
- Review of consent and audio-taping.
- Revisit interview purpose:
  The purpose of this interview is for you and I to build a story of who you are now, that is, to enable me to write, narrate, how you feel about yourself in your body at this point in time.
  Please answer each question in whatever way that feels right to you. There are no right or wrong answers. If you don’t want to answer a particular question, just say so.
- Invite questions and comment about the questionnaire.
- General discussion about life postpartum with reference to Part 1 of the questionnaire.
- Seek further validation of previous interviews — see below.

Outline of questions about current sense of self
Discussion prompted by questions in Part 1 and 2 of the questionnaire. Expand on these questions depending on individual responses, for example:
1. In what ways have you been are you nurturing yourself recently? Do you allow yourself to be nurtured by others?
2. Are you able to express yourself creatively at this time? If so, how?
3. Are you able to express the range of your emotions? Please explain.
4. To what degree do you have the ability and the confidence to take action and to do the things you want to do? Please give an example.
5. Please think of a time, recently, where you have felt really good about yourself. Describe to me what was happening at that time and tell me what you thought and how you felt.
6. Have you felt bad about yourself at all in the recent past, if so how?
7. What did you do to recover from these bad feelings so you feel good again?
8. Please think of the cues that your body gives you and how you respond to them, for example, hunger, thirst, or headache. Describe a recent experience that you have had in responding to your body.
9. Please tell me about a recent time when you have felt particularly moved by life — an awesome, exhilarating moment. (Some possible examples are: when you watch a spectacular sunset, when you first fell in love, when walking in a rain forest.) How did you feel emotionally and physically at this moment? How do moments like this one bring meaning to your life?
10. How have you experienced giving touch in the recent past? Please explain how you felt whilst you were doing this? [Adult as well as baby touch.]
11. How have you experienced receiving touch in the recent past? Please explain how you felt whilst you were experiencing this?
12. If the woman has indicated her willingness to expand on Question 16 from Part One of the questionnaire. In the questionnaire you marked that you may be willing to expand on the question about yourself as a sensual, sexual person who enjoys your body. I do not wish to invade your privacy, however if you are comfortable expanding, in general terms, on the ways that you do or don’t feel yourself to be a sensual, sexual woman I would like you to.

Jenny Parrott, PhD candidate, University of Newcastle
Third interview plan 1
J3. [Original question 13: Issues surrounding sexual abuse and domestic violence are known to affect a woman’s embodied sense of self. Please tell me if you have ever been in one of these abusive situations. Can you describe how these experiences have made you feel?] I’d like to ask you some other sensitive questions now, as with any other questions in this study you are free to decline to answer. If you do choose to answer, answer in whatever way you feel comfortable.

a. Have you ever felt forced to have sex or do/say sexual things that you haven’t wanted to do? How did that make you feel?

b. Have you ever been hit, kicked, punched or physically hurt? How did that make you feel?

c. Has anyone ever controlled your access to money? How did that make you feel?

d. As anyone ever stopped you from having:
   i. contact with family or friends
   ii. threatened to hurt things that you like
   iii. stopped you from making your own decisions, or
   iv. made you feel bad about yourself by putting you down or calling you names.
   How did that make you feel?

e. Have you ever been in a relationship where you have felt afraid? How did that make you feel?

f. Do you experience stress with your relationship with your current partner? How does that make you feel?

g. Do you feel safe in your relationship with your current partner? How does that make you feel?

Review of birth story:
Looking at your birth story now, is there anything else that you’d like to tell me about that experience now?
Prompt to further explore feelings (physical/emotional) specific to her particular story, for example, feelings about what the midwives did or about how her partner touched her.

Questions about changes in embodied sense of self since childbirth

1. Describe how reviewing your birth story makes you feel emotionally and physically now.

2. Think back to how you felt about your body before you had your baby, is this different to your bodily feelings now? Please describe how your bodily feelings are different.

3. If these bodily feelings are different now, please discuss whether and what factors in your particular experience of childbirth influenced this change.

4. Contemplate what you understand about yourself now and compare that with how you saw yourself before you experienced childbirth. If there are differences, describe them. Describe how these are related to the actual experience of childbirth or related to becoming a mother.

5. If you are able to identify differences in yourself that are related to the experience of childbirth (in whatever way) think about how this is influencing your life now. Describe the ways that this change has altered your approach to life.

6. If there are other ways your specific experience of childbirth has affected you and your life please describe them.

Explain process of validation of summary and draft final story.
Seek validation of initial analysis.

Sanny Parratt, PhD candidate, University of Newcastle

Third interview plan. 2
APPENDIX A6: STORY CONSTRUCTION: EXAMPLES

A6.1 INTERVIEW TRANSCRIPT READY FOR VALIDATION

Extract from Dawn’s first interview

J: Can you think of a time, recently or in the past where you felt really, really good about yourself and describe to me what was happening at the time just to give me some context and tell me what you thought and how you felt?

I just feel really good about myself now. Like the pregnancy.

J: OK. So tell me about this feeling of feeling really good about yourself. What is it?

Because I’ve been able to make decisions that I’ve been confident with, like you know when you get pregnant you’re onslaughted with this test and this test and this test. And I’ve said no to all of the tests and I’ve been confident every time of that saying no. And that’s something that I’ve been able to choose. We, but when it comes down to it I’ve been able to say I’m confident, no I don’t need to have this.

J: So the good feeling has come from knowing within yourself that you were making the right decisions.

I really have felt like it’s all been the right thing to do.

J: Is there a bodily feeling that goes along with this positive, good feeling?

Yep, this is my body they’re not going to control it. Is that what you mean?

J: I mean is there actually a physical reaction? A physical feeling inside of you.

Just strength, it’s given me strength.

J: So you feel a strong feeling in side in you.

Like I’ve been growing within. [hands up to chest]

J: When you do that you put your hands in front of your heart or in front of your chest. Is that where the strong feeling is or is it somewhere else in your body? You’ve probably never thought about it. You might not be able to answer that but see if you can.

[pause] Yes, it would be more from here, than from here, or here, or here. [moving hands around to chest, head, neck, belly]

J: It’s more over your chest, above your breasts, than anywhere else.

Yes. But trusting myself, that’s what I’d say. Yes.

J: So the reason why this is a really good time for you, and you feel really good is because you’re trusting yourself. Trusting your decisions.

Yes. Like I believe I am doing the right thing. Like I’m not doing anything to harm this child.
Appendix A6: Story construction examples

A6.2 ANTENATAL STORY DRAFT

Extract from Dawn’s antenatal story draft

I feel really good about myself now, [being] pregnant. I’ve been able to make decisions that I’ve been confident with. I’ve said no to all of the pregnancy tests. This is my body they’re not going to control it. [That’s] given me strength. [As if] I have been growing [from] within, here [in my chest]. [I’m] trusting myself, [my decisions], that’s [why I feel really good]. I believe I am doing the right thing. I’m not intentionally doing anything to harm this child.

A6.3 COLOUR DRAFTS OF FINAL STORY

Words that had been validated by the participant in the antenatal and first postnatal stories were in bold type as were the participant’s words from interview three. Words from the validated antenatal story are coloured purple, those from the validated first postnatal story are coloured blue and words from the third interview are in black. Words in green were drawn from a brief telephone call validating this section of the data prior to final validation of story.

Extracts from Dawn’s final story draft

… I’ve been making decisions that I’ve been confident with. [It] is my body [and] they’re not going to control it [so] I’ve said no to the pregnancy tests: I’m not intentionally doing anything to harm this child, I believe I am doing the right thing. I [have a] really good feeling in my chest [because I’m] trusting myself [and] my decisions, I’m growing from [inside and] that has given me strength (appendix B p.103).

My midwife and the Birth Centre knew I wanted absolute minimal interference [so] they didn’t intervene; [they offered] vaginal examinations [which] I [would refuse]. [The baby had been in a posterior position but I was sure he would turn and he did, then] after 5 hours in the bath I got out (appendix B p.110).

Extract from Louise’s final story draft

There’s not much I can do about [needing intervention but] I’ll try my best without it. Episiotomies scare the hell out of me [but] I don’t fear [the] pain [or] anything going wrong during the labour. Women have been doing it for years and [although] it’s going to be very painful, I’m sure it’s a bearable pain. I’m taking two [phrases] with me [into labour]: my mum has said ‘it’s hard work but you can bear it’ and Stephen’s mum says ‘it’s only 24 hours out of your life’. I’m quite excited about it now, when I think of myself in labour I feel really anxious and really good at the same time (appendix B p.74).
### APPENDIX A7: SAMPLE RESULTS TABLE - QUESTIONNAIRE PART ONE

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<th>Name</th>
<th>Primary caregiver</th>
<th>Meetings prior</th>
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<tr>
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<td>Partner, two friends</td>
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<tr>
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<td>No</td>
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~ 369 ~
APPENDIX A8: SAMPLE RESULTS TABLE- QUESTIONNAIRE PART TWO

Jasmin’s Psychometric results

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<th>Concept</th>
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<td><strong>Hardiness –control over health (HRHS)</strong></td>
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<td>Positively worded items</td>
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Discussion

Jasmin’s story corroborates her psychometric results indicating high levels of optimism, self-esteem and confidence in control over health. These results remain relatively stable throughout the childbearing period. There is a slight lowering of the HRHS in PN2 which fits with Jasmin’s increased awareness of the uncertainties in life. However, none of Jasmin’s responses are remarkably different and the overall picture of self-confidence in health matters remains. Jasmin does develop slight concern over her weight gain in the postpartum. Her responses to the EPDS at PN2 also indicate that sometimes she is anxious or worried for no good reason (item d). Jasmin is quite clearly upset over her birth experience, yet this upset is barely evident in her psychometric results. Perhaps this is because Jasmin does have such a resilient personality. This resilience may also have contributed to her perseverance with and eventual achievement of home birth for her second baby.
APPENDIX A9: CRITERIA FOR APPRAISING QUALITATIVE RESEARCH

The following criteria were developed for reviewers of the Elsevier midwifery journal ‘Women and Birth’. The criteria derive from a study considering the quality and significance of Australian midwifery research (Fahy 2005).

1. Was there a clear and specific research question?
2. Was the research linked to other knowledge via a critical literature review? (this may be integrated)
3. Were rigorous methods sufficiently described and justified?
4. Was the logic of sampling made explicit?
5. Was the sampling adequate to address the research question?
6. Have definition of concepts, issues, condition, experiences, that are core to the study, been included?
7. Was the study conducted ethically?
8. Is there a statement that ethics approval was granted?
9. Were the researchers’ own views identified? (bracketed if appropriate)
10. Was data analysis appropriate to the research design and methods?
11. Are the findings representative of an appropriate diversity of potential participants? (Target population)
12. Was data saturation possible in terms of sufficient numbers of participants and/or sufficient occasions of data collection?
13. Were alternative viewpoints specifically canvassed and presented?
14. Are categories or concepts strongly supported from the data? (Data saturation).
15. Were there explicit and adequate methods for checking validity of data and theoretical interpretations?
16. Are the findings and interpretations plausible?
17. Are the discussion and conclusion sections fully supported by the data presented?
18. Has new knowledge been created that can be transferred to other peoples experiences, midwifery practice, education, administration, policy or politics?