'*Nobody Told Me*': A Foucauldian Discourse Analysis on the construction of childbirth by postnatal women.

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Declaration

I hereby declare that the work presented in this portfolio is entirely my own, under the supervision of Professor Carla Willig.

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Abstract

This study has sought to problematise a lack of woman-oriented, female-subjective discourse constituting birth within social discourse. It endeavoured to map out how postnatal women in the UK draw upon available discourses to construct their experience of birth with each other, with a view to further understanding how this might shape, or indeed limit, the way women are able to subjectively experience birth. A social constructionist epistemology and a critical realist ontology underpinned the work, and a Foucauldian discourse analytic approach was considered an appropriate methodology with which to respond to the research aims. Three focus groups, each comprising four postnatal women, were held to generate talk about their childbirth experiences. What emerged from the analysis was that, in the absence of a complex discourse which constitutes birth fully as a physiological, emotional and psychological process in which the birthing woman is positioned centrally as a subject, women drew upon a range of different discourses (medical, natural, trauma, business), which positioned them multiply, in order to attempt to construct and gain subjective access to different fragmented, aspects of the birth experience. The dynamic ways women sought to position themselves will be considered. By exploring what could, and could not, be gained, experienced and said from these different positions, the potential for an alternative discourse on birth, one which might embrace the power, liminality and complexity of birth and in which the birthing woman is more actively made subject, rather than subjected, will be discussed.

1. Chapter One: Genealogy and Literature Review

1.1. Introduction and rationale

'Nobody told me you can't use toilet paper
Nobody told me that you bleed
Nobody told me you might need a secret place
Where you can scream.' (McNish, 2017)

'As Julia Kristeva says, quoting Mallarmé, "What is there to say concerning childbirth?" I find that question much more pungent than Freud's well-known, "What does a woman want?" Indeed, what does it mean to give birth to a child? Psychoanalysts do not talk much about it.' (Enright, 2005, p.11)

This study was born of a premise, increasingly observed in contemporary literature that there is a lack of talk around childbirth (e.g. McNish, 2017; Lothian & Grauer, 2012; Hennessey 2018). Reading Hollie McNish's (2017) award-winning poetry which sought to put down on paper 'all the things [she] couldn't talk about' around birth and the transition to motherhood, entitled *Nobody Told Me*, resonated with my own first experience of childbirth, and gave rise to this piece of research.

To suggest there is a gap, an 'unsaid', in the construction of childbirth, which some 700, 000 women experience annually in the UK (Knight et al, 2019), might seem absurd, especially given the plethora of 'socio-cultural chatter' and content around birth prolifically published in the western world (Chadwick, 2009, p.110). Yet Pollock's claim that childbirth is 'everywhere but nowhere' (1999, p.1) captures this paradox perfectly. It chimed with my own personal experience of finding a lack of space in which to construct my own experience of childbirth – free from medical, peer and personal judgement – as well as feeling that, despite immersive preparation for birth, nothing I had read or been told prepared me for what happened in birth and how it might leave me feeling.

The significance of birth for the birthing woman, juxtaposed with a lack of talk about it, was brought into the public, political domain in 2017, when MP Sarah Olney raised this discursive dilemma in Parliament on International Women's Day: 'We do not actually talk

that much about childbirth…We just do not have the words. Although the experience leaves a lasting imprint, it is never fully acknowledged. The memory of childbirth remains with us, unshakeable and unshareable, but never fully expressed' (Olney, 2017). That the video of this speech on Facebook alone reports over 2.5 million views and over 20,000 shares to date suggests her words, and indeed Pollock's enigmatic description which constructs birth as being discursively hidden in plain sight, clearly chimed with others too.

It is not, as Olney reasoned, that women do not have the words to describe their experience of birth – birth stories are observed prolifically online and in print (Chadwick, 2009). Rather the suggestion is that something seems to be preventing women from accessing an appropriate discourse which allows them to construct, experience and process birth adequately and publicly. Grosz (1989) captured this lack in her claim that there is no 'woman-oriented' (p.109) discourse on childbirth. This curious dilemma underscores the research.

Given my intention to problematise the unsaid, a turn to language feels appropriate, yet also challenging given birth's embodied, physical, emotional and psychological nature. This might explain the lack of qualitative psychological literature available looking at how women talk, or fail to talk, about childbirth and presents an opportunity for this research. Similarly, whilst the explicit themes of gender, power, sexuality and medicine permeate the subject of childbirth and so a Foucauldian discourse analytic approach feels appropriate, it nevertheless introduces methodological challenges which I will come to expand upon in Chapter Two, and hopefully reconcile with the help of a critical realist ontology (Nightingale & Cromby, 2002). I am aware of the dangers of viewing birth from a completely social constructionist, Foucauldian lens, depriving it of any material, embodied or psychic implications – and reducing the woman purely to text, denied her subjective sense of self (Burr, 2015). Navigating this epistemological and ontological dilemma is vital, not least given counselling psychology's prizing of an individual's subjectivity, but also in terms of the emancipatory aims of this research for birthing and postnatal women.

1.2. Birth, Foucault and Discourse

That reproductive bodies and women's sexuality have long been constructed according to socio-cultural, gendered, medical and political discourse has been widely documented in

feminist and poststructuralist thought (see Malacrida & Boulton, 2012; Malson & Swann, 2003; de Beauvoir, 1997; Butler, 2007). Foucault's *The History of Sexuality* (1978) has also been helpfully utilised by feminists to show how women's reproductive bodies have been, throughout history, targeted and produced by power and disciplinary practice, rendered 'docile', conforming to society's patriarchal 'norm', and made willing participants in their own subjection (Foucault 1978, p.138; Bordo, 2003; Bartky, 1990). But applying Foucauldian theory to the construct of birth does not come without challenge – and deciding to use FDA as opposed to a method which might more straightforwardly give 'voice' to the participating women's experience was something which required much critical reflection.

Foucault has been criticised by feminist scholars for his androcentric, gender-neutral tendencies and his neglect of the role gender plays in discourse (Bordo, 1993; King, 2004). The application of his theory onto childbirth therefore requires a critical approach: his failure to consider childbirth outside of a woman's reproductive capacity in its relationship to state control and the maintenance of a normalising family unit has been regarded as generalising and narrow (Logan, 2012). Nevertheless, such problems do not negate the value that Foucauldian thought and a discursive approach can contribute to feminist areas of research (Bordo, 1993; King 2004; Gergen, 2008), most usefully the way in which concepts such as docile bodies, biopower and micro practices can be used to explore the organisation and distribution of power – what he called discourse.

For Foucault, discourses are systems of knowledge, truth and power (Miller, 2008; Foucault, 1988a) which can define and construct objects and various subject positions (Parker, 1994) which make available 'certain ways-of-seeing the world and certain ways-of-being in the world' (Willig, 2013, p.130). Through disciplinary and indeed institutional power, discourses shape practices which are then taken up by the subject, who, depending on the position available to them risk becoming 'a subjected and practiced body, a docile body' (Foucault 1979, p.138). Discourse can therefore make possible and bring into 'reality' particular practices like childbirth, and subjects, such as birthing mothers – along with the potential for their subjective experience. Hook (2001, p. 524) notes that 'the strongest discourses are those that have attempted to ground themselves on the natural, the sincere, the scientific – in short, on the level of the various correlates of the 'true' and reasonable.'. Using discourse to

research childbirth, therefore, feels particularly relevant, shown to be steeped, over time, in medical and scientific essentialism.

1.3. Foucauldian Genealogy

A Foucauldian genealogy has the potential, as Newnham (2016) describes, to critique the authority of the status quo, and to free subjected knowledges from the powerful effects of expert and essentialist scientific discourse (Gordon, 1980, p.83). They are political in their aim to disrupt and open up spaces for social change – a motivating factor in this research – and offer ways of subverting established power dynamics, by understanding how discourses have emerged, rather than solely asking who is wielding discursive power over whom (1988b). With this in mind, I have decided to structure the beginning of this chapter with a genealogical approach to childbirth.

The aim is to trace what the dominant discourses constructing birth are and how they have developed over time to shape the present practice and possibilities for childbirth in the UK, utilising their effect on and for the birthing individual (Carabine, 2001, p.281). The advantage of integrating a Foucauldian genealogical approach rests in the opportunity of attending to how and importantly why various practices, institutions and policies have emerged and shifted over time. My decision to include one within this chapter was informed by a genealogy's value in its potential to question and critique the power relations which have come to constitute the practices and policies of childbirth presently – which seems key to working out how things can and should be different (Tamboukou, 1999). Without more fully deconstructing and understanding how the practice of birth has come to be normalised or legitimised as the 'truth', the status quo cannot be questioned and challenged, so that present practices, knowledges and discourses constituting childbirth might be conceived of differently. The need for this is explicitly stated in current calls for reform (National Maternity Review, 2015; Knight et al, 2019).

A genealogical approach to childbirth which spans (historical, medical, political) genres is, as extensive literature searches revealed, absent from the academic literature, and I felt that despite word count constraints, a mini-genealogy would provide a useful platform from which the current context of birth practice might be better understood – not least because of

an awareness that as researchers, we inevitably contribute to, and echo, the discursive terrain. I endeavoured to employ broad yet rigorous literature searches across historical, medical and political documents, academic journals and grey literature (such as the history of midwifery or social relations within early-modern childbirth, e.g. Wilson (2013)), paying particular attention to key moments of institutional, practice-based and policy-based change or discontinuity in the shifting landscape of childbirth. In doing so, I have sought to piece together and problematise a succinct but overarching chronological picture of how birth has come to be practiced and normalised currently.

The dominant discourses emerging from the genealogy will then be traced in the contemporary literature. Whilst such a genealogical approach does not provide a systemic line by line analysis, it is nevertheless a deconstructive piece of work, and so it has been helpful to take direction from discourse analysis in structuring the review: namely focusing on how and when discourses emerge, moments of change, discontinuity and struggles of power, and the institutions involved or affected in the production of discourse constituting childbirth (Parker, 1992).

A genealogy's value in seeking to locate a thread between the social world and individual subjectivity is clear – a macro-micro interaction which can offer alternative, more emancipatory, as opposed to descriptive, ways of understanding how we have come to construct and therefore experience our worlds (Willig, Potter, Wickham, Kendall & Hook, 2005). And in analysing how women take up, or do not take up, these discourses in their own constructions of birth, I hope the power relations inherent in birth might be further understood and transformed 'from below': crucial, as Foucault suggests, in locating the potential for resistance (1980, p.94).

1.3.1. c.1500-c.1700: Midwives, morality and the Church

Prior to the 17th century, it has been commonly claimed that birth was largely constructed as an exclusively female domestic practice – something done by women, helped and surrounded by other women, notably midwives, friends or family who had all birthed themselves (Wilson, 2013). Iterative and rigorous analysis of historical (raw and retrospective) literature, outlined below, suggests that a natural discourse emerges which situates birth as a natural,

normal female process, which opens up a dilemma around the positions made available to birthing women – active, agented and capable of and knowing about birth, or more passively tied to their reproductive organs, destined to birth?

Astbury (2017) shows how the natural discourse of birth was heavily informed by religious and social, patriarchal discourses of this period. In the early-modern prioritisation of the family unit, birth was constructed as a 'basic building block for society' necessary for lineage perpetuation (Walsham, 2016, p.122) and a divinely sanctioned gift from God, symbolic of social and moral conformity.

The religious discourse poses a dilemma around birth for women, which makes clear its overlapping links to a gendered discourse. Whilst birth is constructed as a fundamental and celebratory event (Wilson, 2013), it was also constructed as a curse – the Bible decreeing it as something Eve (and women thereafter) must suffer as punishment for the sin of sexuality. Birth is afforded a moral construction, therefore, with women positioned as destined to procreate and birth, yet also destined to shamefully suffer and endure great pain and subjection, because they had sex:

And he said to the woman, "I will increase your trouble in pregnancy and your pain in giving birth. In spite of this, you will still have desire for your husband, yet you will be subject to him" (Good News Bible, 2014, Genesis 3:16).

Informed by the religious discourse's mandate that birth is a necessary, yet painful and shameful act for women, the practice of birth in early-modern England was carried out in gender-segregated birthing rooms and therefore largely away from the male gaze (Wilson, 2019). Much of the critical literature on birth in this period, linked to this, focuses on the postnatal experience of birth as opposed to the act itself – creating something of an unsaid and a gap which might usefully be stressed here.

Birth has been widely constructed in the literature as ending a month after the baby was born, following a woman's 'lying-in' period and the undertaking of a religious 'churching' ceremony (Cressy, 1997; Wilson, 2013). Described as a 'ritual of purification' (Thomas, 1991, p.43), 'churching' coincided with the end of the birthing woman's postnatal bleeding –

which affords actual birth with something of a disordered, messy bodily construction which needs to be hidden from the public eye (Astbury, 2017). The inter-textuality of the natural, gendered and religious discourses seemed to work together, therefore, in the construction of 'churching' to 'symbolically mark – if not explicitly to signify – a moment of bodily restoration, the cessation of blood loss, a social return to a non-pregnant state', as Paster (1993, p.195) puts it.

The birthing woman (and her body) is therefore made acceptable only when cleansed of what the midwifery and nascent medical discourses termed her 'foul liquor' (blood) (Sharp, 1985), and when, as social discourse prescribed, her body had returned to its normal non-birthing state so that a woman's maternal and domestic identity might be restored (Smyth, 2016). Birth, therefore, is afforded less of a meaning in and of itself, and more a meaning in relation to a woman's identity and moral worth, as midwife Jane Sharp in 1671 describes:

Child-bearing is so dangerous that the pain must needs be great, and if any feel but a little pain it is commonly harlots who are so used to it that they make little reckoning of it, and are wont to fare better at present than vertuous persons do, but they will one day give an account for it if they continue impenitent, and be condemned to a torment of hell which far surpasses all pains in Child birth (Sharp, 1985, p.170).

According to the overlapping religious and natural discourses which construct birth as (naturally) painful and dangerous, women who had quick, unobstructed births were correlated with poor, immoral women, often birthing out of marriage, their bodies and wombs constructed as loose and open for the baby to fall out of (Gowing, 2003). Pain, as prescribed in the Bible, was therefore deemed necessary in birth, and something women needed to endure, suffering stoically, to be considered 'vertuous'. This is corroborated in the 16th century as the practice of offering pain relief was criminalised, punishable both for woman and administering midwife with public execution – the interlocking State and Church constructing any such intervention as irreligious witchcraft (Ehrenreich & English, 2010).

Midwives, prior to the 17th century received no formal education in midwifery, and were regulated by the Church. To practice legally, midwives had to pay eighteen shillings to the Church to acquire a license, actively declaring their commitment to the Church, eschewing

witchcraft and pledging to not use 'any kind of sorcery or incantation… not destroy the child born of any woman, not cut, nor pull off the head thereof, or otherwise dismember or hurt the same, or suffer it to be hurt or dismembered by any manner of way or means' (Strype, p.242 in Forbes, 1962, p.280). Danger for the baby, more than the woman, was constructed as the key risk within the patriarchal and religious discourses, where a live baby was needed to perpetuate the family line, and a stillborn baby (unable to be baptised) risked being relinquished to purgatory (Cassidy, 2007).

Such regulation of birth, powerful both at State and individual levels, seems very much to capture what Foucault wrote about in his arguments around biopower. Foucault conceptualised this literally as a power employed over and expressed through the individual body – made useful as a 'machine' and in its 'docility, an integration into systems of efficient and economic controls' – as well as the species body, 'imbued with the mechanics of life and serving as the basis of the biological process: propagation, births and mortality' (1978, p.138). With this in mind, analysis of the discourses emerging in this period suggests that childbirth became a construct through which the Church and State struggled to gain and retain power and control.

In summary, in early-modern Britain, birth was constructed as something natural and bodily, a female experience and destiny, yet one that was prescribed, governed and regulated through natural, gendered, religious, financial, and moral discourse lest it become the opposite – something unnatural and ungodly. Danger was implicit within birth and welcomed when constructed as pain – the birthing woman necessarily needing to suffer to prove her religious observance, moral worth and subservient identity. This afforded women with a position of compliant, docile supporters and bodily vessels of the patriarchal family unit and religious order, or sinful resisters with non-compliant wombs and bodies.

1.3.2. c.1700 – c. 1900: Men, medicalisation and hospitalisation

The 18th century witnessed a fusion of scientific, medical, economic and technological change. Rapid population growth and industrialisation meant that birth rates increased, as did the disparity between the rich and poor – which given assistance in birth needed to be paid for, affected the sort of help available to women depending on their socio-economic position.

The emerging discourses in this period are described below, particularly the medical (which increasingly interlocked with a business discourse in which for some, assistance in birth was constituted as a service to be bought, and for others without financial resource – assistance was denied). As extensive literature searches into the historical and institutional shifts in birth during this period showed, these discourses played a significant role in shaping how birth began to be differently constructed, practiced and experienced.

The institutionalisation of medical and scientific knowledge in this period – through universities and teaching hospitals – meant that the female anatomy and reproductive system began to be pathologized and taught – by men to men (Fife, 2004). Wilson (2019) shows how this translated into a gendered struggle of knowledge and ownership of birth between female midwives and male physicians, in terms of constructing its meaning and also securing fee-paying work. Fife's (2004) look at the language used by male physicians compared to female midwives reveals how the medical discourse in this period began to present birth and the birthing woman differently to that constructed by midwives from within a natural discourse. No longer was birth an exclusively natural female process, divinely overseen, and exclusively 'women's work' (Grundy, 1995). Instead, the medical discourse began to legitimise an objective, pathologizing construction of birth, making it into a dangerous biomedical process to be managed more safely with medical expertise, newly developed instruments (e.g. forceps) and active intervention. A key shift for the birthing woman, as Fife (2004) highlighted, was that the medical discourse normalised the replacement of birthing 'woman' with 'patient' – an objectifying, homogenising and passive positioning, which required a more active subject, a male medical expert, to restore her back to health.

The medical profession's appropriation of tools and technologies (which female midwives were legally prohibited from using) such as forceps and pain relief, also produced an agency shift around birth. A shift in practice followed which prioritised male action over female support – of doing to in birth rather than being with. Hutter Epstein (2010) links this to a significant spatial shift in birthing practice in which women ceased to birth in an upright position on a birthing stool, and were instead encouraged to assume a supine position lying on a bed – a position which better allowed a physician to see birth and apply his tools, clearly affording him more agency than her. In this way, the medical discourse constructed birth increasingly as oriented around the (male) medic as opposed to the birthing woman.

This spatial and material shift in birth, from stool to bed, might be regarded as a negotiation of power through space (which Foucault considered to be relational), in its prizing of (male) medical skill and knowledge over female physiology and subjectivity. Indeed, the mid-late 18th century was a time in which Foucault located a political shift in health – from the individual to the population, which seems to be demonstrated through the medicalisation of childbirth and its accompanying institutionalisation (Foucault, 2007). For the first time in history, birth began to take place in hospital. And as hospitals came into being, it was populations who were afforded subject status, and individual bodies were relegated to the 'object of medical knowledge and practice' (Foucault, 2007, p.151). Consequentially the individual subjectivity of the birthing woman, now patient, was even further lost.

The sheer loss of subject status for birthing women within the medical discourse is perhaps more clearly indicated as Cody (2004) describes how 'women big with child' were actively excluded from mainstream hospitals. This raises something of a dilemma in which birth became increasingly constituted by the medical discourse yet also unattended by it, constructed as something both normal (not worth the attention of general medicine) and abnormal – requiring expert attention and additional medical surveillance in the institutional format of separate lying-in hospitals.

Lying-in hospitals were founded in the 19th century, offering poor women without the resource to pay for medical or midwifery assistance a place to birth. Within these spaces Cody (2004) describes how women were micromanaged with both medical intervention *and* moral reform – the gendered medical discourse utilising a Cartesian split to construct birth both as biomedically dangerous and morally shameful, particularly for women of lower social status. That women took up this positioning willingly suggests how entrenched these discourses had become, and how little agency (poorer) women had come to expect in birth: oversubscription to British lying-in hospitals at this time is widely reported despite the widespread risk of disease (for which women were wrongly blamed as Loudon, 2000a, points out), despite the way the hospitals subjected women to new, experimental medical intervention, and despite the consistently high mortality rates they produced for the birthing woman (Murphy Lawless, 1998).

At the other end of the social scale, for birthing women with access to plenty of financial resource, birth at home with the aid of a male physician was constructed as the ideal (Cassidy, 2007). Medical advances (gained not without the help of trial-and-error at the lying-in hospitals) were utilised to make birth experience less agonising for women. Birth began to be constituted as something deeply undesirable which could be bypassed (with women anesthetised into unconsciousness with chloroform or ether), should they have the financial means to pay for it. With the woman unconscious, it was the doctor who extracted, or gave birth to, the baby (Bourke, 2014).

It was the edges of childbirth that the medical discourse utilised and applied itself to in the 18th and 19th centuries in order to further learning and create a position, for medical experts, of indispensability in birth. Birth became pathologized, constructed as increasingly dangerous – a potentially fatal biomedical process to be made safe with technology, expertise, and financial resource. Experience of the woman was not part of this discourse – to the point it was, for the wealthy, preferable to be removed from it all together, made unconscious. Women were made into passive anatomically constructed birthing bodies: useful and curious tools for furthering medical knowledge, unsanitary containers of disease in need of physical and moral reform, and objects to be intervened upon by agented medics. As medical reform and social progress was increasingly prioritised, women's individual experience of birth and her sense of subjectivity as a birthing woman disappeared.

1.3.3. c.1900 onwards: Medical v. natural discourse, the NHS and risk

At the turn of the 20th century, the medical discourse had normalised birth's 'pathological dignity' as American Dr Joseph DeLee coined it. This functioned to transform the natural discourse's construction of birth as 'normal' which would afford 'anybody, a medical student a midwife or even a neighbour… to take care of such a function' (Fishbein & DeLee, 1949), into something in which medical expertise and intervention was essential, and needed to be paid for.

The standardised application of forceps, episiotomies and offering of 'Twilight Sleep' – an injection of morphine and scopolamine which produced amnesic effects in the birthing woman – exemplifies this. This was a combined birth intervention Dr DeLee is reported to

have applied to over 8000 women in the early 20th century (Cassidy, 2007). Birth was constructed, therefore, as something to be feared, pathologically dangerous and not at all natural, to be known, intellectualised and done by medics, who could remove birth from the woman's memory and then return her to 'better than new' (Wertz & Wertz, 1989, p.142) – sewn up, as if it never happened.

Women compliantly became 'subjected' and made 'docile' in a Foucauldian sense, as they willingly sought to be removed from birth and medically repaired thereafter (Foucault, 1979, p.138). Foucault famously commented that 'where there is power, there is resistance' (1979, p.5), and in response to the increasingly dominant medical discourse a natural discourse re-gained prominence, popularised by UK obstetrician Grantly Dick-Read, as Michaels charts (2017). Dick-Read became an advocate for 'natural birth', constructing it as something in which fear was implicit yet unhelpful and needed to be managed by women through natural breathing and relaxation techniques.

What is noteworthy about this struggle between the natural and the medical discourse is that both discourses were underpinned by the same view (manifest in the dedication to Dr DeLee that Dick-Read made in his book, *Childbirth Without Fear* (2004)): that birth was essentially fearful for women (Michaels, 2017) which needed to be overcome in order to produce a baby. Where they diverged was on the different ways in which to address that fear – be it through medicalised 'safe delivery' (DeLee), or breath-work and natural relaxation techniques (Dick-Read). The implication for birthing women was strikingly shared: birthing women were positioned by both discourses as needing to be taught how to birth and helped to birth by experts.

The natural and medical discourses emerging in the 20th century might be said, therefore, to be deeply informed by a gendered discourse constructing women as weak, inferior, and passive. Whilst a gendered discourse has been hard to evidence in the literature, perhaps suggesting how ingrained and implicit it is in its constituting of birth (an act that distinguishes men from women), the stereotypical gendered constructs of the wildly emotional, inferior female and the ordered rational, in-control male (King, 2004) do seem to bleed into both the natural and medical discourses constituting birth in this period as fearfully uncontrollable, and therefore needing to be expertly controlled.

The need for birth and birthing women to be actively managed emerged at a time when, in the mid 20th century, social and political discourses came together to standardise hospitals in the UK with the inception of the National Health Service (Olszynko-Gryn & Rusterholz, 2019). This was a critical moment for childbirth genealogically, given Foucault's position that hospitals were institutional spaces through which a powerful application of classification, control and discipline were applied on to the individual (Foucault, 2007). Birth began to be more dominantly constituted, at this point, by a business discourse, as a process within an institution to be managed, resourced and accounted for in political, financial and legal terms.

And whilst the Labour Party sought, in 1948, to regulate and make accessible healthcare to all, an attractive proposition given the record high of maternal and neonatal mortality rates in the late 1930s (Loudon, 2000b), birth continued to remain unprioritized within the medical and interlocking political and business discourses constituting hospitals. The 1949 Parliamentary motion, for example, calling for more regulated and accessible pain relief for all women, remained unattended to, as Bourke (2014) observes: it was not until the 1980s when reliable analgesic was reported as being widely offered to birthing women and standardised medical procedures such as episiotomies began to be questioned in terms of efficacy.

One way that the literature explains this prolonged lack of attention to birth within a hospital context is the shift in birth's construction from pathologically dangerous and something to fear to risk (MacKenzie Bryers & van Teijlingen, 2010; Scamell, 2014). It was the shifting constructions of birth as risk as it came to be constituted by the medical and interlocking business discourse (where financial or legal risk became inextricably linked to mortal risk), that have been considered key to shaping and normalising practices of birth in the 20th century, despite the way such practices have been said to limit women's agency and choice (Marshall & Woollett, 2000).

MacKenzie Bryers and van Teijlingen (2010) map out the shifting constructions of birth as risk in the early 20th century. They show how a social discourse emerging from the post-war drive to strengthen the population introduced certain procedures in pregnancy and birth (such as scanning in utero and standardising induction beyond 41 weeks) which functioned to

detect and avert individual risk so as to limit the collective future-oriented risk for society (Foucault, 1991). They also highlight how, later in the 20th century as the NHS took shape, pathological risk for the individual/society became complicated by the collective financial and legal risk of the service providing public care to the individual (RCOG, 1948; Chertok, 1969). Women began to be positioned according to levels of risk (high or low) which determined the sort of care they received – low risk linked, as Carter & Duriez (1986) described, to homogenising factory-line midwife led care, and high risk linked to (more costly) obstetrician management. This produced a hierarchy of medical expertise in which doctors were at the top, midwifes in the middle and women were at the bottom (MacKenzie Bryers & van Teijlingen, 2010).

The contemporary construction of risk has been linked to Foucault's concept of governmentality (Foucault, 1991), endowed with a function of monitoring and observing the population (Lupton, 1999). Theorists show how, within this governmental discourse, individuals are critically positioned as active, with the capacity for self-surveillance. When applied to a construction of pregnancy and birth, this means that once risk has been outlined to a woman, it is she who becomes responsible for averting it, because it is within her own best interests (Budds, Locke & Burr, 2012). When a woman is made aware of the risk to her baby's survival – be it low or high – she becomes accountable for the adverse outcomes, particularly if she refuses to adhere to the monitoring procedures the medical discourse implements to avert that risk.

This potentially offers insight into why, by the late 20th century women willingly submitted to increasingly normalised medical monitoring and intervention to detect risk (to the baby) such as regular pregnancy scans, cervical examinations, foetal heart monitoring and induction, despite, as Johansen, Newburn & Macfarlane (2002) point out, the limited clinical evidence correlating such procedures with safety and foetal survival. The 'just-in-case' position which women take up, having been made aware of the risks of childbirth, is as Scamell (2014) argues, a difficult one to escape.

Indeed, in 1992 a government report clearly stated that 'there is no compelling evidence that hospitals give a better guarantee of the safety of the majority of mothers and babies. It is possible, but not proven, that the contrary may be the case' (House of Commons, 1992, p.

XII). Evidencing that the practices of the medical discourse are discontinuous with increased safety has, however, failed to interact with the way women take them up – as just 2.3% of woman birth outside of the hospital setting currently in the UK (ONS, 2019).

It is progress, choice (of how to birth and where to birth) and safety (in response to danger, and later risk) which the refined medical and natural discourses, together with a more prominent business discourse, offered women in the 20th and 21st century. But as a 1993 (Department of Health) report highlighted, it was these very things, specifically 'choice, continuity and control', which were found lacking for women birthing in NHS hospitals. One way of interpreting this dilemma is to consider the strength of how the dominant discourses all construct birth as something (fearful and/or risky) to be managed, overcome, and made safe with a view to securing the end result – a live baby. And when averting risk (specifically in order to reduce harm or death to the baby) is constructed as the goal of childbirth, the liminality of birth and related to this, women's subjective experience of birth becomes (or continues to remain) unimportant, even selfish. The potential for a female-subjective discourse of birth is, as the contemporary literature alluded to at the beginning of this chapter suggests, denied when safety (the aim of risk aversion) is correlated with the birth of a healthy baby.

1.4. Contemporary literature on childbirth

I will now turn to the contemporary academic and grey literature, attempting to weave it together with the dominant medical and natural discourses, the growing business discourse and implicit gendered discourse, which emerged from the genealogy to try and further understand the current context of birth in the UK.

1.4.1. Medical literature

Birth, according to the NICE (2017) guidelines for 'intrapartum care', is demarcated by timings, stages and measurements which chart a 'normally progressing labour' (p.61) (and introduces the potential for the construct of an abnormally progressing labour). Progression in birth is afforded an action-oriented, goal-focused construction, reinforcing that the medical discourse conceives of birth as a biomedical, bodily process which ends when a baby presents

externally. In the NICE Guidelines, medics are encouraged to 'explain to…women who are at low risk of complications that giving birth is generally very safe for both the woman and her baby' (2017, p.32). Here, birth is afforded a dilemmatic construction in which risk is dismissed yet also mobilised by the mention of safety, and reinforced both by the casual adoption of 'generally' and the guidelines' ensuing reams of information which follow, dedicated to informing medics how to detect, monitor and avert risk in birth.

The guidelines, in their introduction, acknowledge birth empathically as a 'life-changing event' (p.16), and function to instruct medical professionals to provide holistic care, constructing birth 'physically and emotionally', explaining how 'good communication, support and compassion from staff, and having her wishes respected, can help her feel in control of what is happening and contribute to making birth a positive experience for the woman and her birth companion(s)' (p.17). But the fact that all of this needs to be spelled out implies that such a mind *and* body construction of birth and the application of woman-centred care is not necessarily implicit within the medical discourse. The language here also seems to reinforce the idea that birth is essentially uncontrollable – something a woman can only be helped to 'feel in control of' (p.17) and in which the experience of her birthing partner is positioned as being equally as important as the birthing woman's.

Indeed, the ensuing, lengthy guidelines position the 'nulliparous' or 'multiparous' woman as needing to be observed (p.62), recorded (p.42), discouraged (p.63), informed (p.40) and advised (p.46) to do or not do things. This implies that despite the compassionate introduction, the birthing woman continues to be objectified and generalised within the medical discourse, passive in her need to be both surveilled and communicated *to* by medics and midwives, according to the best practice procedures and policy set out by the governing body, NICE.

That women are objectified, as opposed to made agented subjects, by the medical discourse becomes more manifest when the separate NICE guidelines on birth are considered, distinguishing physically and bodily between 'healthy women' (2017) and 'women with existing medical conditions or obstetric complications' (NICE, 2020) such as 'heart disease' or 'obesity' – a positioning which alters the procedural pathways for birth. The way this pathologizes both the birth experience and women's bodies is clear. The fact that there are

yet more separate guidelines for 'antenatal and postnatal mental health' (NICE, 2014) reflects the historic Cartesian dualist split of the medical discourse, perpetuating a construction in which the physical process of birth is made separate from the mental experience, which limits, therefore, the ability of medics to act on the woman as a whole. Within the medical discourse the body is made to take priority, which, in turn reduces a woman's potential to construct (and experience) birth as an emotional or psychological process for herself.

Statistically speaking, the way women are birthing has shifted in the 21st century. A rise in abdominal birth[1] is one of the most significant shifts (Panda, Begley & Daly, 2020). Information collected nationally by NHS Trust in England reported that out of approximately 700,000 births per year, 42% were described as 'normal' (and just 34% 'normal' for first time mothers), the rest were described as 'intervention' which comprised 'caesarean section', 'forceps' and 'ventouse' (Dodwell, 2012). The rhetorical implication here is that birth with intervention does not constitute 'normal' birth. It is noteworthy that out of the statistics outlining how many births involved intervention, there is no mention or statistical reference to elective abdominal birth, despite it legally being an option for women as of 2011 (NICE, 2011), and despite it being reported as a vastly different subjective experience for women compared to an emergency abdominal birth as Zanardo et al. (2016) evidence finding elective abdominal birth to have a more positive impact on women's emotions and feelings around their capacity to bond with their baby following birth.

Gholitabar, Ullman, Griffiths and James (2011) reflect on the 2011 update which allows women to birth abdominally by choice, raising their concerns about this change to policy. They argue that 'appropriate' reasons for 'caesarean sections' rest in the physical – a woman's 'morbidly adherent placenta' or the baby's positioning as 'breech', for example. Whilst they claim to want to 'empower' women 'to make informed decisions' (p.3) about how they birth their baby, the function of the paper seems rooted, however, in voicing concern that the new elective option 'will result in a large increase in caesarean births on maternal request' (p.3) – which they construct negatively.

[1] I use 'abdominal birth' consciously as it reflects my own efforts to endow birthing women with agency, set apart from the construction afforded by the medical discourse, of women having a caesarean section.

Women's choice in birth is clearly being challenged by medical professionals within this discourse, which governs that 'normal' (vaginal) birth is best unless there are medically observed physical complications. The medical discourse here seems to be informed by a historical gendered discourse which constructs birth as something women should naturally suffer, as well as a business discourse which constructs risk not only medically, but also financially: abdominal surgery requires more specialist medical expertise and financial resource than vaginal birth (Donnelly, 2016). What emerges, practically, is that thousands of women are currently being refused a choice of abdominal birth despite it being their legal right and irrespective of the implications this lack of choice has for their subjective experience (Birthrights, 2018).

Informed consent, as an issue pertaining to the ability to exert choice in birth, is something the medical discourse seeks to ensure for women before any intervention in birth is implemented (NICE, 2017), even if that means she, or her baby, are put at risk (Birthrights, 2017). Bordo (2003) suggests that this becomes complicated because of the unique duality (mother and baby) of birth, and because of developing technologies such as 3-D and now 4-D ultrasound monitoring which bring the baby more into being prior to being born, a 'public foetus' as Lupton (1999, p.62) terms it. Bordo claims this diminishes the power for a birthing woman to consent or withhold her consent. Indeed Bohren et al.'s (2015) systematic review of abuse within global maternity care cited 'lack of consent to medical intervention' in birth as a concern specifically evidenced in the UK. This supports evidence from the Birthrights study (2013), which reported that 12% of women in the UK felt that they not consented to internal examinations or interventions in birth.

Scamell (2014) suggests the lack of choice being made available to women (to either request or refuse medical intervention) as well as the normalisation of (and women's willing adherence to) monitoring and surveillance of the woman and baby, are determined by recent constructions of risk within the medical and interlocking business discourse. This can be observed from the NHS's Strategic Plan for 2019-2022 (NHS Resolution, 2020) where risk is explicitly constructed as loss or harm to the mother or more significantly the baby, and also as financial and legal loss to the NHS as a business. Maternity negligence claims, in 2019, made up 10% of all claims lodged against the NHS and represented a substantial 60% of the value of all NHS claims, which in 2019 was estimated at £83 billion.

A paradox seems to emerge, Scamell (2014) suggests, within the contemporary medical discourse. Safety against risk in birth is offered through medical intervention and care – yet this is also the thing being correlated with maternal and neonatal 'harm', death and risk, as recent reports have indicated. The National Maternity Review (2015), and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) report (Knight et al., 2019) were commissioned in response to concerns about the UK's maternal and baby mortality rates, and the standard of care that women were provided with when birthing in NHS hospitals. Two important findings from the MBRRACE report were that maternal suicide is the leading cause of death in women a year after giving birth, and that Black women are five times more likely to die in birth than white women. Here, death, as opposed to, say, distress seems to be being made into the benchmark of failure, used in these reports as the primary impetus for maternity reform within the medical discourse. I suggest this reinforces just how overlooked women's subjective experience and distress in relation to birth seems to be.

The National Maternity Review (2015) offered more direction in terms of unsatisfactory systemic, practical problems within maternity care in the UK and proposed a five-year plan for reform. As a paper which audited birth from within the medical and business discourse (in terms of interlocking medical and financial outcomes) it echoed the genealogy which suggested that the medical and business discourse of birth position women as objectified subjects, marginalised to the extent that their 'story' and voice is powerless in the face of these discourses' more powerful objectives of success in terms of science and healthcare management. It stated that '*many women are not being offered real choice in the service they can access and are too often being told what to do… Hospital services are at capacity with some running at 100% occupancy too much of the time…. time and again mothers said that they hardly ever saw the same professional twice, they found themselves repeating the same story because their notes had not been read. That is unacceptable, inefficient and must change… All these factors contribute to the UK having poorer outcomes on some measures than our peers in Europe, which is unacceptable*.' (p.3).

The report's vision is for maternity services to '*become safer, more personalised, kinder, professional and more family friendly… and for all staff to be supported to deliver care*

which is women-centred' (p.8). The implication being, that in 2015, this was not happening, and as the 2020 update (quoted below), reviewing the NHS's five-year strategic plan for maternity service reform, suggests, still isn't. That 'women-centred' care continues not to be a priority might be inferred from the report's failure to feature a single mention of 'women' or 'woman':

'*Maternity incidents can have devastating consequences for affected children and their families, and can be traumatic for the treating NHS staff. They also have significant financial consequences for the NHS. Claims for negligent brain injuries in birth are generally the highest in value. Obstetrics is consistently the highest cost area for claims, accounting for around 10% of the number of incoming claims and 60% of the annual cost of harm.*' (NHS Resolution, 2020, p.8)

Birth is constructed in the contemporary medical literature firmly as risk – physically so for babies and families, and economically for the NHS. The medical discourse, interlocking with the business discourse, seems, therefore, to remove the woman and her individual subjective experience from the birth process: she becomes objectified, monitored and acted upon in relation to averting risk for the baby and the institution (the hospital trust and NHS).

1.4.2. Natural birth and midwifery literature

A key finding and recommendation for change in the National Maternity Review (2015) was that midwives and obstetricians were commonly at odds in terms of practice, procedure and philosophy around birth. A struggle over the 'contested space' of birth for women, as Darra and Murphy show in their narrative research into how new mothers and midwives describe 'normal' birth (2016, p.18), has been widely reported in the academic midwifery literature. They document how the struggle between midwifery and obstetrics has produced polarised, dichotomous constructions and belief systems around birth which results in a lack of an appreciation for the common ground between the two. Walsh (2010, p.486) links this to the 'mounting evidence that childbearing women's experience of birth are often shaped in the uneasy space between the two', which supports the idea that women's experience in birth is being directly shaped, and crucially limited, by dominant discourse. One striking recommendation in the Review was for them to train together – forging a greater

understanding of each other's' positionings (p.10). The challenge with this, as Darra (2018) anticipates, is that because the natural and medical discourse emerged genealogically in dichotomous relation to each other, they share the same constructions of birth – normal versus abnormal, natural versus medical – orienting themselves differently in terms of the value they place on either side of the dichotomies.

The midwifery literature reports various current constructions of 'normal' or 'natural' birth – terms which are increasingly conflated (Darra, 2009). NICE states that 'normal delivery is defined as that without surgical intervention, use of instruments, induction, epidural or general anaesthetic' (2007, p.2). The Royal College of Midwives define normal birth as 'one where a woman commences, continues and completes labour physiologically at term' (RCM, 2004). Darra (2009) points out how problematic and restrictive such definitions are, and how few women would currently be afforded the position of having birthed naturally given the prolific use of active management (medical intervention) in the 'third stage of labour' for the majority of women (Winter et al. 2007).

Downe and McCourt (2004), by way of addressing this, proposed a new definition for natural birth which was intended to expand out of the rigid normalised one. They constructed natural birth as 'uncertainty, complexity, salutogenesis' (p.4), which sought to remove the pathologizing construction of birth as a process to be remedied with medical intervention and normalise variability. But what seems to have been overlooked is that their new definition remains dichotomously anchored to their interpretation of the medical discourse's construction of birth, which they summarise as 'certainty, simplicity, linearity and pathology' (p.4). Their adoption of the complexity/simplicity dichotomy is interesting – used historically by the medical discourse to justify the need for medicine's specialist knowledge and involvement in birth. A discursive battle to know and therefore own the 'complexity' of birth continues to play out between the dominant medical and natural discourses, effecting a similarly homogenising, knowledge-less position for the birthing woman, subject to the complexity of birth – however it is being variously constructed.

The complexity of birth is constituted by the natural discourse as female 'raw, elemental power' (Davis-Floyd & Cheyney, 2014), which has roots in raising awareness of the workings of the internal female body in birth – a reaction against, it has been suggested, the

medical discourse's historic disinterest in women's internal bodies (Hynan, 2018). In the 1960s, groups of British and American midwives actively sought to highlight this and liberate birthing women from the passive, anaesthetised, supine position the medical discourse had bestowed upon them (Carter & Duriez, 1986). Ina May Gaskin, a prominent American midwife, in her (still popular) *Guide to Childbirth*, exemplifies this. Her tenet was that a woman's body is designed to birth:

'*The problem is that doctors today often assume that something mysterious and unidentified has gone wrong with labor or that the woman's body is somehow inadequate… Remember this… Your body is not a lemon. Your body is not a badly designed machine. You are not a machine. The Creator is not a careless mechanic… I recommend that you learn to think positively about your body*.' (Gaskin, 2007, p.162).

Whilst functioning to empower and liberate women, her statement highlights the natural discourse's interlocking, historical roots with the religious discourse of birth. Constructing birth as a divinely bestowed process on a woman's body, naturally 'designed' to birth is, as feminists have pointed out, problematic in its equating of female destiny with biological reproduction (Friedan, 2013; Sayers, 1982). Furthermore, in planting birth firmly in the body, it reinforces the Cartesian dualist split proposed by the medical discourse and makes a woman's agency, and subjective experience in birth unimportant. Nature (or God), and the female body become the active subjects of birth which ironically removes women (as a whole) from the process, leaving no room at all for women having, or choosing to have, intervention in birth or expressing ambivalence about the experience. To take this to its extreme (as witnessed in contemporary freebirthing literature – see Norris-Clarke, n.d.) distress and or intervention in birth is not allowed for, leading to the implication that risk, complication and loss is equally part of nature and natural destiny: if a woman's body struggles to birth it is because it was not meant to be.

In the UK, the National Childbirth Trust (NCT), founded in the 1960s as The *Natural* Childbirth Trust, is a leading public advocate for the natural discourse (Darra, 2009). Founded with 'a desire to share knowledge and skills with pregnant women everywhere' (Carter, 2015) their mission was to put women at the heart of childbirth and publicly and politically promote the need for 'humane' midwifery-led maternity care in birth at a time

where medical intervention was routinely applied to birthing women (NCT, 2007). Over the last ten years the NCT began to receive public criticism in relation to their exclusively natural stance: 'this is a very politicised, dogmatic and in my experience, scary organisation', public figure and commentator Kirstie Allsop publicly declared, reacting to their prioritisation of natural/normal birth over caesarean section, disapproval of pain relief, and focus on breastfeeding (Walker, 2013). This, as analysis of their recent literature suggests, prompted a departure from birth and a shifting focus to orient themselves as the UK's 'leading parenting charity' (NCT, 2019).

Mander, Murphy-Lawless and Edwards (2018) argue that the contemporary erasure of 'natural' birth is directly linked to the normalisation of medical intervention, and the subsequent contraction of midwifery provision in the NHS. They construct the NHS as a regulatory body constituted by medical, political and financial discourse, currently subjected to governmental cuts and organisational challenge which has negatively and directly affected maternity service provision. Others have agreed (Leversidge, 2016; Dabrowski, 2017).

They actively seek to bring birth into political discourse and offer a manifesto to invest 'natural' birth with the power they argue has been historically denied by the 'capitalist patriarchy' (p.186). They claim, however, that 'change…can occur when midwives themselves take up the responsibility of the collective dissent' (p.7). The effect this seems to have is to reinforce the positioning of birthing women as passive, silenced and unable to know birth for themselves, tied inextricably as a 'service user' (p.181) to their midwife. And in adopting Kitzinger's (2006) position that medical intervention in birth is at best unsupportive, at worst abusive, they continue to construct natural, normal, non-medical birth as best – which merely reinforces and keeps alive the discursive dichotomy it seeks to resist.

Bordo (2003) argued that if power is solely considered to reside in either a victim/abuser, oppressor/oppressed dynamic, resistance can never be realised, because, as Foucault argues, power and dominance does not come 'from above' rather it is exercised much more horizontally, through multiple 'processes, of different origin and scattered location' (1979, p.138). To apply this to the midwifery literature, as long as the construction of birth remains in dichotomous opposition to medicalised birth, and medicalisation is constructed as the 'big bad wolf' (Davis Floyd & Cheyney, 2011), the complexities of power and positionings

available to women in birth will remain inaccessible, and birthing women will be denied the opportunity to take responsibility for their own role in reproducing or resisting the (disempowering) dichotomous discourses governing birth.

The midwifery literature seeks to empower women in birth: to help them feel supported in decisions, informed, and remain agented and active within a powerful female process. But because it continues to construct birth staunchly in opposition to the medical discourse, birth remains subjected to the dominant discourse it seeks to escape, and similarly homogenised. In short, it struggles to find a way out of being, essentially, a discourse which is equally as prescriptive, in its didactic function instructing women how they should (and should not) birth.

Darra's (2009) recommendation that there needs to be a move away from constructions of natural or normal birth feels sensible. Drawing on Winnicott's (1964) good-enough concept provides her with a framework with which to resist the stalemate produced by the natural/medical discursive dichotomy. Instead she suggests moving towards an alternative focus in midwifery practice of 'being with' birthing women and metaphorically holding them as a way of constituting birth. Reappraising the practice of birth in this way suggests both a lack, and a need for, an alternative discourse which might constitute birth as a process in which the woman, and her subjective experience, are positioned centrally.

1.4.3. The psychiatric and psychological literature

If, as suggested, birthing (and postnatal) women's individual subjective experience struggles to be allowed for in both the dominant medical and natural discourses, it feels important to turn to the psychiatric and psychological literature to explore how birth is being afforded a role in relation to a woman's sense of self. In doing so this research might be more usefully positioned within the existing literature, and may also contribute to conversations around reforming perinatal mental health service provision, widely appraised in the UK as unsatisfactory (Slomian et al, 2017; National Maternity Review, 2015), under-researched and neglected within the psychiatric and psychological professions (Howard & Khalifeh, 2020).

Following birth, the psychiatric discourse (a subdivision of the medical discourse) constructs the potential for mental illness, namely postnatal depression (PND), post-traumatic stress disorder (PTSD), and postpartum psychosis (American Psychiatric Association (APA), 2013). Postnatal mental distress is therefore pathologized as a phenomenon to be diagnosed according to predisposing vulnerabilities and postnatal symptoms, for which treatment is offered accordingly. The liminal space of birth, given this discourse's focus on the before and after of birth, becomes lost and because of this, from within a Foucauldian framework, women lose access to a more complex experience of the messier, in-between moments (emotionally and physically) of birth. Whilst research exploring the links between childbirth and postnatal mental health has more recently gained a higher profile in the psychology literature (Michaels, 2017; Bell & Andersson, 2016; Grekin & O'Hara, 2014), the psychiatric discourse with its diagnostic frame and pathologizing construction of mental illness – separate to the bodily act of birth – prevents a firmer link from being made between the two. This limits the possibility of birth being constructed as a crucially transformative and complex physiological, emotional and psychological process, invested with the power to effect subjective experience.

Furthermore, the psychiatric constructions of postnatal distress, particularly PND, have been criticised for their genericness (Howard & Khalifei, 2020) which seems to have an effect of simultaneously pathologizing women's postnatal distress whilst also normalising it. Perkins and Fancourt (2018), for example, construct PND as a pathologized behavioural and psychological change, symptomatically comprising 'fatigue, irritability, disturbance of appetite, insomnia and anhedonia' (p.119). This echoes the general psychiatric criteria for depression (APA, 2013) and seems surprising in its application to (sleep deprived) postnatal women, adapting to a huge life and identity transition – having just given birth. That PND is clinically distinguishable from 'baby blues' (NCT, 2020) in its symptomatic endurance beyond two weeks postnatally issues a pace and expectation for normal emotional recovery following birth, too. As such, the psychiatric discourse mirrors on a 'mental' level the medical discourse's adherence to the hurdle approach, in which childbirth is viewed as an illness or event from which women's physical bodies recover and bounce back to normal (Birksted-Breen, 2000; Thomas, 2017).

This disallows women from taking up a discourse in which birth constitutes ongoing change or loss – physically and mentally. Women are required within this discourse to recover their former psychic self, the expectation being that they shouldn't be negatively changed and affected by birth. Such an appraisal of 'depression' postnatally as illness which can be rectified with treatment also serves to reinforce the gendered social discourse making distress incompatible with the expected joy that newfound motherhood has come to be constructed as, as Lewis & Nicolson (1998) evidence from interviews with mothers which were thematically analysed. They found that PND as an 'illness' was either recruited by women to explain *why* they experience difficulties in early motherhood, staving off a construction that early motherhood is itself difficult or negative, or else starkly rejected because the notion of depression implies that there is serious, disabling problem which women wanted to be distanced from. Either way, a double bind remains in which loss and distress for the woman is disallowed for when social discourse constructs the birth of a live, healthy baby as a happy success. Building on this, the opportunity to consider the way constructions of birth (and not just motherhood, as is Lewis and Nicolson's focus) relate to women's postnatal subjective experience, is here presented.

Whilst the DSM-V (APA, 2013) does not explicitly construct childbirth as trauma in the context of PTSD, the recent adaptations to its criteria for PTSD do make it applicable to childbirth (Crawley et al, 2018) even if, as Ayers, Wright and Thornton (2018) report, PP-PTSD is largely unrecognised and not routinely screened for. Traumatic birth has been correlated widely with both women and their children's long-term functioning, distress and even morbidity (Ayers, Eagle & Waring, 2006). It is approximated that between 3 and 9% of postnatal women meet the full clinical criteria for PP PTSD (Simpson et al, 2018; Grekin & O'Hara, 2014), but psychological research elsewhere indicates many more women (up to 45.5%) construct their birth as traumatic (Soet, Brack & Dilorio, 2003; O'Donovan et al, 2014). As Ayers & Ford (2012) point out, this evidence is largely based on self-report questionnaires for women identifying as having had a pathologically traumatic birth, seeking to improve diagnostic screening and awareness of predisposition to developing PTSD (e.g. O'Donovan et al, 2014). There is therefore room, I suggest, for richer qualitative research into childbirth, both with a general as opposed to pathological focus, and also for research which encourages and embraces naturally occurring talk (which fed into my design to use a focus group design – which is absent from the literature), as opposed to a more clinically

orchestrated dyadic research design, so that an understanding of how women might be recruiting discourse and constructing birth in everyday talk might be gained.

Rodriguez-Almero et al.'s (2019) study into Spanish postnatal women's perceptions of living through a traumatic birth (as opposed to being diagnosed with trauma) suggests themes of being mis/uninformed by health professionals, being disrespected and objectified in birth, and experiencing a lack of support as constitutive factors of birth trauma. This builds on and echoes Ayers et al.'s (2006) work in the UK, which linked birth perceived as traumatic with loneliness, stress and depression for women postnatally. In both studies it was the subjective experience of feeling dehumanised, humiliated and powerless in birth, a feeling of not being seen and heard, that afforded women to retrospectively construct their birth as traumatic – a finding also evidenced in mixed methods research by Henriksen, Grimsrud, Schei, Lukasse & Factors (2017) and also in narrative research by Thomson & Downe (2013), who as an example, compared women's narratives of self-defined (first) traumatic birth followed by a 'positive' birth experience, storying the women's transformation from (lonely, passive, powerless) victim to hero.

It has long been suggested that minimising trauma (perceived or otherwise) in birth should and could be offset with 'sympathetic, constant care with repeated explanations' which lessens women's consequential 'unpleasant emotional upheaval' (Kartchner, 1950, p.25). Simpson, Schmied, Dickson and Dahlen (2018) expand on this, directing that traumatic birth can be prevented with care that meets the woman's explicit and implied needs, as perceived and expressed by the birthing woman herself. If a woman-oriented discourse which allows birth to be constructed according to women's individual needs has been found to have such significant implications for postnatal subjectivity, why then is it so difficult to locate in the dominant discourses that have emerged in the genealogy? It may well be that it is simply disallowed for in the powerfully pathologizing medical and psychiatric discourse, but it has also been found lacking outside of any clinical space, absent from talk between one woman to another (Lothian & Grauer, 2012).

Some feminist literature (Bordo, 2003; Hennessey, 2018; Kristeva, 1980) has explained the lack of talk about certain difficult aspects of women's experience by the silencing, shaming effect produced by the implicit, entrenched gendered discourse which, as the genealogy made

manifest, has long required women's messy, leaky bodies and emotional minds to be hidden. Bordo (2003) draws on Foucauldian thought to argue that women accept the normalising status quo invested in them by the gendered discourse (here, that mess and distress in birth is incompatible with stereotypical constructs of femininity (Cohen Shabot & Korem, 2018)), lest they be positioned as aberrant. Mullins, Wales and Domony (2010) evidence this in their clinical paper which highlights the prevalence of faecal and urinary incontinence following vaginal birth (affecting as many as a third of women) yet the marked lack of women seeking medical help for it. They report that women construct incontinence – and their leaky bodies – as either 'part and parcel' of birth or womanhood or as a shameful secret which remains un-talked about by medics and women, who are 'too embarrassed to ask for help' (p.41).

Chadwick (2009; 2014) has produced narrative qualitative work on birth and birthing women's embodied subjectivities in South Africa, taken from a sample of postnatal women who birthed at home or who chose to birth abdominally, interviewed six-weeks after the birth. She has shown that it is possible for women to 'tell' birth in ways that the dominant discourses don't readily allow, identifying 'counter-stories' in women's talk which allow them, she describes, to take a more agented position of a 'birthing body-subject'. Her position, interestingly, is that 'conventional methods of qualitative analysis' are insufficient to allow researchers to listen in and locate these delegitimised ways of narrating birth, so she proposes that creative ways of utilising qualitative methodology are required. She constructed a new narrative method which combined narrative analysis with Carol Gilligan's 'voice-centred relational method' (Gilligan, Spencer, Weinberg & Bertsch, 2003), seeking to listen for moments of excess in women's stories about their birth – focusing upon 'pace… energy, pitch fluctuations and semiotically driven vocalisations' (2009, p.120), for example, to help reconstruct women's stories as poems, telling birth in a way that offers different linguistic emphases to those afforded in everyday talk.

She claims that it is the fleshy, breathy, embodied ways that women talk about birth that offers women access to other ('lived' and 'undecideable') subjectivities as birthing bodies which are denied by the dominant, medical 'clockwork' discourse of birth. She emphasises the need to listen more and differently (by using creative research methodology and poetic device) to the alternative ways women story birth. Whilst this research is clearly rooted in a different demographic and social context to the one being focused on here, Chadwick offers

interesting evidence to support this research's rationale, that it is not that certain aspects of talk about birth are pre-discursive – unable to be located in discourse – rather that certain constructions and experiences in birth are being prevented from entering into public discourse. Asking what is being excluded and why – the questions underlying this research – feels an important springboard from which to consider bringing about change.

My position and the intention of this research is different to Chadwick's: it is not my aim to utilise the power of the researcher to 'listen' more carefully and creatively to the way women are storying birth (Chadwick 2009; 2014). Or, as Thomson & Downe (2013) do, to layer stories (of mythical heroism) onto women's narratives of birth in order to reconstruct pathological narratives of birth. Rather it is, somewhat plainly, to properly deconstruct what it is that women are, and are not saying about birth (the unsaid being a less graspable focus within narrative research, one might argue). This, together with the lack of deconstructive research into birth in the UK (or elsewhere) was instrumental in my ultimate decision to use FDA in this research.

It is perhaps important to note that the decision, to use FDA, was not initially a straightforward one. As an approach it is not obviously associated with describing and giving 'voice' to women's experience. But on reflection, I came to feel that, actually, FDA (and particularly Willig's (2013)) approach which allows for the freedom and space to focus on positioning and subjectivity) has the potential, paradoxically, to provide a more democratic platform for women's talk about birth (which might give more of a voice to the women participating) than the narrative approaches which characterise the existing literature (e.g. Chadwick (2009; 2014) or Thomson & Downe (2008)), which seem to overly emphasise the researcher's powerful role in interpreting, creatively listening for, or rescripting women's stories into poetry. Taking apart women's talk (as opposed to reconstructing it) felt key to unpacking what is really going on in terms of the way birth is being produced and reproduced in discourse, and how women claim, resist and navigate the positions available to them.

My internal argument about whether FDA was an appropriate method for this research, therefore, was settled by a strong feeling that it is only when the intricate web – of discourse, constructions, practices, positions and subjectivity – can be mapped out and held up to the light, that the way we talk about childbirth (and the way women are able to experience

childbirth) might be reconsidered, transformed, and weaved differently. This is a process, I feel strongly, that has to emerge from the way women are and are not able to talk with each other about birth. FDA seemed to present a method which afforded this, and indeed allowed women's talk – rather than researcher interpretation, listening or reconstructing narratives – the heavier emphasis.

Bordo (1993) states that the pregnant woman is 'supposed to efface her subjectivity' lest she be castigated as the selfish antithetical archetype of the loving mother. I suggest this is even more the case for the birthing woman. This chapter has argued, by highlighting how the contemporary literature is informed by the (predominantly medical, natural, gendered and business) discourses emerging from the genealogy, that a female-subjective, woman-oriented discourse of birth is being disallowed. This limits a woman's capacity to construct, and therefore experience birth as a powerful and complex process, in which she is centrally positioned, and her subjectivity foregrounded.

Gurton-Wachter (2016) described birth as a 'profound, frightening, exhilarating, transformative experience at the boundary of life', a construction which, as Hennessey (2018) observes, is curiously and notably absent within public discourse – spanning the arts, literature and academia – in its fleshy, visceral liminality, particularly when compared to the other boundary of life that is death, which is prolifically constructed, seen and heard. This reinforces the tenet of this research, that there is something intrinsically, specifically connected to birth which cannot be publicly said. This work seeks to trouble just that, with the aim of bringing the 'unsaid' into public discourse – public appearance and representation being crucial, as Willard (2013) puts it drawing on Arendt, 'for the realisation of not only political life, but the constitution of one's very humanity' (p.230).

1.5. Personal reflexivity and research aim

This research came about because of the struggle I felt, after the birth of my first baby, to find a way to talk about the birth, coupled with a fierce desire to do so. I became sensitive to what felt like an ongoing internal struggle of how, and even if I should, bring it up in conversation.

Physically I had healed, recovered and birthed normally – so there was nothing left, it felt, to talk about with my GP or midwives. Meeting other new mothers, we compared the hospitals, whether it went according to our birth plan, how long it took, and we oriented ourselves quite quickly into a rank, of sorts, of danger and risk and trauma – never wanting to present my own birth as more traumatic than somebody else's, and using humour, often, to make the stories lighter. To friends without babies, I remember not wanting to talk much about it for fear of scaring them, besides, my birth had no tangible connection to what theirs might be. The fact was, I told myself, I had a beautiful, healthy baby. The birth was over.

I felt stumped by language, and the lack of space available to me to communicate how affected I continued to be by the birth, long after the bleeding had stopped, the stitches had dissolved, and the blood vessels in my face (burst open in birth) had returned to normal.

My second birth, similar in that I was again induced two weeks late, was medically classified as more risky and traumatic in that I lost two litres of blood and had to get out of the birthing pool with my baby's head in between my legs, because she was stuck. But far from feeling traumatic it felt healing. I felt as if I had done birth, rather than it having been done to me.

I was put in a high-risk recovery postnatal ward, touching distance from another woman, separated by a curtain, who was being pleaded with by her family to pick up and hold her baby, which she was refusing, in silence, to do.

This research, I guess, was born out of a need to find my own voice with which to construct and make sense of my own births, and to understand further my own and other women's silence about birth. It offers a way of recognising and making public the importance and complexity of the liminality of birth for women and its significant role in shaping women's subjectivity and distress postnatally. Liminality – the messy in-betweenness and intricate, shifting, ambiguous relational dynamics – interests me as a trainee counselling psychologist, and strikes me as implicitly constituting of childbirth which comprises, uniquely so, powerful and paradoxical ideas around duality and individuation, and of overlapping and yet separating minds, bodies and emotions. My own personal experience of birth made it feel that the liminal space of birth was made to be shut down and silenced, rather than opened up and publicly embraced, shared or explored. The sanitisation, idealisation and fragmentation of

birth, as illustrated in the genealogy and literature review, suggests that my experience was not unique.

In seeking to explore how other women construct and struggle to construct their births, I hope to draw back the veil which shrouds birth in both secrecy and silence, so that women might more freely talk about the significance of birth from within a powerful female-subjective discourse, and come to experience it with agency.

Kristeva argued that in turning our attention to the biological and social aspects of birth, motherhood, sexual freedom and equality, we have become the first civilisation which lacks a discourse on the complexity of motherhood (2005). As I have sought to argue in this chapter, the discourses of birth emerging out of the genealogy have produced a social context which lacks, too, a discourse on the complexity of birth. It is through locating such gaps and discontinuities that Foucault proposes an archaeology of knowledge might emerge with which to embrace the present condition and the potentialities going forwards, and so it is that gap, the lack of 'woman-oriented' and female-subjective focused talk on birth (as proposed by McNish, 2017; Enright, 2005; Pollock, 1999; Grosz, 1989) that I seek to problematise in this research, with the following questions:

- What are the available discourses on childbirth taken up by postnatal women?

- How do women construct their experience of childbirth postnatally?

- What subject positions, practices and possibilities for subjective experience are made available by these discourses?

2. Chapter Two: Methodology

2.1. Introduction, and methodological rationale

This study seeks to problematise the lack of a woman-oriented, female-subjective discourse of birth, an absence located genealogically and evidenced in the contemporary literature on childbirth. The following research questions have emerged as a way of responding to this lacuna, and as a conscious attempt to bring women's talk (and subjectivities) about birth into public discourse, so that perinatal psychological practice and policy, and counselling psychology's contribution to that, might be more (and better) informed to respond to women's postnatal experience. They are as follows:

- What are the available discourses on childbirth taken up by postnatal women?

- How do women construct their experience of childbirth postnatally?

- What subject positions, practices and possibilities for subjective experience are made available by these discourses?

Because of the deconstructive aim implicit within these research questions which involves weaving together dominant discourse with women's own talk, I chose to use Foucauldian Discourse Analysis (FDA) in this study (Parker, 1992; Willig, 2013). It is a methodology capable of accommodating these research questions, and also the emancipatory goal for research to move beyond fixedly describing how things are, in its theoretical assumption that things – here childbirth – always have the potential to be constructed differently (Willig, 1999).

As suggested in Chapter One, I propose a turn to discourse and language offers a novel way to explore childbirth, particularly from postnatal women's perspective. FDA's ability, also, to consider the practice of childbirth as one embedded within and subject to wider historical, social and institutional contexts, and the inextricable links to ideological themes of gender, power, medicine and control, felt to me, particularly appropriate.

This study seeks to build on existing qualitative research into birth which predominantly takes a narrative approach and where the researcher's story, rather than women's original

talk, becomes the findings (e.g. Thomson & Downe, 2013; Chadwick, 2009; 2014). These tend to reconstruct the potential for women to be positioned and narrated empoweringly – as heroes or fleshy bodies which can counter-act sanitising dominant medical discourse. This research, with a similarly emancipatory aim, seeks to address a gap observed in the literature of deconstructing and mapping out the status quo of birth talk (in place of reconstructing or narrating), and women's related positions, so that avenues for change and resistance might be more firmly located. Narrative research, in its dyadic research design, also neglects to consider language as an action-oriented social exchange (Potter, 2012), which contributed to the decision to employ FDA on a focus group design.

2.1.1 Theoretical framework: social constructionism

Burr (2015) describes social constructionism as a broad church, under which followers bear a mere 'family resemblance'. What unites the subscribers, however, is a theoretical and philosophical conviction that personal and social realities are created rather than discovered (Raskin, 2002). Developed in reaction to the Enlightenment's positivist search for absolute, objective truth and 'reality' concerning the nature of the world through empirical research, it holds that knowledge and indeed 'reality' is historically and culturally specific and relative, which people create and reproduce by communicating with others through language of some form (Burr, 2015).

Contrary to a traditional psychological position which assumes that language is an expression of thought, social constructionism argues that language in fact precedes and determines thought and in doing so produces the practices which constitute our worlds. The way that we think and speak is directly shaped by the culturally specific concepts and categories which have filtered down to us within our culture, made available to us through language (Burr, 2015). That different cultures, or even professional disciplines, use different words to describe the same thing, is widely heralded in support of this epistemological position (Gergen, 2015), and this feels particularly relevant to research on childbirth – in which cultural concepts and traditions have been shown to directly shape the different ways birth is practiced, experienced and made to have meaning (e.g. Shostak, 1983).

If, as social constructionism maintains, we construct ourselves continually in language, then we must also have the capacity to construct, deconstruct and re-construct our identities

through language and the discursive practice (e.g. birth) produced from that language (Hollway, 2007; Henriques, Hollway, Urwin, Venn & Walkerdine, 1984). Given that childbirth is widely constructed in social discourse as intrinsically linked to (and producing of) an identity shift (the act which produces a 'mother'), a theoretical framework which shows how discourses constitute people, through language, as particular kinds of people (e.g. woman, mother, infertile) and how that impacts upon a person's sense of self, feels apt.

Whilst, theoretically, this creates the liberating potential for women to embrace multiple selves and identities (and relinquish positivist, anti-feminist claims to biological essentialism, (Sayers, 1982)), this is necessarily tempered by the 'constraining' premise that 'discursive positions pre-exist the individual whose sense of "self" (subjectivity) and range of experience are circumscribed by available discourses' (Willig, 1999b, p.114). Burman (1999) also raises the dilemma, within a feminist perspective, of pure relativism's supposed potential to generate such 'diffused' identities, but its inability to bestow practices and effects created by an oppressive gendered discourse with a more significant weight in the way they interact with and produce the socially constructed. She cites the practical limitations effected by the gender pay-gap as an example, but aspects of childbirth emerging from the genealogy, such as evidence that Black women are five times more likely to die in birth (Knight et al., 2019), also support her critical position.

This taps into the widely acknowledged criticism of pure relativism for being apolitical (Willig, 1998; Parker, 1998) and, in its deconstructive and descriptive approach, for leading to inaction (Burr, 1998; Willig, 2013). This proves problematic for this (and any) psychological research which is oriented around social and political emancipation – the very thing, paradoxically, which social constructionism, in its capacity to critique positivist mainstream psychology, was originally recruited for (e.g. Parker, 1999; Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995). Whilst offering a liberating way to potentially describe how things are the way they are (and therefore hold a light up to dominant, oppressive discourse and its accompanying practice), Burr raises the issue, critically, of how 'the extreme relativistic views that were often espoused under the banner of social constructionism seemed to lead down a road to social and personal paralysis' (1998, p.14) in its abandonment of any reality or truth.

For if everything can be deconstructed into a multiplicity of perspectives (all of which have no greater claim to truth or reality than another) then how can anybody seek to construct how things might be different and steer social change? Rather than become intertwined in a realist/relativist theoretical debate, as Willig (1998) cautions against, it feels important to be mindful of Bhaskar's (1975) warning against reducing questions of ontology to epistemology, of analysing statements of being in terms of what we can know about being. For this reason, and others outlined below, I have chosen to adopt critical realism which allows for a social constructionist epistemology and realist ontology.

2.1.2. Critical realism – beyond pure deconstruction

As Cromby and Nightingale (1999) suggest, just because we subscribe to the view that our world is socially constructed, does not mean we need to 'adopt unbridled relativism' which makes space for the idea that our constructions are always situated in a material world and in relation to extra-discursive components. Critical realism maintains that just because constructions appear in and through discourse, it does not mean that this is the only context in which they exist, and that there are aspects of our lives which go beyond the exclusively discursive (Sims-Schouten, Riley & Willig, 2007).

Acknowledging this feels vitally and ethically important for research into childbirth, for a number of reasons. Firstly, and importantly, as a way of morally respecting participants' experience or 'truth' of childbirth: to consider, for example, a woman's account of being physically restrained on a bed whilst her abdomen is being cut open as a purely discursive event feels inappropriate and dehumanising. Cromby and Nightingale (1999) note, 'if the body can be anything, it might as well be nothing': when relativism demands that all accounts of the world are equally valid, and all accounts are purely constructions – there cannot be a greater claim to truth for any particular account of something over and above anything else. To apply this to an account of, say, obstetric abuse in childbirth (see Bohren et al., 2015) becomes deeply problematic for counselling psychology research with its commitment to social justice (McIntosh, 2017).

The need to take a political position as a researcher, so that social change might be brought about by putting into practice alternative potential ways of being in the world is denied by the

'non-position' the radical relativist researcher is forced to assume (Burr, 1998). But to stop short of action, to abstain and remain merely as observers and commentators to phenomena and its deconstruction can never, as Willig argues (1998), be a passive act, rather one that legitimises the status quo. Critical realism, in its assumption that there is an embodied, material truth or reality which mediates linguistic construction, allows us to make social realities which can then be taken up or disclaimed. It valuably allows, therefore, the researcher to assume a more moral and political, agented position, to 'guide active intervention in ideological and material struggles' (Willig, 1998, p.92), which resonates with the emancipatory aspirations at the heart of this study.

The purchase on agency that a critical realist ontology affords is appropriate too in its potential to constitute the 'self' more firmly than radical relativism's conviction: if all that there is in the world is produced through, and can therefore be reduced to, social and discursive processes, the potential for the subjective self, and with it a capacity for agency, becomes lost (Burr, 2015). It can be viewed as important only as a topic to study, as Potter proposes (Potter & Wetherell, 1987), or transformed into pawns within a 'language game' as Harré theorises (1989). The person (and participant) therefore, is at risk of becoming so reduced as to become 'empty' (Burr, 2015, p.119), which is problematic if, as Burr contends, social constructionist research is to be considered psychologically useful.

Chapter One has shown that childbirth is a phenomenon long mired in the 'extra-discursive' (embodiment, institutions and materiality), which, as has been noted, pure relativism struggles to account for (Parker, 1992). Sims-Schouten et al (2007) argue successfully for the possibility, using a critical realist lens, that the extra-discursive can exist independently but in relationship with discursive practice, affecting but not determining the discourses being taken up. Critical realism, therefore, affords individuals alternative ways of being in the world, bestowing them with an agency to take up certain discourses (shaped by wider material and social and power structures) over others (Bhaskar, 1975; Burr, 2015), which creates various possibilities for ways of being in the world (Willig, 1999). From an analytical position, acknowledgement of the extra-discursive may, therefore, help with understanding why women account for their birth in one way and not another.

Cromby and Nightingale (1999), in arguing for a critical realist ontology, present the need to acknowledge a material reality which interacts, in a non-linear relationship, with events, interpretations and positions that are then taken up in discourse. In terms of this study, materiality might comprise the space in which birth happens, the strap confining a woman to a birthing bed, the irregular beeping of a heart-rate monitor, which I suggest are not merely factors relevant in our appropriation of them through discourse, inferior to the textual status through which we construct them, rather, inseparable from the way an individual negotiates and constructs her way of being.

Constructionism's difficulty in accounting for the body and embodiment in any way other than that which can be accessed textually, also leads this study to ground itself ontologically in critical realism. Cromby & Nightingale (1999) trace how social constructionism has implicitly come to adopt the 'uniform plasticity' of the body (Cromby & Nightingale, 1999, p.11), which neglects to understand how the biological and physiological interact with the social constructions we discursively create, constituting of experience. The gore of childbirth presents a problem for a pure constructionism, and its interpretation of it (blood-loss, torn perineum) as entirely rhetorical feels inappropriate. Critical realism's ability to consider the 'lumpy, messy, smelly bodies' of childbirth in relation to discourse feels crucial (Nightingale & Cromby, 1999).

Parker (1999), drawing on Foucault, also cites institutions as a necessarily extra-discursive component, detailing their potential to impose real constraints on practice, an individual's actions, and the positions and discourses they consequently take up. Sims-Schouten et al (2007) suggest this is done either by accessing and implementing regulatory or legal resources onto a subject, or by coupling power with knowledge, where understandings may be positioned as real or legitimate. This is relevant to childbirth where institutional bodies such as the NICE guidelines or legitimate access to the NHS all determine practice, and thus constitute experience.

A critical realist ontology, therefore, allows for some notion of reality outside of discourse, which can be accessed in the data (although never reflected as if a mirror image), and should be interpreted as Willig proposes as 'underlying structures that generate the manifestations that constitute the data' (Willig, 2012, p.9). As this is not at odds with social

constructionism's position that knowledge is historically and culturally constituted, I propose to use a critical realist ontology along with epistemological relativity, as a way of responding to the challenges of 'unbridled' relativism without becoming caught up in a realist/relativist debate which often ends in intractable, theoretical stalemate (Burr, 1998).

2.1.3. Foucauldian Discourse Analysis

Michel Foucault was interested in the way that discourses bring people, bodies, and various realities into being, and the social consequences this produced (Miller, 2008). For him, discourse has a meaning which goes beyond an interest in the (micro) linguistic subject matter being drawn upon by a speaker or text for a particular end (Burr, 2015). According to Foucault (1980), discourse can be conceptualised as a system which seeks to represent or regulate knowledge, through practice, at particular social, historical and institutional junctures, and as such, FDA is interested in the relationship discourse has with how people are able (or unable) to speak, think and feel. In seeking to go beyond the text, FDA remains consistent with a critical realist ontology, and in its capacity to consider the complex relationship between discourse, institutions, practice, space and subjectivity (Willig, 2013), it feels appropriate for this study's interest in childbirth – a practice clearly brought into being, shaped and legitimised by powerful, historically constituted, dominant discourse.

FDA requires the researcher to analyse data through a 'lens of discourse/power/knowledge' (Carabine, 2001, p.272) and the relationship between these were, for Foucault, central. Foucault describes how discourses work to produce powerful forms of 'expertise' (1988a), around which subjects/objects constitute themselves or are constituted according to the dominant discourse's 'regime of truth' (Foucault, 1979). FDA allows for analysis of the dynamics implicit in 'bottom-up' talk, located within and also regulated by the 'top-down' dominant cultural, historical discourses and accompanying institutions in a society (Willig, 2013). This macro-micro approach feels important and valuable as a way of acknowledging FDA's fit for understanding how individual subjectivity is produced by and interlinked with discourse – important for this study as a piece of counselling psychology research, and implicit in my decision to use FDA. It is in mapping out the link between discourse and the way that women are positioned by it, or dynamically resist or move between positions, that the production and mechanisms of power which construct normal (and therefore deviant)

practice might be realised and challenged (Willig, 2000), and the implications this has for individual subjectivity might be made more manifest. This is particularly necessary if individuals are to be afforded with, and take up, the power and responsibility with which to resist subjugation and effect change (Bordo, 2003, p.167).

Foucault contends, 'I don't believe that this question of "who exercises power?" can be resolved unless that other question "how does it happen?" is resolved at the same time' (Foucault, 1988b, p.103). And it is FDA's capacity to consider the process of how power is deployed, it being everywhere and diffuse (Gordon, 1980, p.198), repressive and also productive (Bordo, 2003), that offers the potential for more complex, alternative and creative forms of subjectivity to emerge, necessary for resistance and change (Burr, 2015). As an aside, FDA's attention to process, relationship and change seems to fittingly parallel the values implicit within counselling psychology practice, which may also have contributed to why I was drawn to it as a qualitative method.

FDA also felt appropriate for a study into childbirth given Foucault's attention to the body - produced by, and existing in discourse – which he conceptualises as the site of disciplinary power, implicated within a broader process of social control (Foucault, 1978). And whilst he never fulfilled an apparent intention of writing explicitly and extensively about women's bodies (see Sawicki, 1991), his concept of biopower has been widely applied in feminist literature to think about the ways women's (reproductive) bodies are produced, governed and rendered 'docile' through capitalist and patriarchal power's production and application of knowledge, instruments, space, and institutions (e.g. Sawicki, 1990; Bordo, 2003).

In introducing the concept of biopower, Foucault maps out a 'very profound transformation of [the] mechanisms of power' (1978, p.136) emerging in 17th century Europe, in which the sovereign threat to simply take life away from those deviating from society's norms was replaced with a biopolitical attention to living. It was in 'the taking charge of life, more than the threat of death… [that] gave power its access to the body.' (1978, p.142). Biopower then, comprises disciplinary power which targets both the individual body and the species body, 'the two poles around which the organisation of power over life was deployed' (Foucault, 1978, p.138) which seem to strikingly unite in the liminal space of childbirth.

Institutional settings, produced by dominant discourses (such as medical or legal), therefore, distribute power by constructing normalised 'realities' in line with their own interests which become broadly accepted as 'truth' (Gergen, 2015). This 'truth' becomes internalised by individuals in turn and enacted through 'practices of the self' (Foucault, 1988a). Bodies, therefore, are made what Foucault termed 'docile', complicit in practices such as self-surveillance or self-regulation, so as to not be positioned as deviant or immoral. It is this system of power, constituting of bodies, which may be helpful in understanding some of the discontinuities or dilemmas implicit in the rationale for this research and which emerged from Chapter One: for example, women's habituated willingness to be subjected to medical monitoring and intervention in birth as a standardised procedure, despite the lack of evidence correlating it with safety or risk reduction.

Foucault writes specifically about how women's bodies have been particularly sexualised, politicised and medicalised throughout history (1978, p.320). He suggested that the concept of hysteria, a 19th and 20th century phenomenon, was one way that women's bodies responded to this powerful imposition. He conceived of it as a means with which women were able to display a 'front of resistance' to disciplinary power (2006, p.253) and therefore resist their sexualisation and medicalization (Taylor, 2017), albeit within limits. Such a reading of the text, produced towards the end of Foucault's canon, perhaps affords him a more generous engagement with an individual's capacity for agency and subjectivity than is commonly allowed – his emphasis on subjectification as opposed to the subject itself, and his controversial appeal to 'get rid of the subject' altogether (1980, p.117) is a commonly cited critique laid at the door of Foucauldian theory (e.g. Hollway, 1989; Miller, 2008).

I adhere, however, to a more common-sense appropriation of Foucauldian thought, as suggested by Willig (Willig et al., 2005), who argues that a Foucauldian lens affords individuals to be 'constituted by historically and culturally specific discourses and practices, and at the same time acknowledge that this subject experiences himself/herself as thinking, as feeling, as embodied' (p.32). This is a tension which feels appropriate for a piece of counselling psychology research, and also reflects the tension counselling psychology itself needs to engage in – its privileging of agency and subjectivity always being shaped and situated within the limits afforded by psychology (and psychiatry's) own 'regime of truth'.

Using FDA to research a premise that something (about childbirth) is being left unsaid also brings its challenges. Hook (2001) navigates this issue, claiming that whilst it was not Foucault's task to 'raise up the restored power of speech…quelled from various practices' (Foucault, 1981a, p.67) and therefore make heard that which is not at all present in discourse, he did seem motivated to give a voice to the de-legitimised who have been made disqualified from predominant discourse. Such a tenet feels appropriate for this research, and perhaps why Foucauldian thought has been widely utilised by those seeking to highlight female oppression (see Bordo, 2003). When I refer to the 'unsaid' of childbirth, or an 'absence of a female-subjective discourse', it may be helpful here to clarify that my assumption is not that it does not exist, rather it is being, as Foucault states, disqualified and disallowed from entering into dominant discourse. When McNish (2017) stated that '*nobody told me'* about certain aspects of birth, it was made possible only because of an implicit second order positioning (Harré & Langenhove, 1999), which, in line with my understanding of the concept, refers to how people relate to positions being offered to them by others. In other words, taking up the position of being kept in the dark, untold about something, paradoxically operationalises the potential for an alternative (second order) position, in which the potential to have been told about it is implicitly created. This seems to introduce a fluidity and potential for agency within the positions afforded to women through discourse, which is an important construct for this research given its emancipatory aspirations. The notion that something exists to tell is therefore implicit in the statement, '*nobody told me'* and whatever it is, is being silenced and prevented from entering into dominant discourse.

In short, FDA offers the potential to highlight culturally available discourses and in attending to the relationship between discourse, practice, knowledge and power, explore how childbirth has discursively come to be constructed and what that might mean for postnatal women's subjective experience in relation to birth. Because of this it a method deemed appropriate as a way of responding to my research questions. As a critical qualitative method, it may also permit me to bring to light alternative constructions, positions and ways of being (Willig, 2013) and make more manifest talk and discourse around childbirth which has been socially acknowledged as being suppressed and made unsaid by more entrenched, dominant discourse. It offers the potential, therefore, for transgression, which resonates with the thread of social justice embedded within this research.

2.2. Methods

2.2.1. Research design

This study employed FDA (Willig, 2013) as its research methodology to map out how postnatal women drew on the dominant discourses, emerging from the genealogy, to constitute their experience of childbirth. Because of the social context out of which this research developed, rooted in a premise of a lack of talk about childbirth between women (McNish, 2017; Lothian & Grauer, 2012), I decided to collect data from focus groups as opposed to from dyadic researcher/participant interviews.

Wilkinson (1998) describes focus groups as helpful in engaging a small group of people in discussion around a topic to elicit 'how views are constructed, expressed, defended and (sometimes) modified within the context of discussion and debate with others' (p.186). This feels important by way of considering the (agented) capacity of, and function of, women taking up different positions through available discourse, and how this plays out in terms of their individual subjectivity.

A decision to use focus groups was also made with the hope of contributing something novel to the perinatal psychological literature, expanding upon existing qualitative research on childbirth where data is predominantly produced within a researcher/participant dyadic design (e.g. Chadwick, 2009; Thomson & Downe, 2013).

2.2.2. Recruitment

I initially sought to recruit women purposively (Smith & Osborn, 2008) by visiting and handing out flyers at independent mum and toddler groups in North London. This proved challenging. Out of seven groups I attempted to attend, either by turning up in person and asking permission from the organiser over email ahead of time, I was denied permission by three out of the seven. One organiser explained her concern – that the groups were a safe space for mothers with small children. I hadn't anticipated the extent to which mothers were being socially constructed as vulnerable and, whilst with good intention, being institutionally prevented from talking about birth.

For the four groups I was permitted access to, I talked to mothers, explained my research interest and gave out hard copies of the advert (Appendix 1) and a further information sheet for them to take away which offered more detailed information about the research design, what participation would involve and their rights as potential participants (Appendix 2). I took the phone numbers of those interested and asked permission to follow up with a call to give them time to read the information fully. Whilst there was much verbal interest (35 hard copies were handed out), only one woman from that recruitment drive ended up being a participant – the practical challenge of finding childcare for their small children for the duration of a focus group was cited repeatedly as a barrier, and there is the possibility that my physical recruiting presence may have made it difficult for the women to decline interest then and there.

Because of this, I changed strategy and posted a brief advert looking for 'mothers interested in taking part in research into how we talk about childbirth' on four local parenting Facebook groups which yielded a much higher response rate. For everyone expressing interest I followed up with an email, attaching hard copies of the advert and information sheet. Those willing to participate, and able to attend the location, time and date of one of the three focus groups, were then selected on a first come, first served basis.

Wilkinson (2008) suggests that to produce a rich discursive environment, between 4 and 8 people need to participate in a focus group. To allow for last minute cancellations, I confirmed five or six participants per group. For all groups, there were indeed late cancellations, but four participants for each group was deemed sufficient. Participants were not excluded if they knew each other, as some did, given Wilkinson's (2008) direction that focus groups can comprise pre-existing groups of people, which also suited FDA's interest in discursive constructions as action-oriented.

2.2.3. Participants

Three focus groups were held to generate the data for this research, each comprising four women, over the age of 18 (no upper age limit was set as it was unrelated to the research

interest). Participants needed to be fluent in spoken English, and needed to have last birthed more than a year ago. The rationale for this was informed by NICE's (2014) definition of 'postnatal' as lasting up to twelve months following birth, coupled with guidelines that birth should not be revisited verbally in those diagnosed with post-partum post traumatic stress disorder (PP PTSD) (NICE, 2014, a clause which interestingly has since been removed in updated guidelines), and the researcher's ethical responsibility not to put women with undiagnosed PP PTSD at risk.

In order to protect against this as much as possible, potential participants were all sensitively screened over the phone for PTSD using the Revised Impact of Event screening tool (IES-R) (Weiss, 2007; see Appendix 13), selected for its observed validity in terms of assessing subjective distress caused by traumatic events in a number of different populations (Sundin & Horowitz, 2003). The IES-R's use of lay language and fewer (22) items was also deemed a more appropriate screening measure compared to e.g. Foa et al's (2016) Post-Traumatic Diagnostic Scale. Should participants have met the criteria for PTSD (APA, 2013; see Appendix 14), they would have been excluded and sensitively signposted to their GP, and The Birth Trauma Association. I would have followed up with a phone-call to support and manage any potential risk.

Because participants who had birthed within the last year were excluded, it was not deemed necessary to screen for postnatal depression (PND) – a diagnosis only offered within a year of giving birth (NICE, 2014). I decided not to screen for general depression because of the general, and not pathological, focus of the study into childbirth.

Out of the twelve participants (aged between 30-55 years old), all were British. Two were Asian and ten were white. Of these, one was Greek-born, one was born in America, and one in South Africa, the remaining were British born. Purposive sampling was used (Smith & Osborn, 2008) but no attempt was made to recruit participants based on specific characteristics, and I decided not to set a pre-requisite for having birthed in the UK – a cultural and spatial range of birth experience was deemed useful to potentially highlight (by contrast) the discourses unique to birth within the UK, or conversely those common to all women. Not wanting to reduce birth experience to type and draw explicitly on a medical

discourse to construct birth ahead of the focus group, type of birth remained unexplored prior to the focus group.

2.2.4. Pilot focus group

Wilkinson (2008) warns of the difficulties of moderating a focus group, so, after City University Ethics had been granted, a pilot group was held to encourage practice and reflexive thought about my role as moderator. The sample comprised seven (trainee counselling) colleagues who met the criteria for the study and responded to an email requesting participation. As the aim of this group was to encourage reflection on my role as facilitator and to identify any barriers to eliciting rich data, the content of the pilot group was not used in the study, nor was the data transcribed.

Informed consent was explained and obtained and the pilot took place in a teaching room at City University, lasting an hour. It was recorded on a digital audio recorder. A general interview schedule was used with the aim being to generate, rather than participate in discussion, asking questions to keep the discussion going and to encourage participation, without affecting the discourses the women take up, as much as possible (Krueger & Casey, 2015; Wilkinson, 2008). Straight after the pilot I wrote down extensive process notes, documenting any thoughts, feelings and ideas which occurred to me.

2.2.5. Reflections on the pilot focus group

Marks and Yardley (2004) state that it is essential, for a focus group to provide the best possible data, for the moderator to be effective and well-prepared. The pilot focus group furnished me with a fuller understanding of what this meant, beyond having an interview schedule and a safe, comfortable space. It provided practice in dropping the interpretative stance of a therapist in place of that of an empathic moderator – which I realised involved a delicate balance of conversing casually and encouraging free-flowing talk whilst pulling back the talk from motherhood (which it often drifted to) to childbirth.

It required me to think about how to involve all members of the group whilst respecting people's silence, and to provide a space in which women were able to voice different

experiences and values around birth without feeling judged – I hadn't fully realised the extent of the fear of judgement when talking about birth experience, and realising the need to explicitly create a non-judgemental and compassionate space this subsequently became a group rule for the actual focus groups. I became aware that facial expressions and body language – gently empathic, sensitive and encouraging – were valuable and less leading than verbal reactions (e.g., 'that sounds really difficult') which made me uncomfortably complicit as a co-participant and at risk of putting words in to participants' mouths, as Krueger (1998) warns of.

The pilot also made it clear that I needed to streamline the brainstormed questions I used to structure the group: questions such as, 'what does childbirth mean to you?' or 'do you have a sense of how people talked to you about birth before having a baby' were clearly too abstract and confusing. These were removed and, using feedback from the pilot's participants, replaced by a more general schedule (see Appendix 4) as a result, which focused on questions which sought to more simply elicit talk about the birth and provide insight into how women do and do not talk in social contexts about the birth. My dependence on the schedule also became looser – using it more as a guide. Sticking rigidly to the questions in the pilot group, I noticed, prevented me from probing further when talk appeared vague or general. 'Could you say more about that?' became a helpful way in the actual focus groups of eliciting richer data and opening up the discussion further. It also prevented me from creating a space for silence in the group. The interrogative stance I assumed moved talk on rather than allowed it to, more organically, emerge, which was an important learning given that silence and gaps in talk themselves are meaningful discursive communication.

2.2.6. Focus group procedure

The three focus groups each lasted between 89-116 minutes, were recorded on a digital audio recorder, and took place locally: a room at City University and a room at a local mental health charity were chosen for availability, space, and accessibility to the participants. Participants were not paid, but refreshments were provided in order to set a casual tone and to attempt to offset any additional power dynamics implicit in the institutional settings (Fern, 2001).

At the start of each group, I introduced myself and talked at length about informed consent and the participatory right to withdraw at any time up until the beginning of writing (estimated verbally as October 2019). Participants were asked to sign the consent form (Appendix 3). We discussed and agreed group rules (including confidentiality and what that meant, and a compassionate, non-judgemental frame). After offering a brief disclosure about my own birth experiences as context for the rationale for this piece of research, as a way of attempting to offset the researcher/researched dynamic by acknowledging my own stake in the research process (Potter & Hepburn, 2005), I guided the focus groups loosely according to the question schedule (Appendix 4), not sticking rigidly to order or the questions word for word, to ensure the flow of talk and encourage it to be as naturally occurring as possible, whilst giving it structure and ensuring the content of the talk was rooted in the experience of childbirth. My role was to gently encourage the women to open up, whilst moderating the group as a semi-structured discussion and ensuring it did not lapse into a group therapy session.

At the end of the group, I spent around fifteen minutes debriefing the participants fully. We spent time discussing how the participants had experienced the focus group and processing any emotions that had come up. I signposted them to support organisations should they feel the need to process any distress further, and gave all participants my phone number and that of my supervisor should they wish to discuss anything personally after the group (none did). No participants reported feeling distressed. Hard copies of the debrief sheet were handed out (Appendix 5). The importance of group confidentiality was reiterated, as were the parameters of informed consent and their right to withdraw at any point up until the point of writing.

As a way of attempting to agent and involve the participants more fully in the research, I asked the participants to think about how they would like to be represented – offering the use of a pseudonym chosen by them or selected by me, or representation with their own name. Wanting to allow participants to think properly about this, I followed up with an email one week later to confirm their choice. Out of the twelve participants, three requested their real names be used, four reported feeling happy with either a real or researcher-selected pseudonym, four requested a researcher-selected pseudonym, and one selected her own pseudonym. For those who left the choice to me, I decided to assign a pseudonym, in case

their indifference signalled a difficulty in stating their preference born of a researcher/researched power-dynamic. All other identifying details were changed.

2.2.7. Methodological reflexivity

For any piece of qualitative research, researcher reflexivity is of integral importance. Because of the Foucauldian framework of this research, it has been crucial to consider my own positioning and 'authoring' capacity throughout the methodological process (Gergen, 2015; Willig, 2013). Keeping a diary for reflexivity, over the five years it has taken me to complete the research, has been crucial, and forms the basis of what follows.

Whilst I initially sought to gain a diverse range of participants, I became aware that those responding to the Facebook advert were all professional, middle-class women. Since my interest is in the availability of discourses to women constructing birth – I can see that large numbers and a broad range of participants might not necessarily be essential, as discourse analysis cannot account for individual difference (Willig, 2012) and as Silcock (2013) says, 'if a discourse is available to one person it will potentially be available to all' (p.227). But for research interested in the premise that talk is being limited to a group of people (postnatal women), it feels regretful that it doesn't include talk from those who are socially or institutionally (e.g. mum and toddler groups) being prevented from having their talk made public.

My advert was intentionally general – to reflect the study's interest in childbirth's general (and not pathological or traumatic) discursive construction, nor did I want to foreground the way women constructed birth in the focus groups in dominant (medical or psychiatric) discourse. Despite this, it was interesting to reflect on how this was widely (inevitably) received as a construction in itself: anecdotally I had several responses from women who excluded themselves from participation because 'I had a c-section so I didn't really give birth' as one woman said. I hadn't properly anticipated how deeply entrenched the construct of 'childbirth' had become with the vaginal type. Had I realised this, I might have extended the recruitment advert, to emphasise, further to my statement that I was looking for 'mothers, who have had at least one child (over the age of 1), to take part in a study about how postnatal women talk about childbirth' by adding, 'all experiences welcome.'

This may also have opened up the discussion to women who may be drawing on alternative discourses to construct birth, beyond those found in the analysis. One woman contacted me on Facebook, and although unable to attend the focus group, wanted to share her experience that she often felt unable to talk about her birth because for her it was good, even enjoyable, and she felt this isn't something socially allowed for. This was echoed by one participant in the data. It made me realise, retrospectively, how powerful the discourses implicit in the advert were – constructing birth (unavoidably) within a psychological, academic discourse given the visibility of the City University logo and 'Department of Psychology' emphasis. Because of this there is the possibility that the recruitment may have unintentionally both appealed to, and further influenced the talk of, women who constructed their experience of birth as distressing, as opposed to, for example, enriching.

The institutional settings – university room and a meeting room in a local mental health service – may also have influenced how participants constructed their experience, potentially saying what they thought I might want to hear or filtering the way in which it was said. Whilst I considered holding the focus groups in a more neutral venue (debateable as to whether that exists), practicality meant that these were the most convenient, ethical options for participants and myself. I was sensitive to this, and, before recording began sought, through casual small talk, to set the participants at ease, so that they might feel free to speak as freely as possible.

In terms of holding the groups, I feel that my counselling psychology skills and experience of facilitating (psycho-education) groups, allowed me to run them with empathy, sensitivity, and containment. After the pilot group, I felt more aware of how to manage group dynamics as a moderator – such as bringing quieter members of the group into the discussion, and reeling the talk back towards the topic of childbirth (as opposed to motherhood) whenever it wandered.

I agree with Willig (2012) that discourse analysis can be ethically inappropriate for research into accounts of distress or suffering. As my research interest rests in the general construction of childbirth, I felt the method was ethically appropriate. Given the potential for talk about childbirth to be emotionally sensitive, however, coupled with FDA's disregard for

phenomenological experience other than as discursive construction, I made efforts (in the advert, Information Sheet, and in person at the start of the focus groups) to reiterate the discursive (and not experiential) focus of the research, so that, ethically, participants wouldn't feel misinformed. Whilst I left out participant names in the early iterations of analysis (in order to help me treat the data as purely as possible), I then made conscious efforts to build back into the write-up the women's subjectivity, so as not to produce in the write-up faceless 'participants' – which discourse analysis runs the risk of doing, uncomfortably so for the counselling psychologist. After Burr's encouragement (2015), too, to include 'experiences and social location of the participants' (p.158) where useful in terms of giving context to their accounts, I made a conscious effort to represent the women as subjective individuals as much as possible – taking their lead in terms of how they wanted to be named and also including context such as their birthing history or fertility journey in the writing-up.

Whilst focus groups were selected to generate naturally occurring talk, I am aware that they cannot ever fully mirror this, nor could I absent myself fully from the power imbalance implicit in the researcher/researched dynamics (Parker & Burman, 1993; Marks 1993). Constant attention to reflexivity was useful, however, in helping me to acknowledge and be sensitive to my own (multiple) positionings in the group (Pugh & Coyle, 2000) (I have birthed twice, worked as a trainee counselling psychologist with antenatal and postnatal women in an NHS setting, and am engaged in a piece of research into the construction of childbirth in the UK). All of these positions will have likely shaped the way I asked questions and structured the groups – and therefore the way the participants may have been able to respond (Willig, 2013). Similarly, I was aware it would likely influence the 'themes' which I authored in the analysis. Rather than attempting to bracket my own subjectivity off – impossible from an FDA perspective – I kept a reflexivity journal to foster awareness of it. I also remained alive to Wetherell and Potter's (1988) acknowledgement that the process of discourse analysis 'often involves hunches and the development of tentative interpretative schemes which may need to be abandoned or revised.' (p.177). Documenting moments of surprise or discontinuity during the analytic process was a helpful way of keeping track of this and a way of returning to the data with fresh eyes.

The process, as a whole, felt reminiscent of Parker's (1999) call to turn Woolgar's (1998) qualitative methodological 'horrors' – inconcludability, indexicality and reflexivity – into

methodological 'virtues'. I used these as a guide for the research process, treating them seriously as 'part of social and mental life and of the process of creating and critiquing knowledge' as Parker recommends (p.29). This helped manage the 'interpretive gap' with explicit attention to how researcher subjectivity engages with participant subjectivity both in the focus group and analysis, and how that impacts agency and the discourses taken up or consequentially blocked (Parker, 1999).

Perhaps the biggest impact this had on the work, was to highlight my inherently feminist position, and how this affected how I initially approached the analysis. Discussing this with my supervisor encouraged me to untangle my own assumptions from what was emerging in the text, and the way I was rantingly authoring it. I made efforts to shape a softer, more creative and less assuming relationship with the data thereafter. FDA's implicit notion of second order positioning, also, helped me realise the ineffectiveness of the binary oppressed/oppressor position some versions of feminist writing adopts (Bordo, 2003). I hope the research is stronger as a result.

Fairclough (1995) highlights the need for 'critical language awareness' when thinking reflexively about the way we write research. Epistemologically, I cannot claim to discover reality. I am aware that the way I compose and account for my findings is in itself a piece of discursive construction. This prompted careful thinking and numerous decisions about the language I used in writing the analysis. As an example, how I reported birth as vaginal or abdominal, words that the participants did not (at all) use but which I selected as a way to, on a micro level, disrupt the dominant discursive representations of birth as 'normal' or 'c-section'. Such critical reflexivity within the analytic process can promote an alertness to both the power and practices around which the research is conducted, in order to 'interpret the complexity of human life and ask how it has come to be the way it is, rather than adopting assumptions that are relayed through common sense' (Parker, 1999, p.34). Such an approach resonates with this study's epistemological and ontological grounding, and a desire to emancipate rather than merely deconstruct.

2.3. Treatment of data and analysis

2.3.1. Data handling and transcription

I recorded all focus groups, and the pilot, on two digital audio recorders (to guard against a technical failure). I made no notes during the focus group but spent time immediately after the groups making detailed process notes – as a way of capturing thoughts, feelings and patterns which might inform the analysis and to reflect on my facilitator role so that it might continually be improved.

Immediately after the groups I uploaded the data onto my password-protected laptop. Back-ups were then made onto an external hard-drive. The recordings were then deleted from both digital audio recorders. The hard-drive and my process notes are stored in a safe at home. Raw data will be destroyed 12 months after publication.

The focus groups lasted between 89 and 116 minutes long. I transcribed what was being said, including hesitations (e.g. (um), (uh)), the length of pauses (e.g. (.), (..), (…)), and notable non-verbal sounds (e.g. (sigh), (laughter), (group laughter), (tears)) as I felt these were all forms of discursive communication. Because I was using an FDA research design, I did not feel it was necessary to transcribe the more intricate micro details of participant's talk (Willig, 2013).

All identifying details were anonymised. In the initial transcriptions I also decided to leave out names of participants (be it in the form of pseudonym or real name if requested) as a way of helping immerse myself into the data and guarding against (as much as possible) foregrounding the subjectivity of the participants in the analysis. I felt this helped me to approach the data more as a 'corpus of statements' initially (Arribas-Ayllon & Walkerdine, 2008). I added names back in at the third iteration of analysis to build back into the analytic procedure the participants as women with individual subjectivity.

2.3.2. FDA, analytic procedure

Arribas-Ayllon and Walkerdine (2008) offer the disclaimer that there is no single way of carrying out FDA, reminding of the need 'to avoid the trap of formalising an approach that clearly eschews formalisation' (p.91). Procedural guidelines have, however, been developed to provide some sort of rigour to this analytic process and so enhance the usefulness and

quality of its application in research (e.g. Parker, 1992; Potter & Wetherell, 1987; Willig, 2013).

I elected to follow Willig's (2013) six-stage procedural guideline which, whilst not claiming to be a full Foucauldian analysis (as Parker's (1992) twenty step procedure might be considered), felt appropriate not least given the time constraints of the analytic process. More importantly, however, Willig's stages aligned well with my research interests in attending to discourse's constitution of the practice of childbirth, the implication that has for the positioning of birthing women and their subsequent subjectivity.

The six-stages of Willig's FDA procedure, in terms of how I applied them to the data, are outlined below (Willig, 2013, pp.131-133).

1. **Discursive constructions:** This involved highlighting each time the discursive object (childbirth) was constructed in language, paying attention to both implicit and explicit references and also its absence (e.g. 'it', 'having a baby', 'labour').
2. **Discourses:** The various discursive constructions of childbirth were then located within wider social discourses.
3. **Action orientation:** The discursive constructions were considered in terms of their function. This involved asking the question of what was being gained by constructing birth in a particular way at a particular moment in the text, and how it related to other constructions surrounding it.
4. **Positionings:** Discourses make available not only discursive objects, but also subjects, by making available certain positions within networks of meaning that individuals can take up (or resist), and also place others within. How constructions of childbirth created positions for women were identified here.
5. **Practice:** For Foucault the relationship between discourse and practice was central. This stage refers to how the discourses inform practice – what can be said and done from particular positions made available – both in terms of actual childbirth, and the subsequent everyday practices of the postnatal woman.
6. **Subjectivity:** The final stage in the analytic procedure explores how discourse constructs both social and psychological realities. Once a person has assumed a particular position within a discourse, that position effects 'certain ways-of-seeing the world and certain ways-of-being in the world' (Willig, 2013, p.133). Building on the

fourth stage of analytic process, this stage is concerned with what can be felt, thought and experienced from within a particular subject position.

2.3.3. The process of analysis

After having listened to the focus group recordings to familiarise myself with the data, I transcribed them onto three separate Word documents. Whilst doing this I made handwritten notes in a separate notebook to document impressions and ideas as a way of foregrounding the analytic process.

I then applied Willig's six-stage model to each line of data, beginning with the first focus group and moving chronologically through the next two. I hand-annotated each transcript, highlighting first the discursive constructions (stage 1), and then returning to each highlighted construction to apply the remaining stages (using different colours) one after another in full per transcript (see Appendix 6 for an example).

I hadn't anticipated how time consuming and intense this process would be. Particularly at the start, when I was learning to apply the strategy as well as attempting to perform the analysis. By the time I had been through all three focus groups, I was aware that my efforts at applying the analytic procedure were slicker and less laboured, which seemed to free up space to think. Because of this, the analysis towards the end itself seemed richer, and so I returned to all three focus groups for a second round of analysis.

In total, it took about six months of working around 4-5 hours a day. As a process, it felt at times gruelling, never-ending, and seemed in its enormity, to be out of control – not unlike the discursive construction being researched. It was also emotionally intense to be immersed so deeply in women's talk about birth – naively I don't think I fully anticipated how much grief and loss would be implicit within the data, and how this might bleed over into my own experience of birth. I sought to understand and separate this out by journaling and in therapy.

As a way of containing the enormity of the task (and my anxiety), I took a step back from the detail of the analysis. A sequence of zooming in and out of the data characterised the next stage of the process. I turned to the computer to try and categorise the most dominant

constructions according to the six stages (see Appendix 7 for an example). This produced a broad, but useful way of organising the analysis according to the six stages. Thereafter, to re-engage more with depth and breadth, I was compelled to step back into the data and, reading the transcripts in a third iteration of analysis, began to integrate the constructions with supporting quotes from across the groups. This left me with a 330 page Word document (see Appendix 8 for a snapshot). To refine this, I then created an Excel spreadsheet offering a more comprehensive, and searchable, account of the six-stages as applied to the dominant discursive constructions of birth with supporting quotes from across the data (see Appendix 9). This was useful as a base from which to begin to drill down into constructing the analysis and to visibly account for the most recurring constructions and discursive 'themes'.

I then returned to pen and paper to more creatively brainstorm the prominent discursive 'themes' emerging from the data. Appendix 10 shows an example of the lengthy and (somewhat messy) iterative process. At this point, I also created a document which reminded me of the research questions, including additional questions which had grown louder as a result of the analytic process thus far. What became manifest was that my interest lay in troubling how talk about childbirth positioned women, and how and why they assumed certain positions over others, and how this constituted their subjectivity. After much reflection, it felt natural to structure the analysis around the positions being adopted by postnatal women in their constructions of childbirth. This also reflected, and was potentially informed by, the original notes I made when listening to the transcripts at the start of the process, where images of women as vessels, bodies, and victims came to mind.

All of this contributed to how I came to structure the analysis chapter but didn't, on reflection, necessarily determine it. It was in the writing of the analysis that much of the thinking, revising, discarding and honing happened – quite the 'adventure' to coin Willig (2013, p.3), until the final authored analysis felt sufficiently coherent, rich and evidenced.

2.3.4. Demonstrating quality

The guiding principles of sensitivity to context, rigour, coherence, 'fruitfulness' and transparency, as suggested by Potter and Wetherell (1987) and Yardley (2008), were used to guide and also evaluate the quality of this piece of research (please see Chapter 4.7 for more

detailed information on how I went about this) – so that the reader might be fully aware of my own process and relationship to the data. As a way of keeping quality at the forefront of the process, the principles described above were reflected on periodically in a journal and also in supervision, and I sought to be both explicitly reflexive and also critically reflective (Parker, 1999) throughout the process and within the write-up. For research, however interesting, that cannot demonstrate its quality, becomes more of an opinion piece, and less able to make an impact in practical or applied, theoretical or socio-cultural terms (Yardley, 2008). And whilst positivist notions of reliability, validity and generalisability prove difficult for Foucauldian social constructionist research (Parker, 2005) there nevertheless needs to be appropriate measures in place with which quality might be sought and reflected on.

My theoretical position means that I can make no claim to 'discover' a 'reality' or 'knowledge' about childbirth through this research, only to 'author it' (Willig, 2013), in a way that my own subjectivity is clearly implicit. Transparency about the constant attention to reflexivity has also been used to enhance the quality of the research.

2.4. Ethics and permissions

This study sought and was given ethical approval by the Psychology Department of City University (Appendix 11 and 12). This process, whilst familiarising myself with *The Code of Human Research Ethics* (BPS, 2014) allowed me to think deeply about how best to support and protect the participants' rights, safety and wellbeing. It has been said that ethical considerations are often at the core of feminist research (Marecek, 2003), and as this piece of research was born out of a desire to 'seek social justice, to enhance women's voice and influence in society and to explore alternative ways of understanding the world through women's experience' – as Gergen (2008, p.282) characterises feminist research – they needed to be thoroughly considered here.

As part of this, I spoke to participants at length, prior to the group, about informed consent and their right to withdraw, and then allowed time (14 days) for them to reflect on the decision to participate. What consent involved was then explored and reiterated at the start of the focus group, as was their right to withdraw (and a guarantee that their data would be excluded) up until writing had begun, estimated as six months after the groups took place. All

participants were fully briefed and debriefed and signposted to supportive and psychological services should distress have arisen during or after the focus group (see Appendix 5).

I was also aware that in asking women to talk about their experience of childbirth, having argued that a female-subjective discourse is being limited, there was the potential for the talk to generate (perhaps unexpected) emotion and distress. Should participants have become highly distressed in the group, I felt able to use my clinical experience to determine levels of distress, and manage the situation ethically and appropriately, terminating the group if necessary. Aftercare in the form of follow up phone calls or face-to-face meetings for all members of the group was also offered. Incidentally this was not needed, and whilst much emotional content emerged in all three groups, there was sufficient time to process it within the group. No-one reported (or showed) feeling distressed at the end.

Group rules were used to reinforce the importance of confidentiality. All participants agreed not to share anything disclosed in the group outside of it, to facilitate a safe space for all to speak. My ethical responsibility however to consider potential disclosure revealing unethical or poor medical practice or safeguarding concerns, was transparently explained at the outset of the groups, and clarified as an exception to this rule. Whilst I was concerned that this may emphasise my power as a clinician and researcher and affect the researcher/researched dynamic, I sought to offset this with a natural, authentic presence and tone which seemed to inform participants whilst also setting them at ease (Thompson & Russo, 2012).

I explained my commitment to storing data carefully and confidentially, describing that digital data would be kept in a password-protected device, and hard copies and a digital back-up would be locked in a safe. I explained that I would change any identifying details, and offered participants the opportunity to have an anonymising pseudonym selected for them, to choose their own pseudonym or to be represented by their real name – a small but important act after Gergen's (2008) call to use research to amplify women's voices and increase access to their ways of seeing and being in the world - a task central to this research.

3. Chapter Three: Analysis

3.1. Introduction

This research seeks to explore the discourses drawn on by women when constructing their experience of childbirth with each other, with the intention of understanding the implications these constructions have for women in terms of how they are able (and unable) to experience the practice of birth, how they are positioned in relation to birth, and how this shapes subjective experience.

I hope, that in tracing the discursive patterns throughout the data, taken from three focus groups, each comprising four women talking about childbirth, that the dominant discourses around childbirth might be highlighted and points of resistance located, all the time seeking to show how the discourses position the women in relation to birth. The broader hope and intention of the analysis is to, in more fully identifying and understanding the positions available to women, and the way (and reasons why) women might take them up and dynamically move between them, a deeper understanding of birthing and postnatal women's subjectivities might be gained, so that more and better care for women might be provided, reported as being much needed in the literature (National Maternity Review, 2015; Knight et al., 2019; Howard & Khalifei, 2020).

Given this aim, as well as the underlying rationale – that there is a lack of women-oriented talk around birth (Grosz, 1989) which prevents women from being the subjects, as opposed to subjectified objects, of birth – I have made the decision to structure the analysis according to how women are positioned by the discourses being drawn upon. This acts as a conscious attempt, a mini-resistance, to locate and construct women centrally within talk about childbirth, something I have suggested is being limited by dominant discourse. All names have been anonymised and pseudonyms used, unless women requested to be identified by their own names, as three did. In the spirit of representation, I have chosen to refer to the women contributing to this research as women, and not only participants, throughout.

The analysis will be structured according to three overarching positions that emerged from the text, as a way of foregrounding women and their subjectivity in the analysis. These positions are used as anchors to help to map out the intricate web of how the dominant discourses position women in relation to childbirth. Within each of the

overarching positions are many and varying sub-positions, which seem to reflect the very dynamic way women claimed and also disclaimed the positions afforded to them, in a bid, it seemed, to construct and gain access to more and different aspects of birth. To focus on three predominant positions feels somewhat reductive yet necessarily pragmatic, and is also inevitably influenced by my own interpretative labelling of the positions, for which there is, and always will be, many other constructions possible. What I hope to evidence, however, using direct quotes from the data, is that the themes produced here are not entirely speculative and derived from my own subjective position, but rather emerge, through repetitive, iterative analysis within and across each of the three focus groups.

The first and most discernible position for women, when drawing on the dominant medical and natural discourses, is that of 'birthing bodies'**.** Within the medical discourse in which birth is constructed as a medical and physical process, the body became a physiological reproductively-plumbed system. Within the natural discourse, birth is constructed as an idealised, natural female process, and woman are afforded a position of a body which is essentially designed and knows how to birth. These discourses, situated in a binary, oppositional relationship to each other, as noted in the genealogy, function to position the woman differently but both as a birthing body from which a baby is born, split in a Cartesian sense from the rest of her mental, emotional and psychological self, and expected to bounce back after the birth.

The second position becomes available to women when a trauma discourse is drawn upon. When birth is constructed as traumatic, horrifying, a painful struggle, something explosive, '*like a bomb going off*', women are positioned variously as casualties of birth, and are able to access an experience which is physically, psychologically and emotionally affecting, even if they are prevented from openly articulating their '*trauma'*.

The third position emerges when women access the business discourse, which constructs birth as something to be managed pragmatically and objectively within a public (NHS) or private healthcare system, subject to economic, managerial and legal concerns and red tape. A number of (often contradictory) positions are made available to women here: (faceless) labourers in birth, (more agented) consumers of birth and also feedback providers (or recipients) of birth. In negotiating these positions, women mobilise the dilemma this discourse poses – is birth an impersonal business to be publicly managed from the top down,

or an intrinsically personal subjective process to be constructed and experienced by the woman herself?

3.2. Birthing Bodies: The medical discourse

The women in the focus groups all embraced the dominant medical discourse of birth, in which they constructed birth as a biomedical, pathologized process; if not '*normal'* then dangerous and risky which therefore needs to be managed and made safe by medical professionals. This discourse was linguistically represented by scientific and pathologizing markers throughout the women's talk. Birth was estimated according to a '*due date'* of 40 weeks, '*labour'* described as '*progressing'* gradually with '*contractions'* beginning slowly. '*Progress'* was measured by how many '*centimetres dilated'* (a woman's cervix is) and labour culminates with the '*pushing stage'*, after which the baby '*comes out'*, is '*delivered'*, *'is born'* – an overarching indication of the way in which women are denied an agented position in birth by the medical discourse.

Within this dominant discourse, talk took on a collective, overarching function, used by women to '*whittle down the detail'* (Beatrice, 1.2262) into a sanitised clinical construction, functioning to '*nutshell'* (Zoe, 3.1294) the experience into palatable talk, providing a distancing effect for the women from the messy visceral detail or emotional aspects of birth. This discourse was, interestingly, utilised most at the start of all focus groups when women were often meeting for the first time, allowing them to avoid constructing birth as something overly personal, intimate or exposing – which Beatrice and Sally realise and reflect on themselves towards the end of their focus group:

> Beatrice: *Yeah, so you just sort of have your narrative and the way you describe it but I'm not sure you even particularly access the memories when you're talking about it that much. I mean maybe at first, the first few times you're telling it but you kind of almost just sort of have this narrative that you tell.*
>
> Sally: *Yeah. It's not about how you felt about it…Yeah… The anesthetist was doing this and my husband came in, yeah*. (1.2266-2279)

The pathologizing construction of birth offers a collective language for women to share their experience in relation to each other, anchored within a medical discourse which dictates

normality – '*a pretty textbook birth'* (2. 54) as Christina prefaced the early stages of her own birth experience with. The body, within this construction, becomes a passive pathologized site to be operated and intervened upon – a position women take up, it seems, to justify aspects of their birth and manage a subjective feeling of fear around risk – offering themselves up to the medical professionals who within this discourse provide that control and safety.

3.2.1. Passive, pathologized, objectified bodies

> *With type 1 diabetes you have a lot of um, interventions, a lot of care, scans all the time and stuff like that... And they'd tried, we did that whole try to turn her around thing, it didn't work and whatever. So she was breached, and I'm also type 1 diabetic. I was also described, at that stage, as geriatric, associated with 35 which was a term I'd never heard before. So we'd come to the decision, well it was kind of a fait d'accompli that we had to have a c-section.* (1.156-161)

These are amongst Beatrice's first words in the focus group. She takes up the medical discourse and positions her pregnant and birthing body as a pathologized, problematic and objectified site to be intervened upon. Such a heavily medicalised construction of birth and her body removes from her the agency of decision-making – having to have a '*c-section'*, because of how her body is positioned as pathological risk. Should Beatrice have made an alternative decision to birth vaginally, the risk would have to be owned by her. Taking up a position as an objectified body in this way affords the medics, and not the birthing woman, with all the power and decision-making around the birth, but also assigns to them the risk and danger of birth implicit within a medical discourse, which might explain why women recruit it so prolifically. Within this discourse, a woman is made to trade her agency and subjective experience in birth for a sense of physical bodily safety: *'all I could think on lying there was that I feel safe, I feel well cared for. My baby is being well delivered but I'm just not here'* (Beatrice, 1.1577).

Analysis showed how this objectifying positioning left women with a subjective experience of loss or guilt for not having birthed '*properly'* as stipulated by the normal construction of birth that the medical discourse proposes, which mobilises the potential in this discourse for birth also to be constructed abnormally:

> *It makes you feel very bad if you're going to have a c-section and er, you feel that you've failed somehow, you feel that, you know, you didn't do what you were supposed to do, especially for me. I knew at the beginning that I wouldn't be able to have a normal delivery.'* (2.182-187)

Kleio's talk here, in describing society's attitude to 'c-section' – the most medical of births within this discourse – functions to construct non-normal birth as something which needs to be fixed, made right, by medical intervention. When it is the medics who are responsible for birth and the woman is an objectified, pathologized, body to be operated and acted upon, she described a feeling of having done something wrong, or having failed in birth in some way.

To manage these feelings of guilt, women can be seen to adopt the medical discourse's Cartesian split in which the body is made separate from the woman's emotional and agented sense of self during birth. Women assigned the responsibility of things going wrong in birth – a constructed failure – to the body and not to their integrated self as a whole.

This presents a dilemma for the birthing woman around medical safety versus personal agency, as Beatrice describes remembering the moment when her blood pressure '*crashed'* during her abdominal birth. She takes up the medical discourse and embraces the dualist position separating herself apart from her body – positioned as a medical curiosity:

> *I remember the anaesthetist was totally not worried about it, which was in some ways the total right response because you don't want your anaesthetist panicking 'cause that will make you panicky. But they were beside me just sort of going, "Yeah, I don't really know what's going on here because if you look at her levels, that doesn't make any sense really."*
>
> *And they were both so chilled about it, like dancing to the music they put on 'cause they had to put on an iPad because my husband had prepared this CD of classical music and they didn't have a CD player, shame. Um, and I sort of felt like maybe in that moment, that then they could have thought maybe a bit more about my position. But then I think they contradict it 'cause I also just want them to be getting on with their job and doing it. I would prefer them to concentrate on that actually rather than me, if that makes... I don't know.* (2. 1085-2104)

In constructing birth as a medical, emotionless process of and on the body, Beatrice also raises an awareness that something, a different part of her, was not being responded to, which might be conceptualised as an attempt at resisting the dominant discourse which demands that the medics just do their '*job'* and attend to '*that'* as opposed to her, the birthing woman. When positioned as a bodily material object and a pathologized problem, the thinking, feeling part of the woman is necessarily removed from the birth itself and access to an emotional, female-subjective discourse of birth is denied. The medical discourse dictates that to focus on the whole of her, as opposed to just her body, would take away from medical, bodily attention on her but mostly the baby in birth. There is an either/or construct set up within this discourse, that demands the body must be prioritised over the mind – as if a quantifiable, finite amount of care is available from medical resource.

If the woman is positioned as an objectified subject, a pathologized birthing body, she is unable to act, and instead is merely acted upon in practical terms, as Anya also shows. The medical discourse not only forces a position of helplessness onto the woman (necessary to allow her to be helped by medical professionals), but a position of unknowingness and vulnerability to harm also, as Anya's introductory construction of her birth suggests:

> *So my first one, er, was a, well I was finally induced because the labour pains stopped, so… assisted [birth]. They tried ventouse, forceps, um, prepped me for the c-section because she wouldn't come out and I think they managed finally but I think, er, she sustained a lot of, um, damage in the process and so did I, which was clearly very traumatic for me.* (2.32)

Birth here is constructed as something which took an abnormal route – the body stopped doing what it was meant to, which led to practical medical intervention and the body being acted upon. In splitting the body apart from the emotional or active mind, Anya is able to regain some element of control, positioning herself as not entirely destroyed or damaged by the birth. In constructing birth medically as a series of failed interventions, she also positions her birthing body as an object acted on in a not terribly proficient way, and in doing so Anya disclaims the dominant discourse in which medics are positioned as the all-knowing safety-net of birth. Instead she positions them as brutal, haphazard and harmful – damaging both the baby and her body, eliciting traumatic implications for her sense of subjectivity. There is a sense that she seeks to resist the dominant medical discourse in which

medics 'do no harm', whilst nevertheless mobilizing the power dynamics that this discourse demands.

The disparate positions of power and agency created here leave Anya unsure about what actually happened at the moment of birth, she '*thought they managed finally'* to get the baby out. That she describes her birth wholly by medical intervention – the tools applied to her body – keeps her unknowing and disconnected from the liminality of birth, the moment the internal becomes external, which could be argued is a way of limiting (what could be constructed and experienced as) the most powerful moment for the birthing body and woman. As Christina also highlights, drawing on the medical discourse's sanitized language of procedure and tool, the responsibility for the moment of birth is, within this discourse, shifted firmly onto the medics: '*they sweeped me into the emergency room and I had an episiotomy and, um, they pulled him out with forceps'* (2.54). Within this construction, she is disallowed the responsibility of having birthed her baby.

Adopting the position of an objectified birthing body not only denies agency but also access to a more distressing emotional discourse around birth for women. Whilst disempowering in one sense, it also functions to allow the woman to avoid, in these risky medicalized constructs, engaging with the possibility that she or the baby might not have survived the birth. Although Anya constructed (above) the experience as one which was '*clearly very traumatic'*, her formal, list-like manner, like Christina's talk of diagnostically justified intervention, functions to prevent access to an emotional discourse which guards against a subjective experience of frightening loss – seemingly incompatible with the birth of a baby within a medical discourse which pits life against death. The effect this has, paradoxically, is one which mobilises an enduring strength and hardiness in the material body, dehumanizing as it may be. As a birthing body, subjected to the medical intervention of birth, a second order positioning of material endurance in the woman is produced, which seems to resist an underlying, broader gender-based discourse where women are constructed as the weaker sex, replete with their soft, unenduring bodies.

That a woman's strength can only be shown by surviving having been objectified, prepped, intervened upon, and cut open by the medics, indicates a struggle situated within a broader gendered discourse. Here women have to fight to make a claim to strength, and the only way that the (gendered) medical discourse allows for this, is for women to construct it as survival

of bodily destruction – a bouncing back from the pathological danger of birth, as Dr Mangala (a medical doctor who, notably, requested to be named thus within the research) epitomizes.

Dr Mangala drew heavily upon the medical discourse to construct her fertility journey, her pregnancy loss, her IVF process and 'c-section' as a series of medical bodily interventions which her body withstood. Her construction of fertility and birth as a medical process on her body, split off from her emotional sense of self, served to limit an emotional connection with the lengthy, loss-filled road to birthing a baby. This enabled her to remain, subjectively speaking, '*lucky'* and '*strong'*, to have been allowed several bodily interventions which practically afforded her both her own life (removing the ectopic pregnancies) as well as that of her baby (IVF and 'c-section').

> Leah: *And because it [c-section] is major trauma and major surgery. You know, it's something that's huge. It's a really big thing.*
>
> Dr Mangala: *I think I'm probably used to surgeries now, with all the ectopics [laughter]… In fact, I came out and I said, "Look, I think they should put a zip in my tummy. The next time they need to open, they can just open and close [laughter]…Because, after the number of surgeries I've had, I think…And I'm lucky, because… if all of them had been open surgeries, I would have struggled with adhesions and whatnot. Quite a lot of them are laparoscopies – so there was… this [the c-section] wasn't so bad.* (3.3067-3090)

Whilst Leah constructs abdominal birth from within a more emotive trauma discourse as something which is psychologically as well as physically affecting, Dr Mangala responds by drawing on the medical discourse to dismiss, with laughter, a subjective experience of distress and vulnerability, opting to root experience in the body instead of the mental and psychological parts of herself. Her talk objectifies and degrades her own body as broken, which functions as a necessary positioning in order to allow herself to be practically opened up so that the multiple problems she constructs – her body, struggle with fertility and a breached baby – could be fixed. In doing so, her talk accesses a position for the body as one which is materially strong enough to have endured many operations – the only way female strength can be demonstrated within the physically focused medical discourse. This distress-disallowing position is drawn upon, it seems, to challenge the construct of women as the

weaker, more vulnerable and emotional, sex, whilst inevitably, through second order positioning, mobilizes it further.

3.2.2. External and internal bodies

Within the medical discourse, it is clear that women used strikingly scientific and medicalized language to construct their birth. They talk of being '*induced'*, '*scanned', 'monitored'* '*admitted to hospital'*, '*having an amniodrain'*, being '*diagnosed with placenta praevia'*, all of which positions women's bodies as being *done to* in birth. This effects a dilemma around birth's liminality: the focus on the external (outside of the body or onto the body) processes of birth, dictated by the medical discourse, functioned to deny a construction of the internal ones within the woman's body. The gendered implications of the medical discourse, genealogically produced, come to mind.

An absence of internal bodily talk in the women's constructions of birth is noticeable by comparison. Women emphasized the importance of the external birthing environment, for example, to signal shifts within their body, construct their birth and access individual subjectivity. Sophia, for example, described '*freaking out'* at the prospect of not being allowed into the birth centre because of her high blood pressure, and needing to control and rid herself of her internal process in order to achieve her externally focused goal of birthing in a specific place:

> *And I was kind of freaking out about my heartbeat 'cause if there were any risk factors, I wouldn't be able to go into the birth centre. Um, so I was sort of like, "Oh my God, I need my heart blood pressure to come down. I need my blood pressure to come down," which obviously was not helpful. How am I going to make it come down?* (1.2144)

Leah explained that '*there is such a difference between a labour ward and a birth centre*'. The women commonly agreed, tallying birthing centres with calmness and soft lighting, and the labour ward with bright lights and more medical intervention and resource.
Women described themselves as being internally affected in the body by the external environment, as Leah correlates the '*bright lights'* of the labour ward, with '*a stressful environment'*, *'not conducive'* to a good birth experience, which she reasoned as to why Zoe's body shut down in birth. Others described women feeling '*more nervous in the birthing centre*' (3.1593), wanting the safety of '*a more clinical experience'*

(3.1587). When birth is constructed externally, it is the environment that directs and is made to represent the birthing woman's (internal) body, and how practically she is allowed or disallowed to birth.

> Zoe: *I guess they [the labour ward] could kind of take some of the birth centre stuff...like lighting.. being able to put music on…*
>
> Leah: *Yeah positions, yeah,*
>
> Zoe: *And positioning, exactly, so not lying on your back. Like don't just lie on the bed and hope the baby is going to come out'.* (3.1598)

Where you birth within a medical discourse, therefore, is constructed as directly affecting how active or passive a position a woman and her body is afforded in birth. Here they agree that in the labour ward the allowed (literal) position for a birthing woman is supine – lying on her back – compared to a more mobile and active position within a birthing centre. This raises a question of agency, and shows how external context practically affects the way a woman is able to birth. Despite Zoe and Leah's resistance, they nevertheless mobilize the medical discourse which renders birthing women as externally-treated passive bodies, naïve, removed from the birth – hoping that *'the baby is going to come out'* which denies an active position and an internal construction and so experience of birth.

That external factors are needed to construct and shape internal female physical and emotional experience is embedded not only within the medical discourse but also, analysis suggests, an interlocking gendered discourse. This seeks to keep hidden the internal workings within a woman's body – the old adage of the mystical and feared wandering womb of 'hysteria' springs to mind. That a woman's place is lying back and optimistically hoping for the event to be over in birth, as Zoe constructs above, also echoes the old gender-based assignment that a woman should, with unwanted sex, lie back and think of England.

That women's bodies and needs are rendered passive, requiring direction and manipulation externally by another in birth is described by Renata, recalling her second birth experience:

> *And, um…, uh, they said, "Right, what we want you to do is effectively [laughter] get to the point that the head is, sort of…" I think the… did they want the head out there or… anyway, "Get to a certain stage," and then I had to, sort of, waddle forward onto all-fours, because they said that's how we can protect the perineum – that that's from that position….Um… so, I remember, you know, obviously, getting to a certain point, and then… um [laughter], them asking me to, sort of, waddle forward. And you are like, "For fuck's sake, I've got a head between my legs here!"* (3.1451).

Renata takes up a dualist construction, in which her body is being made to do unthinkable things towards the end of her labour, functional in its protective orientation but also limiting in the way that it clearly neglects her emotional and psychological sense of self, and ignores the internal physiological processes of birth. In the lead up to this moment, she described getting in the birthing pool, having to get out because the midwife had added aromatherapy oil which made her '*skin sting like crazy'*, getting back in, getting back out, getting on a birthing stool before having to waddle forwards as she describes above. The entire birth experience is therefore constructed as a series of external processes in which a medical professional maneuvers her birthing body, which limits any discursive space in which the birth can be described and therefore experienced as an internal process by and for the woman herself. Renata's disconnection with how far the baby was moving down through her vagina is notable and suggests a complete disconnection from the internal process of birth. Through this discourse it becomes difficult if not impossible, physiologically and subjectively speaking, to feel that she was birthing her baby:

> *I remember her saying "oh I can feel the baby's head", and I was like, "What? You can only feel it? I thought we were like, that we were about to give birth… you've got me pushing for however long?"* (3.582)

Despite the baby being within Renata's own body at this point, she constructs the externally situated medical professional as the one to '*feel'* the baby's head and direct birth's progress – a limiting position for her in relation to accessing agency and a subjective embodied experience of birth, which leads to her constructing '*we'* gave birth, not her. Women are, within the gendered medical discourse being kept away from knowing their own bodies and the internal processes of birth and denied a much more powerful position of being allowed to access, know and feel the liminal space of birth for herself.

Pushing in birth was reported as something, repeatedly, that the birthing woman is told to do by medical professionals, and at surface level constructs an internal physical act which should afford women an active position. Analysis showed, however, that the medical discourse's neglect of the unseen internal workings of the female body left women struggling to know how to push, as Anya and Josephine report below, evincing feelings of failure:

> Josephine: *Like I was like, "What do you mean push?" and the midwife basically was like whispering in my ear, "Like you're doing a poo," and I was like, "Oh, okay." Like why is that something we don't talk about? I don't even know.*
>
> Anya: *Yes. I think I wasn't able to push because I wasn't told that. It sounds awful because I never figured out what was my pelvic muscle.* (2.793)

The lack of talk and therefore knowledge around the internal physiological workings of a woman's body is evident, and a silencing is created and maintained by an implication of shame. The midwife's whispering highlights how bodily mess, poo, is constructed as incompatible with a dominant construction of women and femininity, disallowed for within a sanitized medical discourse of birth.

Indeed the absence of the mess, chaos, gore of childbirth was striking: out of all three focus groups comprising over five hours-worth of talk about childbirth, the word blood was said six times, vomit five, and vagina a mere twice. Sex was also notably absent, despite its emotional and physiological link to birth. When birth is constructed through a gendered medical lens as an externalised process of and onto the body, women are forced to disclaim their own internal sexual and birthing bodies. This has implications not only for the birthing woman, but also her postnatal care, as Kleio described:

> *How do you take care of your, er, wife, er, because I needed help with my stitches? But I didn't want him, I was somehow protecting my husband, I don't know why. But maybe because I felt that he didn't know anything about it. Maybe he should have some information in order to help me.* (2.1043-1049)

Women are left to bear the unseen internal damage from birth silently and alone, as Kleio constructs of her own torn postnatal body. When birth is constructed as an external process by the medical discourse, internal change or harm – that which cannot be seen – is both

disallowed and made shameful. The birthing body, subject to the trajectory of medical health and illness, is positioned as simply being expected to recover from birth and bounce back. This leads to women's internal physical distress and pain being disbelieved, ignored and the woman, shamefully silenced – others (males) needing to be 'protected' from it. Kleio's talk here signals a resistance to this medical and gendered discourse – allowing for an outlet for her subjective feelings, potentially of anger and injustice and also affords a way for her to signal her strength, having managed the distress and pain alone and without the help of a medical, male other. But it inevitably mobilizes the disempowering gendered discourse which positions women's internal bodies as unknow-able and needing to remain hidden.

3.2.3. Harmful, bad bodies

> *It is like having cancer. You can't… you can't do anything. You can't get better from this overnight*. (Dr Mangala, 3.2434)

More than unknowable and shameful, analysis also showed how the dualist split was recruited by the women to communicate a more complicated positioning, in which the body is afforded an actively malign property, as Dr Mangala suggests above, constructing pregnancy and birth as like a '*cancer'*. The birthing body becomes a harmful one which acts despite of, and at times against, a woman's (helpless) intentions in birth. In taking on this split, women position their bodies as bad, both to signal distress in the only (pathologizing) way available to them, and also in order to preserve a sense of self apart from their body which is not to be blamed, as Dr Mangala shows:

> *You [stutters]… you are normally an energetic person, and however much you try and think, "I'm going to do this, I'm going to do that", your body doesn't work the way you want it to work…it has other agendas, other things*. (2.3336)

Whilst Dr Mangala draws on this discourse and positioning to assuage feelings of failure in birth, Renata draws on it to manage her fear of loss in birth. Her first birth experience was a stillbirth, which she understandably constructed as raising her awareness and anxiety around risk when pregnant with her second child. This led to a construction which positioned her own birthing body as a dangerous vessel for the baby, fuelling her desire to speed up the birth process: *'I just want her out **now…** because I was like, she is safer on the outside*.' (3.419). In describing the final moments of birth, Renata recalls, '*I was just, like, screaming,*

you know, "Just get her out! Just get her out!". Constructing the birthing woman's body, particularly her insides, as dangerous and unsafe, makes it necessary for the medics to be involved, save the situation, and get the baby out. A tradeoff is taken up by Renata, forsaking an alternative discourse and construction of birth which may afford her an embodied connection with and agented role in the process of birth, for a sense of safety bestowed upon her by the responsible medics. In the medical discourse – a woman's body is pitted against that of her baby, and Renata is led to reject her own bad body for the safety of the baby.

Women also alluded, in the unsaid of the data, to the positioning of their bodies as dangerously wild and animal – a product not only of the medical discourse, but a gendered one too, where women have the potential to be otherly and 'hysterical'. Hysterical as a word derives from the Greek for 'uterus', in which a wandering womb was conceived of as an 'animal within an animal' by Galen. This positions women as emotionally and physically unpredictable and threatening – requiring constraint and control from a powerful male other.

To this effect Dr Mangala very briefly described (towards the end of the focus group) how, during her elective abdominal birth, she '*kind of panicked because I felt I couldn't move my legs because of the spinal, so they had to sedate me'* (3.1121). This flyaway comment after talking about birth for over an hour, is revealing in its sparsity. That her panic was responded to in birth somewhat punitively by being given a general anesthetic, leaving her unconscious, unable to be the '*first one to see my child… they all got to see the baby before me. And I felt disappointed*' (3.1128), was something she almost omitted in her talk. Although little is said about her emotional and psychological state other than '*panic'*, that she needed to be sedated reveals a positioning of her as an animal, at risk of endangering the birth process and posing an unruly threat. That she was then completely removed from the birth, having been made unconscious, highlights the power of the medics here, and the complete loss of that for the woman. Why this remained largely untalked about by Dr Mangala in the focus group is perhaps explained further through Kleio's talk, who had a similar experience of being physically bound in birth.

Kleio birthed abdominally in Greece and described how she was tied to the bed and physically restrained during the operation – a standard procedure there (and other countries as I have subsequently learned).

> *I knew everything there was to know about c-section, everything, because I read about it, because I saw that. Thank God I didn't know that in Greece they tie you up. They tie you up. Do I need to know this information? No. Do I tell others about this in a c-section? I'm not gonna say that…I think someone would be more stressed about being restrained rather than being cut or something.* (2.607).

Whilst Kleio's dualist construction functions to separate and therefore establish her rational, researching mind apart from her uncontrollable body, it nevertheless mobilizes the positioning of the birthing body as dangerous and wild. Her talk also perpetuates this positioning and practice by embracing a commitment to silence, driven by her fear of worrying other women about the dehumanizing process. To resist the gendered discourse positioning women as wildlly animal and emotional beings, women are forced to inhabit the inverted, disempowering position of bodies that need to be controlled. Aware of how terrifying and demeaning physical restraint in birth is for women psychologically – constructed as more stressful than being cut vaginally in accordance with a gendered and medical construct of (external bodily) strength – she endorses a dualist split which tolerates physical bodily restraint over a psychological knowingness about it. In willingly remaining unknowing about the procedure, and keeping it secret too from other women, she is able, in the unsaid, to temporarily escape the reality of being positioned as a wild, bad body, needing to be restrained, even if it disallows her from mentally and psychologically constructing and connecting with her birth.

3.2.4. Collective Bodies

The collectivizing effect that this has on birthing women's interaction postnatally is interesting, and observed in Sophia and Sally's talk. Not wanting to be positioned as animalistic and otherly, the women are led to disclaim difference and struggle to locate themselves within discourses which shape their birth in alignment with, or in contrast to, the acceptable general construction of femininity:

> Sophia: *You're shown all these videos of these perfect births, and these women breathing out their babies, so you sort of think, I mean, I certainly did not breathe out my baby, I like mooed out my baby…*
>
> Sally*: You were one of those [laughter]*

Sophia: *Yes, like my memories are obviously quite sketchy but I swear I mooed.* (1.331)

Despite it being a good-natured exchange with shared laughter, the positioning of how women according to medical and gendered discourse *should* be birthing, compared to how a woman *did* birth, is raised. Sophia seeks to disclose the hidden visceral reality behind birth, with her confession of animalistic mooing, which then makes her an outlier, '*one of those*' in Sally's words, and might explain the lack of talk (e.g. '*nobody had told me'* (2. 390; '*nobody seems to… [talk about]'* 3.1142)) about certain aspects of birth.

The positioning of women's bodies as collective has practical implications for how a woman is able to birth and how she is responded to during birth. Although Beatrice disclaims the notion that women's bodies are the same, furnishing them with '*differences we can't even see'* (1.421) like a '*birth channel*' which she suggests could affect things like how painful a birth might be, she nevertheless, in her acknowledgement of the lack of talk around female bodily difference, reinforces the status quo in which women's bodies are conceived of and therefore treated as the same. This highlights the lack of knowledge that the dominant medical discourse affords women not only in terms of the hidden internal workings of the female body, but the differences that lie within:

> *I guess it would be nice to have the discussion more around there can be physiological differences…And I think I find that frustrating… it's almost like we've all got the same body and somehow we have all the same choices and we don't.* (1.407)

Beatrice here describes how talk around women's internal bodily difference is evidently disallowed within a medical and gendered discourse which normalizes and homogenizes birth, women, and the birthing body. This affects the way women birth – their 'choice' and how they are responded to in birth. Renata describes the limiting effect this has on women during birth – how constructions of a collective birthing body prevent individual difference and therefore attention and care:

> *She [Renata's friend] was quite adamant "The baby is coming"…they were like, "no it's not" you know, "you're a first-time mum it's not coming." And I think someone told her to have a shower or something… it kind of it fell out as she got out of the shower… and she tore, like really really bad, and they didn't examine her enough... they didn't*

stitch her right or it got infected or whatever, she had to go in and have it re-stitched like six weeks later. (3.1702)

Not only was Renata's friend not listened to, more sinisterly she was not believed – the medical discourse's generalizing construction of first-time mothers' birthing lengthily produces an infantilizing position for her friend – separated from and unable to possibly know what is going on inside her birthing body. Renata and her friend are here positioned as lay people, unable to understand exactly what went wrong medically with the birth and her postnatal body, as the '*whatever'* implies, reinforcing the construction of the birthing body as collective object. Renata's talk disclaims this – signaling to others the unjust awfulness of the situation for her friend, yet she is unable to break free entirely from it. In constructing her friend's birthing body as a dangerous cavern, her vagina referred to as 'it', being stitched and infected and re-stitched, she takes up that dominant discourse which treats women's bodies carelessly and without personalizing detail, there being no discourse which prioritizes women's experience in birth available.

Renata, Zoe and Leah's talk, in response to the story here, highlights women's attempts at resistance to break away from the dominant medical and gendered discourses which render the body a collectivized object, but at the same time, suggests the difficulty of doing so.

Renata: *And I guess, midwives, you'd just hope that they would understand that variation and listen to the mother…*

Zoe: *Because the mother tends to know what is going on in her body, bizarrely, you know.*

Leah*: It's inside her, yeah, yeah.* (3.1963)

That Renata's resistance is constructed by relinquishing to '*hope'* the idea that midwives would understand '*variation'* within women's bodies and listen to the woman herself, serves to show how deeply entrenched the discourses which deny these things are. Similarly, that Zoe and Leah have to construct, albeit sarcastically, to a group of women who have birthed their babies, that a mother '*tends to know what is going on inside her body'*, '*it'* being inside her, functions to disclaim the collectivizing dominant discourses which pronounce women's

bodies the same, yet through second order positioning, only mobilizes those discourses disallowing individual female bodily experience, further.

That women's bodies are further collectivized and individual subjectivity disallowed *following* the birth, is clear in Josephine's description of the dehumanizing treatment her body was given, positioned as an object to be '*checked'*, silently and generically surveilled and acted upon:

> *...and in the middle of the night they roll you over and check you. And you might be asleep, you might be awake, no one really speaks to you. They just check underneath and they put you back and that is horrific.* (2.1421)

The reported lack of talk between the medic and woman here, positions the woman almost entirely as passive bodily matter, utterly de-individualized to the point at which her subjectivity is deemed irrelevant. That the purpose of this description serves as an example she gives of the things that were not talked about prior to giving birth, and also something that she has never talked about since, signals the shame such positioning elicits: '*I don't think I've ever told someone pre-birth that that's what's going to happen*' (2.1430). The positioning of a woman as a body subjected to generalized medical treatment following the birth forbids speech – both in the moment, and thereafter – the individualistic mental, emotional and psychological parts of the woman unprovided for in this discourse and unacknowledged.

3.2.5. Discarded, insane bodies

To take up the dehumanizing, collectivizing position Josephine describes, whilst disclaiming its inhumanity, nevertheless mobilizes the beastliness with which a woman is positioned, treated and discarded during and particularly following birth. Within the gendered, medical discourse, when a healthy baby has been born, the bodily vessel has fulfilled its purpose and is no longer needed. Without an alternative female-subjective discourse of birth available, silence, however disempowering, is perhaps the only way for women to escape these deeply entrenched power and gender dynamics.

Beatrice describes an interaction with a medical consultant, after her birth experience, about difficulty feeding her baby. She takes up the gendered, medical discourse and allies with the

consultant's forgetful position of her own postnatal body in her talk, which has to be forgotten and discarded so that her baby's can be prioritized:

> *And then I turned round to him the next morning and I said, "Um, listen, I don't suppose the hospital has a pump does it because my breasts are just, this is excruciating." And he was so, he said, "I'm so sorry. I thought about everything else and I didn't think about what you and your body would be doing." And I said, "Well I didn't really think about it either but this has got insane." So he brought in this, it was literally the most manic, kind of insane machine I've ever seen. I put the boobs on, they just, I mean the milk, I could have fed all the babies, it was insane.* (1.1410)

The dualist construction Beatrice adopts here is fascinating. In separating off her rational mind from her body she is able to inscribe psychological judgement onto the body which she constructs as '*insane'*, uncontrollable and separate to her (rational) sense of self. It is also functional in that is allows her to be positioned within a wider discourse of motherhood in which good mothers sacrifice themselves for their children – providing access to a position of a good, all-giving mother able to feed all the babies, as opposed to a bad, selfish one who prioritizes her own body. It is only when discarded and split off, that the body of the woman is able to access and is deserving of help, and then only when the baby has been attended to. The mind/emotional part of the woman, within this, is disallowed mental or psychological care – it not being needed when it is the body, not the mind, which is constructed as mad.

In casting off the body as a separate and '*insane'* thing, Beatrice recruits a split which allows her to retain a sane mind, set apart from her mad body, in order to resist, yet inevitably mobilizing, the gendered discourse of the hysterical, volatile, weak woman. Dr Mangala shows how drawing on this split functions to claw back a position resembling strength for the woman. She disconnects emotional feeling from the physical (surgical) process of birth in her talk, which limits the sort of supportive talk and help subsequently offered, and, in turn limits the distress she is allowed to feel:

> *In hindsight I don't think anybody asked me about how I [laughter] felt or you know, because it was a c-section…And nobody asked. I mean I'm not asking for*

somebody to come and enquire after me… But someone else in my position would want that, would be more needy than me.' (3.1045)

To assume a psychological discourse which constructs emotional neediness in birth is evidently undesirable for a new mother, and disallowed within dominant discourse. Beatrice too resists positioning herself as suffering from a clinically diagnosable psychological label within a surveilling medical or psychiatric discourse, disallowing her to seek and receive support on an emotional level. She again takes up the medical discourse's dualist split, which allows her to seek help only on a '*practical'* level, which provides a way for her to convey how she was coping mentally and emotionally – assuming a traditionally male construct of (physical) health and strength.

I definitely remember going to see my GP and sort of crying at them about how hard I found it and things and they were like, "Oh, you know, have you, maybe you should see a psychologist and talk to someone. Are you sure it's...", I just sort of thought it definitely wasn't post traumatic, um, stress for me I don't think. It wasn't like post, what am I trying to say, postnatal depression. I could tell the difference but yeah, but, um, and that was why it was helpful to have read up so much about it before because I did know that actually in some ways I'm just sort of tired and run down. But it's almost like they asked the question sometimes without the, without… I needed practical help I think, do you know what I mean? (1.1961)

When birth is constructed as a purely bodily process, there is no space for distress. As Beatrice constructs, distress is something that the GP is unable to attend to, and that Beatrice herself disclaims lest she be deemed unfit and uncoping. Practical, material help is constructed as more acceptable and desirable than psychological help. This is represented further by Josephine, who, on experiencing psychological distress postnatally, checked herself in, voluntarily, to a psychiatric setting:

I was seen by a psychiatric ward 'cause I checked myself in at some point to decide. And my little girl around me and all the medicalization we'd had, the woman at the end of it basically said, "You're fine. Anyone would be like you in your situation," like after an hour of talking about it. And I kind of felt relief for seeing her 'cause she was the only person I had a chance to chat with probably eight or nine months afterwards. Um, and I kind of reaffirmation when she said, "No, you're completely fine. Anyone else

> *would be going mental about all this stuff." Um, you know, "You're coping with it really well." And that was weirdly and perversely good but it shouldn't have taken that, either in terms of their resources or in terms of my time and stress to have got there, um, because it could have just been a chat.* (2.486)

Josephine highlights how demonized distress is, and how limited talk is, following birth, claiming validation of her feeling '*mental'* as '*perversely good'*. Such medicalized, bodily constructions of childbirth leave the woman feeling that if she does not bounce back from the birth she is not only not coping, but is dangerous and potentially needs to be removed from her family and baby. It took a psychiatrist to respond to the '*mental'* psychological part of Josephine, and reassure her that her emotions, neglected within a medical discourse and constructed negatively within a gendered discourse which situates women as overly emotional and dangerously hysterical, was a perfectly appropriate response to her experience of birth.

In practical terms this limits talk around the more difficult aspects of birth and women's potential to openly experience birth emotionally or psychologically, as many women described. Renata recalled her standard postnatal follow up with the GP: '*no, it wasn't a discussion about the birth, though – just to check that physically you had recovered from it, I suppose, but certainly not on any kind of emotional level*'. The prolifically observed lack of talk about birth specifically between medical professionals and women after the event - '*nobody asked me'*, '*I don't remember anybody asking'*, '*I don't think I spoke to anybody'*- limits birth from being constructed as anything other than physical bodily process, from which women recover. The limiting implication this has for women's postnatal subjective experience is clear. It is the bodies which are made to go insane, lest the women themselves be castigated as such. Women are expected to bounce back, recovering as opposed to being changed by birth.

3.2.6. Sexual bodies

When drawing on the gendered and medical 'bounce-back' discourse, there is another position made available for women, that of a sexual body, which was largely unspoken in the focus groups – the lack of talk around sex being notable, as if women's sexual body has been made incompatible with a mother's birthing body. Leah's talk, however, did make reference to this in her resistance to being positioned as a sexual vessel for reproduction. Whilst

disclaiming, with humour, the idea that women are willing and able to have sex immediately (six weeks) after birth, she nevertheless mobilizes this disempowering positioning for women as un-knowing and infantilized, positioned *for* sex, as she describes the GP's repetitive cautioning in her six-week 'check-up': *'"When are you using contraception?" they seem to ask you about 26 times [laughter].'* (3.2978)

The shared laughter that followed seemed to signal collective understanding and familiarity. Women are here positioned, within an overlapping medical and gendered discourse, as a sexual object, addressed only in terms of their body, which is afforded a function of sex with a view to childbirth. Subjectively speaking this leaves women in a very passive position, and at a push, one in which childbirth might be conceived of as a punishment for sexual irresponsibility, something they need to be warned against. The body, here, constructed as something that biologically, physiologically, bounces back, disallows for the notion that the other parts of women – both the physical parts (bleeding nipples, stitches still healing) and the emotional ones – might be disinclined to have sex let alone go through childbirth so soon after. Positioned as a body for sex with a view to childbirth, women are detached from the more emotional, psychological and sexual processes involved in an agented pregnancy, childbirth, and postnatal experience. They are pronounced unknowing of their bodies, needing to be told that having sex might end in pregnancy – a preferable position, it might be suggested, than the second order position it guards against, as a sexually immoral woman – incompatible with her newfound identity of 'mother'.

In constructing childbirth within a gendered, medical discourse as a physical process which can only be managed by and known to medical professionals, women are positioned as external bodies to be operated on and manipulated as part of a process. It is a discourse recruited by women as a way of helping them feel safe and the process of birth controlled, but at the same time, it renders women passive, as dangerous bodily vessels, and without agency. Whilst guarding against it being their '*fault'* for things going wrong, this nevertheless disavows their emotional, psychological and sexual sense of self as well as the responsibility for birthing their babies, which are '*pulled out'* of their bodies. Bodies which are later discarded, ignored, and unattended to, collectively considered to bounce back and be ready for the next birth.

3.3. Birthing Bodies: The natural discourse

The women in all three focus groups also drew upon a dominant natural discourse of birth, as a way, it seemed, of reclaiming birth, a means with which to challenge the disempowering, subjectivity-denying position medically constructed birth affords. The natural discourse was drawn upon to mobilize the agency of women, constructing birth very much as something within women's domain and body, a natural process, something which does not need to be controlled or intervened upon by a more powerful and knowing male, medical other. What emerges from the analysis, however, is that this discourse is only made available in response to the dominant medical discourse, and so a binary, territorial discursive struggle around birth ensues – which continues to raise, rather than resolve, issues around the position, agency, and power women are afforded in birth[2].

> *I always wanted a natural delivery because I thought I wanted to experience that. And also…some people are like, "Oh, you had a Caesarean?" They think it's inferior.* (Dr Mangala, 3.160)

In opposition to the medical discourse's construction of birth as risky, out of control and unknown to women, when drawing on the natural discourse women constructed birth as an idealized, value-laden, natural phenomenon without the need for medical intervention. It was made into an experience desired by women as opposed to feared. Dr Mangala, above, states a desire for '*natural'* birth as a prefix to justifying why she '*had to have'* an abdominal birth, so that she can position herself as morally sound, despite, from within the dominant medical discourses, being unable to control and be agented in terms of the type of '*delivery'* she had.

> *I don't remember the first time. The c-section I don't remember. The second time, after giving birth to my daughter, er, the natural way, absolutely great, everything was fine.*

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[2] On a reflexive note, this posed many challenges in terms of representation in writing up the analysis. I have chosen to represent the natural birthing body of women separately, as opposed to alongside, a medical birthing body, to offer it and the positioning it afforded, the space claimed by women in their talk. Because it seems to have developed in response to the medical discourse, there is often a repetition of ideas given the second order positioning inevitably involved. I have strived, as much as possible, to avoid repetition.

> *I ate a burger, I was watching TV, I read a really nice book that I, I thought I was on vacation, honestly.* (Kleio, 2.1482)

Natural birth is constructed by Kleio here as a blissful, memorable experience in comparison to the forgotten lack which constitutes her medical '*c-section'*. Evidently desirable, the postnatal woman is positioned as if on holiday – recovering and, again, bouncing back to a normality of eating a burger, reading and watching TV.

What this normalising idealisation does not allow for, however, is struggle or distress of any sort – physically or emotionally, just as women were disallowed this within the medical discourse. For women who experienced complication, who received medical intervention, who didn't naturally spring back after birth, the natural discourse disallows a position of having birthed naturally and with agency, and as Zoe highlights below, leaves them positioned as naïve, ashamed to have hoped for a birth experience engineered by themselves, caught discursively speaking between a hoped-for natural rock and a chastising medical hard place:

> *So I went in the pool [swallows], and it was lovely. You know, just doing all the things now that are so cringe, listening to a…a playlist, you know, a birth playlist that I put together, wearing my nice tankini that I'd bought specially – just ridiculous.'* (3.243)

Achieving a 'natural birth' is constructed as a holy grail. Women construct is as being afforded to some women but not others, often permitted or disallowed by the medical professionals based on their assessment of women's birthing bodies, as Josephine finds, which leaves women positioned just as passively as, and bound to, the dominant medical discourse they seek to escape: *'All the things that I thought I wanted to do in child birth, I was just told medically went out the window. I couldn't do a natural birth. I couldn't do lots of other things I wanted to do.'* (2.78).

3.3.1. Good or bad birthers

Billie described how an antenatal teacher bestowed upon birth, from within a natural discourse, a value which is then applied to (or withheld from) the birthing woman, positioning her with an identity of being good (or bad) at birth:

Billie: *Um, but then the classic moment was when talking about childbirth, she said, "Well you know what, I would just like to say that the ultimate childbirth experience and what you could all see as kind of a success story would be if you ended up having a home birth because if you end up having a home birth, that just means you are awesome at childbirth."*

Sophia: *Shut the hell up. That is appalling.*

Billie: *And she went, "And you know what, you have a home birth and then you just have a digestive and then you're done." At that point I was literally just like, I was just like thinking, "Okay. I'm the one who's like basically decided to do a surgical procedure 'cause that, the idea of that is what kind of makes me want to cry".* (1, 472).

Natural birth is here constructed as best, as ease and a desirable female phenomenon to be experienced, positioning women as capable of bouncing back after a chocolate biscuit. For those opting against or being disallowed from birthing 'naturally' (more of what constitutes this label shortly), the implication is that they have failed in birth, or failed to experience birth properly. Whilst Billie's talk functions to make apparent the absurdity of this positioning for those not birthing 'naturally', she nevertheless, in her description of upset, mobilizes how entrenched this positioning of value in relation to birth is within the natural discourse. Beatrice, who elected to have an abdominal birth because of the risk put on her pathologized body by the medical discourse, positions herself in relation to the natural discourse as personally being unable to birth properly, constructing her medical, non-natural birth in this discourse as loss: '*why can't I do this?... In a way I would love to be that person who could have that home birth and have a digestive biscuit. I'd love that'* (1.576).

Billie describes how being positioned as a non-natural birther, a bad birther, directly limited her talk in her antenatal group for fear of being judged and excluded by other birthing women:

When I went to that NCT group, 1) I didn't admit I had a choice [around vaginal or abdominal birth], and 2) I didn't say I was going to a private hospital initially….. it felt like there was this very, …"Oh guys? Oh yeah, we're all together in this", and it's all

kind of some… whereas for me, … I thought, I, I don't want to be the one in the room that's not in it, you know. (1.99).

That the natural discourse of birth positions women as judge-able based on their mode of birth – natural or '*surgical'* – was prevalent in the women's talk, and seems to position women within an exclusive club of natural birthers, or alternatively as Billie described, an otherly position of '*not in it'*, excluded from the group. To navigate this almost pack-positioning of women in relation to each other, so as not to be excluded or perhaps exclude others, talk about birth within a natural discourse is made to be limited, and women are once again silenced.

For those that didn't, within this discourse, birth naturally, not only are they left unable to talk about their birth, but as Dr Mangala explicates, they are not asked about the birth either. This creates a norm of silence in which subjective experience of those birthing non-naturally is disallowed: *'not everybody shares their birth experiences, I don't know… In hindsight I don't think anybody asked me about how I felt, because it was a c-section*'.

Interestingly, even for those that did have a positive natural birth experience, the awareness of the divisive power upon a woman's identity of talk embedded within the natural discourse is keenly felt and also leaves women speech-less. Leah, one of the strongest proponents of the natural discourse reasoned that, *'I think part of the reason why I wanted to do this [participate] is because I actually had a really good birth… And I find that it's really hard sometimes to share that.'* (3.653). When judgement is so intrinsically constituting of birth experience, women are made to be fiercely aware of their relationship and positioning to each other – a subjective experience of both envy and loss occurs as a result, and what remains is the clear silencing effect this has:

One of my friends, they had to have a c-section and they said they felt a bit cheated. …and I was like, "You did not want to go through that .. You are envious of me, and I am envious of you." (Dr Mangala, 3.1159)

In constructing birth as a defining aspect of a woman's identity, it effects a distinct awareness of women's positioning in relation to each other. The natural discourse constitutes birth not only as a natural act, but also constitutive of a woman's sense of self. This might explain why talk about birth is so incredibly loaded and limited. The natural discourse seeks to

empower women, but when constructed so rigidly and exclusively it also prevents this, keeping women ranked in terms of their good or bad, natural or unnatural, birthing identity. It limits talk and agency, reducing birth experience to birth type, and therefore limits the potential power for women to construct and connect with the liminal space of birth in which woman's individual subjectivity might be foregrounded. Instead it pits women against each other, recruiting the stereotypically gendered discourse which situates women as negatively emotional: 'envious' or 'jealous' of the other.

3.3.2. The natural birthing body

'Natural birth' was a term prolifically used in the women's talk. What constituted this, with its powerful implications for women's identity and subjectivity discussed above, however, was again rooted, reductively so, in the body. 'Natural' was a word used to signal which part of the anatomy the women birthed via. That natural birth is constructed as vaginal birth was never overtly articulated in the women's talk, but its implicit understanding was staggering and dichotomously set against the medicalized 'caesarean section'. Natural birth is therefore, constructed in this way as a bodily process, without overtly talking about the body (vagina is said just twice across all three focus groups) – creating a dilemma which suggests natural is best but the vaginal reality of birth is also worst, better left unspoken. This tension gives way to an impossible position of ambivalence for women, which Kleio articulates: '*I believe in natural birth and wanted to feel the experience. No I didn't want to feel the experience*.' (2. 1630).

This has practical implications for women, who to manage fear of failure or being positioned as unable to birth 'naturally', are paradoxically made to opt for medical birth – which at least curries a degree of agency that the natural discourse threatens to take away, should an attempt at natural birth be met with constructed failure and the potential for an unnatural positioning for the woman. Zoe revealed how this impacted her, questioning after her traumatic first birth experience: '*would I try and give birth again or would I just be too scared and just want to have a C-Section?*' (3.2050). The natural discourse used here creates a dilemma for birthing women – whether to birth (naturally) and risk subjectively failing, or not to birth at all (in this discourse constructed as having a c-section) and so stave off that sense of failure.

One way that women, within the natural discourse, sought to resolve such dilemmas was to embrace the position of a birthing body – a dualist split akin to that created by the medical

discourse. Different from rendering the birthing body as passive and intervened upon, the natural discourse affords the body with an active, powerful status. It is presented as an all-knowing subject, more involved and crucial to birth than the woman's mind. Leah shows this as she describes a shift in position, from originally not wanting to birth at all (again constructed in this discourse as a medicalized c-section), to wanting to birth vaginally - her body endowed with empowering, positive capability:

> *And I remember doing a lot of research into elective C-sections, and I was like, "I'm definitely going to do that." Like, "Why would anybody go through birth? It sounds horrific.* (3.638)

> *I guess I just really approached it as, "My body knows exactly what it's doing, and it's not going to make a baby that is too big for my pelvis."* (3.777)

Her dualist construction is associated with the natural body taking charge and owning the responsibility for the success of birth, and was facilitated by Leah's '*immersion'* in hypnobirthing literature – as representative of the natural discourse. Whilst it functions to calm her anxiety and struggle with being out of control in birth, a positioning created by the medical discourse, it nevertheless remains limiting: she has to relinquish a more integrated sense of self and agency in her mind part, instead trusting entirely in her body designed to birth. This positioning affords agency in birth not to her as a whole, but to her natural birthing body.

Leah described how natural midwifery literature afforded her knowledge and therefore access to an internal bodily experience during birth:

> *I read [Ina May's] Guide to Childbirth, And I was like, "Oh, this is like, REALLY interesting." You know I had no idea that, like, what the contractions were for, and how they worked, and what it was going to feel like, and you know, the point of everything.* (3.758)

Here, the natural discourse allows Leah to construct birth as a collection of internal bodily workings. Quite apart from following a blind direction to '*push'*, she furnishes herself with knowledge, affording an understanding of why internal contractions happen, what they might feel like and the purpose of internal shifts in

birth which functions to empower her practically and subjectively in birth.
Whilst disclaiming the medical discourse which keeps women in an unknowing position around birth and their bodies, she nevertheless mobilizes it by setting the natural discourse in direct opposition to, and therefore making it inextricable from, the medical. Her surprise about contractions functions to show just how uninformed women are around the internal bodily workings of birth, and needing birth once again to be explained to her by a (midwifery, as opposed to medical) expert.

In terms of practice, Leah's knowledge, a product of the natural discourse, did indeed facilitate for her a birth which she described internally experiencing, something which effected a more agented position in birth, and a sense of awe, subjectively speaking, about the inner workings of her body:

> *And.. then she started to come out. And like, I'd read about how the baby twists, and I remember feeling her turn… "Wow… Did she, did she just turn?" And the midwives were like "yeah". I was like, "wow, okay"*. (3.940)

The ideological dilemma around agency feels complicated here and the question of whether a woman is able to know and more importantly trust what is going on internally within her body during birth is posed by Leah's talk. For her, birth is constructed as internally experienced in the body but this is only made possible by having read expert literature and then having it confirmed by the midwives in the moment. This continues to reinforce the dualist split between knowledge about the birthing body bestowed on to her by others, prioritized over feeling the birth in the body herself. As a consequence, her construction of the liminal space of birth – the moment the internal becomes external – is disallowed for and Leah's agency in the birth experience is lost. With the body working according to its natural design, the baby is reported to naturally '*come out'* of her body with ease and also fantastically so, all of which removes agency from the birthing woman as a whole: *'and it was just this really surreal moment of having, like, a baby in the water being, kind of, born.'* (3.955)

Constructing birth as '*surreal'*, something the body knows how to do naturally, is alluring and, although it removes agency from the birthing woman herself, does position the birthing body with a confirmation of its natural ability. What happens when the birth encounters complication, however (the natural discourse failing to afford a construction of birth as

complexity or distress) is less affirming for a woman as Christina points out: *'I did NCT and I did the NHS classes in the hospital and, um, no one mentions the word traumatic, that it might be traumatic or there might be problems'* (2.33). In this discourse, birth complications mobilize a construction of an unnatural body not meant to birth – which if taken to an extreme level, suggests that the birth isn't always 'naturally' meant to be - *'It was supposed to be natural but it went the other way,'* (Anya, 2.224). The inability of the body, determined by fate, God or Mother Nature, for natural birth, leaves many of the women with painful feelings of failure and a lack of ability, it being for some '*impossible to do it naturally'* (Anya, 2.239), positioning the woman's body with an implication of being naturally unwired for birth.

3.3.3. A body in pain?

A dilemma is posed within the natural discourse around value, ease, and effort. Natural birth, for those afforded it, has been shown to be linked with ease: a serene construction of birthing at home, '*breathing out their babies',* having '*a baby in the water being kind of born'* and then having a chocolate biscuit or burger, without much need for recovery. Yet at the same time, natural birth is also distinguished from medicalized abdominal surgery, especially '*planned'* 'c-section', by effort. In this discourse, women birthing abdominally are not considered to have really birthed their baby, because of their lack of struggle and interestingly lack of pain in birth – as Dr Mangala reflects, '*even if I had a twinge of pain and then needed a c-section, it would have been fine…and now I feel left out in some ways'* (3.1173). She constructs that she cannot know 'natural' birth, because she experienced no pain at all in her body. This therefore effects a complicated construction of natural birth as both ease *and* struggle: the inference being that women should naturally bear within their body the struggle of birth without difficulty, fuss, or noise, and certainly without medicalized pain relief.

Indeed, analysis showed that throughout the construction of birth as a natural process, pain relief was actively discouraged; the unnatural substances were constructed as potentially harmful to both the woman and the baby, known for '*slowing things down*' (3.430), or '*doing funny things to you*' (1. 278). What emerges, however, within this discourse is a construction of pain in the woman's birthing body only in relation to the sort of medical intervention offering pain relief used. A subjective experiencing of bodily pain is disallowed, silenced,

and implied only in relation to whether a woman's body was administered pain relief (bad) or managed without it (good).

When women birth without pain relief there is a subjective sense of pride and goodness produced, as Renata represents: '*I mean the only thing, I guess, that was good was, I did, kind of deliver my birth plan, which was in the birth centre, without an epidural, which was good'* (3.641). The pride that women conveyed having experienced birth without having had an epidural (and conversely the subjective experience of failure mobilized when they have) was interestingly often described as being bestowed upon them by their husbands, '*my husband was very proud that I didn't have any pain intervention*.' (Sophia, 1.2251). The natural discourse interlocks here with a broader gendered discourse, positioning women physically as the weaker sex. A person wouldn't be praised for undergoing a tooth extraction without pain relief, so what is it about childbirth that encourages and lauds women to endure the process without adequate and available pain relief?

Anya recalled her husband predicting, '*you're just going to be begging for that epidural'* (2.216), a limiting position, leaving her without any other way of showing strength (and agency) in birth, other than withstanding significant bodily pain. In adopting the natural discourse, women are afforded power – birth being something women can do naturally within their bodies that men cannot – but somewhat sadistically it is only through experiencing pain and being made to show their strength, silently, through such endurance of pain, that power might be bestowed on the woman by a male.

> *Like I, I hope that my husband thought I was good and strong and didn't object to me with the Pethidine request and, you know, felt more respect for me afterwards, having been through that. I hope that he looks at me and thinks, "Wow, she went through that."* (Josephine, 2.1050).

Josephine's construction of her birth, through the lens of her husband, might be interpreted as a resistance to the natural discourse which denies anaesthetized women an active, good experience of natural birth. But the repeated '*hope'* in her talk serves to mobilize the natural and indeed gendered discourse further, leaving the woman taking pain relief bereft of (male) respect or a sense of having really done birth. When constructions of natural birth discourage the practical use of medicalized pain relief, women are positioned as either good and physically strong and not needing it, or weak, unnaturally formed for birth and, as a way of

managing this sense of failure, needing to suffer it silently to avoid the shame of showing distress. Either way, distress, pain and the messy processes which are associated with pain (e.g. 'vomiting') are disallowed in the natural discourse.

Beatrice shows how this requires women to take up a physical construction of pain – as opposed to psychological. She roots the cause of pain in the unseen internal female body, split off from the psychological sense of self:

> *And the evidence seems to show that, yes, pain control is um to a certain amount psychological and can be changed by different thought processes and things like but it's also going to be about how big is your birth channel, do you know what I mean. ...whatever it might be and differences that we can't even see perhaps in terms of pain, pain control and things like that.* (1.414)

Her talk utilizes the medical discourse here to disclaim the natural discourse which suggests women should birth easily and endure pain without relief, stating that internally there are unseen physical factors which create pain in birth, which women cannot control. She highlights that unless pain is gynecologically evidenced, it is unable to be constructed and therefore believed by an externalizing male medical gaze. It also reinforces the notion that pain, an inextricably medical construction, signals something going wrong: to admit pain by requesting pain relief not only renders a woman unable to birth with natural ease, but also elicits an internal mapping of a woman's body as unnaturally tangled, ill-equipped for birth with a too-small birth channel, which perhaps explains why women choose to take up the natural discourse's dictate of silence, practically seeking to birth without pain relief, lest they be positioned an unnatural birthing body.

When embodied experience is discordant with a dominant construction of natural birth, silence ensues to manage feelings of failure or shame, because, as the natural discourse makes clear, mess and a desire to alleviate agony is not allowed for when a woman is positioned as a natural body designed to birth.

3.4. Casualties of birth: The trauma discourse

The medical and natural dominant discourses position women as passive, homogenous bodies, subject to the powers and knowledge of the medical professionals or Mother Nature

herself, separated from the liminal space of birth and being required to bounce back from it. Women are positioned predominantly as bodies designed to birth naturally, or pathologized objects to be intervened upon, objects from which babies '*are delivered'*. And whilst this has been shown to provide women with a sense of safety or control, it nevertheless denies their mental and emotional subjectivity in birth. In order to afford women an emotional and psychological construction (and therefore experience) of birth, analysis showed how women drew upon a trauma discourse, thereby challenging the construction that birth is a process of and on the body alone. This instills birth with the power to affect women '*even emotionally'* as Dr Mangala described, opening up opportunities, therefore, for distress in birth to be acknowledged and, theoretically, be responded to.

In constructing birth within a trauma discourse women occasionally recruited the psychiatric discourse of trauma – often in order to position themselves in relation to (or more commonly outside of) clinical postnatal mental health diagnoses, but more prolifically, interestingly, they drew upon a more military construct of trauma – absent from the literature review. They constructed birth widely with catastrophic, violent language: '*horrific'* (3.556), something in which Leah '*was 60% sure [she] would die'* (3.605), '*traumatizing'* (3.1993), '*just awful'* (2. 1379), like a '*horror movie'* (2.1935), a '*murder scene'* (1.1840), likened to '*a bomb going off*' (1.1013). Such masculine metaphors (horror, murder and war carrying a stereotypically gendered connotation) and constructs are interesting, I suggest, and reveal the difficulty women have in accessing an alternative emotional or female-subjective discourse which constitutes birth as trauma, death, loss, or distress – these things being essentially incompatible with the dominant medical, natural and implicitly gendered, discourses which constitute birth as joy, success and female destiny.

3.4.1. Injured, changed, silenced casualties

In constructing birth as explosive risk and near loss, women are also afforded a different position to that allowed by the dominant medical and natural discourses – as being affected to the degree that they are changed by birth, rather than merely bouncing back, as Dr Mangala conveys (although it should be said the silence that followed this statement and was verbally recognized by the participants in the group, functions to suggest how subversive a construction this is):

> *Um, after the baby comes, also, it's not like, "Okay, fine, everything is back to normal." You know, you are never going to get your pre-mum status. Physically, mentally, emotionally, you are a changed woman.* (3.2365).

Whilst this discourse allows women to construct and make real a mental and emotional change around birth, it was in the physical where the women were able to more comfortably construct birth as effecting change, suggesting a difficulty in articulating the more psychological aspect of trauma compared to the physical. Physically speaking, women talked extensively about postnatal injury:

> *Your body goes through a lot and especially if you have the tear and the episiotomy to recover that health back and nobody speaks about it, "That's it, you're done. If you have a problem, come back." And I had to literally keep going for help and saying, "No, my body doesn't feel right, I need help. It's not recovered. It's not recovered." By the end of a year and a half after, I just gave up. It's like, "Okay, I'll deal with it." ... So yes, it has clearly completely changed the person I am, the trauma that the childbirth had for me changed me and yes, I think about it often. (*Anya, 2.812)

Anya challenges the dominant discourses' construction that the body heals and returns to its pre-birth status, which allows her to construct change and ask for help, even though the medical systems in place are unable to hear or respond to her (internal) bodily damage. Whilst this discourse gives her a way of making real the trauma and damage which stays with her long after the birth, it also has a silencing effect. As her requests for help are left unresponded to she learns to stop asking for help and has to deal with her damaged body alone. Whilst this trauma discourse has the potential, as it does within wider masculine military rhetoric, for women to be positioned as warriors, even victors in birth, there is a sense that because of the gender discord – trauma itself being historically a medically- or military-defined construction (most commonly, culturally applied to male war veterans), Anya is consigned to live with her wounds alone, a lonely casualty of birth. Silence becomes the only option available to her within a system which disallows for birth to be openly constructed as trauma, and also as a way, potentially, of managing the shame that is ascribed to women's (internal) health within wider medical and gendered discourses as Renata described, struggling to speak the unspeakable: *'incontinence is…is…is terrible…. And that can happen in these good, fast births'*.

In the absence of a (female-subjective) discourse which allows specifically for birth to be constructed as physically and emotionally damaging and distressing, the change that birth effects is often located in the women's talk as a negative construct – a lack – defined in relation to an absence of what there was previously in terms of identity and experience. This functions to resist the normalization of birth imposed by the dominant discourses and allows women to access an emotional and psychological construction of birth, but it remains inherently limiting as it prevents women from articulating that change or trauma:

> Billie*: 'No one can really describe. And I think there's obviously a lot more we could, we should and we could talk about it in so many ways, um, but yeah, I don't know if anyone can really ever explain to you what happens. You know, childbirth for me is, it's that just everything changes in a way that you know, I don't know, ... you know the excitement of it all and then it's actually in that moment that things can happen that lead you in directions that you would never expect. It's quite, I don't know, it's..*
>
> Sally*: It's gobsmacking. There's no words for it really just you know. Even now I don't know.* (1.909)

When birth is constructed as a gargantuan change which is unable to be translated into words – a trauma – it provides women with a way of indicating psychological change and importantly loss (implicit in the change Sally and Billie construct above), but prevents women from constructing it and therefore knowing it more specifically, as Sally states. Even though the women here are able to communicate the edges of it, they are prevented from making sense of it subjectively, left to process (or not process) the trauma inflicted upon them in birth, alone. As Leah put it, '*it's traumatic to your mind, to your body, and you are not processing it while it's happening'* (3. 1420).

Loss in birth experience was cautiously alluded to throughout the women's talk – loss being a seemingly difficult thing to openly acknowledge alongside the birth of a healthy baby, disallowed within the essentialist medical and rosy natural discourses. Josephine points to this lack of talk, where she contrasts the freedom to talk about loss in relation to stillbirth compared to birthing a live baby. Talking about stillbirth, she describes how *'people are allowed to mourn now. They're allowed to recover now from that but we're still not really allowed to mourn about the experience of pregnancy or, I mean mourn's the wrong*

word 'cause it's too much but, but those dialogues aren't had openly at all I don't think'. (2.852)

In constructing the '*experience of pregnancy'* as loss, she resists the idea of birth as a happy experience of creation. It is interesting that, even though she roots the unspeakable loss in the '*experience of pregnancy'* it was actually '*childbirth discussions'* that she was, moments before, talking about – but was seemingly unable to speak alongside the shift in talk to loss here. Her awareness of the power of talk in relation to childbirth is remarkable, reinforcing the idea that there are things about childbirth which are simply not allowed to be said – and loss for the woman when a baby is born healthy, seems to be one of them. Drawing on the trauma discourse, however, with its positioning of women as a wounded, affected casualty, seems to provide a way for women to construct and communicate this without being positioned overtly as an anti-woman, unable to 'feel' appropriate feelings when a baby is born.

Sophia illustrates this, drawing upon the trauma discourse to access and communicate her emotional and psychological distress and loss around her birth in a way that the dominant discourses, through which she earlier constructed her birth as '*positive, good'*, disallowed:

> *Straight after the birth, I'd been up for 46 hours and had, I mean I was like, I was gone. I was dead. I was like, and, and I loved him, sort of, but I was too tired to love him. Like I didn't feel anything actually, if I really am honest. I don't think I felt anything... Yeah, I was completely numb. And so that friend was in my ear at that moment of going, "Don't worry, it's okay that you don't feel anything right now because you probably will." And I remember seeing my husband hold him and feeling love for that unit.* (1.963).

Sophia draws on the trauma discourse to position herself as destroyed physically and emotionally by birth, '*dead'*. From this position, she is enabled to access and justify her feelings of numbness and nothingness, which oppose the dominant gendered and natural constructions of an all loving, benign mother. She is, however, afforded this through permission from a friend's talk and also because she described love for the frieze of her husband and baby together. Her loss is only permitted within certain specific conditions, effecting a second order positioning which permits distress only whilst remaining within a

broader gendered construct of motherhood. As Sophia shows, it is difficult to be positioned as lost, numb, negatively affected by birth without being made into an archetypal Medean anti-woman or anti-mother, as prescribed by the dominant gendered discourse, and so the more prevalent position of a casualty of birth is taken up to signal ambivalence – despite its passive, destroyed, silencing implications.

Sally's talk suggests why adopting a position of a casualty, afforded by a military discourse of trauma, might be more preferable to being afforded a position of being clinically diagnosed as traumatised by birth within a psychiatric discourse – which the women commonly resisted:

> *Well is there anywhere between sort of being normal and postnatal depression? Isn't it okay just to be a little bit knackered and upset and emotional?* (Sally, 1.1976)

Whilst seeking to disclaim the psychiatric discourse of trauma here which denies experience for women outside of normal or clinically ill, Sally's questions nevertheless mobilize it by evoking a second order position, in which the idea that it isn't okay to be knackered, upset and emotional following birth is reinforced. That women strive against being given a clinical diagnosis (the implication being that they may be unsafe and unable to take care of their baby) is also evident in Beatrice's talk, as she carefully guards against a clinical label of trauma or depression – the interchangeability and lack of clarity over the labels functioning to show how undesirable, otherly and unknown a postnatal mental health diagnosis is: *'I just sort of thought it definitely wasn't post traumatic, um, stress for me I don't think. It wasn't like post, what am I trying to say, postnatal depression.'* (1.2013)

Reminiscent of Sally's second order positioning above, women are left needing to be fine lest they be clinically diagnosed, highlighting the gap, the lack of space for distress to be constructed, experienced and therefore sufficiently responded to, following birth. This is reinforced by the limited institutional postnatal care described, a deficit of (practical and) emotional '*support'* and space in which distress might be expressed, shared and worked with, as Anya explicates:

> *There was nothing I could do and there was no support. The midwife just came and measured her jaundice, no jaundice… There was no one to talk to, all the fears in my head… I had a third degree tear and episiotomy, complete, you just feel like you're*

> *just gone, you know... So the after, like the before feels like it's going to be a rosy, pink view and then after it's just grey and black. And I feel like that is something that nobody talks about as much. It took me ages to find support.* (2.273)

So, when birth is constructed as destructive and traumatic for the woman, it allows her to access and signal to others emotional and psychological change – the shift from rosy to black, as Anya puts it. Yet given the lack of an available discourse which constitutes birth as traumatic or distressing beyond the confines of the military or psychiatric trauma discourse, women are unable to construct their experience and subsequent distress more explicitly – leaving it unspoken in public discourse, normalized by silence, and unattended to. Constructed as trauma, and positioned as casualties, birth is made to be kept a secret from other women, the women's repetition of phrases, such as '*nobody tells you'*, '*nobody talks about'* it, '*nobody had told me'* feels reminiscent of the military trauma discourse's mandate, 'don't mention the war'. Constructing birth as unspeakable in this way offers a way for women to resist the 'rosy' normalization of birth, but it prevents, at the same time, women from knowing how to construct it for themselves.

3.4.2. Messy, leaky victims of birth

I reflected earlier that mess and gore was largely absent from the women's birth talk – the unsaid-ness of blood and shit and vomit and hooks piercing water sacs was striking and, I suggest, explained by its incompatibility with the dominant constructions of femininity, natural birth and the sanitizing medical discourse. When it was, occasionally, voiced, women utilized the war-like trauma discourse to construct birth as gore and horror which, as Josephine shows below, raises a dilemma around the extent to which birth can be made known or unknown to women:

> *I mean this probably sounds really familiar but this bit was never talked about before. You have to say to the midwife, "Could you just watch my baby whilst I go to the loo?" and they're like, "No, no, it will be fine," you know. And you're just like, "I've just given birth to this precious thing after all this trauma." And I went to the toilet and there were sort of, I mean it's gross, isn't it, there were like blood clots on the floor where others had been. I mean they hadn't tidied it up yet so it was like a horror movie. And then you go back to your child and then the first poo that they do is this black tar-y, disgusting poo and like… I just remember laughing and literally thinking,*

"How many blood clots am I going to have to walk back through with my wee bag attached to me?" (2.1393)

Here, gore and mess are inextricably tied to childbirth yet at the same time made incompatible with it – a gendered discourse constructing women as weak and unable to cope with the '*gross'* ness of it. Josephine seems to position herself as a victim of the mess, as opposed to an active agent of it, to avoid shame – the subjective product of a gendered discourse in which female bleeding needs to be literally and discursively hidden. It turns the mess and gore into an undesirable part of the birth experience, and certainly incompatible with the sanitized medical discourse and the idealizing natural discourses constituting childbirth. On a practical level, this leaves women shocked and unprepared for the blood and gore, unknowing about birth and their bodies, left with a sense of being unprepared, surprised, and then ashamed of the mess. That a woman has to face, or shed, as Josephine observed of another woman, blood clots privately in the toilet, also constructs bodily mess as something un-central to the birth experience itself, needing to be hidden away, untouchable. Women are forced to experience their mess privately and silently (practically and subjectively), which leaves them shamefully embarrassed by their leaking bodies.

Vomiting in birth was something that was constructed as surprising for women, leaving them with a subjective experience again of silencing shame and disgust at their own messy birthing bodies:

Billie: *Whatever I thought was gonna happen, one thing I had not thought of was I'm gonna vomit whilst I'm giving birth. And it was a real, I was literally like this over the side, you know, just like. It was, you know, if I was having a natural birth, who knows because the pain made me vomit. You don't vomit in a c-section.*

Sophia: *I did vomit in my normal birth.*

Billie*: You did?*

Sophia: *Yeah, yeah, yeah. Right before I went into the last stage and they were like, "Oh great, this means the baby is coming," and I was like urgh, that was not nice.* (1.567).

In both women's talk here, vomit (a word spoken only once more outside of this passage across all focus groups) is made acceptable and allowed only within a rational, logical, medical discourse – a response to pain, or a sign that the baby is progressing. To access an emotional, visceral construction of this part of birth, '*urgh'*, in which the vomit becomes messy and '*not nice'*, the women draw on the interlocking gendered and trauma discourses, positioning them as helpless, distressed, and cautious of articulating it, a subjective experience of shame seeming to prevent the mess being embraced in public talk. Being positioned as a silent victim of birth's mess seems preferable to that of an active culprit, which of course prevents mess from being constructed as a central and likely part of the process, and prevents women from experiencing a sense of togetherness, as Billie and Sophia came to share through their breaking of silence.

Because the dominant construction of women is at odds with the embodied gore of childbirth, women often drew on a third party or a male lens, to access the trauma discourse, as a way of navigating this dilemma. Josephine's recollection of another woman's blood clots like a scene from a '*horror movie'* is echoed in Sophia's recollection of her husband's construction of the aftermath of her birth, which functions to distinguish the mess from her birthing self:

> *My husband… went in to get something that he'd forgot in the room and he said it was like, it was like a murder scene 'cause, well this was the second birth where I had been like, and I just, weirdly, whenever I think about the birth, I have this image in my head of like just blood everywhere, and I definitely did not like the second birth and I remember thinking, I don't want to do this again.* (1. 2198)

The trauma discourse, constructing birth as violent and murderous, functions to allow Sophia to disclaim birth as desirable – the construction made possible by drawing on the dominant natural discourse she used to introduce her birth experience with (as '*positive, good'*). It is the only way she is able to exhibit difficult feelings around birth and access the mess. This is a resistance in and of itself yet one that necessarily mobilizes the construct of a pure, clean woman, even in childbirth. Here, more than a casualty of childbirth, a stronger position is created in which women become victims of birth – an intriguing position which, even in her resistance below, Josephine mobilizes. She uses the discourse as a spring board to signal and endow herself (and other postnatal women) with a strength, yet it is a strength which is

only allowed for through having been attacked or victimized by birth in some way, as opposed to having actively endured and navigated a great, glorious battle:

> *Like it's properly raw and it's probably... and I think we all have to turn around at some point and say, "This has made me stronger. This has made me the person I am and I'm not a victim to it anymore."* (2.1889)

3.4.3. Lucky survivors

> *But whether it's too much to handle, you find those coping mechanisms and we're all strong women who, you know, make it happen and we've survived it and you kind of forget some of those pieces and know when and if you're in that position again, you're gonna survive again because you're resilient.* (Christina, 2.1938)

Christina also constructed birth as something to be survived (and forgotten) from within the trauma discourse, assembling birth as both too much for women to handle but also something women necessarily need to survive. If survival is both inevitable and a product of women's resilience and ability to forget the difficult detail, a dilemma arises: if women *have* to survive and be strong, there is an implication that they haven't really earned it. They are not the glorious warriors championing home a victory, they are the lucky ones who have had to scrape through merely because this discourse dictates that they are entirely weak or materially dead if they do not. Interestingly this has the effect of shutting down thinking, talking and experiencing, as Dr Mangala shows:

> *And so it's hard, yeah…. but it's… I don't know if it's one aspect of me – like, "It's hard, I don't want to think about it," rather than think, "Oh, it was so hard and I did it," and be proud. Like, "It's hard. I don't even want to think about it," is more like it… I'm very lucky, really lucky… but then, is it worth doing all over again?… And I need a life…And like it takes… it literally knocked off three years of my life.* (3.2211)

Within the trauma discourse, distress is made space for within women's experience yet also silenced – because they are made to be lucky and because a subjective experience of gratitude is required to acknowledge their and their baby's survival. Dr Mangala constructs birth as hard, too hard to think about, which stops her from practically allowing herself to allow, proudly, her navigation of and agency in birth. Instead she takes up a passive, victim-

like position which removes her from the birth, her own sense of self and three years of her '*life'*. This practically affects her decision not to go through birth again – her life being set against that of a baby. This is a trope picked up elsewhere by the women – as if their own life has to be lost and experience of birth forgotten in order to make space for that of the baby.

The positioning of women as lucky is one that the women prolifically took up, particularly at the end of the focus groups when reflecting on what they would take away from the experience. They rested on the position created by the trauma discourse that they were lucky to have survived something so dangerous and risky, especially when others haven't:

> *How lucky we are. I mean we're here. It's, it's a life-threatening condition, I mean, you know. Um, we've all had complications, so it becomes even more so whereas normal childbirth maybe isn't life threatening. But people do this all around the world by train tracks, by whatever.* (Josephine, 2.2036)

Childbirth is here constructed within both a trauma and medical discourse – the two struggling against each other to furnish and diminish distress for the woman around birth. It is both dangerous but normally not-so, something done in less safe settings than a western health system, of which the women were acutely aware. This shows how difficult it is for a woman to carve out space for her own individual subjectivity whilst being positioned as lucky to have survived, and grateful to have the safety of the western health system. Subjectively speaking it allows for distress but at the same time silences it out of guilt given the construction that they (and their babies) survived – the implication being, that others didn't.

> *You have one life to live, and you can't live in a place that's dark and, because you're breathing and you're here and you have a baby or two babies and you have to keep going with life.* (Christina, 2.1928)

In this way, survival is forced on women, birth is a trauma to be endured, and women have to be strong and thankful: they are luckier than those who materially did not survive. A (clinically constructed) scale of trauma is therefore created within the broader discourses which makes women fiercely aware of how they are able to represent to others, and allow themselves, a sense of their own struggle and distress around birth. Sally highlights this, constructing how her birth experience (an emergency abdominal birth, in which her baby was

immediately moved to another hospital without Sally because of breathing difficulties) became an '*unspoken thing'* unshared with her friend, because her friend's birth was constructed as more traumatic:

> *At the same time as I had Jenna, about six weeks before, my friend, that I was gonna spend our time together with our new babies, she had a horrendous birth and nearly died, and the baby, well she's the same age as Jenna now but she's got a severe spina bifida. So I couldn't talk to her about stuff because she was in a dreadful situation with her child. I was just going to say but then if you're thinking you're having a bad time and you're a bit upset about your own traumatic thing and you know, I was worried about Jenna in the beginning, I can't really say, oh, you know, I had a bad time and I'm worried about this as well, but anyway.* (1.340)

That distress from a traumatic childbirth experience is pitted against other women's experience seems to be a product of a western, medicalised discourse, in which trauma is defined and set on a continuum, with death at one end of the scale and life at the other. What it does, as Sally describes, is limit talk about the individual's subjective birth experience – forcing it into a better or worse construct and therefore position for the woman. That women should consider themselves lucky because there are always others worse off, was a fundamental construct within the women's talk and, as Josephine describes, leaves women – out of guilt – without a voice, as she represents in her talk which trails off, unable to find the words to construct a valid expression of loss and distress relating to birth alongside concrete baby loss:

> *And I think some people still see it as an absolute trauma and are absolutely traumatised by it, and it's just about… We're sitting here with live babies, not the other way round. That would be even worse. I don't know how you deal with that until… I don't know how you move forward from that actually. Sorry, that's a bit too…*(2.1906)

Rather than difference in birth being embraced, responded to with curiosity and empathy, it is feared, as if there is not enough space for everyone to construct and experience birth as traumatic. A fierce awareness manifests that one woman's distress might invalidate another's, forcing women to stay silent, disempowered and apart from their subjective experience of birth. When Renata takes up the position of having been '*lucky'* to have lost her baby at an earlier stage in pregnancy than others, when Dr Mangala positions herself as '*lucky'* to have

had several keyhole surgeries as opposed to open surgeries when having her ectopic pregnancies removed, when Beatrice '*hesitate[s] to say that it (her ectopic pregnancy) was traumatic 'cause it wasn't at all compared to [Billie's] situation'*, their talk functions to disclaim the victim position for themselves in order to acknowledge the distress of others, but inevitably bestows that position onto another – and so the continuum of trauma, and its pursuit of survivor and escape of victim positioning continues – a delicate undertaking, which the women managed by remaining silent.

Talking about the birth experience postnatally is therefore tainted with responsibility and danger, endowing women with a potentially harmful and damaging power over others – sort of a discursive re-enactment of the culprit/victim dynamic effected within this discourse. Christina highlights how aware women are of the danger of talk around birth, leaving them with a subjective experience of guilt: '*Oh, am I gonna stop you from having a baby? Or maybe I shouldn't give too much'* (2. 1193). Zoe echoes this as she recalls texting friends about her experience, later worrying that she presented them with '*too much detail'* – the notion that there is an acceptable amount of talk and detail allowed for about birth which women have to gauge for themselves and conform to. What is left, is that '*nobody asks'* about the birth, and women struggle to talk about it, for fear of unsettling others, or worse, within a gendered and evolutionary discourse of not '*sharing too much because… they don't want to put people off'* (3.1668): talking about the trauma potentially elicits a more uncomfortable, guilt-ridden harmful position than that of the silenced casualty or victim.

As long as birth continues to be constructed within an action-oriented, (military) gendered and also medically construed continuum of trauma, women cannot come together and find solace in a shared but different experience of birth. Yes, in accessing the trauma discourse women are able to construct birth as significant for their subjectivity and afforded access to physical and emotional change, mess and distress, which the dominant discourses deny. But it continues to create a position of disempowerment - passive victims and casualties to childbirth with their bodies, hurt, wounded, and lucky to have survived. Women are, out of guilt, silenced from talking about their '*war'* and without the words to translate embodied birth experience into language.

The silence prevents '*healing'* talk about birth, instead keeping the emotion '*raw'*, unprocessed and stuck, as Leah notices, '*the emotions are still really raw, like, for everyone*'

(3.3227) even five years following the event. Disclaiming this, many women highlighted the potential for resistance, describing their experience of the focus group as a cathartic one: '*here we are, we're just talking and it's helping'* (Anya, 2.2122). The notion that '*just'* talking can do something to affect women's understanding and processing of birth, in its radical realization, reinforces how unspeakable and enshrined in secrecy birth is, set within stoic male, medical and military trauma discourses constructing birth as action and result as opposed to process.

3.5. Birth workers: The business discourse of birth

Broadly speaking, the dominant medical and natural discourses have been shown to objectify and homogenize women, and the trauma discourse, whilst recruited by women as a way of acknowledging the enduring fear, damage and distress associated with birth, requires much to be left unsaid. What is striking is how women turned to a different discourse (commonly at the end of all three focus groups), which constructs birth as a process to be managed according to public, political and institutional protocol, as a way, it seemed, of seeking to access a public voice and a means with which to resist the silence being imposed on them elsewhere.

The business discourse constructs birth as a process to be spatially, financially and legally managed in a way that seeks to avoid crisis and risk (mortal risk here linked inextricably to the financial and legal). Whilst this does not overtly imbue women with an agented subject status, analysis suggests that it is within the shifting, dynamic and at times contradictory subject positions that this discourse makes available to women – of workers, consumers, feedback receivers and providers – that the potential for public and political resistance might be discursively wrangled with. Furthermore, the gendered underpinnings of the business discourse – stereotypically associated with male, political and financial public power – offered women an anchor with which to identify a lack and therefore need for birth to be constructed as the opposite: a female emotional and relational process within a public, political forum.

3.5.1. Labourers

When birth is constructed as a business to be managed with limited amounts of resources, as the women repeatedly described of the NHS, women's choice and agency in birth becomes

constructed as unimportant. Choice, and what women are allowed to know about birth is actively controlled and filtered by the institution in line with its own needs and preferences. As an example, Sophia explains the normalization of vaginal birth within the business discourse, it being made the cheaper option for the NHS compared to the more financially costly abdominal birth:

> *I think, and actually the research, if they did give you the real research, it says yes, if you have a, a risk free, no problems childbirth, of course it's the ideal. But a planned caesarean is much better than an emergency caesarean so actually there's, so in some ways like, I almost feel it's equitable to... the NHS just doesn't want to say planned caesareans are A-OK because everyone will want one and then they have to pay for them.* (Sophia, 1.537)

Within this discourse, women are made to toil, to literally labour, in birth when it acquires a construct as cost-effective. Their personal choice, knowledge and agency in birth becomes controlled and obfuscated by the more powerful health system, the NHS, within the business discourse. Women were positioned as moveable labourers to be juggled according to systemic logistics, widely reported when women talked about being prevented from being admitted into the hospital or of not being allowed into the Birth Centre because of limited space, or of being denied pain relief because of the limited availability of an anesthetist.

Beatrice shows how this dehumanizes women, made workers within a bigger '*system'* – and reveals how this affects not only their capacity for practical birthing options, but also has significant ramifications for their sense of subjectivity. Here she disclaims her own mental distress because of the lack of provision available to her in relation to prioritized risk – the baby's needs trumping her own in this emotion-less discourse.

> *It's not perfect I guess. We're working in a really imperfect system but there was a lot of care and attention there when they had the time but I had to just accept I'm just not a high priority in this situation and that baby is. And actually, I guess that's okay even though I'm going mental.* (1.1251)

When resources are constructed as being stretched, the woman and her needs other than that of basic survival are so reduced they become lost: women are positioned as faceless workers,

producers of babies, to be managed within a system laden with its economic and resource-based issues.

This is made particularly manifest by Kleio, who, in comparing her birth experience in a very different (private) health system in Greece, constructs the unique organizational context of the NHS as having objectifying and emotionally compromising consequences for the birthing woman. She imagined it would constitute a subjective feeling of being unsafe and distressed postnatally, which Christina and Anya concur with, resigned to limited choice and agency because of economic and management-related demands:

> Kleio: *I felt very safe and I didn't, that didn't allow me to feel bad about anything, er, but now that I'm here, I have to be honest because I hear how things are. I would've gone for therapy in the UK because I can't handle, you know, going into giving birth here. I don't know, it doesn't feel very, you know, safe, you know, who is this person.*
>
> Christina: *But they may be coming to the end of their shift.*
>
> Anya: *Yeah, so that's what happened to me… You know, like the anesthetist is obviously is off somewhere else with someone who's more serious than you. Like I guess we're all used to that, that you can't have a, you can't have your epidural if your anesthetist is busy, so you have to be prepared that at the point you think you need it there may not be an anesthetist around because the woman down the corridor is using that.* (2.1968)

The birthing woman becomes a labouring object to be surveilled, physically fitted in and managed – a collectivizing, dehumanizing position. This is further claimed in both Josephine and Christina's talk when they described having to sign a '*waiver'*, a contract, in the birth process itself, constructing birth firmly within business's legal discourse as something which is risky, carrying with it an element of blame and responsibility. The NHS is positioned as a powerful establishment to which the individual woman, as a labourer, has to contractually submit.

Drawing on this discourse and its subsequent positioning functions as a way of allowing the women to express anger – an attempt at resistance – at their helplessness and the silencing

effect this contract has, designed to prevent them raising claims of negligence. This brings up the dilemma of consent and agency in birth. It seems that women are being pushed into a position of having to consent to be operated on, induced, or intervened upon without fully knowing what that consent entails and without any other option. As Christina describes, given this legal pre-requisite, should the woman refuse to sign, the responsibility (for harm or death to the baby or woman) is put on to the woman herself and blame is averted from the medic, the hospital trust and the collective body of the NHS:

> *So I went from kind of no pain relief, absolute exhaustion, to complete shaking and, and they wanted me to sign a, a waiver form, um, if they needed to do an emergency and I just turned to the midwife at that point and I said, "Surely me, um, voluntarily walking into the hospital means I'm giving you consent to do whatever is necessary to take my baby out," and I, and they needed me to sign this, this form and I physically could not, as they're, you know, dragging me into the room and prepping me.*
>
> *And I just, that part I found really clinical and, and I, I understand because of, you know, they need to stick to, you know, their own, covering their own backs and the safety and, you know, in case of, um, you know people suing and everything else. But I, I just, it took that kind of humanistic point out of it of, you know, "this is survival right now and you're making me sign a form." Um, and that's always just stuck with me and actually, some of the other timelines of actually the contractions and everything you forget about but that was something that was very clinical and very much a point.* (2. 400)

Christina constructs this as a significant exchange in her birth experience. She positions herself as an object here, being dragged into theatre and prepped for surgery, physically unable to sign the '*waiver'* – a contract she constructs as waiving her rights to subjectivity. This construction functions to show the agency fix she sees herself in – needing and wanting to consent to the medical professionals acting to save her baby but having to relinquish agency and power through the silencing effect such a contract demands. She constructs it as '*clinical'*– a tick box procedure which functions to '*cover the backs'* of the medical professionals against potential negligence claims and in direct opposition to something '*humanistic'* which engages with the woman as a subject.

What is interesting here, is that women's recruitment of a clinical, uncaring, business discourse to construct birth as objective risk management is drawn on to afford women with an authority to disclaim it, thereby locating a deficiency and a lack in the existing institutional provision. Positioned as an objectified, contractually obliged worker, the potential, through second order positioning, is created and, as Christina showed above, women were able to establish the need to be positioned as a whole, agented emotional subject in birth. This brings with it the potential to access a discourse which constructs birth and its consensual, agenting aspects, as a deeply emotional and relational process for women, as opposed to an emotionless business transaction.

This speaks to a stereotypically gendered discourse of male objectivity versus female subjectivity, as Josephine recruits in describing a friend's postnatal situation. She constructs the legal consequences of her friend's difficult, risky birth as a male '*macho'* exchange of power, which is set in direct contrast to birth constructed as full of female emotion:

> *They ended up suing the hospital, NHS, and it became very macho and legal and medical for years after. And basically she was going through depression. She had a hard time and she didn't have any, I'm not saying it needed to be feminine help but sort of maternal, or supportive help. It just became immediately, "We can't speak to the hospital because now it's a law case against them".* (2.1059)

When birth is constructed as risk within these legal, clinical, actuarial components of the business discourse, Josephine demonstrates how the woman is removed from the birth, rendered powerless and silent – an individual woman proving little match for a huge organization such as the NHS. Josephine resists this, using her talk to disclaim the reduction of women and birth to evidence, advocating for her friend to construct and therefore process the birth as a (female) emotional process. And whilst her talk functions to indicate the difficulty of mobilizing and voicing a female-subjective discourse against the weightier public '*macho'* business one, it nevertheless allows Josephine a way of introducing it into public discourse and stating the need for emotional support for women postnatally, by identifying its lack.

3.5.2. Consumers of birth

Analysis of women's talk who opted to birth outside of the NHS, either paying to go privately, or who birthed outside of the UK in countries in which paying privately for birth was standardized practice, highlights how the healthcare systems in which women birthed directly affected their positioning and experience. For those birthing privately, the business discourse promises (although doesn't always deliver) a position of consumer – which offers the potential for more choice, power and control in birth (the flipside of which reinforces that those birthing in the NHS are birthing for 'free' – which produces a disempowering position making women grateful and less able to construct birth according to their own subjective need).

Out of the women birthing in the UK, Billie was the only woman to elect to have a '*private'* (paid-for) birth outside of the NHS. She demonstrated how the tensions implicit in the positioning of a consumer of birth is a complicated one. Private birth was constructed as a privilege and in its desirability, something that is subsequently envied in its unavailability to the masses. As Sophia put it, *'I would have liked to go privately, but that's not going to happen for me'* (1.362). Billie took up the position of consumer as she described herself as '*too posh to push'*, posh here signifying wealth and choice to birth both abdominally and in a private setting, yet her self-deprecating humour and heavy justification for birthing privately, however, suggests such a position elicits subjective shame and guilt:

> *I didn't admit I had a choice and I didn't say I was going to a private hospital initially…, I felt like, to be fair, it's because we moved back from the Middle East so I had private health insurance. So, you know, for me to not have come and spent money I could have spent in the private hospital… Again, for me, from a control perspective, I was like, "Why would I not do that?" But again, to be fair, those same women, by the time I gave birth, I did tell them that and they were actually... but again, it's kind of in my mind. I thought I, I don't want to be the one in the room that's not in it, you know.* (1.104)

Here, money, and being able to pay for birth in a private unit is equated with '*choice'* and '*control'* against risk, both of which are constructed as something Billie is uncomfortable sharing publicly with other women, subjectively ashamed and silenced – as if money, power, choice and agency for women in the context of birth is frowned upon. She utilized the

business discourse to access agency in birth, but at the same time that choice and control was considered luxurious, a commodity to be bought, not afforded to the majority, and essentially at odds with the idea that a woman should suffer, naturally, in birth.

When women do achieve the position of consumer with money or, as Anya described, by intellectual capital through clinical persuasion, there is a clear and positive implication for subjectivity – elective abdominal birth affording a difference of '*night and day'* as Anya poignantly constructed it, or preventing Billie from being '*ruined'*. Being afforded a position of consumer therefore, is about more than mere choice around practical birth type (vaginal or abdominal, private or NHS), and desirable in the implications it has for a woman's individual subjectivity, of being able to construct their need to feel safe, agented, and interestingly, cared for.

Part of what the consumer position offered the women, analysis showed, was the promise of access to a consistent relationship with a medical professional. This was different and denied to women birthing in the NHS, bestowing upon women positioned as consumers, theoretically, a subjective experience of safety and control, which Billie tallies with a sense of being held in mind:

> Billie: *'Cause in my mind I'm like, "I like you. You're my safety thing. It needs to be you." And then he, I don't think he quite, he was like, "Well, you know..." 'cause I was saying, "Well what happens if it's, if I, you know, go into labour?" He was like, "Well, you know, it probably will be me but, you know, there's a couple of days where it might be my relief person, who's perfectly capable." And I'm sure that would be fine but I'm like, "No, because I, I want you," like, you know, "I have this relationship with you and that, you're the person who's making me feel like this is all gonna be fine." And I don't think he really got that, as nice as he was because they probably don't, you know, they're just looking at it through a different lens…*
>
> Beatrice: *I wouldn't recognise the woman who did my c-section. I mean she's lovely and we had a nice chat but, um.*
>
> Billie: *Because presumably it was kind of allocated based on whoever was around.* (1.2039)

Billie's talk here is dilemmatic, functioning to show how the business discourse both makes available yet also disallows a position of consumer for a woman, when what a woman wants is constructed as a personal relationship with a professional. When birth is constructed within a business discourse, as a process to be bought and managed efficiently (yet unemotionally), skills are pitted over and above subjectivity and the promise of agented consumer positioning for the woman is lost – irrespective of whether they paid for it or not. And so, whilst Billie disclaims the potential to ever achieve a true position of consumer in birth, what is important is that she is able to construct, in her recruitment of the business discourse, the absence of what she crucially wanted as a consumer and would have helped her feel safe in birth: a relationship in which she felt prioritized and positioned as a whole, emotional subject.

This is something Kleio and Christina further highlight when they both strikingly apply the word '*love'* to describe the relationship between the birthing woman and her consultant specifically in non-British birthing contexts. In doing so, women's use of the business discourse which constructs birth in the UK as impersonal business is both highlighted and resisted:

> *Um…friends who get, er, have birthed in the States love their doctors and, you know, they, they have all their kids with the same doctor and, and they're sending them Christmas cards and there's all of this. And that was the bit that I found really alien, so the after bit, you know, when I'd kind of accepted it all. It was a, "Thank you, I'm here and I'm grateful that I'm here and my baby is healthy and fine." And, and I didn't even know who to write a thank you card to, um, and so I just wrote it to the hospital but it was that I don't even have a name… And I had a really good anesthesiologist and actually it was a nurse that stitched me up because the doctor did it wrong and then they had to undo it, you know. But it was that kind of acknowledgement that there was someone who did a really good job and, and I think that maybe would have made someone's day or that but it was just so far removed from, yeah.* (Christina, 2.2008)

Christina's talk functions to highlight an inherently different birthing system in the US and construct a lack, by comparison, in her own experience in the NHS: a loving family relationship with consistent relational contact for the birthing woman is *'far removed'* from her experience of birth, constructed here as a botched job with herself positioned as a de-humanised object on to which the doctor, anesthetist and nurse all applied their different

skills. She described wanting not only to form a personal connection with somebody involved in the birth, but also to thank them and acknowledge the '*good job'* done to her, which is interesting in terms of the position that might facilitate for the woman. Thanking someone for doing a good job involves an element of evaluation, and that feeding back to the other produces empowerment. She is denied this because of the facelessness with which the system is required to operate, rendering her silent, unable to speak of wrong-doing or issue thanks. Instead, she is left hanging in limbo without a way of acknowledging and making sense of her experience subjectively – as her unfinished sentence represents.

3.5.3. Feedback provider or recipient

A need for a more balanced relationship through language about birth, between women and those working within healthcare systems, is evident in the women's talk, and was widely reported as being denied to women – as Christina expressed above. This was accounted for in the women's talk by a lack of available resource, its absence explained because of '*well, staff, the same thing isn't it? Not enough resources'* (Renata, 3.3134).

All three focus groups, towards the end of the sessions drew on the business discourse to raise the lack of, and need for, a '*debrief afterwards, with the professionals… to try and makes sense of it and see if anyone could give me any answers'* (Zoe, 3. 3099). What this means for women seems to involve a dialogue with medical professionals, a fluid exchange of power and knowledge about the birth experience within a public space, which, as Zoe constructs, might make the experience real, understandable and validated for the woman, as well as contributing to systemic change for the healthcare system, as Leah states: '*the crazy thing is that it will actually help the medical staff as well…. because they would get some feedback on how they performed'* (3.3135).

It becomes clear that women construct a desired debrief as a means of allowing them, more than the medics, to feedback on the birth and the medics' performance in birth. Renata described the feedback she got from the midwives as nice but falling flat – discordant with her experience and somewhat generalizing, untailored to her, noted in her adoption of 'we': '*they all said we did really, really well. And I was like, really? I was screaming, I was swearing… I don't feel like I did well'* (3.631). What she wanted, as she later described, was to have the opportunity to ask the question which had since stayed with her: '*why did you make me push when I wasn't at the pushing stage?*' (3.1370). Women are afforded, within

the business discourse of birth, the position of feedback recipient, but the opportunity to speak, to feed-back and ask questions – to have a public, accountable voice within the healthcare system from which they might obtain a much more powerful and agented position – is being denied.

Women conflated this lack of debrief with an inability for them to understand and process what had happened in birth physically and emotionally. It was as if, without being able to construct birth in a public, official space where experience might be documented and verified, birth took on an unending and intangible construct for the woman – left to deal with the emotional and psychological mess and distress silently and alone. As Zoe stated, a debrief might have afforded her '*a bit of closure at that point … to just not dwell on it in my own mind so much'* (3.3111).

Billie described how a lack of talk or debrief with medical professionals following her ectopic pregnancy prevented her constructing it, and so subjectively experiencing it, as loss. This disallowed her from understanding how very seriously and clearly such an experience impacted her subsequent birthing choices. Talking in the focus group about her experience led her, very emotionally, to '*realise something when people were talking earlier that [she] had never realized before*' (1.1618), which functions to highlight just how lacking, and how important talk about the birth is postnatally:

> *And you know, it was just, you know, you go from I'm not pregnant but I'm healthy to someone saying, "You are, you're pregnant, you've lost it, you know. Actually you've lost a fallopian tube. You might lose both fallopian tubes and actually nearly died." In hours, you know, so in retrospect of course that's going to impact, you know, the birth that you then have but I really didn't think about it so. But to be fair, and maybe that's why I ask the question, no one, he, my obstetrician didn't think to say "that was obviously quite traumatic and do we need to, is there anything we now need to factor into what, you know, what we're doing?" That was not in any way referenced at all…. So I think to be honest, I hadn't actually realised until today that I think the reason I couldn't possibly go through a natural birth is because of the fear of something happening*. (1.1729)

The lack of public talk, a procedural debrief, following both of her birthing experiences, prevented her from making a link between the two, and from constructing the first as a

'birth'. Talking in the focus group, and using the business discourse to construct the (lack of) procedures in place, allowed her to transform the construction of her elective abdominal birth as one in which she earlier positioned herself (detrimentally) as '*too posh to push'*, to something she needed because of her traumatic ectopic pregnancy, which had instilled in her an embodied *'terror thing'* for '*childbirth or anything gynecological'*. Talk within the group allowed her to make sense of her act through a different, more agented and emotional lens. Had the obstetrician, shaped by procedure within the healthcare system, acknowledged the need to situate her subjectivity centrally, the implications both for her practical decision-making and ensuing subjective experience may have been very different.

Analysis seems to indicate, therefore, that women used the business discourse as a way of trying to bring their construction of birth into the public forum and dynamically negotiate positions which afford them more and different aspects of agency in birth. Whilst women struggled, within this discourse, to position themselves as agented subjects given the objective pragmatic construction of birth as an impersonal business, something to be financially, legally and practically managed, the positional dilemmas it produced seemed to afford women to 'consider other forms of self' (Miller, 2008, p.265). This seemed to provide women with a (transgressive) way of mobilizing the potential for an alternative discourse constituting birth as an individual emotional and relational female-subjective process.

4. Chapter Four: Discussion

4.1. Overview

I firmly believe that during childbirth a woman can enter a new dimension of existence, where the film between life and death is at its most fragile. During labour, I feel I've been given the extraordinary privilege of entering a strange place that's not really of this world, but a region somewhere on the periphery… It's not that I don't find it incredibly painful and frightening — of course I do. But I believe that, in the modern world, we lead overly sanitised and cosseted lives. Most of us have no experience at all of the extremities of human existence. (Stroud, 2016)

I ended Chapter One with the intention to trouble the 'unsaid' of birth and an absence of a female-subjective discourse constituting birth in postnatal women's talk. Analysis showed how different discourses are drawn upon by women, which produce certain fragmented aspects of birth, positioning women multiply in an 'array of subject positions' (Parker, 1994, p.245), which influence and often limit their potential to experience birth more fully (for example, when positioned within a medical discourse as a passive, objectified body, women are unable to construct, and therefore experience, birth as an emotional or psychological process). Whilst the hypothesised lack of a female-subjective discourse feels well-supported in the data, it was in identifying the dynamic way women claimed different positions within and between discourses (Parker, 1992), which seemed to signal their dissatisfaction with, and the potential for resistance to, the status quo of how birth is currently being constructed and experienced.

It was in exploring what could and could not be gained by women from those multiple positions that brings the potential for an alternative discourse on birth more clearly into focus. This raises the hope that a discourse which might embrace the power, liminality and complexity of birth, in which the birthing woman and her subjectivity are centrally situated, as evoked in the writings of author Clover Stroud (2016) above, might be brought more loudly into public discourse, which as analysis suggests, is currently being excluded by dominant discourse.

4.1.1. Summary of analysis

Predominantly, women drew on a totalising medical discourse to construct birth as a physical process of and on the pathologized female body, which needed to be medically managed and made safe. Given this, women assumed disempowering, subjected positions of material, passive and even dangerous 'birthing bodies', vessels for the delivery of a live baby. The medical discourse, which offers safety and control by detecting and averting risk (for the baby), was shown to be a difficult one for women to resist (Scamell, 2014), as Foucault's theory around the relational interplay between biopower and the 'docile' body foregrounds (1978).

Because the natural discourse emerged in binary opposition to the medical (as traced genealogically), it is perhaps unsurprising that a similar positioning of 'bodies' was also made available here. Positioned as natural birthing bodies, designed and destined to birth, women's fears around something going 'wrong' could, similarly, be assuaged within this discourse and transferred onto a more powerful other (Mother Nature in place of medical knowledge). It was a discourse drawn upon to offer women an agency in birth denied by the medical discourse by constructing it as a female process which needs no medical intervention. But analysis revealed that women were denied just as much access to agency and choice, or ambivalent emotional experiencing of birth when positioned as 'birthing bodies' by the natural discourse as they were by the sanitising medical discourse. In both cases, the expectation for women to bounce back and recover after the (physical, bodily act of) birth, was clear.

Women were shown to respond to what was disallowed by these dominant discourses by recruiting a military trauma discourse, which allowed them to access more difficult aspects of birth. Through this they could construct birth as physically and emotionally distressing, which effected ongoing change. But against a discursive landscape in which the birth of a live baby and the act of becoming a mother is widely constructed as a happy gain/medical success (as opposed to subjective, messy loss), women were limited from recruiting this discourse overtly and with agency. The need to keep the shameful mess and distress a secret produced disempowering positions for women as casualties, victims, or (material) survivors of birth, left to lick their wounds alone and carry their trauma with them silently.

To access positions which might afford them a public voice (denied when positioned as bodies or fallen victims), women interestingly turned to the business discourse, which constituted birth as a process to be managed according to political, financial and legal protocol. Women were shown to dynamically claim positions (labourers, consumers, feedback providers), which at times were in tension with each other, in a bid to disclaim birth as the objective, unemotional business this discourse made it into. In identifying, and being able to publicly voice their dissatisfaction with the way birth has come to be constructed, and what could not be experienced from the available positions within this discourse, women seemed to locate the potential for an alternative construction of birth to be made real – as an emotional and relational process.

Not wanting, however, to trim the analytic findings down to 'neat, coherent and tidy "themes"' (Chadwick, 2017, p.132) and risk mirroring the way dominant discourses have come to constitute separate aspects of birth reductively, I will use the discussion to reflect on and trouble the questions and discontinuities emerging from the analysis and in conversation with the genealogy, that I have been left with.

4.2. What and why are certain aspects of birth still being left 'unsaid'?

The analysis echoed the premise, '*Nobody Told Me'* (McNish, 2017) discussed in Chapter One, which suggested that certain aspects of birth are being prevented from entering into public discourse: '*nobody had told me'*, '*nobody asked'*, '*nobody speaks about it'*. Coupled with this, was the women's explicit awareness, embedded within the data, of their responsibility as discursive agents. The power ascribed to talk about birth seemed to render women uncomfortably guilty, dangerous, and harmful. To manage this, woman were seen to recruit (safer) dominant discourse to construct birth or else, compliantly, police their own talk about birth, which as Kleio shows, limits what can be known: '*They tie you up. Do I need to know this information? No. Do I tell others about this in a c-section? I'm not gonna say that.'* (2.607).

Women repeatedly expressed fears (and guilty regret) about having said '*too much*', '*oversharing'*, or giving '*too much detail'* (2.1193; 3.1668) when talking with others about

their birth experience, as if there was a need to decorously construct just enough of birth. In this way the discursive dynamics of the dominant medical and natural discourse which were shown to constitute birth rigidly (e.g. vaginal, without pain relief, in a hospital) bled over into the act of talk itself, and the boundaried self-policing of talk about birth by women became normalised.

Talk about birth was endowed with such a power for the women, that going beyond what was discursively constructed as acceptable or enough (as opposed to '*too much'*) had the potential to literally construct an (unspeakable) reality for another, leaving Christina fearing, '*Oh, am I gonna stop you from having a baby?*' (2.1193) and Zoe worrying that her talk might literally '*put people off*' (3.1669). Similarly, there was a sense that constructing certain distressing aspects of their own birth would invalidate, even eradicate, the experience of another, which led Renata to construct her own stillbirth as one which was not as distressing as others', and made Beatrice '*hesitate to say'* her own ectopic pregnancy was emotionally traumatic, when compared to Billie's.

Talk about birth was shown to be actively and powerfully disallowed both in public, institutional spaces as well as a private ones. Josephine indicated the threatening legal and financial consequences of talk about birth to show how it was shut down by the business discourse, '*we can't speak to the hospital because it's now a law case against them*' (2.1059). And the women across all groups highlighted the desire for and yet observable lack of space for talk about birth, '*a debrief*', within a hospital setting – constituted by the overlapping medical and business discourses. For others, talk about birth in a private space was also prohibited, all of which highlights the discursive need to end talk about birth once the act itself is over: '*I found that I would keep talking to my husband about it, but he was like… "Let's stop talking about it now. It's done. It's done. It's done."*' (Zoe, 3.50).

There is the sense then, that through the act of talk, women's experience of birth was required to be limited, made socially acceptable, and ended once a live baby has appeared. This has many implications, but what strikes me most is the way it produces a double bind for women positioned within a gendered discourse. Maintaining a silence about certain (difficult) aspects of birth simply reinforces the stereotypically gendered notion of women as weak and vulnerable – unable to handle and hear the distress or gore of birth. And yet it is only through

that stoic silence (a refusal to be positioned as the noisy, emotional hysteric (see Appignanesi, 2008)) that a gendered discourse allows women to signify their strength and fit for motherhood. Within an implicit gendered discourse, spanning the way birth has come to be variously constituted, actively policing their talk and maintaining a silence about more difficult aspects of birth is perhaps the only way for women to resist being made deviant.

So what is it, exactly, that is made to be so fiercely self-policed by women, that risks breaking the discursive boundary between enough and '*too much'* in their talk about birth? I referenced Julia Kristeva in Chapter One, who openly acknowledged that childbirth is not much talked about (Enright, 2005) and suggested a lack of available discourse on the complexities of motherhood (Kristeva, 2005). I have sought in this research to show that a discourse constituting the complexities of childbirth, too, is lacking. But it is Kristeva's theoretical framework which explores the relationship between corporeality and discourse which might offer direction here, when considering the women's widely reported pressure to keep talk in following the birth, as an interesting inversion of the act of birth itself in which a baby comes out.

Chadwick (2018) used Kristeva to argue that fleshy birthing bodies should be considered as discursive entities in themselves (telling and performing stories). My poststructuralist leaning, together with the notable absence in the data of certain aspects of birth, specifically the stark lack of internal bodily process, female genitalia and sexuality, and the gory viscerality of birth, finds purchase more in Kristeva's notion of the abject (1982). Kristeva proposes, 'it is not lack of cleanliness or health that defines abjection, but what disturbs identity, system, order. What does not respect borders, positions, rules. The in-between, the ambiguous, the composite' (1982, p.4). As Rizq (2013) expands, abjection can clearly be linked to the 'construction of the speaking subject and his or her relationship to culture and language' (p.1281). With this in mind, I suggest that it is the powerful, messy, un-boundaried liminality of birth which is made to be unsaid, abjected from women's experience. This is necessary, in Kristevan terms, so that the natural order of things (women's corporeal boundaries and sense of self) as dictated by historically and culturally constituted dominant discourse, can be maintained and social order restored when a healthy baby (constructed in social discourse as joyful) is born.

More than just '*disgusting'* or '*gross'* then, the visceral, liminal space of birth might be said to be abjected in women's talk, made 'monstrous' in Foucauldian terms (2003b), because such constructions are completely at odds with the dominant normalising construction of woman, mother and femininity. And also because, I tentatively venture, the abjected aspects of birth, if made 'real' through discourse, will only serve to highlight childbirth as a powerful act which, in its visceral difference, is inaccessible to men.

Highlighting the function of the unsaid in birth might make more manifest the relationship between power, discourse, knowledge and practice around birth, so that the subjugated aspects of birth currently being produced through dominant discourse might be reconfigured. This might enable women to construct, experience, and come to know birth differently. And mean that women no longer have to keep secret (and so encounter for themselves unprepared) experiences such as being physically bound to a bed (Kleio), vomiting in birth (Billie and Sophia), wading through blood clots (Josephine), and the edges of loss in birth (Dr Mangala) – for fear of disturbing or harming others, feeling shame, and disrupting the (gender discourse's composition of) natural order. It might also afford, in encouraging diversity and complexity in talk about birth, more empowering and joyful aspects of birth – which Leah described as being similarly silenced – to be constructed.

4.3. Has childbirth really progressed?

If the messy, murkier parts of birth continue to be secreted away from public discourse, the question of whether childbirth has really moved on since early-modern times naturally follows. This feels an important question given the recent reports which show women continue to die in (and following) birth (Knight et al., 2019), at rates which remain discontinuous with the medical discourse's promise of progress and safety (Scamell, 2014).

The genealogy illustrated that historically, dominant discourse has long required birthing bodies to be kept hidden from public sight, returning acceptably to public life only when their 'foul liquor' (blood) (Sharp, 1985) had stopped flowing and a symbolic mark of restoration to social and domestic order could be made (Paster, 1993). This foregrounds and indeed mirrors what analysis highlighted as a socially constructed norm, in which dominant discourse constructs birth as something women bounce-back from, physically and emotionally, perhaps

with a '*digestive biscuit'* to speed recovery. That women need to be reminded to use contraception six weeks after giving birth, as Leah recalled her GP's warning, implies that women are, after the act of birth, made to be mentally and physically returned to their non-pregnant state, ready to fulfil their procreative duties.

Women's construction of pain, too, seemed to reinforce the notion that birth continues to be constituted by archaic gendered discourse. Analysis showed how pain was constructed as a necessary aspect of birth, and one that should be suffered stoically, just as the Bible stipulated (Good News Bible, 2014, Genesis 3:16). Women constructed pain relief as difficult to access: logistically, anaesthetist availability was normalised as being limited, and even when the resource was available, women constructed only a small window in which an epidural might be administered – Renata described being refused an epidural during her stillbirth because it was medically pronounced '*too late'*. The women also constructed asking for and taking pain relief as morally compromising, which positions women who are weak and unable to endure the pains of birth as dangerous anti-mothers, as Josephine described of herself, '*all the Pethidine in my, off my tree, thinking I might even drop him [her baby]*' (2.131). When birth has long been prescribed simultaneously as both women's destiny and yet (painful) punishment to be suffered for women's sexuality, the curse of Eve, it is understandable, nevertheless remarkable, that women's choice and agency around receiving pain relief continues to be so dilemmatic and closely tied to gendered discourse.

The way that women repeatedly constructed such dilemmas around pain relief through a male lens in the analysis points to the enduring power dynamics implicit in the gendered discourse which requires birth to be painfully suffered by women, so that they might remain 'vertuous' (Sharp, 1985, p.170). Anya described her husband's taunts, '*you're just going to be begging for that epidural*'(2.216), Josephine '*hoped'* her husband '*thought I was good and strong and didn't object to me with the pethidine request*'(2.1050), and Renata described saying to her husband, after her birth, '*Don't **ever** let me not have an epidural again'*(3.623). The construction that pain in birth might only be relieved by the permission of a more powerful male other, seems as embedded within contemporary social discourse as it did centuries ago.

When set against a dominant medical discursive backdrop which has come to normalise practices and technologies of birth as progressive in their capacity to detect and avert risk and offer women enhanced choice (Johansen et al, 2002), the idea that women are still expected to suffer in birth seems discontinuous. This forces us to question, rather than overlook, the implicit, entrenched and pervasive discourse of gender which underlies and seems to span the social discourses constituting birth today. A clear dilemma is presented to women: to resist being positioned as weak and immoral, the birthing woman needs to show strength in the only (unagented, disempowering) way allowed for – by enduring the pain of (natural) birth.

As analysis showed, this perpetuates the strong/weak, male/female, natural/unnatural, oppressor/oppressed binaries prolific in talk about birth, leaving women struggling to access a more agented and empowering position. To draw on a different, psychological discourse, however, might offer the potential for women to construct and reclaim 'weakness' in birth differently, which might have alternative implications for women's subjectivity. In considering weakness psychologically, more as a vulnerability constituted by deep emotional and psychological need (Jordan, 2010), it may provide a way for women to sidestep the (negative, limiting) positions that the implicitly gendered discourse affords them of being essentially and stereotypically (female) weak and inferior, or needing to disclaim that with a show of (male) strength.

In doing so it may, I suggest, facilitate the potential for an alternative discourse in which women's physical and emotional vulnerability in birth is not constructed as a deficit which needs to be ignored, got rid of, or controlled by a male or medical other, rather explicitly held up in discourse so that it might be responded to. Birth might, therefore, be more able to be considered as a holistic, powerful process, in line with Stroud's (2016) evocative description of birth as when '*the film between life and death is at its most fragile*'. Within an alternative psychological discourse of birth, women might be afforded access to positions in which their experience and subjectivity is centrally located – held firmly in mind rather than discarded, as the dominant discourses have been shown to produce by constructing birth as an event important only in its capacity to produce a live baby.

4.4. What might an alternative construction of childbirth look like?

In Chapter Two, I argued for the need, within social constructionist research, to not only describe and deconstruct the discourses constituting birth, but also to go beyond that and suggest how, morally and politically, things might be different or better. In venturing that birth might be re-constructed from within a psychological discourse as a powerful physiological, emotional *and* subjective process for the woman, I see a potential for women to come together through their many and different experiences of birth, rather than be kept separate and silenced.

When Kleio and Christina both, strikingly, recruited the word '*love'* to contrastingly describe the relational experience available to birthing women situated in healthcare systems outside of the UK, they seemed to be making space for a discourse which is able to constitute, and allow women to experience, the process of birth as one in which women's emotional needs are foregrounded. Billie echoed this, when she constructed a need for safety in relational terms with her consultant (compared to his skill based construction of safety), and Beatrice, too, as she tentatively expressed that the medics could have '*thought maybe a bit more about [her] position'* (1.2147) rather than just getting on with their '*job'*. Interestingly, it was in dynamically navigating the tensions arising in the emotion-less positions that the objective, pragmatic, skill-prizing business discourse afforded the women, that they seemed able to consider other more emotional and subjective forms of their birthing self (Miller, 2008).

Darra's (2009) recommendation for breaking out of the rigid medical/natural dichotomy of birth, to find a framework of 'being with' women in birth, noted in Chapter One, comes to mind, and might offer helpful direction. It provides a potential for disengaging from the entrenched, inescapable binaries which have historically come to constitute birth – medical/natural, good/bad, success/failure, vaginal/abdominal, with pain relief/without – and instead make space for a discursive focus on birth as a process for the woman, as well as an act which produces a baby. To orient the practice of birth more towards being with, rather than doing to, the woman feels valuable and new, and might provide more agented ways for women to practice birth and approach, rather than avoid, talk about how the many and complex aspects of birth shape postnatal experience.

Of course, in imagining an alternative (psychological or female-subjective) discourse through which birth might be constructed as a complex emotional, relational and physiological process for the birthing woman, it is important to acknowledge the ways that this might limit or constrain those positioned within it – as is inevitably the case with any discourse. There is a risk, perhaps, that in making more space for the messy, distressing liminal space of birth, that the more joyful or enjoyable aspects of birth might be made less accessible to women. Or that in constructing birth as a relational process in which the birthing woman needs to be seen, heard and held in mind, women might be denied therefore a position from which to (more empoweringly) construct having birthed, or done birth, by themselves.

4.5. Positioning the work in relation to existing knowledge

Relating this study to existing literature on childbirth is tricky because, as the literature review reflected (and the analysis supported) specific discourses (e.g. medical, natural, psychiatric, feminist) tend to produce and so represent in research, fragmented aspects of childbirth. For example, existing research has tended to focus on specific birth experience – be it traumatic (pathologically defined, e.g. Grekin & O'Hara (2014) or perceived, e.g. Rodriguez et al., (2019)), or type of birth (homebirths or elective abdominal births (Chadwick, 2009)). Little research, if indeed any, was found in the literature search (despite general search terms used) about how (non-specific) birth is described, constructed, or talked about in everyday settings in the UK and how that might link to women's subjective experience, postnatally. This echoes the genealogical findings which suggest birth has been made to be normal (and unworthy of attention) or abnormal (pathological, risky, new-age – depending on the discourse in question). And whilst discourse analysis has been used to helpfully consider the power operations involved in how dominant discourses come to constitute birth (e.g. Newnham, 2016), to my knowledge, there has been no study which utilises FDA to explore the macro-micro dynamics linking dominant discourse with women's talk. This has produced something of a gap but also provides this research with an opportunity to understand how and importantly why women are constructing, or struggling to construct, birth in the way they are.

For example, recent psychological research has sought to make more explicit the links between childbirth and postnatal experience (e.g. Grekin & O'Hara, 2014; Bell & Andersson,

2016), but its reliance on quantitative methodology and the implicit psychiatric categorisation (PND, PTSD) makes (limiting) presumptions about women's subjective experience, and disallows a more complicated construction of distress in relation to childbirth. And whilst qualitative psychological research has helpfully expanded out from clinical diagnosis and categorisation into, for example, how women perceive trauma in childbirth (Rodriguez et al., 2019), the trauma under scrutiny here continues to be constituted by psychiatric discourse. This has, I suggest, limited researchers' interpretation of, and women's access to, alternative ways of constructing birth. Analysis in this research, for example, found that women drew more prolifically from a gendered military, war-like trauma discourse to communicate emotional or psychological distress and change ('*like a bomb going off*', '*it's like coming back from the war'*), as opposed to a psychiatric one.

Qualitative research has valuably sought to explore women's experience of birth using predominantly narrative methodology (e.g. Thomson & Downe, 2012; Chadwick, 2009; 2018). This has focused on the embodied experience of birth, and how birthing bodies (when presented as risky, heroic or comic, for example) can subvert normative narratives in the dominant (biomedical) storylines. Chadwick's work on birthing women in South Africa (2018) argues that is in the researcher's capacity to listen for 'excessive' moments of talk about birth in which 'fleshy bodies are key to hearing moments of resistance', and that it is through 'fleshy eruptions, birthing bodies spoke back against erasure, telling pleasures and distress as embodied enactments' (p.23). Her argument follows Foucault's (1978) claim that resistance occurs as a result of power being deployed onto the body, and the 'rallying point for the counter-attack' rests with 'bodies and pleasure' (p.158).

I consider my research to build on this, valuing instead FDA's ability to consider the way a range of discourses are being drawn upon by women to construct birth, producing findings which show that a multiplicity of other positions, beyond bodies, are dynamically claimed and disclaimed by women. Existing qualitative research on birth, for example, has predominantly been produced through a dyadic researcher/participant interview research design, which tends to produce static, singular positions for women – for example of a hero (Thomson & Downe, 2013), or a risky body (Chadwick, 2009). I suggest the value in using a focus group design in this study has been to highlight how women, when talking with each other, not only claim or disclaim positions available through the discourses being drawn upon

but dynamically move around and in between different discourses – producing more of a live, discursive web – signalling both women's dissatisfaction with singular positions afforded by dominant discourse and also revealing an attempt at claiming a more complex position and subjective experience, disallowed by any one discourse. Attention to this could be said to afford women with the potential for demonstrating agency by showing how and why they negotiate their identities and sense of self (Burr, 2015). Highlighting more and different positions available to women through discourse might also, I suggest, afford them with more and different avenues for resistance (Taylor, 2017).

It was particularly interesting to note, for example, how women turned to the business discourse to construct 'real' implications for change in the practice of birth – a discursive agency disallowed to women when positioned passively as 'bodies'. It was through constructing her dissatisfaction with clinical and ethical protocol around consenting to abdominal surgery, for example, that Christina was able to construct the need for consent to be discussed in a more '*humanistic'* way, which might transform the practice of having to sign a '*waiver'* whilst being '*dragged'* into the operating theatre to something that needs to be discussed more explicitly with women throughout pregnancy. The implications this might have for their individual subjectivity in birth feels important, and supports the literature which evidences that informed consent in birth is not being properly, ethically acquired in the UK (Bohren et al., 2015).

Furthermore, I hope to add to the qualitative literature by considering what is not being said in relation to birth, and more importantly, given FDA's critical capacity, *why* it is not being said – which other methodologies, such as narrative, oriented around lived experience or the storying of experience may struggle to make claims about.

4.6. Epistemological reflexivity

Because of the theoretical framework of this research, which affords discourse with the power to bring people, bodies and social realities into being (Miller, 2008), reflexive thought has been crucial to help consider the ways in which my own positioning and assumptions have shaped and affected the many aspects of the research process. In short, what might

legitimately be interpreted and gained from the research, itself a piece of discourse (Willig, 2013).

To promote transparency, Yardley's (2000) call for the researcher to be explicit about their ideological positioning and rationale for carrying out the research, was helpful and guiding. The emancipatory aim of problematising my 'hunch' (Wetherell & Potter, 1988) that something about childbirth was (is) being suppressed and kept out of public, dominant discourse has, I hope, been transparently demonstrated throughout as formative to the research questions, methodology chosen and research design.

I have also sought to demonstrate that this personal 'hunch' was substantiated elsewhere in social discourse (e.g., McNish, 2017; Pollock, 1999), in reports calling for more and better birth practice and perinatal mental health provision (Slomian et al., 2017; Knight et al., 2019; National Maternity Review, 2015), and was corroborated in the analysis. In joining together these dots explicitly, the hope is that a better understanding might be gained of how talk about birth relates to its practice, so that practitioners working with birthing and postnatal women might be better placed to understand the complexities of women's individual subjectivities – an aim of feminist qualitative psychology, as Gergen suggests (2008).

It is important to consider how my 'insider status' (Taylor, 2001), as a woman who has birthed and whose experience informed the research's rationale, naturally made me more attentive to the sameness in other women's talk (both within contemporary social discourse and the analysis). This will have inevitably shaped the way I formulated and asked questions, read the data, and produced the analysis. I feel, however, that I was reflexively alert to this throughout, and found it helpful to consider my own positioning more fluidly as if on a continuum, rather than locked rigidly within insider/outsider dichotomy (Thurairajah, 2019).

To limit being overly drawn to sameness whilst facilitating the groups and doing the analysis, which Taylor (2001) suggests can compromise the quality of qualitative research, I sought as a moderator to abstain as much as possible from intervention (whilst being empathically engaged) to limit my impact on the way women recruited discourse. In the analytic process I remained attentive to sameness and differences within the women's talk, too, by using a journal to capture moments of surprise, or discontinuity – an attempt to employ 'reflexivities

of discomfort', as Pillow (2003) recommends is a helpful way of scrutinizing the research process and the researcher's position within it. This was particularly useful to temper my implicit feminist position, and allowed me, by acknowledging it, to separate it out from what was coming up in the analysis.

4.7. Evaluating the study

Reflexivity has, therefore, foregrounded the many aspects of this research process, and has been used to steer and enhance its quality too (Parker, 1999). To guard against the criticism reflexivity sometimes suffers, at risk of becoming an internal passive, even self-indulgent process (Thurairajah, 2019), I also sought to employ the more 'active rebellious practice' of critical reflection throughout (Parker, 1999, p.31). This was useful in provoking questions around how I might be complicit in perpetuating existing discourse in the write-up, and led to me choosing language which I consider interruptive acts of micro-resistance (e.g, choosing to write 'women' more than 'participants', or 'birthing abdominally' as opposed to 'having a c-section').

Because positivist notions of reliability, validity and generalisability are at odds with this research's epistemology (Parker, 2005), alternative criteria were needed to guide and also demonstrate quality, so that the research might be considered useful (Yardley, 2008). I have sought to gauge the quality of the research according to a range of criteria, outlined below, which others have suggested are useful for evaluating discourse analysis.

Potter and Wetherell (1987) suggest that coherence is a crucial criterion. In response to this, I have sought to make explicit throughout the work how the epistemology, ontology, and methodology were chosen to fit coherently with the discursive construct (childbirth) and research questions. Willig (2013) regards analytic quality as internal coherence, in which analytic sophistication might prove persuasive to the reader (who might also be able to consider alternative readings of the data). The rigorous analytic process described in Chapter Two was enhanced by my attention to surprise at what was emerging from the data (for example, I had not expected a military discourse of trauma to be drawn upon more prolifically than a psychiatric or psychological one). This helped prevent me from inserting data into predetermined groupings. The numerous quotes from all women across all focus

groups both to support the positional themes (and highlight positional tensions) might also be seen as evidence of the analysis' internal coherence, an effort made to show how discourses 'fit together and how discursive structures produce effects and functions' (Potter & Wetherell, 1987, p.170).

The transparency around the recruitment, data collection and analytic process noted in Chapter Two offers, I hope, evidence of the commitment to rigour that Taylor (2001) suggests is a prerequisite for good quality discourse analysis. Ethical considerations and reflexive thought were at the forefront of each stage of the research process, and I have sought to integrate them transparently into the write-up, particularly where they might offer insight for the reader around the many decisions made in the research process.

Lastly, Potter and Wetherell (1987) consider 'fruitfulness' to be one of the most powerful ways of evaluating discourse analysis. Defined as 'the scope of an analytic scheme to make sense of the new kinds of discourse and to generate novel explanations' (p.171), it speaks to new and creative ways of being able to research and author phenomena. As far as I am aware, no research has utilised FDA to explore the way women in the UK (or elsewhere) talk with each other about childbirth. This, together with the research's commitment to showing that FDA can be as helpfully applied to understand what is not being said, as it can to what *is* being said and so experienced within a discourse, might satisfy this criteria in a methodological sense. Demonstrating that women dynamically move within and between discourses to claim multiple positions when constructing birth, in a bid to experience more and different aspects (in the wake of a more complex discourse constituting birth) might also be considered a novel contribution to the existing literature.

4.8. Strengths, limitations, and future research

FDA's capacity to say something about the complex and dynamic relationship between discourse, practice, subjectivity and the constitution of social life (Willig, 2013) has been a valuable approach to take in researching childbirth, I suggest, because it has encouraged critical reflection and questioning of that which has come to be normalised and accepted as the status quo. Such a deconstructive approach has the implicit potential to go beyond the text and say something about how things might be alternatively constructed, and therefore

subjectively experienced. A Foucauldian framework provided a valuable way of challenging the widespread 'truth' that 'there are no words' (Olney, 2017) to adequately describe birth, by considering the unsaid in birth not in a pre-discursive sense, rather something which is being actively excluded from discourse and delegitimised (Hook, 2001).

Foucauldian theory has also proved valuable in its potential to locate the distribution of power within and onto the (species and individual) body, with a view to understanding how it might therefore be resisted. This is important because it might provide a deeper understanding of women's complicity and docility in reproducing discourses and practice, and why they might assume positions around birth which do not serve them particularly well (e.g. being physically restrained in birth, or submitting to regular medical monitoring without evidence to suggest its efficacy in averting risk). Understanding this is, as Bordo (2003) suggests, necessary so that women's consciousness about their role in reproducing the status quo might be raised, allowing for greater agency and means of resistance. As Foucault (1980) claimed, where there is power, there is also resistance, and that resistance needs to come from below.

This is all the more crucial, I suggest, because of the topicality of this research, which I see as a strength. Chapter One detailed how practices of childbirth and postnatal care have been said to be in need of urgent reform (National Maternity Review, 2015; Howard & Khalifeh, 2020). This study has sought, in attempting to bridge the gap between the political and personal in birth and in adopting a critical realist approach, which can 'guide active intervention in ideological and material struggles' (Willig, 1998, p.92) and so actively make claims about social and practical change. Women's descriptions, emerging in the analysis, of the need to revise how informed consent is structured and gained during birth, for example, or the desire for a standardised '*debrief*' following birth, are tangible ways the reform called for in the literature might be considered.

A limitation of the work, conceptually, is FDA's struggle to account for individual difference (Willig, 2013). This raises questions about the extent to which subjectivity can be theorised on account of discourse alone and also presents a risk for the researcher of (re)producing a generalising, homogenising construction of 'women'.

In this way, it cannot, regrettably, respond to or engage with the recent MBRRACE's (Knight et al, 2019) findings that Black women are five times more likely to die in childbirth than white women. A clear limitation of this research was that the sample of women participating were predominantly white, middle-class, professional women. And whilst theoretically, it can be argued that if a discourse is available to one, it is available to all (Silcock, 2013), the theoretical underpinnings of such an argument need to be evaluated as constructions themselves produced from within a philosophical, psychological discourse, known for its white, western, male roots (Nkansa-Dwamena, 2017a). There is an urgent, ethical imperative, therefore, to research how Black women and women from ethnic minorities are constructing birth, attending to how the discourses available to them have genealogically emerged. This would embody counselling psychology's commitment to advocacy and research which might make more manifest the ways in which power produces intersectional experience (Nkansa-Dwamena, 2017b).

Another limitation of the study is that, even though Foucault calls for depth over breadth in a genealogy (Hook, 2001), the genealogy and literature review felt reductive, as the unavoidable pressures of word count wrangled with a discursive construct, childbirth, which felt both overwhelmingly large and yet painfully fragmented in its representation in the literature. This inevitably affected the way discourses were able to be located in the analysis, which also felt reductive, ironically so, given the length. This presented me with a dilemma I had to navigate, wanting to provide sufficient space in the analysis for what I have argued is being actively excluded from entering into public discourse. Practical constraints of word count and time pressure produced the need to prioritise that which was emerging with dominance (over that which interested me personally), requiring much to be edited out, such as the alternative ways women positioned themselves in the business discourse, particularly in relation to how they were 'taught' about birth, made 'apprentices' by branded antenatal groups such as the NCT.

Because of this, many more areas for future research come to mind relating to childbirth. And as this research framework has hopefully been shown to shed light on how certain aspects of childbirth are being suppressed by dominant discourse and prevented, therefore, from being experienced by women, my sense is that it might usefully be extended to other aspects of women's health, too, known for being (even more) untalked about than birth (Clack, 2019)

such as menstruation, miscarriage, medical or elective termination, infertility and menopause. And whilst careful ethical consideration and sensitivity would be required to apply discourse analysis to phenomena in which distress and suffering is implicit (Willig, 2012), it feels important to be able to bring to light, and not collude with, areas of women's health which are not acceptably being talked about freely within social discourse. As Willig (1998) maintains, abstaining in research can never be a passive act, rather a legitimisation of the status quo.

If I were to start again, a practical change I would consider would be to host the focus groups in different spaces, specifically public spaces and institutions dedicated to and populated by women such as The Hearth or The Allbright (see thehearth.me and www.allbrightcollective.com/clubs). Over the last year or so, I have watched with interest as these spaces have been established as a way of responding to the (historically and culturally constituted) imbalance of power dynamics, spatially, in public life. The settings used in this research (meeting rooms in a local mental health charity and City University) were chosen for convenience and availability, but these may, however, have encouraged the women to engage with more dominant or socially acceptable discourse, and may have suppressed talk which might position them outside of that. Encouraging talk in spaces specifically designed for and populated by women may have allowed the women to access discourse and construct birth differently.

On a further practical note, having never undertaken such a big piece of research, I feel there have been many learnings both in terms of gathering the data and analysing it, which I might usefully apply to future research. My moderating skills, whilst helped by holding a pilot group, certainly developed and were much better over time: I was more comfortable fluidly engaging with the women, prompting for elaboration and also allowing for silence which I feel did elicit richer data and felt very different to my earlier attempts where I was learning how to be present in the group whilst also wanting to make sure that all bases of the schedule were covered. Similarly, the process of analysis, was one that got better the more I did of it. Even having just found a way of zooming in and out of the data – which I found enormously helpful, had I known that at the outset it might have made the process quicker and more refined. I guess also, I came to feel more comfortable in the not-knowing, which was very much a part of the research process. Having known this at the beginning might have perhaps

encouraged me to embrace the messiness of the process more, which on reflection I spent a lot of energy resisting.

4.9. Personal reflexivity

This research emerged out of my own struggle to find a way to talk with others about my experience of birth. It has offered a way of understanding how my own silence seeped into my postnatal sense of self, blocking access to openly experiencing feelings (which I was later able to put words to – of loss, shame and guilt) which, at the time, didn't make sense in the context of having a healthy, live baby. Reflecting then, as Willig (2013) recommends, on how the research process may have changed me, it has enabled me to re-consider my own fragility and strength in relation to birth, and to embrace more emotional and relational aspects of it, more fully than before.

It has also made me think more deeply about the power of language, which has naturally been a focus throughout the counselling psychology doctorate. Academically, a Foucauldian, social constructionist view of language makes sense to me as a way of understanding the powerful relationship between discourse and practice, and the way it shapes how we come to experience and relate to ourselves and others. But at the same time, I have been alert to a dilemma about being positioned not just as a researcher/academic but also as a person in Rogerian terms (2016), constituted by the humanistic principles underscoring counselling psychology. And whilst I have sought theoretically to adhere to the need to allow for aspects of the participants' (embodied, material, institutional) experience of childbirth to be upheld as real, and not just made real in their appropriation through discourse, I am nevertheless anxious about how the women who participated, and shared their experiences with me and each other, might feel on reading this, as many expressed a wish to do so. Because of the deconstructive nature and indeed reconstructive aim of the research, there is a risk that their words might feel unrecognisable and their experience fragmented, used in a way they hadn't expected, despite my efforts to be transparent throughout that the focus is on the way that talk about birth shapes experience.

The tension here of straddling the personal and the professional in the research process, as I see it, is also something I increasingly experienced in a clinical sense whilst working on the

research. Whilst placed as a trainee counselling psychologist in an NHS perinatal setting, I increasingly experienced the dilemma of how to encourage women to talk and indeed think about birth in a way not completely constrained by dominant medical (or opposing natural) discourse, and indeed how to ethically talk about birth myself whilst being situated firmly in a hospital setting, subjected to clinical protocol which, in many ways, seemed to be limiting choice and agency for women. It was in acknowledging these dilemmas, however, and indeed being immersed in the dialogical nature of the research – the need to simultaneously consider the micro and the macro – which afforded me with a greater understanding and a means with which to deconstruct, and reconstruct, myself as a soon-to-be counselling psychologist. A position, I feel, which is well-placed, perhaps uniquely so, to both redress dominant, oppressive norms whilst also being able to make space for and respond to individual distress.

Linked to these dilemmas, in thinking about the research process as a whole, it has been one characterised by (agonising) decisions about what to include and not include, how to phrase things, doubts about the strength of my argument and the usefulness of the work. This is an important reflection around my own vulnerability, and on the power I felt in the potential to say something 'out loud'. This mirrors the way the women themselves were acutely aware of their own power as discursive agents, which as I have shown, had a silencing effect. What I take from this, is the need to embrace that vulnerability, and find from it a courage of sorts – not to present a truth or claim to discover knowledge, rather to use my voice to encourage difference, debate, and acknowledge the value of bringing birth, at times messily so, more into public discourse, so that hopefully, other women might feel more able to do the same.

4.10. Relevance to counselling psychology and practical implications

Chapter One detailed how practices of birth and perinatal mental health provision in the UK have been widely evaluated as unsatisfactory (Slomian et al., 2017) and under-researched within psychological literature (Howard & Khalifei, 2020). The National Maternity Review (2015) and MBRRACE (Knight et al., 2019) reports, too were commissioned in response to concerns around the high rates of maternal and baby mortality and morbidity, and acknowledge suicide as the leading cause of death in women one year after having birthed. The BPS's Perinatal Psychology Faculty reports that there has been no significant

improvement in maternal death rates since 2003, and furthermore estimates the long-term cost linked to birth of depression, anxiety and psychosis at £8.1billion per year.

What is interesting then, especially given counselling psychology's reputation for aspiring to 'an identity that espouses the complementary aspects of "scientist practitioner" and "reflective practitioner"' (Woolfe, Strawbridge, Douglas & Dryden, 2012) – well placed to bridge the gap, therefore, between research and practice – is that counselling psychology's research and application of thought around the subject of childbirth have been hard to locate in the literature, or indeed in my doctoral training. Reflective of this, perhaps, is how the BPS's faculty of perinatal psychology is situated as a subdivision of 'clinical psychology' (BPS, n.d.), in which specifically 'clinical psychology sessions' are recommended as interventions within 'specialist perinatal mental health teams'. The need for counselling psychology's involvement, given its critical capacity to consider institutional frameworks, Cartesian splits, and its own relationship with dominant medical and psychiatric discourse, feels pressing, and curious in its absence.

At a policy level, incidentally, not a single psychologist was involved in the National Maternity Review (2015) or the MBRRACE (Knight et al., 2019) report. Nor was a single counselling psychologist part of the recent, widely supported open letter (Pregnant Then Screwed, 2020) challenging the changes to medical perinatal policy and practice (because of Covid-19), described as a 'breach of human rights', in which birthing women were denied the support of a partner in birth.

Now more than ever, is there a need for birth to be constructed and experienced differently, and for both postnatal women and (counselling) psychologists to contribute to conversations around birth and postnatal distress. This in itself might valuably redress dominant gendered and medical discourse which currently pathologizes birth and women's physical and emotional 'recovery' so that more, and specifically more woman-oriented, support might be made available to women in and after birth.

The need for more women's groups in which women can talk about their birth experience in a mutually supportive environment is one concrete recommendation from this research. By normalising a space for women to come together after birth and talk about their different

experiences, women might be encouraged to construct (and so process) their birth experience more openly, embracing the complexities of birth and the impact it has on their postnatal sense of self. As Anya said at the end of the second focus group, '*you know, here we are, we're just talking and it's helping'* (2.2129). All the women agreed that a '*debrief*' after the birth was absent, and desired. They all imagined it taking place within a medical, institutional setting, but the underlying function of this debrief seemed to be to voice their experience, so that it could be made real – and that seems tangible in a range of supportive, ethically minded psychological settings, also.

Willig (1999c) describes the various ways that discourse analytic research might effect change: by making space for suppressed or minority discourses, by implementing suggestions about practical reform, and by supporting lobbying. The emancipatory aims of this research have sought to adhere to these principles. By bringing birth's complexity to the fore, and suggesting its powerful potential to shape women's subjective experience and identity, my hope is that it might generate further research within counselling psychology, which might both inform practice and policy concerning birth, as well as highlighting the need for counselling psychologists to become more actively involved in lobbying for change at a political level.

The hope is that this research might also be used to enrich therapeutic practice. By bringing dilemmas about birth to the fore, and allowing counselling psychologists themselves to consider more the complicated role birth plays in shaping women's postnatal subjectivity, and not only once a pathologizing postnatal diagnosis has been given – a more active attention to the presence or absence of birth in the therapy room might be made available.

In terms of mental health provision for postnatal women seeking help for distress, within the NHS CBT is the recommended intervention for postnatal depression and trauma (NICE, 2014), which focuses on cognitive, emotional and behavioural change. Whilst I am not dismissing the value of this, it does seem to reinforce the dominant discourse's pathologizing of distress following birth – as something that needs to be changed rather than relationally supported, held, and made space for. The humanistic underpinnings of counselling psychology seem particularly well placed to attend to this alternative construction of birth and postnatal distress (Woolfe et al., 2012).

Furthermore, in showing how Kristeva's (psychoanalytic) notions of the abject can be helpfully applied to understanding how subjectivity is being limited through the way birth is being talked about, there is also the potential, I suggest, for psychodynamic thought and practice to be integrated into therapy with postnatal women. It may offer a therapeutic framework in which birth might more freely be considered a relational phenomenon, co-constructed with a multiplicity of meaning (Hargaden & Schwartz, 2007), and the murkier, silenced aspects of birth might be more actively tolerated and brought into conscious awareness and public discourse.

Anne Enright (2005) wrote, scathingly, that 'speech is a selfish act, and mothers should probably remain silent'. In saying this, however, she made real the potential for the opposite, for women to talk about birth without being made to feel bad or shameful or selfish. I hope, in this research to have built on that. In having located and analysed an unsaid, I have sought to carve out the potential for a discursive space in which women might talk about, and so experience, more and different aspects of birth, and come to position themselves more powerfully – whether that is in the birthing room, in therapy, in everyday chat, or in public and political reform, so that '*nobody told me'* (McNish, 2017) no longer rings true.

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APPENDICES

APPENDIX 1: Recruitment flyer

Department of Psychology
City, University of London

PARTICIPANTS NEEDED FOR RESEARCH INTO HOW POSTNATAL WOMEN TALK ABOUT CHILDBIRTH

I am looking for mothers, with a child or children over the age of 1, to take part in a study about how postnatal women talk about childbirth.

You will be asked to take part in a local focus group with other mothers, lasting 1-2 hours, which will involve talking about your experience of childbirth. This will be a safe, confidential space in which to talk about childbirth with other mothers.

For more information about this study, or to take part, please contact:
Helena Curran, Counselling Psychologist in Training

Email: Helena.curran@city.ac.uk

Supervisor: Dr Julianna Challenor: julianna.challenor@city.ac.uk

This study has been reviewed by, and received ethics clearance through the Light Touch Research Ethics Committee, City, University of London **PSYETH (P/L) 17/18 40**

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040 or via email: Anna.Ramberg.1@city.ac.uk

APPENDIX 2: Study Information Sheet

Title of study: *'Nobody Told Me': A qualitative study on the construction of childbirth in postnatal women.*

Helena Curran
Email: Helena.curran@city.ac.uk

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it will involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

Childbirth is everywhere – but little research has been done to explore how postnatal women talk about it, and how this, in turn, engages with the way that the expert medical literature writes and talks about it. The findings of this study will be used to inform counselling psychology and other clinical work with perinatal women and also perinatal care and policy. This study forms part of a thesis for the Professional Doctorate in Counselling Psychology at City University and will run for the next twenty four months with a proposed completion date in Spring 2020.

Why have I been invited?

I am recruiting postnatal women over the age of 18, who have a child or children over the age of one. I am looking to form between two and three focus groups of 4-8 women to talk with other mothers about their experience of childbirth. Given the local setting of these focus groups, it may (or may not) be that you know some of the other women taking part in the group. Since the method of this study is a discourse analysis, I wish to emphasise that the focus on this study will be on the way women talk about their experiences.

Do I have to take part?
Participation in the project is voluntary, and you can choose not to participate in part or all of the project. You can withdraw at any stage of the project without being penalised or disadvantaged in any way if you feel uncomfortable or distressed. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

If you wish to take part, you will be invited to attend a focus group in a local setting which will last between 1-2 hours. Details are outlined below:

- ***TIME**: you will be required to attend a focus group with 3-7 other postnatal women who, given the local setting you may or may not know, which will last between 60-120 minutes.*
- ***LOCATION**: the place of the research will be a local community centre for participants' convenience, and will be fully risk assessed.*
- ***FOCUS GROUP**: I, as the Study's researcher, will facilitate the group. I plan to begin by welcoming all participants, and then encourage the group to think about the ground rules – such as respect, confidentiality, not talking over each other, for example – that will help make this group feel a safe one in which you, as a participant, can freely talk about your experience of childbirth. Following this, I, as the facilitator of the group, will seek to engage the group in general discussion about childbirth. The focus in the group will be on talking with others about your personal experiences and the research study itself will be concerned with the language used in these discussions.*
- ***RECORDING**: The focus group will be a one off session and will be audio taped. All recordings will be kept under lock and key and will be accessed only by the researcher.*
- ***DATA ANALYSIS** After the focus group has been recorded, it will be transcribed. During this process any identifying and personal details will be changed to ensure your identity remains anonymous. You will be given the opportunity to choose your own pseudonym, so that you can be represented in the work in a way that you are happy with. Discourse analysis techniques will be used to analyse the data: this pays particular attention to language and how it is used to convey meaning. It is important to make you aware that quotes will be used in the final analysis but that all personal and identifying details will be removed so that those reading the analysis will not be able to identify you. Materials such as tapes, digital recordings and transcripts will be kept safely – in a locked filing cabinet for hard copies, and on an encrypted computer for any digital data – for five years following publication of the thesis.*
- ***CONSENT** You will be asked to sign a consent form once you are satisfied that you understand the study and its rationale.*

What are the possible disadvantages and risks of taking part?
It is possible that during the course of the focus group or following it some emotional upset may be experienced when revisiting your experience of childbirth and the meaning that may have for you, or in hearing the experiences of others.

To this end, you will be asked to observe the anonymity and confidentiality of other participants, and to look after yourself and others in what you choose to disclose. At all stages, you are reminded that your participation is voluntary and you can withdraw your consent at any time.

What are the possible benefits of taking part?

The focus group may provide a safe place in which to talk about childbirth with others, one which you may experience as both supportive and unique in terms of providing a place to think about what your experience of childbirth means to you as a postnatal woman and mother.

You will also be contributing to research which seeks to engage with how a female representation of childbirth is considered (or fails to be considered) in expert medical and perinatal contexts, and the implications that may have in policy and postnatal medical and psychological care for women.

Will my taking part in the study be kept confidential?

All information disclosed by you will be treated as private and confidential. Access to raw data will be restricted to the researcher and research supervisor. All recordings/transcripts will be encrypted,

stored securely and notebooks will be kept in a locked drawer to which the researcher only has access. Confidentiality will only be broken in the following circumstances: should the researcher feel there is a risk of serious harm either to you or others or where the researcher is legally compelled to do so. In terms of anonymity this research aims to comply fully with BPS ethical guidelines, and all participants will be consenting adults whose anonymity will be guaranteed. As such all names and identifying information will be changed to preserve confidentiality and you will be able to choose how you wish to be represented.

Only the researcher will have access to the participants' recruitment details and these will be kept in locked drawers and not disclosed to anyone. Any future use of personal information will only be with the participant's signed consent. There will be no sharing of data with other universities or researchers.

What will happen to the results of the research study?

The findings of the study will be written up for a Doctorate in Counselling Psychology but may also be disseminated more widely through journal publications and academic conferences. Future publications may include the BPS Journal and the Counselling Psychology Quarterly Review. It is important to make you aware that in both the report and the future publications, some direct quotes from your interviews may be used. However all personal details will be changed and so it will not be possible for readers to identify you. If you would like a copy of the research findings, once the study has been completed, you can contact me directly at any point thereafter and I will ensure that you receive it by post.

What will happen if I don't want to carry on with the study?

You remain free to withdraw at any point up until the analysis of the focus groups takes place (which I expect to be April 2018) by notifying me, either in person or using the contact details below. Should this situation arise, all contributions made in the interview will be erased from the recordings and transcripts, although others' surrounding comments will remain intact. Withdrawn participants' data will not be analysed and will not be published. Surrounding data from other participants, including responses to withdrawn participants' comments, will be analysed and may be published as part of the results.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: 'Nobody Told Me': A qualitative study on the construction of childbirth in postnatal women.

You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City, University of London
Northampton Square
London
EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

City, University of London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?
This study has been approved by City, University of London Psychology Department Research Ethics Committee.

Further information and contact details
Researcher: Helena Curran, email: Helena.curran@city.ac.uk
Supervisor: Dr Julianna Challenor, email: julianna.challenor@city.ac.uk

Thank you for taking the time to read this information sheet.

APPENDIX 3: Consent Form

Title of Study: 'Nobody Told Me': A qualitative study on the construction of childbirth in postnatal women.

Ethics approval code: [*Insert code here*]

		Please initial box
1.	I agree to take part in the above City, University of London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve • Participating in a focus group • allowing the group to be recorded (audio)	
2.	This information will be held and processed for the following purposes: • As part of a study which considers how childbirth is talked about by postnatal women. • This study makes up part of the researcher's thesis which is submitted as part of City University's Professional Doctorate in counselling psychology. • The data will be analysed (using discourse analysis) as part of this study and will be quoted within it, although identities will be protected by the use of a pseudonym. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. I understand that the digital recording and any transcripts from the focus groups will be kept in secure conditions (locked filing cabinet for hardcopies and encrypted computer for digital recordings) and that no other person other than the researcher will have access to the original recording. I understand that quotes may be used in the report and any resulting publications but that no information that could lead to my being identified will be included in any report or publication resulting from this research.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project up until it's submission without being penalized or disadvantaged in any way.	
4.	I agree to City, University of London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

Name of Participant	Signature	Date
Name of Researcher	Signature	Date

APPENDIX 4: Focus group agenda

Framework:

- Welcome (warm, polite, introduce myself as researcher)
- Overview of the subject being investigated – how women talk about childbirth – and why participants have been selected
- Ground rules: not to speak over others, no mobiles, no right or wrong answers, issues of confidentiality, consent form signing

Warm up

- Participants asked to introduce themselves
- Opportunity to ask questions

Opening Question example

- We are here to talk about childbirth, and I'm interested to hear about what it means to you. The study itself is focusing on the language that you use to describe this experience. Perhaps you could start by talking about your own experiences of childbirth?

Opening Questions

- I want to get a sense of how you find talking about childbirth…
- Do you think about childbirth much? Do you share your thoughts with others? How?
- When and where do you talk about it?
- How do you talk about it to friends, family, doctors?

Ending

- Of all the things we've talked about today, what to you is the most important?
- Is there anything you feel I should have asked or you would like to add?
- How has it been for you talking about childbirth today?

Debriefing

- Reiteration of confidentiality policy
- Further information about the study and sources of support
- Opportunity to ask questions
- Feedback

(Structure taken from Krueger & Casey, 2015)

APPENDIX 5: Participant debriefing form

Title of study: 'Nobody Told Me': A qualitative study on the construction of childbirth in postnatal women.

Thank you for taking part in this focus group, which is part of a counselling psychology doctoral thesis. The information you have provided in contributing to this focus group will be analysed using discourse analysis techniques, this being the only study to consider how childbirth is talked about in the UK. In focusing on language (verbal, textual and multimodal), this study seeks to consider how the broader social, medical, political institutions talk or write about childbirth, and how that may affect the actual practice of childbirth and also the experience of women postnatally, as well as the way in which postnatal women choose to talk about childbirth with each other, and how that fits and affects their experience.

You remain free to withdraw at any point up until the analysis of the focus group data begins, which is expected to be April 2018, by notifying me, either in person or using the contact details below, stating the Participant ID Number given at the top of this form. Should this situation arise, all contributions made to the focus group discussion will be erased from the recordings and transcripts, although others' surrounding comments will remain intact. Withdrawn participants' data will not be analysed and will not be published. Surrounding data from other participants, including responses to withdrawn participants' comments, will be analysed and may be published as part of the results.

If your participation in this research has evoked concerns or queries about any aspect of your participation, please do not hesitate to raise them with me. Should you wish to you can arrange a meeting with me where your concerns can be discussed in confidence and assistance will be provided to find you further support as necessary. Should anything come up for you as a result of participating in the focus group, I encourage you to speak with your GP who will be able to refer you on to relevant support services – psychological and medical.

Other suggestions for emotional and psychological support include:

The Samaritans (www.samaritans.org), who you can email (jo@samaritans.org) or call on 116 123

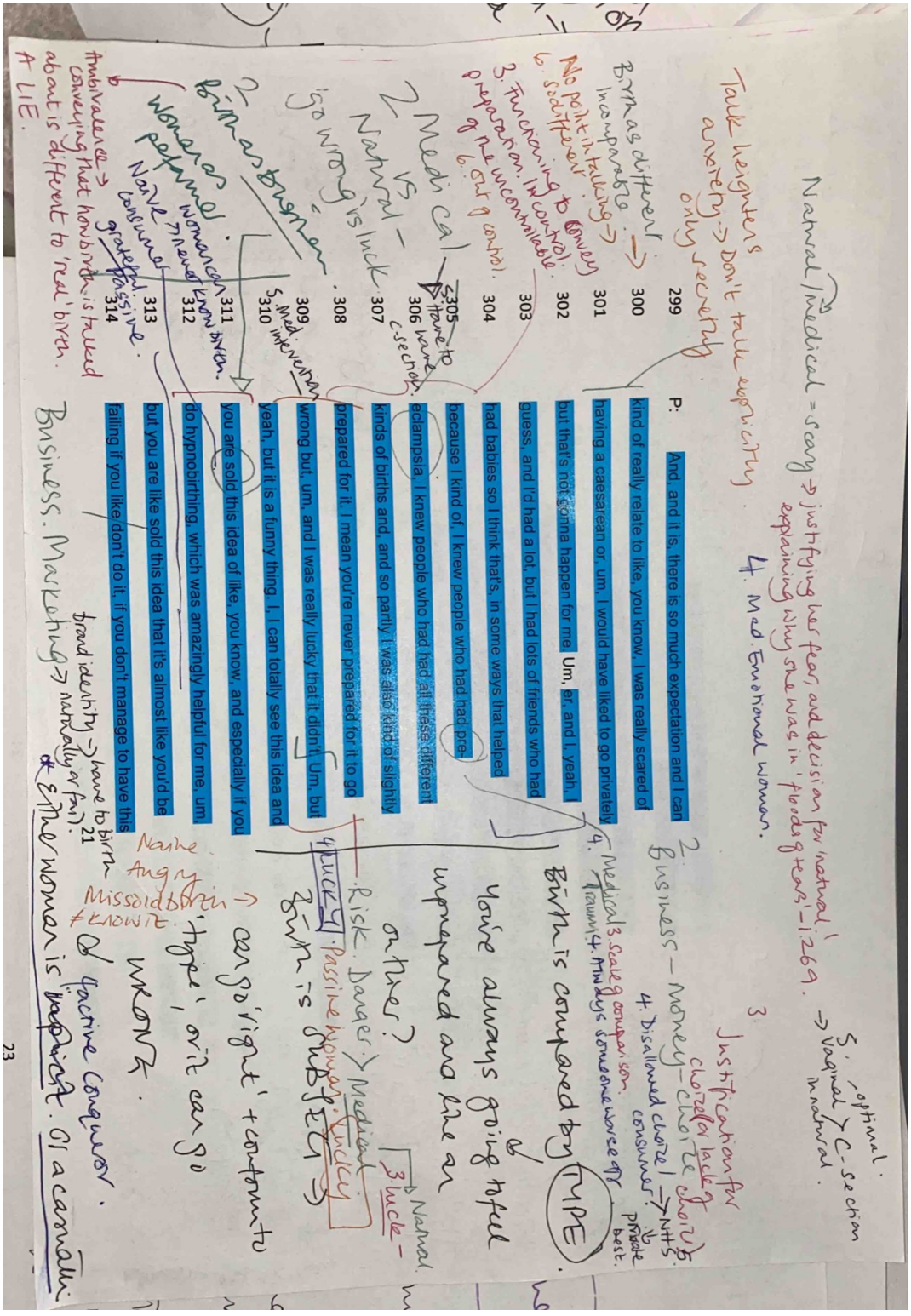
Cocoon Family Support (www.cocoonfamilysupport.org) who offer counselling and support for postnatal women

The Birth Trauma Association contactable through their website (www.birthtraumaassociation.org.uk) or via a closed Facebook group (https://www.facebook.com/groups/TheBTA/).

To find a Counselling Psychologist or therapist you can go to the BPS website (www.bps.org.uk) and click on "Find a Psychologist", or visit the British Association for Counselling and Psychotherapy website (www.bacp.co.uk) and click on "Find a Therapist". If you wish to contact me or my research supervisor in relation to this research, please find contact details below.

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:
Researcher: Helena Curran. Email: Helena.curran@city.ac.uk
Research Supervisor: Dr Julianna Challenor. Email: julianna.challenor@city.ac.uk

APPENDIX 6: Example of initial analysis



APPENDIX 7: Analytic process – table of themes example

Constructions (of the practice of childbirth)	**Discourses (ways of seeing the world)**	**Action Orientation (when a discourse is used and to what purpose)**
Medical process, described in terms of timings, type and pain-relief Pathological – pre-eclampsia Painful or painfree	Clinical and essentialist. Gender? Women should suffer/not suffer/suffer silently	Used to order the process of birth and give it a linear narrative. Used when describing what TYPE of birth was had – linked to identity. Was it birth centre or labour ward – labour ward sometimes reassuring and safe ,and sometimes frightening or 'stressful' Used to describe the physical processes o birth – pain, vomit without recourse to emotion (cartesian split) Used to communicate the risk of childbirth and the seriousness of the risk without emotional overwhelm Seems to describe how tough it was, and how strong the woman is?
Subject Positioning (what rights and duties are being ascribed to different subjects)	**Practice (what can be said and done from those positions)**	**Subjectivity (what can be thought, felt and experienced from those positions)**
Women are passive. Bodies – good birthing bodies or bad broken birthing bodies. Dangerous vessels? Women are strong (withstanding pain) or weak (begging for painrelief) – medics – and men are powerful – they hold the key to relief. They are disallowed an emotional or subjective relationship to birth.	Medics are in charge. Medics control timing, make the decisions. Medics and medicalised birth makes birth safe Because of the essentialist nature of this discourses – things can go 'wrong'. There is a right way and a wrong way of doing things. 'natural' birth is only afforded those with no problems. Medical birth is necessary for any pathological 'problem'.	Failure, Birth has a normal process. Anything else coming up is a problem – of the woman or body. Strong or weak. Success or failure. Passive – unable to act. Acted upon Passive. As if the birth didn't belong to the mother. Mother stupid, naïve for thinking they can do this alone.

Women are lucky and grateful, therefore shouldn't harbour more difficult feelings. Medics are safe, or scary. Woman as animal, medics as calming, quietening with meds. Women don't know how to do it. Subservient women – begging for pain relief	Women cannot birth naturally if the baby doesn't come out vaginally. Ownership of the birth is affected – who birthed the baby. It focuses on birth as a physical process. Not as an emotional one. And a scientific process that women are not told about (women can't handle the horror? ?or keeps them in a needy position in relation to the medics?' Birth is talked about in terms of 'time' 'cm' and 'progress' – feels meaningless in terms of communication. There is a right or wrong way of birthing.	Something a woman can do wrongly – 'ok when she does it properly' – birth and birthing mother as something that is to be judged, observed and intervened on. CONTROL.

Constructions (of the practice of childbirth)	**Discourses (ways of seeing the world)**	**Action Orientation (when a discourse is used and to what purpose)**
Trauma – something that is traumatic, dangerous, risky, surprising – and something which isn't allowed to be thought of as traumatic hard to remember something that is not talked about	Medical. Clinical. – not traumatic – negligence Emotional discourse (physical vs emotional) Healthy baby Gender – war torn, military	When childbirth is being linked to previous or post-gynaecological trauma. Suggests a separate physical and emotional traumatic experience. Used to allow women to anchor themselves in relation to each other – scale of comparison Used to evoke emotion in the other Used to silence the other. Used to determine or apportion blame Access to mess? Emotion?
Subject Positioning (what rights and duties are being ascribed to different subjects)	**Practice (what can be said and done from those positions)**	**Subjectivity (what can be thought, felt and experienced from those positions)**

Women are silenced – because they cannot remember it, because they do not want to talk about their positive experience if others' had a traumatic one, and because somebody always had a worse experience. Women are left – childbirth is an unpredictable beast and women have to go along with it (healthy baby) Childbirth is unspeakable Something not to be enjoyed. Something which is hard to watch – traumatic for the men. Men are harmed. Something women should keep away from men.	No space to talk to men or medical professionals. Information is taken away from women following the birth – negligence.	Women avoid it. Don't talk. Talk in a certain way. Or is spills out in an uncontrollable, hysterical way. Apologetic. Shame or guilt. LOSS

Constructions (of the practice of childbirth)	**Discourses (ways of seeing the world)**	**Action Orientation (when a discourse is used and to what purpose)**
Something that you do Or Something that is done to you. Linked, subset of loss? Business. Similarly something you choose or do not have a choice around.	Natural Medical – choice is unsafe and uninformed. Sometimes there is no choice. Risk – responsibility. Business. Financial. Legal?	Used to suggest a women's sense of agency and control in relation to childbirth Used to describe decision making in birth. Used to communicate fear of birth – choice offered safety for the woman **birth is culturally constructed.** **Used to protect women from the reality of the danger and loss involved in childbirth.**

APPENDIX 8: Analytic process – themes supported with data

Constructions of childbirth

POSITIVE **Birth as a positive experience**	1. 41. ' I had two really great, good births'. 2.193. The good thing is that when, for me, I don't know how it is for other women, as soon as I went to my last month, I was very happy. I didn't care about anything. People kept saying to me different things but nothing really matters. So you didn't, er, I was very relaxed. I was very happy for what was going to happen. So I don't know if it was hormonal, I don't know what was going on. I had this hope. I was very relaxed and happy.
Inverse of positive: people expect you to be happy. Healthy baby?	2.864. You just feel like, "Oh I sound like this really whingy complaining thing," you know, for the three months after when people are visiting you and they, you feel like you're expected to be this really, "Oh I have a baby, I'm so happy," and all you want to do is really talk to your friends about how awful it was.
Medical birth, C-Section – much less traumatic and very happy. Night and day.	2.1572. P: Well for me, second time around, I guess I knew, I had the information of how bad it's going to be so I did feel I remember but it was a planned c-section. When I walked in and they asked me to wait outside the room, um, before they

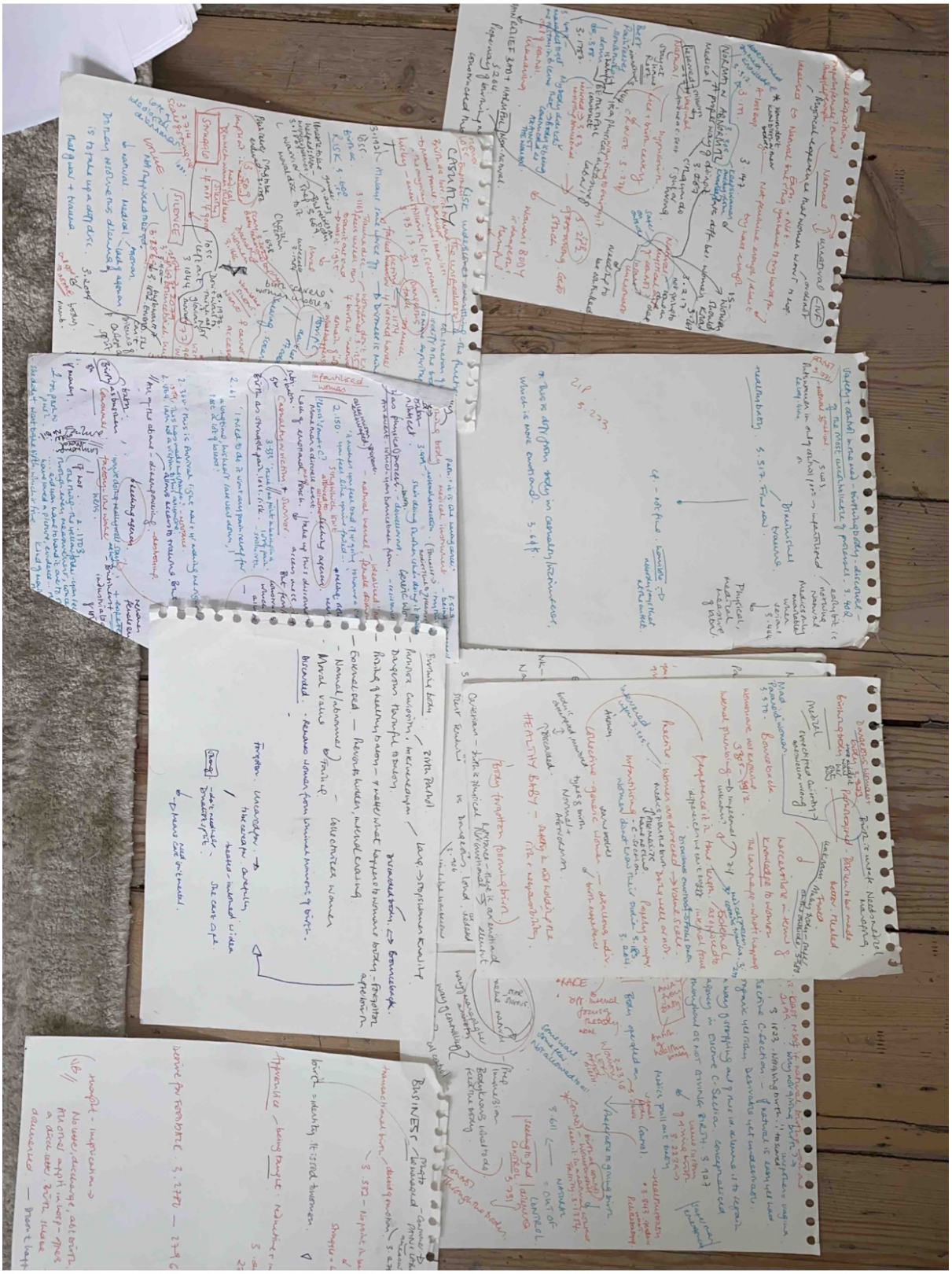
Commented [HC1]: Natural.

1

APPENDIX 9: Analytic process – FDA (Willig, 2013) table incorporating data

	A	B	C	D	E	F	G	H	I	J
1	**POSITION THEMES**	**Construction**	**sub construction**	**text**		**discourse**	**action orientation: what is gained from constructing the object in this way at this point?**	**positioning: what subjects are constructed**	**opportunities for practice are opened up or closed down**	**subjectivity**
72	bodies	birth is constructed and judged as 'good' or 'bad'	BIRTH is being REDUCED , mopped up? Idea that there is something performative about birth - that it is 'judged'. REDUCTIVE. Are women doing this to skim over the trauma?	3.1096 - 111	but I think it is interesting, when you're thinking about , you know, when we use these terms like 'good' or 'bad' births. Like when you hear somebody has had a baby, what is that judged on?	moral	idea that there is something judgement implicit in birth. when it is termed either good or bad it limits difference. RAGE. Perhaps good or bad offers some sort of control.	positions women as good birthers or not - 'doiung it properly'	limits talk about birth - you have to fall into one of two categoriies. Limits processing of the complications.	women are to be judged and give judgement in birth. No room for inbetween mess or ambivalence
73	victim - dangerous talk	experience needs to be told - fear of it being too much	to talk about the birth later is too much - idea that there is the right amount of disclosure around the birth. Also idea that people don't want to hear all the details?	3.1159.	I needed to keep sayoing it.. Too much detail? was it right that it had been like that? She might have come out breasthing... but then the injection? If I'd done it properly, if I'd pushed more.	male, medical, trauma, negligence .	Tbis links to the good and bad: resisting being categorised? But not being able to find the answers to questions. asking questions to try and process and gain an understanding about what happened and why? Need to appoint blame?	position of blame - who was 'right', who was not. UNKNOWING WOMAN	having a space in which medically to answer the questions. Blame game is challenging though. MAYBE A medical debrief isn't best? Rather a DIALOGUE.	guilt, harmful and harmed, unknowing,
74	vessel. Brithing body. An instrument of the birth. Lucky.	childbirth is ended when baby is delivered	notes are taken away from the woman. Don't mention the war.	3.1206	You don't even get your labour notes really... and obviousiky you have got the baby, so that's great.	medical; negligence	the loss of the experinece. Nothing tangible with which to process the birth. Unsure of what the birthing woman is entitled to - sense of not having known what happened in childbirth, and not owning that right bevcause she has the baby.	absent from the birth. Unknowing.	Conversation is shut down dramatically. Woman is left unknowing.	loss. Disbelief - untrusting of own experience. Reminder that birth is phsyical. Not emotional. Property of hospital - ownership lies with the medics not the woman. Bereft.
75	birthing body -	medics directing the birth	birth needs to be over with quickly - child out - for both women and medics.	3.1218	Maybe it was because I was paranoid..really wanted the baby out as quickly as possible	medical	communicate an injustice, using talk to regain power over an experience where they felt powerless.	women passive. Struggling to gain control	women cannot act in the mometn. But later - women want answers. No forum however for that.	Live baby, not woman's experience is the goal. Birth unimportnat
76	war? Loss	childbirth as a 'blur'	means women question their experiencee? **Lack of talk, means it didn't happen.**	3.1253.	did it really happen? It all feels a bit fuzzy.	trauma, medical - not the property of the woman.	women are kept unknowing and unsure about what happened.	absent from the birth. Unknowing.	no agency in birth.	disbelieving, loss,
77	warrior. Survivor	birth as trauma	birth is feelings and sensations.	3.1264.	the actual experience of it *is* traumatic, ...to your mind, to your body and you are not processing it while it's happening'	trauma.	acknowledging the extent of the process of childbirth. Normalising trauma - or normalising the difficulty of 'normal childbirth'	is the woman the victim of the trauma? Medics have the informaiton about what happened. They	normalise the 'truama' of childbirth? Help women prepare for it? Difficult in a medical and clinicla context. Trauma means something specidic.	inability to put words to it? Second order positioning
78	BODIES uncontrollable different and unique - birthing body?	Birth as physical, medically managed process	you cannot plan or predict or know what will happen. But how do you plan for uncertainty. Emotional/physical discord	3.1285; 3.1313	'put your hypnobirthing thing aside and et pushing.'	medical/natural; business	reliquishing control from the women - cannot be held accountable for the difficulty? Blameless. Baby is part of this. Justifying own decision not to make a birth plan, Women's plans are FRILLY and birth is serious business.	women helpless, out of control, and naïve. Birth is phsycial and medical - the domain not of the woman. Medical vs natural argument. Told what to do	women are in a position of being 'disappointed' if they plan, and out of control if they don't. Distinct difference between birth centre and labour ward.	Anger, injustice, shame - naïve.

APPENDIX 10: Analytic process – brainstorming discursive positions



APPENDIX 11: Ethics application

Psychology Department Standard Ethics Application Form: Undergraduate, Taught Masters and Professional Doctorate Students

This form should be completed in full. Please ensure you include the accompanying documentation listed in question 19.

Does your research involve any of the following? *For each item, please place a 'x' in the appropriate column*	**Yes**	**No**
Persons under the age of 18 *(If yes, please refer to the Working with Children guidelines and include a copy of your DBS)*		x
Vulnerable adults (e.g. with psychological difficulties) *(If yes, please include a copy of your DBS where applicable)*		x
Use of deception *(If yes, please refer to the Use of Deception guidelines)*		x
Questions about topics that are potentially very sensitive *(Such as participants' sexual behaviour, their legal or political behaviour; their experience of violence)*		x
Potential for 'labelling' by the researcher or participant (e.g. 'I am stupid')		x
Potential for psychological stress, anxiety, humiliation or pain		x
Questions about illegal activities		x
Invasive interventions that would not normally be encountered in everyday life (e.g. vigorous exercise, administration of drugs)		x
Potential for adverse impact on employment or social standing		x
The collection of human tissue, blood or other biological samples		x
Access to potentially sensitive data via a third party (e.g. employee data)		x
Access to personal records or confidential information		x
Anything else that means it has more than a minimal risk of physical or psychological harm, discomfort or stress to participants.		x

If you answered 'no' to <u>all</u> the above questions your application may be eligible for light touch review. You should send your application to your supervisor who will approve it and send it to a second reviewer. Once the second reviewer has approved your application they will submit it to psychology.ethics@city.ac.uk and you will be issued with an ethics approval code. <u>You cannot start your research until you have received this code.</u>

If you answered 'yes' to any of the questions, your application is NOT eligible for light touch review and will need to be reviewed at the next Psychology Department

Research Ethics Committee meeting**.** You should send your application to your supervisor who will approve it and send it to psychology.ethics@city.ac.uk. The committee meetings take place on the first Wednesday of every month (with the exception of January and August). Your application should be submitted at least 2 weeks in advance of the meeting you would like it considered at. We aim to send you a response within 7 days. Note that you may be asked to revise and resubmit your application so should ensure you allow for sufficient time when scheduling your research. Once your application has been approved you will be issued with an ethics approval code. You cannot start your research until you have received this code.

Which of the following describes the main applicant? *Please place a 'x' in the appropriate space*	
Undergraduate student	
Taught postgraduate student	
Professional doctorate student	x
Research student	
Staff (applying for own research)	
Staff (applying for research conducted as part of a lab class)	

1. Name of applicant(s). (All supervisors should also be named as applicants.)
Helena Curran Supervisor: Dr Julianna Challenor
2. Email(s).
Helena.curran@city.ac.uk **Julianna.challenor@city.ac.uk**
3. Project title.
'Nobody Told Me': A qualitative study on the construction of childbirth in postnatal women.
4. Provide a lay summary of the background and aims of the research. (No more than 400 words.)

There is emerging acknowledgement that childbirth is being constructed and communicated in non 'woman-oriented terms' – both by the postnatal woman (evident in contemporary literary, political and social contexts) and also in the dominant expert medical, psychological, midwifery discourses, which may be seen to shape the practice, and so experience, of childbirth in postnatal women.

Recent perinatal psychological research has highlighted the links between childbirth, women's perception of it, and postnatal experience, specifically in relation to postnatal depression (PND) and post-partum post traumatic stress disorder (PP-PTSD). This suggests, given the idea that there is a 'conspiracy of silence' about women's experience of childbirth, that further qualitative research into how childbirth is constructed, and the implications that has for the postnatal woman's subjectivity, may be beneficial, with practical implications for counselling psychologists' clinical work with perinatal women and also for medical and psychological perinatal practice, care and policy on a larger scale.

This study seeks to expand the existing qualitative research which has focused on the experience of giving birth, and on the narratives women draw upon to story their birth again rooted in subjective experience, by attending to the micro and macro discourses of childbirth in the UK, which have not yet been researched. In turning to language (verbal, textual and multimodal), this study seeks to consider both the broader social, medical, political discourses constituting the practice of childbirth and experience of women postnatally, as well as the way in which postnatal women choose to take up certain discourses, and what that means in terms of their sense of selfhood and subjectivity.

5. Provide a summary of the design and methodology.

This will be a discourse analysis, drawing on a synthesis of discursive psychology (for verbal data), critical discursive analysis (for multimodal data) and Foucauldian discourse analysis (FDA), the micro-macro approach to discourse analysis affording both the broader socio-cultural systems and structures to be explored in relation to the subject positions they create, alongside the way that individuals choose to take up those discourses – important for the researcher as a counselling psychologist in training – in terms of acknowledging the agency of postnatal women.

Given the focus on language, a social constructionist epistemological position will be assumed, combined with a more moderate critical realist ontology, to ensure criticisms about a constructionist's reductive approach to subjectivity and questioning of material reality outside of 'the text' can be reconciled, especially in line with counselling psychology's concern with human subjectivity and agency.

Design and analysis

Expert texts: the study will comprise a FDA of expert texts available to perinatal British women and the professionals and professional bodies that engage with them: medical, midwifery, clinical and counselling perinatal psychological literature, as well as official handbooks and policy texts from bodies such as NICE, DSM, NCT, BPS.

Focus groups: Three groups of 4-8 postnatal women will be formed and discussion around childbirth generated so that the way that childbirth is constructed in naturally occurring talk can be explored. A pilot group, comprising colleagues or friends of the researcher who meet the participant criteria, will also be initially carried out to encourage researcher reflexivity on both moderation and the facilitation: the data from the pilot will not be analysed. A synthesis of micro-macro approaches to the text will be used from a critical stance, allowing micro discourses to be read in relation to the macro other.

Multimodal: Given discourse isn't confined only to the textual or verbal, rather the multimodal, especially in light of the prevalence of social-media connecting and sharing used by this postnatal population, a visual discourse using CDA will also be twinned with FDA to map out how postnatal women are visually constructing childbirth and communicating that construction, and how these discourses may be read in relation to the surrounding discourses. Instagram will be used as the online platform from which data is collected, given the high levels of community involvement and representation (several prominent postnatal women have followers of between 45k-333k).

6. Provide details of all the methods of data collection you will employ (e.g., questionnaires, reaction times, skin conductance, audio-recorded interviews).

Focus groups

Three separate groups of 4-8 postnatal women, over 18, will be recruited by the researcher by visiting and handing out flyers at independent mum and baby groups in separate London locations. The focus groups will last between 60-120 minutes, will be audio-recorded, and will take place at local community centres: the familiarity of the surroundings important so as not to introduce additional institutionally or power-related structures into the discussion, which a university location might. The localised

location may also encourage participation given the participants may need to source childcare.

A pilot group comprising the researcher's colleauges and or friends who meet the participant criteria will be initially held, to trial the focus group schedule and reflect on the researcher's role as facilitator. Data from this group will not be analysed.

A general interview schedule will be used where my aim is to generate, rather participate in discussion, asking questions to keep the discussion going and to encourage participation **(see Appendix 4).**

Participants will be screened by the researcher over the telephone ahead of the focus group (to minimize any inconvenience to participants) using the 22 item IES-R screening measure (see Appendix 7) to exclude diagnosis of PTSD (see Appendix 8 for the DSM 5 criteria), they will be informed about the study, their consent gained, informed about their right to withdraw, briefed and fully debriefed, and signposted to supportive and psychological services should psychological distress surface after the focus group **(see Appendix 1, 2, 3, 5).**

Multimodal (visual) data analysis
I suggest that Instagram is a prevalent mode of communication for this demographic – the rationale being the large number of prominent postnatal women having between 45k and 333k followers). Data will be selected by purposive sampling by the Researcher based on postnatal women with the largest followings, and also by searching via 'childbirth' tags. The data will be collected over the same period that the focus groups are held to ensure a consistent socio-cultural framework with which to use CDP on both sets of data. Only images posted by those with public profiles for public consumption will be selected, in which case consent is deemed not to be required – as suggested in the BPS ethical guidelines for internet-mediated research. Names, avatars and identifying details will be anonymised, including any comments used. Researcher sensitivity and reflexivity will be relied upon to think about balancing the rights and dignity of the subjects with the social benefits of the research.

7. Is there any possibility of a participant disclosing any issues of concern during the course of the research? (e.g. emotional, psychological, health or educational.) Is there any possibility of the researcher identifying such issues? If so, please describe the procedures that are in place for the appropriate referral of the participant.

Discourse analysis concentrates on the language being used as opposed to the experience of the individuals, which typically limits the potential for emotional, psychological distress and upset within research focus groups. However, given the focus groups' emotive nature of the topic, the researcher acknowledges the possibility of participants becoming emotionally involved or upset during the course of, or following, the group, and, drawing on her clinical experience, will think fully and reflexively with her supervisor about how to appropriately and ethically contain that upset.

Should emotional and or psychological distress occur within the group, the researcher will use clinical judgement to determine whether the focus group needs to be stopped. If this is deemed necessary, the focus group will be stopped, the researcher's supervisor will be called, and the researcher will follow up individually with all participants.

Ground rules **(see appendix 4)** concerning group confidentiality and respect will be collaboratively developed at the beginning of the focus group to avoid offensive or disrespectful conflict within the group. The researcher's role as a supportive and protective facilitator will also serve to prevent avoidable distress caused by group conflict and guard against any participant feeling unheard, disregarded, or persecuted.

As this study is aiming to explore 'general' discourses around childbirth as opposed to clinically diagnosed 'traumatic' ones, the risk of distress is also anticipated to be low. Screening will seek to exclude women who meet clinical diagnosis of PTSD (PP PTSD is not recognized as a separate diagnosis by the DSM V) and any women meeting that criteria will be signposted to their GP.

All participants will be fully debriefed and signposted to general mental health support services (Samaritans, GP) and those specific to postnatal women (e.g. Cocoon Family Support).

8. Details of participants (e.g. age, gender, exclusion/inclusion criteria). Please justify any exclusion criteria.

Focus group participants will be postnatal women, fluent in spoken English, over the age of 18 with a child/children over 1 year old (given NICE guideline's definition of a 'postnatal' woman being up to a year after birth considered in connection with the ethical caution, based on NICE 2014 clinical guidelines that birth experience should not be talked about with those suffering from PTSD postnatally: beyond the 12 month marker feels ethically more sound for any participant who may have undiagnosed

PTSD, although initial screening will seek to rule out participants who may experience undiagnosed PTSD as much as possible).

Participants meeting the criteria (A-E) for PTSD according to the DSM 5 (see Appendix 8) (in which there is no specific subsection for postpartum PTSD), will be excluded. Screening for this will be sensitively handled over the phone, after a potential participant has showed interest in taking part in the study and prior to signing consent, using the IES-R (Appendix 7), which the researcher deems, given it's lay language and fewer (22) items, a more appropriate screening measure compared to e.g. Foa's 2013 Post-Traumatic Diagnostic Scale (24 items and includes a list of traumas without mentioning childbirth). Should the potential participant meet the criteria for PTSD, the Researcher will signpost her on to both her GP and relevant organisations such as The Birth Trauma Association. The Researcher will also offer a follow-up phonecall as both support and to manage any potential risk.

Non English-speaking participants will also be excluded.

Three separate groups of between 4-8 women from different London locations will make up the focus groups - the different locations feeling useful in this study's attempt to gain access to as many different socio-cultural and economic groups, and therefore discourses as possible. There will be no upper age restriction since it is unrelated to this study's interest, and given this study's general as opposed to pathological focus.

Participants will not be excluded if they know each other, given Wilkinson's direction that focus groups may comprise pre-existing groups of people or brought together specifically for the research (2008).

Visual data: any 'authors' used will have public profiles (the pictures they post therefore intended for general observation and reposting), will be over 18, and will be anonymised. Any identifying details will be hidden. Any comments used in the analysis will also be anonymous.

9. How will participants be selected and recruited? Who will select and recruit participants?

Focus groups: Women will be recruited via purposive sampling (the rationale for this rather than word of mouth or snowballing techniques, being to reach beyond my own mother and baby network). Participants will be recruited by the researcher by visiting and handing out flyers at independent mum and baby groups in separate London locations to establish a range of socio-economic groups comprising the participants. The groups will not be NHS related. The first 4-8 participants who contact the researcher will be called by the researcher, verbally given more information as well as emailed over a written information sheet **(see Appendix 2**), and sensitively screened for PTSD – which the Researcher will question the potential participant about with questions based on Criteria A, B, C and D for PTSD (DSM 5).

Visual data: Data will be selected by purposive sampling by the researcher, based on postnatal women posting about childbirth with the largest followings (the rationale that a lower end of 45k followers suggests sufficient prominence and reach within the demographic) on Instagram, and by searching via childbirth tags. All 'authors' of posts will be necessarily have public profiles and will be anonymised, as will any public comments to the images used in the analysis.

10. Will participants receive any incentives for taking part? (Please provide details of these and justify their type and amount.)

No financial incentive will be offered for fear of establishing the focus group as an observed piece of research within an institutional framework where participants need to deliver something 'valuable'. Travel expenses need not be offered given the local setting of the research.

11. Will informed consent be obtained from all participants? If not, please provide a justification. (Note that a copy of your consent form should be included with your application, see question 19.)

Focus groups: Yes. Please see Appendix 2 for consent form.
Visual data taken from Instagram: Only those 'authors' of visual posts who have a fully public profile, in which their posts can be seen by anybody with an Instagram account and reposted without permission, will be used: the BPS's ethical guide to internet-mediated research, suggests that in such cases a specific request for consent is not necessary. All identifiable details, names and the names of comments will be changed by the researcher.

12. How will you brief and debrief participants? (Note that copies of your information sheet and debrief should be included with your application, see question 19.)

Focus groups: potential participants will be generally advised of the study's aims – to study ways of speaking about childbirth – at all points (recruitment, phone screening and in briefing and gaining consent before the start of the focus group: **see Appendices 1-4**). This is felt to be important given the criticisms around studies in discourse and language being at risk of disregarding the subjective experience of the individual.

Participants will be fully debriefed by the researcher at the end of the focus group, verbally and with a debrief sheet (**see Appendix 5),** with supportive services provided, and an invitation to contact the Researcher or the Researcher's supervisor should they have questions or wish to withdraw from the study at any time.

13. Location of data collection. (Please describe exactly where data collection will take place.)

Focus groups will be carried out at local community centres, the rationale for this being that the familiarity of the surroundings will hopefully prevent introduce additional institutionally or power-related structures into the discussion, which may affect which discourses the participants take up within the focus group, which a university location might. The localised location may also encourage participation given the participants may need to source childcare.

13a. Is any part of your research taking place outside England/Wales?

No	**x**	
Yes		If 'yes', please describe how you have identified and complied with all local requirements concerning ethical approval and research governance.

13b. Is any part of your research taking place <u>outside</u> the University buildings?

No		
Yes	x	If 'yes', please submit a risk assessment with your application or explain how you have addressed risks.

The focus groups will be held in the daytime, and the researcher will ensure that there is another adult in the building at the same time, aware of the time and duration of the focus group, who has my own contact details, to limit risk in the event of external risk such as a fire/alarm.

The research supervisor will also be aware of the date, time and location of the focus group, should an external event happen or in the event of unanticipated risk occurring within the focus group (e.g. severe psychological or emotional distress or illness), so that they can be available and contactable for support or direction.

The researcher will use her clinical experience and opinion to deem whether risk to an individual or the group is high and outweighs the social benefit of the research, in which case she will consequently stop the group. The researcher's supervisor will be then be called, and follow ups with all participants will be carried out by the researcher, either by phone call or in person, including a full verbal and written debriefing.

13c. Is any part of your research taking place <u>within</u> the University buildings?

No	x	
Yes		If 'yes', please ensure you have familiarised yourself with relevant risk assessments available on Moodle.

14. What potential risks to the participants do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

Focus groups: The focus groups will be held in the daytime, in a room hired within a community centre, with other people aware (within the building, and also the research supervisor) of the time, location and date. A full risk assessment will be carried out and thought about with the research supervisor ahead of time. In the case of unanticipated risk – fire, illness of participant, levels of distress too high – the researcher will use her clinical judgement to end the group, call her supervisor and ensure that each participant is fully followed up with, debriefed and signposted to the relevant support services (Appendix 5).

The researcher hopes to avert risks such as arguments, offensive remarks within the group by full facilitation and collaborative group 'rules' at the start of the group and by representing a supportive but protective presence.

Visual data: given the public data sharing premise of Instagram, there is little risk anticipated in using publically posted images. However researcher reflexivity will be heavilty utilized to ensure that the author's dignity and rights, in line with the BPS general and internet-mediated research ethical guidelines, take priority. Anonymising identifying names and details also aims to avert any ethical risk.

15. What potential risks to the researchers do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

To deal with unanticipated risk (such as fire, a participant becoming violent or ill) the researcher will ensure that the focus groups are held in a prominent, accessible local community centre, with other people – aware of the focus group, its size, duration – in the building at the same time. The research supervisor will also be aware of the time, date, location of the focus group should the group have to be stopped for reasons of risk to a participant or herself, and the researcher will have her phone number readily available should she need it.

In terms of the content of talk generated in the focus group bringing something upsetting or distressing to the conscious experience of the researcher concerning her own experience of childbirth: personal therapy, consultation with her research supervisor and also reflexive journaling will seek to understand, address and work through these – researcher reflexivity being key.

16. What methods will you use to ensure participants' confidentiality and anonymity? (Please note that consent forms should always be kept in a separate folder to data and should NOT include participant numbers.)

Please place an 'X' in all appropriate spaces

Complete anonymity of participants (i.e. researchers will not meet, or know the identity of participants, as participants are a part of a random sample and are required to return responses with no form of personal identification.)	

Anonymised sample or data (i.e. an *irreversible* process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates.)	
De-identified samples or data (i.e. a *reversible* process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location.)	**X**
Participants being referred to by pseudonym in any publication arising from the research	**x**
Any other method of protecting the privacy of participants (e.g. use of direct quotes with specific permission only; use of real name with specific, written permission only.) ***Please provide further details below.***	

17. Which of the following methods of data storage will you employ?

Please place an 'X' in all appropriate spaces

Data will be kept in a locked filing cabinet	**x**
Data and identifiers will be kept in separate, locked filing cabinets	**x**
Access to computer files will be available by password only	**X**
Hard data storage at City, University of London	
Hard data storage at another site. *Please provide further details below.*	

18. Who will have access to the data?

Please place an 'X' in the appropriate space

Only researchers named in this application form	**x**
People other than those named in this application form. *Please provide further details below of who will have access and for what purpose.*	

19. Attachments checklist. *Please ensure you have referred to the Psychology Department templates when producing these items. These can be found in the Research Ethics page on Moodle.

Please place an 'X' in all appropriate spaces

	Attached	**Not applicable**
***Text for study advertisement**	**x**	
***Participant information sheet**	**X**	
***Participant consent form**	**x**	
Questionnaires to be employed		**x**
Debrief	**x**	
Copy of DBS	**x**	
Risk assessment		**x**
Focus group agenda	**x**	

20. Information for insurance purposes.

(a) Please provide a brief abstract describing the project

There is emerging acknowledgement that childbirth is being constructed and communicated in non 'woman-oriented terms' – both by postnatal woman (evident in contemporary literary, political, social and multimodal contexts) and also in the dominant expert medical, psychological and midwifery literature. This study seeks to map out the dominant discourses on childbirth and explore how they constitute both the practice of childbirth, and therefore the experience of childbearing and postnatal women, and the subsequent implications this may have for subjectivity. Using a micro-macro discourse analysis approach, identified as a gap in the literature, expert literature of medical and perinatal texts will be read in relation to naturally occurring talk and discussion about childbirth generated by 2-3 researcher-facilitated focus groups of 4-8 postnatal women and visual data 'authored' by prominent postnatal women on Instagram (which this study classifies as 'authors' with over 45k followers).

Within this framework, the following research questions will be explored:

- What are the available discourses on childbirth offered up by expert texts?
- How do women construct their experience of childbirth postnatally?
- What subject positions, practices and possibilities for subjective experience are made available by these discourses?

Please place an 'X' in all appropriate spaces

(b) Does the research involve any of the following:	**Yes**	**No**
Children under the age of 5 years?		x

Clinical trials / intervention testing?		X
Over 500 participants?		X
(c) Are you specifically recruiting pregnant women?		X
(d) Excluding information collected via questionnaires (either paper based or online), is any part of the research taking place outside the UK?		x

If you have answered 'no' to all the above questions, please go to section 21.

If you have answered 'yes' to any of the above questions you will need to check that the university's insurance will cover your research. You should do this by submitting this application to insurance@city.ac.uk, before applying for ethics approval. Please initial below to confirm that you have done this.

I have received confirmation that this research will be covered by the university's insurance.

Name …… Date……

21. Information for reporting purposes.

Please place an 'X' in all appropriate spaces

(a) Does the research involve any of the following:	**Yes**	**No**
Persons under the age of 18 years?		x
Vulnerable adults?		X
Participant recruitment outside England and Wales?		x
(b) Has the research received external funding?		x

22. Final checks. Before submitting your application, please confirm the following, noting that **your application may be returned to you without review** if the committee feels these requirements have not been met.

Please confirm each of the statements below by placing an 'X' in the appropriate space

There are no discrepancies in the information contained in the different sections of the application form and in the materials for participants.	x
There is sufficient information regarding study procedures and materials to enable proper ethical review.	X
The application form and materials for participants have been checked for grammatical errors and clarity of expression.	X
The materials for participants have been checked for typos.	x

23. Declarations by applicant(s)	
Please confirm each of the statements below by placing an 'X' in the appropriate space	
I certify that to the best of my knowledge the information given above, together with accompanying information, is complete and correct.	x
I accept the responsibility for the conduct of the procedures set out in the attached application.	x
I have attempted to identify all risks related to the research that may arise in conducting the project.	**x**
I understand that **no** research work involving human participants or data can commence until ethical approval has been given.	x

	Signature (Please type name)	**Date**
Student(s)	**Helena Curran**	**8/11/2017**
Supervisor	**Julianna Challenor**	**9.11.17**

Reviewer Feedback Form

Name of reviewer(s).
Daphne Josselin
Email(s).
Daphne.Josselin@city.ac.uk
Does this application require any revisions or further information?
Please place an 'X' the appropriate space

No Reviewer(s) should sign the application and return to psychology.ethics@city.ac.uk, ccing to the supervisor.		**Yes** Reviewer(s) should provide further details below and email directly to the student and supervisor.	X

Revisions / further information required

To be completed by the reviewer(s). PLEASE DO NOT DELETE ANY PREVIOUS COMMENTS.

Date: 10.11.2017

Comments:

Dear Helena,

Thank you for clarifying the few points flagged in my comments. You may also consider 'accepting' the changes discussed with Julianna so your documents no longer display them.

Warm regards,

Daphne

Applicant response to reviewer comments

To be completed by the applicant. Please address the points raised above and explain how you have done this in the space below. You should then email the entire application (including attachments), **with changes highlighted** directly back to the reviewer(s), ccing to your supervisor.

Date: Response:
Reviewer signature(s) To be completed upon FINAL approval of all materials.

	Signature (Please type name)	**Date**
Supervisor	**Julianna Challenor**	**16.11.17**
Second reviewer	**Daphne Josselin**	**15.11.2017**

APPENDIX 12: Ethics approval

Psychology Research Ethics Committee
School of Arts and Social Sciences
City University London
London EC1R 0JD

06 December 2017

Dear Helena and Julianna

Reference: PSYETH (P/L) 17/18 40

Project title: ***Nobody Told Me': A qualitative study on the construction of childbirth in postnatal women.***

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval
Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments
You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants
(b) Change, or add to, the research method employed
(c) Collect additional types of data
(d) Change the researchers involved in the project

Adverse events
You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee (anna.ramberg.1@city.ac.uk), in the event of any of the following:

(a) Adverse events
(b) Breaches of confidentiality
(c) Safeguarding issues relating to children and vulnerable adults
(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

TBC
Ethics committee Secretary
Email: psycology.ethics@city.ac.uk mailto:alice.kingsnorth.1@city.ac.uk

Sophie Lind
Chair
Email:Sophie.Lind.2@city.ac.uk

APPENDIX 13: IES-R: Screening measure for PTSD

IMPACT OF EVENTS SCALE-Revised (IES-R)

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to _____ _____(event) that occurred on _____(date). How much have you been distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Any reminder brought back feelings about it	0	1	2	3	4
2. I had trouble staying asleep	0	1	2	3	4
3. Other things kept making me think about it.	0	1	2	3	4
4. I felt irritable and angry	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
6. I thought about it when I didn't mean to	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8. I stayed away from reminders of it.	0	1	2	3	4
9. Pictures about it popped into my mind.	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb.	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4
16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from my memory.	0	1	2	3	4
18. I had trouble concentrating.	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on-guard.	0	1	2	3	4
22. I tried not to talk about it.	0	1	2	3	4

Total IES-R Score:_____

INT: 1, 2, 3, 6, 9, 14, 16, 20
AVD: 5, 7, 8, 11, 12, 13, 17, 22
HYP: 4, 10, 15, 18, 19, 21

Weiss, D.S. (2007). The Impact of Event Scale-Revised. In J.P. Wilson, & T.M. Keane (Eds.)
Assessing psychological trauma and PTSD: a practitioner's handbook (2nd ed., pp. 168-189). New York: Guilford Press.

AETR2N 22 1/13/2012

Revised Impact of Event Scale (22 questions):

The revised version of the Impact of Event Scale (IES-r) has seven additional questions and a scoring range of 0 to 88.

On this test, scores that exceed 24 can be quite meaningful. High scores have the following associations.

Score (IES-r) **Consequence**

24 or more	PTSD is a clinical concern.[6] Those with scores this high who do not have full PTSD will have partial PTSD or at least some of the symptoms. .
33 and above	This represents the best cutoff for a probable diagnosis of PTSD.[7]
37 or more	**This is high enough to suppress your immune system's functioning** (even 10 years after an impact event).[8]

The IES-R is very helpful in measuring the affect of routine life stress, everyday traumas and acute stress

APPENDIX 14: DSM-5 Diagnostic criteria for PTSD

Posttraumatic Stress Disorder

Diagnostic Criteria **309.81 (F43.10)**

Posttraumatic Stress Disorder

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

   Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

   Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

   Note: In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

   Note: In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Posttraumatic Stress Disorder for Children 6 Years and Younger

A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.