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Voicing the silence: the maternity care experiences of women who were sexually abused in childhood

by

Elsa Montgomery

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ABSTRACT

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VOICING THE SILENCE: THE MATERNITY CARE EXPERIENCES OF WOMEN WHO WERE SEXUALLY ABUSED IN CHILDHOOD

Elsa Mary Wells Montgomery

Childhood sexual abuse is a major, but hidden public health issue estimated to affect approximately 20% of females and 7% of males. As most women do not disclose to healthcare professionals, midwives may unwittingly care for women who have been sexually abused. The purpose of this study was to address the gap in our understanding of women's maternity care experiences when they have a history of childhood sexual abuse with the aim of informing healthcare practice.

This narrative study from a feminist perspective, explored the maternity care experiences of women who were sexually abused in childhood. In-depth interviews with women, review of their maternity care records and individual and group interviews with maternity care professionals were conducted. The Voice-centred Relational Method (VCRM) was employed to analyse data from the in-depth interviews with women. Thematic analysis synthesised findings, translating the women's narratives into a more readily accessible form. The main themes identified were: narratives of self, narratives of relationship, narratives of context and the childbirth journey. Medical records provided an additional narrative and data source providing an alternative perspective on the women's stories. Silence emerged as a key concept in the narratives. This thesis contributes to 'Voicing the silence'.

The particular contribution of the study is its focus on the women's voices and the use and development of VCRM to listen to them. It highlights where those voices are absent and where they are not heard. Women want their distress to be noticed, even if they do not want to voice their silence. The challenge for those providing maternity care is to listen and respond to their unspoken messages and to hear and receive their spoken ones with sensitivity.

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DECLARATION OF AUTHORSHIP

I, Elsa Montgomery

declare that the thesis entitled

Voicing the silence: the maternity care experiences of women who were sexually abused in childhood

and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

- this work was done wholly or mainly while in candidature for a research degree at this University;
- where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- where I have consulted the published work of others, this is always clearly attributed;
- where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- none of this work has been published before submission.

Signed: ……..

Date:……

Acknowledgements

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Thanks are due to all those who made useful comments when I was developing the proposal and to those who subsequently helped with recruitment: CIS'ters who first opened my eyes to the enormity of childhood sexual abuse, counsellors at the local Rape Crisis Centre, midwives and other health care professionals. I am grateful to the team in the Medical Records Department for their assistance with accessing maternity care records. My thanks also go to the maternity care professionals who participated in interviews. I am indebted to the Iolanthe Midwifery Trust for granting me a 'Midwife Award', which funded two training courses on qualitative interviewing skills.

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1. Chapter One: Introduction

1.1 Prologue

One day in December 2005, I was present as two members of CIS'ters (a national support group for women who were sexually abused and/or raped as girls by a family member) spoke to pre-registration students at the university in which I am a lecturer in midwifery. This thesis begins with an extract from the birth story that one of them shared with us. It has been edited to maintain anonymity but is essentially unchanged. This is where my story begins too.

> *…I did a pregnancy test at home, which was positive. Immediately my mind jumped from two blue lines in front of me to labour, in the space of seconds. I was only four weeks pregnant and found out so early due to having severe morning sickness which led to me being hospitalised two days later into the maternity ward. I spent over seven months in hospital, with every complication possible, some were medical, others no reason could be found for them….*
>
> *My first concern with being pregnant was I was no longer in control of what was happening to my body, there was a baby growing inside me which had to come out, and how could I get through this emotionally in one piece.*
>
> *I felt being open about my childhood sexual abuse would help me get the support and care I needed from the midwives at the hospital to get me through this. At my first appointment I summoned the energy and courage to tell the midwife – she did write it in my notes, however subsequent midwives didn't read the notes, and I found myself having to retell the story time and again to different midwives, SHOs, JHOs, Registrars and Consultants.*
>
> *I was told I had a named midwife who would see me regularly. In the first five months I never saw the same person twice, apart from the*

midwives in the maternity ward that became my home for most of my pregnancy.

With survivors it is vital that we connect with someone regularly who we can build trust with, so we can share our fears and concerns with.

There is an immense pressure put on women in general to be pregnant and ecstatic, that it's the happiest time of our lives, we should be so excited about our baby being born and we want to plan our birth plan with excitement and enthusiasm.

For me being pregnant was the most terrifying thing that I ever had to go through as an adult to that point. The loss of control, I didn't want to think about a birth plan because my brain kept telling me I wasn't doing it, that I couldn't do it. I asked very early on in my pregnancy if I could have a planned C Section, so I felt in control, of something. The thought of being alone, going into labour, terrified me beyond belief, but the midwife said best for baby was normal delivery. What about what was best for me???

I felt during my pregnancy I lost my identity as a person and my needs didn't matter, what I thought or felt brushed under the carpet adding to the pressure I felt. Everything revolved around the baby and what the baby needed. I felt like a test tube, nameless, doing a job for nine months and no one cared how the next nine months and labour were going to affect me.

For a survivor who has been sexually abused, our bodies are not a place of nurture, we have been violated, our bodies used by another person. The thought my baby was growing inside me in a place where their sperm had been and my baby had to come out from there where they had also, didn't make me feel good. I associated all gynae areas and other parts of my body with my abuse and this was now the area, now holding my baby.

I can appreciate breastfeeding may be best for baby's and mum's physical health. On my first hospital admission at four weeks pregnant they asked me if I planned to breast feed and continued to ask me every time I attended appointments. My answer was a clear no!!! No way, no chance, I didn't want to do it. They heaped on the pressure of it was best for baby and made me feel guilty for not wanting to do it or even not being willing to try it. The midwife's reply time and time again to me after I said no was… 'So you have not decided!!!' I had decided. I didn't want to do it, I had made up my mind. In that reply to me, she reinforced I didn't have the right to say no and no control over what happened to my body.[1]

There was a still silence in the room as the speaker stood before us and falteringly read the account of her pregnancy, birth and the struggle she had to be heard throughout it. Moved by her account, the students broke in to spontaneous applause as she finished recounting her experiences.

1.2 Background

My study is an exploration of the maternity care experiences of women who were sexually abused in childhood and its purpose is to inform midwifery practice.

I had proffered the invitation to CIS'ters and had gone in to the session described above naïvely, believing that in my clinical practice I had not looked after anyone who had experienced childhood sexual abuse. However, as the second speaker told us of its prevalence I realised that I must have done. This was a very uncomfortable realisation. The speaker highlighted a lack of

[1] Reproduced with permission. The episodes described occurred in a different part of the United Kingdom from the research setting.

research into the subject and indicated that CIS'ters would welcome the opportunity to collaborate with the university in conducting some.

I performed some preliminary literature searches but could find no relevant studies from the UK, although Lis Garratt (2008) has since completed her PhD entitled 'The childbearing experiences of survivors of childhood sexual abuse' and subsequently produced a book from it (Garratt 2011). I found it hard to believe that so little research had been done and was concerned at the apparent lack of consideration for women's needs from a profession that espouses woman-centred care. This prompted my doctoral study.

1.3 Childhood sexual abuse and childbearing women

Childhood sexual abuse has been described as one of the most serious public health problems facing society (Finkelhor 1994; Pereda et al. 2009a). Accounts of personal experiences (Gutteridge 2001; Hanan 2006; Rose 1992; Rouf 1999; Skinner 2010) and individual case studies (Smith 1998b; Tidy 1994) within the midwifery press have testified to the emotional trauma that women who were sexually abused in childhood may suffer during childbirth. They have also recognised the potential for caregivers to make the situation worse. Evidence suggests that there are significant mental and physical sequelae of childhood sexual abuse including depression, substance and alcohol abuse, eating disorders, risky sexual behaviour, gastro-intestinal disturbance, gynaecological problems and chronic pain, among others (Heritage 1998; Hobbins 2004; Itzin 2006; Lukasse et al. 2009; Seng et al. 2008). In addition Lukasse et al. (2009) found an association between childhood abuse (physical, emotional and sexual) and increased reporting of common complaints in pregnancy (such as heartburn, backache, tiredness and constipation).

However, childhood sexual abuse is a hidden issue (McGee et al. 2002; Radford et al. 2011; Simkin & Klaus 2004) and those affected are a silent group (Simkin and Klaus 2004). Women who have experienced childhood sexual abuse feel guilt and shame (Gutteridge 2001; Hobbins 2004; Leeners et al. 2006b; Seng et al. 2002) and can be secretive (Gutteridge 2001). They may feel unsafe and

vulnerable (Rouf 1999) and have a need to retain control (Garratt 2002; Howarth 1995; Rouf 1999; Simpkins 2006). Health care is often reminiscent of abuse for these women (Garratt 2002; Kitzinger 1990; Rose 1992), but from the perspective of the caregivers, the women may be labelled 'difficult' (Aldcroft 2001; Garratt 2002; Rouf 1999; Simpkins 2006).

1.4 Defining childhood sexual abuse

What constitutes childhood sexual abuse is the subject of much discussion within the literature and the definition varies considerably both within and between countries. Issues of age, consent and whether or not there is physical contact are all debated (Cawson et al. 2000; McGee et al. 2002; Radford et al. 2011; Squire 2009).

The following fairly lengthy definition is provided by the Department for children, schools and families (2010 p38):

> [Childhood] *sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.*

Although this definition is detailed and explicit about the range of activity that may constitute childhood sexual abuse, it has some limitations. As Corby

(2006) points out when commenting on an earlier government definition, it does not mention age (of either the child or the perpetrator) and does not differentiate between familial and extra familial abuse.

The following definition from the US National Center on Child Abuse and Neglect is helpful (Roth 1978 p2).

> *Contacts or interactions between a child and an adult when the child is being used for the sexual stimulation of the perpetrator or another person. Sexual abuse may also be committed by a person under the age of 18, when that person is significantly older than the victim or when the perpetrator is in a position of power or control over another child.*

I have defined 'child' as less than sixteen years of age for my research as this is the age of consent in the UK. In reviewing studies of childhood sexual abuse Cawson et al. (2000) discovered that a five-year age gap was most commonly used to quantify 'significantly older'. Although Roth's definition excludes consensual relationships between children, it implies that where a five year age gap exists, even if a relationship is consensual, it could be considered abusive.

Although there may be alternative discourses (Worrell 2001), I am working from a belief that any action performed to obtain sexual gratification from a child warrants the label 'abuse'. Given that not all work is based on this assumption consistency in language is difficult. In this thesis I use terms as employed in the studies under discussion. I therefore sometimes refer to 'abuse' and sometimes 'unwanted sexual exposure'. For the purposes of my research defining what happened to the women when they were children, or indeed who did it, was not essential to understanding the effect it had on them and the impact on their maternity care experiences. As my study accessed women who had already disclosed childhood sexual abuse, they were a self-defining group.

1.5 Prevalence of childhood sexual abuse

Given these definitional issues, establishing the prevalence of childhood sexual abuse is also problematic. In their systematic review of 38 studies from 21 different countries, Pereda et al. (2009a) found rates of between 0% and 53% amongst females and between 0% and 60% among males. However, these figures are somewhat misleading as all but two studies demonstrated a higher prevalence in women than men. The authors acknowledged a high variability among studies and the methodological problems inherent in childhood sexual abuse research. Nevertheless, they recognised it as an international problem. This was confirmed in their slightly later meta-analysis that included studies from 22 countries many of which featured in the initial review (Pereda et al. 2009b). Having excluded outliers, they reported some form of sexual abuse prior to the age of 18 in 19.2% of women and 7.4% of men. One of the studies included in this meta-analysis was a large-scale survey from the UK (May-Chahal & Cawson 2005), that reported unwanted sexual exposure before the age of 16 in 21% of girls and 11% of boys. Funded by the National Society for the Prevention of Cruelty in Children (NSPCC), this random survey of 2869 young people between the ages of 18 and 24 investigated all forms of maltreatment (Cawson et al. 2000). Data were obtained via face to face interviews using Computer Assisted Personal Interviewing. Questions about exposure to particular experiences were asked and answers relating specifically to the participants' own childhood were typed directly in to the computer by the participant. The authors sought to establish robust and replicable measures and their approach should have helped to avoid not only the issue of varying subjective definitions of 'abuse', but also participants' embarrassment which may have interfered with provision of honest answers.

McGee et al.'s (2001) survey on Sexual Abuse and Violence in Ireland (the SAVI report) did not feature in the work of Pereda et al. (possibly because their meta-analysis was of studies that had been published in scientific journals and the SAVI survey was a report from the Royal College of Surgeons in Ireland) It involved 3120 unsolicited telephone interviews. The authors gave careful consideration to the significant ethical issues engendered by their study and achieved a response rate of 71.4%. They report prevalence of 20.4% for contact abuse alone and an overall rate of nearly one third. One of the

strengths of this study is that it comprised a random sample from the general population which, unlike the NSPCC study (May-Chahal & Cawson 2005) was not limited to young people. The random sample selection in both of these surveys suggests that results are likely to be reasonable reflections of the prevalence of childhood sexual abuse. Other studies, such as the cross-sectional study across five Nordic countries by Wijma et al. (2003) broadly corroborate the magnitude of the problem. They found a prevalence of 24% (range 17-33%). However, as these were women attending gynaecology clinics, they were not necessarily representative of the general population. It is well established that those who were sexually abused in childhood have an increased risk of gynaecological problems (Itzin 2006).

The NSPCC recently updated the survey by Cawson et al. (2000). The latest version explored both lifelong and current (past year) child abuse and neglect (Radford et al. 2011). The methodology employed was very similar. Interviews were conducted with 1761 18-24 year olds in addition to 2275 interviews with 11-17 year olds and 2160 interviews with the parents or guardians of children under the age of eleven. Although one aim was to compare results to the earlier survey, the authors also wanted to facilitate comparison with other large-scale studies worldwide and they therefore defined 'childhood' as under eighteen years rather than sixteen as previously. Comparisons between the two studies therefore require caution as there are no directly comparable results in relation to sexual abuse. Their findings suggest that overall 24.1% of 18-24 year olds have experienced some form of sexual abuse. There does not appear to have been any differentiation of this figure by gender. However they report that 17.8% of females and 5.1% of males aged 18-24 admitted to contact sexual abuse during childhood (see section 1.4 for a definition).

Although published figures are likely to be an underestimate (Cawson et al. 2000; Corby 2006; McGee et al. 2002; Radford et al. 2011), it is widely accepted that that approximately one in five women will have had some form of unwanted sexual exposure before the age of sixteen.

1.6 Implications for maternity care

Few women disclose their history of childhood sexual abuse to healthcare professionals (Cawson et al. 2000; Coles & Jones 2009; McGee et al. 2002; Radford et al. 2011). Indeed 41.2% of McGee et al.'s sample had not previously told anyone. Among Radford et al.'s sample no one else knew in 34% of cases where there had been contact sexual abuse by an adult and 82.7% where there had been contact abuse by a peer. It is therefore not possible to estimate accurately how many women seeking maternity care will have been sexually abused in childhood. Furthermore, some women bury memories of childhood abuse (Simkin & Klaus 2004; Williams 1994) and childbirth can be the trigger that causes them to remember (Simkin & Klaus 2004; Waymire 1997). Others fear being judged too much to risk disclosure (Garratt 2002). Inevitably midwives will care for women without knowing of their history (Aldcroft 2001; Garratt 2002; Rouf 1999; Simkin 1992b). This would be of concern for any professional delivering health care, but is particularly so in midwifery which by its nature involves intimate contact. It follows that if services are to be sensitive to women who have experienced childhood sexual abuse there is a need for research into the issue so that their experiences can be understood and maternity care professionals can learn how to support them. However, before considering the specific needs of women who have been sexually abused, an insight into how women in general experience pregnancy and birth is helpful in determining the extent to which those with a history of abuse differ. The following section provides an insight but it is not intended to be an exhaustive review of the literature.

1.7 The experience of pregnancy and birth

Pregnancy, birth and transition to motherhood are profound events in any woman's life (Raphael-Leff 1991; Stephens 2004). They have been described not only as normal physiological processes but also significant social and emotional events (Dahlen et al. 2010). Stewart (2004 p33) suggests that 'Childbirth is, or at least should be, primarily about women's experiences'. It is therefore surprising that there is relatively little research that focuses exclusively on women's experiences of pregnancy and birth. One explanation,

proposed by Larkin et al. (2012 p104) is that maternity services are measured by mortality figures and that women's experiences are not recognised as a 'vital component of that evidence'. Nevertheless, there have been some attempts to explore women's experiences over the years. Margaret Llewelyn Davies' pioneering work (1978) first published in 1915, aimed to allow working women to tell their stories of maternity in their own way. Ann Oakley's classic research (Oakley 1980; 1986) recognised the need for publicly accessible information from women about their experiences. However, this work is as much about transition to motherhood as about the experience of pregnancy and birth. Much of the more recent evidence on women's experiences of childbirth is provided by large-scale surveys (Declercq et al. 2006; Green et al. 1998; Redshaw et al. 2007; Redshaw & Heikkila 2010) and therefore affords limited insight into the aspects of the experience that are of particular concern to the women and the meanings they ascribe to them. Nevertheless, as noted by the authors, the fact that women engage in surveys and are prepared to commit significant amounts of time completing them at a period when they are very busy suggests that they are keen to share their views (Declercq et al. 2006; Green et al. 1998; Proctor 1999).

In the United Kingdom, surveys generally present a positive view of maternity services. Redshaw and Heikkila's (2010) survey of 10,000 randomly selected women who gave birth in a two week period October to November 2009 reported that 88% of women were satisfied with care during pregnancy, 87% during labour and birth and 76% with postnatal care. However, the notion of 'satisfaction' has been criticised in relation to maternity care (Proctor 1999; van Teijlingen et al. 2003). It has also been recognised that older, better educated, more affluent women tend to be over-represented in such samples (Green et al. 1998; Redshaw & Heikkila 2010). These are the women Green et al. (1998) suggest are traditionally thought to have unrealistic expectations of birth as a fulfilling experience and who therefore face disappointment. This would seem to be contrary to such positive evaluations. The evidence in Green et al.'s study did not actually uphold this stereotype. For example, they found that women who wanted to cope in labour without drugs were not naïve about pain and that having high hopes did not necessarily lead to feelings of failure and dissatisfaction. Indeed, women with low expectations who were followed

up from this study had worse psychological outcomes than those with high expectations. In Dahlen et al.'s (2010) grounded theory study of 19 women giving birth for the first time at home and hospital in Australia, women who chose to give birth at home tended to have high expectations but also more realistic expectations of what pain would be like. However in another study, women admitted to unrealistic expectations related to becoming established in labour and these women were disappointed when their expectations were not met (Larkin et al. 2012). In their phenomenological study of women's perceptions of labour and delivery Halldorsdottir and Karlsdottir (1996), discovered that women's expectations could influence their perceptions of the birth experience. Reactions varied between women. Some felt failures if the experience was worse than expected and others were pleasantly surprised if their journey was easier than anticipated. Not surprisingly therefore, when dealing with an issue that has been described as the 'essential experience of being a woman' (Stephens 2004 p42), considerable variation is uncovered between individuals – especially when the methodology permits an in-depth examination of their experiences.

Despite this, there are some consistent themes that occur in both large surveys and smaller qualitative studies. The overarching themes relate to control, the need for information, support and pain. These are inter-related and are discussed below.

1.7.1 Control

Control is a key concept in the literature and can be either internal (i.e. self-control) or external (i.e. related to what others are doing). Both are important to a woman's experience of birth and subsequent emotional wellbeing (Green et al. 1998; Halldorsdottir & Karlsdottir 1996). Lavender et al. (1999), conducted a prospective study of 615 women on factors that contribute to a positive birth experience as part of a larger randomized control trial into the use of partograms[2] in labour. Being in control was seen as a positive aspect of

[2] A chart for recording observations of maternal and fetal wellbeing and progress in labour.

labour and 30% of the participants stated that it was necessary for the maintenance of dignity. This compares to 76% of women in the 'Great Expectations' study (Green et al. 1998) who felt that it was either 'very important' or 'quite important' not to lose control of the way they behaved during contractions. Being out of control can be a frightening experience (Larkin et al. 2012) and leave women feeling helpless (Howarth et al. 2011). Conversely the ability to exercise control can be empowering (Callister et al. 2010). A paper comparing data from surveys in England and Sweden (Schytt et al. 2008), reported that remembering having felt in control during labour at six to eight weeks postpartum was significantly linked to the likelihood of an unassisted vaginal birth for Swedish but not English women. However, English women were significantly less likely to have an unassisted vaginal birth if they had felt helpless. Anderson (2000) highlights a paradox in relation to control and the second stage[3] of labour. She acknowledges that losing control appears to be the predominant fear for women, but also suggests that it is the biggest hurdle that needs to be overcome in order to give birth. From her interviews with sixteen women on their experiences of giving birth, she describes how women need to 'let go' psychologically and allow their bodies to take over. Most women in her study talked of experiencing an altered state of consciousness during the second stage. Other authors describe similar states in which women mentally withdraw from their companions, disconnect and enter a private world (Carlsson et al. 2012; Dahlen et al. 2010; Halldorsdottir & Karlsdottir 1996). In this state, women lose track of time but they do not seem to equate this to a loss of control, even though they have 'let go'. There appears to be a difference between giving up control and losing it. A similar dichotomy exists in relation to external control. Studies generally report that women want to be active participants in decisions relating to their labour and birth (Green et al. 1998; Howarth et al. 2011) and their satisfaction is increased when this is the case. However, they also like to feel that healthcare practitioners have the situation under control (Lavender et al. 1999), particularly in emergencies (Green et al. 1998). Some women wanted to hand over responsibility for taking decisions to staff. This was especially true of the women who birthed in hospital in Dahlen et al.'s study (2010). Howarth et al. (2011) cite a woman who was very satisfied with her experiences even though

[3] The time between full dilation of the cervix to the birth of the baby.

she needed a forceps delivery because the personnel involved talked everything through with her. The sharing of information enables women to make informed decisions and this is an integral part of being in control. The need for information is a recurrent theme in the literature.

1.7.2 The need for information

Information seeking is an important part of taking personal responsibility (Howarth et al. 2011). Books, antenatal classes, the internet and midwives were all sources used by women in Howarth et al.'s study. Given that the participants were recruited via a newspaper advertisement and posters, it can be surmised that they were a motivated population and other women might not have the same views on personal responsibility. Nevertheless Carlsson et al. (2012) report similar behaviour in women attempting to 'maintain power' in their study of women's experiences between labour onset and admittance to labour ward. Dahlen et al. (2010) found that women who were planning home births were more prepared than those who were planning hospital births and this was due to support and information from midwives. Lavender et al. (1999) report that 37.4% of women in their study felt unprepared for labour and this was likewise attributed to lack of information. When explanations were given, women were less likely to view labour negatively and being informed contributed to women feeling in control. The giving of information was linked to control in other studies too (Baker et al. 2005; Green et al. 1998; Larkin et al. 2012). This was something that women felt staff should volunteer rather than expecting them to ask as they were focused on their labours (Halldorsdottir & Karlsdottir 1996). Lack of information was an aspect of care that bothered women in Proctor's study (1999) and this was compounded when staff were perceived as being too busy to ask. Support from staff, especially midwives, was an important part of the experience for women, as was the presence of partners.

1.7.3 Support

Several authors note the importance of women being able to share the experience of labour with a partner (Carlsson et al. 2012; Halldorsdottir &

Karlsdottir 1996; Lavender et al. 1999). The time around labour onset was experienced as particularly lonely if partners were sent home (Larkin et al. 2012). The contribution of healthcare providers was vital to a positive experience too (Anderson 2000; Callister et al. 2010; Schytt et al. 2008). Women are generally very positive about midwives in surveys. For example, the vast majority of women in the study by Redshaw and Heikkila (2010) had confidence in staff and felt that they communicated well. Women reported being treated with respect and kindness. In the study by Lavender et al. (1999 p42), midwives were praised for being 'attentive', a 'great comfort' and a 'real friend'. Proctor (1999) found 'staff behaviour' a consistent theme. Friendliness, supportiveness and good clinical skills and knowledge were valued by women. The attitudes of staff and quality of care are central to women's memories and one negative experience can mar their overall impression (Green et al. 1998). Most women in the study by Halldorsdottir & Karlsdottir (1996) reported both caring and uncaring experiences. Almost all women who were interviewed by Baker et al. (2005) commented on the attitudes and behaviour of staff and over half of these women made reference to negative behaviours including being offensive, harsh and intimidating. It is interesting that negative comments appear more common in the qualitative studies. This possibly reflects the freedom women have to express their own views in these studies compared to structured surveys. Nevertheless, midwives were described as 'friendly, helpful and polite' by participants in Beake et al.'s (2010 p5) qualitative study on postnatal care. This is despite the fact that this aspect of care has consistently been rated more negatively than antenatal or labour care (Redshaw et al. 2007; Redshaw & Heikkila 2010). There was recognition that staff were very busy as there was in the study by Larkin et al (2012). Women appear to blame lack of time on the system rather than the individual midwives.

Positive relationships with staff are an important part of feeling in control (Larkin et al. 2012) and uncaring midwives contribute to unfulfilled needs for control (Halldorsdottir & Karlsdottir 1996). Anderson (2000) suggests that getting to know the midwife is important to women and this is supported by Green et al.'s study (1998) in which 62% of women wanted to be looked after by a midwife they had met. Twenty four per cent had met at least one of the

midwives who looked after them and 66% had some degree of continuity. Unfortunately more recent data suggests that only 18% of women had one midwife throughout labour and 81% had not met any of the midwives caring for them before (Redshaw & Heikkila 2010). Being supported by a midwife was significantly related to achieving an unassisted vaginal birth among Swedish but not English women in the comparative study by Schytt et al. (2008). However, the smaller size of the English sample may have impacted on these results. Data from a caseload holding[4] team (Rogers 2008) demonstrate consistently higher levels of spontaneous vaginal birth and lower levels of intervention compared to the rest of the local service despite being in a deprived area. Comments from women corroborated appreciation of issues highlighted here: control, knowing the midwife, receiving good support and good communication. Midwives are valued for the reassurance they provide. Women in the study by Carlsson et al. (2012) hoped to stay at home until labour was established, but nevertheless wanted contact with the midwife to confirm that their experiences were normal. Dahlen et al. (2010) found that midwives were really important (although not always successful) in enabling women to adjust their expectations. This was particularly true in relation to pain.

1.7.4 Experience of pain

Dahlen et al. (2010) describe labour as a powerful force with which some women were able to work and others fought against. Through providing them with a combination of expert knowledge and sympathy, midwives were able to refocus women when they were overwhelmed by their experiences of pain (Dahlen et al. 2010). When women were able to embrace the pain and give way to it, it was potentially an empowering experience (Callister et al. 2010; Dahlen et al. 2010; Howarth et al. 2011). However many women were not prepared for its intensity (Callister et al. 2010; Green et al. 1998). Overpowering pain decreased women's perceptions of control (Halldorsdottir & Karlsdottir 1996) yet medication could have the same effect. Some women therefore chose to manage their own pain in order to remain clear headed (Howarth et al. 2011).

[4] A model of care in which a midwife provides care for a group of women, throughout pregnancy, birth and the postnatal period, irrespective of her risk factors.

Green et al. (1998) found that women who wanted drug-free labours were more likely to find pain worse than expected. They devised control scores for women and were surprised to discover that women with 'high control' scores had an antipathy to analgesia such as Pethidine and epidurals, despite the fact that it is argued that epidurals allow women to remain in control.

Halldorsdottir and Karlsdottir (1996 p48) describe labour as 'both a universal phenomenon and a highly individual experience'. They suggest that women need a sense of control both of themselves and their circumstances as well as caring and understanding from those around them. This is borne out in other literature discussed here in relation to women's experiences of pregnancy and birth. However, studies that have been considered provide information about particular aspects of women's experience of birth in relation to maternity services. The focus is seldom on experience from the woman's perspective. Where focus is on the woman's experience, it rarely considers the whole childbearing process. None of the studies examined appear to have asked women about childhood experiences. It is not therefore possible to know if any of the women in these studies had a history of childhood sexual abuse.

1.8 Summary

In this introduction I have discussed childhood sexual abuse as a significant issue for the health of many women. I have identified an apparent gap in the knowledge base and have suggested that a study exploring the maternity care experiences of women who were sexually abused in childhood is needed. I have shown that control, the need for information, support, and pain are important aspects of the experience of pregnancy and birth for women in general. Leeners et al. (2006b) suggest that childbirth professionals are hampered by a lack of knowledge about the impact of childhood sexual abuse on experiences of pregnancy and birth and that consequently women do not get maternity care that would be of benefit to them. The following chapter critiques the evidence that is currently available to inform that care.

2. Chapter Two: Literature review

2.1 Introduction

Although the desirability of a thorough literature review prior to a qualitative study is debated (Polit & Beck 2010; Silverman 2005; Spencer et al. 2003; Speziale 2007b) there is an ethical obligation for researchers to establish what evidence already exists. This allows for identification of any shortfalls and avoidance of inappropriate repetition of studies. In addition, Kvale (2007) notes that it is difficult to determine the original contribution a study has made without an insight into existing knowledge on the subject. A literature review also informs decisions about methodology. The issue then becomes not whether a literature review should be done, but the extent of it (Bluff 2005). Carpenter (2007b; 2007c) argues that reviewing the literature prior to fieldwork can be detrimental to qualitative investigation but Glaser and Strauss (1999/1967:253), and Strauss and Corbin (1998) recognise that people will come to studies with some knowledge of literature in the field. For them, the important thing is that they are not 'so steeped in it that they are constrained by it' (Strauss and Corbin 1998:49). Other grounded theorists however, suggest that earlier theoretical interpretations should be subject to 'rigorous scrutiny' (Charmaz 2011 p166).

Guyatt et al. (1995) stress both the need to reduce bias and imprecision in reviewing literature and also the importance of differentiating between weak and strong evidence. The traditional hierarchies of evidence that result from this approach tend to privilege systematic reviews of randomised controlled trials (Polit & Beck 2010) and often exclude qualitative research. This can also exclude the voices of those who are not heard in traditional academic arenas such as vulnerable groups. In considering the related literature for this study I therefore faced the dilemma highlighted by feminist researchers (Edwards & Ribbens 1998; Standing 1998). If I engaged with the academic community in a manner that it recognises, I risked silencing or further marginalising the women and negating the purpose of the study. The literature accessed to inform this research therefore encompassed sources that are not usually admitted as 'evidence' such as autobiographical accounts.

The purpose of the literature review presented in this chapter was twofold: to establish the evidence base specifically related to my study to prevent duplication of existing work and to inform the methodology. Further investigation of literature was employed following data analysis in line with emergent findings. This set them in the context of wider knowledge but avoided pre-empting what the key issues might be.

2.2 Search strategy

Initial searches were conducted in February 2008 on the following databases: British Nursing Index, CINAHL, Maternity and Infant Care, MIDIRS Midwifery Digest, Medline and Web of Science. These searches were updated in January 2010 and again in January 2012 on CINAHL, Medline, MIDIRS, PsycInfo and Web of Science as the other databases were no longer available via the university library. Keywords used were: child abuse - sexual, incest, childbirth, midwifery, maternity care, pregnancy and labour. No date limits were set on the searches, but very little was published on the subject before the 1990s and no primary research published prior to 1994 was identified. Reference lists from resulting articles and book chapters were scanned to ensure that no relevant studies had been missed and in addition regular electronic journal alerts and manual searches of key midwifery journals were used to survey newly published material.

The initial searches revealed a paucity of studies with no directly relevant primary research from the UK, although as mentioned in the previous chapter, Lis Garratt's work is now available. Much of the work published has a related, but not directly relevant focus; for example, mental health, post-traumatic stress disorder, sexually transmitted infection and teenage pregnancy. In addition to Garratt's work (2008, 2011), eight relevant studies were identified, written between 1994 and 2009. Two from Australia (Coles & Jones 2009; Parratt 1994), four from the USA (Burian 1995; Rhodes & Hutchinson 1994; Seng et al. 2002; Tallman & Hering 1998) and two unpublished PhD theses from Canada (Lasiuk 2007; Palmer 2004). A European systematic review was

identified (Leeners et al. 2006b) but this focused on the effect of childhood sexual abuse on pregnancy, birth and the early postnatal period rather than maternity care experiences. Anecdotal accounts and review articles from professional press were also identified. Only papers reporting primary research with a focus on the maternity care experiences of women who were sexually abused in childhood are included in the following review.

2.3 Critical review of the studies

In response to observations made in practice, Tallman and Hering (1998) conducted a retrospective survey of 400 births that had occurred in one Natural Childbirth and Family Clinic in Portland USA over a six year period. Although it is not clearly stated, it seems that this was a survey of maternity care records. To be included in the study, women had to be seen during the third trimester and be planning births either at home or in an out-of-hospital birthing centre. All of the women were routinely asked if they had a history of childhood abuse during the taking of their antenatal history. The results of this study therefore rely on women disclosing their abuse and as the authors acknowledge, are thus likely to under-represent the prevalence. Overall, 136 of the 400 (34%) women admitted to having been abused in some way, of which 40% reported sexual abuse and a further 32% reported a combination of emotional, physical and sexual abuse. The remainder reported either emotional or physical abuse only. Ninety per cent of the births studied were 'out-of-hospital', suggesting that this was a population at low risk of obstetric complications, but detail is scant. The women who had disclosed a history of abuse were significantly more likely to have had a change of third trimester attendant, to have been transported in to hospital (no reasons are provided) and to have used hospital pain medication than those with no such history. As indicated above though, it is possible that some women did not disclose abuse that had occurred. From this the authors conclude that there is evidence of clear correlation between a history of abuse and adverse outcomes in labour. They imply that this was caused by the psychological impact of trauma, but they do not provide the details on background characteristics of the women that would be necessary to corroborate that.

Other research also links childbirth with psychological trauma from childhood sexual abuse. Rhodes and Hutchinson (1994) conducted an ethnographic study of survivors of childhood sexual abuse and their care-givers (nurse-midwives and nurses). This involved participant observation over six years on a labour ward on which one of the researchers seems to have been working. The authors mention review board approval for the study and describe their process of gaining consent, but this is apparently in relation to the interviews. It is difficult to see how informed consent for the observation of behaviour and body language that appears to have occurred over six years could have been obtained. Guided interviews were conducted with fifteen participants: eight staff members and seven survivors. Three of the survivors volunteered after hearing about the study and four were approached after the researcher 'observed unusual behaviour during prenatal visits or labor' (Rhodes & Hutchinson 1994 p214). No further detail is given in the paper as to exactly how these women were approached or whether they had previously disclosed childhood sexual abuse. Direct questions about the sexual abuse as well as questions about specific aspects of labour (such as vaginal examinations and pushing) were asked. Data collection also included the coding and analysis of material from popular and professional literature. In presenting results, quotations are used from both the interviews and previously published data. Rhodes and Hutchinson do not distinguish between the two sets of data and thus the reader cannot make a judgment as to the trustworthiness of the data presented or the context in which it was originally gathered without prior knowledge of the studies included. This was therefore a fairly small-scale study with methodological flaws. It also raises some ethical issues in relation to the identification, recruitment and informed consent of participants. The study concentrates specifically on labour rather than other aspects of the maternity care experience. Given issues of rigour raised above, the credibility of results must be questioned yet, along with Parratt (1994), which is discussed below, this study is frequently cited within the literature. The authors identified 'labouring styles' of women who have been sexually abused: fighting, taking control, surrendering and retreating. They suggest that recognition of these and what they represent may be helpful in preventing further trauma for women.

Like Tallman and Hering (1998), Parratt (1994) conducted her study on the experience of childbirth for survivors of incest following observation of the course of labour in a woman who had been sexually abused in childhood. Although she indicated that she was using a phenomenological approach, she started with a conceptual framework. This framework postulated that similarities between the experiences of incest and labour could lead to an alteration in the course of the childbirth experience. Participants were recruited through 'networking' – one was a previous client of Parratt's and the others were members of incest support groups. Six women were interviewed twice. During the first interview participants 'were asked to speak about their childbirth experiences' (Parratt, 1994:29). No detail about how this was achieved was provided, although Parratt said that she had 'a pre-determined list of issues to be covered' (p29) that she occasionally looked at. The purpose of the second interview was validation of information obtained in the first and included specific questions about the transcript of the first interview. Parratt (1994) recognised limitations in her study: it was small scale, it relied on recall – in one case from 21 years previously and arguably was open to bias from her own perspective as a midwife in private practice. The paper also concentrated on labour and birth rather than other parts of the childbearing experience. Despite these limitations, some interesting insights are provided. Parratt concluded by suggesting that the experience of childbirth for survivors of incest is complex and individual. She identified a need for further research to increase the body of knowledge on the experiences of survivors of incest.

Burian's study (1995) also arose from experience of providing maternity care to a woman with a possible history of sexual abuse. This paper was not identified through database searches as it does not specify *childhood* sexual abuse; however it was found via review of the reference lists of other studies. The research involved audio-recorded interviews with nine women: two healthcare providers and seven abuse survivors, two of whom were also healthcare providers. Five of the women were known personally to the investigators although Burian does not indicate whether these included the healthcare professionals. The other women were recruited having heard about the project. Not all the survivors had children even though the purpose of the study was to guide sensitive care in labour. Transcripts of the interviews were

reviewed by the two researchers and consistent themes identified. No details are provided of any interview schedule and there are no examples of data analysis, although quotations from the participants are used to illustrate the strongest themes identified. These were: disclosure and validation, avoidance of health care, frequent somatic complaints, issues of control and dissociation during medical procedures. Burian concludes that women with a history of abuse need repeated assurance that they are safe and recognises that they may manifest deeper needs that are initially apparent in a clinical encounter.

Seng et al. (2002) described complex and diverse needs in their study of women who reported abuse-related post-traumatic stress. This study sought to discover what the women wanted from their maternity care providers. Fifteen women were recruited through advertisements and subsequent snow-ball sampling. The authors do not state where these advertisements were placed. As the researchers were keen to hear women's views, a narrative approach was employed. They describe four components to the ensuing interviews. The first component of the interview required the woman to offer a 'two-minute' version of her story such as she would tell a casual acquaintance. This approach would seem to discourage the woman from relating her story as she chooses – the essence of narrative (Elliott 2005; Riessman 1993), but on reflection, it did serve the intended purpose of orientating the researcher to the childbearing story. It also recognised that people will tell different stories depending on the audience (Elliot 2005). In the second component, women were asked to tell a more in-depth version, with particular attention to whether abuse was disclosed to the care provider, and what was done by the provider that was helpful or unhelpful. The third aspect required the woman to formulate 'take home messages for providers' (p362) – this addressed the care that she would ideally want. Although this enabled women to identify what was important to them, it nevertheless privileged the researcher's agenda over the woman's chronicling of events. The final phase involved a follow up telephone call the next day to check well-being and to ask if there was anything that the woman wanted to add. Seng et al. base their methodological approach on Riessman (1993). Riessman stresses the importance of not interrupting respondents with standardised questions if a story is to emerge from an interview in which participants organise their experiences to make

sense of events and actions in their lives. Although they deliberately avoided a question and answer approach, as described above, the authors seem to have given a fairly strong steer as to where they wanted the focus of the response to be. They briefly describe their methods of analysis but only provide a few, short examples from transcripts to support their categories, so validation of their findings is difficult. However, through an initial descriptive phase of analysis, followed by an interpretive phase, they were able to distinguish three groups of women who needed different responses from their care providers. The participants of this study had experienced a wide range of abuse rather than specifically childhood sexual abuse and in addition had symptoms of post-traumatic stress. The focus was on what was wanted from the healthcare providers rather than on the experience of maternity care and thus it is not directly relevant to my research. Whether it can be called a narrative study is questionable, but it seems well conducted and has provided a useful theoretical contribution in defining three groups of women: those far along in recovery from trauma, those who were not safe and those who were not ready to know (Seng et al. 2002).

Coles and Jones (2009) concentrated on the postnatal period and considered the issues of touch and examination in both mothers and babies. They conducted semi-structured, in-depth interviews with eighteen women who were recruited through advertisements. Thematic analysis was conducted and a proportion of the transcripts were also coded by an experienced independent researcher to ensure rigour. The key themes they identified: safety issues for survivors and their babies in the clinical encounter and ways of making the clinical encounter safer, led them to recommend the use of 'universal precautions', that is, 'making changes for many to protect a few' (Coles & Jones 2009 p235).

The three PhD theses identified are most closely related to my research. Both Canadian studies were conducted by nurses and had a similar aim although they employed different methodologies. Palmer (2004) designed a grounded theory study to enhance understanding of the experience of childbirth for women who are childhood sexual abuse survivors. Lasiuk (2007) wanted to know about the lived experience of pregnancy and birthing of women with

histories of childhood sexual abuse and as such conducted a phenomenological study.

Palmer criticised the focus on labour and delivery by Rhodes and Hutchinson (1994) and Parratt (1994), arguing instead that it is important to explore the entire childbirth experience. She included the views of healthcare providers in order to enrich conceptual development and theory construction. Women were invited to participate via advertisements and brochures that were made available through the recruiting centre (a therapist's private office), community centres and a parenting magazine. In all, 85 interviews were conducted with 46 childhood sexual abuse survivors and 22 healthcare professionals. This is a large number of interviews for a study of this nature. The number of interviews with each woman ranged from one to three. Most of these took place postpartum (in some cases several years after pregnancy) although two women were interviewed pre-conceptually and followed up after the birth. It is not clear whether these two women already had children. Sixteen members of the recruiting centre staff participated in a focus group and six perinatal nurses (four of whom had disclosed childhood sexual abuse) were interviewed individually. Through processes of coding the data (initially open coding, then axial and finally selective) Palmer developed a theory that had 'protecting the inner child' as its core category. While her explication of this theory resonates with what is reported elsewhere in the literature and her methods appear rigorous, her analytical approach inevitably fragments what the women have said. She recognised a need for the voices of survivors to be heard, but arguably those voices are lost in this fragmentation. This would seem to be a disadvantage of grounded theory as an approach for the exploration of the subject. Palmer wanted to explore the process women go through in managing their childbearing experience and she encompassed the transition to motherhood in her data collection. This is an important issue to explore but the consequence is that her recommendations relate more to social policy than maternity care itself. So although similar, ultimately the focus of her study is different from mine and it does not address the maternity care experiences of women and the implications for midwifery practice.

Although Lasiuk (2007) was researching the experience of pregnancy and birthing among women with histories of childhood sexual abuse, the stories she recounts relate to becoming pregnant and transition to motherhood. Like Palmer therefore, her study does not address in detail the issue of maternity care. Her participants were mostly identified through advertisements in two local publications and posters placed in various localities throughout the city. Two women, public figures in Canada who speak openly about their own childhood sexual abuse, were approached via email. Lasiuk does not say how many women she hoped to recruit to her study, although she does indicate that she was more concerned about the participants' ability to share their experiences than with sample size. She conducted seven interviews in all, both face to face and via the telephone. She does not comment on whether there was any noticeable difference in quality of data between these two types of interview. Clearly it is not possible to see non-verbal cues over the telephone and it can be surmised that some of the richness of the data may have been lost.

The approach Lasiuk took to her interviews was similar to mine (section 4.6.1) in that because she did not want to lead women in a particular direction, she started her interviews by asking them to tell her about their experience of pregnancy and birthing. She describes allowing space, listening carefully, asking questions to clarify understanding and inviting examples. So that readers can hear each woman's distinctive voice, unlike Palmer, she presents their first person narratives. These are long excerpts from the transcripts but she does not indicate how they were chosen. Neither does she say whether they have been altered in order to present them. They read as though they have been edited to an extent and although she talks about conducting 'conversational interviews' (Lasiuk 2007:103) there is no indication of her part in the encounter. The co-creation of the interview data is therefore lost to the reader.

Lasiuk describes interpretative enquiry as a 'creative process' (2007:105). This is well recognised (Mauthner & Doucet 1998; Spencer et al. 2003), but so is the need for transparency and a systematic approach (Barbour 2008; Spencer et al. 2003). Although she discusses repeatedly reading the transcripts for recurring

themes, Lasiuk is not explicit about how she did this and she does not provide any examples of her data analysis that would make the process transparent. She identifies three main themes: living in the wake of childhood sexual abuse, response-ability to motherhood and regeneration. Although these themes appeared to a certain extent in all seven women's stories, certain narratives reflect each one in more detail than others and Lasiuk therefore concentrates on those narratives in exploring the themes. In doing this she quotes extensively from the interview, which helps to validate her interpretations. Despite the issues raised above, this study makes an interesting contribution to the evidence base on childbearing among women who were sexually abused in childhood. Although it will inform midwifery practice, the focus was not on maternity care experiences.

I identified the final study included in this review via a journal alert. Lis Garratt's PhD examined the maternity care experiences of women who had experienced childhood sexual abuse to gain an understanding of the problems these women encounter during the processes of childbearing (Garratt 2008). She also produced her thesis as a book (2011). This is the first study of its kind from the UK and is very similar in aim and approach to mine. I had collected all my data and analysed most of the interviews I conducted with women by the time I accessed her work. Because of the similarities between our studies, Garratt's warrants careful consideration here. She conducted nineteen interviews in all. Seven women were identified via survivor support groups. Ten were midwives who had also experienced childhood sexual abuse and were recruited through advertisements in the midwifery press. Of the remaining two women, one was identified through snowballing and the other was recruited via her health visitor. Three of the interviews were conducted by email due to issues of access (for example one woman lived in Australia) and by Garratt's own admission, these interviews, whilst useful, lacked depth. The others took place across England, spanning Northumberland to the south and this geographical diversity is a strength of the study. Garratt employed grounded theory as a framework. In line with this 'data driven' approach, she analysed interview data concurrently with data collection and analysis informed the questions she asked women in later interviews. Data were coded, but Garratt records disquiet about this and describes the process as being akin to

a pathologist who learns 'something of the impact of disease upon the individual but little about the person and his/her life' (Garratt 2008 p95). She consequently felt compelled to go beyond this and employ a non-exploitative method that would maintain the integrity of the women's stories. Like me, she chose the Voice-Centred Relational Method (VCRM) (section 3.6.2) and describes conducting four readings of her transcripts. However, as this was a very time-consuming process, a limited number of transcripts were exposed to the whole process. VCRM is a narrative approach and by definition therefore asks 'why was the story told in *that* way?' (Riessman 1993 p2). It is difficult to see how women could have been entirely free to recount their stories in a way they would choose when the interview had been informed by previous data collection. Indeed the decision to employ VCRM seems to have been taken retrospectively. Garratt describes the interviews as being unstructured but neither provides details of her opening question nor indicates whether she employed any schedule. However she indicates that the interviews with midwives focussed on the impact of childhood sexual abuse on their midwifery practice.

Although Garratt gives some information about her methodology, detailed examples of data analysis that would provide transparency are lacking. There are however, extensive quotations from the transcripts. No core category is identified as would be expected in a grounded theory study, but neither is there clear evidence of how the separate readings of VCRM informed the analysis. Nevertheless, the study provides a sensitive exploration of the accounts told by participants and provides some useful insights into their experiences. These are encapsulated under the headings employed by Finkelhor and Browne (1985) in their traumagenic model: powerlessness, betrayal, traumatic sexualisation and stigmatisation. Garratt suggests that the destiny of women and midwives are inextricably linked and in a compelling analogy, she likens the powerlessness of women in labour to the powerlessness of midwives working in the often medicalised environment of the National Health Service. However, in making this analogy, the voices of the women in relation to their maternity care experiences are sometimes lost in a critique of the system from a midwifery perspective.

Synthesis of the eight qualitative studies reviewed reveals seven main themes relating to women's experiences of maternity care. Control was pre-eminent. The others were: remembering, safety, vulnerability, dissociation, disclosure and healing. I discuss these further in Chapters Six to Nine in support of my own data. In a forthcoming metasynthesis (Montgomery 2013), I have suggested that 'feeling safe' is a useful metaphor to capture these themes. I return to this in the final chapter (section 11.2).

2.4 Summary

This chapter has demonstrated that research available on the maternity care experiences of women who were sexually abused in childhood is limited. Studies that have been conducted either have methodological shortcomings or a focus that does not adequately explore maternity care experiences through the entire childbearing cycle. The women's voices are sometimes lost – either because of the fragmentation that is an inevitable consequence of some analytical approaches, or because attention shifts to related issues such as the organisational impact of health services. I would therefore concur with Leeners et al. (2006b) that childbirth professionals are hampered by a lack of knowledge about the impact of childhood sexual abuse on experiences of pregnancy and birth. Keeping the focus on the women, my study aimed to address this gap in the available evidence.

3. Chapter Three: Research design

3.1 Introduction

Finding the most suitable research design and strategy can be a challenge for any researcher and the task is particularly difficult when the subject under investigation is sensitive. This chapter explains the methodological approach I chose and my rationale for doing so. The following chapter details the steps I took in making the design operational.

I begin this chapter with a statement of my study's objectives. Its purpose was to explore the maternity care experiences of women who were sexually abused in childhood. The specific question to which I was seeking an answer was 'what is the impact of having been sexually abused as a child on the maternity care experiences of the adult woman?'

The initial objectives were:

- to inform midwifery practice by
    - recounting the narratives of the participants
    - identifying any helpful or unhelpful aspects of maternity care for women who were sexually abused in childhood
    - contributing to the formation of guidance on the maternity care of women who were sexually abused in childhood
- to contribute to the body of research and theoretical knowledge on women's life experiences

As I wanted to understand the experiences of the women participating in my study and to elucidate their perspectives, the qualitative paradigm was

appropriate (Denzin & Lincoln 2005; Pope & Mays 2006; Snape & Spencer 2003). However, this encompasses a diverse range of approaches (Snape and Spencer 2003) and I therefore needed to give further consideration to the nature of the research problem, the participants and the purpose of my study.

3.2 Identifying the problem

I was faced with a number of difficulties in planning research on the maternity care experiences of women who were sexually abused in childhood. The issues I was confronting are sensitive and potentially distressing for everyone involved. Furthermore, I needed to access a hidden population. Richens and Currie (2004) list the sexually abused amongst hard to reach groups for research purposes. In the course of their work on public involvement in food policy, Judith Green and colleagues decided that 'hard to reach' groups were better categorised as 'hard to hear' (personal communication & Mitchell et al. 2006). Societal reactions to childhood sexual abuse that include fear, disbelief and distaste (Barlow & Birch 2004; Gutteridge 2001; Rouf 1999) make women who have experienced it hard to hear. Steel (2004 p2) indicates that 'people whose voices cannot be heard' are a vulnerable group in research and the silence of women who were sexually abused as children is well documented (Gutteridge 2009; Rouf 1999; Simkin & Klaus 2004). As discussed in the previous chapters, I also needed to engage with women for whom loss of control and powerlessness are widely recognised issues (Kitzinger 2006; Parratt 1994). Thus my methodology had to address the twin problems of silence and powerlessness and consequently I chose a narrative methodology informed by a feminist perspective for this research.

3.3 Feminist research

What is meant by feminist research is contested (Harding 1987; Ramazanoglu & Holland 2002) and it was therefore important for me to define what I meant when I attached a feminist label to my study. Harding suggests confusion arises from the fact that method, methodology and epistemology are often used interchangeably and argues against there being a distinctive feminist

method. She points out that feminist researchers use the same basic techniques as any other researcher, albeit in different ways. My study does not claim a feminist methodology but it was informed by a feminist perspective.

Where there *is* agreement is that feminist research seeks to redress the androcentric assumptions upon which traditional science is based. It therefore asks questions that may not have been considered important in main stream science. These often relate to women's political struggles that Harding (1987) suggests take place in the bedroom and kitchen. Childhood sexual abuse is an issue that predominantly (although not exclusively as demonstrated in section 1.5) affects women. It is eighteen years since Finkelhor (1994) identified it as an international problem of considerable magnitude and twenty years since Rose (1992) eloquently described its impact on her pregnancy and birth. Despite this, it has remained a hidden issue and the relative lack of research identified in Chapter Two is testament to this. Harding (1987) identifies three attributes that characterise feminist research. The first two are that it deals with women's experiences (i.e. those that have traditionally not been visible in social science) and that it is for women (i.e. that it aims to provide explanations that women want and need). These are clearly applicable to my study.

The third attribute identified by Harding (1987) is that feminist research locates the researcher 'in the same critical plane as the overt subject matter' (p8). For this to happen, the researcher must be an obvious presence in the study rather than the 'invisible, anonymous voice of authority' (p9) that a more positivist view would assume. The scrutiny to which this inevitably gives rise is potentially uncomfortable for the researcher and Webb (1993) suggests that it increases her vulnerability. However, it is unrealistic to assume that the researcher's background, experiences and agenda will not have an impact. My interest in maternity care experiences and desire to inform midwifery practice undoubtedly influenced my research and gave it a different focus to, for instance, the studies of Garratt (2011), Lasiuk (2007) and Palmer (2004).

Research design

The denial of value neutrality (Harding 1987; Webb 1993) differentiates the feminist approach from much mainstream (quantitative) research and is possibly one reason why feminist researchers tend to favour the qualitative paradigm. The fact that the researcher is a visible presence in the study rather than being shielded by anonymity situates her alongside the participant. There is intention to alter the hierarchy that traditionally exists between the researcher and the researched. A non-hierarchical approach is a key aspect of feminist research (Lee 1993; Oakley 2005) and given the role of power and control in childhood sexual abuse (Barlow & Birch 2004; Garratt 2002; Leeners et al. 2006b; Rouf 1999) it was an important consideration in choice of methodology for me. However, it is naïve to assume that there will be no power differences and the issue of power requires greater scrutiny (section 3.5.1).

In summary, it was imperative that my methodology respected the values, feelings and experiences of the women involved. Childhood sexual abuse is principally a women's issue that despite its magnitude is shrouded in silence and remains hidden within society. Feminist research seeks to overcome the invisibility of women in social research (Lee 1993), to attend to power imbalances and respect women's voices (Webb 1993). For these reasons I chose a feminist perspective.

Although the identification of a feminist perspective delineated the way I approached the study, as discussed by Harding (1987), it did not prescribe my methodology. Webb (1993) outlines the way that feminist research attempts to 'report women's experiences in their own terms whilst also attempting a structural analysis of the conditions of their lives' (p422). This would seem a fundamental requirement in connection with childhood sexual abuse and maternity care. I therefore needed a structure that allowed participants to articulate their experiences in a way that they chose rather than in response to any schedule imposed by me. This pointed to a narrative methodology.

3.4 Narrative research

Although narrative research defies simple definition (Holloway & Freshwater 2007; Riessman 2008; Squire et al. 2008), in essence participants are encouraged to tell their 'story'. Riessman (2008) suggests that in telling stories, people select, organise and connect events in a particular way for a particular audience. There are several reasons why this seemed an appropriate approach for my study. Polkinghorne (2007) remarks on the ubiquitous nature of stories and suggests that personal descriptions of life experiences 'can serve to issue knowledge about neglected, but significant areas, of the human realm' (Polkinghorne 2007 p472). According to Wengraf (2000 p140) the narrative researcher 'gives voice and the printed page to those who require mediation to get their voices into the public arena'. Elliot (2005 p4) contends that narrative is a 'device that facilitates empathy', organising a 'sequence of events into a whole so that the significance of each can be understood through its relation to the whole' (Elliot 2005 p3). For her a common theme in narrative research is a desire to empower participants, allowing them to identify the most salient aspects of a phenomenon. These features of a narrative design, which were in keeping with the aims of a feminist perspective, confirmed for me its suitability for exploring the issues with which I was concerned.

3.4.1 The nature of narrative

The terms narrative and story are often used synonymously in the literature. Sometimes this is a deliberate strategy (Riessman 2008) but often it passes without comment (Andrews et al. 2008; Elliott 2005). The notion of a story as a valid scientific product is contended. However, Koch (1998) argues that through activities such as observing, listening and asking questions that provide rich data, story-telling may 'advance human understanding' (p1189) and therefore be described as a legitimate research endeavour. Whether the material under study is referred to as narrative or story, the researcher is an intermediary in bringing the participant's tale to public attention (Koch 1998, Polkinghorne 2007) and the product is a 'co-construction' (Polkinghorne 2007, Riessman 2008).

Research design

A key aspect of narrative is the construction of events, rather than a simple chronicling of them (Chase 2005). The specific social context in which they take place is also an essential consideration. Narratives will be told in different ways depending on the values and interests of the teller (Riessman 1993). Because narratives are essentially a representation, interpretation by the 'audience' is inevitable (Plummer 1995, Riessman 1993). The interplay between storyteller and listener is therefore a key feature. This means that in my research, my role as interviewer and then the role of consumers accessing the product needed consideration.

Plummer (1995) describes the 'joint actions' required to produce a story. Like Riessman (1993) he contends that another's life is 'unknowable' but also that texts in themselves are meaningless. It is the interaction surrounding the telling that gives meaning. He defines a tripartite model for the construction of a story, initially involving producing and provoking. The first is the telling and the second facilitates this through coaxing, coaching or coercing. This is reminiscent of the interview process in which disclosure is encouraged but I found the notion of 'coercion' an uncomfortable one and at odds with ensuring an ethical approach - particularly as my subject is sensitive. Plummer suggests that the function of the coercer is to shift the nature of the story that is told. However there was a tension here for me with the notion of empowerment. It seemed more appropriate that working within a feminist paradigm my role as researcher (and indeed as a midwife) was to concentrate on coaxing rather than coercion to ensure that the story told was, as far as possible, the one the women wanted to tell. The ways I attended to this are discussed further in section 4.6.1.

The third element of Plummer's model consists of the consumers providing the 'audience' who themselves make sense of what they hear and add their own level of interpretation. Denzin and Lincoln (2005) use the metaphor of light hitting a crystal and reflecting different perspectives to help explain this phenomenon. They support the notion that there is no one correct telling of events but suggest that each telling represents a different point of view. It was therefore important for me to obtain varying narratives for this study in order to gain as full an understanding as possible and to highlight any potential

misunderstandings. Listening to stories from the women was fundamental to the process. However, just as crystal refracts light and changes its course, so those caring for women potentially receive and transmit different messages from those the women sent. The experiences of the healthcare professionals become part of the overall narrative and in turn affect the care the women receive. Therefore I also accessed the documented narratives from maternity care records and explored how professionals involved in maternity care account for and interpret the women's narratives. In the sections that follow I give consideration to the different narratives accessed: in-depth interviews with women, maternity care records, interviews with maternity care professionals.

3.5 In-depth interviews

The methodological approach I chose required a means of data collection that encouraged women to share their stories with me. The sensitivity of the subject and the issues identified at the beginning of this chapter suggested a non-hierarchical method allowing women to retain an element of control was required. In-depth interviews aim to transform the interviewer/interviewee relationship to one of narrator/listener (Chase 2005). Kvale (2007) suggests that the role of the interviewer in a narrative study is to listen, abstaining from interruptions, but occasionally seeking clarification. This was the approach I took and was a way of ensuring that participants were given the 'freedom and time to unfold their own stories' (Kvale 2007 p57). It also helped to avoid the pitfall Britten (2006) identifies in which the researcher's own structures and assumptions are imposed (as appears to have happened in some of the studies discussed in the Literature Review).

Riessman (2008) contends that the goal in narrative interviewing is to generate detailed accounts rather than brief answers, but she acknowledges that creating opportunities for this to happen requires investigators to cede control. However this situation was consistent with my methodological approach and had the benefit of minimising the likelihood that women would disclose more than they were comfortable with. This is a recurrent concern in qualitative research when the exact direction that an interview will follow cannot be

predicted (Lee 1993). It also facilitated 'coaxing' rather than 'coercing' women to tell their stories (section 3.4.1).

3.5.1 Non-hierarchical relationships and the issue of power

A non-hierarchical relationship between researcher and participant is a key feature of feminist research (section3.3). In-depth interviews can allow more 'control' by the participant but the interviewer/interviewee relationship remains hierarchical. As Ramazanoglu and Holland (2002) suggest that understanding power relations is central to feminist research, reflection on the relationship is warranted.

The purpose of any study is to produce new knowledge and therefore a research relationship is ultimately 'product orientated' (Hendry 2007 p496). I conducted this study to gain a PhD and even though I have collaborated with user groups the balance of power inevitably rests with me. I initiated the interviews, steered their content and drew them to a close (Kvale 2007). Brown and Gilligan (1992) question if there can be genuine dialogue in interviews given the power the interviewer has to structure the relationship. I did not consider my role to be engaging in dialogue, but rather coaxing women to tell their stories. Qualitative research relies on the establishment of a relationship that encourages disclosure. 'Doing rapport' (Duncombe & Jessop 2002) is the subject of much feminist debate and although perhaps not 'morally indefensible' (Oakley 2005 p222), it is questionable. Graham et al. (2006) express concerns about whether the warmth of an interview situation could lead to participants disclosing more than they are comfortable with and Kvale (2007) discusses the dilemma created by attempts to gain as much information as possible from a participant whilst still respecting their integrity. As Kvale (2007) recognises, there are no easy answers to this dilemma and he suggests that it makes strong demands on the ethical sensitivity and respect of the researcher in knowing how far to go with questioning.

3.6 Analytical approach

As Riessman (1993) explains, the *way* something is recounted can be as significant as *what* is said. It is particularly important when, as in this case, the meaning ascribed by the woman is as crucial as the chronological events. These concerns guided my decisions on analysis of interview data. Narrative is used in fields as diverse as literature and the human and social sciences (Elliott 2005). There are correspondingly diverse modes of narrative analysis. I decided that the Voice-centred Relational Method (VCRM) was the most appropriate for my study. In the next section I briefly outline some alternatives and explain the reasons for my choice alongside an exploration of VCRM.

3.6.1 Narrative analysis

Riessman (1993 p1) describes narrative as 'inherently interdisciplinary' and suggests that narrative analysis takes the story itself as its object of investigation. Whilst this avoids the fracturing of the text, common in traditional qualitative approaches, it creates a tendency for attention to be on the story rather than the teller. This is illustrated in the classic analytical approach of sociolinguists Labov and Waletsky (1967). They identified the component parts of a narrative which they labelled orientation, complication, evaluation, resolution and coda. This focus on the structure of the narrative rather than what it reveals of experience and meaning does not sit comfortably with a feminist approach. Furthermore, for them, for something to be defined as a *narrative*, the temporal sequence of the event relayed must be retained. However, according to Riessman (1993 p2), narratives offer the story teller the opportunity to 'impose order' on their experiences and 'make sense of events and actions' about which they speak. It is questionable whether they will do that in chronological order. Elliot (2005) concurs with Labov and Waletsky and stresses chronology as defining narrative but other authors place less emphasis on it. Wengraf (2001 p115) suggests that the sequence of events is only part of a complete narration. Narratives relying on temporal sequence comprise just one aspect of Mishler's (1995) typology. However, there is a bigger difficulty than the issue of chronology posed by Labovian analysis for use in sensitive research. That difficulty is typified by the type of question asked. Labov's approach requires that participants tell 'what happened?' In

sensitive research that aims to explore experience, it is more illuminating to ask 'what was it like?' This latter question is better able to reveal 'different and sometimes contradictory layers of meaning' (Squire et al. 2008 p1) than the Labovian approach.

The Biographical Narrative Interpretative Method (BNIM) is experience-centred (Squire 2008). It seeks to cede control of the interview to the participant (Jones 2003), beginning with a 'single question that invites narrative' (Wengraf, 2001). It therefore seems more suitable for studying the accounts of women who have been sexually abused. BNIM has a clearly prescribed process for conducting the interview followed by a methodical and painstaking process of analysis. After asking an opening question, the researcher listens without interruption, prompt or probe to the participant for as long as it takes for the story to be told. A second interview conducted after a short break allows the researcher to request elaboration on any issues raised by the participant. This has to be done strictly in the order in which the participant gave the account, thus keeping the emphasis on the way the story is told. A possible third interview, conducted at a later date after initial analysis of the first two, provides an opportunity for any questions the researcher might have to be addressed. This process results in two texts: the *lived life* (a chronological biography which may require some sorting by the researcher to put events into temporal order) and a *told story* (which exposes the way the events and actions were experienced and are now understood by the narrator). The concern that Labovian analysis fails to reveal experience and meaning therefore appears to be overcome with BNIM. However, closer consideration reveals similar problems with the two methods. According to Wengraf (2001), analysis of the told story requires examination of its textual structure and this involves categorization of the transcript into description, argumentation, report, narrative and evaluation (the DARNE typology). Again this shifts the focus away from the narrator onto the narrative itself. Although BNIM begins by allowing the participant to speak, it is questionable whether their voice can be heard in the end product. For research concerned with breaking the silence of its participants, as is the case in feminist research, this loss of voice is problematic. However listening is at the heart of VCRM.

3.6.2 The Voice-Centred Relational Method

VCRM has been employed in several studies that have researched sensitive issues including postnatal depression (Mauthner 2002), experiences of miscarriage in older mothers (Frost 2004) and parents' perspectives on grief and loss following the death of their baby (Jones, personal communication). It has its origins in developmental psychology during the 1970s and 1980s in the work of Carol Gilligan and colleagues in the USA. In the course of her work on the psychological development of women and girls, Gilligan (1993) came to recognise that she was listening to distinct voices that represented divergent ways of viewing the world. Although she used masculine and feminine labels to describe these voices, she was clear that gender was not an absolute distinction between them. They were rather categorised by themes representing different ways of thinking. Essentially the 'feminine' voice was one that privileged relationship whereas the 'masculine' privileged separation. The particular voice that came to Gilligan's attention - that which sought relationship with others as opposed to separation - was not valued in the patriarchal society within which she worked. Indeed, the dominant view of the time held that these voices represented steps in a developmental progression – the masculine voice being further along that progression than the feminine. However Gilligan argued that they were 'contrapuntal' – a musical metaphor suggesting two discrete entities occurring in parallel rather than sequence.

As their research on girls' psychological development progressed, Brown and Gilligan (1992) began to uncover conflict in what they were being told by the participants. This arose from the girls' attempts to maintain connections with others as they entered adolescence. The researchers realised that they were uncovering a complex situation in which a multitude of voices could be present in individual accounts. The researchers also realised that the structured, researcher-led approach to interviewing that they were employing was stifling their attempts to connect with the girls. They became increasingly constrained and uncomfortable with this approach and recognised their need to remain 'in relationship' with the participants of the study in order to hear what they really wanted to say, required a more flexible stance. The questions they considered to be key in this process were: who is speaking, in what body, telling what story about relationship (from whose perspective or what vantage point) and in

what societal and cultural frameworks (Brown & Gilligan 1992), leading to the development of a 'listener's guide'. The method was later developed and critiqued by feminist researchers Natasha Mauthner and Andrea Doucet (1998; 2003).

Mauthner and Doucet (1998) had identified listening to women and reflexivity as being vital to the research process - both of which are intrinsic to VCRM. However they talk in terms of multiple 'readings' of the data, rather than the 'listenings' discussed by Brown and Gilligan. This shift is not something about which Mauthner and Doucet comment, either in their initial critique or their later writing (2003) but Gilligan et al. (2006) are clear about the fact that the steps involved are 'listenings' not 'readings'. This is because the former requires active participation from both teller and listener. I discuss my approach in Chapter Five (section 5.6).

Irrespective of the terminology used, formal analysis is an iterative process in which the data is examined on a number of occasions. On each occasion the researcher specifically attends to a different aspect of the narrative. As sociologists, setting participants within social, structural and cultural contexts was important to Mauthner and Doucet (1998). Given the nature of my subject, it was also important to me and I therefore used their four 'readings' of the data to guide my analysis although in practice, I returned to the data many more times than this suggests. The readings were:

- reading for the plot and the researcher response
- reading for the voice of the 'I'
- reading for relationships
- reading for the socio-cultural context

More recently, Gilligan et al. (2006) have outlined ways in which their original listening guide has developed. Their presentation of the 'voice of the 'I' was of particular interest to me. This remains a means of tuning in to how the

participant speaks of herself, but the authors proposed the use of 'I-poems' here. In these, each instance of the pronoun, connected verb and other related words is extracted and placed on a separate line, thus building a skeletal version of the text, which has the appearance of a poem. Gilligan et al. suggested that this could capture something not necessarily immediately evident from the text but nonetheless central to its meaning. I found it a helpful way of identifying particular moods and changes in the way participants were speaking.

The fourth reading described by Gilligan et al. (2006) represents a shift away from consideration of the social and cultural context to 'composing an analysis' (p266). This requires the researcher to synthesise what has been learned about the participant in relation to the research question and in comparison or contrast to other participants' accounts. I considered this a key phase for my study given that I wanted to inform clinical practice. It formally recognises the imperative of the researcher to move beyond a collection of intricately considered anecdotes, illuminating as they may be, to provide an analysis that lays claim to a wider application. Although Brown and Gilligan (1992) did not originally detail such a process, other researchers have tended to employ it in analysing their data. For example, Mauthner and Doucet (1998) recount their need to move from detailed case studies to confront the data set as a whole. This involved an analysis of over-lapping themes and sub-themes. Likewise Frost (2004) combined VCRM with thematic analysis so that neither the woman's voice nor pertinent themes were lost. Therefore, in addition to the four readings outlined above, I conducted a further reading to produce a thematic analysis of each transcript. The themes I identified were compared across all the transcripts with the aid of an excel spread sheet.

The Voice-Centred Relational Method offers a highly structured framework for a close and systematic reading of a narrative, but, because it is based on multiple listenings/readings of the data it also demands a large investment of time. Indeed the amount of time required to conduct analysis with VCRM is a common criticism of the methodology (Fairtlough 2007; Frost 2004; Mauthner & Doucet 1998; Paliadelis & Cruickshank 2008). However, a major benefit is that it delays the fragmentation of an experience into researcher-imposed

themes until detailed analysis of the whole has taken place. It embeds the narrative within its social context and reflexivity is an integral part of the process. Thus the impact of the researcher is more explicit – something that is important considering the 'audience's' role in the construction of a narrative (Plummer 1995). There are nevertheless issues that require further consideration and I return to these in Chapter Five.

3.7 Maternity care records

As discussed in section 3.4.1, examination of the maternity care records of the women interviewed provided the 'professional' documented narratives of the women's childbirth journeys. It gave an insight into how professionals involved in maternity care accounted for and interpreted some of the events that comprised the women's narratives.

Maternity care records are health records that document a woman's care throughout the childbearing cycle. Their purpose is to inform any healthcare professional involved in a woman's care of the information required to look after her safely and appropriately (NHS Litigation Authority 2012). According to the NHS Litigation Authority (NHSLA) (2012 p51) they 'provide a contemporaneous and complete record of the woman's treatment and related features'. The Nursing and Midwifery Council (NMC) (2009a p4) advises that records should be 'factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation'. Garratt (2008) suggests that medical notes appear to be solid and unchanging. This implies objectivity. However, the NMC notes that the nurse or midwife is required to use professional judgment to determine what is relevant and should therefore be recorded. This is key in understanding medical records as 'narratives'. Riessman (2008) includes health records in her list of what may constitute narratives and in defining 'narrative', she writes of events perceived as important being 'selected, organised, connected, and evaluated as meaningful for a particular audience' (Riessman 2008 p3). There are two aspects of this definition that are worthy of further exploration in the context of this study: the selective nature of narratives (discussed further below) and the particular

audience for whom they are written. The NMC lists eleven reasons for record keeping, the last one being 'helping to address complaints or legal processes' (Nursing and Midwifery Council 2009a p2). However, as discussed by Jones and Jenkins (2004) protection from litigation is often deemed a prime function of the notes by midwives. A hypothetical legal audience is therefore a consideration for anyone writing in the records. In a shift of focus from the first edition of the book (Jenkins 1995), when the emphasis was very much about protection from the law, Jones and Jenkins suggest that a more positive view relates to providing accounts of care that allow for clarity and continuity. In this case, other members of the healthcare team are the most likely audience. This reflects a generally more user-centred rhetoric in recent years; for example, the NMC (2009a) now advises that the client should be involved in the process of record keeping where possible – something that was not explicit in the first 'Standards for records and record keeping' published by the NMC's predecessor (United Kingdom Central Council for Nursing 1993). This being said, the imperative for organisations to meet the requirements of the NHSLA, with its concomitant reduction in Clinical Negligence Scheme for Trusts (CNST) contributions, militates for a more prescriptive approach to documentation with managing claims and complaints a considerable driving force.

The importance of health records in research is widely recognised (Hammersley & Atkinson 2007; Robson 2011) and although medical records transmit first-hand accounts (Cohen et al. 2007), their tendency to be selective is well documented (Cohen et al. 2007; Prior 2003). Hammersley and Atkinson (2007) suggest that official documents should be treated as social products and for Robson (2011) there is an important relationship between the content and context of a document. The context includes institutional, social and cultural aspects as well as the purpose of the document. The context for my study encompasses institutions that are increasingly audit focussed (Power 1997). As alluded to above, the advent of the NHSLA in 1995 and subsequent CNST is likely to have impacted on the way that records are kept, given that maternity standards include audit of records (NHS Litigation Authority 2012). However for the purpose of my study any difference between what might have been recorded prior to 1995 and what would be recorded today is less important than the enduring narrative of an individual woman's experience. Hammersley

and Atkinson (2007 p132) suggest that records construct a 'documentary reality' and note the privilege granted by virtue of that documentation. Similarly the early work of Sally Macintyre (1978) demonstrated how maternity records were 'made' and how as far as healthcare professionals were concerned women quickly became what their records said they were. The implications of this for the women in my study are explored further in Chapter Ten (p193).

Data derived from medical records are 'unobtrusive' (Robson 2011) in that they were not produced with a research study in mind. This has both advantages and disadvantages. The use of documents eliminates the possibility of reactivity - i.e. change produced through the researcher's use (Robson 2011). It could therefore be argued that the narratives found in the notes are more authentic than those obtained in interviews with professionals (section 4.6.2). However, there are potential difficulties in using documents that were not created for the purposes of research as they are unlikely to address the specific needs of the study (Robson 2011). Authenticity and accuracy are important concepts in documentary research (Drew 2006). The authenticity of the documents I accessed is not in question as I obtained originals from the Medical Records Department (section 4.6.3), but the issue of accuracy requires consideration. Cohen et al. (2007) write of the need to establish the credibility of the author and this includes their level of expertise and experience. Underlining the status of medical records as narratives, Robson (2011 p349) asks 'who produced [them], for what purpose, and from what perspective or mindset' – questions reminiscent of those posed by Brown and Gilligan (1992) in developing VCRM. The key issue for my study is that whoever wrote in the records, they constitute the official version of events and as such they provide a different perspective on the women's experiences. As recognised by Aaslestad (2009) in his examination of psychiatric records, the notes do not recount the experiences of the women, but the experiences of the staff caring for them. Staff and patients will always have different perceptions of reality. These perceptions were of interest because they illustrated how the women's experiences were perceived by others.

3.8 Interviews with maternity care professionals

The purpose of this phase of the research was to explore the understanding and insight midwives and obstetricians had of issues that arose from the women's narratives. Given the relational ontology on which the interviews with women were based, a means of data collection that exploited interaction and social context was desirable. According to Wilkinson (1999), human experience is constructed within specific social contexts, of which relationships are part and as discussed in section 3.4.1, social context is important in the construction of narratives. Contextualisation is also imperative in a feminist study, together with a non-hierarchical approach (Wilkinson 1999). These issues all pointed to the suitability of group interviews for exploring the views of professionals.

Green and Hart (1999) suggest that group discussions, unlike focus groups, bring together peers who have a pre-existing relationship. This was the case in my study. However, Finch and Lewis (2003) use the terms 'focus group' and 'group discussion' interchangeably. Given that both aim to uncover social processes; I am also using the terms interchangeably. Interaction is a key aspect of the way data are collected via group discussion (Barbour & Kitzinger 1999; Finch & Lewis 2003; Morgan 2001; Wilkinson 2004) and this can lead to a richness of data that may not be possible from individual interviews (Walsh & Baker 2004). For Wilkinson (1999, p66) they provide an 'interactive social context within which meaning-making can be observed'. A contribution from one participant may stimulate a response from another (Bluff 2006) and challenges or questions from within the group can trigger extra material, prompting participants to reveal more (Finch & Lewis 2003). Group discussions can be used to 'unpack the social construction' of sensitive issues, (Kitzinger & Farquhar 1999, p156), which made them a suitable means of data collection for my study. The role of the researcher in facilitating group discussions is to allow as much relevant dialogue as possible to be generated from within the group while ensuring that the aims of the research are met (Finch & Lewis 2003). However, as the number of people involved inevitably shifts the balance of power away from the researcher to the participant, group discussions are more likely to be egalitarian than individual interviews (Wilkinson 1999; Wilkinson 2004). The benefits of homogeneity versus

heterogeneity within groups are debated within the literature (Bluff 2006; Finch & Lewis 2003). Bluff argues that discussion can be inhibited within multi-professional groups and Finch and Lewis warn that less heterogeneity can be tolerated when dealing with sensitive subjects. The decision was therefore taken to keep discussions with midwives and obstetricians separate. Details of how the discussions were conducted and the data analysed are found in Chapter Four (section 4.6.2).

3.9 Summary

In this chapter I have identified the nature of the research problem and my approach. As I was researching a sensitive issue in a 'hard to hear' group a narrative study from a feminist perspective was designed. Differing perspectives were explored through in-depth interviews with women who were sexually abused in childhood, examination of their maternity care records and discussions with maternity care professionals. I have reviewed the suitability of VCRM as a means of analysing the women's narratives and have outlined the readings I conducted. These were: reading for the plot and my response, for the 'voice of the I', for relationships and for the socio-cultural context. A further reading enabled me to identify themes. The following chapter details the processes involved in making the study operational.

4. Chapter Four: Generating the data

4.1 Introduction

Having identified my research design in the previous chapter, I now turn to the processes employed in generating the data, from collaboration with stakeholders, through recruitment and obtaining the data to strategies employed in protecting the wellbeing of all concerned with the study.

4.2 Accessing stakeholders

Obtaining the narratives identified in the previous chapter inevitably required negotiation with a number of stakeholders. Although specific contacts established are discussed in the relevant sections, there are some general issues that warrant consideration first. Lewis (2003) recognises that negotiating access to a setting is a vital part of the early stages of research but there were important broader issues than simple access to be addressed. As indicated in Chapter One, my study was inspired by listening to members of CIS'ters speak to student midwives. Consultation with CIS'ters was therefore an essential first step. Following email exchange and a face to face meeting with a couple of members of the group, my credentials were presented to a Trustee meeting and they approved collaboration on the research in principle. CIS'ters remained a key point of consultation throughout development of the proposal - which was amended in light of issues they raised - and during the study.

Initial consultation also occurred with local healthcare professionals. This was important not only as a means of negotiating access but also to gauge support for the study and to hear concerns and suggestions in relation to its design. A midwife suggested that an Independent Sexual Violence Advisor from the local Rape Crisis Centre would be a useful contact. Unexpected collaboration with the centre occurred as a result. Reactions to the study were overwhelmingly positive and this reaffirmed the relevance of this research.

4.2.1 Public and Stakeholder involvement

There is an expectation that there will be public involvement in research (Department of Health 2005). Public involvement means an 'active partnership between patients, members of the public and researchers in the research process' (Tarpey 2011 p3), but is often confused with 'public engagement' which refers to people as 'subjects' of research. It was not feasible for me to access the public directly given the nature of my subject, so I was reliant on representative groups. Not all authors would view this as 'public involvement'.

Researchers have grappled with what public involvement really means and how effectiveness might be judged (Barber et al. 2007; Boote et al. 2005; Telford et al. 2004). The Department of Health envisages involvement of service users, their carers or representative organisations. Similarly Barber et al. (2007) who use the term 'consumer involvement' and Smith et al. (2006) who refer to 'user involvement', include both individuals and organisations. According to these definitions, my involvement with CIS'ters and the Rape Crisis Centre constitutes public involvement. However, Beresford (2003 p36) restricts his definition of 'user' to someone who 'receives or is eligible to receive social, health or welfare services' and excludes organisations or individuals who support them. I question the feasibility of user involvement on those terms within the confines of a small-scale study such as mine - particularly given that I was investigating a sensitive issue on a hard to reach group. Elsewhere, Beresford (2005) questions the notion of 'hard to reach' and claims that it is a euphemism for those facing exclusion and marginalisation. Nevertheless, the fact that women who were sexually abused in childhood are hidden within society is an inherent part of the problem. While that is the case, they remain 'hard to reach' other than via their organisations.

My collaboration with the user groups has brought both benefits and challenges. Beresford (2003) highlights the role that user involvement has in reducing the power differentials within the research process. This is a definite strength in a feminist study but the shift of control created some difficulties for me in managing the research process. These are discussed in the following sections.

4.3 Identification and recruitment of participants

4.3.1 Women who were sexually abused in childhood

Various strategies for identifying women to be interviewed were considered. As discussed in Chapter Two (section2.3), Lasiuk (2007) and Palmer (2004) both advertised for participants. However, CIS'ters were concerned about advertisements in public places and the possible impact on unknown, potentially vulnerable women who may not have access to support mechanisms. This form of recruitment was therefore discounted and to avoid the problem potential participants were all approached by an intermediary known to them (CIS'ters, healthcare professionals, rape crisis counsellors). One consequence of this was that all women invited to participate in this research had disclosed their abuse to someone. This makes them atypical, as many women who were sexually abused in childhood do not disclose (Cawson et al. 2000; Coles & Jones 2009; McGee et al. 2002). This is a limitation of the study but one which enabled an ethical recruitment strategy. Another consequence is that the various agencies became gatekeepers to my research. There were benefits to this. These agencies helped identify respondents, accessing potential participants that I might not otherwise have found (Barbour 2008) and they were able to help support the women, minimising distress. However, I have no way of knowing exactly what recruiters said to the women about the study. As Barbour (2008 p57) recognises:

> *[I]ndividuals may impose their own idiosyncratic sampling strategies – either intentionally or unintentionally – which may prevent us from speaking to some people to whom we would like to speak.*

I am aware that on occasions they decided not to approach some eligible women - principally when they felt women were particularly vulnerable.

4.3.2 Sampling

The purpose of the study was to gain as rich an understanding as possible of the effect of childhood sexual abuse on women throughout pregnancy and childbirth. I therefore required a purposive sample of women who had

experienced maternity care and who had been sexually abused in childhood (Speziale 2007b). Both Ritchie et al. (2003) and Barbour (2008) recognise the need for rigour in sample selection irrespective of the fact that participants with particular experiences are being sought. They advocate the use of sampling frames to aid identification of a range of participants. However the population I needed to access was largely hidden. Although the pool of eligible women was potentially large, the number of women it was possible to reach was much smaller and I had to adopt a pragmatic approach to sampling.

Snowball sampling is often recommended for hard to reach groups (Barbour 2008; Lee 1993) although it is recognised that lack of diversity in the resulting sample can be a problem (Lee 1993; Ritchie et al. 2003). Again, because of the sensitivity of the issue, it is not a route I took. Miller (1998) documents challenges related to curiosity from one participant about what another had said in connection with her relatively sensitive research on transition to motherhood and this confirmed my decision.

4.3.3 Inclusion criteria

Although no formal sampling frame was utilised the following inclusion criteria were employed.

Participants must have:

- experienced maternity care within the local maternity service
- had some form of unwanted sexual exposure that began prior to their sixteenth birthday
- been over eighteen years old at the time of interview

It was necessary to stipulate the local maternity service due to the need to access maternity care records. The issue of 'unwanted sexual exposure' was to exclude young teenagers who had entered consensual peer relationships. CIS'ters expressed concern about the language as for some women, due either to grooming or to the fact that their abusive relationship was the only affection

they were afforded, the experience may not have strictly been unwanted. However, it was difficult to find language that was not equally value laden.

4.3.4 Exclusion criteria

Decisions were also taken over exclusion of some women. Women of any ethnic background were eligible for recruitment but because of the sensitive nature of the research, women for whom speaking or understanding English was difficult were excluded. Women requiring any sort of interpreter or translator were not recruited for reasons of sensitivity and confidentiality. Women who had the potential for either personal or professional contact with me were also excluded (but see section 4.3.5). 'Personal contact' included women I did not know but might see through chance encounter following an interview. I did not want to risk causing them embarrassment or discomfort should that happen. The same reasons applied to those with whom I have professional contact (such as students or colleagues), but in addition it was important that no one felt coerced to participate in any way. The Social Research Association (2003) suggests that no group should be disadvantaged by routinely being excluded from consideration for participation in research. This view is supported by Steel (2004) who includes people who cannot speak or understand English well in his list of those who may be seen as vulnerable or marginalised. I excluded this group from my study because I felt it was inappropriate to expect a woman to speak about these sensitive experiences through an interpreter. I was also concerned about the effect of an interpreter on the woman's narrative. Temple and Edwards (2002) refer to this as 'triple subjectivity' and for me it was important not to add another layer of interpretation. Ethical issues in relation to the interpreter herself also needed consideration. The emotional impact that sensitive research has on the whole team and the potential for distress is well documented (Lalor et al. 2006; Malacrida 2007; Wray et al. 2007). It was not deemed ethical to put an interpreter at risk of emotional harm.

4.3.5 Personal disclosure

Three women with whom I potentially have professional contact volunteered to participate and this was something that I had not anticipated. Jackson and Fraser (2009) also report unexpected disclosure in their study on midwives' knowledge and attitudes towards caring for sexual abuse survivors. It presented me with an ethical dilemma. I had not known the history of these women and it must have taken courage to approach me. Their disclosure changed the dynamic between us irrespective of whether or not I interviewed them as I now have knowledge I did not have before. I talked about the situations as they arose mainly to my non-clinical supervisor (to avoid any inadvertent breaches of anonymity). The decision was taken not to recruit one of them due to the nature of our professional relationship but to seek ethical advice on interviewing the other two. Ethical approval was duly given. I have not disclosed which of the participants this involved and I have been very careful not to use any excerpts from their transcripts that might expose their professional background.

4.4 Accessing women

Potential participants were approached by one of a number of intermediaries known to them. Initial recruitment via healthcare professionals began with community and caseload holding midwifery teams. I attended as many team meetings as possible to discuss the study and to seek support during the first six months of recruitment. I regularly visited the community office in the co-located birth centre[5] to check that all the midwives present were aware of my study. Midwives with whom I had contact were given a sticker for their diary. Reminders were put in the newsletter that is circulated to midwifery staff on two occasions and were also provided on one of the mandatory study days. My recruitment strategy was later expanded to include other healthcare professionals. I made contact with various people from a variety of professional groups requesting meetings to discuss the research. Although supportive of the study in principle, most of them did not feel they had contact

[5] A birth centre is a maternity unit for low risk women, run by midwives. Sometimes these are co-located within consultant units and sometimes they 'stand alone.'

with suitable women. However following attendance at one of the Health Visitors' professional meetings, they agreed to support recruitment.

Details of the study were sent out in the CIS'ters newsletter in October 2008 and again in March 2009 (Appendix 1). This is mailed to women throughout the country. A flyer was also sent to approximately 250 members from local counties (Appendix 2). Flyers for the study were included with the information that is given to women on referral to the Perinatal Mental Health Team (Appendix 3). Rape crisis counsellors were also alerted to the study by a flyer (Appendix 4).

Research packs were left with the agencies that were supporting recruitment. These contained: introductory letters for women who met the inclusion criteria (Appendices 5a-5c), a reply slip (Appendix 6), a stamped addressed envelope and Participant Information Sheet (Appendix 7). Guidance for those who were to hand out the packs was attached to each envelope (Appendices 8a-8c). The Introductory letter explained the nature of the research and gave assurances about both the voluntary nature of participation and confidentiality of all information obtained in the course of the study. It also indicated that returning the reply slip did not commit the woman to participation. As the women returned the reply slip directly to me, the person who had given them the letter did not find out if they had decided to participate unless the woman chose to tell them. Equally I did not know the identity of any woman who had received a pack. This was to reduce the likelihood of women feeling obliged to take part. However, it meant that there was no means of issuing reminders. This was a limitation in relation to an effective recruitment strategy, but was a necessary compromise for protection of the women.

4.4.1 Contacting women

All of the women who a returned reply slip provided telephone numbers for me to call. On speaking to them I reiterated what the study was about and checked whether they had any questions about the information they had received. At this stage all of the women indicated willingness to participate so arrangements were made for an interview at a time of mutual convenience in a

safe, private location of the woman's choosing. Two interviews took place at the University, one at my home and the remainder took place in women's homes. The day before the allocated time, I telephoned to confirm arrangements, giving the woman the opportunity to withdraw from the study if she chose. One woman decided that she did not want to go ahead with the interview at this stage.

Graham et al. (2006) note the importance of giving information about the study on more than one occasion and a member of CIS'ters felt that some women may be overwhelmed by a very broad opening question. During the confirmatory telephone call, I therefore reiterated the areas likely to be covered in the interview. I also asked the women to think of a pseudonym by which they would be known in the study.

4.5 Accessing maternity care professionals

4.5.1 Midwives

I met with the senior midwifery managers at the Trust in which the research was based to discuss potential arrangements for the interviews that would maximise the likelihood of recruits but minimise impact on the service. Two dates were identified. I emailed all midwives within the trust via the group email address sending an Introductory Letter (Appendix 9) and Participant Information Sheet (Appendix 10). Posters informing midwives about the discussions were placed in the main Obstetric Unit. A follow up email was sent reminding midwives about the interviews and one further reminder was sent after the first group interview had taken place. Nine midwives agreed to participate. One was unable to make either date proposed and I spoke to her on her own. Two midwives were unable to attend on the day and consequently the first group comprised four midwives and the second two. Experience as a midwife ranged from two to twenty six years and group members had worked in all areas of clinical practice.

4.5.2 Obstetricians

I spoke to the obstetrician responsible for conducting and overseeing the Royal College of Obstetrics and Gynaecology training and education in the local NHS Trust about possible recruitment of Obstetric Registrars to a group interview. I sent the fourteen local registrars an Introductory Letter (Appendix 11) and Participant Information Sheet (Appendix 10) by post and email. Three indicated that they were interested in participating, but of those, two did not respond to further communication. I therefore conducted an individual interview with one obstetrician.

4.6 Generating data

4.6.1 In-depth interviews with women

Britten (2006) advocates the use of an open question that encourages the participant to tell, followed by questions to probe or seek clarification. Frost (2004) asked broad and open questions in her study of early miscarriage in late motherhood, which allowed women to provide answers that reflected what was important for them, in their own words. Koch (1998 p1186) suggests that '[t]he existential question 'What is it like being…'' is often the only question that needs to be asked. Although van Manen (1997 p67) is concerned about such unstructured interviews going 'everywhere and nowhere', Lee (1993) cautions against trying to put things in pre-determined categories that could stifle exploration of meaning. Starting out with a schedule inevitably means coming to the interview with pre-established ideas (Speziale 2007a) and Chase (2005) argues that by definition, someone's 'story' cannot be known, predicted or prepared for in advance. She implies that apparent digressions may turn out to be pivotal and that the researcher must be open to anything that is said. I therefore began each interview with the opening question:

"I'd like to find out about what being pregnant and having a baby was like for you. Starting however you want, please could you tell me?"

Generating the data

Although the focus of my study was maternity care experiences, I did not want to channel the women's responses towards my own agenda. The question I asked provided freedom for them to explore what was important about their childbearing experiences. This produced some insights that would not otherwise have come to light and that will increase understanding for those providing care. I had some prompts in case women did not know how to begin, but did not have to use them and women spoke freely to me. My interview guide (Appendix 12) provided a checklist of things to remember both before and after the interview, reminded me of possible probes and was a place for me to jot down anything that I wanted to explore further. I frequently found though that women illuminated my queries later in their narratives without me having to probe.

Awareness of issues of power was important and I used various strategies to avoid exploitation of the participants. In light of concerns by both CIS'ters and the Perinatal Mental Health Team, I gave women assurances that I was interested in their maternity care experiences and that I would not therefore ask them about their childhood history. They had the freedom to tell me their experiences however they chose and before the interview began, I stressed that they were at liberty not to answer questions I posed. After the interview I reminded them that I would like to use verbatim quotes and gave them the opportunity to refuse this. The fact that I did not have an interview schedule reduced the opportunities for me to structure the account. Comments made by some of the participants indicated that they had thought through what they wanted to say and how they would say it beforehand.

There is debate as to whether one-off or repeat interviews are better in sensitive studies (Lee 1993). The Ethics in Social Research study (Graham et al. 2007) found that participants felt better able to disclose information to someone they would not have to see again. On the other hand, Cornwell (1984) identified that she was told both public and private accounts during her longitudinal study and that the latter were more likely to emerge in subsequent rather than initial interviews. She also found that private accounts were more often elicited in response to an invitation to tell a story, rather than to direct questions. I chose to interview the women once only. This was both to

minimise the potential for distress and to recognise the pragmatic difficulties of repeated commitment if the women had young children. However, one of my interviews stretched over two occasions at the participant's request as she had not told me everything she wanted to before her children were due home from school.

I digitally audio-recorded all of the interviews and transcribed them verbatim. Kvale (2007) recognises that transcription is an interpretive process necessitating choices about how the spoken word is translated onto the printed page. Although it was very time-consuming, I found transcribing the interviews myself a valuable experience, allowing immersion in the data and attention to nuances that could easily have been missed. People employ elongated vowels, emphasis, pitch and repetition to highlight what is important to them (Riessman 1993). I recorded these devices as far as possible. My transcription also included pauses, sighs and changes in tone or speed of speech. If a pause lasted four seconds or longer, I noted its length on the transcript. Shorter pauses and occasions when women began a word or sentence but did not complete it were denoted with an ellipsis (…). Garratt (2008) omitted her own short interjections ('yes', 'mm') to make the transcript more readable, but I included mine to demonstrate how the narrative was co-created. I also took field notes immediately after the interview, including any memorable non-verbal communication, which I included in the transcripts.

4.6.2 Interviewing maternity care professionals

The individual interview with the midwife took place in her home. All the other interviews were conducted in a classroom situated within the Midwifery School in the Consultant Obstetric Unit. Two rooms were booked for the group interviews in case any participant became distressed. I acted as facilitator and at the two group interviews one of my supervisors was present to observe the process and take notes. At the start of each interview I reminded the participants about my research and outlined the purpose of the discussion. I stressed that the discussion was not 'about' sexual abuse and that there were no right or wrong answers. The emails had indicated that participants did not require any expertise in the subject area. We established ground rules which

are outlined in Table 4-1 Participants were given the opportunity to add any further ground rules they wished to observe. Each participant was given a leaflet outlining sources of support before the discussion began (Appendix 13). They also signed consent forms which included permission for use of verbatim quotes (Appendix 14). The discussions were digitally audio-recorded and later transcribed.

Table 4-1 Ground rules for group interviews

1.	Confidentiality:
a.	I will not divulge who has participated
b.	I will not transcribe names
c.	Details of the discussion to stay within room
2.	Participants should talk to each other rather than the facilitator
3.	It is acceptable to disagree with each other's point of view and articulate it
4.	One person to speak at a time

Hughes and Huby (2002) note that vignettes are both a useful focus for discussion in individual interviews and stimulus for group discussions. They do not require participants to have an in-depth knowledge of the topic under study. I consequently derived anonymised vignettes from the interview data and used these to prompt discussion (Appendix 15).

Rather than conducting detailed verbatim transcription, I noted the substance of the discussion in transcribing the interviews with professionals. However, as Wilkinson (2006) is critical of the absence of interaction in analysis of group discussions, I also documented where there was agreement or disagreement among the participants. I noted the nature of interactions between them. For example, one comparatively newly qualified midwife was keen to learn how her more experienced colleague managed situations that arose in the course of the discussion. Several of the interactions were therefore educative or informative

in character. I transcribed verbatim any part that felt especially significant and I regularly noted timeframes on the transcript so that I could return to the recording with relative ease. I did this frequently to check meaning during analysis and write up. I then conducted a thematic analysis in a similar fashion to my fifth reading of the women's transcripts and created grids on spread sheets to demonstrate where and how the themes emerged.

4.6.3 Maternity care records

I asked women for permission to access their maternity care records at interview. All of them gave consent and I recorded this on the consent form along with the information needed to trace the notes in the Medical Records Department (Appendix 16). Following the interview I emailed these details to the medical records supervisor who then obtained the records for me. The supervisor knew that they were required for research purposes, but not what the study was about. There are potential issues of confidentiality where a researcher has access to records that were not collected for research purposes (Robson 2011). Although the women gave their consent, those writing the records did not. However, support of audit and research is one of the reasons for keeping records recognised by the NMC (2009a) and staff should therefore anticipate such usage. Security of the records and the confidentiality of all concerned were given high priority. I only had access to the records of participants in my study and I did not remove them from the Medical Records Department. I used an electronic proforma (Appendix 17) to transcribe information from the records. Although this introduced the risk of transcription errors that would not have occurred if photocopies had been taken (Robson 2011), it prevented any breach of confidentiality that recognition of handwriting or signatures could have caused. Demographic details, medical history, details of the progress of the pregnancy, labour and birth and the narratives written by the professionals caring for the women were transcribed. No identifying features of any person involved were recorded. Where staff making the records had used abbreviations, I copied them. This included the use of arrows. An example from Sue's notes is shown below. Sue had been admitted at thirty two weeks of pregnancy with her third baby:

Generating the data

↓*FMs today x3 o/e ceph free FHHR*

Although it is not entirely clear what the 'x3' means in this context, I interpret this entry as follows: 'Reduced fetal movements today – three noted. On examination the fetal head is free of the pelvic brim. The fetal heart was heard beating regularly'.

I noted when observations had been taken but did not record the details when they were within normal limits. Hammersley and Atkinson (2007) suggest that records depend on shared cultural assumptions for intelligibility. As a midwife I have inevitably made assumptions about the meaning and significance of the entries.

These transcriptions were read in parallel with the transcriptions of the women's interviews. A sixth formal reading of the interview transcripts was done in which I noted any mention of the medical records. I also noted specific details given by the women of events and timings relating to their maternity care. I then compared these to the records. This gave an insight into the writer's presuppositions and perspectives (Hammersley & Atkinson 2007). These insights are described in Chapter 10 (p193).

4.7 Ethical issues

I gained ethical approval for the study from the local NHS Research Ethics Committee. The expansion of my recruitment strategy constituted a 'substantial amendment' to the protocol and necessitated further endorsement from the same committee. Given the sensitive nature of the subject (Lee 1993) close attention was given to ethical aspects from the outset.

4.7.1 Maintaining the wellbeing of participants

All potential participants were approached by a third party who was known to them. As discussed in section 4.4, I did not know who had been approached

and the third party did not necessarily find out whether the woman decided to participate. Although it is common practice to inform the General Practitioner (GP) of a person's involvement in research, GPs were not informed in this case as evidence suggests that the majority of women will not have disclosed abuse to professionals (Cawson et al. 2000; McGee et al. 2002; Wijma et al. 2003).

Attention was given to the possibility that participants might become distressed due to their involvement in the research and the reliving of potentially painful experiences. However, Graham et al. (2006) identified that even interviews that were painful could be a positive experience. Women in Frost's (2004) study were pleased that the research was being done and Sque (2000) found that none of her participants who were distressed accepted the offer to terminate an interview. Lee (1993) discusses strategies for dealing with distress in interviews and, in common with Remen (1996) believes that the most appropriate approach is to 'endure and share'. Legard et al. (2003) suggest that when a response such as distress is shown, the interviewer should mentally register the fact but not interrupt if the participant continues to talk. This is the approach that I took in this research. For example, Sue was quite tearful during some of her interview, but did not stop recounting her experiences. At no point was she unable to talk, so I waited and listened as she continued.

At the end of the interview, as in Frost's research (2004), the participants were asked if they had found anything too distressing. Some acknowledged that recounting their experiences had been hard, but said it had not been too distressing. However, this is not necessarily reassuring. Johnson and Macleod Clarke (2003) report a situation in which a participant admitted to being very upset by an interview despite having denied it at the time. At the recommendation of CIS'ters, I asked women to identify their personal sources of support at the beginning of the interview and these were recorded on the consent form. Afterwards I gave each of them a leaflet outlining sources of support (Appendix 13). I updated this every four weeks during the period of data collection to ensure the information was current. I sent a thank you letter to the participants following the interview reminding them of these support mechanisms (Appendix 18).

4.7.2 Maintaining my wellbeing

Lalor et al. (2006) demonstrate a significant impact on all members of the research team when dealing with distressing narratives. This is corroborated by Malacrida (2007) and Wray et al. (2007). Strategies for my own protection were therefore an important consideration. I did not conduct more than one interview per day and made sure that I had a network of supportive friends and access to a work-based counsellor to whom I could turn if necessary. I kept a reflexive diary not only as an important part of the research process but also as a means of analysing my emotional response. In terms of my personal safety the Faculty's Lone Worker Policy was employed, although it was amended slightly in order to ensure participant's confidentiality. This involved sealing participant's details in an envelope on which was written the time and date of the interview. This was given to one of my supervisors and returned to me for shredding afterwards.

4.7.3 Anonymity

I assigned each participant a code number when they returned their reply slip. At interview they provided a pseudonym by which they would be known for the study. This was recorded on page two of the consent form and transferred as soon as possible to a file containing code number and pseudonym. Once this was done I shredded page two of the consent form. Thus there was no place in which participants' real name and pseudonym were stored together. Participant anonymity was also maintained by my transcription of the interviews.

4.7.4 Confidentiality

None of the documentation sent to potential participants explicitly named childhood sexual abuse. I ensured that no names of people or places mentioned in interviews were recorded in transcripts. In addition, I was careful to avoid what Lewis (2003 p67) refers to as 'indirect attribution'. This meant taking care with the verbatim quotes I have used – for example not using quotations that could alert readers to the professional background of the participants. It also meant omitting or slightly altering some details when

there was potential for identification of participants through them. I sought specific permission to use verbatim quotes during the process of gaining consent and checked at the end of the interview that participants were still happy with this.

The participant information sheet outlined the measures I intended to employ to protect people's identity but also indicated that this confidentiality would be broken if any disclosure was made indicating that a child was at risk, necessitating disclosure to a child safeguarding practitioner. This did not occur.

4.7.5 Healthcare professionals

It was possible that some of the focus group participants and those recruiting women would have had personal experience of sexual abuse. Leaflets outlining sources of support were attached to each research pack and marked for the attention of the healthcare professional concerned. All the maternity care professionals who participated in interviews were given the leaflet prior to the interview. Discussion with the Trust's Occupational Health Department confirmed that any participant could self-refer if in need of support. This was indicated in the letter of invitation.

4.7.6 Data confidentiality and security

The study was designed in accordance with the requirements of the Data Protection Act 1998 and following advice from university legal services and the UK Clinical Research Collaboration. Reply slips giving contact details of the participants and consent forms were stored in a locked cabinet in a locked office at the university. They were kept separately from transcripts and recordings. Copies of the reply slips were secured in sealed envelopes in a locked cabinet in a separate locked office.

Interview recordings and transcripts were saved onto my personal, password protected laptop computer that has a firewall and regularly updated virus protection. All relevant files were also saved onto my password protected drive

at the university via the Virtual Private Network (VPN). Although the Medical Research Council (MRC) (2005) advises that recordings should be archived in their original form, concerns were raised by CIS'ters about the possibility of participants being recognised from their voice. Therefore participants were given the following choice as to what happened to their recording on completion of my doctorate:

- Preservation of the recording in its original form, identified only by pseudonym, and archived securely at the university. In this case, I would be the only person to listen to the recording.
- The recording could be destroyed but authenticity of the transcripts would need to be verified by one of my PhD supervisors reviewing random parts of the recording together with the transcripts. The identity of the woman would not be revealed.

All of the women chose the former option.

4.7.7 Consent

Participants were asked to complete and sign two copies of the consent form (Appendix 16) prior to commencement of the interview. I stressed the voluntary nature of participation and that women were free to withdraw, even part-way through an interview, if they so wished. One copy of the consent form was given to the participant and the other copy was filed with the reply slips. The process of gaining consent from maternity care professionals was discussed in section 4.6.2.

4.8 Member validation

For some authors returning to participants to check the researcher's interpretation is an important part of validation of findings (Polkinghorne 2007). However others recognise that this is not always either practicable or desirable and may create an undue burden on participants (Carpenter 2007a). There is a particular issue in narrative research in which new stories may be

created in the telling of old ones (Frank 1997; Koch 1998). Garratt (2011) offered all participants in her study the chance to review their transcripts but several declined despite their willingness to have the information included in the report. She surmised that the information was too painful for the women to see in print. Given the potential for distress, I decided that member validation was not appropriate for this study.

4.9 Summary

Given the sensitivity of the research, it is important to be transparent about the processes involved and this chapter has consequently detailed them. I alluded to some of the complexity involved in my approach in the previous chapter. I explore my specific mode of analysis and reflect on these complexities in the next chapter.

5. Chapter Five: Producing women's narratives

5.1 Introduction

In this chapter I present details of the participants and examine some of the issues that arose during the fieldwork. I provide a worked example to demonstrate my analytical approach.

5.2 The Participants

Recruitment to the study was a slow and challenging process. I interviewed nine women between November 2008 and March 2011. The interviews were approximately 60-90 minutes long but one lasted nearly four and half hours and took place on two separate days. Three of the women were recruited via CIS'ters, two via the Rape Crisis Centre and two via midwives. A further two volunteered having learnt about the study at work (section 4.3.5). At the time of interview women were aged 28 to 52. Between them they had twenty live-born children, four early miscarriages and one termination of pregnancy. Only one of these early pregnancy losses was mentioned during the interviews; I learned of the others from medical records. One woman's children had been taken into care and subsequently adopted. The number of children for each woman ranged from one to four and the age of the children at time of interview was nine weeks to twenty eight years. In common with other studies (Garratt 2011; Parratt 1994; Seng et al. 2002) some women therefore spoke of events that had occurred many years before. However evidence suggests that women generally recall labour and the birth of their children accurately, even 15-20 years later (Simkin 1992a). Of the 20 live births, 15 were normal births at term and one was pre-term[6]. Three were forceps deliveries, and one was a pre-term emergency Caesarean Section. None of the women had planned home births, although two transferred into hospital from home during the first stage of labour[7]. Both Garratt (2011) and Parratt (1994) report a large

[6] Prior to 37 weeks of pregnancy.

[7] The period from the onset of labour to full dilation of the cervix.

proportion of home births among the women in their studies. One woman had not remembered her abuse at the time of her pregnancies. Of the others, three disclosed their abuse to the professionals caring for them in pregnancy and five did not. Seven women reported some form of depression during the childbearing year. This is a common finding among abused women (Leeners et al. 2006b; Palmer 2004). Two women had been living in violent relationships when they had their children but were no longer with those partners at the time of interview. The other seven women were married. At least six of the women were still in relationships with the father of their children. This contrasts with Palmer (2004) who reports that most women in her study were no longer with the biological fathers of their children. All of the women interviewed were white, British and reported heterosexual relationships. The lack of diversity is therefore a limitation of the study.

5.3 Challenges with recruitment

The challenges I faced with recruitment reinforced the view that the women I was targeting are a hidden, hard to reach population. Health Visitors were approached because they have a longer term relationship with women than midwives and CIS'ters suggested that women may be more likely to disclose to them. However, when I made contact with the teams to remind them of the study, the vast majority said they had no one with the relevant history on their caseload. This was also what obstetric physiotherapists and the psychosexual counselling team reported.

Of the 160 research packs distributed to those assisting with recruitment, 23 were removed from boxes. Over twice as many women were therefore approached than decided to participate (although it is possible that not all of the packs were handed to women). This could be for a number of reasons. They may not have wanted to talk about their experiences or they may have been too busy given that some of them were being approached immediately after childbirth. As there was no mechanism for reminders, it is possible they forgot or thought it too late by the time they were ready to reply. In order to meet the requirements of ethical approval, my Participant Information Sheet (Appendix 7) was relatively long (five pages) and this may have deterred some

women. This compares to two pages for Lasiuk (2007) who conducted a similar study in Canada. One woman withdrew from the study the day before the interview because she did not want to become upset.

CIS'ters had not anticipated that finding participants would be as difficult. On reflection, they suggested that women who were still struggling with their experiences were probably not in a position to talk about them. Those who had worked through their experiences might be reluctant to rekindle bad memories. It is also possible that there are women who have been abused but who have had no issues with maternity care and did not therefore believe that they had anything to contribute to the study. I was reliant on the good will of professionals to identify and recruit women for me. I regularly visited the office from which many community midwives worked in the first few months of data collection. During this time I was acutely aware of how busy staff were and did not want to get in their way. I was also cognisant of the fact that childhood sexual abuse could be a personally difficult subject for some.

Difficulty in recruitment is a recognised issue in researching sensitive topics. Tierney et al. (2010) describe problems recruiting to a study on eating disorders and obesity. They suggest that putting the onus on women to complete and return recruitment information from home – as I did - could be a barrier. Indeed they eventually advertised on a website, and had to conduct telephone interviews because of geographical distance from participants. The appropriateness of conducting telephone interviews on sensitive subjects could be questioned but Tierney et al. found that their participants liked the anonymity. However non-verbal cues from the interviewer are an important part of coaxing a woman to tell her story (Kvale 2007) and for Legard et al. (2003 p142) an in-depth interview is an 'intense experience' for which a physical encounter is essential. Lasiuk (2007) advertised in local papers for her study on 'the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse' and recruited seven women, two of whom were public figures she approached herself. Tierney et al. (2010) conducted eight interviews overall. My recruitment is not therefore out of kilter with some other studies on sensitive subjects. Furthermore, Kvale (2007) suggests

that fewer interviews with time for preparation and analysis may be better than a larger number.

5.4 Definitions of childhood sexual abuse

As discussed in Chapter One (section 1.4), the women in this study were a self-defining group. I did not ask them about their childhood history during the interview, but in the course of relating their maternity experiences to me, some aspects emerged. Most of the women experienced abuse over a number of years that was perpetrated by one or more adults known to them. Sally and Mia's stories are different in that they were subject to isolated attacks that happened outside the home environment. Sally talked in terms of 'abuse', whereas Mia used the term 'rape' – the only one of the participants to do so. One of the participants from the interviews with maternity care professionals mentioned a woman who appears to have a similar history to Mia. When approached about my study this woman apparently declined to participate as she did not consider that she had been 'abused'.

5.5 The creation of narratives

The interactive nature of narrative interviews is well documented (Barbour 2008; Legard et al. 2003; Riessman 2008). In this study, I was keen to avoid interruption of the flow of the story being told (Kvale 2007) so listening was as important as questioning (Barbour 2008; Kvale 2007). This approach was nevertheless part of the 'joint action' (Plummer 1995 p20) involved in the production of stories. Kvale (2007) acknowledges that with another interviewer a different interaction may be created and different knowledge produced. In my introductory letter I introduced myself to potential participants as a 'midwife and researcher' (Appendices 5a-c) and this may have affected the story told. However, it was clear that I was not viewed as part of the maternity services by most of the participants. For example, both Sam and Louise referred to maternity staff and other professionals in the third person.

Some narratives felt more rehearsed than others. Sam had clearly thought through what she wanted to say and also spent time indicating aspects of care that she thought might be helpful to other women. These were born out of her experiences but were not necessarily part of her 'story'. Jane had pieced her story together retrospectively because she was not aware of her abuse at the time of having her children:

> *…any connections I make with my experience of umm pregnancy, childbirth, whatever, labour, um you know, in view of my history, I actually subsequently made if you like…* (Jane, p2)

Others seemed to be feeling their way during the interview as this extract from Sally's interview shows:

> *Elsa: and actually the examination when you had the epidural was OK*
>
> *Sally: Yeah, but you're still being ab… you're still having it but it's a different – maybe because you can't – I don't know! I can't ….*
>
> *Elsa: So somehow there was something worse*
>
> *Sally: Yeah*
>
> *Elsa: about the – the thought of what was gonna happen under anaesthetic than…*
>
> *Sally: Yes – because I wasn't in control maybe…*
>
> *Elsa: Mm*
>
> *Sally: Maybe that's what it was. Maybe… because I was, because I didn't know what was going to happen.* (Sally p14).

Kvale (2007) suggests the interview may be a learning process, participants may make new connections in the course of the interview and that meanings may change for them. Again, this seems to be the case for Sally:

> *…this is the first time that I've ever spoken about it. Um… which is probably good because it's given me … I've realised why, you know… I just … cos there's quite a couple of key things there …* (p31).

Taylor et al. (1995 p128-9) report similar reactions from a participant in their study:

> *…because when I answer these questions, I realise things that I did not even picture.*

The narratives created also differ according to the agendas the women brought to our meetings, their reasons for participation and the extent to which they had dealt psychologically with the events they were recounting. Despite the differences in how much the stories felt prepared, all the women spoke freely. This may be a measure of the fact that they participated because they felt 'ready' to tell their story. For example, Linda contacted me via email several months after receiving a research pack. She stated that at the time she was given the information she felt unable to participate, but now felt differently. When I met Sue she told me that she had been excited earlier in the day at the prospect of 'doing something useful' but was now feeling nervous. She had a nervous flush across her neck as we spoke and was frequently tearful. In response to my opening question Sue started to explain how pregnancy had been a 'scary' experience but soon stopped:

> *I don't know where to start (laughs) ask me a question!* (Sue p1)

Despite this protestation she continued without any prompt from me.

The motivation for participation for some women was therefore congruent with my objectives of raising awareness of the impact of childhood sexual abuse on maternity care. Others seemed to have different agendas. There was a

disparity between the story I was expecting and the one Louise wanted to tell. Louise had been in foster care since the age of eight, but gave no indication as to why. She began a relationship with a 22 year old at the age of 15, which is by definition abusive (section 1.4), but it appears to have been consensual - even though it eventually became violent. Louise's children had been taken in to care and she was still very angry about it:

> *I do not understand why, they couldn't keep us safe. I still don't understand it. Why Social Services had to go to so drastic measures to take my children away so, so, so that they – yeah – I don't regret not - them keeping 'em safe, or them moving 'em out, but <u>why</u> couldn't they've moved me out.* (Louise p20)

Louise divulged little of her feelings other than anger and her responses to my questions were very literal.

> *Elsa: And how did you adjust to being a Mum?*

> *Louise: I don't know. I think I just did it. I don't, I don't know <u>how,</u> but it was, I just done it – if you get what I mean by that. I just – I thought, well, I'm on my own, no-one's helping me, so basically, there you go. I don't know how we did it, and I still don't know how I did it, but I just, I dunno, I just done it. I d… I can't explain how. I still don't know.* (p 13)

The extent to which this is a product of different expectations of language is difficult to determine but my interaction with Louise felt more superficial than with the other women. She sometimes mentioned things that were reminiscent of issues raised by others, but my probes did not lead to a deeper understanding:

> *Louise: …I'm not very good around strange people. I gets really nervous, really tensed up when like strange people are around me. I hate it.*

> *Elsa: Do you know why that is?*
>
> *Louise: I dunno. I don't know. I've always been like it. I just, I can't – how can I explain it? I can't deal with crowds of people or can't deal with like strange people – I dunno, it's just I've always been like it, I always have been like it.* (p 18)

Enosh and Buchbinder (2005) warn of the importance of trying to understand the participant's own reality rather than trying to drive them towards the 'hidden reality' that is part of the researcher's agenda. Hollway and Jefferson (1997) analyse an interview in which they struggle to coax the type of answers they were expecting from a participant. They suggest that not only was there misunderstanding of the meaning-frame between participant and researcher, but also that they might have been up against the participant's established defences. Both these scenarios are possibilities for my interview with Louise. This exposed a need for me to listen to the questions I was asking and be more explicit about what I meant. However Kvale's caution (2007 p89) is salutary:

> *The dilemma of wanting as much knowledge as possible, while at the same time respecting the integrity of the interview subjects, is not easily solved.*

Having collected the narratives, analysis was required in order to gain an in-depth understanding of their meaning for the women and to allow for wider application of the findings.

5.6 Analysing interview data

Data analysis is a challenging process requiring both creativity and a systematic approach (Spencer et al. 2003). In qualitative studies analysis inevitably begins during data collection (Barbour 2008; Pope et al. 2006) and continues during the writing up of results. Qualitative researchers have been criticised for not being explicit about how analysis is conducted (Mauthner &

Doucet 1998; Spencer et al. 2003); the purpose of this section is to avoid that accusation in my study. As discussed in section 3.6.2, I employed the Voice-Centred Relational Method of analysis for the interview data, which involved four initial 'readings' of the transcripts. Although the formal readings of data are explained below, it is important to recognise that analysis also occurs in the mulling over of data at other times and when not 'at work'.

In section 3.6.2, I alluded to the shift in language between Brown & Gilligan's (1992) 'listening' to the data compared to the 'reading' of Mauthner and Doucet (1998). Although there is no suggestion that Brown and Gilligan necessarily meant 'listening' to be taken literally, the recordings were clearly considered an important part of the process. Perhaps the language used by Mauthner and Doucet (1998) reflects less emphasis on the spoken word and suggests that the transcript was a more important tool for them. In the following discussion I assume that 'listening' refers to a process in which recordings of the interview are played back whilst reading the transcript and 'reading' relies just on the transcript. It was important for me to have listened carefully to the interview recordings as a feel for the tone of voice, hesitations, silences and the volume at which the participants speak adds much to the richness of the data. It is not always possible to capture these aspects adequately during the interview itself. I acknowledge that even recordings are abstractions – body language, posture and gestures are inevitably lost (Kvale 2007) – even if detailed field notes are taken and non-verbal communication is included as far as possible in the transcript.

Immersion in the data is an important part of qualitative research (Speziale 2007a) and it is difficult to see how this can be achieved without having listened to the recordings. However, only one of my interviews lasted for less than an hour and this meant that listening to the recording for each part of the analysis was not feasible. I listened carefully to the recording as I transcribed the interviews, which was a key component of familiarisation with the data, and on one further occasion. This second listening allowed both for proof-reading of the transcript and for attending to the plot. Subsequent analytical steps involved 'readings'. In practice, as implied by Fairtlough, (2007) the stages are separate more in concept than in practice. As with analysis in general, the

processes of reflection, attending to different voices and comparing different stories begin at the time of the interview and are constantly with the researcher. They are much more fluid than the description of four 'readings' implies (section 3.6.2). Other researchers (Brown & Gilligan 1992; Garratt 2008; Mauthner & Doucet 1998), describe literally tracing the different voices with coloured pencils on the transcripts for the second, third and fourth readings (they managed the first reading differently – see section 5.6.1). This would provide a visual representation of the multi-layered nature of the narratives, however for clarity, I separated out each reading. Working from electronic versions of the transcripts I preserved only the sections of text that related to the particular voice to which I was attending. In the following sections, I reflect on the four readings in turn and provide a worked example of my analysis.

5.6.1 Listening for the plot and researcher response

The first formal consideration of the data within VCRM requires not only that the plot is uncovered but also that the researcher reflects on her response both to it and the participant so that she can be alert to any likely biases. Brown and Gilligan (1992) and Mauthner and Doucet (1998) advocate setting the transcript out on a page with two columns. The participant's words are entered in the first and in the second, the researcher's response to them is noted. I initially found this first reading the most problematic of the four. It was difficult to know how to record the 'plot' particularly when the story told was not linear. Having conducted and then transcribed the interviews myself I had a fair sense of what the stories involved and how I had reacted to them. I noted in my reflective diary as much detail as possible about the setting and my reflections on the interview, the participant and her story as soon as practicable afterwards. Further reflections occurred during the subsequent readings. I found that annotating the text with comments was the most helpful way to record these reflections. As subsequent interviews, their transcription and analysis took place, a process of comparison across them inevitably occurred. Thus the text was also annotated where similarities between different participants became apparent.

I faced some dilemmas in managing the data. The main benefit of 'reading for the plot' was to gain an impression of the story. However, I had to recognise that it was not possible to present all the details – not least because identification might be possible. However if I edited it too much I was no longer telling the woman's story. I eventually captured the plot by summarising the participant's story once I had finished transcribing and it was still fresh in my mind. These summaries necessarily change the order in which the participants recounted happenings to provide a coherent synopsis and are therefore an abstraction and my interpretation of their stories. However, I tried to remain faithful to the way the women spoke and used their words where possible. I occasionally omitted events and was not explicit about others where I was concerned that they could have enabled identification of the women. This was generally in relation to events from the woman's past that were not related to maternity care experiences. The plots are presented in Chapter Six (section 6.2).

The plots provide summarised narratives for each woman. Because they essentially chronicle events, they are different from narratives told in the interviews in that there is less focus on the women's emotional struggles and meanings endowed by them. However, they represent the tangible presence of those women in the research product and give an overall impression of them that can be brought to mind when considering the more detailed analysis.

5.6.2 Subsequent readings

As detailed in section 5.6, I conducted these readings with electronic versions of the transcripts in front of me and selected the parts that related to the particular voice. I present below a worked example, which enables me both to demonstrate the process of analysis and to reflect on my approach. This begins with an unedited section of the transcript from Sam's interview, chosen because it was part of a narrative that provided examples of all the readings.

> *…and so you suck yourself back in and sort of pull it all back in and push it down and just put up with it and also, when you've got other people in the room with you, they get anxious too so you find yourself*

trying to placate them and, and sort of calm them down even though you know, I, I'm anxious!

Elsa: Mm

Sam: And so, it's just not good! You end up using much more energy, I think, than you probably need to, because really when you're in labour you should be concentrating on yourself, not on everyone else! But you find yourself doing that because they get worried, they can see how much pain you're in and if you're needing like a top up or someone to come and give you some help, um many times I've had to have the person that's with me in the room to actually go out of the room and go and find a midwife to get some help because I mean pressing the buzzer don't make much difference at all because they're already busy, so you sort of want – they're outside, so you are, I have been left in the room on my own 'n sort of wondering 'Oh when are they gonna come back 'n it is, it is like a prison.

Elsa: Mm

Sam: It really is horrible. And plus you can't open the windows and you can't get out of the windows cos it only opens about two inches and I don't know, it is very, very scary. Um and when – I quite often have ended up on the drips because um fluids and um being stuck in the bed, that's really, really horrible cos um, you know when they put the monitor round your tummy and you're stuck there and you got, you got like a cannula comin' out of your wrist or whatever and then you've got the monitor goin' round your tummy and you're like really stuck and and cor just stuffed if you want to go to the toilet, you know you're like 'Ooo!' No it's not nice and I, I dunno, sometimes I, well many times I've felt like – I really don't wanna be 'ere but I'm stuck here and it, it creates a resentment just in that time of – you know, you spend all of the pregnancy sort of looking forward to having this, this baby an' and preparing and then at the last minute, it's like, cor I don't know,

you end up like resenting the thing that you're giving birth to because you're thinking 'You're making me go through all this!' and 'if only I hadn't got pregnant!' (Laughs) and it's not a good thing! Um, I dunno, it's quite scary, y'know? You think, and when people are like all happy around you, like y'know, just I don't like this, (intake of breath) and …um, what else can I say…

The following sections demonstrate how the subsequent readings were created.

5.6.3 Reading for the 'Voice of the I'

For this reading, I extracted instances of where the woman used a personal pronoun, along with the immediately connected text. These were then arranged on separate lines to create an 'I-poem' (Gilligan et al. 2006). The I-poem created from the extract of Sam's transcript is presented below.

I, I'm anxious!
I think
I've had to
I mean
I have been left
I don't know
I quite often
I, I dunno,
sometimes I,
I've felt like
I really don't wanna be 'ere
I'm stuck here
I don't know
if only I hadn't got pregnant!
I dunno
I don't like this
what else can I say

In creating these poems examples of the 'I' that were simple statements of fact were omitted (for example, although not shown in the extract above, at one point Sam said 'I'm Rhesus negative'). In line with a feminist approach, these I-poems returned focus to the woman rather than her story. They provided insight into her underlying mood, her areas of strength, weakness and

uncertainty. They illuminated where women struggled to speak, when they were empowered, or, as in this example when disempowered.

5.6.4 Reading for relationships

The third reading required identification of parts of the narrative that implied connection or relationship. For my study this included connection to the pregnancy and baby. Again, this is shown below for the extract of Sam's interview.

> *when you've got other people in the room with you, they get anxious too so you find yourself trying to placate them and, and sort of calm them down even though you know, I, I'm anxious!*
>
> *really when you're in labour you should be concentrating on yourself, not on everyone else!*
>
> *But you find yourself doing that because they get worried, they can see how much pain you're in*
>
> *you end up like resenting the thing that you're giving birth to because you're thinking 'You're making me go through all this!'*

This reading demonstrated how women sought relationships with others, the times that they put others before themselves, how they reacted to their pregnancies and where they lacked connection too.

5.6.5 Reading for the socio-cultural context

The fourth reading focused on the wider context. This included both the physical environment and less tangible constructs. As demonstrated by the example from Sam, the birth environment and the structure of the maternity services were key aspects of this reading in my study:

I have been left in the room on my own 'n sort of wondering 'Oh when are they gonna come back' 'n it is, it is like a prison.

And plus you can't open the windows and you can't get out of the windows cos it only opens about two inches

You think, and when people are like all happy around you, like y'know, just I don't like this, (intake of breath)

However, although not as obvious in the chosen extract, it also related to phenomena such as society's expectations of women as mothers, its reaction to childhood abuse and living within violent relationships.

VCRM was a vehicle through which detailed readings of the women's narratives provided insights that may not have emerged with a more traditional analytical approach. However, as discussed in section 3.6.2, to meet my study's main objective of informing practice, I needed to synthesise these accounts into a meaningful whole that laid claim to wider application. The thematic analysis described in the next section was the means by which this was achieved. The initial four readings made the thematic analysis stronger and in the following chapters data from these readings are used to corroborate the themes by which the chapters are structured.

5.7 Thematic analysis

The data synthesis began with a further formal reading of the transcripts to identify and label codes. There was considerable thematic overlap between the women's accounts, even though their stories were different. Some parts of the text represented more than one code, confirming the multi-layered nature of the narratives. Table 5-1 shows the codes and themes represented in the extract from Sam's interview presented above. How these relate to the remaining codes and themes is demonstrated in Figure 5-1.

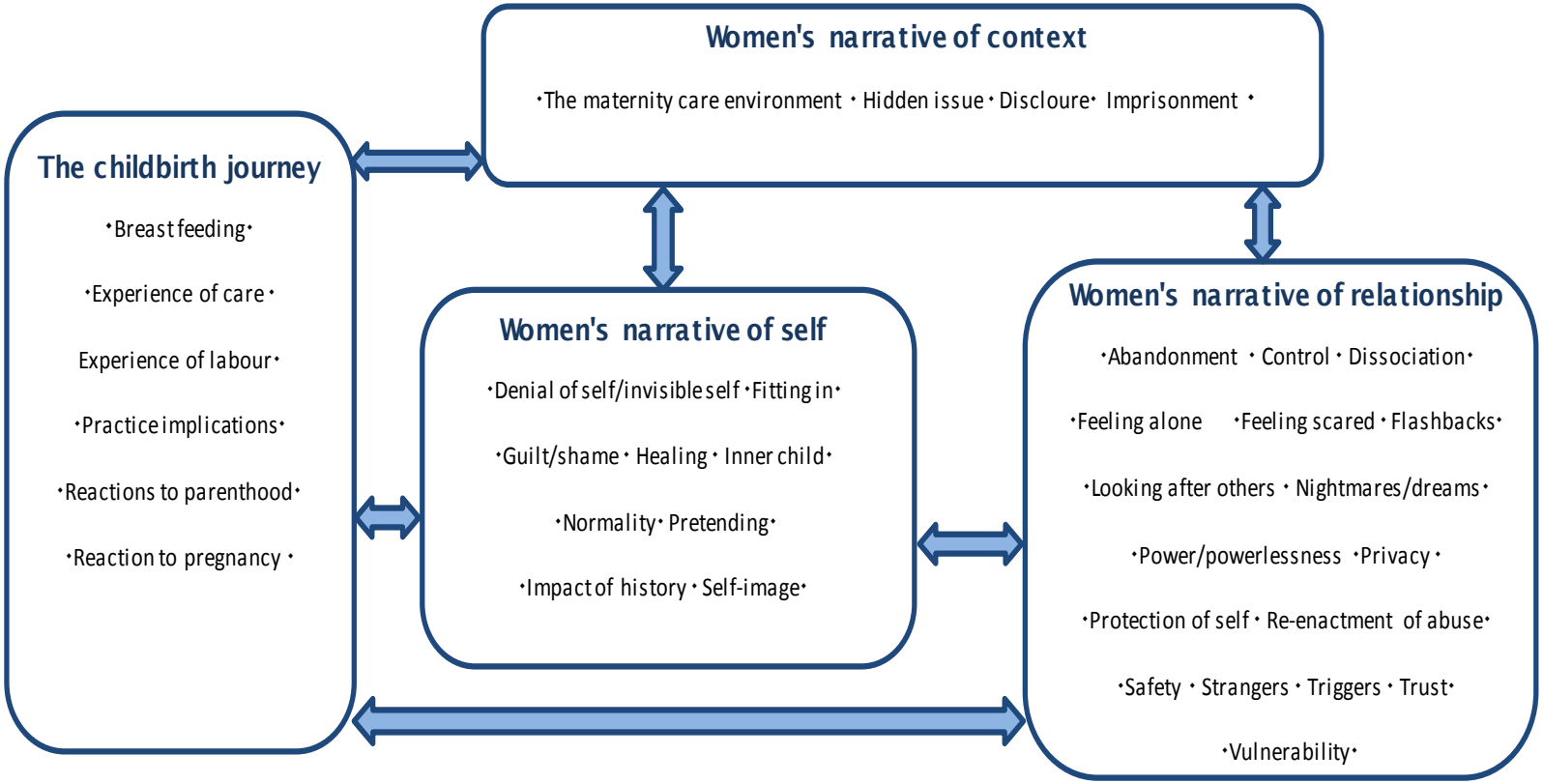
Table 5-1 Example of thematic analysis

Example of text	Code	Theme
• *and so you suck yourself back in and sort of pull it all back in and push it down and just put up with it*	Denial of self/invisible self	Women's narratives of self
• *when you've got other people in the room with you, they get anxious too so you find yourself trying to placate them and, and sort of calm them down* • *because really when you're in labour you should be concentrating on yourself, not on everyone else! But you find yourself doing that because they get worried*	Looking after others	Women's narratives of relationship
• *they're outside, so you are, I have been left in the room on my own 'n sort of wondering 'Oh when are they gonna come back*	Abandonment	Women's narratives of relationship
• *And plus you can't open the windows and you can't get out of the windows,* • *being stuck in the bed, that's really, really horrible cos um, you know when they put the monitor round your tummy and*	Imprisonment	Women's narratives of context

you're stuck there, • *I really don't wanna be 'ere but I'm stuck here and it, it creates a resentment*		
• *you spend all of the pregnancy sort of looking forward to having this, this baby an' and preparing and then at the last minute, it's like, cor I don't know, you end up like resenting the thing that you're giving birth to*	Relationship with baby	Women's narratives of relationship

Lasiuk (2007 p106) suggests that 'a theme is not something encountered in a text, but rather a way of illuminating meaning'. Codes from all transcripts were reread and grouped to refine them, which produced four overarching thematic categories. These reflected the woman's view of herself, her experience of others, which, in maternity care often led to 're-opening of the wounds', the context of experience and the woman's journey through childbirth. Examining the categories I had created, I realised they reflected the readings of VCRM. I therefore relabelled them as follows: women's narrative of self, women's narrative of relationship, women's narrative of context and the childbirth journey. Figure 5-1shows how the codes were grouped to form these themes and how they relate to each other. The way the woman experiences herself influences the way she approaches other people and receives their attempts to form relationships with her.

Figure 5-1 Conceptual representation of thematic analysis



The wider socio-cultural context impacts on both the woman's experience of herself and of others and in turn how they respond to her. The childbirth journey is affected by each of these themes. The themes provide a translational analysis by which healthcare professionals and others can access the women's stories.

5.8 Summary

In this chapter I have provided details of the participants of my study and discussed the challenges I faced with recruitment. I have demonstrated the mode of analysis for my interview data and have reflected on some of the processes involved in the co-construction of knowledge. The following four chapters are organised by the themes described above. In them, I present the findings from my interview data that were common to most of the women to whom I spoke.

6. Chapter Six: The childbirth journey

6.1 Introduction

In the previous chapter I demonstrated my analysis of the data from in-depth interviews with women and suggested that the emergent themes were a means by which the women's narratives could become accessible to a wider audience. As this study's first objective was to inform midwifery practice by recounting the participants' narratives, a detailed consideration of their stories is essential and the next four chapters serve that function. The implications of these narratives for midwifery practice are discussed in the final chapter.

In the context of a study on maternity care experiences, the theme 'the childbirth journey' in part reflects women's experience of care and is therefore an important consideration. One of the strengths of a narrative methodology is that the focus on the participants' stories and accounts is retained. In keeping with this and the feminist approach I have chosen for the study, it is imperative that the women remain visible and that their stories are heard. Below, I present the plots derived from the first reading of the interview data (section 5.6.1). These are of necessity an abstraction but nevertheless represent the tangible presence of the women. These are often harrowing stories. I have shortened them in line with the focus of the research. Although these accounts are not first hand, they attune readers to the women's individual experiences. Their voices are heard in the direct quotations I employ in subsequent chapters.

6.2 The individual stories

Elizabeth: Elizabeth has two children born four years apart who were aged two and six at the time of interview. Prior to her first pregnancy she thought that she would not be able to have children. Elizabeth believed that her abuse was something in her past that she had dealt with and she considered that she was leading a normal life. However the onset of pregnancy coincided with an

overwhelming onslaught of memories and flashbacks[8] that began even before she discovered she was pregnant at six weeks gestation. These memories brought back events of her childhood in great detail and included things she had not remembered until then. The experience of pregnancy and labour was a lonely one as no one knew what she was struggling with and she therefore felt unsupported. She feared that she would be a bad mother and that her baby would be taken away from her – especially as her own mother was implicated in her abuse. Eventually she felt so overwhelmed that she believed she would be better off dead and that her baby would be better off without her as a mother. She tried to kill herself but was prevented by her husband. Despite a referral to the Perinatal Mental Health Team, she did not really disclose her abuse until she began therapy when her first baby was about eighteen months old.

Her first experience of pregnancy and childbirth was extremely traumatic and by the end of it she felt as though she had been through her abuse again. It was an unplanned pregnancy, although very much wanted and she still feels guilty about having negative thoughts about it and feeling suicidal when pregnant. Her baby was delivered by forceps and she describes being surrounded by strangers and under the spotlight to give birth. Vaginal examinations were particularly painful and done without her permission. Five days post birth she was transferred to a Mother and Baby Mental Health Unit. She succeeded in breast feeding following support from a community midwife and this was a very positive experience that made her believe that her body could be useful for something.

She was determined that her second pregnancy would be different and realised that she would have to speak out about her wishes if she was to get the experience she wanted. She was desperate not to go back to the Maternity Hospital and fought for a home birth. Unfortunately she had to be transferred from home in labour as the baby had got stuck. However, she was accompanied by a sympathetic midwife, who took her wishes into

[8] The reliving of a situation as if there.

consideration and was sensitive to Elizabeth's needs. Once that midwife had left she again felt that her feelings and concerns were invalidated.

With hindsight she believed that her first baby 'saved' her as being pregnant and having a baby forced her to face things and she feels that she has come out of it a whole person.

Helen: Helen was very excited about being pregnant and expected to enjoy it but it was not the lovely experience she hoped it would be. She put on a lot of weight and struggled with her body image, finding it hard to believe that her husband would still find her attractive. She was pregnant in the summer and suffered with very swollen legs for which she had to wear support stockings – adding to her discomfort. Helen's labour eventually began a week late after she had a membrane sweep[9]. She found the contractions extremely painful and went in to hospital believing she would need an epidural. However, when she was examined she discovered that she had made very good progress and decided that she would be able to cope with the pain if it was going to be over soon.

As predicted by the midwives, Helen soon got to the stage when she could begin to push but unfortunately despite putting every effort she did not make progress and the decision was taken to transfer her to labour ward where she had a forceps delivery. Helen subsequently bled very heavily and passed out, causing her midwife to push the emergency bell to call assistance. Helen woke up, barely clothed, surrounded by strangers and remembers this as a very traumatic experience.

Helen's stitches became infected in the days that followed and she eventually required two operations to solve problems. With hindsight Helen believed these problems may have been an exacerbation of damage that was caused by her abuse but of which she was not aware before the birth.

[9] The membranes that surround the baby are separated from the cervix by the practitioner's finger. The procedure is used to induce labour.

Helen loves being a mum, although she frequently worries that she is a bad mother and compares herself unfavourably to other mothers. She is also concerned about how to protect her child without being over-protective.

Helen and her husband were agonising over whether to have another child. Helen was scared of the prospect and particularly feared the lack of control that she experienced around the time of her first birth. Although Helen did not want to tell everybody about her abuse, she was concerned about how to alert those who might need to know. She also knew that if she embarked on another pregnancy, she would need to discuss plans for her birth very carefully as she could not face going through a repeat of her first experience.

Jane: Jane had three children within a violent marriage. She did not recall her childhood history until she subsequently left her husband. She approached her pregnancies with an emotional detachment that enabled her to deal with them as a series of practical procedures to work her way through. Jane's husband was present for all of the births. For her, this was part of appearing normal and presenting a practical, rational, intelligent front.

Her first baby was born half an hour after her arrival at hospital and the birth was a shocking experience for her. With hindsight, Jane realises that the pain she experienced in the second stage of labour was reminiscent of her abuse. In response to the pain, she stopped breathing and could feel herself disappearing. Likewise, she found the fact that her membranes ruptured on the floor disturbing, something she now also realises was reminiscent of her abuse. She shut down whilst being stitched after the birth and feels that it took her a while to take on board the fact that she had had a baby.

Her second child was born with the membranes intact. She remembers being concerned for the student midwife who was hoping to be able to deliver the baby before going off duty and analysing what was going on in her body as if

from the outside. The third time, her membranes went before labour began and she went into labour following an internal examination.

Going home with the babies was daunting as she had felt very settled in hospital. Although she was well supported by the midwives and health visitor, she experienced unreasonable behaviour from her husband who showed little recognition of what caring for a baby involved.

Although she bonded with the babies, as with pregnancy, her approach postnatally was very mechanistic. She just got on with the job and she did not make emotional connections with her body until a long time later.

Linda: Linda had a wonderful pregnancy and fantastic midwife-led care[10]. However, her path into motherhood was more problematic and was overshadowed by her need to strive for perfection. She now realises she was almost doomed to fail as her expectations were so high that she was never going to be able to meet them. Hounded by the thought that the abused become abusers, she felt the need to rewrite history. She was terrified that this cliché might actually be true of her yet at the same time was determined to prove it wrong. Linda feared being labelled by professionals as a potential abuser and consequently did not divulge her history to the midwives or health visitor. She not only wanted to show her mother what it was to be a good mother but also to demonstrate to other women how well she could manage. She therefore needed to have a 'textbook labour' and to be the best breast feeder.

Linda felt really well physically during pregnancy but by the end was terrified of the responsibility of bringing a baby into the world and was scared that she would not be good enough to look after her child. Having a baby was not at all what she was expecting and it took a long while for her to bond. She admits to fantasising in the first few months about her baby having a cot death so that she would not have to have the responsibility of looking after him, yet would

[10] A model of care for low-risk women in which the midwife is the lead professional.

not be to blame. Her life as she had previously known it disappeared and it became dominated by routines that she believed proved she was the perfect mother and that would give her baby the best start in life. However these routines often prevented her from leaving the house and she became very isolated. Linda now regrets the pressure she put on herself and is sad that she was not able to enjoy her baby in the moment rather than worrying about what was coming next.

Louise: Louise had her children within the context of a violent relationship with a man who was about seven years older than her. She had previously lived with foster parents. Louise was sixteen when she fell pregnant and although this was a shock to her, it was not completely unwelcome. Her experience of being pregnant was horrible as she felt alone and unsupported throughout. She had few social networks she could rely on and did not find the professionals involved in her care helpful.

She was not ready for the birth of her first baby but was given a council flat the day after the baby was born. By the time her second baby arrived she was living in a refuge. Her first baby was born at home, unattended and her second by emergency Caesarean Section following a road traffic accident. Pregnancy was 'just a bump growing' and she remembers little of either birth. Louise does not feel that she was given any help to look after her children and she was particularly bothered that she could not participate in the care of her second child.

Louise says she learnt the hard way what it is to be in a violent relationship as both of her children were taken into care and have subsequently been adopted. She feels that social services were in the wrong and that she has been punished as a result. She despises the fact that they could not keep her safe and enable her to keep her children.

She lives in constant fear that her boyfriend will discover where she is living. Her current partner would like children, but Louise cannot face the prospect of going through the same experience again.

Mia: At the age of nine, Mia was raped by an older boy in front of a group of other boys. She had kept this from her parents for fear of getting into trouble and had grown up believing she could not get pregnant. She was therefore both surprised and incredulous when she found out she was expecting a baby and did ten pregnancy tests before she would believe it. She feared 'punishment' for what had happened to her as a child and was consequently worried that there would be something wrong with the baby. She had a phobia of being sick and was also worried that she would have suffered damage as a result of the attack and would not be able to give birth normally as a result. She contemplated abortion, about which she now feels bad. Once she had decided to keep the baby, these worries, plus her fear of vaginal pain or trauma that would remind her of her rape, made her determined to have a Caesarean Section. When her midwife asked why, Mia disclosed her abuse. She built a trusting relationship with her midwife – something she considers crucial for someone in her position. As pregnancy progressed she enjoyed being pregnant and was proud of her changing body and prepared for a vaginal birth at home.

Mia laboured quickly, but experienced a couple of triggers that caused flashbacks in late first stage that firstly made her decide to go into hospital and secondly made the experience once there traumatic despite sensitive care. Mia was grateful that her midwife organised an epidural for her, even though she was advanced in the first stage of labour, and believes this limited the trauma she experienced. She elected for an epidural with her second child too and really enjoyed that labour.

For a long time Mia could not believe that she had had a baby and she was reluctant to see people. Initially she did not want to breast feed because she did not like the idea of being tied to the baby and was worried about getting

too close in case something went wrong. However she breast fed both her babies successfully.

With hindsight, Mia is glad that she had two vaginal births as she has now proved that she is capable of giving birth. She believes that the birth of her second child in particular has helped her get over what she experienced in childhood.

Sally: Sally has two children who were in their twenties by the time of the interview. She had been abused as a five year old child by a stranger. This came to light when she told her mother about money the man had given her to buy sweets. She was driven round in a police car and the man was found and subsequently given a two year prison sentence. However, on release he attacked an eight year old child – something that leaves Sally feeling bitter as an adult.

As a result of her abuse, Sally finds sexual intercourse very difficult. She had not had a sexual relationship before she met her husband and she feels fortunate that her husband has been very understanding about it over the years. She became pregnant quickly following the decision to try for a baby both times. She found that during her first pregnancy she kept thinking about her experience as a child and being taken back to it. She also felt the need to hide her body – including from her husband. She found antenatal examinations an invasion of her privacy and always tried to keep herself covered during them. Sally hated being pregnant because of the changes that were occurring in her body. Body image has always been a problem for her.

During her first labour Sally had an epidural which enabled her to relax as she had been getting quite anxious. She recalls feeling particularly anxious about the thought of an examination and asking for it to be done by a female. She was upset by her husband taking photographs of the birth and the thought of private pictures being seen. She had mild postnatal depression afterwards. Her second labour was much more problematic. With hindsight she wonders

whether this was because she did not have an epidural and was therefore much more aware of the pain. The pain associated with the actual birth was particularly hard for her and reminiscent of her abuse. However, one of the most difficult aspects of the experience was the presence of a male medical student who delivered the baby despite Sally refusing permission for him to be present. Her postnatal recovery was complicated by some retained placenta which necessitated a transfer back from the community unit to which she had moved after birth and its removal under anaesthetic. This was also very traumatic – a fact that Sally puts down to the lack of control she had during the procedure.

Sally was diagnosed with postnatal depression following the birth and received treatment for it. She has not ever felt as close to her second child as her first and wonders whether the events surrounding labour were contributory factors.

Sally breast fed both her children and did not have any problems with it. She was very protective as a parent and was reluctant to let her children out of her sight as they were growing up.

Sam: Sam has had four children, but did not disclose her abuse to any of her care givers because she did not think they would be interested. She was also afraid they would think badly of her if they found out about it, put her children on the 'At Risk' Register and potentially take them away from her. There was much about being pregnant and having children that brought back memories of her abuse and it was a scary experience. She felt uncomfortable with strangers 'doing things' to her and she was worried about what footsteps in the corridor, leading up to her room might signify. She felt trapped in hospital where all her coping strategies – such as keeping busy - were taken away from her. She felt the need to be good and fade into the background so that she would be allowed home, but at the same time, she resented feeling invisible. Sam felt constrained by much of her maternity care. This was also true of breast feeding because it made her feel trapped by someone else.

One of Sam's children was born prematurely and she was transferred to a unit elsewhere due to lack of cots in the local neonatal unit. Although at first she was terrified that the attention she received there was because the staff were checking up on her, she soon began to feel comfortable with the space and slower pace in the new unit. However, again there were aspects that brought back her childhood. When she was a child, a young relative had died in intensive care following an accident for which she felt responsible. She therefore felt very guilty when her child ended up in intensive care too. Sam's mother had left home when Sam was a child and she felt that she was abandoning her baby in the same way when she left the neonatal unit. Sam felt a lot of guilt – for having a premature baby whom she left in the neonatal unit, for the fact that other parents became anxious when her baby required emergency treatment on the neonatal unit, for causing anxiety among her own relatives. She also felt that her abuse has a knock on effect and hurts those she loves as well as herself.

Secrecy had become a way of life for Sam and a way that she coped. She acted the 'star patient' to cover her fear, pretended to be someone that she was not and hid reality from her friends. She felt like an outsider on the postnatal ward and found it difficult mixing with first time mums. She felt isolated as her family were not able to visit her and she therefore had no way of letting off steam. However on the neonatal unit, once she was familiar with it, she was able to help and support other mums and felt good about it.

Sam wants to be a good parent to her children who she says are her 'jewels' but when she falls short, she worries that she is like her own parents. However she sometimes wishes she had not had children, because then she would not have had to remember so much of her abuse.

Sue: Sue found her first pregnancy a very scary experience because although she wanted a baby, she did not want to have to go through pregnancy and birth. As a child she had been told that she was strange and would never have a normal baby. She really believed this and felt as though she was carrying an alien inside her. Consequently she blocked out her pregnancy and did not look

at the screen when she had scans. Her fear of pregnancy also related to the fact that she would have to let other people into her life – something she found very difficult because she found it hard to trust. She knew too that people would need to touch her and that was a horrible thought.

She really wanted to be normal and enjoy her pregnancy but could not and instead felt like a freak. Her feelings took her back to how she felt as a child – vulnerable and scared. She suffered nightmares and was particularly worried about them during antenatal admissions to hospital. She did everything she could to stop herself sleeping in hospital because she did not want nightmares in a place that she felt vulnerable. The set-up in hospital was difficult both on the wards and in clinics as she could hear footsteps but did not know who was coming into her personal space.

Sue's first labour was induced and was a very unpleasant experience but once her baby was born, despite previous fears that her child may resemble her abuser, she instantly loved her and had all that she ever wanted. When she became pregnant soon afterwards, she was very upset as she did not want to have to go through pregnancy and birth again. However, the midwife she had got to know first time looked after her, accompanied her to appointments to act as her advocate and cared for her during labour and birth. As this was a much better experience, she entered her next pregnancy in a calmer state. Unfortunately it was not possible for the midwife she knew to be with her for the birth and although she felt very safe with the midwife who looked after her in labour, her progress was not entirely smooth and the overall experience was so traumatic that she cannot contemplate another pregnancy, despite the fact that she would love more children.

Postnatally, Sue had no problems and was in her element. She now enjoys giving her children the childhood she never had.

6.2.1 Commentary on the stories

These stories represent the individual experiences of nine women and provide the backdrop to the synthesis of their narratives that ensues. Although the stories are very different, there are similarities between both them and those reported in the literature as will be explored further in the following chapters. I did not ask the women about their childhood history although on occasions they mentioned something of what had happened to them in explaining the effect it had on their childbearing experiences. Six of the women appear to have been abused over a period of time by one or more family members. Louise said nothing of an abusive past. As previously mentioned (section 1.4) Sally and Mia were different from the other women in that they were abused by non-family members in more isolated attacks. Unlike the other women, both Sally and Mia spoke of difficulty with subsequent sexual relationships. Gutteridge (2001), describing her own experiences and Smith (1998b), presenting a case study, both write about such difficulty but this was after abuse by their fathers over a number of years. Gutteridge admits that she could never enjoy the sexual act as her body was 'somehow conditioned not to relinquish shame' (p314).

Jane was the only woman in my study who had not remembered her abuse at the time of having her children; but this is not an uncommon occurrence. Two women in Parratt's (1994) study and 'several' from Garratt's (2011) had not remembered their history when they had their babies. Rose (1992) describes how her memories were submerged until she was in a safe enough place for them to surface and this is very reminiscent of Jane who explained:

> *I'm one of these people that didn't recall my childhood history until it was actually safe to do so because I was actually in a domestic violence relationship so, you know, it was not really safe for me psychologically for me to start exploring all that sort of stuff.* (Jane p2)

Garratt (2011) also notes how women may release memories when it is safe to do so – often after the death of the perpetrator. 'Forgetting' has been described as one of the most common and effective ways that children deal with abuse (Bass & Davis 2002).

Irrespective of whether they had disclosed their abuse, most of the women found aspects of their maternity care experiences difficult – even with the support of a trusted midwife. Linda was the exception to this. Physically her pregnancy was 'wonderful. Absolutely amazing…' (Linda p1) and her midwives were 'absolutely fantastic' (Linda p16), yet prior to the start of the interview she described the whole experience as 'cataclysmic'. It became clear as she recounted her story that it was parenthood that Linda found difficult rather than her maternity care experiences. As will be seen in section 6.5, issues related to parenthood were common among participants of this study, but Linda's response was more exaggerated.

There were elements of the women's childbirth journey that were integral to their maternity care experiences but some of which were outwith their dealings with maternity services. These are discussed below. The parenthesis following quotations contains the name of the person from whose interview they are taken and the page of the transcript. Because Sam's interview spanned two separate occasions, quotations from the second are marked with a 'b'.

6.3 Reactions to pregnancy

Gutteridge (2001 p314) says 'women that have been damaged through sexual abuse come to have their babies fragile in spirit'. It is clear that pregnancy was an overwhelming experience and bitter sweet for several of the women. This is demonstrated by these phrases taken from the initial moments of the interviews:

> *My first baby it was – I suppose the one word that I would sum it up with is traumatic. It was – horrendous.* (Elizabeth p1)

> *being pregnant wasn't what I thought it was gonna be. I thought it was gonna be all exciting and you know, I couldn't wait for movements and I couldn't wait for all the scans and all the different things like that, but actually it wasn't quite turned out [sic] - and then I ended up not enjoying it.* (Helen p1)

> *I suppose first time…it was exciting, it was daunting…* (Jane p1)

> *being pregnant was terrifying but amazing because, I felt full of hope…. (5 second silence during which Linda struggles with tears) that I could … rewrite history… and that I would be able to get it right.* (Linda p1)

> *My experience of being pregnant was horrible at the same time as good.* (Louise p1)

> *when I got pregnant, um, it was very difficult.* (Sally p1)

> *…everything was just totally over my head and I was just totally led by everyone… and I just felt like I had to be on my best behaviour. Um, y'know, do exactly what I'm told and and really like put my trust in them but also being really, really scared.* (Sam p1)

> *It was scary. Um… I wanted a baby, but I didn't want a baby because I didn't want the process of being pregnant.* (Sue p1)

Several of the women expressed surprise that they had become pregnant. Elizabeth had been told that she would have problems getting pregnant. She did not elaborate on this point, but a history of polycystic ovaries[11] is noted in

[11] A condition affecting the functioning of the ovaries that can sometimes cause infertility.

her maternity care records. Others assumed they would not be able to because of their abuse:

> *I always thought that I was far too damaged to have children, so when I actually fell pregnant, I was like 'wow – how did that happen?' I really thought that I would be so messed up inside that I could never give birth, never have children…* (Sam p32)

> *I was worried that I'd never be able to get pregnant – cos I hadn't told anyone or I thought that I'd have some sort of like damage from it.* (Mia p1)

Kitzinger (1992) reports that women often believe themselves to have been damaged by abuse and notes that pregnancy can either challenge or confirm such perceptions. Incredulous that she could be pregnant, Mia had performed ten pregnancy tests. Lasiuk (2007) describes a similar reaction in her study.

Although not concerned about physical damage like Sam and Mia, Linda believed that not being able to have children would be the 'ultimate punishment' (p43) for having taken her stepfather away from her mother. She would not then be able to prove that she could be a good mother. Other women mentioned punishment too. Mia, when told that she needed a scan to investigate polyhydramnios[12] during her second pregnancy, was convinced there would be a problem with her baby as she had 'got away with it' (Mia p13) first time. As she had not been 'punished' for her abuse as a child, she did not expect to escape as an adult. This led to an ambivalent relationship with the fetus:

> *I did sort of think that when I was pregnant I didn't associate myself with the baby cos I thought the more attached I got to her, if something happened to her, the worse I would feel.* (Mia p45)

[12] An excess of amniotic fluid.

Sue was also unwilling to engage with her baby. Having been told as a child that she would never have a normal baby, she was frightened of what was inside her. Her anguish is evident in the following I-poem:

I didn't
I didn't wanna know about the baby inside me
it wasn't that I didn't want it
I just
I was scared
I just couldn't tell anyone that
I suppose
I kind of blocked the pregnancy a bit,
I didn't wanna see the baby on the scans
I didn't
I felt like there was this alien inside me
I'd always been told things as a child
I was strange
there was no way that I was gonna ever – have a, have a baby that would be normal
I wasn't normal
I just didn't want
I didn't want to know what was inside me
I didn't wanna see it on the scans

The image of the fetus as an alien is used by women in other studies too: 'It was like that Sigourney Weaver film where she had that alien inside of her' (Lasiuk p116). Like some of the women in my study, this woman did not feel any sense of attachment to her baby. The distance experienced by Jane and Louise, was less ambivalence to the baby than a measure of general separation from their feelings. For Louise, being pregnant was:

> *Just a bump growing, basically, that was all – I know that sounds really horrible, but it was just a bump growing.* (Louise p11)

Jane believes that she 'psychologically defended [herself] by constantly repressing what had happened' (p7) and the consequence of that was that:

> *'anything to do with me physically or emotionally was very much about in a box and over there'* (Jane, p1)

A similar response was found by Seng et al. (2002) among women who were 'not ready to know'. They describe how women compartmentalise the abuse away from their everyday thoughts and lives. The effect of this for Jane is demonstrated by the following section of I-poem in which her psychological separation from her body is evident.

it was almost like it wasn't me
I would shut away my own vulnerable bits
I suppose
if I was in a different place
I think,
I was very… very… defended
my body was very disconnected
I was able
I was very aware of my body
It could have been somebody else's
I could have been watching
I wasn't actually watching
I didn't feel anything

Despite their emotional distance, neither Louise nor Jane described the pregnancy itself as an unpleasant experience. However both Sally and Helen disliked being pregnant, even though they were excited about having a baby and Helen had expected to enjoy pregnancy. Both of these women struggled with body image. Once pregnant, Sally felt the need to hide her body from her husband:

> *because I was so ashamed of my body, um… because I, I, I've always been quite a big girl anyway – even when I was a child I was quite a big girl and um… when I got married I lost a lot of weight and I, you know, I felt really good, funnily enough (laughs) cos I felt nice and slim and elegant sort of thing (laughs), um and then when I got pregnant I got – you know, I just – I just hated it* (Sally p24).

And for Helen:

> *I think that, I think I just didn't enjoy it because I was just huge and just so unattractive! And that's just – you don't want… you know everybody says about 'oh, when you're pregnant you blossom'. I didn't see any blossoming.* (Helen p31)

Stewart (2004) notes the very different responses that women may exhibit in relation to their pregnant bodies and while some women in this study hated the physical changes pregnancy brought, others were more positive. Once she was used to the idea of being pregnant, Mia, like Hanan (2006) who felt that being pregnant was what her body was for, enjoyed her first pregnancy:

> *I was really proud that I was pregnant. I was really pleased that I was fat and I was getting bigger…* (Mia p37)

Others were overwhelmed by what the pregnancy represented:

> *you think 'Oo, it's my responsibility, I've got no choice' – you can't be separated, it's not like you can take it off and put it on the table or you know, have a little bit of a break and then put it back on. You're stuck with it.* (Sam p6)

Grant (1992) recognises that the loss of control of one's life imposed by a newborn can pose problems. Nevertheless, Sam took the responsibility of being pregnant seriously and looked after herself for the sake of the baby – even when she did not want to. For Linda the responsibility weighed heavily too:

> *as the pregnancy went on, the responsibility – all the – the feeling of the huge responsibility that I was taking on was absolutely enormous.* (Linda p1)

For some women the concerns of pregnancy evaporated when the baby was born. For others they persisted - as discussed in the following sections.

6.4 Relationships with the baby

Jane continued to segregate her physical and emotional self following the birth. Although she did not have any problems bonding, it took her a while to take on board that she had a baby first time. The mechanistic approach she took to care in pregnancy continued with the physical care of her babies – including feeding them. This experience was corroborated by many of the women in Palmer's study (2004) who referred to themselves as 'mechanical' – but for them attachment was a challenge too. The women in my study differed considerably in their initial reactions to their children and also demonstrated a variety of responses between babies.

Despite her fears during pregnancy and real concerns that her baby would resemble her abuser, Sue loved her first daughter immediately:

> *my baby was the most beautiful baby I'd ever seen (laughing) when she was born.* (Sue p2)

Feeling horrible about her negative thoughts she quickly banished them. However she found bonding with her second baby more problematic, despite a good pregnancy and birth.

Having been afraid during pregnancy that there would be something wrong with her baby, Mia continued to worry that something was going to happen to her after she was born:

> *So for ages after having my daughter, I still thought that something was gonna happen to her…* (Mia p45)

Sam's fears were more grounded in reason as one of her babies was born at twenty seven weeks gestation:

> *…you think 'well if I bond with this, then I'll get hurt even more'… and where I've been hurt a lot already in my life, and I know what it feels like, um and that's something I do have a great knowledge of, it made me even more harder to bond with him and to be able to like get over that…* (Sam, p24-25)

Like a woman in Lasiuk's (2007) study, Linda's expectation that she would feel overwhelming love for her baby did not materialize:

> *but I definitely remember not bonding. There, there, I was told there was this 'bonding'. And I waited and I waited. And I don't know how long it took. Probably took years. I definitely didn't – I definitely didn't have a bonding in the first … first few weeks. Definitely.* (Linda p29)

Instead of the feelings she expected, Linda felt scared and angry:

I was terrified of him
I couldn't do it
I was scared of him
I couldn't do it
I was scared
I wouldn't be able to do anything about it
I remember

She described a cycle of responsibility, resentment and guilt:

> *I was resentful. Resentful that – he was here and I had to look after him and I couldn't do it. And then guilt would set in and just this sort of circular set of emotions would – I would look at him and feel this enormous sense of responsibility, then I would feel resentment then I would feel guilt.* (Linda p21)

Resentment and guilt are recurrent themes. Sam looked forward to having her babies and feels lucky to have had children. However, she resented them too as being pregnant made her remember things from her past that she wished had remained buried. Sally loves her second child but feels that she rejected her at birth and, similar to Sam, believes this is because she relived her childhood experiences during the birth. Helen was glad her baby was growing but was sometimes so uncomfortable during pregnancy that she wished he would stop moving to give her a break. However, she made a conscious effort to facilitate a relationship with him during pregnancy as she feared postnatal depression given her history of depressive illness. The scan was important in this respect and she decided to find out the sex of the baby too.

Linda admitted to fantasizing about cot death – something about which she now feels shame, but which she shared with me to emphasise how serious her situation was.

> *I thought if he, if he were to be a victim of cot death, I wouldn't have the responsibility any more, but I wouldn't be guilty of anything.*
> (Linda p7)

Again, this is mirrored in Lasiuk's study:

> *Lots of times I felt, "Well I almost hope this child doesn't make it", just to prove to everybody that you know, I'm not supposed to be a mother.*
> (Lasiuk 2007 p140)

Despite some negative feelings, the women were overwhelmingly protective of their children as shown by their reactions to parenthood.

6.5 Reactions to parenthood

Sam referred to her children as her 'precious jewels' and was keen to be the best parent she could, given that she had been so badly let down by her own parents. She wanted her children to be 'important and safe and cared for' and have 'all the things that [she] never had' (Sam p43b). Sue admitted to living her childhood through her children and relished giving them the childhood that had eluded her. Likewise, Linda's determination to be a 'perfect mother' was born of her desire to show her mother how it should be done because she believed she had been failed by her mother as a teenager. This striving to become the ideal mother is reported elsewhere but inevitably leads to feelings of guilt when women fall short (Wilkins 2006). The whole issue of becoming a mother is fraught for women with a history of childhood sexual abuse not least because they lack confidence in their ability to mother (Leeners et al. 2006b; Palmer 2004). Elizabeth kept her fears in check by the assurances received from other people that she is good at it:

> *people say 'You are a good Mum and you're doing the right thing' and that kind of keeps it under – it doesn't spiral out of control.* (Elizabeth p17)

As has already been implied, much of women's ambivalence to parenthood surrounds the perceptions women have of their own mothers. Rose (1992) experienced fear washing over her during her second labour that she would be a bad mother like hers was. Elizabeth particularly struggled because her mother had been implicated in her abuse and she was frightened she would be the same:

> *And all the way through my pregnancy with [my first son] I had, I, I, I had this image of this … a monster being in me that was gonna make me into this horrible person and make me hurt my son.* (Elizabeth p15-16)

Fear that women might harm their children is common (Kitzinger 1990; Kitzinger 1992). In particular women were mindful of the cliché that the

abused become abusers and, terrified that this might be true of her, Linda found herself analysing her actions in caring for her son. Palmer (2004) and Lasiuk (2007) both cite examples of women's concerns over what are acceptable boundaries when touching their children. Whether or not women doubted themselves, they assumed that other people would be watching them for any signs of misdemeanour. Linda was worried that:

> *I would immediately have this label. That watch her, you know, just watch what she's doing because she's abused therefore, you know, she's gonna turn in to an abuser.* (Linda p2)

Even six years after the birth of her first baby, Elizabeth was scared that he would be taken away from her. This fear has huge implications not only for how women respond to parenthood but also for the women's relationship with healthcare professionals and is discussed further in section 9.5.

Women were concerned about their ability to protect their children (See also Rouf 1999).

> *but I kept on thinking 'God, you know, I've gotta protect her now!'* (Sally p10)

> *But I'm so scared of, of smothering [my son] and also, protecting him is a real big issue.* (Helen p51)

Several of the women recognised that any mother will want to protect her child, but Helen believes that this desire is heightened in her and is terrified of leaving her son with anyone. Other women expressed similar concerns. Mia could not believe that she had a baby:

> *I didn't want anyone to pick the baby up – I don't know if that's normal but I didn't want anyone to pick the baby up or anyone to go near it.* (Mia p44)

(Her use of the impersonal pronoun is interesting here given her reticence in becoming attached to the baby.) Mia found that she did not want to leave her baby and had no interest in returning to work after having her (her career had previously been an important part of her life). Sally's children were never out of the sight of either her or her husband and Sue wanted to be the only person to protect her baby. Trusting partners to provide appropriate baby care can be an issue (Kitzinger 1990; 1992; Lasiuk 2007) and this was Sue's experience on one occasion:

> *I trust my husband a hundred percent, I have absolutely no worries about him – but I found myself panicking once because he was upstairs changing her nappy and he was taking a long time about it and I panicked. I thought he's abusing her! Well, in actual fact he was bloomin' well playing round and round the garden with her. She's had her nappy changed and was completely dressed but she's just learnt to giggle and do her first laugh… and that was hard, that really was hard because I just wanted to pick my baby up and run, because I didn't want anyone else protecting her.* (Sue p13)

It was hard on her husband too. Sue explains that he was cross that she had interrupted a special time between him and the baby.

Gender of the baby is recognised as an issue for women who have been sexually abused (Heritage 1998; Palmer 2004) and it played a part in some of the women's reactions to parenthood in this study. Sue did not want a boy because of fears that he might resemble her abuser, yet she was scared about having girls in case they were abused. Sally struggled with postnatal depression after the birth of her second baby and kept reliving her childhood experiences. She wondered if that was related to the fact that she had a girl.

Few of the women said much about life with their babies once their maternity care was over, but Linda's reaction to parenthood was a very important part of her story. She described her initial response to her baby in the following heart-rending terms:

> *I got out the birthing pool, I was lying on the bed and I looked across and he'd been all swaddled up and he was in this crib and I looked across the room and I just thought 'my God! I can't, I can't look after you! (Tearful) You know, I'm not gonna be any good, your life is gonna be crap, I can't take responsibility for you.* (Linda p5)

Once home with him, Linda's life became subsumed by her quest for perfection. She described the setting of rigid routines that often kept her confined to the house. When she did venture out she would retreat if the baby cried for fear of being judged. Although Linda's reactions seem extreme, they are reflected in the experiences of the women in Wilkins' (2006) small scale grounded theory study in which 'doing it right' is the core category. This quest for perfection permeated every aspect of her child care – including breast feeding.

6.6 Breast feeding

Eight of the nine participants in this study initiated breast feeding. Given the relationship that women with a history of sexual abuse have with their bodies, this seems surprising but is in line with studies that suggest that although it may be difficult for them, more women with such a history intend to breast feed than those without (Leeners et al. 2006b).

Louise formula fed her first child but said nothing about how she came to make that choice. However, it is clear that she did not feel supported in looking after her baby:

> *when I had my first baby, why couldn't someone sit with yer and say to yer 'look you can breast feed 'em, you can bottle feed 'em, you can do this, you can do…' None of that is explained to yer, none of it.* (Louise p24).

Her second baby was on the neonatal unit having been born at thirty two weeks gestation. Although her maternity care records indicate that she was expressing breast milk, again she did not feel supported. Sam's fourth baby was also born premature and she expressed milk for him initially. She had varying degrees of success breast feeding her other children. She breast fed her third child for eleven months but gave up with her first within a couple of days of the birth while still in hospital. Her experiences mirror those reported in the literature. Sam is even more sensitive about her breasts than her genital area and therefore found the 'help' she received very difficult:

> *And then all of a sudden they're trying to get you to whip it all out and stuff it in this baby's mouth 'n – it's just not good!* (Sam p6)

Lasiuk (2007) reported similar distress from one of her participants and Garratt (2011) was struck by the brutality of the help given to breast feeding women and the lack of respect for bodily integrity too often displayed. However, this was not the experience for most of the women I interviewed. Sue is a strong proponent of breast feeding and did not have any problems with it. Thankfully the healthcare professionals she encountered showed her more respect than is reported by Garratt:

> *I had no problem breast feeding, which I'm lucky with, I know that a lot of people do, but I remember the midwife and the health visitor saying 'Oh, do you want me to check your nipples?' No I didn't! I was doing fine!* (Sue p14)

Elizabeth was very keen to breast feed her baby – not least because she felt it would prove that she was a good mother. In hospital she experienced both a 'reductionist approach' and 'disconnected encounters' (Schmied et al. 2011):

> *you get so much conflicting advice. Somebody says to do it this way and another person says to do it this way and, and I was overwhelmed with everyone saying different things and I just wanted somebody to sit with me and just say 'this is how you do it' and spend time with me. Umm – but peo... somebody would come and spend five minutes and show me and then the next person would say 'oh no, you're doing it wrong' and show me a different way and then leave and I ended up just thinking 'oh, I, I just don't know what to do, I want to do it but I don't know what to do. I don't know how to do it properly'.* (Elizabeth p26)

But once home, she was helped by a community midwife who sat with her on and off for two days until feeding was established. Elizabeth really appreciated this vote of confidence in her.

> *I thought 'she actually believes - the fact that she's spending time with me, and wants me to do this as much as I want to do it, she obviously believes that I can do it' And um – and that really gave me confidence that I could go on to do it.* (Elizabeth p27)

Linda believed that breast feeding was best for the baby, but also felt it might help her to bond. However, as with other aspects of her parenting, she was determined to be the 'perfect breast feeder' and was reluctant to ask for support in case people thought she was a failure.

Mia had not initially wanted to breast feed as she had not wanted to be tied to the baby. However she did and was pleased, believing it made her feel happier and helped to prevent depression:

> *it makes you not be able to leave them and it does make you bond, it does make you have to sit there when you have to look after it and you can't pass on the responsibility to anyone else. That's what's good about it and I think it makes you feel happier as well.* (Mia p45)

This reaction is the opposite of Sam's and of what is reported in the literature (Hobbins 2004). Not being able to 'escape from it', Sam felt that:

> *…it is, it's like being it's like it's happening again because you are being controlled by another person. And even though I really tried not to feel like that, it happened every single time um that I tried breast feeding. I felt that immense feeling of being controlled by someone else.* (Sam p6)

Heritage (1998) noted that breast feeding was the trigger for one woman in her care to remember her abuse and others have described how breast feeding per se can be reminiscent of abuse for some (Beck 2009; Palmer 2004; Parratt 1994). This does not appear to have been the case for any of the women in my study.

6.7 Summary

This chapter has accompanied the nine participants of my study on their childbirth journey. Some aspects explored in it are things any woman having a baby might experience. However, as is shown in the following three chapters, the meanings ascribed to these events by women who have histories of childhood sexual abuse may be very different. An insight into these meanings and an understanding of their implications are crucial in providing sensitive care.

7. Chapter Seven: Women's narratives of self

7.1 Introduction

One of the main themes arising from the in-depth interviews related to women's experiences of themselves. A consideration of this aspect of their narratives is critical in understanding the way they approach pregnancy, birth and their maternity care.

7.2 Self-image

A child's sense of self develops by degrees and comprises both the 'existential' and 'categorical' self (Miell 1995). Among the features of the former are an awareness of one's agency and the uniqueness of an individual's experience as distinct from others. The categorical self is thought to be the aspect most influenced by social factors. Miell (1995) emphasises the role of social context in developing a sense of self. Among the assumptions on which Raphael-Leff's (1991) seminal work on the psychological processes of childbearing is based is that adult behaviour is rooted in earlier experiences. Because childhood sexual abuse occurs at an early stage of development, it has a significant influence on women's perception of self and the world around them (Garratt 2011). Rouf (1999) believes it to be an experience that can harm one's sense of self. Tallman and Hering (1998) postulate why this might be the case. They explain how trauma creates a break in a person's self-boundary. Where that trauma is significant a wound in the sense of self is unavoidable. A child's response may be to cover up the wound which can create inflexible scars and cause an inward retreat. Women entered pregnancy with a view of themselves that had been shaped by their childhood experiences. This was true irrespective of whether they believed they had left their experiences in the past or whether they remembered their abuse at the time their pregnancies. There are two related aspects to the issue of self-image; one is physical and is a function of the relationship the women have with their bodies. As noted by Stewart (2004), body image is an important aspect of the presentation of self. The other is ontological and is related to the women's perceptions of who they are. Leeners et al. (2006b) quote figures suggesting that between 74% and 96% of

women with a history of childhood sexual abuse have physical and emotional scars. Women in my study were rarely positive about their self-image. In section 6.3, I discussed how for some women, body image affected their reaction to pregnancy. This was a major issue for Helen who describes sitting and crying when she looked at herself in the mirror. Stretch marks were a problem for her too:

> *I wasn't ready for that at all – to wake up one morning and see that I'd turned into a map!* (Helen p2)

Helen compared herself unfavourably to her friends, believing they all had 'nice bumps' (p34) when pregnant and looked better than she did. This also extended to how she viewed herself as a parent:

> *…and then all the other friends will look great and you know, they'll be handing their children far better than I am'.* (Helen p49)

One of the participants in Lasiuk's study (2007) articulated a poor relationship to her body, but felt that she had this in common with many women irrespective of whether they have a history of abuse. This notion is supported by Stewart (2004 p26) who comments on the 'complex and often unsatisfactory relationships' that many women have with their bodies. Nevertheless, a poor relationship with the body is recognised by other women who have been abused (Rouf 1999). Helen took it further; not only did she not like her body, but she did not like herself very much either.

> *cos you've gotta like yourself and I haven't liked myself for many years. And as much as I say 'I don't wanna say this is because I was abused', I think a lot of it is from that, because it's just – you just don't like what happens.* (Helen p49)

Helen was more comfortable with her body prior to pregnancy, but if, as Stewart contends (2004), in Western society people's moral worth is now

judged more by appearance than behaviour, the link between poor body image and not liking oneself can be understood. Even though she was reluctant to do so, Helen linked how she felt about herself to what had happened to her as a child. Sally voices something similar:

> *I just hated my body. I, I still haven't got a very good (sharp intake of breath) relationship with it now, but um… I just felt… I've already - may… I don't know, maybe it was to do with when I was again, a child, it had been abused…* (Sally, p24)

Although Sally started by talking about 'my body' in this extract, she objectified her body in relation to her abuse: 'it had been abused ….' The following section of Sally's I-poem, in which she also uses the second person, reinforced this view:

your body
after that, your body's not your own.
You never feel that
your body's ever gonna be your own
Because it's been – abused, really…

Including alternatives to 'I', such as 'you' and 'it', as I have done here, provided additional insights into the women's view of themselves. Jane's I-poem presented in section 6.3, demonstrates the same use of the impersonal pronoun. Rhodes and Hutchinson (1994) recognise that women may speak of the body as though it is a separate entity from the mind. Courtois and Courtois Riley (1992) suggest that many women who have been abused are alienated from their bodies and are often ambivalent about their body's reproductive capacity. Again, I indicated that this was an issue for some women in my study in Chapter Six (section 6.3). Not only did Sam believe that she was too damaged to have children, she also saw herself as 'damaged goods, as no good' (Sam p31). Elizabeth also expressed negativity in relation to her body:

> *I felt like my body was … just not a very nice thing. I didn't feel, I never felt beautiful, I never felt attractive.* (Elizabeth p28)

As Howarth (1995) points out body image is an important part of pregnancy and the way a woman sees herself has implications for the way she copes with it.

Linda was striving for perfection as a parent because:

> *I'd never pleased anybody. I'd never really been good at anything. And that's what – this baby was gonna do it. This baby was going to be how I made my mark, in this world.* (Linda p6)

Yet as she now realizes, Linda was setting herself up to fail and was very hard on herself:

What have I done?'
What have I done?
You stupid cow
What have you gone and done
You've brought this child into the world
and <u>you</u> are not gonna be able to do this
You can't do this
Why did you
why did you ever think
you'd be good enough to do this?
you stupid woman

However, for some of the women, although they entered pregnancy with a very negative self-image, having a baby changed the relationship they had with their bodies. Elizabeth went on to say:

> *But having [my first son] I actually thought 'oh, my body's actually useful for something…My body's actually been made for something useful.' And that made me feel so much better about myself, um – that my body could be actually used for some good and, and could make this beautiful baby.* (Elizabeth p28)

Sam's altered perception of her body enabled her to change her perception of herself:

> *… my body has been able to withstand some awful stuff and still be able to do what it's supposed to do and work on the positive sides of like - and I am still a person and I'm still worthwhile and that I am allowed to be a Mum.* (Sam p33)

These sentiments are closely mirrored by a participant in Garratt's study who felt that she had lost control of her body when she was small and had not been in control of it since. Having had two children it had done 'wonderful things' and she felt 'really powerful' (Garratt 2011 p178).

The boy who attacked nine year old Mia had told her that she was too small to get pregnant and this is something she carried into adulthood with her. After having two vaginal births she said 'it's definitely made me get over it' (p29) and was able to assert

> *…well, there was nothing wrong with me at all!* (Mia p29)

This notion of childbirth as an experience of healing is reported in the literature. Kitzinger (1990) suggests that it can enable women to take pride in their body as good for something other than sex and abuse and Palmer (2004) suggests that labour can be empowering as women learn that their body can do something right. 'Regeneration' is major theme in the work of Lasiuk (2007) who describes how childbearing can be profoundly positive and healing.

However, notwithstanding the examples discussed above, this was less evident in my study. Despite some more positive reactions, there is still a sense that the women felt themselves somehow set apart. This is in keeping with 'stigmatisation' in Finkelhor and Browne's traumagenic conceptualisation (1985). For example, when Sam was transferred from the local unit due to a lack of available neonatal cots to a smaller more 'family-oriented' hospital, she was suspicious of the attention she received:

> *at first I found it really hard to deal with because I thought that they were so attentive because they were checking up on me cos they didn't trust me, because there was something wrong with me.* (Sam p2b)

Elizabeth thought she was going to be a terrible mother and was convinced that the maternity care staff thought that too – especially when she was moved to a mother and baby mental health unit a few days after her first baby was born:

> *I thought it's best if he doesn't stay with me then, I asked them to take [my son] away and I thought 'they obviously think I'm going to be a terrible mother, I'm going to hurt him and that's why they think I've got to go to [the unit]'* (Elizabeth p8)

As a child Sue had been told that she was not worthy of a baby and had grown up with the notion that she was a freak. Elizabeth also used the word 'freak' to describe how she felt on the postnatal ward. She continued:

> *it's one of the things I struggle with most days any way, that I'm not normal and I wish I was normal. I wish I was the same as everyone else.* (Elizabeth p24)

Normality is something that was important to several of the women.

7.3 Appearing normal and fitting in.

In Smith's case study (1998b) 'Mary' explains how it had been her ambition for ten years to be like other people. This was also the goal for women in my study. Growing up, the frame of reference for these women had been different from others. Sam began to realise that her experiences were not usual when she learnt about sex at school:

> *'I already know lots of stuff! Why don't they know this stuff? Didn't their Dads do this?'* (Sam p21b)

Helen's epiphany came when she was able to discuss her situation with young relatives who were going through the same thing:

> *you find out actually as I did that actually there's other family members going through it all and we all twigged together that actually it wasn't just us in the world – and actually this wasn't normal cos to us it was kind of normal because this had sort of been happening for years and you just carry on with it.* (Helen p40)

Finkelhor and Browne (1985) suggest that when children find out that others have shared experiences some of the stigma is assuaged, however, when women in my study realised that this was not what most people experienced, they were keen not to appear different:

> *I hate the idea of sometimes going round as if you've got a label on your head that says 'I've been abused'. And you just think 'I don't want – I don't want that. I want people to treat me as normal'…* (Helen p3)

It was important for the women not to be defined by their abuse, or to feel that they were being treated differently because of it:

> *But I'm still not gonna tell anyone cos I don't want people to feel sorry for me – my husband even now is like nicer to me. If I shout he's like 'is that why you're shouting?' and I'm like 'well, not really!'* (Mia p37)

But nevertheless, they often did feel different:

> *because in antenatal class and postnatal class I, I almost felt like I had a … banner on me and although I didn't and it's perhaps a bit stupid saying it, it's how I felt and I don't know if that's just during pregnancy - I think it's … in everything you do in life so…perhaps not unique to being pregnant or anything but I did feel a little bit – odd, um, people didn't understand me…* (Sue p17)

> *cos you're in a ward with loads of other strangers and other mums and if you're like not feeling very chatty or very sort of happy, or you know, elated – like some people get really buzzed up on it – um it's almost like you're – it confirms that feeling that you are weird, that you don't fit in, that you are an outsider.* (Sam p7)

The consequence of this was that there was a lot of pretending.

> *I just learnt to pretend to be like everyone else, but I'm not really and I never will be.* (Sam p46b)

> *and on top – and then you're trying to pretend that everything's OK. That was the hardest thing. [Elizabeth alludes to her job here] I just felt that – I've got to pret…I've got to make sure that everyone thinks everything's normal.* (Elizabeth p2)

Even though she had not remembered her abuse at the time, Jane was 'playing the game' whilst in a violent relationship.

> *[my husband] was present and in one sense that was OK because for me at that time, I suppose it was…, it was … me being 'normal'.* (Jane p4)

A woman in Lasiuk's (2007) study described how important being a 'normal person' was to her so that she could fit in to society. The women in my study tried hard to fit in too. Concern about being different from others left them feeling outsiders. They felt this particularly keenly on the postnatal wards as the following quotes from Linda show:

> *I would look around at these women and think 'you all know what you're doing. You all know the routine and you know who's who, you know who to ask, you know where to go'. And I was just plonked in this bed and I knew nothing. And I didn't belong in the club.* (Linda p24)

She particularly remembers a multiparous[13] woman who appeared very much at ease:

> *But I was just jealous… and I hated her… and do you know (tearful) I've never forgotten that image (sniffs). Just (intake of breath) this jealousy that these people were experiencing something so (whispers) different.* (Linda p19)

Feeling that she did not fit in, Linda:

> *just wanted to get out, because I didn't belong with all these women.* (Linda p19)

[13] A woman who has given birth to at least one baby prior to the current pregnancy.

In order to appear normal and fit in, the women were keen not to draw attention to themselves as the following I-poem from Elizabeth shows:

I thought
I don't want to be a bother to anybody
I don't want to take up more time than I should
I don't want to
I don't want to irritate anybody
I'd never dared
I just did what I was supposed to do

Sam was even more submissive:

> *you know that they're like so busy and you can see that and you're thinking 'well, I'm not gonna say anything, I'll just sit there and put up with it and just be good, you know, cos they'll let me out soon. You know, if I don't bother them or like make too much fuss, they'll just think I'm alright and I can go home and then I'll sort out any problems when I'm at home.* (Sam p5)

However, these evasive actions were often at considerable personal cost to the women and rendered them invisible.

7.4 Invisible self

Sue was keen to hide:

> *–you just wanna … curl up and be part of the wallpaper. You just don't want to make a fuss or anything.* (Sue p7)

Deciding to speak out, Elizabeth was uncomfortable with her uncharacteristic behaviour:

> *it's frightening – I'm not the sort of person to – like I said, I'm not a difficult person normally, I normally just like to blend in to the background and not be noticed.* (Elizabeth p17)

This desire for invisibility was in part linked to the need to hide their abusive histories – whether their childhood abuse, or in Jane's case her experience of domestic violence. It links to the issue of disclosure, a really important subject that is discussed in section 9.5. Not being noticed therefore sometimes denied the women support they might have been offered:

> *I think, I think if I'd presented differently, if I'd been, you know, in a sort of more emotional or more, more upset or distressed then I might have got questions, but as it was it was right, well it was fine, so, everything was fine.* (Jane p3)

With hindsight Linda acknowledged that had her abuse been out in the open things would have been different:

> *what it would have done was made me realise that – I wasn't – I didn't have to be scared of them. I didn't have to be and I didn't have to be <u>good</u>. I didn't always have to do the right thing and prove that I was perfect in case they were wondering.* (Linda p17)

As it was, she kept how she was really feeling to herself. Although the women wanted to fit in and not be noticed on one level, on another it confirmed their views of lack of self-worth engrained from childhood and fostered resentment. Often women denied their own needs in order to meet the needs of others. Sam, in common with several of the participants did not want to bother the midwives who appeared busy. This response to recognition that staff are stretched has been reported in relation to maternity care in general (Baker et al. 2005; Proctor 1999). As Sam neither wanted to approach midwives nor make her labour companions anxious, her response was to bury her concerns:

> *you suck yourself back in and sort of pull it all back in and push it down and just put up with it.* (Sam p3)

But the effect was detrimental to her:

> *because I feel that I sort of retracted in to myself, it meant that I was easier to be ignored yeah? So then I feel invisible and that makes me feel really, really, really angry because I'm thinking 'well, I'm here, you know, everyone else is getting a better deal than me, I'm still here but no one's noticing me'.* (Sam p8)

Elizabeth had similar experiences;

> *I know midwives are busy, but I – that really does come across that midwives are really busy and they haven't got time, so I didn't want to ever bother them with what was going on with me.* (Elizabeth p6)

But on the postnatal ward, having barely eaten and not slept for several days, she was desperate:

> *and I thought, 'well what have I got to do for someone to notice that I'm really not feeling well?'* (Elizabeth p7)

Smith (1998b p26) explains how 'Mary', the woman she interviewed, did not mind what happened to her as long as 'the midwives would find [her] acceptable'.

Linda admitted to having lost all sense of self on becoming a mother:

> *my life just disappeared. Everything revolved around this child. Everything. I felt my <u>whole</u> – reason for being was this one individual.* (Linda p21)

When one of her friends suggested that she should think about herself, she had no comprehension of what that meant:

> *And I said 'what do you mean?' I didn't understand that, I didn't understand 'think about me'.* (Linda p9)

The lack of perception that it is acceptable for women who have been sexually abused to have and express their own needs is recognised elsewhere (Simkin 1992b; Skinner 2010). Losing herself was an aspect of motherhood that took Helen by surprise:

> *I didn't realize how actually you completely lose yourself.* (Helen p45)

This phenomenon is well recognised in the literature related to becoming a mother and is not peculiar to women with a history of sexual abuse (Oakley 1986; Rogan et al. 1997). However, it is one example of the way the women denied themselves to meet other people's needs. Wanting her experience of early motherhood to be something it wasn't Linda:

> *laughed when visitors came and I smiled and I put the right face on. But inside… (sniffs, four second silence). Inside I was – just silently screaming.* (Linda p19)

Covering up the truth of what was going on was a behavior pattern to which the women reverted – especially if they felt threatened. One of the participants in Burian's study (1995) suggested that the most pro-survival thing she could come up with was to co-operate. This approach was demonstrated by Sam:

> *I'd learnt how to cover things up as a kid and I – again it was a coping strategy that I'd learnt, you know if you give that persona that you look alright, that you are functioning to a certain level, people leave you alone, they back off, they give you more space, they're less likely to encroach on my like personal space, they're less likely to blame me for behaving wrong or interacting socially wrong. So, I could sort of like hide, yeah, I could give the false impression that I was alright when I wasn't.* (Sam p22b).

But again, this was not helpful behaviour on a personal level:

> *I do what I have to do and I'll be good and do as I'm told and that and do all the things that they want me to do, but, it's at a really high cost because, um, I promised myself when I was a kid that I wouldn't let anyone hurt me …and … sometimes I find that I get a bit confused that um I'm like not honouring my promise to myself.* (Sam p22)

Coles and Jones (2009) provide a comparable example of a woman who felt guilty for not sticking up for herself in the face of professional power. As well as denying themselves directly, the women were often passive when apparently ignored by others.

In the previous chapter I demonstrated how Sam resented the emotional cost of pregnancy to herself (section 6.4). This conflict between a woman's (damaged) self and her baby is evident elsewhere too. Stewart (2004) suggests that although during pregnancy the gaze is ostensibly on the woman, in reality she is often little more than a vessel or incubator. Rouf (1999 p30) was made to feel like a 'second rate means of carriage' by healthcare professionals who did not seem to appreciate that although she had her baby's interests at heart, it did not stop her having her own needs. Elizabeth experienced something similar:

> *obviously the baby is important, you've got to keep the baby safe, but also the mother's important as well. And what the mother wants is really important and… (five second silence) and um, what I wanted wasn't really taken into account.* (Elizabeth p32)

Palmer (2004) described two seemingly competing elements in her theory of 'Protecting the inner child'. There was a tension between the woman's need to protect herself and her need to protect the baby. If she was feeling vulnerable, the balance tipped in favour of the former. If she was feeling resilient, it tipped in favour of the latter. Elizabeth's vulnerability is evident in the following extract in which she describes struggling with healthcare professionals' perceived detachment:

> *I thought 'well, how can they just go back to their normal life. How can they leave me in this – in such pain and, and feeling so – suicidal and so awful and just pretend that I don't exist and walk away an' – and not give me another thought. I feel very insignificant.* (Elizabeth p22)

The result of invisibility and denial of their own needs meant that the women felt insignificant and ignored. Not being heard was a problem on a number of levels.

7.5 Silence

In common with women in other studies (Coles & Jones 2009; Garratt 2011) some participants were not able to speak. In labour Mia had to keep her silence as her mother was with her and knew nothing of the abuse. However, on transfer into hospital, she experienced frightening and powerful flashbacks that left her unable to say anything. During the interview she juxtaposed what it was like being held down and attacked as a nine year old with being restrained in the birthing pool by her mother and husband. She could not say 'get off me' either time. In her I-poem it is difficult to know to which she is referring:

I think
I think
I can remember
you can't speak
I couldn't actually talk
I was totally like silent
I couldn't even say it was hurting me

Helen also compared being unable to say no to her abuser as a child to not speaking up for what she wanted in labour. She was beginning to realise that she should not blame herself for what happened as a child and goes on to say:

> *but as an adult going into situations, I didn't know what I was doing on the first time of having my son, and going through all of that…* (Helen p28)

She concludes:

> *I don't think in labour you've got the right head on your shoulders to actually say all the things that you do and don't want saying…* (Helen p28)

Linda wonders now why she did not speak up when she was told she needed to get out of the birthing pool:

> *I suppose I thought, she's speeding it up because it's more convenient. That was the one thing I do remember thinking. It will be more convenient for everybody if I just have the baby now. She's probably tired, she's probably had enough and I've got to do what I'm told. I didn't – never at any stage did I think that I could say 'no, I'm not getting out of the pool, I'm staying where I am.'* (Linda p37)

With hindsight she wonders if she was afraid that the midwife would leave her:

> *In fact now I've said that, that possibly drove my fear. That if I didn't do what she told me, then I might lose her.* (Linda p37)

Linda's language in these extracts is common to several of the women and could be interpreted as a transaction in which she adopts the ego state of a 'Child' (Berne 1964). It appears to reflect an unequal power dynamic that will be explored more in the next chapter (section 8.8).

Other women did speak, but were not heard. Over two decades later, Sally was still deeply upset by the presence of a male medical student at the birth of her second child, even though she had refused consent for him to be there:

> *but I just feel that the … they weren't listening to me.* (Sally p8)

One of the participants in Burian's (1995) study commented that it is really important to listen to what is *not* being said. In Sally's account, staff neither listened to what she did say, nor what she did not:

> *I mean never discussed it with the midwives or anything – maybe I should have. Maybe I um, they didn't – I mean there was a question why I didn't want a m… any male doctors or any male midwives.* (Sally p8)

Having felt very insignificant and invisible when having her first baby, Elizabeth knew she would have to fight to be heard the second time:

> *and it's a shame that you have to think, well, I'm gonna have to fight for what I need this time, rather than it just being there and people being supportive and – understanding…* (Elizabeth p17)

It was possible for women to overcome the silence and regain some control. Elizabeth was determined to speak up for herself during her second pregnancy. The result was that the midwife:

> *really listened to me and took everything that I wanted into account, um – and made sure that [my second son] was safe as well. Umm… (six second silence) so it made a huge difference second time. You actually feel like you're valuable and what you say is important and um – and valid – what you've got to say and what you want is actually – a good enough reason to get what you want.* (Elizabeth p23)

However, sometimes women needed someone else to be their voice. Like finding the courage to speak out for themselves, this helped women to feel much less vulnerable.

> *but just having people that you know that are on your side. That are supporting you. Um that are being your voice – cos you don't actually feel like having that voice. So actually somebody that's being there and being your voice – and I think that's actually where my husband comes into it. He's normally my voice.* (Helen p55)

Sam and Mia both felt that talking to me was important – both on a personal level and also to break the silence that surrounds the subject:

> *I think all of this is gonna help, it really will. And the more people like me like actually just bite the bit and talk, I mean no-one's gonna know what goes on in our heads and no-one has done for a long time, um because we're too scared to talk.* (Sam 56b)

> *if I didn't tell my Mum, how you can get somebody to tell you I don't, I don't know. That's the thing. That's why I'm telling you this now, cos I think it is important cos I've never ever spoken to anyone about it at all…* (Mia p19)

Other women confessed that they had not really spoken of their abuse previous to the interview and this was Palmer's (2004) experience too. Rouf (1999) notes the way that mention of childhood sexual abuse can silence a room and leave people squirming with discomfort. Faced with this sort of reaction, it is not surprising that women feel guilt and shame about their histories.

7.6 Guilt and shame

It is recognised that guilt and shame are among the reasons that women may keep silent about their sexual abuse (Finkelhor & Browne 1985; Hobbins 2004; Leeners et al. 2006b; Seng et al. 2002). Linda had believed for 30 years that she was to blame for 'encouraging' her stepfather to abuse her:

> *I felt that I must have been in some way provocative, encouraging, some sort of Lolita-type figure…* (Linda p45)

She felt enormous shame as a result and had spent her life trying to atone by being the 'perfect daughter' and then the perfect mother too. In a similar vein, Sam felt as though she was a 'co-conspirator':

sometimes I feel like I'm
like I should be in trouble
like I should be punished
that I am bad
Like how stupid am I?
I should have realised
I should have stopped it earlier
I should have done something

Hobbins (2004) talks of how child victims may carry a tremendous burden of guilt and may believe they are to blame. This is very evident in what Sam says:

> *I'm the person – half the person that's done it as well. And it's really hard to get away from that guilt feeling of – that it's my fault – or it's half my fault, or I agreed to it or I must have done something to make this happen or I should've known what was happening to me or I should've done something more.* (Sam p57b)

Five year old Sally could hear her mother sobbing when she found out what had happened:

> *you think that you're the one that's done wrong. You know, you really do. You think … you know, you think you've done really naughty – oh…and that plays on your mind for years.* (Sally p21)

And so guilt, shame and secrecy become a way of life that follows a child into adulthood (Gutteridge 2001). I discussed ambivalence to pregnancy in section 6.3. Negative thoughts about either the baby or pregnancy became a further source of guilt for the women. Sue had been scared that her baby would be an 'alien' and look like her abuser. She reports feeling horrible that she had had negative thoughts. Elizabeth was so overwhelmed by the deluge of flashbacks she experienced while pregnant that she seriously considered suicide:

> *it's an awful feeling to feel suicidal and be pregnant – cos you're responsible for this life as well and um – it's a huge responsibility, um an awful thing to feel – and even now I still feel guilty about that, um … it wasn't him that I – I loved him and I wanted him, it was me that I struggled with.* (Elizabeth p4)

The last phrase of this extract from Elizabeth's transcript is significant, 'it was me that I struggled with', because it demonstrates the way that the negative self-image engendered in childhood impacts on the way the women respond as adults. Palmer (2004 p80) suggested that for the women in her study 'feelings of being wrong, bad, guilty and shameful seemed to be intrinsic to their sense of worth'. This appears to be true for the women in this study too. As discussed previously, Mia was convinced that she would be punished as an

adult for what had happened to her as a child. Looking at her newborn baby, Linda not only said 'I can't do this, I'm gonna mess this up' but also 'I'm no use' (Linda p5). Sam was apologetic over several aspects of her care. This is demonstrated by her reaction to her premature baby being on the neonatal unit:

> *I've done something wrong! I'm really bad, you know, I, I, I, should have looked after myself better.* (Sam p5b).

There is an interesting parallel between these words and those she uses when blaming herself for the abuse. She felt bad that he needed to be there in the first place and also that she could not stay with him all the time. Leaving the neonatal unit to go home to her other children brought back the way her own mother had walked out during her childhood:

> *I felt immense guilt because I felt like I was abandoning him.* (Sam p15b)

In addition Sam was concerned for the anxiety other parents reported when her son became ill on occasions:

> *Oh my God, y'know, I'm hurting everyone!' I'm not just hurting myself, my family, my son's struggling for his life and he's hurting because otherwise they wouldn't be giving him morphine for the pain … and then I'm impacting on all these other parents and scaring the life out of them and it's like all my fault!* (Sam p8b)

Sam had come to accept that the effects of her childhood abuse would not go away. Not all the women felt the same but its impact can nevertheless be detected in their narratives.

7.7 Impact of history

The women displayed a range of reactions to their history, but however they responded, its legacy was evident. Sam recognised that her abuse was 'sort of encompassed as part of the person that I am' (p9). She described it as a bag that she carried around with her. She tried to ensure that it was a small bag, but sometimes found it became bigger. A participant in the study by Coles and Jones (2009) similarly realized that her abuse was not something she would get over, but something with which she had to learn to live. Sally was more resistant:

> *It all comes back! And it shouldn't really, it should be laid down to rest, but it's – just comes back again.* (Sally p30)

But she realized that she needed to get on with her life and 'deal with it'. Like Sally, Helen wanted to move on and did not want to blame everything on her abuse. However, she was aware of its impact:

> *I can't keep letting my past affect my future. Um, but unfortunately it's a huge part of my past. And, you know, it does affect quite a lot of things…* (Helen p53)

The possibility that abuse was in the genes was something that was a major concern to some of the women (section 6.5). This had initially overshadowed Sue and Linda. Even though she had always wanted to be a mother, Sue had considered not having children because of it:

> *a lot of people say 'Oh it's the genes, if you're abused you abuse' and that's said an awful lot and that it's genetic and that it carries on through families – which made me think I never, ever wanted children, because I wanted to stop that. But it's not true and I believed it for so long, but it's not true, it's not true one little bit um and I'm so glad that I, I can prove that to people.* (Sue p13)

Other women believed that they had left the abuse behind them:

> *but because I suppose until I got pregnant I thought it was – it wasn't important - cos I did feel OK, I did feel – normal…* (Elizabeth p4)

Elizabeth was living what she considered to be a 'normal life' and was completely unprepared for the onslaught of flashbacks she experienced even before she discovered that she was unexpectedly pregnant:

I'd lived through flashbacks
things that I'd not thought about for years
things that I thought I'd dealt with
and that I thought were OK
I didn't understand what was happening
I couldn't even find words to explain
I wanted the baby
I wanted [my son]
I was so overwhelmed

Coles and Jones quote a participant from their study who was beginning to understand connections between her behaviour and her abuse:

> *Sometimes you do things you don't even realize you do because of your past.* (Coles & Jones 2009 p233)

But it was only through having a baby that Mia realised the effects of her history on the way she lived her life:

> *Because I didn't, I, I've never, I've gone my whole life without really talking about it thinking that it's <u>nothing</u> to do with anything that I've done, till after I've had children realising a lot of stuff that I've done has got something to do with it. But, you know, literally through having a baby.* (Mia p42)

Although having children was a healing experience for Mia, she acknowledged that life could have been different for her:

> *But it is a bit annoying now cos I feel that a lot of things that I have done in my life, I would've been able to like push myself a little bit further forward, if that hadn't have happened to me.* (Mia p29)

Sam also indicated the impact of what had happened to her in a similar way:

> *I've only been able to do half of what I could, I know I could do and if I hadn't 've had to carry this around with me and hide it like it's some kind of horrible – well it is a horrible secret, but because society don't know how to deal with it, it's like – that's where I'm going to the horrible place I've been feeling like a co-conspirator.* (Sam p57b)

She referred to her abuse as a 'life sentence'. Not all the women would share that opinion, but its effects can be seen in the women's reaction to their history down the years.

7.8 Summary

This chapter has explored the narratives women told in relation to themselves. It has shown how their sense of worth was affected by their childhood experiences and how their response was often to silence themselves or try to hide. In turn, this impacts on the way the women relate to others.

8. Chapter Eight: Women's narratives of relationship

8.1 Introduction

Brown and Gilligan (1992) developed their voice-centred method of analysis from the standpoint of a relational ontology – a belief that women's psychological development relies on the ability to make connections with people and the need to be in relationship with them. This implies that women who lack connection may be vulnerable and their perception of their relationships is therefore important. By definition, midwives are 'with woman', making maternity care relational. The manner in which women approach relationships and the way they are received is thus an important consideration in the exploration of their maternity care experiences. Women's experiences of silencing themselves, their attempts to fade into the background and fit in described in the last chapter meant that they frequently found themselves alone.

8.2 Feeling alone

It is possible to feel alone without actually being alone, as a woman in Dahlen et al.'s study (2010) discovered. Feelings of isolation are frequently reported in the literature among those who have been sexually abused (Hanan 2006; Heritage 1998; Hobbins 2004). There was a tension for the women between seeking relationship and protecting themselves from others – particularly if those others were strangers.

Convinced that people would believe her to be a bad person if they knew what was going on in her head, Elizabeth kept her troubles to herself and consequently felt unsupported and alone:

I just felt
I couldn't say
I just felt completely unsupported
I felt completely isolated
The way I would describe it now
I felt like
I was on the outside
I couldn't get in
I couldn't connect with anybody
there was a barrier between me and everybody
I couldn't connect with anybody

Elizabeth described this as like a bubble. Everybody else was inside, but she could not get in. This metaphor is evocative of one used by Virginia Woolf, who was also sexually abused in childhood, in which she describes herself wrapped in cotton wool (DeSalvo 1989). Although Elizabeth was on the outside looking in and Virginia Woolf was on the inside looking out, the sense of separation is evident in both images. The fact that no one knew what was going on for Elizabeth made the feelings of isolation worse:

> *I felt alone with all these thoughts and worries and, and, and flashbacks um, felt completely isolated with it. Couldn't tell anybody.* (Elizabeth p16)

Women would have valued being able to share their experiences. Sue had been part of both ante and post natal groups but felt completely different from the others:

> *When I was pregnant, I would have loved to have …had support from friends…or, who had been through what I'd been through and had babies…and if I could have had the support from people that you don't have to talk about all your childhood with, but they know - nothing need ever be mentioned but they know how you're feeling. If I could've had that, I think I might have felt a bit better.* (Sue p16)

But Sam even felt set apart from other women who had been abused:

> *Everyone's different, no-one's the same, but I find that even with other abuse um survivors, I, I'm different and it makes me feel so isolated and alone.* (Sam p17b)

Sam valued friendships and one reason she kept her abuse to herself as a child was fear of losing them:

> *and it's like 'Oh, I wasn't gonna tell anyone, how could I tell them, you wouldn't wanna be my friend any more y'know and I'd have no one. I wouldn't have any semblance of normality and then how- what, what life have I got? I'd have nothing!'* (Sam p54b)

Unlike some of the women, contact with others was an important coping strategy for Sam:

> *but if you can't do that with the people on the ward, it's really – you're like an island on your own and that makes it really horrible an' that's probably been my worst times is when I haven't been able um to work with other mums.* (Sam p21)

Yet she nevertheless preferred to maintain a certain distance:

I always try to sort of like have some kind of protection
I do connect with people
I only take it to a certain extent
I can't afford to be completely open
I have to keep some of it inside me
and like to protect myself from other people
I have been hurt badly by people that are supposed to have been looking after me

One participant from Parratt's study (1994) sought isolation in order to protect herself, but in my study the need to protect themselves compounded the women's sense of isolation. Jane's story is interesting in relation to this. Her protection of self at the time of her pregnancies was a factor of repressed

memory of abuse. I demonstrated in section 6.3, that she defended herself psychologically and that this required a separation of mind and body. Reading for relationships in her interview revealed the impact this had on her connection to others. She used 'we' only once during her interview – when she was referring to other survivors (of childhood sexual abuse):

> *a lot of survivors are very emotionally defended, you know, it's like – 'feelings - what feelings – we don't have 'em!* (Jane, p12)

When she talked of others, it was often in purely factual terms – there was no emotional dimension:

> *…and again my husband was working away, and I had two kids at home … so I had to get my parents in…* (Jane, p3)

Although she did not give the impression of an isolated existence – she had just returned from holiday when her first child was born and talked of involvement in a voluntary organization - there was little sense of association with others in what she said.

> *[Having a baby] just wasn't talked about in our family and … I didn't have any friends sort of like close round … there wasn't that opportunity to share with other mums to be or other mums…* (Jane, p5)

Ambivalence over involvement with people was manifest in several of the narratives. The reason is evident in Sam's I-poem on the previous page which mirrors the betrayal described by Finkelhor and Browne (1985). Grant (1992 p221) calls betrayal of trust the 'cardinal sin' because once it has been broken it is very difficult to trust again. Sue was afraid of letting others into her life, which was one reason she was anxious at the start of her first pregnancy:

> *I do have a lot of trouble trusting people because I kind of think that everybody's been sent to me by my abuser to be horrible to me.* (Sue, p2)

Louise reported not wanting to get too close to people:

> *I hate to say it but when I do make friends, I tend to stay back, away from them…* (Louise, p15)

and Sam admitted that:

> *it's really hard to be able to like connect with other people.* (p30)

Elizabeth craved the opportunity to connect with someone:

> *I wanted somebody to know that it was awful but I wanted to know that that person was gonna support me and I didn't think anybody would. I thought that everyone would just hate me and think I was a terrible person and that I didn't deserve to have this baby…* (Elizabeth, p3)

Linda's isolation came following the birth and was a consequence of her quest for perfection. She dared not go out in case her baby cried and she was judged by others:

> *And yet the irony of it all is, that in trying to create this perfection, I was more stressed, more exhausted utterly isolated and I probably didn't give him the childhood – the relaxed, happy childhood that I would have liked to have given him.* (Linda p10)

The result of this was that she regretted having her baby:

> *I just was – on my own, isolated and …wished I hadn't had him… terrible thing to say, isn't it. But, that's initially how I felt.* (Linda p43)

Pregnancy was a very lonely experience for Louise. Pregnant at seventeen, she found her boyfriend unsupportive:

> *Like I said, I had to go all through it on my own and – I remember, I remember going to the hospital and going having the scans done and there's all these couples holding hands and holding their bellies and rubbing them and stuff like that and there was me all on my own.* (Louise p7)

This also corroborates her lack of connection with her pregnancy (section 6.3). Louise did not feel that maternity care professionals were supportive either and when she received the attention of a health visitor it was not an affirming experience:

> *I've always been on my own, always, since … a long time basically. I'm not used to having people around me. I'm not used to that. When, when, when I've had the kids, it was health visitor this, health visitor that – people having a go at me and I thought well who's these people coming in all of a sudden. I just, I felt as though that I was surrounded, by strange people. I'm not very – how can I explain it – I'm not very good around strange people. I gets really nervous, really tensed up when like strange people are around me. I hate it.* (Louise p15)

Although Louise could not articulate what it was about strangers that made her uncomfortable, Sam gives an inkling. Her experience was of staff trying to be supportive and praising her but she found this hard to take:

> *I just think 'yeah, that person's just saying that and y'know, they don't really mean it and you see everyone as enemy – anyone could be a potential person to hurt you because that trust is not there.* (Sam p32)

Trust is discussed in more detail in Chapter Nine (p173) but, as demonstrated in the I-poem presented previously, the reason it is a problem is described by Sam:

> *I have been hurt badly by people that are supposed to have been looking after me…* (Sam 13b)

It can be understood from this why relationship is potentially difficult for women – particularly where strangers are involved. Sue still carried fears about her abuser's power to hurt her. In the following extract she is talking about her first labour, which was induced, long and involved an epidural:

> *a lot of adult involvement – different adults that I didn't know, that I hadn't been introduced to and perhaps in the middle of labour I wasn't, wasn't the best place to introduce a new person to me, because I do have a lot of trouble trusting people because I kind of think that everybody's been sent to me by my abuser to be horrible to me.* (Sue p7)

Her use of the word 'adult' is interesting here. She had just been talking about how difficult aspects of her labour had been and revealed:

> *deep down you just turn yourself back into that seven year old that, that was treated so horribly and had things forced upon them…* (Sue p6)

Summing up her third experience of maternity care Sue says:

> *I just felt as if I was being taken away from this life and put in with the evil people who took my childhood away – that's what I felt. I just wanted to be left alone.* (Sue p11)

Being among people she did not know and could not trust was obviously terrifying for Sue but she was not alone in this. Most of the women indicated that they had felt scared at some point during their childbearing experiences.

8.3 Feeling scared

All the participants in Lasiuk's (2007) study felt fear and anxiety throughout pregnancy. 'Scary' was a word that Sam used frequently during her interview. This related to many aspects of her care: loss of choice and control, lack of information, the labour ward environment, being reminded of her abuse and fear of the unknown. Several of these aspects are encompassed by other themes and I address them elsewhere in the text.

As in Sue's extracts in the previous section, the voice of the child can be heard in Sam's fear:

> *I think I was conditioned right from an early age, so that programming's always gonna be inside me and when someone's either like threatening my personal like intimate spaces or hurting me, or telling me to do stuff and I'm like feeling threatened, I will do exactly what they say. I will be the best patient they can possibly have. I'll be that star patient. But I'm not. I'm actually screaming inside. I'm like absolutely terrified. I'm expecting them to hurt me. I'm being good because I don't want them to hurt me anymore.* (Sam p40b)

Part of her fear with her first pregnancy related to the fact that she knew it would mean that strangers would need to 'do things' to her. This was also frightening for Sue:

> *I knew that I was going to have to let other people into my life that I don't like doing, really.* (Sue p1)

Uncertainty was difficult for Elizabeth:

> *I find it very – scary to never know whether I'll be seeing one midwife or the other and um… who will be doing what to me. I found that very … stressful.* (Elizabeth p33)

But the difficulty went beyond not knowing who she was going to see for her antenatal appointments. Elizabeth's mental health was parlous during her first pregnancy (section 7.6). She thought she was losing her mind and was worried that she would never get better. She was desperate for some reassurance but did not get it:

> *I just wish somebody had said 'It's OK, and you're going to be OK and this is fine' um… and 'we're gonna help you' and nobody, nobody could say that so it was very frightening.* (Elizabeth p3)

Some women were frightened by the pain of labour. In Helen's case this was because she was labouring quickly and was not prepared for the intensity. Once she discovered that she was making excellent progress, she realised she could cope and felt calmer. Leeners et al. (2006b) recognise that fear of pain or injury in sexual body parts can be an issue for these women. Mia's fear was linked to her abuse. She was anxious about the prospect of having any vaginal pain and being reminded of her attack as she was giving birth. Unlike the other women in the study, Mia had originally requested a Caesarean Section due to this fear but having disclosed the abuse to her midwife agreed to a vaginal birth. Caesarean Section for maternal request has received a lot of media attention but in a recent survey of maternity care experiences in the United Kingdom (Redshaw & Heikkila 2010) only 2% of the women having an elective Caesarean did so for maternal request without any clinical reason. There is an acknowledged link between fear of childbirth and abuse (Lukasse

et al. 2010; Lukasse et al. 2011; Nerum et al. 2006) and also between abuse, fear and request for Caesarean Section (Lukasse et al. 2011). In the following extract from Mia's interview, her fear is evident and she displays the 'fighting response' described by Rhodes and Hutchinson (1994). Mia is describing her reaction to feeling pressure from her baby's head and links the pain she was experiencing and her need for an epidural with feeling scared:

> *…but just like literally the pain was just like through my whole body. It's not normal is it to have pain – I don't know if it is normal to have a pain (laughing) in your whole body, whether it is that painful, but it was like absolutely horrendous so I needed to have that epidural cos I was just scared.* (Mia p3)

In their study on the effects of crisis-oriented counselling on fear of birth, Nerum et al. (2006) discovered that women who had achieved a vaginal birth remained pleased with their choice. As discussed in the previous chapter (section 7.2), Mia's vaginal births were ultimately healing experiences for her and she was pleased that she had not had a Caesarean Section. Nevertheless, the prospect of her second labour was frightening while she was pregnant and she said it was only because she trusted the midwife that she did not press for a Caesarean. Elizabeth was scared of getting pregnant a second time after having such a terrifying experience first time round and indeed it was four years before she had her second baby. Linda's fear anticipating birth was that she would need a Caesarean. She wanted:

> *the textbook pregnancy, the textbook delivery, the textbook baby, the textbook post-delivery experience…. If I couldn't have had that baby vaginally, I would have (intake of breath) completely felt a failure. That would have been a disaster.* (Linda p39)

However, having had a vaginal birth, Linda was scared of the baby – something that she had not anticipated. Her concern was in relation to her ability to care for the baby in the way that she wanted:

> *I was scared of him because – he would – it, it was as though he was - the thing, that would - he was the thing that would prove to everybody that I couldn't do it. I was scared that he would, he would show me up. As being a complete failure.* (Linda p20)

Often though, feeling scared was related to being reminded of what had happened to the women as children and there were many examples of this. As Sam said 'it's almost like it's happening again…'

8.4 Re-enactment of abuse

By its very nature, maternity care is intimate. Seng and Hassinger (1998) recognise that it is difficult to provide it without having to cross a client's body boundaries at some point. The potential for care of women who have been abused to compound suffering and trauma is widely recognised (Garratt 2002; Gutteridge 2009; Rose 1992; Rouf 1999). Sometimes there are very specific aspects that remind a woman of abusive situations she experienced in childhood. Sometimes rather than just being reminded, a woman is transported back as if it was happening at the time. I discuss these triggers and flashbacks in the next section. These events are individual in their nature, often unpredictable and are not necessarily avoidable. However, there is also much about maternity care that is external to the woman and is more predictably difficult for her. With insight and forethought healthcare professionals may be able to minimise the impact these aspects have on a woman.

Linda was different from the other participants of this study as she did not recall finding any of the aspects of her physical care problematic. However, the experience of several of the women can be summed up in the words of Elizabeth whose baby had been given a large formula feed on the postnatal ward without her knowledge and consent:

> *my whole childhood was about everyone doing stuff to me. Never asking, just doing stuff to me and now someone's taken my baby and they've not even asked.* (Elizabeth p27)

For Elizabeth this was yet another example of being overlooked and it was clearly disempowering. Helen was involved in decisions relating to her care. Having reached full dilatation quickly her labour became complicated in the second stage. She understood the necessity for interventions and even welcomed them, but that did not stop the experience being difficult:

> *actually at this point I'm not that happy about what's happening, but my other head says it's fine cos I know it's got to happen, but one head says, you know, I don't really want this to happen'.* (Helen p9)

In common with other women, she mentioned people 'doing things to her' that she did not really want several times. Parallels to childhood are obvious. For example, nineteen year old Sam was glad of her mother's support during her first labour:

> *Cos all they do is come in, like mess, fiddle with you, do things to you and then they don't really tell you what they're doing…and then they disappear again and leave you and it's almost like you're sort of waiting for the door to open. You don't know who is gonna come through, what's gonna happen, 'n it is very, very frightening.* (Sam p1)

This image of not knowing who was going to come into their personal space was a very powerful one in the interviews of Sam and Sue. Many women with abuse in their histories cannot tolerate having their back to the door – which is a particular issue during the citing of epidurals (Simkin & Klaus 2004). Sue mentioned the anxiety that approaching footsteps caused her on a couple of occasions. In the following example she had been admitted to the antenatal ward:

> *I, I'm completely scared of the dark and to lie there with someone walking into your little curtain bit and turn the light off was horrible because you can hear the footsteps coming … and, and you know, footsteps have a real big meaning when you've been treated not well as a child. And those footsteps – you just don't know who they are until they come round the curtain and um and then switch the light off and you're so scared…* (Sue p3)

The way in which the care environment may mirror abusive situations is recognised in the literature. This includes the way women are often supine (sometimes only partially clothed), being addressed by upright staff who may be seen as authority figures and being watched by students (Hobbins 2004). Sam particularly mentioned having difficulty with staff standing over her as does one of the participants in Burian's study (1995).

Rouf (1999 p30) notes the way that procedures that are routine for staff may be 'strange, frightening intrusions' for the women. This is something of which Prescott (2002) is also cognisant. The vaginal examination is an obvious example of one such procedure and most people would expect it to be difficult for women with a history of abuse. Nevertheless the literature abounds with incidences where healthcare professionals have been insensitive in conducting vaginal examinations – even sometimes when a history of abuse was known to them (Burian 1995; Garratt 2008; Kitzinger 1990).

Sally was clearly upset by an examination she had during her second pregnancy in which a swab was taken.

> *But then, I couldn't get why, why, you know, why do you have to keep on touching me, why … in those –private parts. I still had that in my head. Even after having one child and obviously, to get pregnant, you, you know, you have to have intercourse…* (Sally p4)

She linked being touched with her abuse and appeared surprised that it was an issue for her even though she had become pregnant and had already given birth. However Simkin (1992b) believes that invasive procedures are likely to be difficult for adults when their body boundaries were not respected as children. Sue had a similar response to the examinations she had in the course of her induction of labour with her first baby:

> *and I just can't cope with it at all, I really can't and I know people were saying 'well you're having a baby, you've got to deal with things like that, but I couldn't, at all, I really couldn't (intake of breath) and um, I don't know – it felt basically as if every person that came in that room did an internal and that was horrible …it was horrible and I – how it makes you feel… is how it made you feel when you were a child. It really does…* (Sue p6)

The staff with whom Sue came into contact did not seem sensitive to the fact vaginal examinations may be difficult for some women. Elizabeth was concerned at the prospect of examinations and indeed did find them painful and intrusive. She decided that:

> *as long as people respect me and as long as people ask then that should be fine…* (Elizabeth p9)

However, this was not her experience:

but it's almost like they, I felt they thought they had a right to do it… (Elizabeth p9)

Courtois and Courtois Riley (1992 p222) suggest that if healthcare providers dismiss women's experiences they 'become another betrayal in the betrayal that surrounds abuse'. Unfortunately both Sue and Elizabeth were treated with disdain when they indicated that their examinations were painful:

> *they were really, really painful and I- the midwives on the ward just kept telling me to stop being so silly- everybody goes through it, everybody has it done…* (Sue p7)

> *It was just very, very painful and they kept on saying 'It shouldn't be painful, we don't know why you're saying it's painful', but it was. It was painful, umm – and just very intrusive.* (Elizabeth p9)

Whether or not the examinations 'should' be painful, they clearly were for these women. One of the participants in Burian's study made a very eloquent plea after her pain was ignored:

> *'why can't somebody see that I'm in pain? …hear my voice, hear me! Just don't say 'Oh, there's nothing wrong with you, 'and 'it's all in your head' and everything else. What I feel in my body is because of my head, because of the abuse I've been going through.'* (Burian p255)

Grant (1992) provides a reminder that that psychological pain can cause physical pain and distress.

Vaginal examinations were not universally difficult for women. Although she struggled with repeated examinations following her baby's birth, Helen accepted them when in labour. The key factor was that she trusted the midwives who were looking after her. This was a strong finding in Garratt's (2011) research too. She noted that it is not necessarily what is done to women, but the manner in which it is done that is important – something that was also evident in the 'Great Expectations' study (Green et al. 1998). Sadly though, maternity care experiences often replicate abuse and women feel violated (Garratt 2011; Kitzinger 1992; Prescott 2002).

Whilst women expected that some of these experiences would be traumatic, others took them by surprise. Sue agreed to administration of Pethidine during a slow labour. However, in common with a participant from Parratt's

study (1994), she recognised the effect it had on her and regretted her decision:

> *when I was a child I was often given sedatives or um sleeping tablets that made me feel very out of control as a child and it gave me exactly the same feeling…* (Sue p9)

Even though she trusted her midwife to keep her safe, she was afraid that her abusers were 'getting to her as well'. This demonstrates that although sensitive care can be a major factor in helping to ensure that women's maternity care will not be a re-enactment of their abuse, it does not guarantee it. In attempting to keep her safe in the birthing pool while the midwife organized an epidural, Mia's mother and husband were pushing against her shoulders. This transported Mia back to the time of her abuse.

8.5 Flashbacks and triggers

Care in labour is very likely to cause flashbacks. According to Barlow and Birch (2004) this may be due to fear of the unknown, unpredictability of what is happening or a loss of control of what is happening to the body. All of these could have been precipitating factors for Mia in the situation mentioned above. She provided a vivid description of seeing her abuser's face leaning over her in place of her birth attendants:

> *in that birthing pool it was absolutely horrendous cos I'd never really had nightmares about it or anything really but in that birthing pool I could see his face, which I couldn't really remember and how he looked and everything like he was on top of me in that pool and like I'd floated out of the situation that I was in and I was seeing it and nobody else was like around.* (Mia p21)

The flashbacks she experienced brought back long-forgotten memories. This was Elizabeth's experience too and it was clearly very distressing.

> *I was absolutely gob-smacked I didn't know where these things were coming back from, things I had not even remembered in my conscious mind, um – and it was – just – very, very frightening and it was just all of the time. Every waking moment, was just being bombarded with them.* (Elizabeth p14)

Elizabeth is adamant that these were not just memories; it was as though she was actually re-living her past:

> *I could see what somebody was wearing, I could see how the room was decorated, I could see where the furniture was and it was like you were actually there living it – again.* (Elizabeth p15)

Prescott (2002) advises that any aspect of treatment can trigger flashbacks and that women may panic or go rigid in response. Mia was glad that her midwife knew her history because otherwise she feared that people would think she was just 'kicking off' for no reason. Women were very aware that they probably came across as difficult. Sue's flashbacks could be triggered by things that she knew might appear petty to others. She gave the example of someone sitting in a chair next to her in a crowded clinic. The only way that Elizabeth could prevent flashbacks was to keep busy. This was Sam's strategy too, but it was very difficult in hospital. With nothing to distract her, all her 'tools' where taken away from her. Being stuck in a bed with people coming into the room made her 'be the kid again' (Sam p29).

Jane did not suffer from flashbacks during her pregnancy, although as her history later began to emerge she was plagued with them. However, she did experience what with hindsight she realises was a body memory (Rothschild 2000). At the point of crowning[14], the pain she experienced was very reminiscent of her abuse and she stopped breathing:

[14] When the widest part of the head is born.

> *I had this tendency to sort of breath out and stop, under extreme stress, or, or pain, and so there was this, you know, sort of like – and I, and I, and I could feel myself disappearing because I couldn't, I couldn't breathe in, even though she [the midwife] was asking me to.* (Jane p2)

She went on to explain:

> *it's almost like when things are so similar, even if you don't know that there's a connection, it's almost like your body makes it anyway and you and and it takes over.* (Jane p14)

Parratt (1994) describes a similar experience from a woman who shut down completely during labour, until she realized that she was damaging her baby. Simkin (1992b) corroborates Jane's experience, suggesting that body memories may make a woman react in the same way she did to her abuse. Seng et al. (2002) suggest that healthcare providers should assume that women who are 'not ready to know' will be triggered by situations that are reminiscent of abuse. Indeed, although it was not the case for Jane (or any woman in my study), many women remember their abuse for the first time during pregnancy or labour (Grant 1992).

A trigger is, in this case, an action, situation or word that kindles a memory of abuse (Heritage 1998) and can be any emotion, sensation or experience resembling it (Seng & Hassinger 1998). The smell of cement was a trigger for Sally because she was abused on a building site. For many women pregnancy itself is a trigger (Courtois & Courtois Riley 1992; Hobbins 2004; Leeners et al. 2006b; Palmer 2004; Rouf 1999; Seng & Hassinger 1998) and this was the case for Elizabeth and Sally. The whole process of having a baby triggered dreadful memories for Sam to the extent that she admitted she would have had an abortion had she anticipated the effect of having her daughter:

> *it was the best thing but the worst thing all in the same moment and it was the best thing cos I actually – y'know, being a Mum and, and like y'know, creating something that's so precious but then the worst thing was it made me remember and have to deal with this and that's not good…* (Sam p57b)

Elizabeth and Mia both mentioned vaginal examinations as triggers but there was a very specific issue for Mia. In order to be gentle, some midwives insert one finger first and then another at the start of an examination (Liu 2003). This exactly replicated what Mia's abuser had done. Pain – particularly during the second stage - is a well-recognised trigger (Grant 1992; Leeners et al. 2006b; Waymire 1997). I have already mentioned Jane's experiences – although she did not realise the significance of what she was feeling at the time. The prospect of the pain terrified Mia but having been through the birth she admitted that the pain was *not* the same for her:

> *and it's nothing like, the pain – in the birthing pool it was – that's only because of my own head, I lost it, because mentally I just lost it.* (Mia p5)

Nevertheless, her distress cannot be denied. However Sally's pain was very reminiscent of her abuse and was one reason why her second labour, without an epidural, was so difficult:

> *and … it's that pain…. I'll never forget that. It's, it's …it's horrible. You don't forget it. And that's the same as when you're having your baby. You're going through pain, although it's, it's gonna be a good result, it's still… you still remember that – I can't – you can still remember that pain.* (Sally p12)

Parratt (1994) recognises that determining what will trigger a memory is very individualised and not something that the women are necessarily able to predict. This reinforces the need for staff to be sensitive to unexpected

reactions from women and tolerant of seemingly inappropriate behaviour. Sam was being helped to change her gown with an intravenous infusion in situ. Given that her carers knew nothing of her history, they could not have understood that this was difficult for her:

> *having someone helping with dressing and undressing – that is a bit of a not good area for me as well. I don't like that cos it's like that's out of my hands and that triggers memories for me too because I do that. I undress and dress myself; no one else does that for me. The only other time someone else has done that is when I was being abused, so although they don't realise and they think they're helping and they're really nice and it's like – and then I have the double whammy of feeling really guilty because it's a really lovely, nice, helpful person who is totally oblivious and then I feel like I'm a real bitch because I'm not as grateful as I feel that I should be.* (Sam p36b)

Mia's midwife was aware of her history and responded to her distress in late first stage of labour at home. However, she was not cognisant of the fact that it was an innocent action on her part that was the trigger:

> *I thought I was gonna have her, have him, have her at home basically and I could feel the feeling to push and then she did an internal examination then it gave me like a bit of a problem in my head and she got a torch out, which is what he used to do. He used to get like a torch out to look cos it used to be like in a den, sort of thing, so, so she got a torch out and it was dark and I started thinking I needed to go to the hospital.* (Mia p2)

Mia was transferred in to the unit, but unfortunately, as has already been discussed her distress was compounded by being restrained on her back in the birthing pool.

Gutteridge (2001) expresses surprise at how childbirth broke down the defence mechanisms by which she coped with life. It is obvious from the examples described above that pregnancy and birth were capable of suddenly and unexpectedly catapulting women back to their abuse and breaching their defences too. This left them feeling very vulnerable and unsafe.

8.6 Safety and vulnerability

According to Palmer (2004), as women progress through the phases of the childbearing cycle they experience increasing effects of their abusive past and feel more vulnerable. In this study, much of the vulnerability arose from women's feelings of exposure. Feeling safe seemed to be linked to confidence that they were not going to be reminded of their abuse. There is a marked contrast between the language of exposure that the women used in relation to their maternity care experiences and the impression they gave of hiding and trying not to be noticed in their narratives of self. Elizabeth wondered if anyone was 'selling tickets outside' for her labour, when, laid with her 'legs wide open' a doctor and entourage of students entered the room. She was very aware that the blinds were open at the windows and was left feeling:

> *like you're some freak show that everyone's looking at.* (Elizabeth p22)

Several women in Anderson's (2000) qualitative study on the second stage of labour used imagery of the circus too, describing themselves as a freak or side show. The lithotomy[15] position was a particular anxiety for women, as Helen describes:

> *they put my legs back up into the poles again, so I'm legs akimbo, everybody can see everything.* (Helen p23)

[15] Women's legs are flexed and supported by poles on either side of the bed.

Linda felt safe in the birthing pool and 'could have smacked' the midwife when she suggested that Linda needed to get out:

> *But I didn't wanna get out and be all exposed. And just be that legs ohh – I mean even when I have a smear now, I hate that position of everything on view, in the traditional, medical way.* (Linda p35)

Palmer (2004) recognises that when triggers experienced by the women outweigh their coping strategies imbalance results and their response is to protect themselves. The women's need to protect themselves in the face of exposure is evident. Sue tried hard not to sleep in hospital where she felt vulnerable and as already mentioned preferred to keep the light on. Sam was torn between hiding away and watching out:

> *I mean I can never sleep in the hospital, and when they make me stay in overnight, it is horrible, it's, I'm just like – I've got the cover right up to my face and I'm like really, really scared. I tuck in all the covers really, really tight and I try and sleep with my back to the door but then I feel really, really vulnerable and so I turn around and I face the door but then I'm like, watching things too much, um specially if the curtain's open of the ward on to the corridor…* (Sam p21)

Garratt (2011) describes similar issues with sleeping. Faced with people leaning over her in clinical situations, Sam's reaction was to pull her arms across her chest to shield herself and part of being a 'star patient' was about maintaining her safety as she had as a child:

> *You know, tell me I'm good because at least then you're not telling me I'm bad. But that's the only way I know how to be, because it's n… and that's what I meant about losing control because if – when I've broken down, I'm not being good, I'm not like doing what I've been told, I, I have lost it then. I am totally like flailing. I'm inside my head I'm just like screaming 'help! Get me out of here!' and if I have actually shown*

> *that, it's like really dangerous for me cos I'm – then they'll really know what I'm feeling and how I am feeling inside.* (Sam 41b)

The hospital environment was often not one in which the women felt safe. Other researchers have found that women with a history of sexual abuse are more likely to have home births (Garratt 2011; Parratt 1994). As discussed in Chapter 5 (section 5.2), none of the women in my study achieved planned home births although Mia and Elizabeth both hoped for one. For Elizabeth, this was an attempt to gain the control and feelings of safety that eluded her at her first baby's hospital birth. Although she ended up in hospital, her experience was in stark contrast to the first time. Part of this was having a midwife who listened and treated her with respect. Palmer notes that when women feet vulnerable they hold back from connecting. However the converse also appears to be true. When the women in my study were able to form relationships with midwives they trusted, they felt safe. The importance of a trusting relationship between the woman and her midwife is recognised by Tilley (2000). She also recognises the harm that is done if that trust is abused; 'if we … take control, ignore her cries and leave her humanity in tatters' (Tilley 2000 p20). The women in my study needed to retain control in order to feel safe.

8.7 Control

As discussed in Chapter One (section 1.7.1), the importance of control for any woman in labour is widely recognised (Baker et al. 2005; Green et al. 1998; Halldorsdottir & Karlsdottir 1996; Simkin 1991) although surprisingly it did not feature in the recent survey by Redshaw and Heikkila (2010). Several authors suggest that it is paramount for women who have been abused (Burian 1995; Palmer 2004; Parratt 1994). Two women in my study, Mia and Louise, did not mention control during their interviews and Linda only mentioned it once. When I probed about her strict routines, Linda suggested that they were her attempts to be in control of the situation. This is a strategy that Burian (1995) recognises as a way of retaining control. For the other women, control was a key issue and several stressed their need for control. Helen, a self-confessed 'control freak', admitted:

> *I just, I think I need to be - I need to be in control. For me that's a big word.* (Helen p28)

She went on to explain:

> *when I was a child and all this crap was happening to me, I wasn't able to be in control. It all happened against my wishes, but I was a kid and it's adults and you know, they're the ones doing it – you don't have any right – you don't have any say really.* (Helen p28)

Sally expressed similar sentiments. One aspect of her childbirth experience that she found very difficult was the need for her to have some retained placental tissue removed under anaesthetic following the birth of her daughter. She attributes her distress over this to lack of control during the procedure and links it to her childhood:

> *Yes – because I wasn't in control maybe. Maybe that's what it was. Maybe… because I was, because I didn't know what was going to happen. I didn't … because I wasn't in control; when I was five. And I think that's probably what it is.* (Sally p14-15)

And as was often the case with Sue, the echoes of her childhood can be heard in the following extract related to control:

> *so very, very scared of, of people (quietly, voice breaks) it was people and being hurt and being made to feel like a child and, and being out of control of my body; yeah, which is what I did feel like in my first pregnancy…* (Sue p4)

On questioning, she clarified that she was not *made* to feel like a child but she was taken back to how she felt as a child.

Pregnancy itself can represent a loss of control (Skinner 2010).

> *I felt very much trapped, I, I think that would be a very consistent theme of being, hav… being in labour, um – possibly during the pregnancy as well, of this feeling of being controlled an' an' being manipulated by other people and not feeling like I could do what I wanted to do.* (Sam p7)

> *and I just felt a bit – again, out of control. This baby was taking over.* (Helen p30)

Helen struggled during labour for similar reasons and the fact that she could not predict when labour would start was a challenge for her.

> *I just felt totally out of control. This was all happening to me and you can't stop your body from having contractions, you can't – you know it's got to cos you've gotta have a baby, um and I can – I s'pose in a way you know you get pregnant because you want to have a baby and you've got all these ideal plans and I had all this ideal stuff and none of it actually went to plan and that's – I'm a planner as well. I have to – in control, what a surprise!* (Helen p35)

These aspects of control are 'internal'; they relate to women's control of themselves (Green et al. 1998). Leeners et al. (2006b) suggest that both self-control and feelings of control over what is being done to a woman are important for a 'successful' birth. The latter is part of 'external' control (Green et al. 1998), which was also important to the women in my study, both in terms of the environment and interactions with staff. Sam felt very out of control when she had her first baby but at the time put that down to being young. She later realised that it was a consistent theme.

> *You know, and it's like everything's out of your hands, you're like totally out of control and it's a really, really, like dangerous time. I mean I, it makes me really, really anxious – I wanna get out of there then, you know, even if it means like leaving the baby there!* (Sam p4)

Sue did not enjoy being in hospital where she felt out of control either:

> *I didn't enjoy it at all, being in hospital. And um … you know, that was the, the main things and also sort of different people coming along – both medical staff and not and I've – because when I was in hospital you didn't have your community midwife who knew my situation, all I wanted to do was to scream out for my, my, my midwife who knew me and sort of perhaps made allowances for me.* (Sue p3)

Sam linked lack of control with not knowing what is happening:

> *it's not so bad when they're doing the scans 'n stuff because they seem to talk to you a bit more and tell you what they're gonna do – and they tell you - even simple things like 'the gel's gonna be cold or it might be cold' and 'my hands are cold' and they seem to sort of like the talking seems to put you more at ease cos you know what to expect and you know what's gonna happen…* (Sam p3)

The sharing of information has been identified as an important aspect of control (Baker et al. 2005; Green et al. 1998). This was the case for Jane who indicated that control was very important to her and that as part of it she 'needed to know':

> *So the worst thing that anyone can do, or any experience I could be in is just not to know. Umm and it's even things like, you know, like even now, where I sit – I can't sit with my back to the door, because I just say 'oh well that's fine' but actually the reason I sit is not because I'm*

worried, it's because it's so I know, if anything changes I know, and that's OK, so I'm safe and I feel comfortable. (Jane p9)

Certain aspects of the environment were very intimidating. Sue described waiting in a consulting room in a hospital antenatal clinic. This also relates to her issue with footsteps:

…you're not choosing to go into the room to meet someone, you're going into the room and someone's coming in to meet you. And you haven't got a clue whether it's the consultant you've been told that you're gonna meet or whether it's someone else or whether they've got students with them or whatever. And I found that really intimidating (intake of breath) because it's a hard enough decision to trust someone to go into a room to meet them, but when you're put in a room and someone comes in, you haven't made that choice. (Sue p4-5)

Choice is an important aspect of control (Baker et al. 2005). Women who have been sexually abused often appear 'demanding' (Grant 1992; Simkin 1992b; Skinner 2010; Tidy 1996) as they attempt to gain control. Elizabeth felt that everyone thought she was being difficult as she tried to make her needs heard:

As soon as I don't have control then I start panicking and and get very scared um and I try to make - during my pregnancy with [my first son] I had tried to make my wishes clear that I wanted things a certain way, umm and one of them was not having loads of people in the room, umm… I wanted to be listened to, I wanted people to pay attention to what I said – and nobody did. (Elizabeth p11)

Rhodes and Hutchinson (1994) identified 'taking control' as one of their labouring styles. For these women elaborate birth plans may be a way of imposing their will on their labours. Rouf (1999) was grateful for the assistance of a supportive midwife in helping her to see where she needed flexibility in her plan. Helen had made a flexible birth plan. This was not a problem all the while she was under midwifery-led care but the situation

changed when she transferred to the labour ward. Helen's exasperation is evident in the following extract:

> *But all of a sudden it was like 'right, well, we're now taking over'. You know, it's like 'well you need to be on this machine and, and although I understand, I know why, it's like 'we're gonna strap this machine to your tummy because, we need to listen to the baby and oh, your legs need to be up in this position now and (intake of breath) and now we're gonna give you injections here and oh, we're gonna put this on now and oh you need, you need a tube in your hand because you know, you might, might need fluids, or in the end you might need blood', um and this machine's being brought in and the doors were open and it's just so, you just feel like saying 'everybody stop!' Even though I didn't want them to because I didn't want the contractions carrying on. If the contractions could have stopped at the same time, that would have been great. Just say 'right stop! What are you doing, why are you doing this, what are you doing umm – just let me have a bit of control here!'* (Helen p37-38)

She was left determined that if she decided to have another baby she would be much more prescriptive in what she wanted. The fact that she was not yet sure of the decision – or whether she could get what she wanted is evident at the end of this I-poem:

I do have to have control
I do have to
I do have to
this is where I'm coming from
I lost it last time
I don't want to lose it again
I'm sure
I can hope
I hope

Helen's experience corroborates Baker et al.'s (2005) suggestion that women are content for professionals to make decisions, providing they are included. They indicate that there is an important distinction between control being

'given up' and 'taken away' (Baker et al. 2005 p332). This is also demonstrated by Elizabeth's experience. She had spent a lot of the night talking to a midwife and was relieved that someone had listened to her. Her feelings changed however, when her psychiatric nurse was contacted without her knowledge afterwards:

> *and that's what I needed; somebody to take control and just say 'it's gonna be OK and we're going to do something about this, and you're not on your own anymore.' Umm… the relief that somebody's actually taking some of that load off of you, and sharing it with you and saying 'we're gonna do this with you' was enormous. Huge relief, um… and it would have been great, it would have been fine – but then everything was done behind my back. So they're taking control, but they've taken all of the control and said 'we're gonna do everything and we're not gonna involve you in any decision'.* (Elizabeth p20)

When women were able to gain control, they felt safe and validated. However, when it was taken away from them the experience was very disempowering.

8.8 Power and powerlessness

Stewart (2004) suggests that it is vital to recognise the manifold ways in which professional power can undermine and devalue a woman's experience of pregnancy and childbirth. I have already provided several examples from my study where the women perceived that not only was their experience undermined but they also felt invalidated as people. There are further examples:

> *She didn't listen to anything and I, I, we, we did end up – I felt … I felt she didn't respect anything I said and I felt – stupid. That's how I, when I look back at those few hours I stayed at the [hospital] after having [my second son] I just thought 'they think I'm stupid!' They don't think I know my own mind, they don't think – or they think I'm …*

> *they think I'm a stupid little girl and they don't want to listen to me.* (Elizabeth p23)

Anderson (2000 p104-5) found that women in her study made comments about feeling 'like a naughty little schoolgirl' too. Women who feel they are treated like children by caregivers may regress to childlike behaviour (Grant 1992). As noted in section 7.3, Sam was very submissive in the face of people she did not know:

> *if I'm with someone who I don't know, and is a stranger and probably medical and possibly could have potential power, massive power over me and my life, I will be very, very um … <u>good</u> y'know? Um, I'll be the best I can be (very quietly) cos I don't want 'em to hurt me, y'know and it's so scary…* (Sam p54b)

Skinner, who felt that the power was skewed against her in favour of her care providers, gives an interesting insight into the implication of continued disempowerment:

> *By following my lead of acting as the submissive patient, my providers confirmed what I already felt about myself – that I was powerless to control my body and must submit to someone else.* (Skinner 2010 p181)

The number of times women used language that indicated disempowerment in the hospital environment is concerning. For example:

> *you don't know all these tricks and you think you can't touch anything, you think you'll be told off if you do anything, um – and sometimes you do get told off for stuff so, you know, if you get a scary midwife who's gonna be like thundering in and goin' 'You can't do that, you can't do this'* (Sam p21)

> *… they just kept having a go at me and stuff like that and I felt as though that I was doing wrong.* (Louise p15)

Women commonly complained of being 'told off' both in my study and elsewhere (Garratt 2011; Parratt 1994). When the women found the courage to make their needs known, they often felt undermined:

> *I think I said to somebody 'I don't know what I've got to do. Do I have to change him?' And she just looked at me as though I was stupid. As though I was – in some way I had special needs – I mean she possibly thought that. She possibly thought – I – was – just didn't have a clue! But I had this baby and I didn't know what to do with it.* (Linda p20)

Powerlessness was a prominent theme in Garratt's (2011) study and there is little doubt where the balance of power lay in the interactions between the women and staff in mine:

> *I felt like I had to do things their way – I remember somebody coming and swaddling him. And, and wrapping him like a mummy - is that, I mean is that the normal – I don't know if that's typical practice – and saying to me 'oh this is what you do'. And I remember thinking 'God – don't…' I can feel the anger in me now – 'don't do that to my child!' It was like a straight jacket. But did I do anything? No. I did nothing about it, because – I had to do what they told me because they were in charge and I had to stick very much to the rules.* (Linda p25)

Women felt the need to hide what was really going on for them. In common with a woman from Parratt's (1994) study, Sam was desperate not to appear weak:

> *I do feel like I've failed in that I should have been stronger and not like – it's like - to me it's like giving in y'know, it's like showing weakness um if I showed weakness during my abuse, um … I dunno, it… it wasn't really acknowledged yeah, it was almost like it didn't make any difference, yeah, I could be crying and it would still happen. D'you see what I mean, it wouldn't – if you'd start crying it wouldn't stop it, um it would just continue…* (Sam 29b)

Yet once staff realised she was struggling they put supportive measures in place for her. Baker et al. (2005) recognise that the ideal strategy is reciprocity. Where information and power are shared, women can be empowered as active participants in their care. This is what Elizabeth would have liked:

> *Your voice is taken, what you want is not taken into consideration, it needed to be somewhere in the middle. If someone said 'we'll take control, but we'll do it with you' and we're gonna help you but you're gonna be involved in this as well…* (Elizabeth p21)

It was possible for women to alter the balance of power (section 7.5). Facing the prospect of a second pregnancy Helen realised the importance of getting the support she needed:

> *I do have to have people on my side and I do have to have doctors and the midwives whoever are gonna look after me to say 'this is where I'm coming from, this is where I lost it last time and I don't want to lose it again.'* (Helen p38)

There is a marked contrast between Elizabeth talking about her first baby's forceps birth and deciding to take control second time. In the first I-poem she is struggling to be heard and her tentative use of language in the middle makes her powerlessness palpable:

I don't have control
I start panicking
I try to make
I had tried to
I wanted things a certain way
I wanted to be listened to
I wanted people to pay attention
I felt
I think
I felt so
I, I felt almost like an animal
I had everyone just looking at me
I felt embarrassed
I felt degraded
I felt dirty
I felt horrible! Horrible!
I just wanted to run away
I couldn't
you're stuck
you're just
you've got to go
You've not got any choice.

In the second I-poem she talks with a much stronger and more determined voice:

I'm gonna have to say something to somebody
I think
if I'd asked for help
I suppose knowing
I felt
I won't let it
I won't let it spiral out of control
I will insist
I will
if people think I'm difficult then so be it
I will keep going on
I won't do it on my own this time

Barlow and Birch (2004) suggest that sexual abuse is not purely about sex but about power, control and domination. Bass and Davis (2002) talk of the pervasiveness of childhood sexual abuse and recognise the damage it can cause to someone's sense of control. If, at a time when a child should have been gaining an understanding of her own agency (Miell 1995), she instead learnt that she was powerless, it can be seen why, for women with a history of sexual abuse, clinical encounters can be very damaging when these feelings are re-ignited (Coles & Jones 2009; Palmer 2004).

8.9 Summary

The narratives of relationship recounted by the women in this study demonstrate the extent to which connections they attempt with others are influenced by their childhood experiences. In the context of their maternity care women have reported relationships that were often reminiscent of their abusive past, irrespective of whether they trusted the midwife. Those who have had their trust betrayed in childhood and have been hurt need safety and protection. Pregnancy and childbirth challenge that need and the women in this study, in common with those in other studies, have provided evidence of a vulnerability that makes relationships difficult. As will be seen in the following chapter, the socio-cultural context in which women given birth reinforces the sense of separation women carry with them.

9. Chapter Nine: Women's narratives of context

9.1 Introduction

The immediate context for the stories recounted in this thesis is the maternity care environment within the National Health Service in England. As will be seen in both this chapter and the next, the structures and constraints of the system have considerable impact on those both receiving and providing care. Yet everyone involved in these stories is also influenced by wider social mores. Societal attitudes and taboos influence the women and those with whom they interact. This chapter is concerned with some of these issues as recounted by the participants of the study.

9.2 The maternity care environment

Women appreciated being able to build good relationships with midwives, which has been identified as important in successive surveys (Green et al. 1998; Redshaw et al. 2007; Redshaw & Heikkila 2010). Linda experienced midwife-led care:

> *And they were absolutely fantastic. And everybody should have midwifery-led care…. I mean they (getting tearful) – if I hadn't had those midwives, I don't know what it would have been like. I really don't know.* (Linda p16)

She found it hard to believe that one of the team would attend her in labour but was really grateful that they did; assessing her at home in early labour and giving her the choice as to where she had the baby. Sam did not experience the same model of care and felt it keenly when the midwife she had come to know during pregnancy was not with her for labour:

> *I'd built up a relationship with the midwife and then when she wasn't there when I had um my oldest son, I felt real resentment, you know, like 'How could you leave me!' I was really depending on her being there and although she warned me that I probably wouldn't get delivered by her, it was a real sense of um, being like abandoned.* (Sam p7)

Sam goes on to describe how meeting new midwives was like:

> *… being thrown to the wolves cos you don't know who these other midwives are and so you're having to make in rea… in a real like um stressful time, like real quick decisions on whether you can trust this person…* (Sam p7)

A similar sense of abandonment is evident in Sue's account of how the midwife who had looked after her during labour asked someone else to repair her perineum[16]:

> *and she was from what I could understand an experienced midwife, but she brought somebody else in to stitch me after having the baby and um she just left.* (Sue p10)

Elizabeth needed to know that she was not going to be left. She just wanted to hear that:

> *this is fine and we're with you and we're staying with you and you're safe and you're OK and we're not leaving you.* (Elizabeth p24)

Helen really appreciated the fact that her midwife stayed on for the birth after the end of her shift and for Mia the one-to-one care she experienced was very important to her because of the need for trust. Part of this relates to being

[16] The area between the vaginal opening and anus that is often torn during childbirth.

valued as a person. Expressions of kindness that demonstrated confidence in the women did a lot to boost their morale but the opposite was also true. Louise resented being treated like a number rather than a person. When Elizabeth was struggling most after the birth of her first baby, she found it particularly difficult that staff could walk away from her when she was in distress. The following quotation from Elizabeth seems to encapsulate the dichotomy identified by Wilkins (2000) between the professional relationship desired by women and the professional practice expected by midwives:

> *People are doing their job and most people just want to do their job with as little fuss and hassle as possible um… and I suspect, considering my second pregnancy was normal and OK, that for most people that's fine. But you get, you get the minority like me, who aren't fine and who need extra help and um, and then it's not really a job. You're doing – y- y – I thought 'how can they - how dare they see this as just a job! They're supposed to be here to make me feel safe and to make this OK and they're not doing that'.* (Elizabeth p 21)

Elizabeth would have really appreciated knowing her midwife and having continuity of care, particularly so that any problems could have been detected early. Kirkham (2000) recognises how continuity allows for the growth of a relationship that can foster trust and therefore allow the needs of the women to be met. The benefits of midwifery-led care (Hatem et al. 2009) and support during labour (Hodnett et al. 2012) are well established. It can be surmised that women who find connecting with strangers difficult and have issues with trust are even more likely to benefit from such models of care. Sue had a 'trusty midwife' for two of her pregnancies, but had heard from friends that continuity was lacking and this was a concern for her in contemplating another pregnancy. Knowing the midwife meant that:

> *they would know you and you haven't got to explain anything. I wasn't one to tell people anyway but if you were you haven't got to explain everything several times over.* (Sue p18)

Having a protector she could trust was very important:

> *Trust is a big thing. For you to know that that person is there for you. Because, let's face it, in my childhood no-one was there for me.* (Sue p19)

It is possible to establish trust without a long term relationship (Rouf 1999). Elizabeth had the experience she hoped for with her second child and, despite not having met her prior to labour, the midwife listened to her and took notice of what she wanted:

> *you just want somebody to take time, um and to think that you're important enough that they want to care…* (Elizabeth p13)

Participants needed midwives to be 'with woman' and had this in common with other women who have been abused:

> *I just wanted someone, if they couldn't wake me from this nightmare, to at least hold my hand through it.* (Skinner 2010 p181)

Time was often in short supply and the women, like those from other studies (Beake et al. 2010; Dykes 2005), were acutely aware of it and the stress under which midwives were working. Of all the women, Louise was most negative about the care she received and did not feel that her need for information, help and support had been met. Yet even she excused this by acknowledging that staff were busy. Despite the reputation of women with histories of sexual abuse being 'difficult' and 'demanding' (Grant 1992; Simkin 1992b; Skinner 2010; Tidy 1996) the women in my study were keen not to get in the way. I have already discussed how Sam and Elizabeth did not want to bother over-stretched midwives (section 7.4):

> *and you can see them buzzing around like bees, you know, they're here, they're there, they're all over the place. You can see that they're so stressed and you think … I don't really want to make it worse.* (Sam p19)

Baker et al. (2005) found that women in their study often mentioned lack of resources in connection with perceived unsupportive behaviour from the staff too. Sam uses particularly graphic language in relation to the times she felt unsupported on labour ward:

> *…my vision of the labour ward is like some big torture chamber, it is! It's like a dungeon! It's horrible! And everyone's stuck in the rooms, not knowing what's goin' on an' when someone's gonna come back an' it's quite scary 'n you can see that the midwives are so like, um snowed under it's really, really obvious 'n you don't wanna like be a pain.* (Sam p3)

This reflects language of imprisonment that is common to several of the accounts.

9.3 Containment

There were two diametrically opposed aspects to the issue of containment. In addition to language of imprisonment, there is related language of fortification that is present mostly in Jane's account. Sometimes women felt protected by the defences around them, but more usually they felt constrained by the maternity care environment. Sometimes there was actual physical restraint and sometimes not.

Participants in Palmer's study (2004) talked of the loss of their childhoods due to abuse and being imprisoned inside themselves as a result. Jane had:

> *shut away [her] sort of like vulnerable bits.* (Jane p6)

and describes herself as being 'very, very defended', by which she meant there was a 'separation between sensation and meaning' (Jane p6). I demonstrated in Chapter Six (section 6.3) the impact that this had on Jane in terms of emotional connection. Although this was a safety mechanism for her, it is also possible to construe this as imprisonment inside herself.

Some women specifically likened the maternity hospital to prison. Sam's language even in relation to discharge is reminiscent of probation:

> *I'll just be good, wait my time and hope they let me out soon. Um it's like – no, it's not nice, I mean I've never been in prison, but if, if it's like the hospital then I have many times (laughs) you know?* (Sam p8)

Likewise, Linda could not wait to get out:

> *But it did feel like a prison. Very much like a prison. And I had to behave, I had to stick by the rules, I had to do it their way, no deviation at all. And I couldn't wait to go!* (Linda p27)

The article on maternity care experiences by Baker et al. (2005) is entitled 'I felt as though I'd been in jail', so this image is not confined to women who have been sexually abused. Unfortunately as there is no elaboration in the article related to the title it is not possible to compare it with my study. However, it is easy to understand why women with histories of sexual abuse find it difficult being stuck in a bed enduring people 'doing things to them' that are not welcome, as described by several of the women in my study. This is also noted elsewhere (Smith 1998b; Waymire 1997). Having their legs placed in lithotomy poles and/or epidurals inserted compounded the issue for women. Sam had an epidural with her first baby and vowed she would never have another:

> *If I'm stuck on a bed, an' I can't get out, that is just like horrible it is, and then people coming in the room all the time and it, it triggers flashbacks.* (Sam p29)

Elizabeth struggled with the reality of one too:

> *…I had asked for an epidural, which did help with the pain, but then you're just on this bed and you can't move…* (Elizabeth p11)

Helen had an operation under spinal[17] anaesthetic in the postnatal period:

> *…it was very difficult because umm I'm lying in the middle of a room, on a bed, unable to move, can't get away.* (Helen p22)

Green et al. (1998) express surprise that women in their study were less likely to want epidurals if they had a 'high control score'. However the lack of control that accompanies lack of mobility seems a plausible explanation as to why that is the case.

Although common to several of the women, Sam talked about being trapped more than others. Even things that were done with good intention could be problematic – for instance locking the door on labour ward, which was presumably to ensure privacy:

> *and they lock the door as well, I can't get out! I'm locked in there, I'm like trapped! I am like a trapped animal then.* (Sam p32b)

One time on the postnatal ward she was next to a woman from a different background and found this very difficult. This led to resentment – especially as she had no one with whom she could share her feelings:

[17] A quick-acting local anaesthetic injected into the fluid that surrounds the spinal cord.

> *so when the people did come into the ward that could have helped me or I could have asked for help, by then they're the enemy and I'm like 'I can't stand any of you, I just wanna get out of here!' And again, that's sor…mak… that's where I get the sort of prison feeling from, of, you're put in with anyone, everyone…* (Sam p17)

For Sam, knowing that there was an escape route left her with 'some sense of self'. Without it she was anxious and stressed but nobody knew why and she was not able to tell them:

> *…society still does not like to swallow this sort of thing, they still wanna push it under the carpet, they still wanna make out that it doesn't happen…* (Sam p30)

The fact that childhood sexual abuse remains something that is unspeakable in society adds to the burden carried by those it affects.

9.4 Hidden issue

Three of the nine women interviewed indicated that their abuse had come out into the open before adulthood. Even so, it was not something those women spoke of freely. The perpetrator of Sally's abuse was caught and imprisoned yet she had not spoken of it in detail prior to my interview – even to her husband, although he was aware it had happened:

> *…because I thought, well, what's the point? What's the point - not even my sister or anybody. Just kept that … because what's it gonna solve, really, what is it gonna solve?* (Sally p30)

Although she believes that sexual abuse is more in the open now, it was not spoken about at the time she was having her children:

> *I never, ever discussed why or, or… you know, never went in to detail with what happened – because I didn't think it was appropriate. I didn't think it was – the right thing to do really, I suppose. It, it's within yourself.* (Sally p9)

The fact that it is 'within yourself' suggests that it is not society's problem and by implication the fault rests with the individual. Garratt (2011) provides several examples of where signs of abuse were missed or ignored. One of the participants in her study had gone from being a 'model student' to 'a poor achiever who regularly truanted from school' (Garratt 2011 p51). This woman was left wondering why nobody noticed. Similarly Mia reported a dramatic change at the time of her abuse. Her mother has told her that she was very clever until she was about nine years old (the age at which she was abused) but:

> *I was really naughty like afterwards, like really naughty and I think they're – you - they thought it was I was dyslexic.* (Mia p25)

Garratt (2011) recounts how another participant was left feeling culpable after she had attempted disclosure at school. The woman explained:

> *When I was eight at school, I did say once on the dinner table that my dad did things to me that I didn't like, and I was told by one of the teachers, 'We don't talk about those things at dinner'.* (Garratt 2011 p51)

Although not as explicit, Sam believes there were clues in her behaviour that were missed and that would lead to questions being asked now. One day, aged about ten, she was drawing with her friend:

> *…we drew a really graphic picture of a sex act, but we were really good sketchers, we could do stuff like that and my Mum um my friend's Mum found it and I ended up getting kicked out on to the street because it just looked like I was being really rude and like you know, not – it's not appropriate behaviour…* (Sam p10b)

Sam was blamed for something that she had not known was wrong and it is not surprising that she then felt the need to hide her abuse. She now realises that that was not clever:

> *but at the time I probably thought I was being really clever, because I didn't trust anyone, didn't wanna be hurt anymore. And also I was deadly (almost whispers 'deadly') embarrassed.* (Sam p52b)

It is ironic that despite the fact that childhood sexual abuse is such a 'horrible secret' (Sam p57b) the women often felt themselves to be 'marked out' (Garratt 2011 p52). In common with participants in Garratt's study, Sam worried that everyone must know what had happened to her:

> *I felt like I, I used to walk around like I had a placard – you know one of those sandwich boards on - like saying what had happened.* (Sam p53b)

Childhood sexual abuse remains a social taboo (Barlow & Birch 2004) and the women were very aware of it. Sam had to 'carry her abuse round' with her:

> *and hide it like it's some kind of horrible – well it is a horrible secret, but because society don't know how to deal with it…* (Sam p57b)

Consequently women were often worried about how they would be viewed if they divulged their history:

> *I thought that everyone would just hate me and think I was a terrible person and that I didn't deserve to have this baby.* (Elizabeth p3)

> *Absolutely – terrified that at some point, somebody was gonna find out, that I'd been abused and that they were going to put this label on me and watch me. And look out for the signs that I was somehow dodgy.* (Linda p2)

Some women had experienced reactions that confirmed their views:

> *I've had many times when I've really gone out on a limb and tried to talk to people and it is like vacant, really vacant looks or, or people just wanna run for the door and it's 'oh God, no, she's kind of a freak or she's weird or damaged goods'* (Sam p31)

Even those who should have been in a position to support the women had not known how to deal with disclosures:

> *I've had people like, like I dunno, a psychiatric nurse before, after I had my first son, an' I had postnatal depression, an' um I just told her some of the things that had happened in my life and she had to have a fag cos it did her head in…* (Sam p26)

> *even that counsellor – cos obviously what happened to me is quite horrific and I did start and I could tell that he thought actually this is quite – I could actually see that he thought it was quite bad…* (Mia p31)

Women then felt the need to protect others. Mia's response to her counsellor was to refrain from telling him anymore. Sam described her strategy when she felt that people might not be able to cope with what they were hearing:

> *so you like, don't wanna hurt them, because you know what the hurt inside is like and I don't wanna hurt them like that so I just like just let a little bit out, like a little tap and just see how it goes but if it doesn't go very well then I just knock it off.* (Sam p27)

One of the participants in Burian's (1995) study described a similar strategy. She would start with a little bit of information and if she felt comfortable with the way the person responded would give them more.

Linda talked of the 'elephant in the room' and would have liked the subject to have been in the open so that:

> *they* [healthcare professionals] *could've allayed my concerns, or at least, empathised with the fact that I was worried about it.* (Linda p4)

But the issue remained unspoken for Linda and others. Elizabeth did not disclose her abuse even after referral to the Perinatal Mental Health Team and it was eighteen months after her son was born that she was able to access the help required to address the cause of her problems. Mia saw the boys who had been present at her attack as she grew up – yet even the one who had been visibly upset by it did not ever mention it:

> *I've seen the boy since - cos he lived in my road – that pulled me away …. I know that he knows that's happened to me and it's just like really weird nobody's ever discussed it.* (Mia, p20)

There is evidence that the women felt the burden of the secret they were carrying as will be shown in the following section. However, even though

several of them indicated that they would have liked the issue to have been brought out into the open during their maternity care, few felt able to mention it. The fact that childhood sexual abuse remains a hidden issue makes disclosure very difficult.

9.5 Disclosure

As discussed in section 5.2, only three of the women disclosed their abuse to those looking after them in pregnancy (although Elizabeth did mention it to the midwife who cared for her during her second labour and birth). This is a common finding. Only one of the participants in the studies by both Burian (1995) and Coles and Jones (2009) had felt able to disclose to healthcare providers and most of the women in Palmer's (2004) study had not disclosed. Nevertheless, 'telling' is clearly an extremely important issue to women in this study and others (Draucker & Martsolf 2008). It is far more complex than whether or not to divulge a history of childhood sexual abuse. Draucker and Martsolf (2008) recognise the complexity that surrounds disclosure and suggest that rather than being seen as a discrete event it is better understood as a series of complex interactions. This construction fits my interpretation of what the participants of this study experienced. It is important to note that disclosure is not a single event. For example, Sam had initially disclosed her abuse when she discovered that her step sisters were also being abused and her father was prosecuted and imprisoned as a result. However, Sam was one of the women who did not reveal her history to her maternity care providers. Helen told the two midwives who shared her antenatal care about her abuse, but did not want it recorded in her medical records for all to see.

The woman's sense of self, her ability to relate to others and the socio-cultural context within which she is living all converge in relation to disclosure. There are two competing elements with which the women have to contend in relation to it. One is a desperate need to keep the secret of their childhood sexual abuse hidden from healthcare professionals for fear of what they will think (Garratt 2011) and the other is a desire to share it so that staff can understand how difficult the experiences are for the women. The fact that childhood

sexual abuse is associated with shame and secrecy (Draucker & Martsolf 2008; Finkelhor & Browne 1985) creates an initial hurdle to disclosure:

> *I know lots of people that don't speak about this sort of stuff…because they are so fearful um of the repercussions of what this does to people…* (Sam p33)

> *I don't want to go around with a label on my head, letting everybody know' – it's a personal thing…* (Helen p20)

In Chapter Seven, I suggested that the women's narratives of self were greatly influenced by their childhood experiences. Palmer's work (2004) demonstrates the extent to which the abused child is carried within the adult woman. When the woman is least resilient, the need to protect that inner child is greatest. Disclosing abuse requires exposure of a very vulnerable part of themselves, which has a two-fold effect. Firstly the women fear disapproval:

> *if I reveal how damaged I am or what happened to me, then they will just look at me as a bad person, think that I can't cope and take my kids away and medicate me up to the eyeballs and that's not gonna help - y'know!* (Sam p55b)

> *I would have <u>died</u> if… the fear if she had known, what she'd have thought of me. I, I would have just been so ashamed.* (Linda p4)

Secondly, if they decide to tell, they need to be absolutely sure that they can trust the person with that information:

> *I just wanted people to know. I wanted somebody to know that it was awful but I wanted to know that that person was gonna support me and I didn't think anybody would.* (Elizabeth p3)

You, you've gotta be really careful like who you, who you say it to. (Mia p43)

Mia did not disclose to the first midwife she met:

…she was like one of those hard core, like old (laughing) style ones and so I didn't, I didn't say anything… (Mia p2)

But felt able to once she had tentatively explored related issues with someone she felt could cope with the information:

I didn't tell her straight away, but I was, I was basically saying to her that I needed to have a Caesarean and stuff and she sort of asked me why I thought I needed to have a Caesarean… (Mia p2)

It did not occur to some women that they should share the information:

I mean I never thought that anyone would take any notice of the fact that I'd been abused as a kid, um, you know, but may be now, with hindsight, I'm thinking maybe I should have said something to the people that were working with me but I dunno, it's like – it's so complex a thing in itself. It's like, how much do you say, how much do you not say, you don't wanna end up like making that person like really hate you or treat you in a funny way… (Sam p8)

But I would never have thought – ever to tell. Never. (Linda p4)

A major concern for the women was what would happen if they did reveal their history. As is implied by some of the quotations above, there was a real fear among some of the women that their children would be taken away from them and this was a fear they carried for years:

> *…if I told them this they might think that again – the abused becomes the abuser yeah? And that they would put me on, on – as soon as my kid would be on the 'at risk' register…but it's that fear of thinking 'they're just gonna think that I'm gonna be at risk and I'll be on the perinatal and before I know it I'll be dosed up to the eyeballs and my kid'll be whipped away'.* (Sam p46-47b)

> *it had got worse as time went on. That fear that at some point the school might find out or, you know, and social services would be involved and it, it's irrational in some ways, but it's there.* (Linda p2-3)

Linda suggested that:

> *… unless we can take away this awful cliché (huh) that the abused become the abusers. Then, I don't know if anybody will ever be really free of fear enough to talk.* (Linda p47)

The women who had disclosed had different views and experiences of how the information should be managed. Sue's GP knew of her history and offered to talk to the midwife:

> *So I, I didn't say anything to my midwife, but my doctor had actually said something any way. Um which was good, because I didn't feel as if I wanted to or could.* (Sue p1)

Her history was recorded in her medical records and when it was acknowledged, it was appreciated by Sue. However, Helen did not want her history recorded in her medical records. In common with women from other studies (Seng et al. 2002) confidentiality and control over what happened to the information were serious concerns for her and she was particularly worried about the implications of computerized records:

and let it be only the people who need to know. You know, it's not like Chinese Whispers. We don't want the whole – the whole – you know, you have this image that actually when a few people do know, you have an image of when you walk in that they all start looking at you and – you know. (Helen p56)

Heritage (1998) recognises women's need for control over what is written about them but feels that documentation of their history is helpful because it prevents women having to repeat disclosures. She advises reminding women of the confidentiality of their medical chart. However, this fails to address Helen's concern about being able to choose who to tell.

Even though the midwife who cared for Sue during her first two pregnancies knew about her abuse and was trusted by her, the issue still appears to have been shrouded in silence:

I couldn't tell this to the midwife – although she was aware of my situation, I couldn't tell her that. But I so desperately wanted her to know that – I don't like people touching my body at all – whether it be my shoulder, my arm, my stomach – anything. And I never got that through to her, in my first pregnancy. (Sue p1)

Childhood sexual abuse is not something that women feel able to talk about freely:

Um, the hardest thing was for me to say 'I need help and this is what's going on'. I couldn't, I couldn't do that. I needed to know that it was OK to um, to tell somebody. (Elizabeth p5)

I don't know if I would have actually said, because I – may be because – I mean maybe during my pregnancy, if they'd said you know, 'do you have any issues or ….' Maybe that might have… (Sally p34)

But it is nevertheless something they would have appreciated being addressed (Palmer 2004):

> *I think it should be taken a bit more like um – not seriously but may be just acknowledged, because no one ever asked me like you know, had I had anything in my past that could possibly make me more sensitive than I would be if I hadn't been like damaged or you know, used in that way. But it's finding the right words.* (Sam p9)

> *I hoped that somebody would just … just say one thing and make me think they actually will want to listen, and they'll want to understand and they'll want to help. And nobody, - nobody did…* (Elizabeth p5)

Women would not necessarily have responded to a direct question (Garratt 2002), but there was a desperate need for someone to notice what was unspoken and give voice to the silence:

> *But then it wasn't – I didn't discuss it through my antenatal and they knew that I was very shy. Um… you know my GP, um knew I was very shy…but never discussed – I just used to – I used to hide myself – all the time, it was horrible!* (Sally p33)

> *And nobody just came and said to me, nobody came and said 'Are you alright…. You know, is this what you expected it to be?' That, you know, that's the que… that's what – a question that I think it would be really – brave and really good to ask because I think … if somebody actually dared to say 'is it what you expected?' people might give an honest answer. But if people say 'Are you OK?' If they're like the, the natural response is to say 'yes, I'm fine.'* (Linda p27)

The women recognised that childhood sexual abuse is a difficult subject for staff to deal with too:

> *But it's broaching it … It takes a lot – I think it takes a lot … for a professional, for a midwife or whatever to ask, ask that question – or round about it because it's a very, very delicate area.* (Sally p34)

> *But I dunno, like a young midwife is not gonna be able to handle that kind of information, are they.* (Mia p42)

These views are corroborated by research evidence (Jackson & Fraser 2009) and are resonant in the professional narratives reported in the following chapter.

9.6 Summary

A consideration of the context of experience has revealed the importance of midwives being 'with woman' to act as protectors and advocates. Without this, and sometimes even despite it, the women felt confined by the context of maternity care. Even though this was distressing, women were not able to voice their concerns as childhood sexual abuse remains hidden in society and the women have learnt to keep silent about it. The women wanted their distress to be acknowledged but outright disclosure was often not an option. Healthcare professionals need to be attuned to what is not being said but they too are frequently working with constraints. The next chapter explores the professional narratives that relate to the women's experiences. Hearing the women's stories from the perspective of those who care for them provides further insight into the maternity care experiences of women who were sexually abused in childhood.

10. Chapter Ten: Narratives of maternity care professionals

10.1 Introduction

If 'stories' are produced through joint actions (Plummer 1995), an appreciation of the perspectives of the health professionals caring for women is required to explore fully the maternity care experiences of those who were sexually abused in childhood. The way that professionals interpret what is happening for the women will in turn affect the care they offer and the way women respond to it. I explored these perspectives through group and individual interviews with midwives and an obstetrician, in addition to examination of the maternity care records. As only three women had disclosed to healthcare professionals, confidentiality prevented any deliberate approach to those who actually cared for the women. However, in view of my aim to inform practice, the perspective of current practitioners is helpful. This chapter presents these data and demonstrates how professional narratives converged with or diverged from those of the women. The first part examines data from interviews with maternity care professionals. The second part considers the relationship between the records and the women's stories.

The seven midwives and one obstetrician who participated in interviews were self-selected and a very small proportion of those invited to attend. These data must therefore be interpreted with caution. The low response rate could be for a number of reasons. Midwives and doctors work under considerable time pressure and may not have felt able to commit to participation. The subject area is challenging and is not one that people are always comfortable discussing. It is also a hidden subject and although the introductory letters (Appendices 9 and 11) stated that experience working with women with a history of childhood sexual abuse was not required, those invited may have felt that they had nothing to contribute. The obstetrician who participated expressed surprise that her colleagues did not appear interested, but Rhodes and Hutchinson (1994) report that both midwives and an obstetrician

questioned how knowing about sexual abuse would change their management. The poor response rate may therefore reflect professional priorities.

As explained in Chapter 4 (section 4.6.2), vignettes derived from the interview data were employed to guide discussion (Appendix 15). All participants were aware of the focus of my research and may have been influenced by this. However they all acknowledged that scenarios presented were familiar. For example, with reference to the vignette of Mia in the birthing pool, one of the midwives felt 'it could be any woman' (Interview D, p1) and the obstetrician suggested that she would not 'associate it with anything untoward' as 'pain and exhaustion is a toxic combination' (Interview C, p6).

10.2 Organising the data

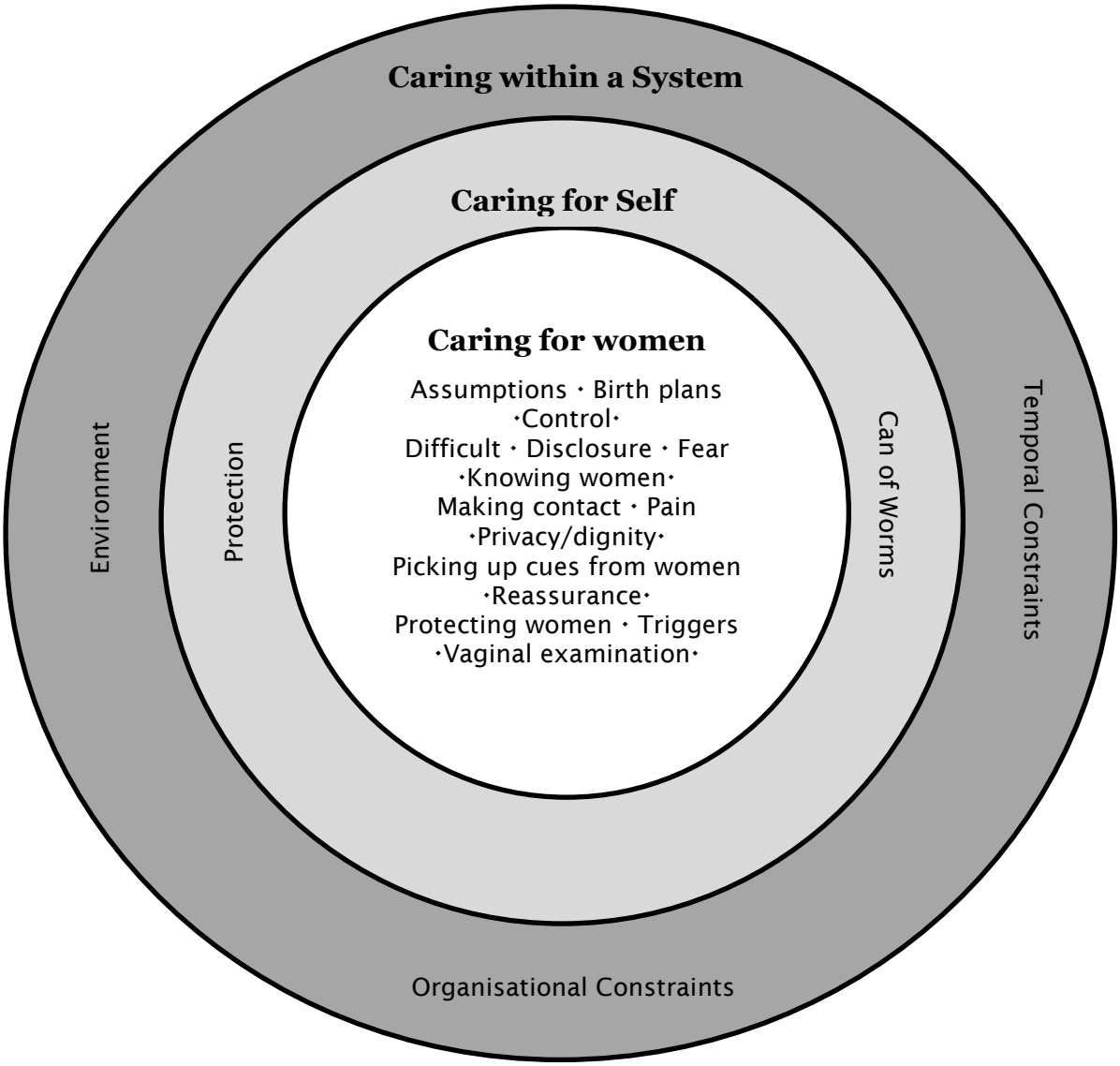
As demonstrated in Figure 10-1, most of the data from these narratives related to the care of women. However, this care was delivered within a system and the maternity care professionals found themselves caught between meeting the needs of the women and ensuring that they were delivering an efficient service. They articulated challenges in caring for women where a traumatic history was either known or suspected and caring for themselves was therefore important in meeting the needs of both the women and the organisation.

Aspects of the data that particularly illuminated the professionals' perspectives on the women's narratives are discussed in the sections that follow. I refer to the four interviews by letter in the order in which they were conducted (e.g. the first interview is A).

10.3 Caring for women

I demonstrated in Chapter 9 (section 9.2) that women valued relationships formed with midwives. Knowing women well was viewed by professionals as important in interpreting their behaviour.

Figure 10-1 Narratives of professionals - conceptual representation



10.3.1 Knowing women

There was general agreement that awareness of the woman's history is helpful in caring for her:

> *When you walk in to something cold and you have no idea what the scenario is, it's very hard…* (Interview A, p4)

Two of the midwives interviewed were working within caseload-holding teams and others had done so. This system of care was seen as an advantage in getting to know women and forming relationships with them. Women who had experienced similar continuity were appreciative of it. Midwives discussed the challenge of forming relationships with women during time-limited clinic appointments – especially if there was lack of continuity in those clinics. They suggested that knowing the women assists recognition of changes in behaviour or reactions that are out of character. One midwife expressed her hope that women with problems in their history would be cared for by caseload-holding teams or that they would have been seen by a consultant midwife:

> *I would have hoped that if there was something in her past she'd either be being caseloaded by midwives - who knew, if it hadn't been written in the notes, or she'd seen a consultant midwife and there'd be a letter in the notes, not necessarily outlining what her past was, but outlining her concerns and how she wanted to be managed.* (Interview D, p2)

However this assumes that disclosure will have occurred, which is contrary to the evidence (Burian 1995; Cawson et al. 2000; Coles & Jones 2009; McGee et al. 2002; Palmer 2004). Without disclosure, midwives are reliant on picking up cues from women and correctly interpreting their meaning. The obstetrician stressed several times the importance of not making assumptions about a woman's behaviour:

> *So she could be very anxious because she feels very strongly about something and maybe feels she needs to argue her case against me because she assumes I'm of a different opinion or she may have had a previous traumatic birth or she may simply be anxious because she's not sure whether she's put enough money in the parking metre, and I think the important thing is just not to assume.* (Interview C, p1)

10.3.2 Picking up cues from women

Cues that were discussed were often not tangible, but reliant on a 'sixth sense' (Interview A, p10). Several participants mentioned awareness of unspoken issues:

> *…but I just sensed there was something else underlying there and I still don't know what the details are but all I could pick up it wasn't just about the clinical bits, the factual events…* (Interview C, p2)

> *I see lots of women who I think there's something else going on here and I'm not getting to the bottom of it.* (Interview B, p8)

Responses from women providing clues of 'another agenda' were reported (Interview C, p4), ranging from women not wanting to make a fuss to being hostile and angry. Displays of emotion that seem 'out of proportion to the factual events' (Interview C, p5) were also warning signs. One midwife described being alerted if one of her caseload persistently fails to keep appointments. At the other extreme, cause for concern is the woman who:

> *…is always phoning for an extra appointment. There never actually seems to be anything really wrong, but she needs to be seen by somebody'.* (Interview A, p11)

A midwife's suspicion may also be raised in connection with physical examinations. One midwife noted that a woman's body tensed during a 'birth talk' on mention of vaginal examination. Further discussion elicited that the woman 'was not good at smears'. This enabled the midwife to explain vaginal examinations in labour to her and discuss issues further. Another midwife suggested that if a European woman is hesitant about being touched or revealing her abdomen, she would explore any issues the woman might have earlier in pregnancy than would be her usual practice. This raises interesting questions about cultural cues. The same midwife had worked in an area with a

large Asian population and expected the reluctance of those women to bare their abdomens:

> *That's all to do with modesty. You didn't suspect that that had any other hidden meaning because that was just a very cultural behaviour….* (Interview A, p13)

As all the women in my study were white British, differences in 'cultural behaviour' could not be explored in this research.

Sometimes cues are more overt. Midwives talked of women who 'are up off the bed' if their labia are touched (Interview A, p5). Although discussing anticipated reactions to vaginal examinations was part of the way some midwives practised, it was recognised that for many women the issue would not have been explored prior to labour, as reported by Stewart (2005). In her exploration of experiences of vaginal examination in labour, Stewart talks of the 'verbal asepsis of vaginal examinations' (p592) in which midwives use euphemisms or abbreviations when referring to the genitalia and are rarely explicit about the process. One midwife in my study had been asked how she would 'get the ruler in there'. This midwife reports taking more care with the explanations she now provides about what will be involved in examinations and how dilatation is measured.

When considering Mia's scenario, one midwife said she wonders 'what's going on if women are like that' (Interview B, p4). Mia's behaviour is reminiscent of the 'fighting style' described by Rhodes and Hutchinson (1994). They suggest that this style is most likely to alert the care giver that 'something unusual is going on with this woman' (p216). They also suggest that if caught off guard, 'the care-giver may feel irritated and wonder if a melodrama is being staged for her benefit' (Rhodes & Hutchinson 1994 p216). Midwives in my study acknowledged that it is not easy caring for women exhibiting such behaviour. One admitted finding it scary too:

> *I can start feeling my anxiety levels rising when they get distressed. It's difficult watching someone who's flailing around and really upset and panicking. That's really hard to watch. And I feel like I've let them down in a way, by things getting like that.* (Interview B, p2)

This midwife described a situation in which a woman in her care became unresponsive after a vaginal examination. She initially felt fear because she thought the woman was fitting but this was followed by frustration when she realised that the woman 'had just taken herself away' (Interview B, p6).

Several midwives described strategies they used to 'get women back' and refocus on their labour. There was an awareness that women 'went away' but the assumption on the part of the healthcare professionals was that they needed to reconnect so that the women could regain control of their labours. There was no suggestion that 'going away' might be a woman's means of being in control. Strategies described were making eye contact, sensitive use of touch and talking to women quietly after a contraction. Rhodes and Hutchinson (1994) and Burian (1995) agree that keeping a woman grounded in her labour is the appropriate response. However, some women might find this difficult. For Sam, 'coming back' could be problematic:

> *So I have like a time lapse because I'm having to bring myself back to the - and to answer the questions and that is when it really messes up for me because I start to tense up my muscles and then, because I'm there, and it's hurting and it's like in the like sensitive parts of my body…* (Sam, p31b)

Palmer (2004) recognises that where dissociation is a coping strategy, 'staying in the present' may not be helpful and the work of Anderson (2000) suggests that entering an altered state of consciousness and 'letting go' may be an important part of any woman's labour.

There was recognition that judgement was needed as to whether touch was an appropriate strategy. In response to the scenario where Sam was being helped to change her clothes (Appendix 15), one midwife said that she would wonder why Sam did not want to be touched. However, she recognised that some women cope by withdrawing into themselves and that this behaviour does not necessarily signal abuse. Making contact with women was considered crucial in supporting them and this included both talking and touching.

> *Sometimes – obviously in this situation it may not have been right, but a hand on their arm just to stroke them – not to hold them or anything, but just, you know, some kind of contact or on shoulder to say 'you are OK, this is normal, tell me how you are feeling'. Just physical contact – does work.* (Interview A, p3)

This is the approach that Elizabeth really wanted but rarely found during her maternity care:

> *and that's all I wanted to hear, that I was normal and I was OK and this is fine and we're with you and we're staying with you and you're safe and you're OK and we're not leaving you…* (Elizabeth, p24)

While some women may find touch very difficult, particularly in relation to vaginal examinations, midwives had also experienced the opposite end of the spectrum. One recalled a woman for whom vaginal examinations appeared very easy. Aware of a history of abuse, the midwife had expected 'a lot of vaginismus[18] and things like that' but ended up thinking 'what's her problem?' (Interview D, p12). Midwives found women with no apparent inhibition 'disconcerting' and acknowledged that difficulties could go unheeded if women are 'flaccid and floppy' during vaginal examinations (Interview A, p5). Rhodes and Hutchinson (1994) suggest that women who submit like this to labour and display the 'surrendering' style' are often seen as 'good patients'. The women's narratives revealed their need for midwives to hear their hidden

[18] Spasm of the vaginal muscles.

messages but also their reluctance to speak out about their abuse. The issue of disclosure was raised by participants in all the interviews with professionals and the underlying assumption seemed to be that this was a desirable outcome.

10.3.3 Disclosure

Experience of disclosure was mixed among the professionals interviewed. One midwife expressed surprise at how few disclosures occurred despite open and non-directive questioning. Another had found that most of the women who had disclosed to her had done so at booking[19]. These women seemed to have come to terms with their abuse and to be very open about it. The obstetrician concurred and suggested that in her experience women who are ready to disclose to healthcare professionals have usually been through counselling. Seng et al. (2002) characterise such women as 'far along in recovery from trauma'. They seek 'collaborative allies' among healthcare providers to help avoid triggers for posttraumatic stress reactions in maternity care and facilitate posttraumatic growth.

The midwives all indicated that it is important to give women the opportunity to disclose. One recognised the need for women to retain control of the process and advocated 'inviting disclosure':

> *I'm inviting you to if you'd like to, because it's under your control as well, rather than 'I got it out of you'.* (Interview B, p11)

Control is important (section 1.7.1 and section 8.7), but one of the fears expressed by the women I interviewed was the lack of control over what would happen to the information once divulged. One midwife recalled a woman she cared for who:

[19] The first antenatal visit during which the woman's history is taken.

> *…was quite happy for people who needed to know, to know enough. What she didn't want was it all written on paper, photocopied and sent all round [the city].* (Interview D, p9)

This midwife had worked with several women who had disclosed abuse but had generally found out about it from the General Practitioner or a comment the woman had made. It was not something she asked at booking as it is 'not one of the set questions'. Another more junior midwife admitted struggling with the idea of asking direct questions and said that she 'felt nosey' but was getting better at it (Interview B, p9). Very few midwives in Jackson and Fraser's (2009) postal survey had dealt with a disclosure and only 15% of the 372 asked felt able to do so. Read et al. (2007), writing in the context of psychiatry, suggest that not being sure how to respond is one reason why clinicians do not ask the question.

One midwife recalled a recent full disclosure enabling plans to be put into place that she felt had prevented anything distressing happening to the woman. However, the experience of both Mia and Sue demonstrates that even with disclosure and sensitive care distress is not necessarily averted. There was recognition of lack of disclosure, that it does not happen willingly and that disclosures represent 'the tip of the iceberg' (Interview B, p8). One midwife reflected that 'you can't force women to disclose things' (Interview D, p13) and another recognised that if women deny a problem it is necessary to 'go from there' (Interview A, p7). A concern was that if women do not disclose, it is not possible to know how their maternity care may affect them for the rest of their lives. I would argue that this may be the case even following disclosure.

Tidy (1996) suggests the midwife's job is easier if the abuse is out in the open and this gives an inkling that the needs of the institution are a factor to be considered. At the end of their discussion, in debating what could be done to help women to disclose, the midwives from interview A began to question whether they actually wanted to ask the question:

Midwife 2*:* *But then do we want to ask the question and open up a can of worms [Interruption from Midwife 4 we don't want the answer] that has been dealt with? And have we got the facilities to help answer it if we do open a can of worms? (Murmured agreement from others)*

Midwife 1*:* *That is the question (laughs)*

Elsa*:* *It's a very big question!*

Midwife 2*:* *So out of Elsa's research… (Laughter)*

Midwife 4*:* *Do we have the time, the knowledge, the experience and the skills?*

Midwife 1*:* *Yes, that's what it's all about, those four things*

Midwife 2*:* *and the will.* (Interview A, p22)

These are key questions that arose in all the interviews with professionals and that were recognised as issues in the women's narratives too.

10.4 Caring within a system

Several authors have commented on the impact of 'the system' on the working practices of midwives. Garratt (2008 p121) describes her personal experience of 'serving the institution, not the women' and Baker et al. (2005) discuss the way midwives' day-to-day working is governed by the institutional context. In her ethnographic study of encounters between midwives and breast-feeding women, Dykes (2005) concludes that when midwives are working under pressure, there is a tendency for them to become institutionally orientated rather than woman-centred. Lack of time concerned midwives in this study who felt it sometimes prevented them truly focussing on women's needs.

10.4.1 Temporal constraints

There was recognition that women need time and reassurance to overcome their anxieties. Much of the discussion centred on the challenge of providing those things within clinic settings. It was agreed that the caseload-holding

midwives were more likely to be able to provide opportunities than those working in the consultant unit, but those working in Birth Centre settings also felt they were able to initiate conversations. For one midwife, booking women a slot at the end of a clinic was a strategy used to create more time. However lack of time to explore issues was generally berated and clinics were described as a 'conveyor belt':

> *They're in. they give their wee, they have their blood pressure checked, they have a quick feel [of their abdomen] and they're out.* (Interview A, p8)

Similar focus on routines and procedures has been noted in the postnatal environment (Dykes 2005). The result is that the needs of the women go unmet for fear of the 'can of worms' mentioned in two of the interviews:

> *Sometimes midwives are reluctant to ask questions that may give them an answer that they haven't got time to deal with.* (Interview A, p8)

Even if questions are asked, the challenge of being available to listen was also recognised:

> *It's one thing to ask the question but another to give vibes that you have time to hear the answer.* (Interview A, p9)

In common with other studies (Baker et al. 2005; Beake et al. 2010; Dykes 2005), the women in this study were aware of these pressures and were reluctant to be demanding of limited time (section 9.2). Women therefore risk disempowerment within the system and are not active participants in their care (Baker et al. 2005). Garratt (2011) argues that midwives are disempowered too. Stephens (2004) writes of the frustration that midwives feel when time pressures mean they offer a service that does not meet women's needs. The

midwives I interviewed articulated frustration at temporal and other constraints.

10.4.2 Organisational constraints

In her study on the 'emotion work' of midwives, Hunter (2005) discovered that senior midwives, in being responsible for delivering a universal service, were perceived by junior staff to be more 'with institution' than 'with woman'. This supports Kirkham's (2010) view that a successful service on an organisational level may mean fragmented care for the individual. The midwives in my study ranged from those with considerable managerial experience to relatively newly qualified staff. However, all of them intimated that they felt a tension between providing an efficient service, which requires a degree of standardisation, and meeting the individual needs of the women. One midwife put it like this:

> *The service, I suppose, wants them to get on and have a baby safely without causing too much fuss….* (Interview B, p4)

and in relation to women who are perceived as difficult to look after:

> *Their behaviour is throwing obstacles in the path of everyone who is trying to help them.* (Professional interview B, p4)

Kirkham (2012 p48) writes of midwives being 'painfully aware that the standardised response does not fit the individual' and this view was evident among the participants of my study.

As discussed above, lack of time within a busy clinic schedule was a key factor for all the healthcare professionals in this study. However concerns went beyond this. The midwives in Interview A felt that 'customer relations' were missing and that the service was run to meet the need of the medical profession rather than the women. The scenario of Sue anxiously sitting in a

consulting room waiting for the arrival of the doctor (Appendix 15) triggered their discussion about the environment both in the outpatient's department and on labour ward where the medical team discuss the 'case' outside the room before going in to meet the woman:

> *It's about taking the power away from the women for the convenience of the medical team.* (Interview A, p21)

Medical needs were perceived to be of higher priority than social needs. One midwife admitted that:

> *All I'm thinking of is 'oh God, what medical thing haven't I picked up on…'* (Professional interview B, p12)

She felt that there should be more emphasis on social aspects but:

> *I'm more likely to get into trouble for missing something medical! (Professional interview B, p12)*

Stephens expresses a similar sentiment:

> *Where medical dominance has promoted the taking of blood pressure and testing of urine over all else, midwives are caught in the middle, expected to carry out these rituals of antenatal care with all the time pressures of the modern maternity system which leaves them unable to move beyond this…* (Stephens 2004 p45)

Another midwife provided examples of individual needs appearing subordinate to 'rules' that have to be followed. She recounted caring for a woman who had 'pseudo fits and pseudo seizures' throughout the second stage of labour that

had been deemed 'all psychological'. Caring for this woman had been challenging and documenting the care contemporaneously proved difficult:

> *I got hauled up because my documentation, too much of it was written in retrospect. Very frustrated by that, because she was just so hard to look after.* (Interview D, p3)

She later described the care of a woman with a history of rape:

> *I had to really cajole her to let me listen in to the fetal heart and feel her stomach abdominally, to do the routine midwifery stuff…'*
> (Interview D, p6)

Hunter (2005) discusses the methods by which compliance is ensured within institutional settings - particularly among students and junior midwives. Although the midwife providing the examples above was not junior, there is a definite sense that she was doing what was expected for 'every woman' rather that what she believed was right for the individual. There was also nevertheless an awareness of professional accountability and fear of complaint or litigation. Another midwife felt that she was:

> *…almost twisting their arm to persuade them that we need to get this trace* [cardiotocograph[20]]*. We need to monitor the safety of your baby and you…* (Interview B, p4)

The interviews with healthcare professionals provided evidence that staff felt constrained by the context in which they work. They articulated the ideal of compassionate woman-centred care, but it appears that striving for it could sometimes prove uncomfortable for them when balancing other institutional demands. Kirkham (2000) suggests midwives want to feel safe in their work

[20] A simultaneous electronic recording of the fetal heart and uterine contractions.

and this inevitably means that professionals have to look after themselves in order to survive within the system.

10.5 Caring for self

The obstetrician remembered a 'typical door handle situation' where she had asked a woman a question as she was about to leave the clinic. The woman 'turned round, sat down and burst in to tears' (Interview C, p3). The doctor explained:

> *Having asked the question and provoked this response, I just didn't feel I could kind of cut her short.* (Interview C, p3)

She admitted:

> *I just didn't know how to put the lid back on.* (Interview C, p3)

She talked to the woman for about thirty minutes and then had to contend with an impatient healthcare assistant who wanted to show the next woman in and an irate registrar. She consequently learnt to 'become more careful about asking open questions'. Rhodes and Hutchinson (1994) encountered healthcare professionals who were unwilling to engage with the subject of sexual abuse:

> *I really don't have time to open this can of worms* (Rhodes & Hutchinson 1994 p219).

Elizabeth used the same image and recognised the work created for staff:

> *I thought people just don't want to get involved. Because it's opening up a whole can of worms and they're gonna have to - it's gonna create a lot, a lot of work for somebody, people, someone's … someone's not just gonna be able to open this and then walk away and say 'well that's it, we're done', it's gonna be a lot of work for somebody - to help me…* (Elizabeth p25)

Professionals may feel the need to maintain a certain distance between themselves and women in their care with suspected histories of abuse. Garratt (2011) identified the concept of 'professional dissociation' from the midwife participants of her study, which they employed to cope with the huge demands placed on them. Kirkham (2012) suggests there is a continuum of separation between midwives and mothers and categorises professional dissociation as a damaging way of coping at one end of the spectrum. At the other end is 'detachment' that allows space to open up response to women. She postulates that standardisation of care creates pressure towards the damaging end of the continuum. Likewise, Tilley (2000) suggests that regimented care, sometimes characteristic of labour wards, may protect staff rather than benefit clients. Difficulties faced by staff were evident in my interviews. In the context of looking after women on labour ward, one midwife explained:

> *The expectation is that you're going to get a lovely trace [cardiotocograph] with no loss of contact but if she's leaping around all over the place, that's going to be really hard to do.* (Interview B, p4)

Agreeing with her another midwife admitted to feeling very uncomfortable on the occasions she had had to document that her client did not feel able to allow auscultation of the fetal heart:

> *Just document it and cross your fingers!* (Interview B, p4)

Women who are out of control can be difficult to look after and it was suggested that assistance with caring for them is not always available. However, as noted by Kitzinger (1990 p38):

> *The good nurse or midwife is expected to cope and get on with the job while the good patient is supposed to play a compliant role in the smooth running of the institution.*

Tidy (1996) recognises how unnerving it can be for professionals when women have unexpected body memories. This was the midwife's experience caring for the woman who had 'taken herself away' (section 10.3.2):

> *I felt awful cos I thought 'God, it's something I've done, I've made her do that!'* (Interview B, p6)

This can make the midwife's job harder (Tidy 1996), a fact that was acknowledged by Elizabeth who sensed that professionals were distancing themselves from her:

> *and I, I could see that from everyone else looking in, I would be frightening, but I was frightened myself and I just thought I just need somebody, just one person to hold me and say 'this is OK and we're gonna make you better' and um, and everyone just pulled away and I could see it in their face that they thought 'too much for us to deal with' and we don't want to get involved'.* (Elizabeth p17)

Healthcare professionals may feel disturbed and at a loss as to how to respond to a woman's distress, leaving them feeling undermined in their professional role (Kitzinger 1990). Barlow and Birch (2004) are aware of the need for staff support and guidance but the work of Jackson and Fraser (2009) suggests that it is not yet available to many midwives.

In addition to the challenges of providing care for these women staff may face personal challenges (Barlow & Birch 2004; Heritage 1998; Smith 1998b). One of the midwives talked about the 'immense emotional toll' of looking after some women and described her perception of three different groups of midwives. The first group are those who are not mindful of abuse and who may 'choose to block that sort of thing out' (Interview D, p9). Others have:

> *dealt with their own thoughts and how they deal with themselves in situations like that…* (Interview D, p9)

These midwives constitute the second group. She believes the third group to be more vulnerable. This is to do with what is happening in their lives rather than how experienced they are as midwives. Kirkham (2000) draws parallels between the needs of midwives and of women and interestingly, the three groups described by the midwife are redolent of those described by Seng et al. (2002) among women suffering abuse-related post-traumatic stress (section 2.3).

The narratives of the healthcare professionals demonstrated cognisance of the issue of childhood sexual abuse and a keenness to provide women with sensitive care. The relationship between healthcare professionals and women was central to this care. However, in order to contribute to the efficient running of a stretched system and survive within it, they did not always invite the confidences they wanted to hear. The women's narratives suggested that they were aware of the pressures faced by staff and they tried not to increase demands on them. Women's needs were therefore sometimes subjugated to the needs of the organisation and their stories were neither voiced nor heard. This silencing of women's stories is also evident in the examination of their maternity care records.

10.6 Narratives in maternity care records

As discussed in section 3.4.1, it is accepted that there is no one correct telling of events, but that each telling represents a different point of view (Denzin & Lincoln 2005). The maternity care records tell part of the women's story as interpreted and recorded by the healthcare professionals with whom they came into contact during their childbirth journey. I argued in section 3.7 that these records can appropriately be described as 'narratives'. Comments made by some of the women suggested they believed the records would recount their labour and birth in detail. On several occasions women said to me 'you'll see from my notes….' This rarely occurred as the women expected, although as shown below, there is reasonable concurrence between Elizabeth and her midwife on one such occasion. For clarity, in the sections that follow I have presented extracts of the women's interview transcripts in italics and extracts from the maternity care records in boxes. The boxes are divided in two with my transcription on the left and an explanation of terms on the right. Square brackets in the transcription signify that I have noted an occurrence from the records without copying full details.

Approximately twelve and a half hours elapsed between the administration of prostaglandin gel to Elizabeth to induce her first labour and diagnosis of full dilatation. During that time she had ten vaginal examinations, four of which were performed in a ninety minute period in which it is documented that she was very distressed. Elizabeth's account is presented below:

> *…I mean during the labour and and the birth, um, you will see in my notes (Nervous laugh) that I did, I did scream at the midwifes. There was no um…I j… I felt like I wasn't involved in any of it. I felt like everyone was doing things around me and to me without even asking. Umm and one of the things I found really difficult was the internal examinations and I, I felt, I mean maybe I wasn't with it and may be they did ask, but I don't ever remember anyone saying 'we've got to do an internal examination, is that OK?' They just kept on doing it and d… and it felt like it was happening really, really regularly. And every time it really, really hurt and the last time they did it I li…I, I fe… I*

> *mean, I might, my memory might not be perfect, but I remember trying to kick the midwife and saying 'just get out of me, I've had enough, I've just had enough of it'. And she, she got really cross with me and she thought I was being really difficult, um and even then I thought 'well why do they think I'm reacting like this?* (Elizabeth p8)

Elizabeth believed that the midwife was very angry with her over this episode and she returned to it later in her interview:

> *I know she wrote it in my notes in red, so I know obviously she thought it was – a terrible thing that I'd said and um, she wasn't very pleased with me. But it wasn't even my – it wasn't conscious. It was just – it just came out.* (p31)

There was no evidence of red ink or any other form of emphasis in the notes, but rather a factual recounting of key events as perceived by the staff involved. This is demonstrated below in the relevant section from Elizabeth's records. As discussed in section 3.7, this type of reporting would be expected from the guidance on record keeping from professional bodies (Nursing and Midwifery Council 2009a).

Transcript	**Explanation**
04.40 one hour since last VE – for VE to see if fully dilated, 04.50 Elizabeth had consented for a VE but finding it very difficult to tolerate a VE at all and so I have waited until she is happy to have a VE if she wishes, FH 156bpm, CTG continues. 05.10 Elizabeth agreed to a VE again, but on performing this has shouted for me to 'get out' and leave her alone – VE not attempted again. S/B [midwife] who discussed the situation with the S. Reg. Plan – either to have VE at 06.00 or for Dr to VE now. Elizabeth to decide, 05.15 Elizabeth very distressed at the whole	VE – vaginal examination FH – fetal heart bpm – beats per minute CTG – cardiotocograph S/B – seen by

situation, she would like to Dr to come and see her and make a decision.	S.Reg – senior registrar

The expectation of women in relation to their records is interesting. The advent of 'Birth Afterthoughts' services[21] mean that women may become part of the 'audience' accessing the notes. Helen found Birth Afterthoughts a helpful process in enabling her to understand the perspective of the obstetrician following her traumatic birth.

> *…but as the time went on, things started to play on my mind. Why did this happen, why did they have to do so many internals, why, why did I bleed so much, why – just so many questions. Did I really have to go through that much pain? …. Um, so I did actually um, have a – one of the midwives come round here with the notes and everything and she went through the whole thing – which was really good. <u>Really good</u> because I could see it then from the doctors point of view as well as mine.* (Helen, p27)

Elizabeth's experience of the same service was less positive. At the end of her interview when I had stopped recording, she expressed anger over the lack of consent she experienced for her vaginal examinations. Neither she nor her husband recall permission being obtained. As far as Elizabeth is concerned, the fact that she discovered that consent had been recorded in her notes was another example of her own experience being invalidated. Garratt (2008 p94) recognises the difficulty that discovering such a contradiction can pose:

> *Women may emerge from a childbirth experience feeling devastated by it, only to find that their version of events conflicts totally with the 'official' account contained within their notes.*

[21] A service in which a woman can discuss her birth experience and go through her maternity care records with a midwife any time after the birth.

This raises questions about 'whose knowledge counts' (Stewart 2004) and is an example of the way women's voices may be absent from their own stories.

As discussed in section 3.7, the NMC expects that professionals will decide which aspects of care are relevant to the notes. This means that different people might provide slightly differing accounts of a woman's labour and birth. In the course of her American work on operation reports, Pettinari gained a sense that records are a 'fluid matrix of processes' (Pettinari 1988 p xiv) rather than concrete 'things'. She demonstrated the interpretive processes involved in translating what occurred in the operating theatre to the dictated account of the surgery and the final written report. She also showed how the style of reporting changed as the residents progressed through their training, with a shift in emphasis from process to findings. According to Garratt (2008), good records tend to be accepted as authoritative versions of a concrete 'truth'; they appear solid and unchanging and are therefore seen as reliable. Yet she provides an example of 'documentary poetic licence' on the part of a midwife participant who cared for a friend in labour and who 'listened in as minimally as she could' whilst indicating in the notes that she had done so every fifteen minutes (Garratt 2008 p238).

Records should therefore be seen as interpretations and one version of the truth. As with any narrative, it is important to know the context in which records were written. The different perspectives of the women and the healthcare professionals are demonstrated by a comparison of the two sets of accounts, examples of which are juxtaposed in the next section.

10.7 Defining moments in the women's narratives

Several of the women's narratives contain details of events that appear pivotal to their childbirth experiences and define their stories for me. It is clear from the way the women related these events that they had a significant impact on them at the time and in some cases for many years afterwards. Below I present extracts from the women's accounts, followed by what was written in the notes relating to the same events. I am not suggesting that direct comparison of the

two accounts is warranted as they were produced in different circumstances, for different purposes and at different times. The medical records detail the care given to the women and are meant to be contemporaneous and written chronologically as far as possible. The women gave retrospective accounts of their experiences and rarely did so in chronological order. (The exception was Helen who provided an almost chronological account of the events surrounding her pregnancy, labour and birth during the first half of her interview). Different emphasis and meaning may be ascribed to events recalled at a distance:

> *There is, of course, a complicated relationship between narrative, time and memory for we revise and edit the remembered past to square with our identities in the present.* (Riessman 2008 p8)

Several women had 'processed' their recollections through counselling or therapy and as discussed above, both Elizabeth and Helen had reviewed the records of their maternity care through the 'Birth Afterthoughts' service. Most of the women were not chronicling events – for example neither Elizabeth nor Sally mentioned antenatal admissions to hospital (for example for pain, decreased fetal movements, urinary tract infections) in their accounts. Nevertheless consideration of the differing perspectives provides some interesting insights.

Jane: Jane did not remember her abuse until after having her three children. Here, she is recounting her first labour. She had arrived at the hospital when her cervix was already fully dilated:

> *… the first sort of like connection if you like with any previous history was, was … when I was actually in second stage and the pain - and I just stopped breathing. I didn't stop breathing completely, I, you know in the sense that it was a medical emergency, but I, I could hear the midwife sort of saying 'Will you please breathe in!' because I had this tendency to sort of breath out and stop, under extreme stress, or, or*

pain, and I, and I could feel myself disappearing because I couldn't, I couldn't breathe in, even though she was asking me to… (Jane p1)

The midwife will have had little time to write notes until after the birth and it is not possible to ascertain how busy the ward was at the time, but the account in the records is brief and says nothing about Jane's reaction:

Transcript	**Explanation**
19.00 Admitted at full dilatation, spont. ruptured membranes, ceph visible 19.00 142R 19.10 NVD female infant.	Cervix fully dilated on admission to the ward. The membranes (waters) surrounding the baby had broken spontaneously. The baby's head could be seen. Fetal heart beating at 142 beats per minute. NVD - Normal vaginal delivery

Sue: Sue found her third labour and birth so traumatic that at the time of interview she could not contemplate having another baby, even though she would have loved a larger family. Having spent four hours on labour ward contracting strongly, she had been told that she was not in established labour and she should go home. Very distressed, she remained in hospital and eventually got in the birthing pool:

Anyway, they ran the pool and I got in the pool and as soon as I got in the pool my waters broke and the baby was in distress because the baby had poohed.

Elsa: *Mm*

Sue*: So then, there was suddenly this mad panic to get me out the pool and I couldn't bloomin' well move! And they were all pulling at me to get me out the pool and they were pulling me and it … and… and it*

was really weird because then they sort of shuffled me – I could hardly walk! And I don't know whether that was the Pethidine, or the gas and air I was still having or whether it was just in the late stages of that I couldn't walk. And um, so my husband said 'get up on to the bed' that was in the room and this one midwife said 'no, we've got to take her somewhere else' and that was it for me, they really were coming to get me, these people from my childhood who, who'd given me so many … things that I would happen to me in later life, sort of threats, it was all happening to me, it really was, all happening. Cos they were getting me out of the room and I was nearly naked and they were removing me from the room, so someone pulled a blanket off the bed and put it round me and took me down the corridor and there was about six people, I was leaning on all of them and as soon as I got in this other room, they said we've got the get the baby out and luckily I did feel the urge to push and, and she did come out and she was quite, I think she had been quite distressed for a while in there so … my husband couldn't cut the cord or anything and she was taken on to the resuscitation unit I think but um, it was just – the whole thing was just really, really, horrible. (Sue p10)

The notes, written in retrospect, say:

Transcript	**Explanation**
6.25 ?SROM ?urine. Sue reporting she needs to push. Wait to see what happens through next 2 contractions. Nothing obvious, decide to go to the pool 6.35 Transfer to pool room 6.45 FHHR contractions 3:10 strong and painful 6.50 Into the pool. [Obs recorded] SROM in the pool – fresh mec seen.	Fluid seen that may indicate that the membranes have ruptured spontaneously or is possibly urine. FHHR - fetal heart heard, beat regular. Experiencing contractions at a frequency of three in ten minutes. Obs – [my abbreviation here] –

Explained to Sue needs to get out of the pool. FHHR, transfer back to room. Paeds informed, resuscitaire in room.	observations e.g. temperature, pulse, respiration rate, blood pressure. Mec – meconium – the first bowel movement passed by a newborn. Can be a sign of distress if passed before birth. Paeds – paediatric doctors Resuscitaire – resuscitation unit for newborn babies.

Mia: When she was having her first baby, a vaginal examination triggered a flashback for Mia towards the end of the first stage of labour. This necessitated her transfer in from home to hospital so that she could have an epidural. She was accompanied by her husband and mother but her mother was unaware of her history:

> *I couldn't actually say anything, so I was in silence – my Mum was there, so I couldn't say anything about what w… I was feeling.* (Mia p5)

She spent time in the birthing pool while waiting for her epidural to be inserted.

> *So when I got to the, the hospital, they put me in a birthing pool, um, which – was fine, but it was basically they put me on my back, which is not good, if you, if you've been raped, you don't wanna be put in labour on your back either. Cos I was in pain, I kept lifting myself up and because my Mum, by this point they'd gone to get me an epidural cos luckily she [the midwife] knew and I think that if she hadn't 've known, they wouldn't have let me have an epidural.*
>
> Elsa*: Mm*

Mia: *Cos they would've thought that I was just kicking off really, for no reason. And um, but I know now, like when I was in that birthing pool, like the pain was just literally all the way through my body and I kept – and basically, they were like lifting me up and my husband and my Mum, because I was coming out of the water kept pushing me back down so it was making my head remind me of it cos they kept – they were pushing my shoulders…*

Elsa*: Mmm*

Mia*: down and they were forcing me down, so I felt like and I could see it all like happening, like his face and everything and so I needed to have an epidural.* (Mia p3)

The notes report:

Transcript	**Explanation**
No rooms available at present & anaesthetist in theatre. Explained this to Mia and she is very calm – breathing without screaming and not forcing the pushing. [Obs recorded]. 21.30 FH 145. Coping really well [mother and husband] coaching her well. Still asking for epidural.	FH – fetal heart

Sally: The extract from Sally's interview describes her second labour. Without the epidural she had first time round, she was finding labour tough and relentless:

They wanted me to – have a – they wanted a male medical student in and … I think I just said, I said I, I, I can't remember what I said to them… but I just didn't want the male medical student, I just didn't want him in. But the male medical student was still there. I'm trying

to think what happened…. Cos I just remember this – I mean, he was a nice enough guy, but I didn't want it!

Elsa*: Mm*

Sally*: I didn't want, you know – and because it was my second, I didn't sort of stop, you know,*

Elsa*: Yes*

Sally*: it was only – a very quick – well, six hour labour so it wasn't…*

Elsa*: Mm*

Sally*: And, but obviously I just did that under my own steam, um and that was awful. Just the thought of just … having – oh, just… and [my husband] took photographs again (laughs in exasperated fashion). But he didn't take the photographs so – obvious that time, but he, you know, you could see… I've still got photographs of the male student – in there*

Elsa*: Mm*

Sally*: You know, the medical student. But I don't underst… because you, because you're in that – you don't really know what's going on*

Elsa*: Mm*

Sally*: as you probably know yourself. You - when you're, when you're having a baby, you don't – you know, but you don't know. Because you're dealing with the pain, and you're dealing with other things … and I knew there was, I knew there was um … I knew, I knew, I knew*

the nur… I knew the mi… I think this is, I don't know, how can I say this… I knew the midwife was there, and I remember, my, I mean, my husband was there and there was this – I just remember this male s… m-m-male …. They asked me and then he was still there!

Elsa*: Mm. Even though you said no?*

Sally*: Yeah – he was still there and I couldn't get my head – but then I couldn't didn't know, I just wanted to get this baby out*

Elsa*: Mm*

Sally*: you know. But he, he delivered her. He delivered her and I was just so upset over it!* (Sally p5)

As shown below, the records say nothing about a medical student's presence and I could find no details of the accoucheur on the microfilm. However, even twenty six years after the event, the distress his presence caused Sally remains evident.

Transcript	**Explanation**
18.45 Admitted from home with a history of irregular contractions since 13.00. ?? RM becoming regular OA [observations, abdominal exam, urinalysis, CTG] VE see partogram (4-5cm) 19.20 Pethidine and sparine given 20.00 contracting 5:10 FH 134 regular, MP 96, 20.20 IVI set up because Hb low 20.45 contracting 5:10, FH 135 reg.	RM – ruptured membranes. OA – on admission CTG cardiotocograph VE – vaginal examination Partogram – a specialized chart for recording observations and progress in labour. Pethidine and sparine – drugs given for relief of pain and nausea. MP – maternal pulse

pushing 21.10 VE to assess see partogram (anterior lip) using entonox FH stable. 21.35 ceph visible, type 1 dips to 90. 21.45 normal delivery with perineal grazes.	IVI – intravenous infusion (a drip) set up [here] due to anaemia (Hb – haemoglobin), as a precaution in case of haemorrhage. VE – vaginal examination. Anterior lip –a small amount of the cervix can still be felt. Entonox – 'gas and air' used for pain relief. FH stable – fetal heart rate stable. Ceph visible – the baby's head can be seen. Perineal grazes – superficial damage to the skin between the vagina and anus sustained.

These accounts do not necessarily conflict with each other but the aspects selected for inclusion by staff are not aspects that the women emphasised. For example, the notes seldom mention the distress recounted by the women. However, as few staff had any awareness of the women's history they had no reference point from which to appreciate their perspectives. In exploring the mother-community midwife relationship, Wilkins (2000) suggests that the language of the professional does not articulate the women's experiences and that as a result women are alienated from their own experiences. The same appears to be true of the way women's childbirth experiences are recorded in their maternity care records.

10.8 Representations of truths

The differing perspectives of health care professionals and women therefore created very different 'stories'. This raises interesting questions as to the ways in which the accounts differ. There are many retrospective studies, mine included, that rely on the memory of events that have often occurred many

years before (Garratt 2008; Parratt 1994; Seng et al. 2002). This creates concern over recall bias. Comparing what women said when asked about their experiences of pregnancy and childbirth with what was recorded at the time by the healthcare professionals provides an opportunity to test the extent to which accounts correspond. As previously stated, women did not chronicle every detail of their journey through pregnancy and birth. Nevertheless, where facts are recorded both in the interviews and the notes there is generally a considerable degree of correlation between them – particularly in relation to timing. Talking of events that had occurred twenty years before the interview took place, Jane recalled that her first baby was born within thirty minutes of her arrival in hospital. The notes show the birth ten minutes after the time of admission was noted. Therefore at the most there is a discrepancy of twenty minutes but this may be largely accounted for by the time it took Jane to get to labour ward and in to the room and the subsequent arrival of the midwife. Some sixteen years after having her baby Linda was worried that she had 'probably got all my timings wrong'. But she continues:

> *I do remember thinking at quarter to eight I think it was, I was in the bath. And then I got scared, because I thought, if anything happens, I want to be in hospital.* (Linda p32)

Her husband called the midwife and was invited to take Linda in to the hospital. Her time of admission was recorded as 20.15. Linda recalls:

> *he was born about two in the morning – [the midwife] was with me 'til about three, four o'clock I went up to the ward.* (Linda p18)

The notes record the birth at 02.04 and Linda's admission to the postnatal ward at 04.20.

Although there is an hour's difference in the time Sue says she arrived on labour ward with her third baby and that recorded in the records, she remembers having a vaginal examination at 'about three o' clock in the

morning' and the midwife needing to get a second opinion about it. In the notes, the initial examination was recorded at 02.40 and the second opinion at 03.15. Even Louise, who felt that she had blocked out a lot of her experience, remembered giving birth at five past eleven – a ten minute difference from the medical records. As her baby was born unattended at home and an ambulance was called afterwards a slight discrepancy is not surprising. The biggest difference in timings between the women and the records occurred in relation to Mia's labour. She talked of her labour being:

> *…fine at the house, it was just that like – and it was fine once I'd had the drugs, it was just literally like that – I don't know how long it was, that half an hour, was bad.* (Mia p41)

Her records indicate that two and a half hours elapsed between the vaginal examination she had at home just prior to her transfer in to hospital and the siting of the epidural. Mia's labours had occurred no more than three years previously. Other women were recalling events that had happened over twenty years before. As reported by Simkin (1992a), memory lapses seemed to be few and more a matter of degree than substance. Furthermore, the fact that events were omitted from the women's accounts does not necessarily imply that they had forgotten them, but rather that they did not hold particular significance for them in the context of my study. Overall, the accounts suggest that women recall the events of their births very accurately. However occasional discrepancies and differences in emphasis raise questions as to which account is taken to reflect the 'truth'.

10.8.1 What is the 'truth'?

Simkin (1992a) suggests it could be argued that medical records provide the true account of what actually happened. This is a commonly held view, the assumption being that notes are objective and accurate (Hewson & Bennett 1987). An appreciation of medical records as 'narratives' belies this perception. However, Anderson (2000) maintains that women are socialised into believing that a professional's version of reality must be more accurate

than their own and the example provided below demonstrates the propensity of professionals not to trust the woman's account:

> *Doctor [reading case notes]: Ah, I see you've got a boy and a girl.*
>
> *Patient: No, two girls.*
>
> *Doctor: Really, are you sure? I thought it said… [checks in case notes] oh no, you're quite right, two girls.* (Oakley 1980 p41)

In their comparison of women's accounts versus medical records as potential sources of research data, Hewson and Bennett (1987) concluded that both are subject to variation from the actual events and that there is little evidence that medical records are more accurate. Simkin (1992a) supports this view and also notes the absence of psychological and emotional aspects within them. Aaslestad (2009) was interested in finding out how the patient is given a voice and made visible in medical files and concluded that there is little evidence of the person about whom the report was written. He observed that what is written in the notes is not a reflection of the patient's experience but rather that of the professionals on the ward. This is understandable as it could be argued the person writing the record will potentially be as much under scrutiny in the future as the person about whom it is written.

While for Riessman (2008) understanding meanings for individuals is often more important than verifying facts, communication of actual events is clearly of paramount importance in medical records. However, denial of the 'meaning', as demonstrated in section 10.7 above, denigrates the very real experiences lived by the women. According to Griffith et al. (2010 p127) 'If it is not in the notes it can be difficult to prove that it happened….' The converse is also true and this was addressed by one of the midwives in the interviews:

> *…you can be in a room with a woman, standing looking at the notes, ticking the boxes, writing the notes, not actually looking at the woman, not actually reading the woman, not actually caring for the woman –*

but it's written down, so you've given the care! (Professional interview D, p15)

Supporting this view, Hamersley and Atkinson (2007 p131) discuss the notion that records are 'tokens of the fact that relevant personnel went about their business competently and reasonably' rather than being literal accounts of what happened.

Riessman (2008 p186) contends that stories that diverge from established 'truth' can sometimes reveal 'silenced voices and subjugated knowledge'. The almost total absence of the women, their emotions and struggles from the accounts recorded in the maternity care records as demonstrated above is very evident. The women are therefore in danger of being written out of their own stories.

10.9 Summary

A woman's perception of her birthing experiences will influence her long-term psychological well-being (Smith 1998a). I have demonstrated in this chapter that these perceptions may not be congruent with those of the professionals providing the care. However, professional interpretations of how the woman is experiencing her birth could in turn affect the care she is offered. The health care professionals in this study seemed to be working from the premise that disclosure of abuse was desirable yet the overall experience was that disclosures were neither forthcoming from the women nor easy to elicit. Professionals were therefore reliant on a 'gut feeling' that the woman was struggling but at the same time were reluctant to provoke a response from women that they did not have the time, knowledge or skills to address. This mirrors the perception of the women who generally wanted their distress to be noticed but who could not always voice it. Caring for women who have been sexually abused can be challenging on both a professional and personal level and staff needed to look after themselves in order to continue to function within the system. Women were silenced as a result. I have argued that medical records can be defined as narratives with concomitant subjectivity and

relation to context. These narratives reflect the truths of those completing them as much as of the women they are about. Consequently women are absent from their own stories.

11. Chapter Eleven: Voicing the silence

11.1 Introduction

In the preceding chapters I recounted the women's narratives of their maternity care experiences, considered one 'official' version of the parts of those narratives recorded in their maternity care records and explored responses of maternity care professionals to aspects of the stories told. In my final chapter I draw together the threads of these narratives and propose that the concept of 'silence' unites them. Providing examples from my data, I reveal the extent of silence in the narratives and the implications of this for practice before drawing final conclusions.

11.2 Silence

I found silence in women's 'narratives of self' where they tried not to be noticed, faded into the background and 'fitted in' so as to appear 'normal'. Pretence and denial of their own needs was part of this silence for some and as discussed in section 8.3, followed patterns of childhood behaviour. For example, Sam had 'been good' so that she could be 'let out [of hospital] early' but the associated cost to herself was evident:

> *You know, I can do the humour and give y'know; I can be whatever you want me to be! <u>But I can't be myself</u>.* (Sam p48b)

Women's narratives of relationship demonstrated how hiding what was happening for them originated in part from beliefs instilled in childhood regarding their normality and worth. They reported feeling isolated, concerned over further betrayal of trust and feared being judged a 'bad person'. Silence therefore pervaded connections with others. Elizabeth 'couldn't tell anybody' how awful things were for her. Mia did not articulate her distress when held down in the birthing pool not only because her mother did not know her history but also because of flashbacks:

> *…even now, I can remember them like physically like - the force and not – you can't speak… and that's what it was like in that birthing pool – I couldn't actually talk.* (Mia p16)

Sam's I-poem describes what silence was like for her:

I might be anxious
I might be crying
I can't tell them what it's about

Elsewhere Sam talked of how her fear left her 'screaming inside', yet she portrayed the 'star patient' to those caring for her.

Despite often keeping silent, women also reported wanting to be heard during maternity care. 'They weren't listening to me' was a common complaint and women were upset by it. Having spent a night talking to a midwife, Elizabeth felt better until she discovered that decisions had then been taken behind her back:

> *Your voice is taken, what you want is not taken into consideration…* (Elizabeth p21)

Women frequently found encounters with hospital staff disempowering and the maternity care environment was not one in which they felt comfortable to speak out. Aware of how busy staff were, Elizabeth 'didn't want to ever bother them' and Sam decided that she was 'not gonna say anything'. Discussing women's reluctance to ask anything of midwives, Kirkham suggests that overstretched midwives may 'see little point in listening to women' (2010 p255). The maternity care professionals who participated in this study indicated their desire to listen but nevertheless their narratives tell of how they were reluctant to ask questions when they did not have time to hear the answer. Opening a 'can of worms' could create challenges in managing

workload and consequently they learnt to be 'careful about asking open questions'. The effect was to further silence the women.

Women's narratives of context demonstrated their appreciation of being able to form trusting relationships in the maternity care setting. As discussed in section 9.2 they welcomed kindnesses that indicated they were being heard and valued as individuals. Reflecting the experience of the women in this study, Kirkham (2010 p255) suggests that 'being heard validates and affirms us'. The opposite is also true and I have provided many instances of women feeling unheard and invalidated. In the following example Elizabeth had been told by the midwife that she should not be sleeping:

> *I was thinking, again completely invalidate everything that I feel - and actually, there is good reason I'm tired, because I've been up all night,…you just end up feeling stupid. I just felt, I shouldn't be feeling like this and huh and they tell you how you should be feeling…*
> (Elizabeth p24)

Women were fearful of divulging how they were really feeling and were therefore keeping a 'horrible secret' hidden from others. As discussed in section 9.4, because childhood sexual abuse is associated with shame and secrecy, it is an unspeakable issue. The negative reactions that Sam and Mia had experienced when they did talk of it to professionals reinforced their reluctance to speak. Fear that 'the abused becomes the abuser' also kept women silent lest they should be deemed 'somehow dodgy' and have their children removed from them.

The hidden nature of childhood sexual abuse and the resulting silences, created untold stories which obscured its impact from those providing care and consequently limited the support that could be offered. Elizabeth's mental

illness, Mia's intrapartum[22] transfer to hospital and Sam's decision to stop breastfeeding are examples.

11.2.1 Untold stories

Miller's (1998) differentiation between 'public', 'private' and 'personal' accounts is useful for considering the untold stories within the women's narratives. While maternity care records represent a public account of the women's childbearing experiences, private accounts are those shared with friends, family and in a few cases healthcare professionals. Behind these discourses there is a personal account which is often hidden. I was privileged to be offered a glimpse of some of these personal accounts. As discussed in section 6.2, Elizabeth was overwhelmed by frightening flashbacks and negative thoughts during pregnancy but felt unsupported:

> *…I suppose because I couldn't put in to words what I felt and what was happening, I couldn't um – nobody could really help me properly cos I couldn't explain…* (Elizabeth p1)

After making an attempt on her life, she was referred to the Perinatal Mental Health team and was transferred to a psychiatric mother and baby unit following her baby's birth. However she did not reveal her childhood history, from which she believed her condition stemmed, until eighteen months later when she entered therapy. Apart from the midwife who attended her second birth, no maternity care professionals knew of her history and it was not documented in her notes. Mia expected to give birth at home but began to doubt her ability to cope after a vaginal examination, during which the midwife produced a torch, triggered a flashback (section 8.5). Anyone seeking an explanation from the notes for her subsequent transfer to hospital would infer that the need for an epidural was the reason. As discussed in section 6.6, Sam gave up attempting to breastfeed her first baby after a few days. She described how:

[22] During labour.

> *Having a midwife like touching me there (indicates chest), was really probably worse than like the down below um examines, um because I dunno, that is even more of a sensitive area for me personally…* (Sam p5)

She found the 'help' she was offered to latch the baby distressing and in addition while breastfeeding she felt as though she was being controlled by someone else, which was difficult for her. The decision to stop was a big relief:

> *…almost as soon as I'd decided not to breast feed, to give up on it, it was like a massive weight was lifted off my shoulders and I could actually enjoy it an' an' like think 'Oh, I've just had a baby!* (Sam p6)

Women's mental health, intrapartum transfer from home to hospital and cessation of breastfeeding are topical issues in maternity care and I return to them in section 11.10. These women's stories remained untold during their childbirth experiences and although the woman's immediate concern was addressed in each example, the cause of their distress remained concealed. Narratives of the maternity care professionals implied that women's disclosure was desirable even though few had experienced it. One midwife said she would expect to see some indication in the medical records if there was a history of childhood sexual abuse. However, this occurred for only two of the nine women in my study. Women may not want these details to be documented. Helen, who was one of the few women to have disclosed her abuse to those caring for her, was adamant that it should not be written in her notes. The silence that surrounds childhood sexual abuse is one of the biggest challenges to surmount if maternity care professionals are to understand fully women's needs. Strategies for addressing the silence therefore require consideration.

11.3 Voicing the silence

The findings of my research confirm that those who were sexually abused in childhood are a 'hard to hear' group (Mitchell et al. 2006): they are reluctant to speak out, midwives are too busy to hear if they try and society is not ready to listen. The women wanted to be heard even though they were not always explicit about their true feelings and did not necessarily want to disclose:

> *I hoped that somebody would just … just say one thing and make me think they actually will want to listen… every time that I went to my midwife appointment I'd think 'oh please let her notice that something's not right and just ask that one small question and then I can get some help'* (Elizabeth p5)

This implies that healthcare providers must 'listen for the unspoken'; defined by Taylor et al. (1995), as listening when 'there is no voice or where [women] have silenced their experience or have simply not been heard' (p14). It entails picking up on cues like women asking for Caesarean sections for no apparent reason, as Mia did, or being alert to requests like Sally's for female members of staff. Some women will not be able to speak because their abuse is buried too deep. Writing about caring for victims of torture, Racine-Welch and Welch (2000) suggest that 'even silenced people tell part of their story to those who are acutely watchful' (p138) as was the case when Jane held her breath during crowning:

> *…even though I wouldn't allow - somewhere I wouldn't allow myself to make the cognitive connection, my body made the connection.* (Jane p14)

Caring for women in Jane's situation may mean reading the unspoken messages sent by the body and this is not easy if concerns cannot be articulated by either party. When cues provided by women are missed, there is a risk that traumatic experiences in clinical encounters pass 'undetected and unknown' (Coles & Jones 2009 p235). This circumstance was of concern to

midwives in my study yet seeking disclosure was acknowledged as difficult. One midwife wondered whether women were waiting to be asked and another speculated:

> *Is it like domestic violence – if we don't directly ask a woman she won't tell?* (Interview A p14)

There has been an expectation that midwives will screen all women for domestic violence since 2003 when the National Institute for Health and Clinical Excellence (NICE) published its first antenatal care guidance (National Institute for Clinical Excellence 2003). Although midwives were advised to provide an environment in which disclosure was possible, there was not the same emphasis on asking about sexual abuse. When I first embarked on this research, it seemed obvious to me that childhood sexual abuse and domestic abuse should be approached in a similar fashion and that all women should be asked about it. After listening to the women, my views have changed.

11.4 Should we ask the question?

Many authors support routine enquiry about experience of sexual abuse (Courtois & Courtois Riley 1992; Grant 1992; Grimstad & Schei 1999; Heritage 1998; Hobbins 2004; Leeners et al. 2006a; Leeners et al. 2006b; Seng & Petersen 1995). The main argument in favour of screening is that it will warn healthcare professionals of difficulties women may face and therefore facilitate provision of appropriate care (Aldcroft 2001; Seng & Petersen 1995). Seng et al. (2008) report that the vast majority of women who had been asked about abuse in their study were satisfied with the way the nurse had broached the subject. The implication was that screening was acceptable to women. This mirrors findings in relation to screening for domestic abuse (Bacchus et al. 2002). Not asking may perpetuate messages that childhood sexual abuse should not be discussed (Prescott 2002; Smith 1998c). However the situation is complex, as demonstrated by the women in this study (section 9.5). In contrast to the findings of Seng et al., Leeners et al. (2006b) found evidence in their review that 97% of women had experienced negative reactions to

disclosure such as silence, shock or doubt about either the veracity or the relevance of the disclosure. Sam and Mia reported similar experiences. Seng et al. (2008) warn that a question may elicit a negative response even if there is a history of abuse. They report that clinical screening only identified 26.5% of the women who had been identified in a research setting. It is well established that most women do not disclose to healthcare professionals (Burian 1995; Coles & Jones 2009; McGee et al. 2002; Palmer 2004; Radford et al. 2011) and it seems that routine enquiry will not alter that. The need to trust the person to whom the disclosure is given, lack of confidence that disclosure will be treated with sensitivity, concern over confidentiality and spread of the information to more than those who need to know, fear of judgement and the repercussions of disclosure were all barriers mentioned by women in my study. Those who cannot remember their abuse will inevitably deny a history yet may be adversely affected by it during pregnancy and birth. Leeners et al. (2010) found that 40% of their sample, drawn from a German society providing care for sexually abused women, had not remembered their abuse at the time of their pregnancies. Sexually abused women were at higher risk of pregnancy complications than their matched non-abused counterparts but there was little difference between those who remembered and those who did not (Leeners et al. 2010). Disclosure to trusted midwives who provided sensitive care did not prevent Mia and Sue finding aspects of their childbirth experiences traumatic. Elizabeth was overwhelmed by flashbacks from the beginning of her pregnancy that she struggled to understand and it was a long time before she linked them to her history. It is therefore questionable how helpful universal screening would be. If the question is asked and a negative response is given, healthcare professionals may be less attuned to behaviour that signifies a problem. Kitzinger (1997) is concerned about the intrusion of asking and Tidy (1996) discusses the importance of disclosure being initiated by the woman rather than the caregiver.

Howarth (1995) finds the idea of screening at booking controversial due to unfamiliar surroundings, lack of rapport with the midwife and lack of privacy for those conducted in clinical settings. For Smith (1998c p39), the worst scenario would be for sexual abuse to be 'relegated to a tick box on a 'booking form'', although Mia suggested that she might have found disclosure easier if

she had been able to tick a box on a form. Smith (1998c) favours the indirect approach of signposting the services of a specialist midwife, but Helen said she would:

> *<u>hate</u> the idea of having an 'abuse midwife'. Because if you are going to that midwife, everybody knows you've been abused! That would be horrific!* (Helen p59)

None of the women in my study indicated a strong desire for screening, although, like the women in the study by Coles and Jones (2009), they would have appreciated healthcare professionals who 'opened the doors' to discussion. Seng & Petersen (1995) believe that asking the question communicates to the woman that she is not alone and that staff are open to knowing about her experience and its impact. This is an important message but it can be communicated by means other than direct screening, such as the 'Universal Precautions' recommended by Coles and Jones (2009). One of the women in Garratt's study (2011) had such a positive experience with her midwife that she did not believe that disclosing her abuse could have made her care any better. Garratt concludes that it is not necessary to know a woman's history to care for her sensitively. My current view is that open communication demonstrating a genuine interest in the woman is preferable to asking the question directly. This is more empowering for women because they retain choice and control over the sharing of their distress and/or history. It should not be necessary for a woman to lay open to scrutiny a very private part of herself in order to receive compassionate care. However, this creates a dilemma for staff who potentially will neither enquire nor be told about a woman's history. In Chapter Ten, I discussed the necessity of 'picking up cues' from women, which the midwives admitted often meant reliance on a 'sixth sense'. Given these challenges, the question remains as to how women with a history of childhood sexual abuse will be identified.

11.5 Identifying women with a history of childhood sexual abuse

Parratt (1994) suggests the majority of births from her study could be described as 'uneventful'. The same could be said for most of those in mine – especially if access to them is via accounts in the maternity care records. Fifteen of the twenty births from my study were unassisted vaginal births at term. Some of the women had a more complicated time: Louise experienced a pre-term emergency Caesarean section following an accident and Sam was transferred to a different unit for the pre-term birth of her fourth child following an antepartum haemorrhage[23]. Helen bled heavily after a forceps delivery, lost consciousness and on regaining it found herself surrounded by strangers, barely clothed. Any woman would be disturbed by events such as these. The evidence from this study and others (Garratt 2008; Parratt 1994) suggests that the majority of women with a history of childhood sexual abuse will have apparently normal, uncomplicated births. They will not therefore necessarily be distinguishable from other women during clinical encounters and Kitzinger (1997) cautions against identifying them as a discrete group with 'special needs'. Nevertheless, as the purpose of this study is to inform practice about the maternity care experiences of those with histories of childhood sexual abuse, a consideration of what women want and whether that differs between those who have been abused and those who have not, warrants consideration.

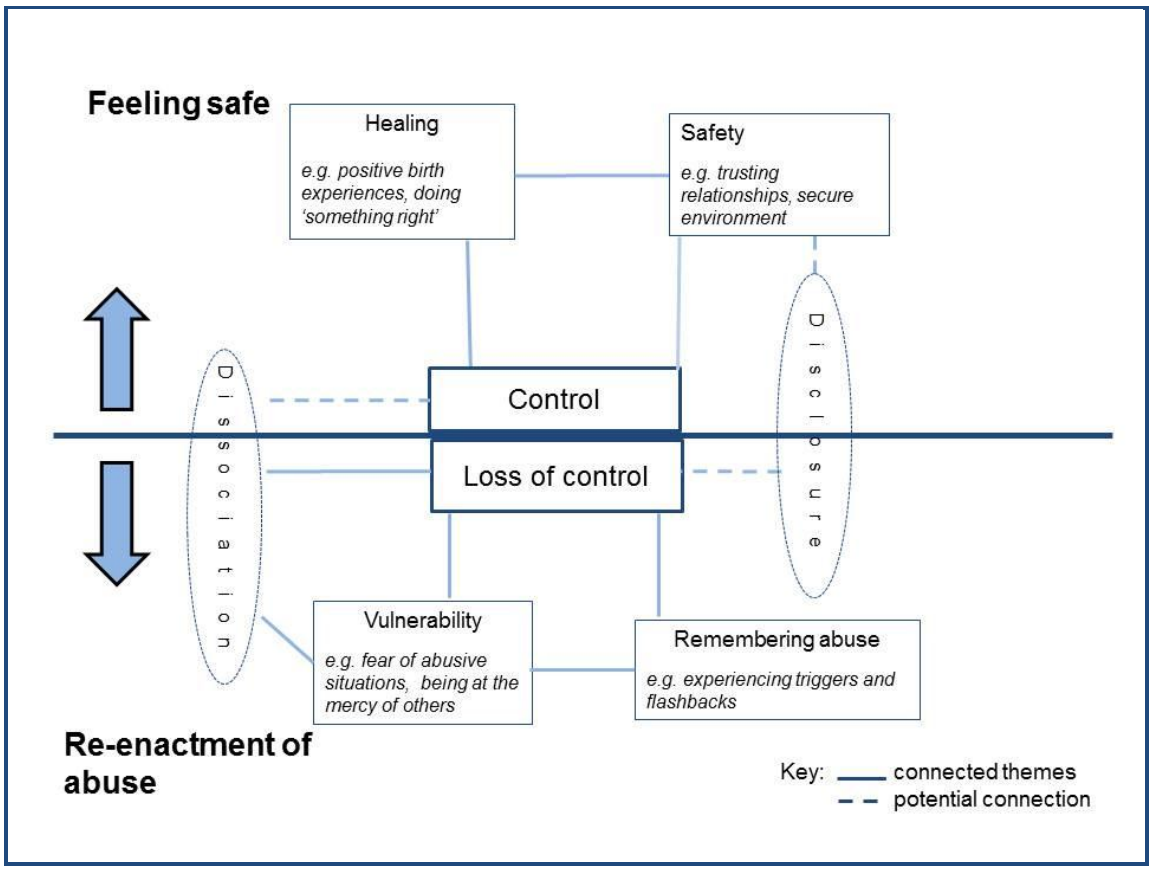
11.6 What do women want?

In Chapter One (section 1.7), I presented evidence of the importance of control for women's experience of birth and subsequent emotional wellbeing and I showed in Chapter Two that it was a pre-eminent theme in studies of women who have been sexually abused in childhood. It also emerged as an important concept in my data. O'Hare and Fallon (2011) argue that the basis of control is 'knowing': the woman must know herself (internal control), know others (external control), and know 'why'. In this tripartite construction there are

[23] Bleeding from the birth canal after 24 weeks of pregnancy but before the baby is born.

echoes of the narratives of self, relationship and context I used to present the accounts women shared with me. I have suggested that 'feeling safe' is a useful metaphor for what women want during their childbirth experiences (section 2.3). This was upheld by my data and control was critical to this, as shown in Figure 11-1. The bold line horizontally bisecting the figure marks the boundary of control. Above it are themes which may promote feeling safe and below are those which may produce the opposite feelings.

Figure 11-1 'Feeling safe': A conceptual framework



Physical safety has been a strong discourse in relation to place of birth and the need for technologies available in hospitals, but has not always served to empower women (Kirkham 2000). Walsh et al. (2004) describe 'psychological safety' - women's desire for kindness, information and support and Walsh (2006 p236) argues that psychological safety 'seems to combine environmental and relational aspects of labour and birth in securing a safe,

protective and nurturing setting…'. This type of safety was important to the women in my study:

> *…it was warm and it was safe and it was dark and there wasn't people staring at me and um I did it exactly how I wanted to do it.* (Elizabeth p23)

However, for women with a history of childhood sexual abuse, 'safety' also means not being reminded of their abuse (Figure 11-1). When women lose control they feel vulnerable and may be reminded of abusive situations. Disclosure can lead to loss of control over what women consider to be 'a personal thing'. Even though disclosure to a trusted midwife can be helpful, the experiences of Mia and Sue demonstrate that it does not provide immunity against being reminded of abuse during childbirth. Dissociation may be used as a mechanism to retain control but is more commonly a means of escape in the face of trauma. Although not mentioned by all of the women in this study, it was part of the narratives of Jane, Louise, Mia and Sam and is a common theme in the literature (Burian 1995; Coles & Jones 2009; Garratt 2011; Lasiuk 2007; Palmer 2004; Parratt 1994; Rhodes & Hutchinson 1994; Seng et al. 2002). As the following section demonstrates, dissociation also contributes to the silence surrounding childhood sexual abuse.

11.6.1 Dissociation

Astbury (1996) suggests that dissociation can be interpreted as 'the psychological defense [sic] that symbolises the victim's attempt to escape overwhelming experience' (p180). Dissociation is a major theme in Garratt's work (2011), taking several different forms ranging from long-term amnesia to a deliberate short-term protective mechanism. The various forms she describes are reflected in the stories I heard. Jane had not remembered her abuse at the time of her pregnancies and she spoke of how she:

> *psychologically defended [herself] by constantly repressing what had happened.* (Jane p7)

Despite her amnesia, the impact of childhood sexual abuse was evident in what Jane recounted, as discussed in the preceding chapters. It was, however hidden from Jane and those caring for her. Mirroring Jane's words, Rhodes and Hutchinson (1994) talk of how women are able to 'defend' themselves through dissociation. Louise, whose memory of the events surrounding the birth of her first baby was scant, appears to have 'defended' herself from events she found traumatic:

> *I was in that much shock, after, after having her, I just – I think I've blocked everythink out…* (Louise p5)

Dissociation was a feature of both the surrendering and retreating styles described by Rhodes and Hutchinson (1994). Women who 'surrender' may be seen as 'good patients' and may be eager to please. In some ways this reflects Sam's position:

> *…the midwife's going 'Oh, this is my star Mum' and stuff, but I wasn't, I was just being really good…* (Sam p41b)

But unlike Jane who was protected from her memories and Louise who blocked hers out, Sam was hiding what she actually felt:

> *I was hurting, I was not like doing really great, I'm not her star Mum. I'm absolutely terrified; I'm just doing what I've learnt to do.* (Sam p41b)

However Sam did 'retreat' on occasions, particularly when faced with unpleasant procedures:

> *Well, what I do um is I spot – I know it sounds a bit – a bit like a ballet dancer spots. I will like focus on like for example a picture on the wall…* (Sam p30b)

Dissociation was a strategy used when physical flight was not possible:

> *…because I can't run, and I can't fight or anything, I just flop. Y'know, I just like – I try to be like a dead fish or something.* (Sam p33b)

'Taking herself away' from the situation was one way Mia coped with what had happened to her as a child. Prior to having her children she had really enjoyed acting. Mia was one of the women for whom, in retrospect, giving birth had been a process of healing. It is interesting that psychological flight was no longer important to her having been through that experience:

> *I think I wanted to do that all the time because I wanted to put myself in being somebody else and now I'm not really interested in being somebody else.* (Mia p25)

Dissociation therefore hides the issue of childhood sexual abuse from those caring for women and sometimes even from the women themselves.

At the beginning of this thesis I asked 'what is the impact of having been sexually abused as a child on the maternity care experiences of the adult woman?' I have demonstrated that the answer is encapsulated in the notion of 'silence'. If women are to 'feel safe' maternity care professionals need to minimise the chances of re-enactment of abuse but silence intensifies the challenge.

11.7 Implications for practice

I embarked on this research envisaging that at its completion I would be able to identify helpful or unhelpful aspects of maternity care for women who were sexually abused in childhood that would guide professionals in the care in they offered. I have travelled a similar road to Garratt (2008), who reached the end of her study without her expected list of 'do's and don'ts'. I have learnt that

what is helpful or unhelpful depends on the woman, how she is at that particular time, her relationship with those providing care, their attitude and the context. This indicates the importance of individualised, woman-centred care. I do not therefore intend to make specific recommendations, which might suit one woman but not another, and which as Garratt (2011) implies risk becoming formulaic. Instead I have identified issues that are prevalent in the stories told and extrapolated some general implications for practice from these.

11.7.1 Professional awareness

Given the estimated prevalence discussed in section 1.5, it is likely that there will be women within maternity services every day who were sexually abused in childhood (Gutteridge 2009). Childhood sexual abuse remains a hidden issue despite its prevalence and its absence from documents that guide professionals compounds the situation. For example, it is not mentioned in the NICE guideline on 'pregnancy and complex social factors' (National Institute for Health and Clinical Excellence 2010), despite its relevance. Although there is limited 'research' to steer the development of guidelines, my study has corroborated existing evidence that childbirth can be traumatic for these women. Specific mention of women with a history of childhood sexual abuse is needed in such guidelines to raise the profile of the issue. It is also needed in NMC standards that guide and support delivery of pre-registration midwifery programmes (Nursing and Midwifery Council 2009b). This would ensure that curricula encompass it. As recommended by Jackson and Fraser (2009), inclusion in both pre-registration and post qualifying midwifery education is vital to raise professional awareness of the issue.

11.7.2 Discovering women's needs

Most of the women in this study were cared for by professionals who had no knowledge of their history and midwives reported receiving few disclosures. As discussed in section 11.4, I do not recommend routine screening for childhood sexual abuse. However, it is important that staff convey openness to discussion so that women realise it is an acceptable subject to broach.

Voicing the silence

Telling women that for some, pregnancy can trigger unexpected memories or feelings and that they are welcome to talk about it if it happens to them, may provide an opening if a woman wishes to talk. It is, however, of paramount importance that the woman retains control over if and when she discloses. Practise of indirect ways of approaching the subject was shared by midwives, including asking women about experience of cervical smears. This is a helpful strategy to facilitate discussions when approaching labour.

If women decide to disclose, it is crucial that they retain choice over what happens to the information, including whether or not it is documented in the notes and with whom it can be shared. If women are to avoid having to repeat disclosures, familiarisation with notes is imperative for staff caring for women they do not know. This was demonstrated by Sue. The following refers to the midwife who was called out to her for her third birth by which time her 'trusty midwife' was working elsewhere:

> *she said to me 'I've just been reading your notes and I can completely understand and if ever I do anything that … that …hurts you or you don't want' she said 'just give me a nod' she said and, and the way she said it was really nice… I just knew she was gonna be alright, and a good midwife.* (Sue p8)

The midwife's approach also helped to establish a trusting relationship.

11.7.3 Relationships with midwives

Trusting relationships, fostered by open communication are an important aspect of 'feeling safe'. Women in this study experienced many disempowering interactions with staff which left them feeling vulnerable. They wanted to be treated as individuals (Garratt 2011). Louise was unhappy at being 'treated like a number' and Elizabeth was distressed when those caring for her appeared to be doing 'their job and nothing more'. Signs that women would be taken seriously were appreciated and they wanted someone to listen. Habitual enquiry regarding women's welfare leaving genuine space to answer

is required ('how *are* you') (Seng et al. 2002). This avoids the immediate response of 'I'm fine' discussed in section 9.5.

Like Garratt (2011), I have shown that developing good relationships with midwives is important to women whose trust was betrayed in childhood and who frequently have low self-esteem (Finkelhor & Browne 1985). Although continuity of care is not essential for an affirming experience, I recommend it for women with a known history of abuse. Where available, caseload holding is a particularly suitable model enabling women and midwives to work together to promote 'safety'.

11.7.4 Promoting 'safety'

Gutteridge (2001 p315) suggests that service provision should be 'sensitive to the fragility of the unseen 'layers' that are part of every woman'. This indicates, as recommended by other researchers, (Coles & Jones 2009; Parratt 1994) the need for universal sensitivity. Healthcare professionals should approach all women mindful of potential hidden trauma. Compassion if women appear to struggle with something that makes no sense to the midwife and openness to the spoken and unspoken messages conveyed will demonstrate recognition of the woman's difficulties and provide validation for them. 'Compassionate care' is at the heart of the Chief Nursing Officer's vision (Cummings & Bennett 2012). Dignity and respect are key aspects. Women in this study often felt that dignity and respect were lacking and ways to rectify that are highlighted below.

The women had spent their childhoods lacking control over what happened to their bodies (section 8.7). Disempowerment in the birthing environment re-ignited those feelings. Some of the most distressing episodes for women occurred when control was taken from them. Leap (2012) urges consideration of who has the power in any given situation and its manifestation in modes of communication. When women are 'told off', unsure of what they are 'allowed to do' and left feeling 'stupid', it is clear who has the power. Berne (1964) identifies three 'ego states': Adult, Parent and Child. His work, written in

1950s America, portrays a view of women that is misplaced today. It is also reliant on Freud's theories which have been heavily criticised in feminist circles (Astbury 1996). Nevertheless these ideas may be useful for viewing interactions in healthcare settings (Hollins Martin 2011). The women's words reproduced above suggest that they are being sent messages from a 'Critical Parent' and receiving them as a 'Child'. It is not surprising that this learned response is distressing for women given their experiences as children. If they are to be empowered in their interactions with healthcare professionals and remain in control of what is done to them, rational Adult to Adult interactions are required. However, there are occasions when Parent to Child transactions are helpful. For example, Elizabeth's frightened 'Child' needed a 'Nurturing Parent' and found one in the kindness of a midwife:

> *I think most of the time I felt totally unsafe. I felt … I wanted to feel safe again, and I wanted – cos I felt so out of control, I felt my behaviour was out of control, my flashbacks and my memories were out of control – everything I did was out of control. And I, and I felt – very, very unsafe, very vulnerable. And I just wanted somebody – almost like that midwife at the end, when I was waiting to go to the [mother and baby unit] – she just held me really tight and that's what I kind of wanted all the way through – for someone to just hold me and say 'this is gonna be OK, we're gonna, we're gonna help you, we're gonna be with you and do this with you'.* (Elizabeth p21)

There were many aspects of maternity care that were difficult for women. Not surprisingly invasive procedures such as vaginal examinations could be traumatic. Women were more likely to be able to cope with these if they trusted those conducting them, retained an element of control and gave consent. Respect for the woman's bodily integrity is therefore essential, including during support offered with breast feeding. Current advice is that a 'hands off' approach should be used in helping women to feed (UNICEF UK Baby Friendly Initiative 2008). This is particularly desirable in relation to women who have been abused. Other less obviously intimate aspects of care were difficult too and were often unexpected by the women. Examples from my study include footsteps in the corridor, effects of Pethidine, help with

changing clothes, having a mouth swab taken and production of a torch during a vaginal examination. Garratt (2011 p189) suggests that 'the most useful guide to providing appropriate care for a woman with a history of abuse is the woman herself'. This is sound advice.

Without knowing the context for the woman, staff will not understand her response. Indeed, women might not even have a context for their own distress (Lasiuk 2007). Vigilance to cues of distress and a sensitive response is needed. The best course of action will vary from woman to woman and it is crucial, especially when women have a history of abuse, that decisions are made *with* the woman rather than *for* her (Stewart 2010). As demonstrated by the narratives of the professionals, caring for women whose responses are unexpected can be perplexing. Staff need support too. A midwife specialising in care for women with a history of sexual abuse may create unacceptable challenges to confidentiality (section 11.4). However, to assist healthcare professionals and benefit the care of women, I recommend that someone with specialist knowledge is available for support, consultation and training.

Finally, as demonstrated in sections 9.5 and 10.4.1 temporal constraints were a significant factor in perpetuating the women's silence as they were reluctant to speak and staff were reluctant to encourage them. NICE (National Institute for Health and Clinical Excellence 2010) recommends that there should be flexibility in the system to cater for longer and more frequent appointments for women with complex social needs if necessary. This should include women with histories of childhood sexual abuse.

11.8 Limitations of this study

This was necessarily a small-scale study based in one geographical area. Although the participants came from different socio-economic backgrounds, they were all white, British, heterosexual women and lack of diversity is therefore a limitation. The birth experiences of some women occurred many years before and although recall is not a major concern, the context of maternity care today is potentially very different. All the women in this study

had disclosed their abuse to someone, albeit not healthcare providers. It is possible their experiences are therefore different from those who have never disclosed. As sole researcher, I conducted and analysed all the interviews (with the support of my PhD supervisors). Some other studies using VCRM have done so within an interpretive community (Brown & Gilligan 1992; Doucet 2006; Mauthner 2002). Taylor et al. (1995) recognise the importance of such a community in asking 'who is listening'. Consideration of the narratives within an interpretive community could have alerted me to aspects of the stories I was not able hear. Attention to 'who is listening' has not so far been explicit in this thesis. With Plummer's (1995) tripartite model in mind I have considered the 'producer' and the 'audience' and now give consideration to my role as 'provoker' in the narrative process.

11.9 The narrative of the researcher

I have acknowledged my presence in the research process by writing in the first person throughout. As interviewer, transcriber and analyst, I was an active participant in production of the narratives (Riessman 2008), which are a consequence of the unique interactions between the participants and me. As implied in section 1.2, my path to this research was unexpected. I came to it as a white, middle class woman, with a professional background of lecturer, midwife and nurse. I was aware of childhood sexual abuse as an issue but was blinkered to its prevalence and impact. I had neither personal experience of it nor any specialist knowledge. The insights I have gained through this research are now manifest in my teaching. I also came to the study as a neophyte researcher. I had attended training courses on qualitative interviews[24] but had little experience of conducting them. Although I had chosen a non-hierarchical approach, I was aware of the power differential between the participants and me and was anxious about the interview appearing exploitative to them. On occasions I was drawn to reassure or console but did not want to intervene inappropriately during the recounting of difficult or painful events. A suitable balance between verbal and non-verbal encouragement, silence and interaction, was sometimes difficult to judge. Another interviewer might have

[24] Funded by a 'Midwife Award' from the Iolanthe Midwifery Trust.

made different judgements and elicited different narratives as a result. Women spoke freely to me. Some raised concerns over confidentiality prior to the interview but these were allayed by discussion of the processes in place. One of them, aware of CIS'ters' regard for confidentiality, felt that they must trust me to allow access to members and this reassured her. Given that I wanted the women to have freedom to tell their stories in their own way, I did not consider 'dialogue' during the interview appropriate. Nevertheless, reciprocity occurred in other ways. Sam indicated that talking to me was 'part of her healing'. Louise wanted to view her notes and I provided information about accessing records. Mia was contemplating pursuing prosecution and I informed her of an Independent Sexual Violence Advisor who might be able to help her.

I have scrutinised the accounts presented to me and have given careful consideration to perspectives of the maternity care professionals who potentially comprise part of the women's audience. In listening to the women, I have come to appreciate their courage in sharing their stories with me. In so doing they trusted me with a very personal part of themselves. Although they had control over what they recounted, they surrendered influence over what happened to it. I have shown that control is of paramount importance in enabling women to feel safe and loss of control may be reminiscent of their abuse (section 11.6). I felt enormous responsibility to be true to their accounts and to avoid betrayal of the trust they vested in me. However I was also alert to the problem of identifying too closely with them and therefore losing the detachment required to produce a creative space (Kirkham 2012).

The years I have spent on this study have also created my own narrative, which as 'co-producer' of the other narratives, merits exploration. I have gained experience as a researcher and learnt a huge amount in the process. My journey began with discomfort and bemusement. My initial response was that if all women were treated with dignity and respect, problems that the members of CIS'ters were describing could essentially be prevented. In many ways, as can be inferred from the preceding sections, I have come full circle but I have been irrevocably changed in the process. I also came to the research as a mother. My daughters were aged twelve and fifteen when I embarked on my PhD. I am relieved that they were not younger as I think my awareness of

childhood sexual abuse would have had considerable impact on their up-bringing. There is now always a question in the back of my mind when I watch interactions between young girls and older males, and that saddens me. Garratt (2008 p121) suggests that there will be 'no return to innocence' for her after her research but maybe for me this is better characterised as 'no return to naivety.' The fact that I did not see childhood sexual abuse does not mean that it did not happen. As demonstrated by my thesis, the silence and secrecy that surrounds the subject is a huge part of the continuing problem. Until society at large surmounts its discomfiture the problem will remain.

11.10 The need for further research

Many silences remain and need further exploration. There are women I was not able to reach whose experiences are important: those who have never disclosed, those who may have felt they had nothing to offer this particular study and those from other cultural backgrounds. Although childhood sexual abuse is recognised as an international problem (Pereda et al. 2009a), Corby (2006), highlights the importance of cultural context in both definitions of childhood and abuse. Practitioners frequently encounter women with different cultural norms. As mentioned in section 10.3.2, midwives sometimes interpret behaviour as 'cultural' in women from minority ethnic groups that might alert them to a possible history of abuse in Western women. Further investigation is needed into the cues and behaviour exhibited by women from other ethnicities who have experienced sexual abuse. In section 11.2.1, I referred to the untold stories of Elizabeth, Mia and Sam and alluded to their pertinence to current midwifery issues. The last three confidential enquiries into maternal death in the UK have identified psychiatric illness as a leading cause of death (Oates & Cantwell 2011). The recently published Birthplace National Cohort Study (Hollowell et al. 2011) found a transfer rate of 21% among the planned home birth group. The latest figures for the UK indicate that although 74% of women initiate breastfeeding, there is only a 46.9% prevalence rate by six to eight weeks (Department of Health 2012). An exploration of the untold stories behind these statistics could furnish the profession with valuable information to support women. Several of the women in this study spoke of the impact of

their childhood sexual abuse on partners. Their untold stories also warrant exploration.

11.11 Conclusion

My thesis began with the story of a woman who struggled to be heard and to maintain a sense of herself throughout her maternity care. Her experiences have frequently been mirrored in the stories told by the participants of this study. In Chapter One, I identified childhood sexual abuse as a hidden, international problem affecting approximately one in five women. Many of these women access maternity services without disclosing their history of abuse to the professionals providing their care. In Chapter Two, I reviewed the studies that have been conducted on the maternity care experiences of women who were sexually abused in childhood and found that the evidence base was limited. Chapters Three and Four detailed the narrative study from a feminist perspective I conducted to address the gap in the available evidence. I demonstrated how I produced the women's narratives in Chapter Five. Chapters Six to Nine explored their maternity care experiences via the overarching themes of the childbirth journey, narratives of self, relationship and context. Chapter Ten considered one 'official' version of the parts of those narratives recorded in their maternity care records and explored responses of maternity care professionals to aspects of the stories told. The methodological approach I took recognised the importance of listening. I listened to the women and in my final chapter I have shown that I heard silence. In recounting their narratives I have begun to voice that silence. The power and eloquence with which the women spoke radiates from the pages of this thesis. Women accessing maternity care are at very different stages of understanding and healing (Barlow & Birch 2004; Rhodes & Hutchinson 1994). This can be confusing for women and perplexing for those caring for them who are probably not aware of a history of abuse. As Burian says (1995 p252), it is not possible to change what has happened to these women but 'we can hear their voices, learn from them, and change the way we respond to them in our practice'. I have suggested ways that maternity care professionals can respond to them. Above all, if every woman was treated with dignity and respect, more may emerge from the experience feeling empowered rather than violated.

Having started with the words of a woman, it is fitting that I end in the same way:

> *…you never know where somebody is on their journey – it's not just the fact that there's lots of people that experience it, but you never know where people are in terms of their processing of it.* (Jane p19)

The challenge for those providing maternity care is to meet women wherever they are on their journey, to listen for their unspoken messages and to receive their spoken ones with sensitivity.

11.12 Postscript

Since completion of this thesis, allegations about the widespread involvement in childhood sexual abuse by Jimmy Savile, a well-known media personality in the UK, have come to public attention. The subsequent report, produced jointly by the Metropolitan Police Service (MPS) and NSPCC, is entitled 'Giving victims a voice' (Gray & Watt 2013). Confirming what I have found, it highlights the extent to which many people have kept childhood sexual abuse secret for decades. Echoing images from my study, Esther Rantzen referred to childhood sexual abuse as a 'prison of silence' during an interview for BBC News on the day the report was launched. Organisations such as the National Association for People Abused in Childhood (NAPAC), the NSPCC and Rape Crisis have reported a huge increase in calls to their helplines from people who have no connection to Jimmy Savile in the wake of the media attention. These events have been called a 'potential watershed' (Gray & Watt 2013 p23) as victims of non-recent abuse appear to be coming forward in confidence that they will be taken seriously. It remains to be seen whether those affected will still feel able to voice their silence once the media glare fades.

Appendices

Appendix 1 – Items for CIS'ters newsletters

UNIVERSITY LOGO

The maternity care experiences of women who were sexually abused as children - The MACaSA Study.

Nearly three years ago, CIS'ters came to talk to student midwives at the University of [redacted] for the first time. As their lecturer sitting in on the session, I was deeply affected by what I heard. Until that point, I would have said that as a midwife I had not looked after any survivors of childhood sexual abuse. Given the statistics that we were hearing about, it became increasingly clear to me that I must have done. I was really concerned to think that I may have inadvertently made childbirth a more traumatic experience than it could have been for the women in my care. The MACaSA study (Maternity After Childhood Sexual Abuse) has come about as a result, involving close collaboration between CIS'ters and the University.

Despite the fact that as many as 1 in 5 women have been sexually abused as children, there has not yet been any research in this country into their maternity care experiences. The purpose of this study is to find out how having been sexually abused as a child affects what it is like to have a baby as an adult. We believe that understanding this will begin to identify which aspects of maternity care are helpful and which are unhelpful for women in this situation. The overall aim is to improve the experience of having a baby for survivors.

The study has gained ethical approval from the [redacted] Research Ethics Committee (study reference number 08/H0504/57). There will be three parts to it: interviews with survivors, review of their maternity care notes (if they give permission) and focus groups with maternity care professionals. We are now looking for about 20 women who would be prepared to take part in the research. ***They must have had their baby in the [redacted] area.*** The interviews will take place between December 2008 and December 2009. If you, or someone you know, may be interested in taking part – or if you would simply like to find out more about it - please contact the CIS'ters office.

Elsa Montgomery
Lecturer in Midwifery
School of Health Sciences, [redacted]

UNIVERSITY LOGO

The maternity care experiences of women who were sexually abused as children - The MACaSA Study.

In the edition of the newsletter that was sent out last autumn, I wrote about the MACaSA study (Maternity After Childhood Sexual Abuse). I explained how it came about after I had invited CIS'ters to speak to student midwives at the University of [redacted]. Listening to the lecture, I was concerned that, due to lack of knowledge, midwives may inadvertently be making childbirth more traumatic than it need be for women who were sexually abused as children. I was surprised to discover that there had been no research in this country into maternity care experiences of survivors and decided, in collaboration with CIS'ters to do something about it. The purpose of the MACaSA study is therefore to find out how having been sexually abused as a child affects what it is like to have a baby as an adult. Understanding this will begin to identify which aspects of maternity care are helpful and which are unhelpful for women in this situation. The overall aim is to improve their experience of having a baby.

There are three parts to the research: interviews with survivors, review of their maternity care notes (if they give permission) and focus groups with maternity care professionals. The first two have already begun with people giving generously of their time and experiences. They have shared some very helpful information with me that I will eventually be able to feed back to groups like CIS'ters, to midwives and other health care professionals.

I would really value being able to talk to some more survivors and have allocated the rest of this year to do so. If you, or someone you know, has had a baby in the [redacted] area and may be interested in taking part – or if you would simply like to find out more about it - please contact the CIS'ters office.

Elsa Montgomery
Lecturer in Midwifery
School of Health Sciences, University of [redacted]

[redacted] Research Ethics Committee study reference number 08/H0504/57)

Appendix 2 – CIS'ters Flyer

UNIVERSITY LOGO

The MACaSA Study: Maternity After Childhood Sexual Abuse

An exploration of the maternity care experiences of women who were sexually abused as children.

Despite the fact that as many as 1 in 5 women have been sexually abused as children, there has not yet been any research in this country into their maternity care experiences. The MACaSA study aims to change that. The purpose of the study is to find out how having been sexually abused as a child affects what it was like to have a baby as an adult. We believe that understanding this will begin to identify which aspects of maternity care are helpful and which are unhelpful for women in this situation. The overall aim is to improve the experience of having a baby for women who were sexually abused as children.

CIS'ters has been working with Elsa Montgomery, who is a lecturer in midwifery at the University of [redacted], to design the study. We are looking for survivors who would be prepared to talk to Elsa about their maternity care experiences for the research.

If you are a survivor, have had a baby in the [redacted] area, are over 18 years of age and are interested in finding out more about the study, please contact the CIS'ters office. We will send you a pack explaining the research in more detail. Finding out about the study will not commit you to taking part if you decide not to take it further.

CIS'ters contact details:

Telephone: Gillian – [redacted]
Email: admin@cisters[redacted]

REC Reference: 08/H0504/57
PNMH team flyer
Version 1: 22-05-09

Appendix 3 – Flyer for Perinatal Mental Health Team

UNIVERSITY LOGO

The MACaSA Study: Maternity After Childhood Sexual Abuse

An exploration of the maternity care experiences of women who were sexually abused as children.

Sadly, childhood sexual abuse is very common. As many as 1 in 5 women may have been affected. We know that being pregnant and having a baby can be particularly difficult for women who were abused in childhood but despite this there has not yet been any research in this country into their maternity care experiences. The aim of the MACaSA study is to change that. The purpose of the study is to find out how having been sexually abused as a child affects what it is like to have a baby as an adult. The overall aim is to improve the experience of having a baby for women who were sexually abused as children. This research is being done as part of a PhD through the University of Southampton.

The research is being conducted by a midwife who lectures at the University of [redacted] She is looking for women who may be willing to talk to her as part of the study.

You could help if you

- Have had a baby in the [redacted] area (including [redacted] etc)
- Experienced sexual abuse as a child
- Are over 18 years of age and
- Are willing to talk about what being pregnant and having a baby was like for you

WOULD YOU LIKE TO FIND OUT MORE ABOUT THE RESEARCH?

If so, please hand the slip at the bottom of this flyer to a member of the Perinatal Mental Health team. They will then give you more details about the study. Getting this information will not commit you to taking part. It is up to you to decide. You do not have to tell anyone what you decide to do.

✂----------

The MACaSA Study

Please would you let me have more information about this study?

Name: _____

Address _____

Appendix 4 – Flyer for Rape Crisis

UNIVERSITY LOGO

The MACaSA Study: Maternity After Childhood Sexual Abuse

An exploration of the maternity care experiences of women who were sexually abused as children.

Despite the fact that as many as 1 in 5 women have been sexually abused as children, there has not yet been any research in this country into their maternity care experiences. The purpose of this study is to find out how having been sexually abused as a child affects what it is like to have a baby as an adult. I believe that understanding this will begin to identify which aspects of maternity care are helpful and which are unhelpful for women in this situation. The overall aim is to improve the experience of having a baby for women who were sexually abused as children. This research is being done as part of my PhD.

What will the research involve?

- **Interviews with women who were sexually abused as children**
- **Review of their maternity care records**
- **Focus groups with midwives and obstetric registrars**

Who is eligible to take part?

Any woman who

- **Has experienced maternity care through [redacted] Hospitals Trust**
- **Had some form of unwanted sexual exposure that began prior to their 16th birthday**
- **Is currently over 18 years of age**

However, due to the sensitive nature of the research, women should not be invited to take part if:

- **They find speaking or understanding English difficult – especially if they require an interpreter**
- **There is the potential for either personal or professional contact with me. In effect, this excludes midwifery students and women living in the [redacted] area**

I would really appreciate your help to recruit women. If you see a woman who you think would be prepared to take part in the study, please could you take a research pack from your office, write her name on the introductory letter and give the pack to her. If she would like to take part she should then return the reply slip to me in the stamped addressed envelope.

If you have any questions or for further details please contact: Elsa Montgomery, Lecturer in Midwifery, Email: [redacted] Tel: [redacted]

Appendix 5a - Introductory letter via CIS'ters

Direct dial: [redacted]
Email: [redacted]

Dear

I am a midwife and researcher and am writing to tell you about some research I am doing through the University of [redacted]. You have been given this letter because you are a member of CIS'ters who has had a baby in [redacted]. I would like to invite you to consider taking part in the study.

I am studying the maternity care experiences of women who as children had similar experiences to you – an area where so far there has been no research published in this country. If you decide to take part in the study, I would like to talk to you about your experiences and with your permission, look at your maternity care records. I have enclosed an information sheet that tells you more about the research and what it would involve for you.

I hope that reading this letter does not stir difficult memories for you. I know that some of the things that I would like to talk to you about might be painful. However I think that finding out about what having a baby was like for you is important. I believe it is a first step towards trying to ensure that the care midwives offer women is helpful and does not make things more difficult for them.

I have been working with CIS'ters in planning this research. In order to protect your confidentiality, I have asked Gillian to give these letters to women. It is important to me that you do not feel any pressure to take part. I do not know who has been given a letter and I will not know unless you choose to contact me. If you would like to find out more about the research, or are willing for me to contact you about it, please return the reply slip to me in the envelope provided. This will not commit you to taking part.

Thank you for taking the time to read this letter.

Yours sincerely

Elsa Montgomery
Lecturer in Midwifery

Appendix 5b – Introductory letter via Health Care Professionals

Direct dial: [redacted]
Email: [redacted]

Dear

I am a midwife and researcher and am writing to tell you about some research I am doing through the University of [redacted]. You have been given this letter because you have had a baby in the [redacted] area and have spoken to a health professional about experiences you had when you were a child. I would like to reassure you that no one has shared this information with me. I would like to invite you to consider taking part in the study.

I am studying the maternity care experiences of women who as children had similar experiences to you – an area where so far there has been no research published in this country. If you decide to take part in the study, I would like to talk to you about your experiences and with your permission, look at your maternity care records. I have enclosed an information sheet that tells you more about the research and what it would involve for you.

I hope that reading this letter does not stir difficult memories for you. I know that some of the things that I would like to talk to you about might be painful. However I think that finding out about what having a baby was like for you is important. I believe it is a first step towards trying to ensure that the care midwives offer women is helpful and does not make things more difficult for them.

I have been working with midwives from the [redacted] Hospital and many other health professionals in planning this research. In order to protect your confidentiality, I have asked them to pass on this letter if they know of anyone who may be willing to take part in the study. It is important to me that you do not feel any pressure to take part. I do not know who has been given a letter and I will not know unless you choose to contact me. If you would like to find out more about the research, or are willing for me to contact you about it, please return the reply slip to me in the envelope provided. This will not commit you to taking part.

Thank you for taking the time to read this letter.

Yours sincerely

Elsa Montgomery
Lecturer in Midwifery

The MACaSA Study (REC Reference: 08/H0504/57)
Version 2: 16-06-08
Introductory letter via RCC

Appendix 5c – Introductory letter via Rape Crisis

Direct dial: [redacted]
Email: [redacted]

Dear
I am a midwife and researcher and am writing to tell you about some research I am doing through the University of [redacted] You have been given this letter because your counsellor thought you might be interested in the study and you have had a baby in [redacted]. I would like to invite you to consider taking part in it.

I am studying the maternity care experiences of women who as children had similar experiences to you – an area where so far there has been no research published in this country. If you decide to take part in the study, I would like to talk to you about your experiences and with your permission, look at your maternity care records. I have enclosed an information sheet that tells you more about the research and what it would involve for you.

I hope that reading this letter does not stir difficult memories for you. I know that some of the things that I would like to talk to you about might be painful. However I think that finding out about what having a baby was like for you is important. I believe it is a first step towards trying to ensure that the care midwives offer women is helpful and does not make things more difficult for them.

I have been working with counsellors from the Rape Crisis Centre in planning this research. In order to protect your confidentiality, I have asked them to give these letters to women. It is important to me that you do not feel any pressure to take part. I do not know who has been given a letter and I will not know unless you choose to contact me. If you would like to find out more about the research, or are willing for me to contact you about it, please return the reply slip to me in the envelope provided. This will not commit you to taking part.

Thank you for taking the time to read this letter.

Yours sincerely

Elsa Montgomery
Lecturer in Midwifery

Appendix 6 – Reply Slip

UNIVERSITY LOGO

The MACaSA Study

Reply slip

I am willing to be contacted /have some questions I would like to ask about your research. I understand that being contacted does not commit me to taking part.

My name is: ……..….

The best way to contact me is:

☐Telephone. My number is ……...

If I cannot answer the phone I am happy for you to leave a message **YES/NO**
(Please note - I would identify myself by my name only if I left a message for you)

The most convenient time for you to call me is…….

☐Email. My email address is ……..

☐Other – please give details:

…….

……..

☐I would prefer to contact you and will call you on [redacted]

(Please note - If I can't answer the phone when you call, there is a password protected voicemail that only I can access. Please leave a message and I will get back to you – usually within 3-4 days)

Appendix 7 – Participant information sheet

UNIVERSITY LOGO

Information about the research

The MACaSA Study

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the research if you wish. Take time to decide whether or not you want to take part.

- Part 1 tells you the purpose of this study and what will happen to you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.

Please contact me if there is anything that is not clear or if you would like more information (telephone Elsa Montgomery on [redacted] or email [redacted]

Part 1

What is the purpose of the study?
Over 5000 women have babies in [redacted] each year. On the basis of surveys that have been done in this country and abroad, it is possible that up to 1000 of those had unwanted experiences in childhood that may affect them later in life. Despite this, there has not yet been any research in this country into the maternity care experiences of women in this situation. The purpose of this study is to find out how having had these experiences as a child affects what it is like to have a baby as an adult. We believe that understanding this will begin to identify which aspects of maternity care are helpful and which are unhelpful for women in this situation. The overall aim is to improve the experience of having a baby for these women. This research is being done as part of a PhD.

Why have I been invited?
All the women who are being asked if they would be willing to take part in the study have had a baby in the [redacted] area. Some are members of the support group CIS'ters, others have spoken to health care professionals or counsellors about experiences that they have had in the past that may be relevant. Because I do not want anyone to feel any pressure to take part and because your privacy is important, I have asked not to be told who has been given this information sheet.

Do I have to take part?
No, it is up to you to decide. If you would like more information before you make your decision please get in touch. If you think you would be willing to take part please return the reply slip to me and I will contact you. I will go through this information with you and ask you to sign a consent form to show that you have agreed to be part of the study. You are free to change your mind without giving a reason. The person who gave you this information sheet does not need to know whether you have decided to take part unless you choose to tell them.

What will happen to me if I take part?
After I receive your reply slip I will contact you - usually within 3-4 days. I will make sure that you have understood the information you have been given about the study and I will arrange to meet you at a time that is convenient to you. We will need to meet somewhere safe that we can talk with privacy, but you can choose the place. This may be for instance, at your home or the university. I will ask you to talk about what having a baby was like for you. I am keen to hear *your* experiences so there are no right or wrong answers. I will not ask you to talk about your childhood experiences. It is difficult to say exactly how long this will take, but it is likely to be about 1-2 hours. I would like to record our discussion by audio tape. I will ask you to choose a name by which you will be known for the research - your real name will not be used unless you particularly want it to be. I would like your permission to quote the words you have used in the reports of my research and if you are concerned about being recognised you may prefer not to allow me to do this.

I would also like your permission to look at your maternity care records – the notes that the midwives and doctors made when you were pregnant and having your baby. This is so that I can get gain as full a picture as possible of what having a baby was like for you. I will only do this if you give your consent.

What are the possible disadvantages and risks of taking part?
You may find it upsetting to talk about what having a baby was like for you – especially if it was a difficult time. You will be able to say that you do not wish to talk about a particular aspect of it or withdraw from the discussion at any time. I will give you details of sources of support you can contact if you do feel upset afterwards.

What are the possible benefits of taking part?
I cannot promise that the study will help *you* but I hope that the information will help improve maternity care for women in the future.

Will my taking part in the study be kept confidential?
Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2 of this information sheet. Nobody else will know that you have taken part in this study unless you choose to say. The only time that I would break your confidence is if you tell me that a child is currently at risk of harm.

What happens after our meeting?

I will contact you after our meeting to thank you for your participation in the study

What if there is a problem?
Any complaint about the way you have been dealt with during the study will be addressed. The details are included in Part 2 of this information sheet.

Thank you for taking time to read this sheet.

This completes Part 1 of the information sheet.
If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

UNIVERSITY LOGO

Information about the research

The MACaSA Project

Part 2

Will my taking part in the study be kept confidential?

All information which is collected from you during the research will be kept strictly confidential. If I look at your maternity care notes, I will not record your name, address, date of birth, baby's date of birth or hospital number so it will not be possible to recognise you.

How will you protect information about me?

The reply slip you send back to me will be kept in a locked cabinet in a locked office. A copy will be taken and put in a sealed envelope in another secure place. The name you have chosen for this study will never be stored with your real name or personal details.

I will personally transcribe and analyse the interview data. I will be overseen by my PhD supervisors. Interview recordings and transcripts will not include your real name. Once the study has ended, records of all your personal details will be destroyed. You will be given a choice as to what happens to the recording. Usual research practice is that it is stored securely at the university for 15 years. If you do not want this to happen, I will destroy the recording once my PhD is completely over. However, if I do that, one of my supervisors will need to listen to parts of it so that she can check that I have typed up what you said accurately. Transcripts will be kept for 15 years at the university in a locked place with limited access and will then be disposed of securely.

If you are willing to participate I will need you to give written consent to these arrangements.

Will my General Practitioner (GP) be told that I am taking part in this research?

No, I will not inform your GP that you have taken part in this research, unless you have specifically asked me to.

Who is organising this research?

This research forms part of a PhD and is being organised through the University of [redacted]. It has been developed in collaboration with senior midwifery managers at the [redacted] Hospital in [redacted] and CIS'ters. I have also been in contact with [redacted] Rape Crisis Centre and other health care professionals.

Who has reviewed the study?
All research involving the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights and dignity. This study has been reviewed by [redacted] Research Ethics Committee (B).

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to my supervisors at the university, Dr [redacted] or Dr [redacted]. If you remain unhappy and wish to complain formally, you can do this by writing a letter to the School's Research Director (School of Health Sciences, University of [redacted]. The letter should specify:

- the title of the research project
- the nature of the complaint

Further information and contact details

For any further information about the research contact:

Elsa Montgomery
Lecturer in Midwifery
School of Health Sciences
University of [redacted]
[redacted]

Telephone: [redacted]

Email: [redacted]

Appendix 8a - Guidance for recruiters – CIS'ters

UNIVERSITY LOGO

The MACaSA Study (Maternity after childhood sexual abuse)
Guidance for recruiters – CIS'ters

Thank you for your help with this research. The following guide provides you with some information about the study and what I am asking you to do.

Please contact me if there is anything that is not clear or if you would like more information (telephone Elsa Montgomery on [redacted] or email [redacted]

What is the purpose of the study?
Despite the fact that as many as 1 in 5 women have been sexually abused as children, there has not yet been any research in this country into their maternity care experiences. The purpose of this study is to find out how having been sexually abused as a child affects what it was like to have a baby as an adult. I believe that understanding this will begin to identify which aspects of maternity care are helpful and which are unhelpful for women in this situation. The overall aim is to improve the experience of having a baby for survivors. This research is being done as part of my PhD.

What will the research involve?
There will be three parts to the research: interviews with survivors, review of their maternity care notes and focus groups with maternity care professionals.

Why have I been asked to help?
This research has been developed in collaboration with CIS'ters and the group has given me permission to access potential participants. As a member of CIS'ters, I am asking you to help identify anyone who may be willing to take part. I am also hoping to recruit through health care professionals (for example midwives and health visitors) and [redacted] Rape Crisis Centre.

What are you asking me to do?
Please give a research pack to any woman you know who was sexually abused as a child, who has had a baby in the [redacted] area and who you think may be prepared to take part in the study.

This pack contains:

- An introductory letter
- A participant information sheet
- A reply slip
- A stamped addressed envelope for returning the reply slip.

Please could you add the woman's name to the top of the letter where I have left a blank space? I would be grateful if you would keep a record of how many packs you give out but I do not need to know who you have approached. Although, in order to prevent the women feeling under any pressure to take part, they do not need to tell you if they decide to participate, I will encourage them to so that you are aware of who may need extra support. If they need further information, or if they do decide to participate, they can either return the reply slip to me or contact me directly.

Who is eligible for inclusion in the study?
Anyone can be included who:

- Has experienced maternity care through [redacted] Hospitals Trust
- Had some form of unwanted sexual exposure that began prior to their 16th birthday
- Is currently over 18 years of age

However, due to the sensitive nature of the research, women should not be invited to take part if:

- They find speaking or understanding English difficult – especially if they require an interpreter.
- There is the potential for either personal or professional contact with me.

What will happen to women if they take part?
After I receive their reply slip I will contact them - usually within 3-4 days. I will make sure that they have understood the information they have been given about the study and I will arrange to meet them at a time of mutual convenience in a safe private location of the woman's choosing to conduct an in depth interview. This will cover their maternity care experiences and is likely to last 1-2 hours. The interviews will be audio-recorded and women will be asked to choose a pseudonym to help protect their identity.

I will also ask their permission to look at their maternity care records so that I can gain as full a picture as possible from different perspectives, of what pregnancy and childbirth was like for them.

The voluntary nature of taking part in the research will be stressed to the women and they will be able to withdraw if they change their mind – even part way through the interview. I will follow strict ethical and legal practice. All information will be handled in confidence and every effort will be made to protect the participant's identity.

Who is organising this research?
This research forms part of my PhD and is being organised through the University of [redacted]. It has been developed in collaboration with CIS'ters, midwifery managers at the [redacted] Hospital, and the [redacted] Rape Crisis Centre.

Who has reviewed the study?
This study has been reviewed by [redacted] Research Ethics Committee (B) and has gained a favourable opinion.

Further information.
For further information please contact Elsa Montgomery, Lecturer in Midwifery, University of [redacted].

Telephone: [redacted], email: [redacted]

Appendix 8b - Guidance for recruiters – Health Care Profs

UNIVERSITY LOGO

The MACaSA Study (Maternity after childhood sexual abuse)
Guidance for recruiters – Health Care Professionals

Thank you for your help with this research. The following guide provides you with some information about the study and what I am asking you to do.

Please contact me if there is anything that is not clear or if you would like more information (telephone Elsa Montgomery on [redacted] or email [redacted]

What is the purpose of the study?
Despite the fact that as many as 1 in 5 women have been sexually abused as children, there has not yet been any research in this country into their maternity care experiences. The purpose of this study is to find out how having been sexually abused as a child affects what it was like to have a baby as an adult. I believe that understanding this will begin to identify which aspects of maternity care are helpful and which are unhelpful for women in this situation. The overall aim is to improve the experience of having a baby for women who were sexually abused as children. This research is being done as part of my PhD.

What will the research involve?
There will be three parts to the research: interviews with women who were sexually abused as children, review of their maternity care notes and focus groups with midwives and obstetric registrars.

Why have I been asked to help?
I am asking you to help recruit women because you are a professional who may have had women in your care who have disclosed childhood sexual abuse. I am also hoping to recruit through other health care professionals, CIS'ters and [redacted] Rape Crisis Centre.

What are you asking me to do?
If you are aware of a woman who was sexually abused as a child, who has had a baby in the [redacted] area and who you think may be prepared to take part in the study, please give them a research pack. These packs should be not normally given out while maternity care is continuing. The women will not necessarily be people you are currently seeing, but they should be women you are able to see in person. It is important that they do not receive this pack in the post.

The pack contains:

- A leaflet outlining sources of support for your information.
- An introductory letter
- A participant information sheet
- A reply slip
- A stamped addressed envelope for returning the reply slip.

Please could you add the woman's name to the top of the letter where I have left a blank space? I would be grateful if you would keep a record of how many packs you give out on the form provided in the box. However, I do not need to know who you have approached and, to prevent the women feeling under any pressure to take part, they do not need to tell you whether or not they decide to participate. If they need further information, or if they do decide to participate, they can either return the reply slip to me or contact me directly. You will not be asked to be involved any more.

Who is eligible for inclusion in the study?
Anyone can be included who:

- Has experienced maternity care through [redacted] Hospitals Trust
- Had some form of unwanted sexual exposure that began prior to their 16th birthday.
- Is currently over 18 years of age

However, due to the sensitive nature of the research, women should not be invited to take part if:

- They find speaking or understanding English difficult – especially if they require an interpreter.
- There is the potential for either personal or professional contact with me. In effect this excludes student midwives and women living in the [redacted] area.

What will happen to women if they take part?
After I receive their reply slip I will contact them - usually within 3-4 days. I will make sure that they have understood the information they have been given about the study and I will arrange to meet them at a time of mutual convenience in a private location of the woman's choosing to conduct an in depth interview. This will cover their maternity care experiences and is likely to last 1-2 hours. I will not ask them about their childhood abuse. The interviews will be audio-recorded and women will be asked to choose a pseudonym to help protect their identity.

I will also ask their permission to look at their maternity care records so that I can gain as full a picture as possible from different perspectives, of what pregnancy and childbirth was like for them.

The voluntary nature of taking part in the research will be stressed to the women and they will be able to withdraw if they change their mind – even part way through the interview. I will follow strict ethical and legal practice. All information will be handled in confidence and every effort will be made to protect their identity.

Who is organising this research?
This research forms part of my PhD and is being organised through the University of [redacted]. It has been developed in collaboration with midwifery managers at the [redacted] Hospital, CIS'ters and the [redacted] Rape Crisis Centre. I have consulted with many other health care professionals too. Dr [redacted] (Consultant Midwife) is one of my supervisors.

Who has reviewed the study?
This study has been reviewed by [redacted] Research Ethics Committee (B) and has gained a favourable opinion.

Sources of support
The leaflet with the research pack is for your information. I will give the women one after the interview.

Further information.
For further information please contact Elsa Montgomery, Lecturer in Midwifery, University of [redacted]
Telephone: [redacted], email: [redacted]

Appendix 8c - Guidance for recruiters – Perinatal MH Team

UNIVERSITY LOGO

The MACaSA Study (Maternity after childhood sexual abuse)
Guidance for recruiters – Perinatal Mental Health Team

Thank you for your help with this research. The following guide provides you with some information about the study and what I am asking you to do.

Please contact me if there is anything that is not clear or if you would like more information (telephone Elsa Montgomery on [redacted] or email [redacted]

What is the purpose of the study?
Despite the fact that as many as 1 in 5 women have been sexually abused as children, there has not yet been any research in this country into their maternity care experiences. The purpose of this study is to find out how having been sexually abused as a child affects what it was like to have a baby as an adult. I believe that understanding this will begin to identify which aspects of maternity care are helpful and which are unhelpful for women in this situation. The overall aim is to improve the experience of having a baby for women who were sexually abused as children. This research is being done as part of my PhD.

What will the research involve?
There will be three parts to the research: interviews with women who were sexually abused as children, review of their maternity care notes and focus groups with midwives and obstetric registrars.

Why have I been asked to help?
The Perinatal Mental Health Team has expressed willingness to support recruitment to this study. It has been agreed that a flyer about the study will be included in the information that women are given on referral to the team. I would appreciate your help with making sure women are given these flyers and a research pack if they request one please.

What are you asking me to do?
Please could you make sure that a flyer is given to every woman who is referred to the Perinatal Mental Health Team? There is a reply slip on the bottom of the flyer that women will give to you if they are interested in taking part in the study. If you receive one of these please would you give the woman one of the research packs from the box in the office at [redacted].

The pack contains:

- A leaflet outlining sources of support for your information.
- An introductory letter
- A participant information sheet
- A reply slip
- A stamped addressed envelope for returning the reply slip.

Please could you add the woman's name to the top of the letter where I have left a blank space? I would be grateful if you would keep a record of how many packs you give out on the form provided in the box. However, I do not need to know who has been given them and, to prevent the women feeling under any pressure to take part, they do not need to tell you if they decide to participate. If they need further information, or if they do decide to participate, they can either return the reply slip to me or contact me directly. You will not be asked to be involved any more.

Who is eligible for inclusion in the study?
Anyone can be included who:

- Has experienced maternity care through [redacted] Hospitals Trust
- Had some form of unwanted sexual exposure that began prior to their 16th birthday.
- Is currently over 18 years of age

However, due to the sensitive nature of the research, women should not be invited to take part if:

- They find speaking or understanding English difficult – especially if they require an interpreter.
- There is the potential for either personal or professional contact with me. In effect this excludes midwifery students and women living in the [redacted] area.

What will happen to women if they take part?
After I receive their reply slip I will contact them - usually within 3-4 days. I will make sure that they have understood the information they have been given about the study and I will arrange to meet them at a time of mutual convenience in a private location of the woman's choosing to conduct an in depth interview. This will cover their maternity care experiences and is likely to last 1-2 hours. I will not ask them questions about their childhood abuse. The interviews will be audio-recorded and women will be asked to choose a pseudonym to help protect their identity.

I will also ask their permission to look at their maternity care records so that I can gain as full a picture as possible from different perspectives, of what pregnancy and childbirth was like for them.

The voluntary nature of taking part in the research will be stressed to the women and they will be able to withdraw if they change their mind – even part way through the interview. I will follow strict ethical and legal practice. All information will be handled in confidence and every effort will be made to protect their identity.

Who is organising this research?
This research forms part of my PhD and is being organised through the University of [redacted]. It has been developed in collaboration with midwifery managers at the [redacted] Hospital, CIS'ters and the [redacted] Rape Crisis Centre. Dr [redacted] (Consultant Midwife) is one of my supervisors.

Who has reviewed the study?
This study has been reviewed by [redacted] Research Ethics Committee (B) and has gained a favourable opinion.

Sources of support
The leaflet with the research pack is for your information. I will give the women one after the interview.

Further information.
For further information please contact Elsa Montgomery, Lecturer in Midwifery, University of [redacted]

Telephone: [redacted] email: [redacted]

Appendix 9 – Introductory letter - midwives

Email: [redacted]

REC Reference: 08/H0504/57

22nd November 2010

Dear midwifery colleague

I am a lecturer in midwifery and am writing to tell you about some research I am doing through the University of [redacted] that I very much hope you will agree to be part of. I am writing to invite you to participate in a focus group discussion.

My study is known as the MACaSA study which stands for Maternity After Childhood Sexual Abuse. This is an area where so far there has been no research published in this country. I have already spoken to a number of women who were sexually abused as children and have looked at their case notes. For this part of the research I would like to hold discussions to explore professionals' understandings of some of the issues that have arisen. I am planning two groups for midwives and one for obstetric registrars. I have enclosed an information sheet that tells you more about the research and what it would involve for you.

The groups for midwives will be held in a classroom in the school on level F of the [redacted] Hospital. They are scheduled for 25th January 2011 at 13.30 and 15th February 2011 at 13.30. Refreshments will be provided. If you are interested in participating, please could you either return the enclosed reply slip to me via internal post to the University address, or reply via email with the information included on the reply slip. I will get back to you to confirm arrangements. You do need to have any experience of looking after people who have been sexually abused to take part.

Thank you for taking the time to read this letter.

Yours sincerely

Elsa Montgomery
Lecturer in Midwifery

FOCUS GROUP REPLY SLIP

I am willing to take part in a focus group for the MACaSA study. I understand that I will be given a consent form to sign at the time.

My name is: _____

The best way to contact me is:

☐**Telephone:** _____

☐**Email:** _____

☐**Other:** _____

I am available on:

☐25th January 2011 at 13.30

☐15th February 2011 at 13.30

Signed _____

Position _____

Appendix 10 – Participant Information Sheet - Focus Groups

UNIVERSITY LOGO

Information about the research
The MACaSA Study

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the research if you wish. Take time to decide whether or not you wish to take part.

- Part 1 tells you the purpose of this study and what will happen to you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.

Please contact me if there is anything that is not clear or if you would like more information (telephone Elsa Montgomery on [redacted] or email [redacted]

Part 1

What is the purpose of the study?
Over 5000 women have babies in [redacted] each year. On the basis of surveys that have been done in this country and abroad, it is possible that up to 1000 of those had experiences in childhood, such as unwanted sexual contact, that may affect them later in life. Despite this, there has not yet been any research in this country into the maternity care experiences of women in this situation. This study aims to explore those experiences. We believe that understanding this will begin to identify which aspects of maternity care are helpful and which are unhelpful for women who were sexually abused as children. The overall aim is to improve the experience of having a baby for these women. This research is being done as part of a PhD.

Why have I been invited?
In order to gain as full an understanding as possible of the maternity care experiences of women who were sexually abused as children, varying perspectives are being studied. I have already interviewed women who were abused as children and I have examined their maternity care records. I now need to consider the perspective of those, like yourself, who may care for these women. I am inviting midwives and obstetric registrars working in [redacted] to take part in a focus group discussion that will explore some issues that have arisen from my analysis so far. I am hoping to hold two groups for midwives and one for registrars.

Do I have to take part?
No, participation is entirely voluntary. If you would like more information before you make your decision please get in touch. If you think you would be willing to take part please return the reply slip to me and I will contact you to confirm details. You are free to change your mind without giving a reason.

What will happen to me if I take part?
There will be separate groups for midwives and registrars. On the day we will meet in a classroom at the [redacted] Hospital and refreshments will be served. There will be two people running the group. I will facilitate the discussion and a colleague will be there with me to take notes and ensure that everything goes smoothly. Before we begin officially, I will check that everyone understands the purpose of the group and give an opportunity for you to ask questions. I will then ask you to sign a consent form. We will agree some ground rules for the discussion. I would like to audio record the proceedings and will transcribe the discussion. I will ask you to outline briefly your professional experience to date so that I can have details of group composition. I will not ask you to state your name. If any names are revealed in the course of the discussion they will not be transcribed. I would like your permission to use verbatim quotes in reports and any articles or presentations but I will take care not to use any details that could identify you.

What are the possible disadvantages and risks of taking part?
It is possible that the discussion will cover topics that you find upsetting. I will give everyone details of sources of support that can be contacted if you do feel upset afterwards. You may also self-refer to the Occupational Health Department.

What are the possible benefits of taking part?
I cannot promise that the study will benefit you personally. I hope that it will help inform practice in the future and may contribute to professional guidelines for the maternity care of women who were sexually abused as children.

Will my taking part in the study be kept confidential?
Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2 of this information sheet. The only time I would consider breaking confidence is if unprofessional conduct were to come to light during the focus group discussion. In this case I would initially take the issue to my supervisor of midwives. Anonymity would be maintained for the research participants during this discussion. Her advice would be followed concerning any further action deemed necessary.

What happens after our meeting?
You will not need to have any further involvement with the study after the focus group discussion. Once I have completed the research, I would like to present the results to your teams.

What if there is a problem?
Any complaint about the way you have been dealt with during the study will be addressed. The details are included in Part 2 of this information sheet.

Thank you for taking time to read this sheet.

This completes Part 1 of the information sheet. If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

Part 2

Will my taking part in the study be kept confidential?
All information which is collected from you during the research will be kept strictly confidential. The reply slips and consent forms will be kept in a locked cabinet in a locked office at the university. There will be no other record of who takes part and no one outside of the group will be informed. Transcripts will be stored separately from the reply slips and consent forms. Recordings and transcripts will be archived in the university for 15 years after the end of the study and then disposed of securely.

Who is organising this research?
This research forms part of a PhD and is being organised through the University of Southampton. It has been developed in collaboration with senior midwifery managers and obstetricians at the [redacted] Hospital in [redacted], the support group CIS'ters and the [redacted] Rape Crisis Centre.

Who has reviewed the study?
This study has been reviewed by [redacted] Research Ethics Committee (B) and has gained a favourable opinion.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to my supervisors at the university, Dr [redacted] (Dr [redacted] while [redacted] is on sabbatical) or Professor [redacted]. If you remain unhappy and wish to complain formally, you can do this by writing a letter to the School's Research Director (School of Health Sciences, [redacted]). The letter should specify:

- the title of the research project
- the nature of the complaint

Further information and contact details

For any further information about the research contact:

Elsa Montgomery
Lecturer in Midwifery
[redacted]

Telephone: [redacted]
Email: [redacted]

Appendix 11 – Introductory letter - obstetric registrars

Email: [redacted]

REC Reference: 08/H0504/57

5th October 2010

Dear Dr *
I am a lecturer in midwifery and am writing to tell you about some research I am doing through the University of [redacted] that I very much hope you will agree to be part of. I am writing to invite you to participate in a focus group discussion.

My study is known as the MACaSA study which stands for Maternity After Childhood Sexual Abuse. This is an area where so far there has been no research published in this country. I have already spoken to a number of women who were sexually abused as children and have looked at their case notes. For this part of the research I would like to hold discussions to explore professionals' understandings of some of the issues that have arisen. I am planning two groups for midwives and one for obstetric registrars. I have enclosed an information sheet that tells you more about the research and what it would involve for you.

The group for registrars will be held in classroom 3 (F114) in the school on level F of the [redacted] Hospital, 29th October at 14.00. Refreshments will be provided. I have also sent you this information electronically. If you are interested in participating, please could you return the reply slip to me via email so that I have an idea of numbers?

Thank you for taking the time to read this letter.

Yours sincerely

Elsa Montgomery
Lecturer in Midwifery

FOCUS GROUP REPLY SLIP

I am willing to take part in the focus group for the MACaSA study. I understand that I will be given a consent form to sign at the time.

My name is: _____

The best way to contact me is:

☐**Telephone:** _____

☐**Email:** _____

☐**Bleep:** _____

☐**Other:** _____

Signed _____

Appendix 12 – In depth interview guidance

The MACaSA Study

In-depth interviews - guidance

Prior to the interview

- Ensure that id card has been shown
- Check understanding about study
- Participant to sign two copies of consent form (ask her if she would like one, if not indicate that a copy will be kept should she change her mind)
- Remind participant of the fact that:
    - she does not have to answer any questions that she would prefer not to
    - she can terminate the interview at any time
    - She should ask for clarification if she doesn't understand
    - There are no right or wrong answers – I'm interested in her views
- Gain permission to record interview
- Record chosen pseudonym

The interview – questions and prompts

As recommended by Britten (2006) and Walsh and Baker (2004) start the interview with an open question.

- "I'd like to find out about what being pregnant and having a baby was like for you. Starting however you want, please could you tell me?"

If the woman does not know where to begin, the following suggestions may be given:

- How did you found out you were pregnant
- Tell me about your pregnancy
- How did labour begin?
- What was it like taking your baby home?

Further questions will be for the purpose of clarification or probing (Britten 2006).

As suggested by Bluff (2006) the following prompts may be employed if required:

- Are you saying that…
- What do you mean by that?
- Silence

However, as advised by Hollway and Jefferson (1997), care will be taken not to interrupt the narrative as far possible. This may mean simply nodding or repeating the last words used by the participant by way of encouragement.

After the interview
If not already covered ascertain whether the participant remembered the abuse at the time of the pregnancy:

- "Some women say that they have buried the experience of being abused so deeply that they don't remember that it happened for many years. From what you have said I understand that: that is not the case for you/that may have been your experience too."

☐ Check whether there is anything the participant would like to add

☐ Check whether anything has been too distressing

☐ Remind about use of verbatim quotes

☐ Provide details of support groups/counselling sessions

☐ Check on preferred option for recording

- Archive recording in its original form
- Ask supervisor to verify authenticity of transcript and destroy recording on completion of PhD

☐ Thank the participant for her time and valuable contribution

Appendix 13 – Sources of support

The MACaSA Study
Sources of support

Thank you for taking part in the MACaSA study. I really appreciate the time and effort you have given and your valuable contribution. If you find that some of the things we talked about have triggered bad memories for you and you would like to talk to someone about it, this is a list of numbers you may find helpful.

Birth Afterthoughts	[redacted] 6834	If your call is not answered, you can leave a message to be called back. Offers a chance for you to discuss your birth experience with a midwife, no matter how long ago your baby was born
CIS'ters	[redacted] 8080	Self-help network. The helpline is open Saturdays: 10am-12 noon. At other times you can leave a message to be called back.
NAPAC support line.	0800 085 3330 www.napac.org.uk	The free phone helpline can be reached on: Monday.10:00am-9:00pm, Tuesday 10:00am-9:00pm, Wednesday 10:00am-9:00pm, Thursday 10:00am-9:00pm, Friday 10:00am-6:00pm No answer phone available.
Samaritans	08457 90 90 90 www.samaritans.org	24 hour help line
[redacted] Rape Crisis	[redacted] 6313 [redacted]	The telephone helpline can be reached on: Sunday 7 pm – 10 pm, Tuesday 10 am – 1 pm, Thursday 1 pm – 4 pm. On Tuesday the helpline may be staffed by male and female counsellors. At other times, if your call is not answered, you can leave a message to be called back.
Women's Aid	0808 2000 247 www.womensaid.org.uk	Free phone number. 24 hour national domestic violence helpline

Appendix 14 – Consent form – Focus Groups

UNIVERSITY LOGO

CONSENT FORM

The MACaSA Study

Researcher: Elsa Montgomery, Lecturer in Midwifery,
School of Health Sciences, [redacted]

☐ I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction.

☐ I understand that I my participation is voluntary and I am free to withdraw at any time.

☐ I agree to take part in the above study

☐ I agree to the focus group discussion being audio taped

☐ I agree to the use of direct quotes in research reports and publications

Name	Signature	Date

Researcher name	Researcher signature	Date
Elsa Montgomery		

Appendix 15 - Focus Group Scenarios

Scenario 1

Mia is a primigravida who has made very good progress in labour. She is in the latter part of the first stage and is in the birthing pool. She is being supported by her mother and husband but is very distressed. Each time she has a contraction she pushes her body up out of the water. Her mother and husband, concerned for her safety try to push her back into the water.

Scenario 2

Jane is a primigravida who is in the 2nd stage of labour. The head is advancing well but as the head crowns Jane stops responding to instructions. In particular, having breathed out she will not take a breath in again.

Scenario 3

Sue is attending an antenatal clinic in the Consultant Unit. She has been shown in to the consulting room and is waiting to be seen. She is very anxious.

Scenario 4

Sam has an IVI in situ. She has a member of staff with her who is being kind and attentive, helping her to change her clothes. However, Sam does not seem pleased.

Scenario 5

Elizabeth is pregnant for the first time. She feels 'like she is losing her mind' but does not know if that is normal. She really hopes each time she asses a midwife that someone will notice that she is feeling bad and give an indication that they want to listen to her, but they never do.

Numerical code:
REC Reference: 08/H0504/57

Appendix 16 – Consent form

UNIVERSITY LOGO

CONSENT FORM

The MACaSA Study

Researcher: Elsa Montgomery, Lecturer in Midwifery,
School of Health Sciences, [redacted]

☐ I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction.

☐ I understand that I do not have to take part and that I am free to change my mind without giving any reason (even if this is part way through the interview)

☐ I agree to take part in the above study

☐ I agree to the confidentiality policy set out in the information sheet

☐ I agree to the storage of information about me as set out in the information sheet

☐ I agree to have my interview audio taped.

☐ I give permission for the researcher to access my maternity care notes.

If yes: My hospital number is:
My date of birth is:
When I had my baby I was known as:
When I had my baby I lived at:

☐ I agree to the use of direct quotes in research reports and publications

☐ I confirm that I have support available to me

I can get support from:

Name	Signature	Date
Elsa Montgomery		
Researcher name	Researcher signature	Date

Numerical code:

REC Reference: 08/H0504/57

CONSENT FORM (cont.)

☐ I understand that I will be able to choose a name that is not my real name for use in the study to protect my identity.

My real name is: _____

The name I have chosen is: _____

NB This page of the form will be shredded after your chosen name has been recorded. Once this is done, your chosen name will never be stored in the same place as your real name.

Appendix 17 – Case note proforma

The MACaSA Study: Case note proforma – to be completed electronically

MACaSA study numerical code		**Pseudonym**				
Age		**Gravida**		**Parity**		
Ethnic group:						
Occupation:						
Medical history:						
Pregnancy number	**Gestation**	**AN complications?**	**AN admissions?**	**Type of birth**	**Length of labour**	**LB/SB**
Is CSA documented in notes		YES/NO				
Details of antenatal complications:						
Details of antenatal hospital admissions						
Antenatal narrative						
Labour narrative						
Postnatal narrative						

Appendix 18 – Letter of thanks

[TO BE PRODUCED ON FACULTY [redacted] HEADED PAPER]

Date

Dear

The MACaSA Study

I wanted to say how much I valued you giving up your time and talking to me about your maternity care experiences for my study last ***. I hope that you didn't find the experience too difficult. If you do feel upset at any time, please remember the sources of support that we recorded on your consent form and on the leaflet I gave you at the end of the interview.

I believe that this research will give midwives a better understanding of women's needs when they are pregnant and having their babies. This will help us to improve care in the future and your contribution was a valuable step along the way. I really appreciated the chance to talk with you – thank you.

With best wishes

Elsa Montgomery
Lecturer in Midwifery

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