UNIVERSITY OF SOUTHAMPTON

FACULTY OF HEALTH SCIENCES

Volume 1 of 1

Journeying through confidence: A grounded theory study exploring women's confidence for birth

by

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Thesis for the degree of Doctor of Philosophy

7th March 2019

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF HEALTH SCIENCES

Thesis for the degree of Doctor of Philosophy

JOURNEYING THROUGH CONFIDENCE: A GROUNDED THEORY STUDY EXPLORING WOMEN'S CONFIDENCE FOR BIRTH

Emily Victoria Fraser-Mackenzie

Supporting women's psychological needs during pregnancy is an important aspect of providing good quality maternity care. In an attempt to support women's psychological wellbeing during pregnancy, a local National Health Service Trust, developed Confident Birthing Workshops. These workshops aimed to try and increase pregnant women's confidence for birth. Research exploring childbirth self-efficacy, fear of birth and childbirth expectations suggests that women's confidence for birth is likely to affect their long-term psychological wellbeing. However, there has not been any research exploring women's confidence for birth. This PhD therefore aimed to develop a theoretical understanding of the factors that women perceive to influence their confidence for birth, during pregnancy. It is then hoped that the local National Health Service Trust can use this understanding to support the Confident Birthing Workshops.

In order to develop a theoretical understanding of women's confidence for birth, a constructivist grounded theory approach, using interviews and internet discussion forum data was taken. This data was subjected to grounded theory analysis and led to the development of a substantive 'Journeying through confidence' theory. The social processes within the theory are divided in to the following five categories: 'Gathering and interpreting information while journeying through pregnancy', 'Relationship with pregnancy and baby', 'Preparing', 'Communicating' and 'Evaluating previous experiences'.

The 'Journeying through confidence' theory, is the first theory to provide an understanding of the factors that women perceive to influence their confidence for birth, during pregnancy. This theory has resulted in several suggestions to improve clinical practice, such as, changing the approach that maternity services currently adopt when creating birth plans with women. Further research is needed to explore what factors women perceive to influence their confidence for birth during labour and the postnatal period.

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Academic Thesis: Declaration of Authorship

I, Emily Fraser-Mackenzie declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

'Journeying through confidence: A grounded theory study exploring women's confidence for birth'

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. 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;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. 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;
5. I have acknowledged all main sources of help;
6. 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;
7. None of this work has been published before submission

Signed: .....

Date: .....

Acknowledgements

Firstly I would like to express my sincere gratitude to my supervisors Dr Maggie Donovan-Hall and Dr Ellen Kitson-Reynolds for their continuous support throughout my PhD. I really appreciate their constant patience, knowledge and encouragement. I feel so privileged to have had the best possible advisors and mentors for my PhD journey, which has been made all the more enjoyable thanks to their support. I would also like to thank my external supervisor Dr Elsa Montgomery for her insightful comments, support and encouragement.

My sincere thanks also goes to all of the mothers who participated in my study, thank you for helping me to better understand women's confidence for birth. Thank you also to the Maternity Service User Committee for their advice and support with designing this study.

I would also like to express my gratitude to my clinical colleagues for their constant support and interest in my PhD. In particular, I would like to thank Janice Mackenzie and Clara Haken for their mentorship over the last four years.

Finally thank you to my friends and family for encouraging me to apply for the PhD in the first place and for their continued love and support thereafter. In particular, thank you to Mum, Dad, Hattie, Miff and Pete, I could not have done this PhD without your endless support.

Definitions and Abbreviations

DH	Department of Health
MSLC	Maternity Service User Liaison Committee
NHS	National Health Service
the Trust	The local NHS Trust
NICE	National Institute for Health and Care Excellence
the Fellowship	The Clinical Academic Doctoral Fellowship
NIHR	National Institute of Health Research
Antenatal	Before birth, during or relating to pregnancy
Intrapartum	During labour and birth
Postnatal	Relating to or donating the period after birth

Table 1: Table of abbreviations and definitions commonly used during this thesis

Chapter 1 Background to the PhD

1.1 Introduction

This PhD has been completed as part of a clinical academic doctoral fellowship with a local National Health Service (NHS) Trust (hereinafter 'the Trust') and the University of Southampton. The aim of this PhD was to develop a theoretical understanding of women's confidence for birth. This focus on confidence for birth arose from continual collaboration with the Trust, to develop a research project that would be both useful and relevant to clinical practice. At the start of the fellowship the Associate Director of Midwifery and Women's Health was developing strategies to provide a more holistic maternity service. One of these strategies involved running new Confident Birthing Workshops, which aimed to enhance pregnant women's confidence for birth. I was asked to evaluate these workshops as a starting point to my PhD, which led to a study utilising constructivist grounded theory to explore women's confidence for birth more widely. This chapter provides background information for the clinical academic doctoral fellowship, holistic maternity care, the Confident Birthing Workshops and my evaluation of the workshops which led to researching confidence for birth.

1.2 Reflective account of the clinical academic doctoral fellowship

Clinical academics work in healthcare, practicing as clinicians to improve, maintain or recover health, while simultaneously researching new ways of delivering outcomes for the patients they care for (National Institute of Health Research (NIHR), 2016). By immersing themselves in the clinical setting, clinical academics are in an excellent position to ensure that their research is applicable in day-to-day practice and care, as well as being able to interpret and apply research findings in a practical and useful way (Association of UK Univeristy Hospitals Association of UK University Hospitals (AUKUH), 2016). This dual role also allows the clinical academic to combine their clinical and research careers, rather than having to choose between the two (NIHR, 2016). Clinical academic roles are joint appointments between a healthcare provider and a higher education institution, in which both organisations support the post. A successful clinical academic will be able to demonstrate not only that they are an excellent researcher, but also that they can lead and inspire others in the clinical field (AUKUH, 2016).

The development of clinical academic roles has been endorsed by several recent papers, including:

- ‘Midwifery 2020: Delivering Expectations’ (Department of Health (DH), 2010)
- ‘Delivering high quality, effective, compassionate care’ (DH, 2013)
- ‘Developing the best research professionals’ (UK Clinical Research Collaboration UK Clinical Research Collaboration (UKCRC), 2014)
- ‘Health Education England Strategic Framework’ (Health Education England Health Education England (HEE), 2014)
- ‘Leading Change, Adding Value’ (NHS England, 2016a)

Recent evidence also confirms that pursuing research through clinical academics has multiple benefits for patients, services and individuals. These benefits include improved clinical outcomes, increased treatment options, increased evidence-based care, effective utilisation of resources, increased reputation, income generation, and increased engagement with staff (DH, 2010; Finlay, 2012; NHS Education for Scotland, 2014; AUKUH, 2016) .

I began the clinical academic fellowship as a newly qualified graduate midwife, and therefore the past four years have been an incredible journey and a steep learning curve, both clinically as well as academically. For the first six months of the fellowship I worked full-time as a clinician to focus on gaining the skills required to be a competent midwife. Then I spent the next three years working a 60:40 split of PhD to clinical practice. For the last six months of the fellowship I had planned on taking the clinical time back and working full-time as an academic for that period. However, when this time came I was reluctant to stop my clinical practice because I really enjoy and get great satisfaction from working as a midwife. Therefore, I took out a separate clinical contract with the Trust to maintain my practice as a midwife throughout the reminder of my PhD. Being a clinical academic and immersing myself in the reality of clinical practice has therefore been an integral part of shaping this PhD. Balancing the demands of clinical practice with those of academia has been extremely challenging, particularly given how inexperienced I was in both arenas. Initially I felt so lacking in confidence as a midwife that I was too embarrassed to tell anyone in clinical practice that I was also doing a PhD. Fortunately, throughout the fellowship I have grown in confidence so that I now feel proud and passionate to be a clinical academic midwife.

Being a clinical academic has had many benefits, enabling me to develop my clinical skills in a variety of different community and hospital settings. I have also been able to develop my research skills and knowledge by conducting a service evaluation and a study based in constructivist grounded theory. Throughout the PhD I have received regular supervision from my supervisors, Dr Maggie Donovan-Hall and Dr Ellen Kitson-Reynolds, as well as less regular supervision from my external supervisor Dr Elsa Montgomery. I have also completed the Faculty of Health Sciences research training programme, which covered a

broad range of research methods and techniques. In addition I have also attended and presented at local, national and international conferences, building my clinical academic network. This has included poster presentations at the International Confederation of Midwives (ICM) conference (2014), the Royal College of Midwives conference (2014), and the Society for Reproductive and Infant Psychology conference (2015). In addition, I also gave oral presentations at the Hampshire Hospitals NHS Foundation Trust perinatal mental health conference (2015) and the Maternity, Mother and Baby conference (2017), as well as in multiple University of Southampton postgraduate research forums and conferences (2014–2018).

Throughout the fellowship I have had mentorship from a Consultant Midwife at the Trust, as well as fostering a close collaborative relationship with the Trust and the Associate Director of Midwifery and Women's Health. The fellowship has also enabled me to pursue my own interest of enhancing psychological wellbeing during pregnancy in both clinical practice and academia. I have become a perinatal mental health champion for the Trust, and in 2017 I won a local award for 'Midwife of the Year' after being nominated by two patients who I cared for as their community midwife, both of whom had extremely complex psychological needs. In academia I have furthered my knowledge of psychological strategies not only through my PhD topic but also by becoming an active member of the University of Southampton mental health scholarly forum.

During the fellowship I also had mentorship from a Consultant Midwife at the Trust, as well as fostering a close collaborative relationship with the Trust and the Associate Director of Midwifery and Women's Health. The fellowship has also enabled me to pursue my own interest in enhancing psychological wellbeing during pregnancy in both clinical practice and academia. I have become a perinatal mental health champion for the Trust, and in 2017 I won a local award for 'Midwife of the Year' after being nominated by two patients who I cared for as their community midwife, both of whom had extremely complex psychological needs. In academia I have furthered my knowledge of psychological strategies not only through my PhD topic but also by becoming an active member of the University of Southampton mental health scholarly forum.

The flexibility of the fellowship has also allowed me to apply for and gain other activities to advance my clinical academic career, such as being a panel member in 'Fitness to Practice' hearings at the Nursing and Midwifery Council (NMC) and a peer reviewer for the British Journal of Midwifery and NIHR. In 2017 I also enhanced my leadership skills by attending a three-day residential Leadership and Development course as well as completing a six-week online course on Leadership and Innovation in Healthcare. I hope that this combination of experiences will enable me to continue working as a clinical academic in the future as I have thoroughly enjoyed the fellowship.

1.3 Holistic maternity care

The transition to motherhood is a major developmental life event (Mercer, 2004). Becoming a mother requires marked changes in goals, behaviours, responsibilities, family dynamics and friendships (Raynor and Oates, 2014; Hollway, 2016). As a result the transition to motherhood can place an immense degree of strain on women and their families (Hennekam, 2016). Maternity services in England typically provide care for women from eight weeks of pregnancy through to the postnatal period (period after giving birth) (DH, 2013). Maternity services are therefore ideally placed to support this transition by providing holistic care, supporting a woman's physical and psychological wellbeing (Collins and Draycott, 2015). For the purpose of this thesis, holistic care is defined as treating the whole person by taking into account their psychological and social needs as well as any physical symptoms (Stevenson, 2010).

Holism is not a new concept, but in a modern healthcare context it seems to focus our attention on something that the Western world has lost – the care and treatment of the whole person (Margereson and Trenoweth, 2010). In the West, throughout the twentieth century the biomedical model (focussing on purely biological factors) has delivered remarkable achievements in various fields of healthcare. As a result of the biomedical model there have been many new and effective medications as well as surgical interventions, resulting in increased survival rates for both mothers and babies (Albert and Tim, 2017; Shinkins *et al.*, 2017). However, it has also become clear that the biomedical model does not account for the lived experience of the individual, and as such it is inadequate for improving the overall sense of health and wellbeing for women and their families (Margereson and Trenoweth, 2010).

Over time many people have recognised the potential value of holism. For example, in 1927 Adler stressed the importance of understanding the individual as being embedded within the larger wholes of society, from interpersonal relationships to the social groups one belongs in (Shon and Barton-Bellessa, 2015). Then, in 1955 in 'The Psychology of Personal Constructs' the psychologist Kelly recognised the interconnectedness of feelings, thoughts and behaviour, which is still described as a radical approach in psychology to this day (Winter, 2013). Holistic care principles are also influenced by Engel's 1997 bio-psycho-social model. Engel argued that there was a need to move away from the biomedical model and develop a new framework that takes into account the reality of conditions, such as diabetes, as human experiences, not just as disease abstractions (Engel, 1992). The bio-psycho-social model is a broad view that attributes health to the combination of and relationship between biological, social and psychological factors.

Personally, I see holistic care as an expansion of the bio-psycho-social model to include a focus on cultural and spiritual needs. The 'Statement of Belief' published in 2005 by the International Confederation of Midwives (ICM) most closely aligns with my perspective on holistic care as a midwife and researcher:

> Midwifery care combines art and science. Midwifery care is holistic in nature grounded in an understanding of the social, emotional, cultural, spiritual, psychological and physical experiences of women and is based upon the best available evidence (ICM, 2005:1).

For me this statement about holistic care epitomises everything that I strive and struggle to achieve as a midwife when working clinically. Indeed, holistic care has been a driver to improve the quality of maternity services for many years, discussed in several recent DH reports such as the 'National Service Framework for Children Young People and Maternity Services' (DH, 2004), 'Maternity Matters' (DH, 2007) and 'Midwifery 2020: Delivering Expectations' (DH, 2010). The 'Changing Childbirth' report (DH, 1993) is a seminal text for maternity services, being one of the first government reports to stress the need for women to be placed at the heart of their maternity care, emphasising choice, continuity and control as key principles in achieving this. However, by its very definition holistic care, is extremely broad, and is therefore difficult and costly to achieve. For example, 23 years later the most recent maternity service review (NHS NHS England, 2016b) set out a vision for the planning, design and safe delivery of maternity services over the next five years. This review reiterated the importance of holistic care, and described how change had not always happened or been achieved as was initially hoped in the 'Changing Childbirth' report. In particular the maternity service review describes improving quality of care by focussing on personalised care, continuity of care, better postnatal and perinatal health care and multi-professional working. All of these recommendations require maternity services to refocus on providing holistic care to women.

Alongside maternity service reviews and DH papers, successive enquiries into maternal deaths in the UK have identified that women with additional social and psychological needs are more susceptible to pregnancy-related deaths (Centre for Maternal and Child Enquiries Centre for Maternal and Child Enquiries (CMACE), 2011; MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK, 2015). Deprivation and vulnerability continue to be markers for increased risk of maternal death and stillbirth. The most recent enquiry into maternal deaths between 2009 and 2013 in the UK (MBRRACE-UK, 2015) reports a number of examples of tunnel vision in clinical thinking, and stresses that maternity services must work with women, viewing their health holistically:

> Women from vulnerable populations still have a disproportionate risk of dying prematurely, possibly as a result of the multiple health and social challenges they face. This report provides a number of examples of 'tunnel vision' in our clinical thinking – increasing evidence of clinical subspecialisation and an inability to view the woman in a holistic manner and provide for her needs appropriately and effectively. The clear message to us all, whether doctor, midwife, nurse, manager, allied health or social care professional, service planner or policymaker, must be that we need to practice and embed the patient centred care that we all preach. This means providing the kind of care that takes into account the entirety of the woman's health and social needs before, during and after pregnancy. (MBRRACE-UK, 2015:i)

Although the above quote from MBRRACE-UK (2015) stresses that providing holistic care is the responsibility of all professionals involved, holistic care can be extremely challenging to achieve in a NHS that continues to suffer from a shortage of midwives, who provide the bulk of maternity care. The Royal College of Midwives (RCM) estimates that there are 21,800 full-time equivalent midwives currently practising in England, and that the UK is currently short of 3,500 full-time midwives (RCM, 2016a). However, it is difficult to determine the total number of midwives currently practising in the UK because the NMC stopped keeping a separate register for midwives and nurses in 2008. A recent survey conducted by the RCM (2016b) surveying Heads of Midwifery found that over a third (38.6%) of maternity units had to shut on a total of 281 separate occasions over a year period (between 2015 and 2016), because they could not cope with demand for the service. Shutting maternity services has serious patient safety implications, as women have to give birth at units they are not familiar with, and potentially have to travel longer distances when in labour to reach these units (The King's Fund, 2012). Furthermore, 13.6% of Heads of Midwifery reported that they had reduced other services in the last year, such as parenting classes as well as breastfeeding and bereavement support, due to budget cuts (RCM, 2016b). These are exactly the kinds of services that facilitate holistic care. Worryingly, the shortage of midwives is likely to be perpetuated by further staff leaving. In a recent survey of over 2,000 midwives across the UK who had left the profession in the preceding two years or who were intending to leave in the next two years, over half (52%) said they were not happy with staffing levels and that not being able to deliver the quality of care they wished to due to staffing levels was their main reason for leaving (RCM, 2016b).

In summary, holistic care seems to be integral to providing good quality maternity services. If women are cared for only according to their biological needs, this can have

adverse consequences on their health. However, in an increasingly pressured NHS maternity services need simple and effective methods to enhance holistic care that are not too costly of resources.

1.4 Implementing holistic maternity care

As discussed in section 1.2, at the beginning of my clinical academic doctoral fellowship I worked hard to collaborate with the Trust to develop a PhD project that would be helpful and relevant. During these early discussions it became clear that the Trust wanted to improve holistic care within their maternity service. Given the complexities of providing holistic care, the Trust decided to start running Confident Birthing Workshops for pregnant women and their partners. These workshops were viewed by the Trust as being a tangible method to provide holistic care by supporting women to feel more confident during pregnancy and birth. A similar style of workshop had been started by the Associate Director of Midwifery and Women's Health in a previous Trust. She felt that the workshops were positively received by women and their birth partners. However, a formal evaluation of the workshops had never been conducted. I therefore carried out a service evaluation as a starting point for this PhD. A service evaluation was felt to be an appropriate methodology because the Trust's focus was on how this particular service was viewed and experienced by the service users, rather than measuring the workshops against standard care. This was especially pertinent given that there was no prior standard for the workshops to be benchmarked against. The service evaluation was always intended to be a starting point for this PhD journey which provided the focus on exploring confidence of birth for this doctoral work.

Data were collected via a questionnaire from February 2014 to April 2015 and a total of 221 pregnant women completed the service evaluations. The service evaluation suggested that women's confidence for labour and birth was significantly increased after attending the workshop. Furthermore, content analysis exploring participants' explanation of their confidence rating revealed many different themes about women's confidence, ranging from 'feeling empowered by the workshop' and 'having a positive outlook for labour' to the workshop 'bringing them out of denial'. These findings suggested that confidence for birth was important to women during pregnancy and that confidence could be a valuable concept to further explore. Therefore a systematic search of the literature was conducted to explore what was already known about women's confidence for birth. This scoping review is presented in Chapter two.

Table 2 provides a summary of the whole thesis, illustrating the titles and purpose of each of the six chapters in this thesis.

Chapter	**Title of chapter**	**Purpose of chapter**
Chapter 1	Background to the PhD	Provides background for the PhD and clinical academic doctoral fellowship as a whole. Also provides context for the focus on holistic maternity care and women's confidence for birth
Chapter 2	Scoping review	Scopes out the available literature relating to women's confidence for birth to ensure that this PhD results in the creation of new knowledge through original research. The results of the scoping review also enabled creation of the study aims.
Chapter 3	Constructivist grounded theory approach	Provides a detailed account and rationale for the methodology and methods used. Also discusses adjustments to the project design, such as change in recruitment strategy, due to unforeseen circumstances.
Chapter 4	The process of developing a grounded theory exploring women's confidence for birth	Provides a detailed description of the specific processes used for this grounded theory study through four cycles of data collection and analysis to generate the grounded theory model
Chapter 5	Journeying through confidence – the grounded theory model explained	Presents the results of the data collection and analysis by discussing the grounded theory model as a whole and then according to each category
Chapter 6	Discussion and implications for practice	Discusses how the grounded theory model fits with other literature and policy, suggestions for clinical practice, the strength and limitations of the model and plans for future work

Table 2: Summary of the overall thesis

1.5 Conclusion

This chapter has provided background to the PhD study exploring the influences on women's confidence for birth. Collaboration with the Trust and my role as a clinical academic doctoral fellow was central to developing the PhD project. The international and national drivers for providing holistic maternity care further emphasised the focus on confidence for birth, attempting to provide a tangible method for enhancing holistic maternity care through Confident Birthing Workshops. As a starting point for my clinical academic doctoral fellowship I therefore conducted a service evaluation which suggested that pregnant women's confidence for labour and birth was significantly increased by attending Confident Birthing Workshops. However, the evaluation also raised several questions about women's confidence for birth which required a scoping review to explore the existing literature on women's confidence for birth. This scoping review is presented Chapter 2 and led to the development of the grounded theory PhD project.

Chapter 2 Scoping review

2.1 Introduction

Chapter 1 presented the background to the motivation to explore women's confidence for birth in further detail, in order to be able to put the findings from the service evaluation into context to assist with a clinical academic project. As a result a scoping review was conducted to explore what was already known about women's confidence for birth. Despite searching the literature extensively, no studies were identified that explored women's confidence for birth. Therefore a grounded theory study was developed to explore this phenomenon.

Reviewing the literature is a contentious issue in grounded theory (Bryant and Charmaz, 2007b). In their original statements, Glaser and Strauss (1967) encouraged researchers to delay reviewing the literature relevant to the substantive area of research until the grounded theory is almost complete. Delaying the scoping review was intended to prevent the researcher imposing existing theories and knowledge into the study process and outcomes (Glaser and Strauss, 1967; Mills and Birks, 2014). However, both Glaser and Strauss (1967) also acknowledged that no researcher entered the field as a blank slate and researchers enter with a broad knowledge. Throughout the evolution of grounded theory both Glaser and Strauss continued to reiterate this position warning of the risks of contaminating the grounded theory (Strauss and Corbin, 1990; Glaser, 1992; Corbin and Strauss, 2008). Unfortunately following this advice was not possible for this study because a formal scoping review was required for ethical and peer approval prior to data collection. As this is a PhD project, a review of the literature was also important to ensure that this research would add a unique and valuable contribution to the field. Charmaz (2014) and Hussein *et al.* (2014) both argue that reviewing substantive literature prior to data collection is the reality for many modern grounded theorists. Furthermore, this study is using the grounded theory methodology specifically because no substantive literature exploring women's confidence for birth was identified when reviewing the literature, so contamination of the research findings should not be a problem.

The scoping review identified literature exploring three topics that were appraised as being useful for providing context to women's confidence for birth. These topics were: childbirth self-efficacy, childbirth expectations and fear of birth. Three studies were also

identified that explored women's confidence for a physiological birth, which are also discussed. However, these studies explored concepts relating to confidence and not confidence in itself. The rationale for including these topics and how the findings from these concepts compare to exploring women's confidence for birth are discussed throughout the chapter. Finally, the development of the research question and aims that resulted from the scoping review is presented.

2.2 Method

2.2.1 Searching for relevant literature

A systematic scoping review was undertaken to explore what is known about the influences on women's confidence for labour and birth. Five core bibliographic databases, outlined in Figure 1, were accessed to search for literature from a wide range of journals, books and dissertations. These databases were selected because they contained material relevant to the subject area, and they are evaluated in Appendix C. The search terms were deliberately kept broad to prevent the early exclusion of relevant results, focussing on the key concepts of 'confidence' and 'birth' as demonstrated in Table 3.

1. Cumulative Index of Nursing and Allied Health Literature (CINAHL)
2. Excerota Medica Database (EMBASE)
3. Medical Literature Analysis and Retrieval System Online (MEDLINE)
4. Psychological Information Database (PsycINFO)
5. Web of Science

Figure 1: List of databases searched

Key concept	**Search terms used**
Confidence	Confiden*
Birth	Childbirth Lab?or Intrapartum

Table 3: List of search terms for scoping review

Table 4 presents the number of results of literature that were identified from searching the terms in Table 3 in the databases in figure 1. This search was originally conducted in May

2016 and then repeated on: November 2016, June 2017, December 2017 and March 2018. The results shown in Table 4 with a total of 29,008 pieces of literature identified were correct at the time of the most recent search in March 2018.

	Search 1 (S1)	**Search 2 (S2)**	**Search 3 (S3)**	**Search 4 (S4)**	**Search 5 (S5)**	**Search 6 (S6)**
Database	**Confiden***	**Childbirth**	**Lab?or**	**Intrapartum**	**S2+S3 +S4**	**S5+S1**
CINAHL	289,558	24,808	39,711	3,538	61,331	6,123
EMBASE	526,199	25,640	117,726	8,881	141,507	10,134
MEDLINE	460,430	18,870	118,003	7,654	136,137	6,175
PsycINFO	83,642	5,490	37,980	373	41,921	801
Web of Science	461,152	15,049	233,851	7,470	249,801	5,775
Total						**29,008**

Table 4: Number of results found when searching the databases for relevant literature

In addition to identifying 29,008 items of literature from searching the research databases, the Cochrane library was also searched to ensure that there were no systematic reviews already carried out on this subject. Finally, a hand search of literature relevant to 'confidence' and 'birth' was also conducted using popular internet search engines and by checking the reference lists of relevant studies with the help of a librarian. This hand search identified 8 further items of literature that seemed to be relevant to the search terms highlighted in Table 3. The total number of literature found that potentially related to women's confidence and birth was therefore 29,016.

2.2.2 Refining the literature

The refining process of how the initial 29,016 papers were refined to 88 papers, is illustrated in Figure 2. Firstly, all duplicates were removed and the abstracts were screened according to the exclusion criteria shown in Table 5. However, an exception was made for three pieces of literature that were included in the scoping review despite being published earlier than 1993, because they seemed to be seminal work that was often cited in more recent literature. These exceptions were Bandura (1977) study on self-efficacy theory, Marce (1858) study identifying fear of birth as a concept and Dick-Read (1959) development of the Fear-Tension-Pain cycle.

Then 1429 papers were read in full and reassessed for relevance to both 'confidence' and birth' to better understand the influences on women's confidence for birth. A total of 1336 papers were not eligible for inclusion in the scoping review because they related to either confidence or birth alone, and not the two concepts together. A further 30 studies were also removed during the eligibility stage of refining the literature because they were opinion papers, as per the Cochrane recommendation to include only primary research in scoping reviews. Although no studies were identified that explored women's confidence for birth, 88 studies were included in the scoping review because they seemed to be relevant and useful for providing context to this research area.

Exclusion criteria	**Rational**
Literature pre-1993 excluded	The 'Changing Childbirth' Report (DH, 2013) was used as landmark for this scoping review, as it impacted nationally on the language used in maternity care and the debate around how care should be provided and by whom. Therefore articles pre-1993 were excluded (McIntosh, 2013).
Literature not written in the English language excluded	Excluded due to the complexities and resources required for translation.
Literature not relevant to both 'confidence' and 'birth'	Excluded as unlikely to be relevant for understanding the influences on women's confidence for birth.

Table 5: Exclusion criteria applied to screen the literature

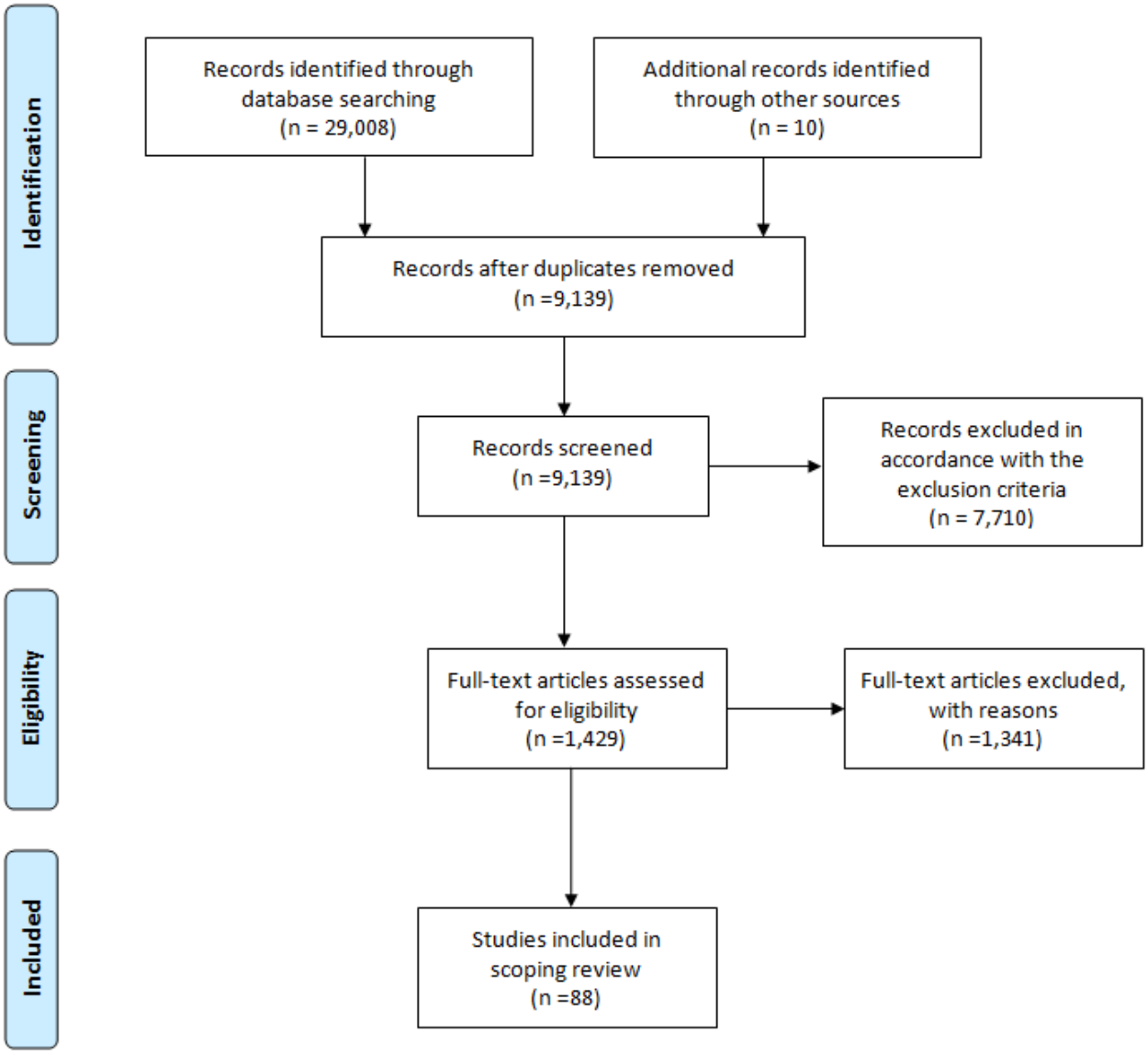


Figure 2: Demonstration of the literature refining process using the PRISMA (2009) Flow Diagram (Moher *et al.*, 2009)

2.3 Overview of Findings

The 88 identified studies were individually appraised using an amalgamation of two popular critiquing tools by Parahoo (1997) and Caldwell *et al.* (2011) (Appendix D). Both critiquing tools were valuable because they took into account quantitative and qualitative approaches to research, and they provide a list of broad headings that encompass both approaches. However, Parahoo (1997) is more comprehensive in terms of quantitative research, while Caldwell *et al.* (2011) provide more detail on

qualitative research. Using an amalgamation of both critiquing tools enabled all of the qualitative and quantitative studies to be evaluated.

All the papers were judged to be of appropriate quality to be included in this scoping review. However, comments on the individual quality of the papers will be discussed throughout the presentation of the results. The papers were then reread and logged in a table with key information about the study aims, methodology, population and sample, data collection, findings and limitations (Appendix E). Through tabulating each of the studies and reviewing their content, four general patterns emerged. These patterns related to the following four themes:

- country of origin
- research design
- data collection method
- research focus

2.4 Findings: Patterns within the literature

2.4.1 Country of origin

The greatest number of research papers originated from Europe, which accounted for 40% of the literature included in this review. The United States of America (USA) and Australia followed with 24% and 9% respectively. Most of the remaining literature was from Asian countries such as China and India. Although all European countries have similar healthcare needs, there are important differences between each country. For example (Christiaens *et al.*, 2008) demonstrated significant differences between Dutch and Belgian women's birth expectations. Of the European studies, only five (21%) were based in the UK; the majority (52%) of the European studies were Scandinavian. This is a particularly important consideration for the generalisability of the literature exploring fear of birth, because Scandinavian countries have specific maternity care teams for women with fear of birth during pregnancy (Nilsson *et al.*, 2010). America, Australia and Asia all have very different healthcare systems to the NHS, which again makes transferring the research findings to the UK problematic (Cheyney *et al.*, 2015). For example, many states in America do not have registered midwives; instead, women are normally cared for by an obstetrician in a highly medicalised healthcare system. This is very different to the UK maternity framework which focuses on holistic and woman-centred care. Furthermore, the

unique NHS system of care in the UK makes it very challenging to compare other maternity services with the UK. Further research is needed to explore confidence for birth in the unique structure of the NHS in the UK. This study aims to contribute towards this knowledge base.

2.4.2 Methodology

A quantitative approach was by far the most dominant research design within the literature, accounting for 79% of the papers included in this review. Confidence for a physiological birth was the only research topic not addressed by any quantitative studies; this may be because so little is known about this topic that studies focussed on being exploratory. The most popular design for quantitative studies was longitudinal (39% of the quantitative studies). A longitudinal design is advantageous because it can reflect shifts in measured variables during pregnancy, labour and after birth (Wright and Markon, 2016). Only 16% of papers used a qualitative approach, with the remaining 5% being scoping reviews. The paucity of qualitative data suggests that an exploratory qualitative study would be useful for examining the influences on women's confidence for birth.

2.4.3 Data Collection

All of the quantitative studies used questionnaires to collect their data. No consistent measure was used for the questionnaires exploring childbirth expectations. However, the majority of the questionnaires investigating childbirth self-efficacy and fear of birth used the Childbirth Self-efficacy Inventory (CBSEI) and the Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ) respectively, aiding comparison between studies.

All of the qualitative studies collected data with interviews. This is a traditional and appropriate data collection technique, but with 36 million adults accessing the internet every day, the way in which we communicate as a society is changing (Office of National Office for National Statics, 2017). Further research incorporating online communication would be useful to reflect the current changes in societal culture.

2.4.4 Themes identified from the literature

Literature relating to four different themes appeared to be relevant to exploring women's confidence for birth. These themes were: women's confidence for physiological birth, childbirth self-efficacy, childbirth expectations, and fear of birth. The literature relating to these themes and how the findings may relate to women's confidence for birth is now discussed according to each theme.

2.5 Confidence for a physiological birth

Three studies were identified in this scoping review that set out to explore women's confidence for birth (Brown, 1998; Coughlan and Jung, 2005; Leap *et al.*, 2010). All of the studies had a very specific focus on the characteristics of the pregnancy care required to help low-risk women develop the confidence to give birth physiologically. This focus on physiological birth is likely to have arisen from the re-emergence of facilitating physiological births as an important topic in the literature and clinical practice over the last two decades (ICM, 2010; Kennedy *et al.*, 2010). This advice remains relevant to date. The Maternity Care Working Party (2007) in the UK defined physiological birth as birth:

> without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery
>
> The Maternity Care Working Party (2007:1)

2.5.1 Gaining confidence for a physiological birth

All three studies that explored women's confidence for physiological birth were qualitative in design. Brown (1998), Coughlan and Jung (2005) and Leap *et al.* (2010) utilised grounded theory, grounded theory plus interpretive phenomenology, and qualitative descriptive approach respectively. However, Brown's (1998) methodology was hard to appraise because there was very little description of the grounded theory methods used; perhaps due to the age of the paper and style of journal writing in 1998 rather than methodological weaknesses. The studies included 66 women in total who were interviewed during the first six weeks after giving birth. Brown (1998) and Coughlan and Jung (2005) only included women who had an uncomplicated birth (not defined) or a spontaneous vaginal birth respectively.

Brown (1998) explored women's search for knowledge, their perceptions of self-efficacy and their patterns of involvement in childbirth. Themes identified included "knowing all I could", "confidence" and "nature of the woman/provider relationship". Brown (1998) described the search for knowledge as a key concept for enhancing women's confidence for a physiological birth. Brown (1998) also concluded that pregnancy care providers are key to developing this knowledge and helping women to feel empowered to participate in their individual care

Exploring agency (independence, ability to act in their own interest) in healthcare from the patient's perspective was the focus of Coughlan and Jung's (2005) research. Agency was understood by participants as the ability to discuss healthcare information, make informed choices and have those choices respected by their care provider (Coughlan and Jung,

2005). Women who received care from midwives rather than physicians reported the greatest satisfaction. Midwives were typically the women's top source of information, and women reported that their midwives helped them to feel more confident in their ability to give birth (Coughlan and Jung, 2005). Leap *et al.* (2010) asked participants to reflect on the support and preparation for birth that they had received from their midwives. Themes identified were: "building confidence during pregnancy", "continuity of carer: knowing who would be there in labour", "building confidence to give birth at home", "learning from other women's stories in the antenatal groups", "support for coping with pain in labour", "she believed me when I didn't believe in myself", and "pride and elation after birth" (Leap *et al.*, 2010). The women noted that the trusting relationship with their midwives helped them to build confidence in their ability to labour and give birth without pharmacological pain relief. Women linked their increased confidence to midwives providing information and discussing choices in a collaborative way (Leap *et al.*, 2010).

Overall, the above three studies suggest that women prefer a respectful and connected partnership with their maternity care professional, through which they gain knowledge and confidence for a physiological birth. Although qualitative studies do not aim for generalisability, it is helpful to consider the transferability of study results to other settings (Holloway *et al.*, 2010). Transferability to UK maternity care settings is limited because, while all the studies included women from diverse socio-economic groups, two out of the three studies were based in the USA and Canada with all participants either being insured or fee-paying (Brown, 1998; Coughlan and Jung, 2005). Leap *et al*.'s (2010) study was conducted in the UK but all participants were recruited from the Albany Midwifery Practice, a specific midwifery case-loading model that no longer exists today. Being cared for by the Albany Practice would have meant that the participants had two named midwives for every aspect of their maternity care, providing unusually good continuity of care compared to standard practice across the UK. In itself this level of continuity of care may have influenced women's confidence for a physiological birth.

2.5.2 Summary

Although the studies are badged as exploring women's confidence for a physiological birth, none of the studies actually explore confidence as a concept in itself. Each study appears to have adopted a different interpretation of what they perceive confidence to mean to women. For example, Coughlan and Jung (2005) focus on agency, whereas Leap *et al.* (2010) explores sense of support and Brown (1998) investigates sense of knowledge and self-efficacy. It therefore appears that there are no existing studies that have directly explored women's confidence for birth as a concept in itself, or investigated

what influences women's confidence for birth. Furthermore, recent national figures for birth rates in England suggest that 13.9% of women have a caesarean birth, 14.9% of women have a medically induced birth (where labour is artificially started), 39.4% of women do not have anaesthetic before or while giving birth, and 12.9% of women have a forceps or ventouse birth. This means that while facilitating physiological births where possible is ideal, for many women a physiological birth is not the reality that they experience, and nor can we assume that a physiological birth equates to a positive birth experience. Therefore, a study exploring women's confidence for birth more generally could be more helpful for all women, including the majority of women who do not have a physiological birth.

2.6 Childbirth self-efficacy

Of the three other psychological concepts (childbirth self-efficacy, fear of birth and childbirth expectations), the branches of literature exploring childbirth self-efficacy and confidence are probably the most closely related to each other. Confidence has been described as closely related to self-efficacy, and the two terms were used interchangeably in some of the papers that were reviewed. 'Confidence' is broadly defined to include both a belief in one's own abilities and the ability to succeed (Stevenson, 2010; Zedeck, 2014). 'Self-efficacy' is derived from Bandura's Social Cognitive Theory (Bandura, 1977), and differs from the more general construct of 'confidence' as it refers to people's sense that they will achieve a specific goal. It also differs from the broader concept because expectations are specific to particular behaviours. For example, a woman might have a high sense of self-efficacy for coping with early labour, but low self-efficacy for the pushing stage of labour. Another difference between self-efficacy and confidence is that self-efficacy is focussed on attrition. Bandura argues that the higher your self-efficacy, the more likely you are to pursue a goal, and ultimately to be reinforced by the outcome of your efforts. This is supported by modern literature across many different behaviours – for example, students' motivation to learn (Wäschle *et al.*, 2014), weight loss (De Vet *et al.*, 2013; Armitage *et al.*, 2014) and smoking cessation (Berndt *et al.*, 2013; Ochsner *et al.*, 2014).

Self-efficacy involves two expectations: outcome expectancy (that the behaviour, if properly carried out, will lead to a favourable outcome), and self-efficacy expectancy (that one can perform the behaviour properly) (Bandura, 1988; Bandura, 1997). Outcome expectancy for childbirth is a woman's belief that specific behaviours could enhance their ability to cope with the experience of labour and birth (Lowe, 1993). In contrast, self-efficacy expectancy for childbirth is a woman's belief in, for example, her ability to use specific coping behaviours during labour. Perhaps research to date has focussed on self-

efficacy because it is more specific and therefore an easier concept to study than confidence.

There are four main sources for developing a sense of self-efficacy, shown in Figure 3 (Bandura, 1998;1997;2008):

1. Personal experience of success, such as past childbirth experience
2. Observing effects produced by the actions of others, for example watching a birth
3. Social persuasion and encouragement from respected others, such as childbirth educators
4. Modifying one's stress response. Anxiety, stress, fear and fatigue all have a detrimental impact on self-efficacy, while a negative mood also diminishes it. By interpreting one's physical arousal as something positive, one can eel enhance one's mood and feel energised. A positive mood enhances perceived self-efficacy.

Figure 3: The four main sources of self-efficacy (Bandura, 1988; 1997; 2008)

Given that Bandura's first source of self-efficacy is personal experience, it is interesting that the majority of the studies exploring self-efficacy were conducted using nulliparous (women who have not given birth before) participants only. Although this has advantages because it means that previous birth experience, which is potentially a significant and highly variable factor, is being controlled for, it feels as if the self-efficacy of multiparous women, who make up the majority of women giving birth (Office of National Statistics, 2015), has been somewhat overlooked. Schwartz *et al.* (2015) found that multiparous women did indeed have higher self-efficacy scores than nulliparous women, supporting Bandura's theory. Nevertheless, regardless of parity Schwartz *et al.* (2015) also reported that women who indicated low childbirth knowledge, who preferred a caesarean section and who had high fear of birth scores all reported lower self-efficacy. This suggests that childbirth self-efficacy is more complicated than the four sources suggested by Bandura. Perhaps exploring women's confidence for birth will give a broader understanding of what influences their feelings about birth.

2.6.1 The influence of self-efficacy on pregnancy experiences

Six studies have explored the impact that women's self-efficacy had on their pregnancy experiences. All of the studies found that if women had high levels of self-efficacy, they tended to have a more positive experience of pregnancy compared to women with low

self-efficacy. Increased antenatal childbirth self-efficacy was also associated with decreased end-of-pregnancy discomfort (Sun *et al.*, 2010), lower antenatal anxiety (Beebe *et al*., 2007), decreased fear of labour (Lowe, 2000; Salomonsson *et al*., 2013b), better psychological adaptation to pregnancy, and more confidence in requesting pain medication (Larsen and Plog, 2012). A recent Swedish cross-sectional study using composite measures, carried out by Carlsson *et al*. (2015), found that childbirth self-efficacy was correlated with positive dimensions such as vigour, sense of coherence and maternal support, and negatively correlated with previous mental illness, negative mood states and fear of childbirth. This study suggests that childbirth self-efficacy is a positive dimension that contributes to wellbeing during pregnancy, and thereby acts as an asset in the context of childbirth. As part of routine antenatal care we currently ask women about their mental health, but we do not ask about their self-efficacy for birth. It may therefore be helpful to keep in mind that previous mental illness could also serve as an indicator for low childbirth self-efficacy.

These findings support Bandura's theory that emotional arousal is an important source of self-efficacy, as shown in Figure 3. However, a limitation of these quantitative studies is that it is not clear what comes first, high fear or low self-efficacy. Perhaps qualitative exploration of women's confidence for birth will help us to understand these psychological concepts further. Overall, because confidence and self-efficacy are closely related concepts, these findings suggest that high levels of confidence may also have the same positive impact on women's pregnancy experience. Therefore, confidence for birth is an important psychological concept to understand further.

2.6.2 The influence of self-efficacy on women's preferences for birth

The association between increased childbirth self-efficacy and pregnant women's intentions for care was examined in three studies (Dilks and Beal, 1997; Slade *et al.*, 2000; Williams *et al.*, 2008). Dilks and Beal (1997) found that participants with greater childbirth self-efficacy had greater intentions to attempt vaginal birth after caesarean. Slade *et al.* (2000) determined that those with greater childbirth self-efficacy had greater intention to use non-pharmacological pain coping strategies during labour. Both these studies suggest that self-efficacy may therefore have a large impact on maternity services and resources. If women have a high sense of self-efficacy and therefore have a greater desire to have a vaginal birth rather than planned caesarean, or to avoid epidural analgesia, and these desires are realised, then this is much less costly for maternity services. However, what was not clear from either of these studies was whether these intentions during pregnancy were then realised for birth. Also, the third, more recent study by Williams *et al*. (2008) examined the intention to use non-pharmacological methods to

cope with labour, but did not find an association with childbirth self-efficacy. The difference in findings could be due to methodological weaknesses in Williams *et al*.'s (2008) study, because the Childbirth Self-efficacy Inventory scores were used as a proxy for measurement of participants' beliefs about non-pharmacological pain management methods, rather than measuring the beliefs directly. However, overall these findings suggest that women's confidence during pregnancy may be important to explore further, as there is the potential for confidence to also influence women's preferences for birth, because it is such a closely related concept to self-efficacy.

2.6.3 The influence of self-efficacy on labour experiences

Nine studies examined the influence of childbirth self-efficacy on women's labour experiences, with most studies focussing on the association between childbirth self-efficacy and various aspects of labour pain. A positive association was found between increased childbirth self-efficacy and lower active labour pain (Larsen *et al.*, 2001; Ip *et al.*, 2009; Gau *et al.*, 2011), as well as less suffering during active labour (Stockman and Altmaier, 2001; Berentson-Shaw *et al.*, 2009; Ip *et al.*, 2009). However, childbirth self-efficacy did not predict pain scores during early labour in the one study that examined this phase of labour (Beebe *et al.*, 2007). Neither did childbirth self-efficacy predict pain scores during transition in the two studies that examined this phase of labour (Slade *et al.*, 2000; Berentson-Shaw *et al.*, 2009). Furthermore, Slade *et al.* (2000) found that the associations between greater childbirth self-efficacy and greater intention to use non- pharmacological coping methods during labour were not linked to actual use of coping methods during labour.

All of the studies exploring the relationship between self-efficacy and labour pain used appropriate statistical analysis, with Berentson-Shaw *et al.* (2009) using the most sophisticated statistical analysis with hierarchical regression and composite measures. Composite measures have the advantage of exploring multiple variables at once, but can result in a loss of the ability to examine and predict childbirth outcomes with precision. Furthermore, it is important to note that the Berentson-Shaw *et al.* (2009) model only accounts for 27% of the total variance of in composite pain and distress, indicating that there is still a lot of variance that is unexplained. Perhaps looking at the broader psychological concept of women's confidence will help to explain this remaining variation.

Two studies explored women's satisfaction with their births and found that greater childbirth self-efficacy was significantly associated with greater satisfaction (Christiaens and Bracke, 2007; Berentson-Shaw *et al.*, 2009). Overall, these studies suggest that if women have high self-efficacy, they will have a more positive labour experience. There is

therefore the potential that women's confidence may have the same positive impact on labour experiences, which needs to be further researched.

2.6.4 The influence of self-efficacy on women's experiences after birth

Four studies have explored the association between childbirth self-efficacy scores and perinatal outcome during the postnatal period. Increased childbirth self-efficacy was associated with decreased post-traumatic stress disorder symptoms in one investigation (Soet *et al.*, 2003) but not in another (Goutaudier *et al.*, 2012). However, there was more consistency in findings exploring childbirth self-efficacy and parenting, with stronger childbirth self-efficacy associated with stronger identification with the motherhood role (Sieber *et al.*, 2006), parenting self-efficacy and parenting knowledge (Svensson *et al.*, 2009). Although these findings are encouraging in terms of the wider importance of childbirth self-efficacy, they do not fit within Bandura's (1977) theory, which cannot explain why increased childbirth self-efficacy leads to enhanced parenting. This is because working within Bandura's (1977) traditional framework would suggest that antenatal, intrapartum and postnatal self-efficacy are all separate phases. Exploring confidence rather than specific self-efficacy phases would enable the childbirth experience to be explored as a continuum, which could be useful for a deeper understanding of the childbirth process.

2.6.5 The ability to influence women's self-efficacy during pregnancy

Four studies using randomised control trials found that childbirth self-efficacy could be increased by interventions during pregnancy (Ip *et al.*, 2009; Gau *et al.*, 2011; Rahimparvar *et al.*, 2012; Abbasi *et al.*, 2018). A randomised control trial design is advantageous for exploring the relationship between self-efficacy and interventions because as many sources of bias are removed as possible, so the results are more likely to give a true result (Bowling, 2014). Rahimparvar *et al.* (2012) and Ip *et al.* (2009) explored the impact of educational interventions during pregnancy with 150 Iranian and 133 Chinese nulliparous women respectively. These studies both found that the educational interventions significantly increased women's childbirth self-efficacy and reduced their perception of pain and anxiety during labour. Gau *et al.* (2011) found that women's self-efficacy and pain experienced during labour were significantly improved by participants completing a birth ball exercise programme. Abbasi *et al.* (2018) reported that women who received an educational booklet at 30 – 34 weeks of pregnancy had significantly increased childbirth self-efficacy when they were in the active phase of labour at 4-5cm dilation of cervix. However, it should be noted that all of these studies only measured self-efficacy at specific points during pregnancy or labour, so if participants'

levels of self-efficacy fluctuated the studies may not have captured the complexity of their sense of self-efficacy during pregnancy and birth, in the same way that a qualitative study may be able to.

One study by Kennedy *et al.* (2011) found no positive effect of an antenatal intervention aiming to enhance childbirth self-efficacy. Kennedy *et al.*'s (2011) study was a three-year randomised control trial that explored the differences between women receiving group or individual antenatal care. The generalisability of these findings was limited as there was a small number of participants (88 pregnant women) from a very specific setting (the military) in the same area of the USA. Kennedy *et al.*'s (2011) findings must also be interpreted with caution because the primary focus of the study was to evaluate whether modified antenatal care enhanced the adequacy of antenatal care, rather than self-efficacy per se.

Overall, the research about women's childbirth self-efficacy is positive and suggests self-efficacy can be improved during pregnancy. This is useful given that the studies identified in this scoping review suggest that self-efficacy impacts on women's experience during pregnancy, labour and after birth. Furthermore, it is also possible that as with self-efficacy, women's confidence has the potential to be influenced during pregnancy, as suggested by the findings of the service evaluation on 'Confident Birthing Workshops'. If this is the case, then once a theoretical understanding of women's confidence has been developed, this understanding can be used to enhance women's confidence and in turn improve their overall experience during the start of motherhood.

2.6.6 Qualitative understanding of self-efficacy

Despite the reported benefits of women having high childbirth self-efficacy, only one qualitative study was identified which explored self-efficacy for birth. Salomonsson *et al.* (2013) explored childbirth self-efficacy among 17 first-time mothers with severe fear of birth. Salomonsson *et al.* (2013) found that behaviours for coping with labour and birth were related to six domains of childbirth self-efficacy: concentration, support, control, motor/relaxation, self-encouragement, and breathing. Most of these behaviours referred to capabilities to carry out (self-efficacy expectancy) rather than beliefs in effectiveness (outcome expectancy) (Salomonsson *et al.*, 2013: a). These findings suggest that coping with labour and birth for women with severe fear of birth is challenging and complex. However, this study only explored self-efficacy for women with high levels of fear of birth. A qualitative study exploring women's confidence for birth more generally may therefore be helpful for providing a broader understanding of how we can potentially improve women's maternity care experiences.

2.7 Childbirth expectations

2.7.1 Women's expectations of childbirth

Three studies explored women's expectations of birth. Expecting to have a vaginal birth was a key finding for two studies exploring childbirth expectations among 334 young childless women (D'Cruz and Lee, 2014) and for seven women who were pregnant with their first baby (Martin *et al.*, 2013). D'Cruz and Lee (2014) reported that 84% (289 participants) expected to have a vaginal birth, while Martin *et al.* (2013) also reported that all women expected a healthy baby. D'Cruz and Lee (2014) indicated that women expected technical expertise from obstetric-led care and emotional support from midwifery-led care. Given that these studies were conducted in Australia and America, which have higher caesarean rates than the UK (30.3% compared to 22%), it is therefore likely that women in the UK also expect to have a vaginal birth (Gibbons *et al.*, 2010). In addition to these studies, Malacrida and Boulton (2014) qualitative research found that many women in their study expected to endure pain, and even considered experiencing 'proper' pain to be a rite of passage to becoming a mother. As a result, women saw a vaginal birth as an accomplishment and an unplanned caesarean as a failure. Perhaps this means that women look beyond a biomedical model of birth, and that rather than treating labour pain as abnormal and something that needs to be treated with analgesia, pain is considered to be an important part of labour that should be worked with rather than against. Exploring women's confidence for birth will enable further exploration of a holistic approach to maternity care.

2.7.2 The impact of childbirth expectations

Childbirth expectations seem to be an important influence on women's overall birth experience. Five studies were identified that explored the association between childbirth expectations and childbirth experiences. Two large longitudinal studies from the 1990s examined the relationship between expectations and experiences in some depth with samples of 852 and 388 women respectively (Slade *et al.*, 1993; Green *et al.*, 1998). This methodology is very effective for determining variable patterns over time, and is more powerful than a cross sectional study which only collects data at one point in time. Green *et al*. (1998) found that positive expectations of birth were associated with greater control in birth, greater satisfaction and emotional wellbeing. However, negative expectations were associated with finding birth less fulfilling, being less satisfied with birth, and reporting less emotional wellbeing after birth. Slade also found that expecting positive emotions during birth was predictive of experiencing negative emotions.

Ayres and Pickering (2005) added to these findings with their longitudinal questionnaire study exploring the relationship between anxiety and birth expectations. Ayres and Pickering reported that anxiety in pregnancy was associated with expecting less positive emotions during birth, more negative emotions during birth, less control, and less support during birth. Christiaens and Bracke (2007) also confirm these findings with a longitudinal questionnaire study of 605 women, reporting that the more women's expectations are met, the more they feel satisfied with their childbirth experience.

However, a more recent repeated measures study found no correlation between birth expectations and birth experience (Fair and Morrison, 2012). These contradictory findings may have resulted from methodological weakness in Fair and Morrison (2012) repeated measures study, which had a very small sample size in comparison with the other studies, involving only 31 first-time mothers at one obstetric practice. This increases the chance of a type two error (incorrectly retaining a false null hypothesis), thereby decreasing the generalisability of the results to the rest of the pregnant population. Overall, it seems that if women have positive expectations for birth, they are more likely to have a positive birth experience. This has important implications for clinical practice because if maternity services can improve women's expectations for birth, they may also be able to improve women's birth experiences. Perhaps understanding and improving women's confidence for birth is a tangible way for maternity services to improve women's experiences.

2.7.3 The influences on childbirth expectations

Women's expectations of birth appear to be complex and dynamic. Slade *et al.* (1993) assessed women's expectations for birth during pregnancy and then compared these with postnatal reports of actual experiences. Slade *et al.* (1993) found that women hold both positive and negative expectations of birth, that these dimensions are independent of each other, and that they relate in different ways to birth experience. Since then further studies have continued to add to the complex picture of women's expectations, with more recent research now suggesting that women's expectations are influenced by anxiety (as discussed in section 2.7.2) as well culture and parity, as well as other background characteristics (including age, level of education and mental health).

i) Culture

A recent scoping review concluded that culture influences women's expectations of birth, particularly in relation to expectations of control, support, care providers, health of the baby, and pain during birth (Moore, 2016). Expecting to feel in control during labour was identified as important for women across many different cultures. However, women had

different definitions of 'control' which were culturally derived. For example, Finnish women described being in control as staying calm, being aware of events, cooperating with the midwife and controlling pain, whereas Jewish women described remaining in control as staying calm during the pain of a contraction by praying, reciting the psalms or moaning (Melender, 2006; Rassin *et al.*, 2009).

Expectations of support during labour also varied according to women's culture. Around the world labouring women are commonly supported by female relatives, female friends and female midwives (Davis-Floyd, 2003). Immigrant women may therefore be shocked to find that Western women bring their husbands with them to the birth for support, as this is taboo in many traditional cultures (Berry, 1999; Wiklund *et al.*, 2000; Cheung, 2002; Brathwaite and Williams, 2004; Reid and Taylor, 2007; David *et al.*, 2009). The tradition of female support during labour is also an important consideration for maternity services, given that there are currently around 103 male midwives practising in the UK (Pendleton, 2015). However, even in non-Western countries traditional cultural values are shifting regarding expectations about birth. For example, women from cultures that traditionally value experiencing the pain of birth, such as traditional Chinese and orthodox Jewish cultures, are now increasingly deciding to use epidural analgesia for pain management (Brathwaite and Williams, 2004; Semenic *et al.*, 2004). This implies that influences on women's expectations of birth are fluid and alter according to current culture.

Moore (2016) conducted a scoping review about women's childbirth expectations exploring literature from many different cultures and included both qualitative and quantitative research, emphasising the importance of understanding multicultural expectations of birth. There are several limitations to this review, first because there was little evidence of a systematic search or appraisal process, with no clear explanation of the literature refining process or how many papers were identified. However, a systematic search of the literature for this scoping review only identified one additional key paper exploring the influence of culture on birth expectations that was not included in Moore's review. This paper by Christiaens *et al.* (2008) compared Belgian and Dutch women's expectations, finding that Dutch women had more negative expectations and experiences of birth compared to Belgian women. These findings further support Moore's (2016) argument, highlighting that even within European countries with fairly similar populations there are cultural differences in birth expectations. Another limitation of Moore's (2016) findings is that many of the studies were conducted in predominately White, well educated, "middle class" populations, and lacked participants who did not speak the researcher's native language.

The significance that culture has on women's expectations is also important when reviewing the existing body of evidence, given that only two of the studies exploring

women's expectations were conducted in the same country as the study population for this PhD.

ii) Parity and other background factors

Three studies were identified that explored parity (the number of times a women has given birth) and other background factors in relation to childbirth expectations. Ayers and Pickering (2005) reported a number of differences in expectations and experiences between nulliparous and multiparous women, although these differences were not consistent. In other words, it was not simply that multiparous women were more 'accurate' than nulliparous women in their expectations, due to their previous birth experience. It was more complex than this; for example, nulliparous women were more 'accurate' about maternity staff's control over analgesia, while multiparous women were more 'accurate' about control over position and analgesia. A possible explanation for this is that there were real differences in the way maternity staff cared for women depending on whether or not they had given birth before (Ayers and Pickering, 2005). Hauck *et al.* (2007) conducted a qualitative exploratory study with 11 nulliparous women and nine multiparous women who between them had experienced 31 births. These findings add further weight to the argument that influences birth expectations, with multiparous women reporting more positive birth expectations. Multiparous women who reported unfulfilled expectations from their previous birth described subsequently adapting their expectations to be more realistic, to avoid disappointment with their future births (Hauck *et al.*, 2007).

A recent prospective regional cohort study of 1042 Swedish women by (Hildingsson, 2015) also supported these findings, reporting that nulliparous women had higher expectations than multiparous in relation to support from partner (mean score 3.46 vs 3.34, p=<0.01) and midwife (mean score 3.77 vs 3.64, p=<0.001). These findings raise interesting questions about whether women are creating unrealistic expectations of birth from unreliable sources of information, or whether maternity services are failing women by not achieving these expectations. Furthermore, Hildingsson (2015) suggests that the influences on birth expectations were more complex that parity alone, with other background characteristics influencing birth expectations. For example, younger women (under 25 years old) were more likely to expect greater support from their partner (mean score 3.86 vs 3.70, p=<0.001) and to expect to participate in decision making (mean score 3.15 vs 3.06, p = <0.05) (Hildingsson, 2015: 7). Fearfulness, level of education, and self-reported mental health were all also found to influence birth expectations (Hildingsson, 2015).

Overall, the research exploring women's background factors suggests that anxiety, parity, culture and background characteristics are important considerations in relation to

women's expectations for birth. This suggests that women's expectations for birth are based on many different complex influences, and it may therefore also be the case that women's confidence for birth is also influenced by these same factors.

2.7.4 The relationship with researching women's confidence for birth

In conclusion, women's expectations for birth are an important influence on their birth experience. It seems possible that if we can understand women's confidence for birth and positively influence their confidence, then we may be able to positively influence women's birth expectations, reducing their anxiety and in turn improving their birth experience. Furthermore, understanding the diverse influences on women's expectations for birth has been useful for scoping out the potential influences that may also impact on women's confidence for birth. In order to test this hypothesis, we need to first understand what influences women's confidence for birth.

2.8 Fear of birth

2.8.1 Prevalence and definitions of fear of birth

The literature explored for this scoping review suggested that one in five pregnant women experience moderate fear of childbirth, while 6–10% of all pregnant women worldwide suffer from severe fear of childbirth (Hanna-Leena Melender, 2002; Poikkeus *et al.*, 2006; Rouhe *et al.*, 2009; Demšar *et al.*, 2018). However, there is currently no agreed definition of what fear of birth is, largely due to differences in diagnostic testing (Haines *et al.*, 2011) . The differences in diagnostic testing have also led to varying evidence for the prevalence of fear of birth, with reported proportions ranging between 7% and 26% of women in high income countries fearing childbirth (Hofberg and Ward, 2004; Kjærgaard *et al.*, 2008; Fenwick *et al.*, 2009; Laursen *et al.*, 2009). Fear of birth has been documented as early as 1858 by the French psychiatrist Marcé:

> If they (women) are primiparous, the expectation of unknown pain preoccupies them beyond all measure, and throws them into a state of inexpressible anxiety. If they are already mothers, they are terrified of the memory of the past and the prospect of the future. (Hofberg and Brockington, 2000: 83)

Marcé was writing at a time when none of the modern forms of analgesia, such as Entonox (gas and air), were available, and specifically addressed fear of pain as a predominant concern for nineteenth century pregnant women. A more recent study by Henderson and Redshaw (2016) reported that fears related to birth are more complex and include worries about uncertainty of labour onset, caesarean birth, duration of labour and

embarrassment. In the UK, Hofberg and Brockington (2000) labelled fear of birth as 'tocophobia', derived from the Greek, 'tocos' (birth) and 'phobia' (fear). These psychiatrists published a review of 26 case studies of women referred to them with fear of birth, developing two diagnostic terms: 'primary tocophobia', affecting women who have not given birth before; and 'secondary tocophobia', characteristic of women who have given birth previously (Hofberg and Brockington, 2000).

In the context of these discrepancies in definitions and prevalence of fear of birth, perhaps by exploring women's confidence for birth, rather than focussing on abnormality and tocophobia, we can develop a basis for how women normally develop and interpret their feelings about birth. Confidence is a lay term that could provide a more positive way of thinking, compared to fear of birth and tocophobia. Confidence and fear are related psychological concepts, and gaining a better understanding of women's confidence for birth could therefore help to further understand fear.

2.8.2 The impact of fear of birth

In total, 15 studies were identified in this scoping review that explored the impact of fear of birth. Several of these studies cited Dick-Read (1959) as producing seminal work on the psychology of childbirth by developing the 'fear-tension-pain' cycle, linking women's fear and anxiety to muscular tension and pain during labour. The fear-tension-pain model proposed that high levels of fear lead to increased muscular tension, causing increased pain which in turn further heightens the woman's level of fear (Dick-Read, 1959). Dick-Read's work reducing fear of birth continues to be important for several reasons. Fear and anxiety activate a hormonal stress response in pregnant and labouring women (Lederman, 1995; Alehagen *et al.*, 2005), which can result in labour dystocia or protracted labour (Lowe, 2007; Laursen *et al.*, 2009). Other outcomes related to fear of childbirth include: voluntary infertility, pregnancy complications, increased analgesic use in labour, increased childbirth interventions, both planned and emergency caesareans, postnatal depression, post-traumatic stress disorder and impaired maternal-infant relationship (Ryding *et al.*, 1998; Bewley and Cockburn, 2002; Geissbuehler and Eberhard, 2002; des Rivières-Pigeon *et al.*, 2004; Hofberg and Ward, 2004; Waldenström *et al.*, 2006; Nieminen *et al.*, 2009). All of these outcomes can have consequences for a woman's physical and emotional wellbeing, her role as a mother, and her relationships with her baby, other children and partner (Ogrodniczuk, 2004). Confidence and fear of birth are closely related psychological concepts, and therefore these findings suggest that confidence is important in further research because lack of confidence for birth may also lead to these same negative consequences.

2.8.3 The influences on fear of birth

Six studies have demonstrated that previous birth experience influences fear of birth (Waldenström *et al.*, 2006; Nilsson and Lundgren, 2009; Nilsson *et al.*, 2010; Nilsson *et al.*, 2012; Storksen *et al.*, 2013; Fairbrother *et al.*, 2018). Parity (the number of times a woman has given birth) can influence fear of birth, Fairbrother *et al. 's* (2018) questionnaire study of 643 pregnant women reported that participants who had not given birth before had higher levels of fear of birth. However, Fairbrother *et al.* (2018) also suggests that fear of birth appears to more complex than being influenced than parity alone and can depend on how women perceive their experience of giving birth. Nilsson *et al.* (2012) found that fear of birth was associated with a previous negative birth experience and a previous emergency caesarean section, both during pregnancy and one year after birth. Until recently it had been assumed that obstetric complications lead to a negative birth experience (Waldenström *et al.*, 2006). Both Nilsson *et al.* (2012) and Storksen *et al.* (2013) found that women's perception of the overall birth experience as negative was a more important association than obstetric complications in predicting fear of birth. Indeed, the majority of the 1357 women in Storksen *et al.'s* (2013) study who experienced obstetric complications did not have a negative overall birth experience and did not develop a fear of birth. This demonstrates the complex nature of birth experience, which incorporates subjective psychological and physiological processes that are influenced by social, environmental, organisational and policy contexts (Larkin *et al.*, 2009).

The above studies used longitudinal observational designs, so they can only describe associations between variables rather than prove causation. However, this design is appropriate for this research topic as it would not be ethical to deliberately give women a negative birth experience. A recent qualitative study by Nilsson *et al.* (2010) also supports these studies, reporting that women described their previous birth experience as 'etched in their minds', giving rise to feelings of fear, loneliness and lack of faith in their ability to give birth, as well as diminished trust in maternity care.

In addition to previous birth experience, there is some evidence to suggest that previous experience of violence or childhood trauma can also influence fear of birth. A Norwegian study found that women who reported being exposed to physical or sexual abuse had a significantly higher score for fear of birth compared to women who reported no abuse (Heimstad *et al.*, 2006). These findings are supported by a more recent Danish study by Schroll *et al.* (2011), which found that women with a lifetime experience of sexual or physical violence appeared to have an increased risk of severe fear of birth after delivery, compared to women who reported never having experienced violence. Other studies have focussed on childhood sexual abuse specifically, finding that a history of childhood sexual abuse was significantly associated with severe fear of birth, as well as being significantly

more likely to find birth a highly frightening and negative experience (Lukasse *et al.*, 2010; Montgomery *et al.*, 2015; Leeners *et al.*, 2016). These findings are not surprising, given that birth involves very intimate body experiences, such as vaginal examinations and parts of one's body that are typically associated with sexual activity. It therefore seems highly likely that birth is a more emotionally difficult experience for women with a history of sexual abuse.

However, a challenge with this research is that it is difficult to estimate the prevalence of women who have experienced violence or trauma in their lifetime, due to the complexity of detecting violence and also because there is no consistent international definition or instrument to measure this (Watts and Zimmerman, 2002). Nonetheless, given that a study in a Western sample of women estimated that one third of women have experienced violence within the last ten years, this is an important consideration for maternity care professionals (Records and Rice, 2009).

In contrast to the research focussing solely on the influences of previous experiences, another study found that intrapersonal factors (taking place or existing within the mind) can also influence fear of birth, but interpersonal factors (relating to relationships or communication with people) do not (Hamama-Raz *et al.*, 2016). These authors found that for women who had given birth before, age and intrapersonal factors were significantly associated with fear of birth. Specifically these factors were attitude towards pregnancy and birth, body image and delivery preference. However, for nulliparous women only intrapersonal factors were associated with fear of birth; these factors tended to be attitudes towards pregnancy and birth, and delivery preference for caesarean. Fairbrother *et al.* (2018) also included some demographic data in their questionnaire study and reported that women who have a higher socio-economic status (as indicated by family income and education status) had lower levels of fear of birth. Hamama-Raz *et al.* (2016) and Fairbrother *et al. (2018)* studies provides a useful explanation as to how intrapersonal factors can influence fear of birth, but caution should be exercised in generalising these findings, because a convenience sample and online surveys were used to collect the data which could lead to potential bias.

As well as this literature exploring factors that can influence fear of birth, a recent meta-analysis of ten quantitative studies by MoghaddamHosseini *et al.* (2017) found a significant effect of educational interventions and hypnosis on reducing fear of birth during pregnancy and the postnatal period. Furthermore, the meta-analysis reported that the educational interventions may be more effective than the hypnosis interventions in reducing fear of birth. These findings suggest that a lack of accurate or sufficient knowledge about pregnancy and childbirth may therefore also be a factor that influences fear of birth.

An RCT of 659 first time mothers in Finland, explored the relationship between enhanced 2-hour childbirth education and fear of birth during pregnancy (Haapio *et al.*, 2017). This study reported that the mothers in the intervention group receiving the enhanced childbirth education had less childbirth-related fear than mothers in the control group (Haapio *et al.*, 2017). The results of this study suggest that fear of birth may be reduced by a one-off educational intervention. However, further research is needed to study the effects of childbirth education on pregnant women.

Overall these studies suggest that fear of birth can be influenced by several different factors, including previous birth experience, history of violence or childhood sexual abuse, parity, age, intrapersonal factors and educational interventions. It therefore seems possible that women's confidence for birth may also be influenced by these factors. Furthermore, women's confidence for birth may also be a psychological factor that we can improve through interventions such as educational interventions or hypnosis.

2.9 Conclusion

This chapter has described a systematic search and appraisal of the literature relevant to further understanding women's confidence for birth. No studies were identified which explored women's confidence for birth. However, 88 studies were synthesised to investigate current knowledge about women's confidence for a physiological birth, childbirth self-efficacy, childbirth expectations and fear of birth. Although these concepts were distinct from confidence, they provided some insight into the varied and complex factors that may also influence women's confidence for birth. Furthermore, these studies suggested that confidence for birth is an important concept to research because it may have a long term impact on women's psychological . However, because there is not currently any research about women's confidence for birth, the notion that confidence is an important for birth is an assumption that needs to be tested. Before the importance of women's confidence for birth can be tested, an understanding of women's confidence for birth and what influences this needs to be developed. This PhD study therefore aims to develop a theoretical understanding of women's confidence for birth in the UK. A better understanding of what influences childbirth confidence may enable maternity services to help women improve their childbirth confidence and ultimately have a more positive birth experience. This research may also help maternity services in the UK to better understand women's psychosocial needs, given the scant number of papers (five) relating to childbirth self-efficacy, childbirth expectations and fear of birth that have been conducted in the UK. The research question at the outset of the second and main phase of this PhD was therefore:

"What are the perceived influences of confidence for birth during pregnancy and labour in the United Kingdom?"

In line with grounded theory methodology, this research question was broad and flexible and was refined during the grounded theory process. The research objective developed from the scoping review, and the research question was:

> **To develop an understanding of the social and psychological processes that women perceive to influence their confidence for birth during pregnancy and labour.**

The focus will be on 'perceived influences' based on the psychological literature, particularly the literature on social support, suggesting that individuals' perceptions of an experience are more critical than the actual experience (Michailidou *et al.*, 2015). Chapter 3 explores the grounded theory methodology and the methods used to achieve the research question and objective.

Chapter 3 Constructivist grounded theory approach

3.1 Introduction

This chapter presents a rationale for the methodology and methods used to explore the influences on women's confidence for birth. This includes a discussion of the choice of qualitative paradigm and grounded theory methodology. The evolution of grounded theory and the divergent paths taken by the methodology's founders, Glaser and Strauss, is also explored. This leads to a justification for choosing a second-generation constructivist grounded theory methodology. The overall study design will also be explored, including a discussion about how theoretical sampling was achieved through four cycles of data collection and analysis.

This chapter also provides a broad overview and rationale for the methods used in this study. Data was collected from two sources: interviews, and an online discussion forum. The methods for data collection and analysis from these sources will be explored. Ethical considerations for both data sources will be discussed throughout the chapter. This leads into Chapter 4, which goes on to present a detailed step-by-step account of the actual grounded theory process used for this study. Both this chapter and the next have some sections that are written in the first person, in order to demonstrate the reflexive research process conducted throughout data collection and analysis.

3.2 Research paradigms

Researchers are guided by principles that combine beliefs about ontology, epistemology and methodology. These terms are defined in Table 6, below using definitions from Lincoln *et al.* (2011) and Creswell and Creswell (2013).

Term	**Definition**
Ontology	What is the nature of reality?
Epistemology	What is the relationship between the researcher and that being researched?
Methodology	How do we know the world or gain knowledge of it?

Table 6: The terms used to develop the study paradigm

The combination of beliefs about ontology, epistemology and methodology is shaped as a paradigm, or in other words, “a basic set of beliefs that guides action” (Guba, 1990: 17). Sections 3.2.1 and 3.2.2 provide a rationale for the paradigm wherein I have positioned myself as a researcher. Discussing my underpinning paradigm should help to improve the quality and transparency of this PhD by providing a holistic view of my approach to research. This includes how I believe knowledge is viewed, how I see myself in relation to this knowledge, and the methodological strategy that I have used to discover new knowledge.

3.2.1 Rationale for choosing a qualitative paradigm

Approaches to research can broadly be divided into quantitative and qualitative paradigms. Qualitative research focuses on the qualities of entities, processes and meanings that are not experimentally examined or measured in terms of quantity, amount, intensity or frequency (Gerrish and Lacey, 2010; Denzin and Lincoln, 2011). In contrast, quantitative studies emphasise the measurement and analysis of causal relationships between variables, not processes (Curtis and Drennan, 2013). Furthermore, while qualitative researchers believe that rich descriptions of the social world are valuable, quantitative researchers are deliberately unconcerned with such detail and focus on the process of developing generalisations (Burns and Grove, 2009; Lincoln *et al.*, 2011).

This study sought to develop a theoretical understanding of women’s confidence for birth. A qualitative approach therefore became necessary to allow rich description of the social processes and meanings influencing women’s confidence for birth. Moreover, as identified from the scoping review in Chapter 2, very little is known about women’s confidence for birth, so it is therefore important to first develop an understanding of women’s confidence for birth before quantitative methodologies can be used to test this understanding. For example, it would be challenging to develop a questionnaire to measure confidence for birth without having in-depth knowledge of the constructs that need to be included within it.

3.2.2 Rationale for choosing a constructivist paradigm

The following five paradigms structure most research: positivist, post positivist, critical theory, constructionist (or interpretivist), and participatory (Creswell, 2014). Qualitative research tends to sit within a critical theory, constructionist or participatory paradigm, while quantitative research tends to sit within a positivist or post-positivist paradigm (Lincoln *et*

al., 2011; Mills and Birks, 2014) (Lincoln *et al.*, 2011b; Mills and Birks, 2014). A summary of the five major research paradigms and their associated ontology, epistemology and methodology can be found in Table 7.

	Positivist	**Post-Positivist**	**Critical theory, Feminism and Ethnic**	**Constructionist**	**Participatory and Postmodern**
Ontology What is the nature of reality?	Belief in a single identifiable reality. There is a single truth that can be measured and studied. The purpose of research is to predict and control nature.	Recognise that nature can never be fully understood. There is a single reality, but we may not be able to fully understand what it is or how to get at it because of the hidden variables and a lack of absolutes in nature.	Human nature operates in a world that is based on a struggle for power. This leads to interactions of privilege and oppression that can be based on race or ethnicity, socioeconomic class, gender, mental or physical abilities or sexual preferences.	Our knowledge is constructed through our lived experiences and through our interactions with other members of society. Therefore multiple realties exist and are dependent on the individual.	Participative reality – subjective-objective reality, co-created by mind and the surrounding cosmos. Based on democratic participation between researcher and subject. Freedom from objectivity with a new understanding of the
Epistemology What is the relationship between the researcher and that being researched?	Belief in total objectivity. Researchers should value only scientific rigour and not its impact on society or research subjects	Assume we can only approximate nature. Interaction with research subjects should be kept to a minimum. The validity of research comes from peers (the research community), not from the subjects being studied.	Research is driven by the study of social structures, freedom and oppression, and power and control. Researchers believe that the knowledge that is produced can change existing oppressive structures through empowerment.	Subjectivist: enquirer and enquired into are fused into a single entity. Findings are literally the creation of the process of interaction between the two. Researchers believe that people construct their own understanding of reality.	Holistic: replaces traditional relation between 'truth' and 'interpretation' in which the idea of truth precedes the idea of interpretation. Findings are co-created with the participants.
Method-ology What is the process of research?	Belief in the scientific method. Value a 'gold standard' for making decisions. Grounded in the conventional hard sciences, belief in falsification principle that results are true until disproved.	Researchers should attempt to approximate reality. Use of statistics is important to visually interpret our findings. Belief in scientific method. There is an attempt to ask more questions than positivists because of the unknown variables involved in research.	Search for participatory research which empowers the oppressed and supports social transformation and revolution.	Individual constructions are elicited and refined hermeneutically (concerning interpretation) and are compared and contrasted with the aim of generating one or few constructions on which there is substantial consensus. Relies on naturalistic environments.	Political participation in collaborative action enquiry; primacy of the practical; use of language grounded in shared experiential context. Using deconstruction as a tool for questioning representations

Table 7: A summary of the key research paradigms, adapted from Creswell and Creswell (2013) and Lincoln et al. (2011)

Following the decision to conduct qualitative research, two key factors influenced the choice of a constructivist paradigm. First, once the study aim had been identified, grounded theory became the obvious choice of methodology (see section 3.3). Unusually for qualitative research, the grounded theory methodology traditionally sits within a positivist paradigm (Charmaz, 2014). However, second generation grounded theorists have developed constructivist grounded theory, enabling this methodology to sit within a constructivist paradigm. As a researcher, midwife and woman my ontological and epistemological beliefs about the world are firmly positioned within a constructivist position. Constructivism is a branch or variant of constructionism, which is the belief that there is no meaning in the world until we construct it and that meaning is affected by social interactions (Crotty, 1998; Ernest, 1999; Kukla, 2000; Kim, 2001). Constructivism expands on constructionism by arguing that people create meaning through social interactions and the objects within their environment (Ernest, 1999; Kim 2001). This means that reality is constructed through human social interactions, and knowledge is a human product that is socially and culturally derived and learnt through social processes. Table 8 is adapted from Kim (2001) and provides examples to demonstrate the relationship between constructionism and constructivism.

Paradigm	**Description**	**Example**
Constructionism (or Social Constructionism)	There is no meaning in the world until we construct it. The meaning we make is affected by our social interpretation of the thing. The meaning we derive for objects arises in and out of interactive human community.	Even if you bump into a tree, you cannot get meaning directly from the tree because you have ingrained social interpretations of the tree. You will also assign meaning to the tree based on your social background, and it will be a different meaning from what any other person will have for the tree.
Constructivism	A branch or variant of constructionism. People create meaning through their interaction with each other and the objects in the environment.	If you bump into a tree, you can get meaning directly from the tree but that meaning is combined with social interpretations of the tree. The meaning you assign to the tree will still be a different meaning from what any other person will have for the tree.

Table 8: Descriptions of constructionist and constructivist paradigms

Selecting a traditional positivist approach and assuming that there is a single identifiable reality contradicted my philosophical beliefs and experiences, because I think that everyone has their own perception of reality. Like Charmaz (2014), I identify with constructivism because I have experienced objects and places giving me meaning as well as social interactions. This is why the research question aims to explore women's perception of what influences their confidence for birth. Therefore, conducting this study using a constructivist grounded theory approach satisfied the methodological requirements for the study aims, as well as my own beliefs as a researcher and woman.

3.2.3 Rationale for choosing grounded theory

The scoping review in Chapter 2 demonstrated that there is very limited research exploring confidence for birth. The aim of grounded theory is to generate theory, and this methodology is therefore ideally suited to researching under-theorised phenomena such as women's confidence for birth. Another advantage to using grounded theory is that Glaser and Strauss were medical sociologists, and therefore basic social and psychological processes are key to this methodology. This is ideal for exploring the psychosocial construct of 'confidence' and what influences women's confidence for birth. Table 9 demonstrates some of the other research methodologies that were considered to explore women's confidence for birth, but which were discounted in favour of grounded theory. The descriptions of the methodological approaches in this table were adapted from Gerrish and Lathlean (2015).

Methodology	Reason discounted
Case study research	Case study research explores a phenomenon in its context and assumes that this context is a significance to the phenomenon. This was therefore not appropriate for this study that aims to explore what influences women's confidence for birth during pregnancy on a general level, rather than focussing on a specific context.
Ethnography	Ethnography gives a detailed description of culture or subculture. This is therefore more appropriate to explore, for example, a group of patients in a particular setting, rather than confidence for birth as a general construct. Also, participant observations are a key data collection method for ethnography. With no previous research exploring women's confidence for birth, it would be very challenging to observe 'confidence'.
Narrative research	Narrative enquiry is a research approach based on stories of experience. Data sources might be narrative, oral histories, diaries, autobiographies or visual images. Using this approach, it might be challenging to separate out confidence for birth from the experience of pregnancy and birth in general.
Phenomenological research	Phenomenology uses descriptions and/or interpretations of everyday human experiences as sources of qualitative evidence. It was felt that adopting a phenomenological approach would make it difficult to focus on the specific psychosocial construct of 'confidence', rather than the experience of pregnancy and birth in general.

Table 9: Other methodologies for conducting qualitative research that were considered for this study and then discounted (Gerrish and Lathlean, 2015)

3.3 Grounded theory methodology and approaches

3.3.1 Introduction to grounded theory methodology

Grounded theory methodology was developed by Barney Glaser and Anselm Strauss in the 1960s, who define grounded theory as:

> the discovery of theory from data – systematically obtained and analysed in social research. (Glaser and Strauss, 1971: 1)

Grounded theory is characterised by two key attributes: first, the constant comparison method, which aims to iteratively develop codes, concepts and categories through data analysis; and second, theoretical sampling, which is used to identify and select rich data sources to explain a phenomenon (Charmaz, 2006; Hallberg, 2006). These features aim to develop a substantive theory that explains a process within a particular social context through the experiences of the people operating within it (Creswell 2007). This study therefore aimed to explain the process of how women's confidence for birth is influenced during pregnancy in the UK by exploring the experiences of women who are either pregnant or who have given birth recently. This was achieved using the methods outlined in Figure 4, which are described as the defining components of grounded theory by Charmaz (2014).

- Simultaneous involvement in data collection and analysis.
- Constructing analytic codes and categories from data, not from preconceived logically deduced hypotheses.
- Using the constant comparison method to make comparisons during each stage of the analysis.
- Advancing theory development during each step of data collection and analysis.
- Memo-writing to elaborate categories, specify their properties, define relationships between categories, and identify gaps.
- Sampling aimed toward theory construction (theoretical sampling)

Figure 4: The defining components of grounded theory (Glaser and Strauss, 1967; Glaser, 1978; Strauss, 1987)

3.3.2 The history of grounded theory

As discussed in section 3.2.2, Glaser and Strauss' original grounded theory sat within a positivist paradigm, valuing scientific method by collecting data through an emergent and iterative process (Glaser and Strauss, 1967; Glaser, 1978; Glaser, 1992; Lingard *et al.*, 2008; Charmaz, 2011b) (Glaser and Strauss, 1967; Glaser, 1978; 1992; Lingard *et al.*, 2008; Charmaz, 2011). By providing a rigorous scientific method for qualitative research, Glaser and Strauss aimed to counteract the growing tensions between quantitative and qualitative research in the United States in the early 1960s. Qualitative research was losing ground in sociology because it was deemed to lack transparency by not being theorised, explicated or coded in accessible ways. In 1965 Glaser and Strauss used a grounded theory approach to explore dying as a social ritual that permeated the lives and care of terminally ill patients. These novel methods were later published in '*The Discovery*

of Grounded Theory: Strategies for Qualitative Research', refocussing qualitative research on the methods used for analysis (Glaser and Strauss, 1967). Grounded theory has since been cited as pivotal in debunking the positivistic assumptions of the time, providing an alternative research method beginning with the research data and placing emphasis on situating theory within this data (Denzin and Lincoln, 2011).

While the principles of grounded theory outlined in Figure 4 remain the same, since Glaser and Strauss' classic statement in 1967 they have taken the methodology in divergent directions. Glaser remained fairly consistent with the earlier model, continuing to define grounded theory as a method of discovery and treating categories as emergent. Strauss (1987) moved grounded theory towards verification and a post-positivist paradigm, with his co-authored works with Corbin providing more directive guides for conducting grounded theory (Strauss and Corbin, 1990; Strauss and Corbin, 1998). However, Glaser felt that 'forcing' the coding through one paradigm and/or down one conditional path ignored the emergent nature of grounded theory. Strauss and Corbin (1990) countered Glaser's argument by cautioning that if researchers did not use their model then their grounded theory analysis would lack density and precision.

While much has been made of the split between Glaser and Strauss, both strands of grounded theory have advantages. Glaser's approach is more flexible and emergent, while Strauss' approach is more structured and directive. In their original statement of their methods Glaser and Strauss (1967) invited readers to use grounded theory strategies flexibly in their own way. This could be interpreted to mean that if researchers stick to the core principles of theoretical sampling and constant comparison, then regardless of which strand of grounded theory they choose, they should still produce a good quality theoretical understanding.

3.3.3 Rationale for choosing Charmaz's constructivist approach

In addition to these two divergent strands, grounded theory methods have evolved even further with second generation grounded theorists who have developed the original model in their own way. These grounded theorists include authors such as Birks and Mills (2015) and Urquhart (2013), who have produced practical guides to grounded theory that are not aligned to any particular territory. Both Birks and Mills' (2015) and Urquhart's (2013) texts provide information as to how the authors conducted their grounded theory. This practical guidance formed background reading during the planning stages of this PhD. However, Birks and Mills' (2015) and Urquhart's (2013) texts were both too basic to provide a

detailed understanding, or to be allow me to use their grounded theory methods when conducting this study.

Charmaz (1990, 2000, 2001, 2006, 2008, 2011, 2014, 2015) appears to be the most published and well known second generation grounded theorist. Charmaz (2000) developed constructivist grounded theory, writing that with this method of grounded theory she sought to:

> reclaim these tools to from a revised, more open-ended practice of grounded theory that stresses its emergent, constructivist elements. (Charmaz, 2000:510)

Charmaz (2014) provides a detailed account of conducting constructivist grounded theory research in her book *'Constructing grounded theory'*, which was used to provide guidance throughout the PhD.

The other popular second generation grounded theorist who was briefly considered and then discounted was Clarke (2005) and her book *'Situational analysis: Grounded theory after the postmodern turn'.* Clarke (2005) references and agrees with Charmaz's constructivist approach to grounded theory. However, rather than coding for basic social processes, which underpins traditional grounded theory, Clarke (2005) replaces these processes with situational analysis. This analysis method involves creating situational maps, social worlds or arenas maps and positional maps (Clarke, 2005). The creative nature of Clarke's (2005) situational analysis appealed to me, but I found her guidance very complex and confusing. Clarke (2005) writes herself that her book is not designed for beginners in grounded theory or qualitative enquiry; I was a novice in both areas, and it is therefore not surprising that I found Clarke's (2005) advice difficult to follow. Charmaz (2014) provided a much more suitable guide to grounded theory for me, since I was conducting this PhD as a novice grounded theorist.

Charmaz (2014) places emphasis on the researcher as an interpreter of data, co-creating the theory with the research participants. Besides being compatible with ontological and epistemological beliefs that people create meaning through social interactions, Charmaz's constructivist approach has several other advantages. First, although Glaser's famous dictum 'all is data' encouraged creative thinking about which data sources to use in this study, Charmaz (2014) makes a valid point that the quality of data is very important and cannot be overlooked. Second, Charmaz encourages a pragmatic approach towards scoping reviews and transcribing interviews verbatim. Charmaz (2014) argues that it is now impossible for modern researchers to conduct a grounded theory study without doing a scoping review first, due to stringent ethical procedures. Charmaz argues that

researchers should audio record interviews and then transcribe verbatim, rather than picking out the cream as suggested by traditional grounded theory (Glaser and Strauss, 1967; Charmaz, 2014). This allows the researcher to give his or her full attention to the research participant, and to obtain detailed data (Charmaz 2011, Urquhart 2013). Writing copious notes during the interview may also disrupt the flow of the interview and prevent adequate eye contact (Holloway *et al.*, 2010).

3.4 Study design

'All is data' (Glaser, 2001:145) is a well-known grounded theory dictum, encouraging researchers to gather data from more than one data source according to what will advance the emerging themes and theory (Charmaz, 2014). Indeed, several nursing studies have been criticised for using incorrectly applied grounded theory as they have only used interviews and no other data sources (de Chesnay, 2015). Using more than one data source also helps to focus on social processes rather than the lived experience of participants (Birks and Mills, 2011). In this study, data were gathered from interviews (source one) and an online discussion forum (source two), because these sources seemed to provide the best data to answer the research question.

Stemming from its sociological roots, a combination of observations and interviews are the most common data sources for grounded theory studies. However, this study focuses on subjective experiences of women's confidence for birth, and because very little is known about confidence for birth at this stage, it seemed impossible to observe 'confidence'. Therefore observations were not used as a data source for this study.

3.4.1 Rationale for using interviews as a data source

Interviews were felt to be an appropriate method of data collection because they enabled an in-depth exploration of participants' experiences, facilitating the generation of theory (Charmaz, 2014). Interviews also allowed the selection of research participants who have first-hand experience on the phenomenon being explored (women's confidence for birth). Therefore, both pregnant women and women who had given birth within the last two years were interviewed. This allowed for the exploration of different perspectives before and after birth. Charmaz's 'intensive' interviewing style was used; intensive interviews aim to be gently guided, one-sided conversations, which explore a research participant's perspective on their personal experience with the research topic (Charmaz, 2014). Key characteristics of intensive interviews as described by Charmaz (2014) are:

- Selection of research participants who have first-hand experience that fits the research topic
- In-depth exploration of participants' experience and situations
- Reliance on open-ended questions
- Objective of obtaining detailed responses
- Emphasis on understanding the research participants' perspective, meaning and experience
- Practice of following up on unanticipated areas of enquiry, hints and implicit views and accounts of actions

Intensive interviewing is a flexible and emergent technique that aims to open interactional space for ideas and issues to arise, allowing possibilities for immediate follow-up on these ideas and issues. Therefore data that emerges from intensive interviews is the co-construction of both the interviewers and the participants during their conversation. Remaining flexible and emergent as a novice interviewer was quite challenging to begin with, but became more natural and comfortable with practice. For example, see the memo in Figure 5 being reflexive about developing intensive interview technique.

Intensive grounded theory interviews have definitely taken a while to master. I find it works well to ask the participant to tell me their pregnancy and birth story first, without interrupting and making notes to be able to create a timeline of their journey. I then try and use their timeline to go back over events, fitting in my questions that are trying to draw our developing concepts as I go along, in accordance with their timeline. Initially I struggled with trying to simultaneously listen to a participant's response and thinking of which question to ask; next however I quickly learnt that this strategy didn't work effectively. Therefore I became comfortable with pausing during the interview. Pausing and sometimes making a little note after the participant's response enabled me to ensure I had fully explored a topic with the participant before then moving on to the next. Pausing also seemed to give time for the participants to think, and quite often I would find that they would start talking again, unprompted, as they remembered something else. In fact, rather than making the interview stilted, using regular pauses seemed to make the interviews more natural and conversational than they had been previously.

Figure 5: Memo reflecting on developing intensive interview technique

3.4.2 Rationale for using an online discussion forum as a data source

In 2017 90% of households had internet access in the United Kingdom (UK), with 80% of adults accessing the internet every day. Since 2006 daily internet use has grown from 35% to 80% (Office for National Statics, 2017). This rapid growth in the internet has revolutionised communication and social networking, providing information in a quick, easy and publicly accessible manner (Hewson *et al.*, 2003; Hooley *et al.*, 2012). As a result, the internet has become an increasingly popular source of health-related information (Weston and Anderson, 2014; Sayakhot and Carolan-Olah, 2016). Many pregnant women use the internet as a source of information and as a means to help them deal with doubts, and to navigate pregnancy-related decisions (Romano and Lothian, 2007; Lagan *et al.*, 2011; Song *et al.*, 2012).

In the UK there are several popular websites that provide reliable pregnancy-related information, such as the National Health Service (NHS) 'NHS Choices' website, the National Childbirth Trust (NCT) website, and Baby Centre (Weston and Anderson, 2014). In addition to using these websites, recent studies exploring internet use during pregnancy found that online forums were also commonly used as a source of information. An online discussion forum is a website where people can hold conversations in the form of a posted messages (Weston and Anderson, 2014; Sayakhot and Carolan-Olah, 2016). These forums offer individuals new opportunities to communicate and engage in supportive interaction with other individuals facing similar challenges, through the medium of asynchronous (not existing or occurring at the same time) written communication (Coulson, 2014). Online discussion forums differ from chat rooms in that messages are often longer than one line of text and are temporarily archived.

Johnson (2015) compared face-to-face support groups and internet use for women seeking information and advice in the transition to first-time motherhood. This study reported that first-time mothers found seeking out information and advice through the internet offered them a safe space to 'test' or legitimise their new identity as a mother. However, compared to the websites described earlier, there is very limited, if any, moderation in online forums. This means that there is the potential for misleading or inaccurate information, and for people to deliberately disrupt or deceive the group (Winzelberg, 1997; Mo and Coulson, 2014). The online discussion forum was therefore seen as a rich data source that could potentially provide highly relevant and valuable data that would add quality to this research. Furthermore, it was considered that participants discussing their confidence for birth in a more natural setting with their peers, rather than in a research interview, may provide a different perspective on the data.

3.4.3 Combining interview and discussion forum data

Figure 6 demonstrates how the cycles of interview and online discussion forum data collection and analysis led to the development of a grounded theory.

Figure 6: Overview of this study

3.5 Theoretical sampling

Theoretical sampling was used for this study. This sampling method is pivotal to grounded theory as it helps to elaborate and refine theoretical categories (Charmaz, 2014). Glaser and Strauss (1967:45) originally defined theoretical sampling as:

> The process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges.

Theoretical sampling is a deliberate, non-random method of sampling that does not aim to represent a population, but rather to identify data-rich sources that develop new insights into an area (Breckenridge and Jones, 2009). As demonstrated in Figure 6, theoretical sampling is an iterative process. This means that interview and discussion forum data were collected in cycles, with analysis from previous cycles leading to the next cycle of data collection.

The purpose of theoretical sampling is to obtain data to help explicate categories. Therefore this sampling method is unique in pertaining only to conceptual and theoretical development (Charmaz, 2014). The flexible nature of theoretical sampling has been challenging for a PhD study because it meant that at the outset of the study it was not possible to know exactly:

- The nature or type of data that would be needed to develop the theory
- How many participants or the number of online discussion forum threads that would be collected and analysed
- When, where or how data would be generated and collected

Strategies such as regular supervision, flexible ethical approval and keeping a notebook of the decision making process during data collection and analysis helped to solve some of these challenges. A particular challenge to this study has also been integrating the two sources of data through theoretical sampling. Originally simultaneous data collection from both interviews and the online discussion forum was planned. However, it quickly became apparent that this would be impossible within a PhD project due to the vast quantities of data available through the discussion forum website. Therefore, in line with the emergent processes of theoretical sampling and encouraged by grounded theory, at the beginning of each data cycle I carefully considered and explored which data source to use. This

resulted in interview data being collected for the first three data cycles, and then the discussion forum data was collected in the fourth data cycle. This approach enabled me to capture broad ideas about women's confidence for birth from women who had recently experienced this phenomenon themselves, and then as the concepts and categories become more formed they provided enough structure to be able to search through the discussion forum in a meaningful way. Furthermore, data collection using the sources in the manner described in Figure 6 enabled the depth of analysis that is essential for grounded theory methodology.

A pragmatic approach to data collection was adopted; with eight interviews from women who had recently had a baby providing a breadth of data to start developing tentative concepts in the first cycle. Then four interviews in the second cycle provided a different perspective, because the participants were pregnant with their first baby at the time of interview. The second cycle built on the data from the first one, but the concepts and tentative categories still felt underdeveloped. Therefore, 13 more interviews were collected in a third cycle to further develop these categories. Finally, online discussion forum data helped to develop the theory by providing a depth of data that had not been obtained through interviews in relation to how social media influences women's confidence for birth. Following the completion of the fourth cycle, all the categories and concepts within the grounded theory appeared to be as developed as possible, achieving theoretical saturation. This process is outlined in much more detail in Chapter 4 and resulted in a grounded theory model named '*Journeying through confidence*' being developed.

Data saturation occurs when theoretical categories are 'saturated' with data (Charmaz, 2014). This means that the categories were felt to be robust because no new properties had been found and the established categories accounted for patterns in the data (Glaser, 1978). Theoretical saturation was reached by defining, checking and explaining the relationships between categories and the range of variation within and between the categories throughout the study (Charmaz, 2014). Using a different data source for the fourth cycle of data collection and analysis also helped to confirm that data saturation had been reached.

3.6 Memo writing to improve reflexivity of the study

A constructivist grounded theory approach acknowledges the influence that researchers have over the research process. The adoption of this type of approach meant that reflexivity was an integral part of this study. Reflexivity is the process of critical reflection

on one's own biases, theoretical predispositions and the entire research process (Urquhart, 2013). Reflexivity is associated with enhancing quality in qualitative research by promoting rigour, which in turn increases confidence, congruency and the credibility of the findings (Freysteinson *et al.*, 2013; Darawsheh, 2014). It is important to make the distinction between reflexivity and reflection. Reflection is a means of looking back to gain insight, while reflexivity is a process of self-awareness and scrutiny that is bidirectional, encouraging a more self-conscious awareness of who we are as researchers and the decisions we make in the research process, as well as their potential impact on others (Engward and Davis, 2015).

Throughout the grounded theory literature, researchers are encouraged to avoid forcing the data into preconceived codes and categories (Charmaz, 2014). Therefore, engaging with reflexivity about preconceptions is critical for all grounded theory research. Adopting a constructivist grounded theory methodology further reiterates the importance of reflexivity by acknowledging that our theories are 'constructed' through our past and present interactions and experiences (Brunero *et al.*, 2015).

Memo writing has been used as a tool to facilitate reflexivity throughout this study. Memos are the narrated records of a theorist's analytic conversations with him/herself about the research data (Urquhart, 2013). Memo writing is fundamental to grounded theory because it prompts researchers to analyse their data and codes early in the research process (Charmaz, 2015). Indeed, Glaser describes memoing as the 'bedrock of theory generation' (1978:83), with memos helping the researcher to organise and interpret the social worlds of their participants (Lempert, 2007). Memo writing for this study began during the planning stages and continued throughout data collection, analysis and write-up. Many examples of memo writing have been included in Chapter 4 to help establish credibility for this study, and also to demonstrate how the memos influenced the grounded theory process.

3.7 Ethical approval

Ethical approval for this study was granted by the University of Southampton and North West – Preston NHS Research Ethics Committee (reference 15/NW/0949). Local Research and Development approval was also gained from the Trust in which the study was conducted. Ethical considerations for each form of data collection and analysis are discussed in section 3.8.4 (for interview data) and section 3.9.1 (for internet discussion forum data).

3.8 Interview data collection

3.8.1 Recruitment

Two recruitment methods were used to collect the interview data. First, midwives were given participant information packs and asked to hand these out to women who met the inclusion and exclusion criteria. The participant information pack can be found in Appendix F and included a covering letter, a participant information sheet and a flow chart of what to expect if they decided to take part in the study.

However, this recruitment method was resource intensive and only three participants were recruited in two months, so an amendment was made to recruit participants through a study website. A link to this website was then shared via Facebook and email by the local Maternity Service user group. This recruitment method was much more effective than recruiting through midwives. Indeed, there was such an overwhelming response to this advert that over 100 responses from potential participants were received within a matter of hours. This list of potential participants was then used for all of the cycles of data collection that required interview data, with no need to re-advertise the study. Figure 7 provides a summary of how this over recruitment was managed.

Both the information pack shared by midwives and the study website contained a link and the password for a short iSurvey (a University of Southampton questionnaire tool). Potential participants were able to access the iSurvey via any device with internet connection to record their contact details and indicate that they were interested in taking part in the study. On average it took participants about two minutes to complete the iSurvey. The iSurvey contained questions such as 'Are you over the age of 18?' to try and ensure that potential participants meet the inclusion and exclusion criteria. Alternatively, potential participants were able to contact me directly by email or a dedicated study mobile phone number.

Service users were consulted about the study on several occasions at local Maternity Service Liaison Committee (MSLC) meetings and through email. The service users were particularly involved with developing the participant information sheets as well as creating and advertising the study website. On the service users' advice efforts were made to make the participant information sheets visually appealing and a flow diagram was added (see Appendix F).

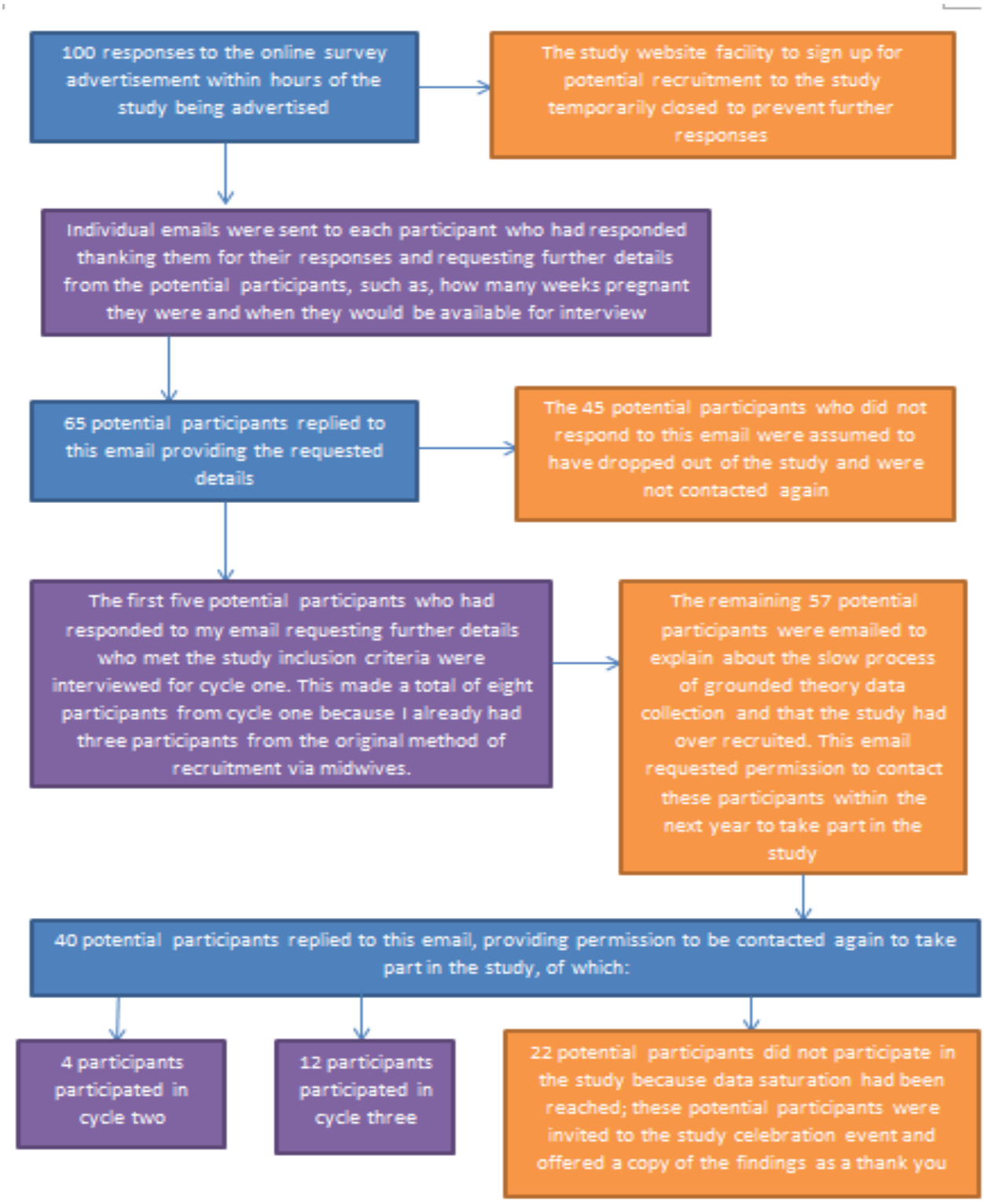


Figure 7: Demonstration of how over recruitment was managed

Figure 8 provides a memo which discussed how managing recruitment was one of the most challenging aspects of this PhD project.

A challenge with this grounded theory methodology has also been managing recruitment of interview participants. Recruitment in accordance with theoretical sampling required being flexible and managing first under-recruiting and then over-recruiting. Initially, I tried to recruit interview participants through midwives and spent lots of time and effort trying to encourage midwives to offer potential participants recruitment packs. This included strategies of: visiting groups of different midwives in person, bringing them cake, trying to make the recruitment pack as enticing as possible and creating continuous professional development certificates for midwives. These efforts resulted in the recruitment of three participants in eight weeks. On discussion with the midwives it seemed that they felt under too much pressure doing their jobs to remember to have the time to be able to offer potential participants recruitment packs. I felt that I had exhausted all of my options in terms of promoting the study as much as possible and incentivising midwives to remember to offer the recruitment packs to their patients. I therefore had a rethink and decided to try using social media to promote my study via the MSLC; I created a simple study website which contained the same information that had been in the paper recruitment pack and the MSLC advertised the study website on Facebook. I was anxious about getting ethical approval to make this amendment in recruitment strategy as this seemed to be a break away from traditional recruitment methods. However, I quickly got the required amendment approvals and within hours of the MSLC advertising the study I had over 30 responses from potential participants wanting to take part in the study (I had been hoping for 10-20 responses over several weeks). This was quite an overwhelming response and required strategies to manage the over-

recruitment that I had achieved. Strategies included contacting each participant individually to find out more details about whether they were pregnant or not, and then arranging interviews over the course of months to give enough time to collect and analyse the data and collect data in accordance with theoretical sampling. At the time it felt quite frustrating that I was doing grounded theory and so couldn't intensively conduct all the interviews as soon as possible. However, once I started the process of data collection and analysis I was grateful that I was theoretically sampling because it provided the opportunity and time to properly reflect on the interviews. Having now created the substantive grounded theory I feel that constructivist grounded theory was definitely the right approach for this study and has shaped myself as a researcher (encouraging me to be more creative and patient) as well as the study findings.

Figure 8: Memo discussing the challenges managing recruitment in a grounded theory study

3.8.2 Inclusion and exclusion criteria for interview participants

The inclusion and exclusion criteria described in Tables 10 and 11 were used for all interviews regardless of the cycle in which the data was collected.

Inclusion criteria	Justification
Women who were eight weeks or more pregnant. This may be their first baby or they may have had a baby before.	Including pregnant participants in the sample aimed to help understand what is currently impacting on their confidence for birth. Pregnant women normally have their first appointment with maternity services at eight weeks of pregnancy. A concern when considering recruitment was recruiting a participant who then went on to miscarry, causing undue stress on the participant if they then had to contact me to cancel the interview. If women are at least eight weeks pregnant then they are less likely to have a miscarriage and would have support from maternity services if they did miscarry (Abuelghar *et al.*, 2014).
Women who have given birth within the last two years.	Including participants who have recently given birth should enable participants to look back over their pregnancy and birth to explore what impacted on their confidence. If they have given birth within the last two years, this should enable participants to remember their feelings as accurately as possible. They will also still be in contact with their health visitor for support should they wish to discuss their confidence for birth further following the interview. Studies suggest that women can recall their pregnancy and labour-related events from thirty or more years ago with good accuracy and reproducibility (Tomeo *et al.*, 1999). Therefore a time period of two years was not felt to raise the possibility of a negative impact on participants' recall of their confidence for birth.
Women booked for care with the NHS Trust where this study was being conducted with.	This study was being run as part of a Clinical Academic Doctoral Fellowship in partnership with an NHS Trust (see section 1.2 of this thesis). To comply with research governance the participants must have had care within the Trust that had granted ethical approval. Furthermore, one Trust was practical and manageable for a grounded theory PhD project. Any disadvantages to collecting interview data from only one Trust were felt to be counterbalanced by collecting data from a UK-wide online discussion forum.

Table 10: Inclusion criteria for interview participants

Exclusion criteria	Justification
Women who the midwife felt had such a complex pregnancy that it would not be appropriate for the additional demands of the study to be placed on them.	This exclusion criterion was applied to women to avoid causing additional stress or demands on participants, as their welfare overrides the interests of the study.
Women who had suffered from a serious adverse outcome such as miscarriage, foetal abnormalities or stillbirth.	This exclusion criterion was applied to women to avoid causing additional stress or demands on participants, as their welfare overrides the interests of the study.
Women who were under the age of 18	Including women who are pregnant and have had a baby under the age of 18 would involve a more complex ethical and safeguarding process, which this small PhD project did not have the resources to implement. Furthermore, existing research suggests that teenagers experience pregnancy and birth differently to adults, and this may confuse data analysis rather than advance theory development at this very early stage in exploring confidence for birth (Angela *et al.*, 2009).
Women that I have provided clinical care for in my role as a midwife.	To respect women's autonomy so that they did not feel coerced into participating in this study. Furthermore, as a community midwife my role is to provide the majority of maternity care for women during pregnancy, which may mean that they might not feel comfortable discussing a potentially important part of their pregnancy and birth experience.

Table 11: Exclusion criteria for interview participants

3.8.3 Developing the interview guides

Although interview guides are not traditional in grounded theory, Charmaz (2011, 2014) encourages using guides to enable researchers to think through how to word questions. Charmaz (2014) argued that this helps novices (such as myself) to avoid blurting out loaded questions, and prevents interviewers from forcing responses into narrow categories. Therefore, interview guides were used for all of the interviews in this study.

Cycle one began with very few exploratory questions, and through the cycles of data collection the number of interview questions increased and became more specific, in line with theoretical sampling, to further develop the existing categories (Birks and Mills, 2011). For example: 'Can you think of anything that has made you feel more confident for labour?' was a question in cycle one, whereas 'Some people have suggested that birth planning affected their confidence for birth, what are your thoughts on this?' was an interview question in cycle three. The full interview guide for cycle one can be found in Appendix G

Three pilot interviews were also conducted prior to data collection. A concern with piloting, particularly in grounded theory research, is that it can contaminate the main study (Jones and Alony, 2011). However, because I had no previous experience of conducting research interviews, pilot interviews felt essential to develop interview technique (van Teijlingen and Hundley, 2001; Nunes *et al.*, 2010). Data from the pilot interviews was not analysed to prevent contamination. The pilot interviews were helpful in developing my confidence in interview technique, and for developing an understanding of the impact the interviews might have on the participants, as well as myself (see Figure 9). Pilot participants were encouraged to provide feedback on how they found the pilot interview process.

Sociodemographic information was not collected from either interview or online discussion forum data. It was not possible to collect sociodemographic data from the online discussion forum participants with this method of online message analysis. Although collecting sociodemographic data from interview participants was possible, this data did not appear to be relevant during this exploratory stage of researching women's confidence for birth. As previously discussed the purpose of grounded theory sampling is to generate theory rather than sample for generalisability. It was therefore important not to make assumptions that sociodemographic data may influence women's confidence for birth and rather take this information from the data. It was taken into consideration that some literature exploring a similar psychological concept to confidence for birth of (childbirth self-efficacy) suggested that age and education status may influence women's childbirth self-efficacy. However, this study focuses on women's confidence for birth and given that this is the first study to explore this concept it feels as if it is too early to test out whether or not these factors also influence confidence for birth. Once the first understanding of the process involved in women's confidence for birth have been developed then the theory can be tested to see if it is influenced by women's confidence for birth. The Data Protection Act (1998) states that data collected must be adequate, relevant and not

excessive. It would therefore be unethical to collect sociodemographic data on a 'just in case' basis when there was no clear relevance to doing so.

Something that I was not expecting was how emotionally affected I would be by the interviews. Naively, prior to piloting, I had thought that my clinical experience regularly discussing pregnancy and birth as a midwife would equip me well for discussing these experiences as a researcher. Why is listening to women's birth experience as a researcher so different to listening to them as a midwife? I think that the key to this question is the word 'listening'. I have always hoped that I am a compassionate midwife and consider listening to clients a very important aspect of my role. However, conducting these pilot interviews has opened my eyes to 'proper' listening. Deliberately giving participants the time and space to think and answer my research questions fully. As a result, I felt as if I relived their experiences with them during the interview. I will therefore ideally only interview one participant each day.

Not only did the interviews affect me but they also appeared to have an emotional impact on my participants, with two participants becoming a little tearful during the interview. The email feedback that I got from participants after the pilot interviews was really helpful in confirming this. As a result, I have now adapted my preamble before the interview to discuss the possibility that the participants may find the interview emotional. Despite appearing to find interview a little emotional pilot participant feedback to both myself and my supervisors indicated that they enjoyed the interview experience.

"…It was great thank you. Sorry for the tears! It's funny how things can still affect you 17 months down the line…" Pilot Participant Two.

Figure 9: Extract from memo following completion of three pilot interviews

3.8.4 Conducting the interviews and ethical considerations

All interviews were conducted individually face-to-face by me, a practicing midwife. All participants were interviewed either in their own home or at a local NHS Trust site of their choice. Most participants brought their baby or toddler to the interview with them. This seemed to work fairly well and did not appear to impact on the quality of the transcription or interview. If anything, being able to play with or hold their baby or toddler often seemed to help participants relax and make the conversation feel less like a formal interview.

Careful consideration was given to some of the potential challenges that could occur as a result of conducting research interviews about birth as a practicing midwife. Before starting the interviews, I was open and honest with the participants and explained that I was a midwife. This felt important for several reasons – first because I was asking participants to share very personal experiences, and so it felt respectful to share that I was a midwife. Second, I was practicing as a midwife in the Trust where I was collecting data, and so I was worried that if I did not disclose my status as a midwife, participants might then see me in my role as a midwife at a later stage and feel betrayed. Finally, I have a duty of care as a midwife and so needed to explain at the start of each interview that if we discussed something that seriously concerned me about patient safety, I would need to discuss this further with a senior midwife.

Interviews were digitally audio-recorded to enable verbatim analysis. Most participants became visibly emotional or were tearful at some point during the interview. When this happened the participant was given plenty of time, and I offered to take a break or stop the interview completely. As noted in Figure 9, it was recognised that this was a possibility from the piloting stage, and therefore lots of effort was put into rapport-building before the interview started, and time was taken at the end of the interview to debrief about how the participant found the interview. All participants were sent a thank-you email the following day and invited to a thank-you celebration event in May 2018 (see section 6.11).

Despite acknowledging my role as a midwife, I always introduced myself as a PhD student first; this was done in preference to emphasising my midwifery profession which might have suggested 'expert' status. Each interview also started by emphasising that although I was a midwife, I was there as a researcher to listen to their story and feelings. However, if they had any midwifery questions I could answer them at the end of the interview. After the interviews I encouraged several participants to contact the local birth debriefing service. I also encouraged one participant to contact the maternity customer care coordinator for the Trust, because I felt that her extremely negative perception of care should be dealt with more formally. It felt important to empower the participants by encouraging and providing information for them to refer themselves to these services, rather than the referral coming from myself. This also enabled a clear division between my researcher and midwife roles.

3.8.5 Transcription of interviews

Given the emergent nature of grounded theory, each interview was transcribed shortly after completion while the data was still 'fresh', as advised by Glaser and Strauss (2009). The interviews were transcribed by a professional transcriber recommended by the University of Southampton. The decision to get the interviews professionally transcribed was due to the time constraints of working part-time as a researcher and wanting to simultaneously collect and analyse data. Once each interview was transcribed, the transcripts were read through while listening to the audio recording to check for accuracy. Transcribing interviews can aid the researcher to fully immerse themselves in their data. However, using professional transcription enabled the time to memo and begin early data analysis on each transcript before collecting the next interview, in accordance with good theoretical sampling technique.

3.9 Data collection using the internet

3.9.1 Sources of data

One of the largest parenting internet discussion forum websites in the UK, with at least 7.2 million individual users, was used to collect the discussion forum data. This parenting site was chosen because it is one of the two most widely used online discussion forums in the UK. This forum provided an extremely large volume of easily accessible information about women's experiences of pregnancy and birth. While there are many other forms of social media such as Twitter and Facebook, using the discussion forum seemed to be the most practical and efficient source for data

collection, within the limits of this research project. Another advantage to using the online discussion forum was that users could post anonymously, this was felt to help ensure that the data collected would reveal what lies beneath the surface, which Charmaz (2014) encourages when considering data sources. The website moderators were contacted directly and gave their permission for data to be anonymously collected from their site (see Appendix H for confirmation of approval).

3.9.2 Seeking expert advice

Collecting and analysing data from online discussion forums is still fairly new and novel in health sciences research, and therefore advice was sought from Professor Neil Coulson via a telephone consultation. Professor Neil Coulson is an international expert in researching peer online support communities. Professor Coulson's advice was really helpful and provided the basis for the strategies for data collection and handling of data for this study.

3.9.3 Online discussion forum data collection method

Data were collected using the website search tool facility. This enabled terms such as 'confidence' and 'birth' to be searched for. However, every search term resulted in an extremely large number of hits; for example, the above search terms resulted in 296 results, listed in order of relevance to the search terms, with a sentence summarising the thread. A large number of results were excluded because the website's search facility included any results that were relevant to either search term. All relevant threads were then copied and pasted into a Word document and given a number (this process is commonly referred to as data scraping).

During the process of copying and pasting the threads into the Word document, names of members were omitted to protect members' privacy. Personal or clinical information that risked revealing members' identities was also excluded. All participants who had started the thread were given a pseudonym.

A fictional post has been created in Figure 10 below to explain the language used for collection and analysis of the online discussion forum data.

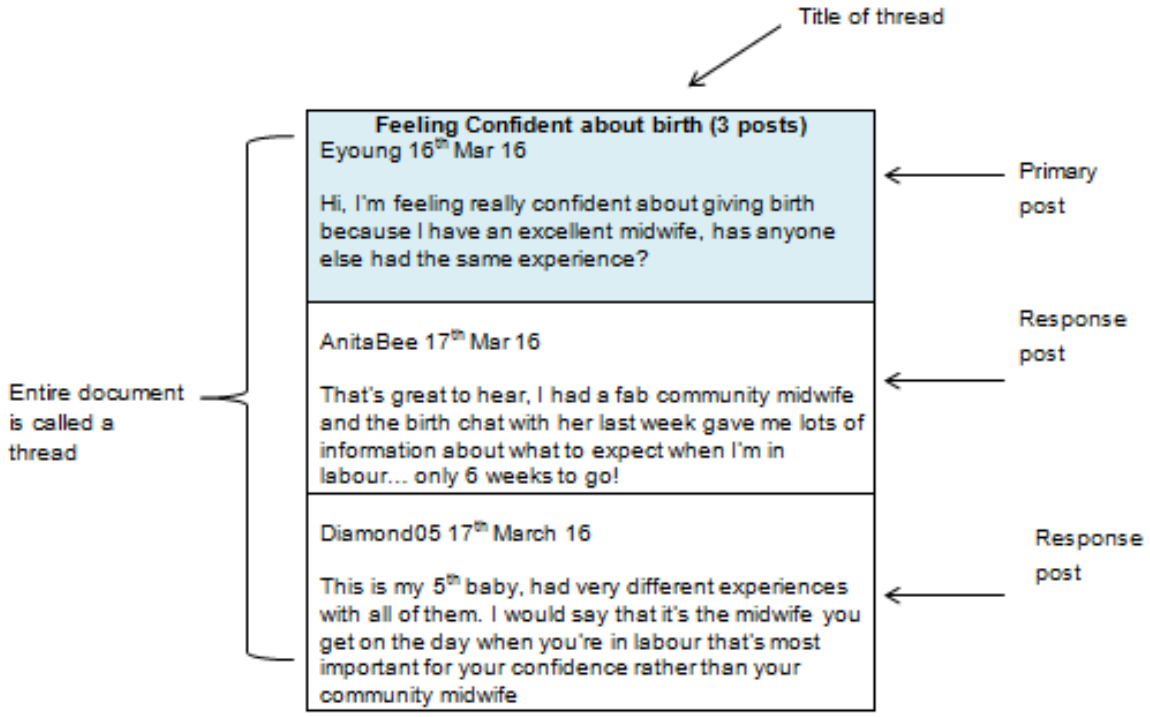


Figure 10: A fictional thread illustrating the difference between a thread and a post

4.9.1 Ethical considerations for social media data

Given the rapid and novel way in which the internet has developed, it can be difficult for researchers to ensure that pre-existing ethical standards are properly met, due to a lack of clear and widely accepted guidelines (Hewson *et al.*, 2003; Hooley *et al.*, 2012). The internet has changed the nature of privacy, enabling personal data to be routinely made openly available (Hooley *et al.*, 2012). The distinction between the private and public data domains on the internet had been raised as an issue for researchers and has yet to be resolved (British Psychological Society, 2013). All data that were used for this project have been placed in the public domain and were available to be viewed without having to register with the parenting discussion forum. However, it is unlikely that parents posted their comments with the intention of them being used for research. Therefore, to protect posters' anonymity and confidentiality, efforts were made to reduce traceability through search engines. Only short segments of original posts were used, and published material that may be widely read, such as journal articles and quotes, may be paraphrased or amalgamated to further reduce traceability, as suggested by the British Psychological Society (2013). The message analysis was to involve observation only, and no participation in

the discussion forum was undertaken. Permission was also gained from the moderator of the website to use anonymous quotes as data for this study.

3.10 Grounded theory data analysis

Charmaz's (2014) book entitled 'Constructing grounded theory' provided detailed guidance on the coding process, which was used to aid data analysis. In grounded theory coding means naming segments of data with a label that simultaneously categorises, summarises and accounts for each piece of data (Charmaz, 2014). Grounded theory analysis aims to move beyond concrete statements in the data to make analytic sense of stories, statements and observations. Charmaz's (2014) approach to data analysis includes three levels of coding:

1. An initial phase involving naming each word, line or segment of data (development of codes)
2. A focussed, selective phase that uses the most significant or frequent initial codes to sort, synthesise, integrate and organise large amounts of data (development of concepts and categories)
3. Theoretical saturation and sorting (development of the theory)

In addition to these levels of coding, writing down any analytic ideas in a memo at every stage of analysis is also encouraged by Charmaz (2014). The relationships between codes, concepts, categories and theory are demonstrated in Figure 11.

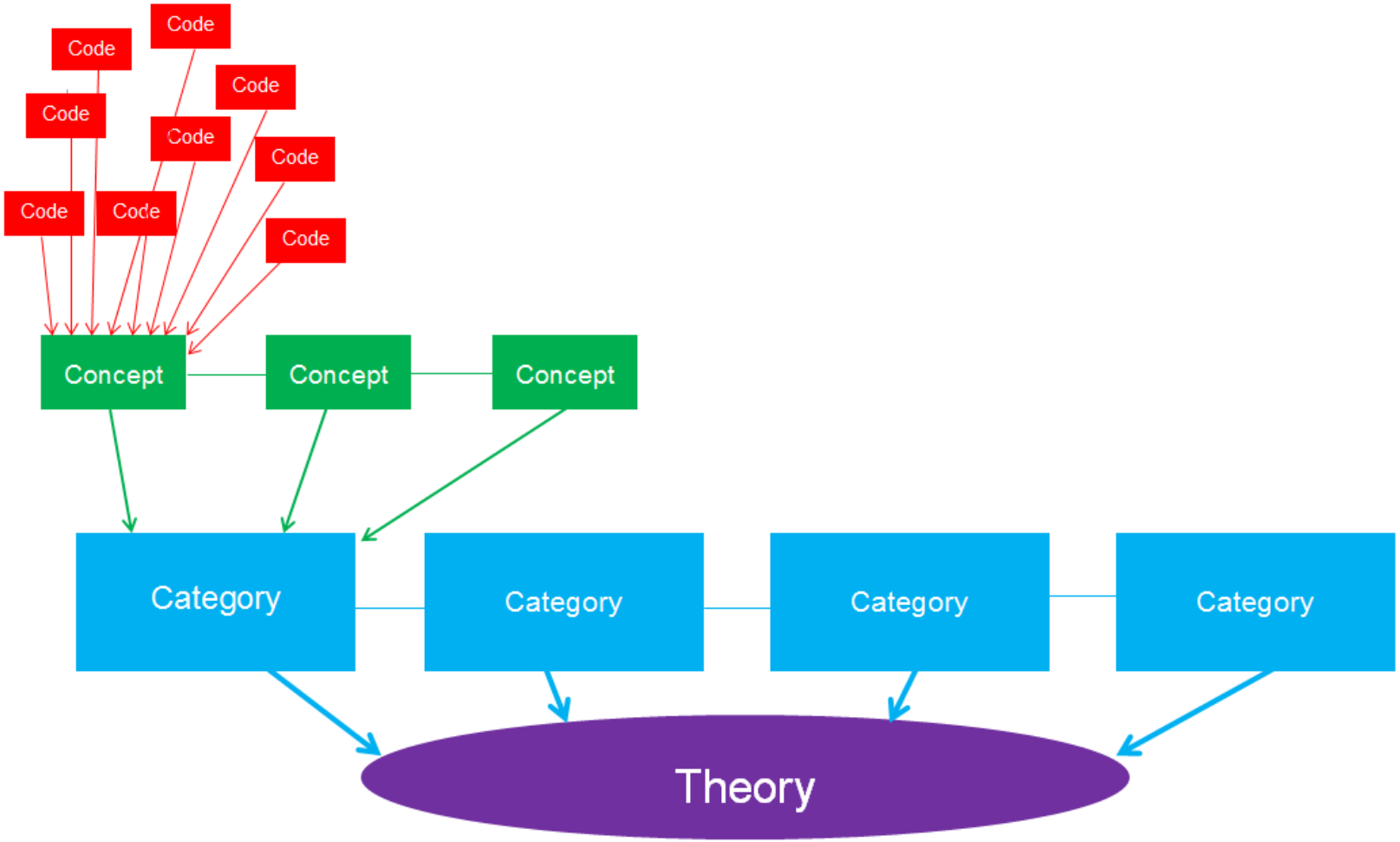


Figure 11: The relationship between codes, concepts, categories and theory

3.10.1 Initial coding

Initial coding was conducted on each individual interview transcript or online discussion forum thread following every cycle of data collection. This initial coding aimed to stick closely to the data, showing actions and emotions from the participants' points of view in order to be able to define what was happening in the data and begin to grapple with what it means. Sticking closely to the data helped to remain open to all possible theoretical directions indicated by reading the data, which was critically important for this stage of analysis. Coding using gerunds was employed for the initial coding to help focus the analysis on social processes rather than lived experience. A gerund is an English verb which ends in 'ing' but that primarily functions as a noun (Stevenson, 2010). Using gerunds for initial coding was initially developed by Glaser (1978) and continues to be promoted by Charmaz, who provides the following examples of gerunds and their noun forms to demonstrate the strong sense of action and sequences with gerunds:

> 'describing versus description', 'stating versus statement' and 'leading versus leader'. Charmaz (2014:120)

By sticking closely to the data and using gerunds, the fluidity of participants' experiences should be preserved and an insider's view should also be reflected (Charmaz, 2014). Personally, I found that using gerunds for initial coding was extremely helpful, enabling me to interact with the data and bring the participants' voices alive. I saw a vast improvement in the quality of my analysis once I started to use gerunds for initial coding, and therefore I used gerunds for all initial coding.

3.10.2 Focussed coding

Once initial coding had been completed, focussed coding was conducted in every cycle of data collection. Focussed coding uses the most significant or frequent initial codes to sift through and analyse large amounts of data. Focussed coding requires decisions about which initial codes make the most analytic sense to categorise the data, advancing the theoretical direction of the work. This process is more than simply selecting which code is the most interesting; rather, it involves concentrating on what the initial codes say and making comparisons between them.

3.10.3 Theoretical saturation and sorting

The process of initial and focussed coding continued through gathering data to focus on the developing categories and concepts within these categories. Knowing when to stop gathering data has been one of the most challenging aspects of this PhD, requiring

support from my supervisors who were more removed from the data collection and analysis process than myself. Due to the immersive process of grounded theory I was so lost in the data that I struggled to realise that my categories were saturated and new properties were no longer emerging. Taking a step back from the data and asking questions such as 'What does this category mean?' and 'How does this category compare to the other categories?' helped to explicate the theory and enabled me to decide whether or not I needed to collect more data, or whether I had reached theoretical saturation.

Charmaz (2014) writes that the prospect of reaching theoretical saturation is often more daunting than it needs to be because researchers misunderstand what is meant by the term. Theoretical saturation is not seeing the same pattern over and over again; rather, it is feeling that your categories are robust because you have found no new properties within these categories and the established properties account for patterns within the data (Glaser, 1978; Holton, 2007; Charmaz, 2014). Theoretical saturation is therefore reached when you have defined, checked and explained relationships between categories and the range of variation within and between your categories. Practical strategies such as diagramming and integrating memos were helpful throughout this stage of analysis.

3.11 Ensuring the quality of this study

The quality of research is traditionally judged by three criteria: reliability (that a test can be repeated with the same results), validity (that the results reflect the reality they claim to represent) and objectivity (that the researcher has uncovered reality without contaminating it in any way) (Flick, 2008). However, these criteria arose from quantitative research methods and are not always appropriate for measuring the quality of qualitative research. For example, objectivity is an inappropriate criterion for this grounded theory study because objectivity assumes that a truth or independent reality exists, when in fact a constructivist approach is being used to explore women's perception of their confidence for birth.

However, Guba (1981) constructed four criteria that are more appropriate than traditional positivist measure of quality to determine the trustworthiness of qualitative research: credibility (in preference to internal validity), transferability (in preference to external validity/generalisability), dependability (in preference to reliability) and confirmability (in preference to objectivity). These criteria remain relevant and are often cited in current research papers and textbooks on qualitative research today – for example, Shenton (2004) and Gerrish and Lathlean (2015). Tables 12 to 15 demonstrate how each of these criteria were met during this grounded theory study according to each of Guba's (1981)

principles. These tables give several references to the next chapter in this thesis (Chapter 4), which provides a step-by-step account of the actual grounded theory process conducted for this study.

Credibility (Does the study test/measure what is actually intended? How congruent are the findings with reality? Internal validity)
• Grounded theory is a research method that is well established in both qualitative research in general and nursing/midwifery research in particular. • As a clinical academic I worked in the Trust clinically, developing early familiarity with the culture of the participating organisation before the first data collection dialogues took place. This helped to establish a relationship of trust between both parties and enabled me to gain an adequate understanding of the organisation. • Two different sources of data were used – social media and interviews. Using different methods can compensate for their individual limitations and exploits their respective benefits. This also enabled different viewpoints on women's confidence for birth to be analysed as the social media participants were not talking to a researcher/midwife. • Midwives and the MSLC advertising study website acted as gatekeepers. This should have meant that participants only took part in the study if they were genuinely willing to take part and were prepared to offer data freely. Lots of effort was also put into rapport-building with interview participants, which should have encouraged honesty when contributing data, enabling them to be as frank as possible. Social media participants were not posting their comments with the intention of being researched. • Regular supervision was held throughout the PhD, enabling debriefing sessions between myself as the researcher and my supervisors. • I had peer scrutiny throughout cycles of data collection through postgraduate research forums, a mental health scholarly forum and clinical colleagues. • Theoretical sampling enables a form of member checking, allowing codes and categories to be tested by the next cycle of study participants. • Memo writing enabled reflexive commentary throughout the data collection and analysis. • Experienced supervisors oversaw the data collection and analysis. • A thick description of women's confidence for birth was produced by the grounded theory analysis. • The scoping review in Chapter 2 examined previous research relating to women's confidence for birth prior to data collection.

Table 12: A demonstration of how credibility according to Guba (1981) was achieved

Transferability (external validity/the extent to which the findings of one study can be applied to other situations)
• A transparent description of the methods used is presented in this chapter, and Chapter 4 presents the actual grounded theory process used. • The number of organisations taking part in the study and where they were based are described in this chapter. • Any restrictions on the type of people who contributed to the data are presented in the inclusion/exclusion criteria in chapter 3. • The number of participants involved in the study is described in this chapter. • The data collection methods that were employed are described in this chapter and demonstrated in Chapter 4. • The time period over which data was collected is described in Chapter 4. • Including data from internet discussion forums helped with the transferability of the study findings because this provided a larger sample.

Table 13: A demonstration of how transferability according to Guba (1981) was achieved

Dependability (reliability/if the work were repeated in the same context with the same methods and same participants, would the same results be obtained?)
This chapter and Chapter 4 include descriptions of: • The research design and its implementation • The operational details of data gathering, addressing the minutiae of what was done in the field • Reflective and reflexive appraisal of the project The grounded theory process chapter in particular provides in-depth methodological description to allow this study to be repeated.

Table 14: A demonstration of how dependability according to Guba (1981) was achieved

Confirmability (objectivity/steps taken to help ensure as far as possible that the work's findings are the result of the experiences and ideas of the informants)
• Regular memo writing during data collection and analysis encouraged reflexivity. • Chapter 4 provides an audit trail of the step-by-step research decisions to allow the study findings to be scrutinised • My research predispositions have been openly discussed throughout this thesis. • Two different data sources and methods were used, which should help to reduce the effect of investigator bias.

Table 15: A demonstration of how confirmability according to Guba (1981) was achieved

In summary, Guba's (1981) principles of credibility, transferability, dependability and confirmability have been carefully considered to try and ensure that this PhD provides good quality research.

3.12 Conclusion

This chapter has explored the rationale for using a constructivist grounded theory approach to study women's confidence for birth. The rationale for using interview and online discussion forum data has also been discussed, as well as the methods used to collect each data source. The methods used for grounded theory data analysis have also been described. Chapter 4 aims to improve the quality of this PhD by demonstrating the exact process of how theoretical sampling, initial coding, focussed coding and theory development were conducted during the four cycles of data collection for this study.

Chapter 4 The process of developing a grounded theory exploring women's confidence for birth

4.1 Introduction

The aim of data analysis was to develop a theoretical understanding of the factors that women perceive to influence their confidence for birth. Chapter 3 provided the rationale and explanations for the methods used to conduct constructivist grounded theory data collection and analysis. This chapter presents the data analysis process to demonstrate how the grounded theory of 'journeying through confidence' (the JTC theory) was developed. Theory generation was achieved through four cycles of data collection and analysis. In total, data from 25 interviews (from 22 participants) and 14 social media threads were collected and analysed. Each stage of initial coding, focussed coding and theory development will be explored to show the process by which codes, concepts and categories were developed. An overview of this process can be found in Table 16. Examples of reflexive memos are also included throughout the chapter because memo writing was an integral process for moving data analysis forward. Most of the data analysis was performed by hand and so photographs of some of this analysis are included in this chapter. All the names given to participants in this chapter and Chapter 5 are pseudonyms to protect participants' anonymity.

Some grounded theorists have been criticised for not being transparent and showing how their theory was actually developed (Rupp, 2016). By providing a detailed account of the data analysis process, this chapter aims to improve the credibility of this work and the study findings. The principles of credibility, transferability, dependability and confirmability were discussed in Chapter 3. In order to meet these principles of quality in qualitative research, this chapter aims to make the study findings more transparent, presenting a detailed account of the data analysis. This means that readers will be able to check which data is a statement from a participant and what is an interpretation by me, as the researcher. By using a constructivist grounded theory approach I accept that every reader may have a different interpretation of the data in this study.

Cycle	Data	Analysis process
One	Eight interviews with women who had recently given birth one or two times. One woman was also pregnant during the interview.	Individual initial coding using gerunds – focussed coding – creation of eight key codes – focussed on coding for social processes (action and emotion codes). Developed concept of journeying through confidence and made decision to focus on the pregnancy section of the journey. Realisation that 'confidence' is complex and not a linear concept. Reflexivity: dramatic improvement on quality of analysis since upgrade.
Two	Four interviews with women during their first pregnancy (one at 18 weeks pregnant, three at 35–39 weeks pregnant)	Individual initial coding using gerunds – focussed coding for action and emotion codes separately – sorting of codes – developed four tentative categories for actions – added emotion codes into categories and refined categories – added focussed codes from cycle one – refined and added categories – created tentative framework of categories, concepts and codes.
Three	13 interviews women who had given birth recently one or two times. Two women were also pregnant during the interview.	Individual initial coding using gerunds – focussed coding using categories from framework created in cycle two – refined framework and added depth to categories – created some new categories – added data from cycles one and two – (concepts and codes) further refined framework – created mind map – further refined framework. Information gathering became a core category/pivotal code. Detailed analysis: memoing, sorting, describing, comparing, refining categories, and developing theory. Online discussion forum data identified as a potentially important form of communication.
Four	14 online discussion forum threads relating to confidence and birth, which included a total of 270 individual posts.	Individual initial codes using gerunds – focussed coding – confirmed online discussion forums are an important source of communicating. Confirmation that theoretical saturation had been reached by identifying all the existing categories within the JTC theory and not identifying any new categories.

Table 16: Overview of data collection and analysis process

4.2 Reflexivity throughout the grounded theory

The reliability of the whole research process can be also be demonstrated by reflexive documentation. As discussed in Chapter 3, with constructivist grounded theory the relationship between the enquirer and the enquired about is important because people construct their own understanding of reality. As a result a conscious effort was made throughout data collection and analysis to be reflexive about my own influence on the data, aiming to improve the credibility of the findings. Charmaz (2014) writes that memo writing consists of private conversations that grounded theorist have with themselves as they take their codes apart and analyse what they might mean. This was exactly my experience of memo writing; I found that writing memos throughout the data collection and analysis enabled me to explore my ideas and scrutinise and improve my codes. Memo-writing also encouraged me to examine my assumptions and express any doubts that I had about the data analysis. I got into the habit of memo-writing several times a day when working on my PhD; often I would find myself writing a memo containing thoughts about my data that I had not realised I had until I had written them down. Memo writing was therefore integral to the data analysis process by helping me to make sense of my data.

This reflexive process of memo writing began prior to collecting any data in cycle one, by writing a memo about the preconceptions or thoughts that I had about confidence for birth. This included my personal perspective as a researcher, a midwife and a woman who has not had children (but hopes to one day). It was helpful to review this memo several times throughout the data analysis, particularly when forming categories and concepts. An extract from this memo can be found in Figure 12.

For me as a woman growing up I always felt that birth is something to dread - a burden that women have to suffer, and it was only once I started doing midwifery and was privileged to be part of many births that I realised that birth can be an amazing and empowering experience. I think that this is partly why I am so interested in how to build women's confidence for birth, because I hope to have children in the future and want to be able to build my own confidence for birth…

…I am a midwife and will continue to practice clinically throughout data collection and analysis. I am conscious that this may bias me towards thinking that midwives are important for women's confidence. As a community midwife I feel like I regularly build women's confidence for birth, appointment by appointment, particularly if they had a negative birth experience in the past…

Figure 12: Memo: My thoughts about confidence for birth before starting data collection

This chapter also aims to demonstrate the credibility of the study by showing how the theory of 'journeying through confidence' was developed and grounded in the data. Indeed, using the grounded theory methods of theoretical sampling and constant comparison should have ensured that the developing theory was grounded in the data. Memo writing should also have enhanced the credibility and confirmability of the study by providing reflexive accounts trying to make sense of the relationships between the researcher and the research process. Furthermore, although many quotes from the data are included in Chapter 5 (the findings chapter), this chapter hopes to demonstrate the credibility of the theory by showing readers exactly how the categories were developed.

4.3 Cycle one

4.3.1 Participants in cycle one

For the first cycle of data collection, eight interviews were conducted with women who had given birth within the last two years. These participants were asked broad questions about

their confidence for birth during pregnancy and labour. All of the participants had given birth either once or twice before, and one participant was pregnant with her second baby when interviewed. Table 17 provides a summary of these participants' experiences, to provide context for their data.

Pseudonym	Existing children	Currently pregnant?	Type of birth(s)
Mia	1 x 20-month-old boy	Yes	Vaginal birth and 4th degree tear in hospital
Lin	1 x 5-month-old girl	No	Induction and vacuum (ventouse) birth in hospital
Ava	1 x 15-month-old girl	No	Vaginal birth in hospital
Olivia	1 x 4-year-old boy and 1 x 20-month-old boy	No	1 x vaginal birth and episiotomy in hospital 1 x water birth at home with retained placenta
Emma	1 x 3-year-old girl and 1 x 1-year-old boy	No	2 x vaginal births in hospital
Fiona	1 x 6-month-old boy	No	Induction and unplanned caesarean in hospital under general anaesthetic
Holly	1 x 6-month-old girl	No	Forceps (failed vacuum attempt) in hospital and 4-litre blood transfusion
Tallulah	1 x 23-month-old girl	No	Induction and unplanned caesarean in hospital

Table 17: Interview participants in cycle one

4.3.2 Memo writing directly after each interview

Detailed notes and memos were made directly after each interview, and only one or two interviews were conducted every week. This provided time to be reflexive about how I performed in my role as an interviewer and what the key codes seemed to be, which helped early comparison between interviews. For example, an extract from one of these

memos is illustrated in Figure 13. This memo discusses one of the comments that Emma made during her interview: “I’m surprised this doesn’t put you off having children actually.” This comment caused me to be reflexive about how the fact that I hadn’t had children myself may have influenced the interview. At the time of conducting the interview I was so focussed on the interview that I did not give very much thought to the comment, but writing a memo about the comment after the interview enabled me to fully consider it and what it may have meant. Writing memos after each interview enhanced the data analysis by helping me to be reflexive about my role as a researcher, and the impact that this had on every interview.

Emma appeared to be deep in her account of her birth experience and then what seems to be an aside comment: "I'm surprised this doesn't put you off having children actually." Emma didn't pause for me to respond and continued on with her narrative straight away. I found this comment a stark reminder that I am getting a story of participants 'experience that may be a specific version because they are talking to me as a researcher and woman.

Was Emma concerned about how her story may impact on me as a potential mother one day? Was Emma talking to me woman to woman rather than participant to researcher? I've not had this comment before from women that I look after when I am their midwife, perhaps because of the power balance. Maybe this is positive because Emma was talking to me as an equal or peer rather than me having authority over her.

Is this because of the lengthy preamble and rapport building that we had before starting the interview? I don't remember saying that I don't have children or that I wanted children. I wonder how this came up in conversation. I don't think I would have volunteered it, so did Emma ask me directly? Perhaps it was important for Emma to take into account others' perspectives when discussing her pregnancy and birth. I will be more mindful of how I answer questions about whether I have children in future interviews, as I want to have minimal impact on my discussions with participants. Having said that, I wonder if I had shared that I do want to have children one day, Emma may have disclosed more to me in case it would be helpful to me personally one day.

Figure 13: Example of memo made directly after an interview

4.3.3 Initial coding using gerunds

Once each interview had been professionally transcribed, the transcripts were individually coded using gerunds to help focus on coding social processes. Each transcript was coded by hand, writing initial codes in the right-hand column and using gerunds where possible. Memos were also written in blue pen if anything struck me about the data, aiming to be reflexive and also observe interactions between the participant and myself as the researcher. Photographs of coded transcripts can be seen in Figure 14, and Table 18 provides an example of this initial coding.

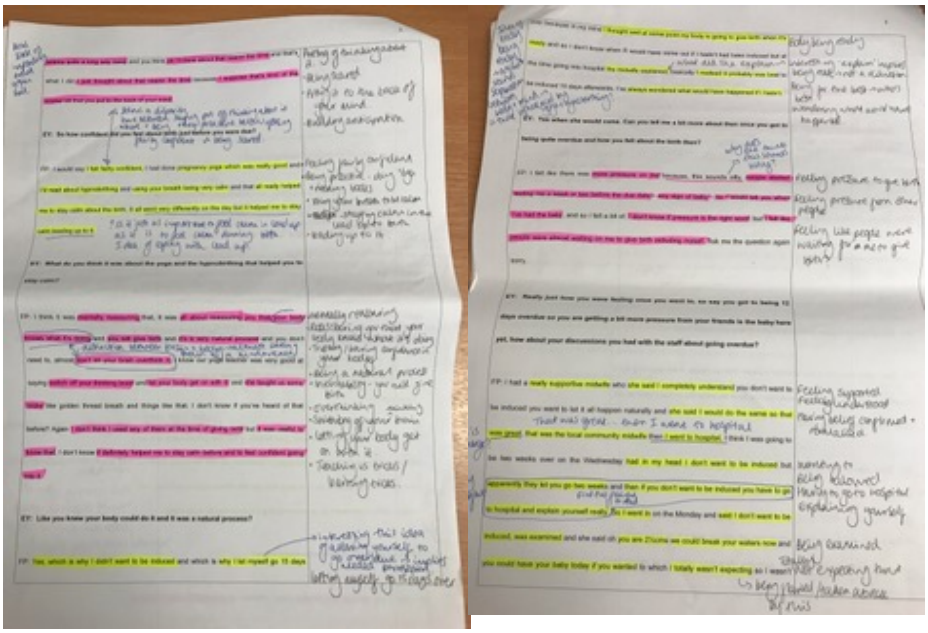


Figure 14: Photographs of original coded transcripts

Transcript	Initial codes
EY: How confident did you feel once you were in the room bouncing on your ball with gas and air?	
Emma: Once I was there I stopped worrying	Stopping worrying.
because I had confidence in the medical team there	Having confidence in the medical team.
I thought that it's OK and also there is someone else	Thinking it's OK.
in charge so when I was at home it was me making	Someone else in charge.
decisions about whether well should I phone them,	Handing over responsibility to the medical team.
should I go to hospital, what's happening whereas	Having to make decisions at home.
when you are there you've got a midwife saying oh	Not knowing what's happening.
yes you are this many centimetres dilated and then	Midwife telling me what's happening.
everything is ok because someone else is looking	Feeling looked after.
after me.	Feeling reassured by someone else looking after me.

Table 18: Example of initial coding

4.3.4 Reworking initial codes

Following this process of initial coding, each code was written by hand into a notebook. Re-writing the initial codes by hand provided an opportunity to carefully consider each code and whether it accurately captured the social processes occurring within the data. Initial codes were reworked if required. Each code was numbered to be able to match

the codes with the raw data in the transcript. To help this process of initial coding a thesaurus of codes with synonyms and antonyms was created, which enabled me to consider whether each code was labelled using the most appropriate wording. An extract from this thesaurus can be seen in Table 19.

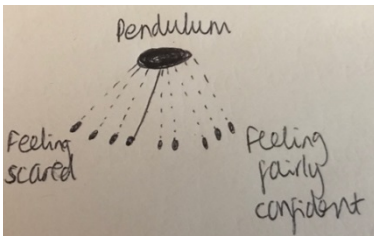
Word	**Synonyms**	**Antonyms**
Able	Adept, adequate, capable, competent, easy, good, intelligent, ready, smart, strong	Disinclined, inadequate, incapable, incompetent, inept, slow, stupid, unable, unintelligent, unskilled, unsuitable
About	Around, any, almost, nearly, roughly, approximately	Afar, away, distant, remote
Accomplishment	Completed, ability, achievement, capability, deed, effort, exploit, feat, performance, skill, talent, triumph	Failure, forfeit, idleness, ignorance, impotence, inability, incapacity, incompetence, weakness
All	Complete, entire, full, greatest, gross, outright, perfect, total, utter	Incompletely, non, zero
Allowed	Grant, acquiesce, avow, concede, confess, own, let on	Deny, disagree, disavow, disown, dispute, dissent, reject, repudiate, disallow, disapprove, forbid, prohibit, protest, refuse, resist, withstand

Table 19: Extract from coding thesaurus

4.3.5 Memo writing during initial coding stage

Memos were also created using pictures and diagrams to try and make sense of the data. Memo writing during initial coding was useful because it helped me to move from simply describing an experience towards a conceptual analysis of it. For example, the

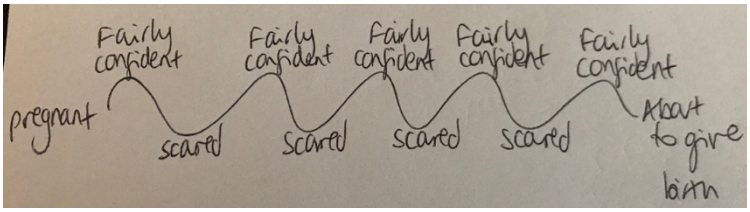
memos in Figures 15 and 16 enabled me to compare Lin's initial codes and consider the momentum of Lin's confidence as a whole.



I am struck by how Lin's story seems to alternate between feeling fairly confident (by preparing for birth and feeling informed, reassuring herself and trying to stay calm) versus feeling scared and worrying (putting off thinking about the birth and feeling birth is inevitable).

It seems that confidence for birth is not as simple as either feeling confident or not confident. For Lin, confidence appears to be fluid, like a pendulum swinging between scared and fairly confident.

Does this indicate that events during pregnancy can have a great influence over confidence because confidence is always in state of flux? This makes me reflect on an earlier memo I wrote about Lin appearing to contradict herself; now it seems that she is not contradicting herself at all, but that the two levels of confidence are co-existing in tandem together and she is fluidly moving between confidence levels.



(This memo is continued over the page...)

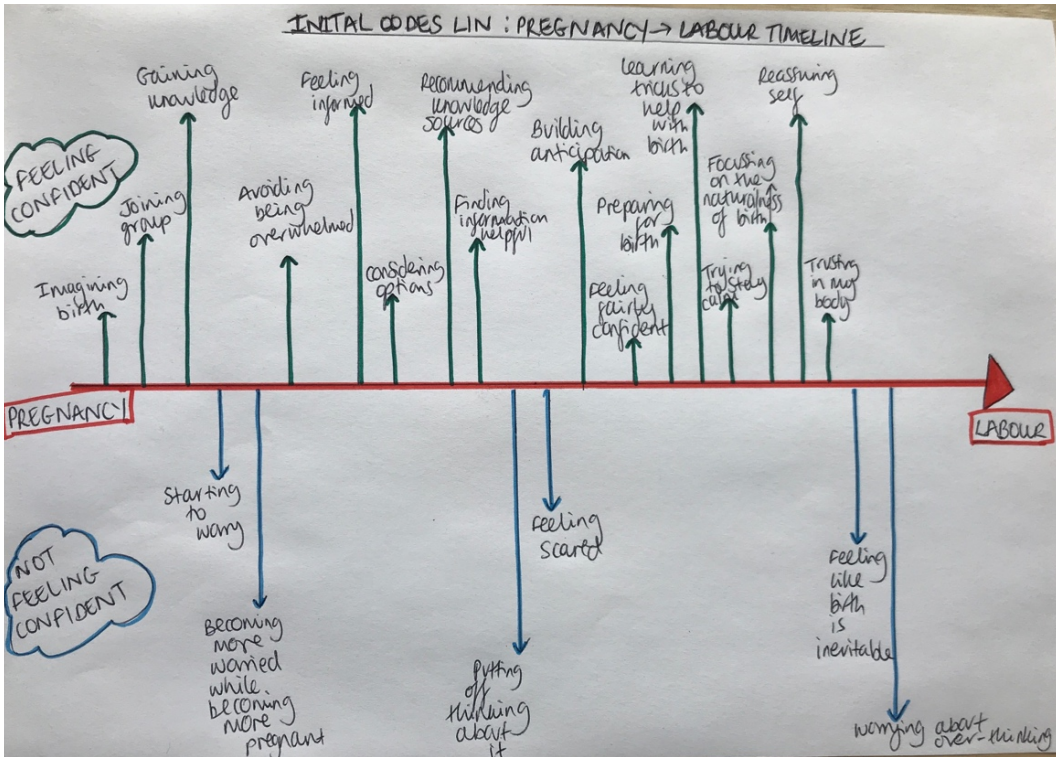


Figure 15: Memo about feeling fairly confident and feeling scared

When coding Lin's description of going into hospital to discuss having an induction (process to artificially start labour) I am struck by how much receiving conflicting information seems to be central in affecting Lin's confidence during this stage of her pregnancy. Lin did not want to be induced but went to hospital as she felt she had to explain herself and was told "you're already 1.5cms, we could break your waters and have a baby today". This seems to convince Lin to have an induction. Then she goes to the labour ward the next day and is told that she's only 1.5cms and it's too early to break her waters. When coding this section of the transcript I visualise a tornado of spiralling lack of confidence when Lin gets information that conflicts the previous information she had received.

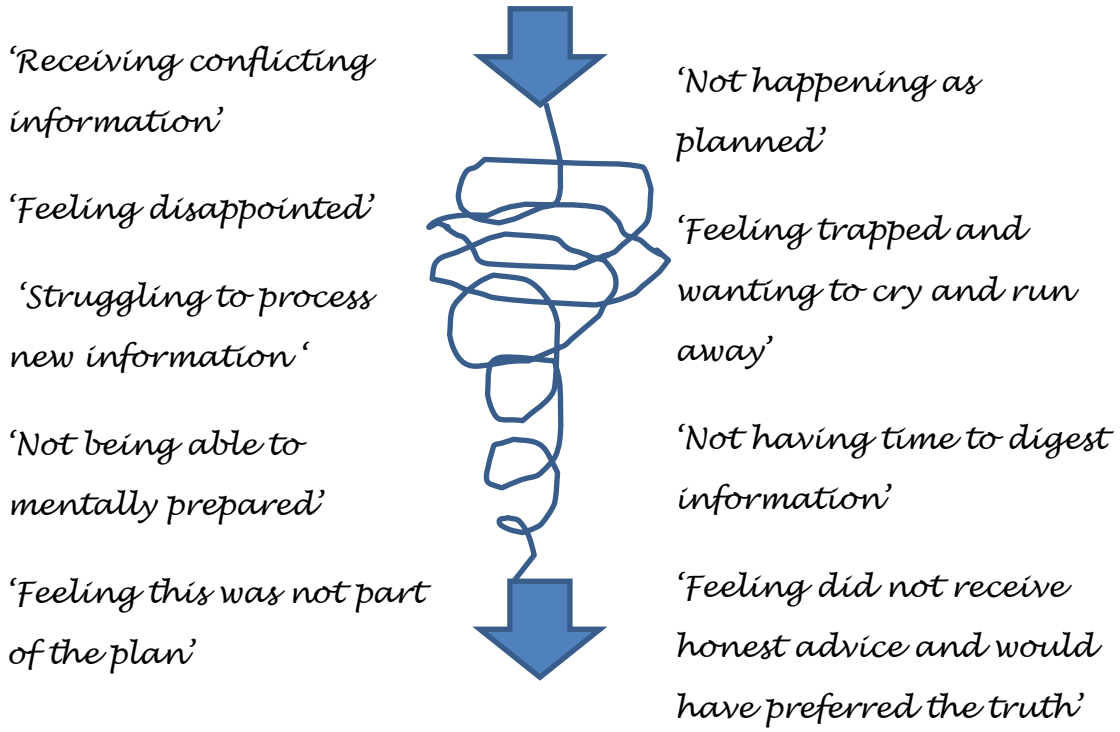


Figure 16: Memo about conflicting information

4.3.6 Beginning focussed coding

Once sufficient memos had been created to make sense of each individual transcript, focussed coding began by summarising the initial codes for each participant using colour codes for 'pregnancy' or 'labour' and 'feeling confident' or 'not feeling confident'. Figure 17 provides a photograph of this process, for Holly's initial codes. This process helped to make sense of the data by making comparisons between codes – for example, by sorting which codes indicated a lack of confidence and which codes indicated increased confidence. Summarising the data for each participant also enabled me to consider how the initial codes fitted together as a whole.

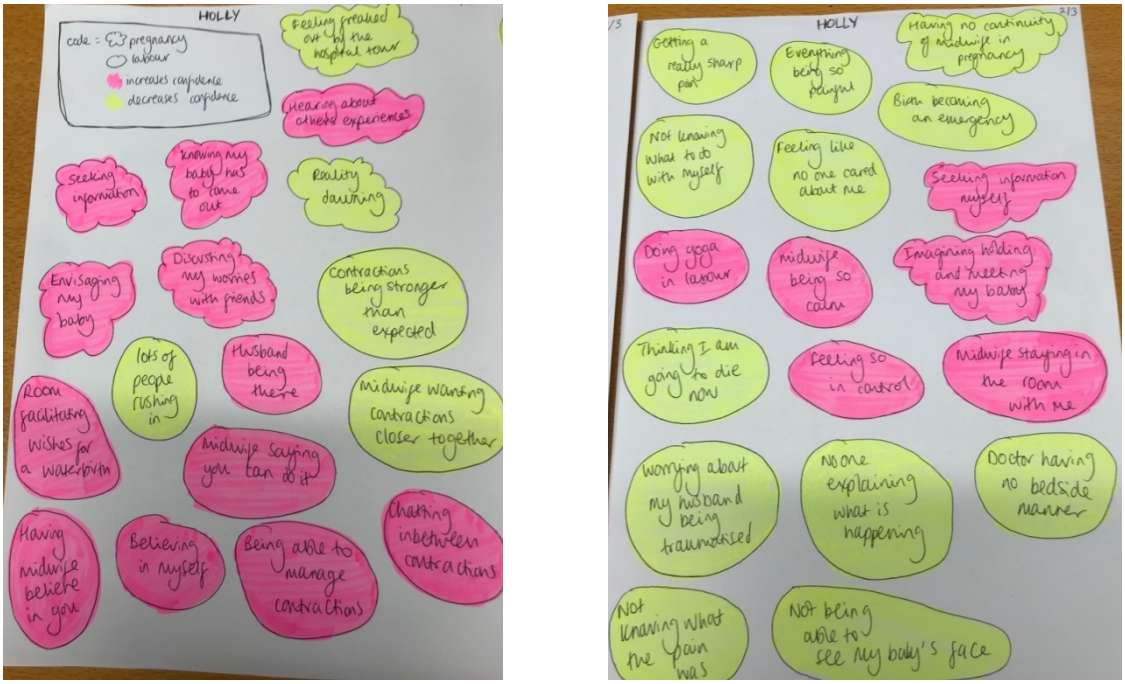


Figure 17: Summarising and sorting initial codes for Holly

4.3.7 Focussed coding comparing initial codes between participants

Following the process demonstrated in Figure 17, these codes were then tabulated so that the codes for every participant could be compared with ease. This tabulation process is shown in Table 20, and the full table can be found in the Appendix I. This table enabled me to compare how codes from each participant were similar or different.

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
Ava	Seeking positive birth stories	Worrying about pain	Having somebody to talk to	Midwife not listening to me
Emma	Seeking information	Being concerned about being actually in labour	Having confidence in medical team	Contractions feeling so painful

Table 20: Example of tabulated initial codes

4.3.8 Focussed coding collating significant initial codes

Collating and comparing the codes from each participant, as shown in Table 20, furthered the process of focussed coding. Next the codes for actions and emotions were summarised and collated in two separate tables (one for actions and one for emotions). Tables 21 and 22 below show extracts from each table.

Collated action codes – cycle one
Story telling • Story telling being a key source of information – impacting on confidence • Having little control over receiving barrage of stories – reducing confidence • Seeking and gaining confidence from positive stories • Developing coping strategies – ignoring negative stories, trying to pick out fact from fiction/making sense of stories, rationalising stories • Negative stories – reducing confidence • Variety of stories being confusing – reducing confidence
Interactions with hospital staff reducing confidence • Hospital staff institutionalising me and taking my control away reducing confidence – having to explain yourself/persuade staff, treating me like I'm not an intelligent person, threatening stillbirth if I don't comply • Making me feel like my baby is more important than me • Poor communication – reducing confidence – not understanding

Table 21: Extract from initial codes table for actions

Collated emotion codes – cycle two
Empowering • Feeling empowered by my community midwife • Midwife making me feel like my own views are important • Feeling able to make vague decisions
Reassuring self • Reassuring self • Gaining reassurance from others' birth stories • Rationalising that lots of people give birth; people give birth so it will be easy • Knowing that asking for an epidural came from fear • Feeling that people with the worst stories share most willingly

Table 22: Extract from initial codes table for emotions

This collation of the initial codes identified early concepts such as, 'storytelling', 'empowering' and 'reassuring self'.

4.3.9 Focussed coding developing the concept of journeying

Comparing the codes and developing early concepts further reinforced early memos that confidence seems to be variable. As a result I was struck by idea of journeying and women journeying through their pregnancy, with their confidence for birth in a constant state of flux. Searching for images of journeying and exploring how these images related to my data was a critical moment for providing clarity and structure to my data, as seen in Figures 18 and 19.

Figure 18: Photograph of memo on journeying through confidence, page 1

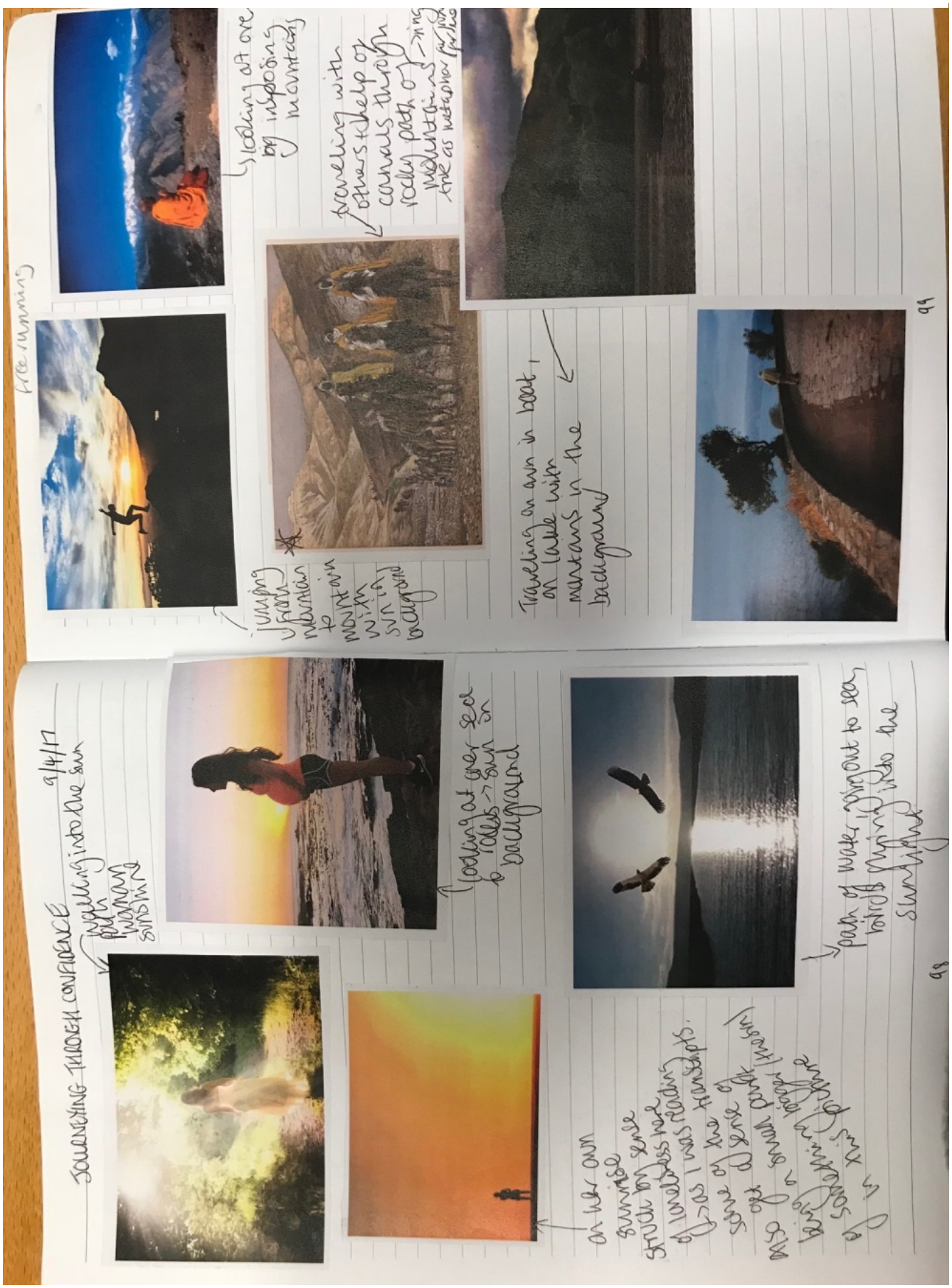
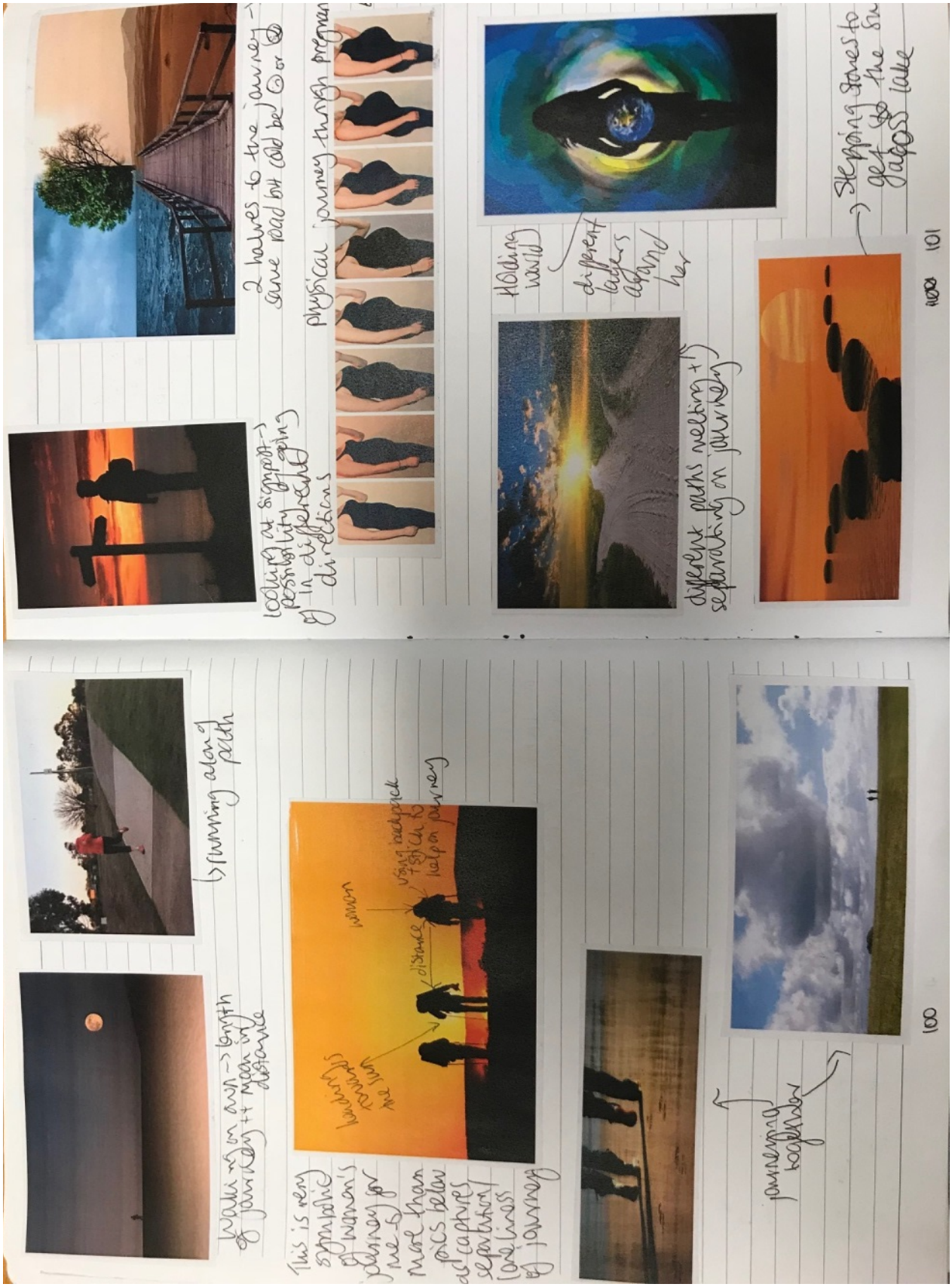


Figure 19: Photograph of memo on journeying through confidence, page 2



These memos and images of journeying helped to add clarity and direction to my analysis. From this memoing I created an early simplified diagram of 'journeying through confidence', illustrated in Figure 20.

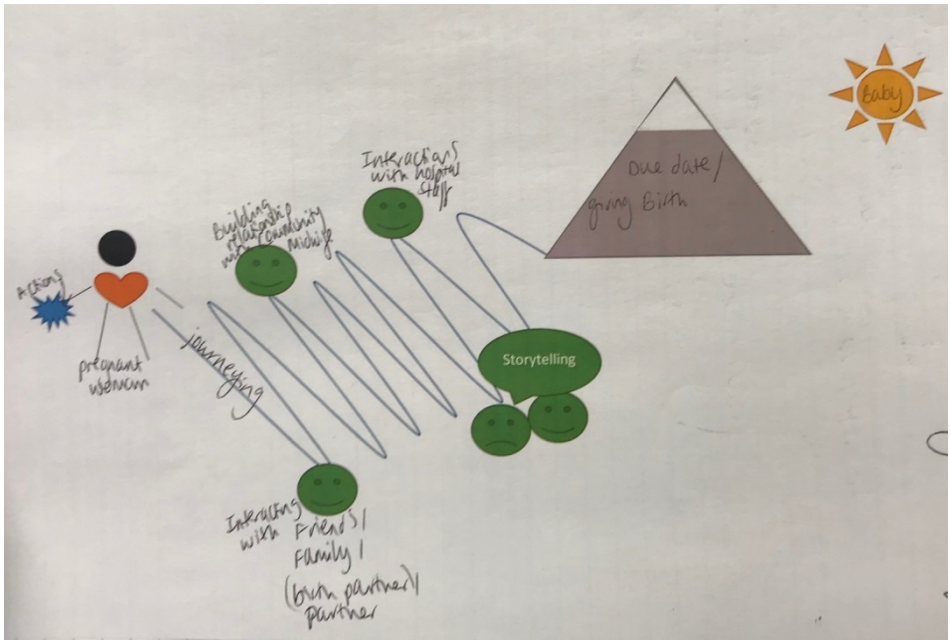


Figure 20: Simplified early diagram of journeying through confidence

In Figure 20 birth is represented as a mountain, with the due date an immovable and impending fate that will have to be encountered at some point. The baby is represented by the sun – in other words, an untouchable hope that can be seen on the horizon. Pregnancy was represented as the long and winding path to the mountain. At this stage of analysis, tentative concepts that seemed to influenced women's confidence for birth were grouped as follows: 'interactions with friends/family', 'building relationship with community midwife' and 'interactions with hospital staff'. Reflecting on the concept of journeying, three distinct phases of journeying through confidence were developed. An unexpected finding was that participants seemed to find that their postnatal experience (the first six weeks after giving birth) had a substantial impact on their confidence for future births; the phases of the childbearing continuum are illustrated in Figure 21.

Figure 21: Phases of the childbearing continuum

When reviewing the analysis from cycle one in supervision, the data was so rich that a decision was made to concentrate only on the pregnancy section of 'journeying through confidence' for this PhD, in order to be able to conduct the detailed analysis required for grounded theory analysis within the time constraints of the study. The data collected regarding birth and postnatal journeying will therefore be analysed for post-doctoral work at a later date. This decision was discussed in supervision following my upgrade exam. My upgrade examiners also advised that I should have a smaller, more specific focus for my PhD, rather than confidence for birth in general.

Once the decision had been made to focus only on what influences women's confidence for birth during pregnancy, a second iteration of Figure 22 was developed. The emotion codes (yellow) and action codes (pink) from Tables 21 and 22 were used for this diagram.

I coloured the emotion codes yellow and action codes pink, and divided these up (not in linear order) to help understand the large number of influences on women's confidence for birth during pregnancy, arranging them on the path leading up to the mountain (labour and giving birth to their baby). This is shown in a photograph of the whole analysis and then a close-up photograph of some of the codes within the analysis (Figures 22 and 23 below).

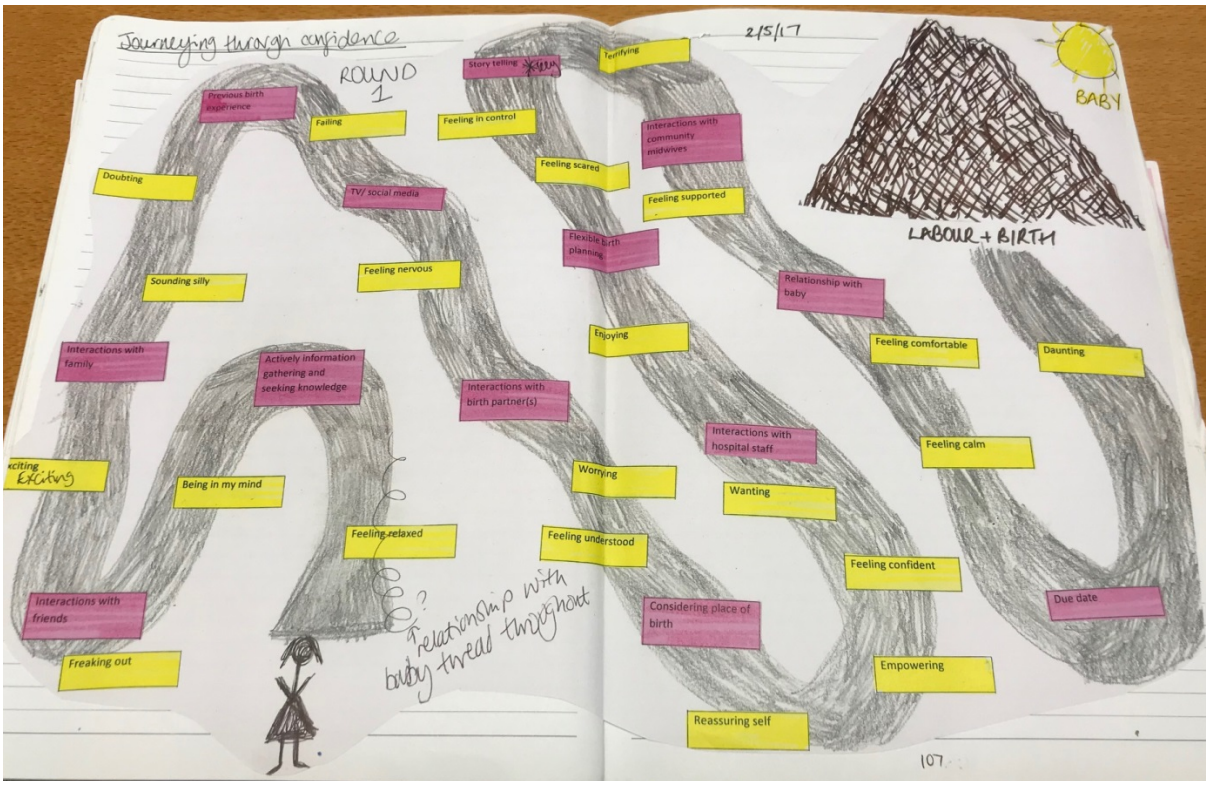


Figure 22: Photograph of diagram of journeying through confidence during pregnancy, with initial action codes in pink and initial emotion codes in yellow.

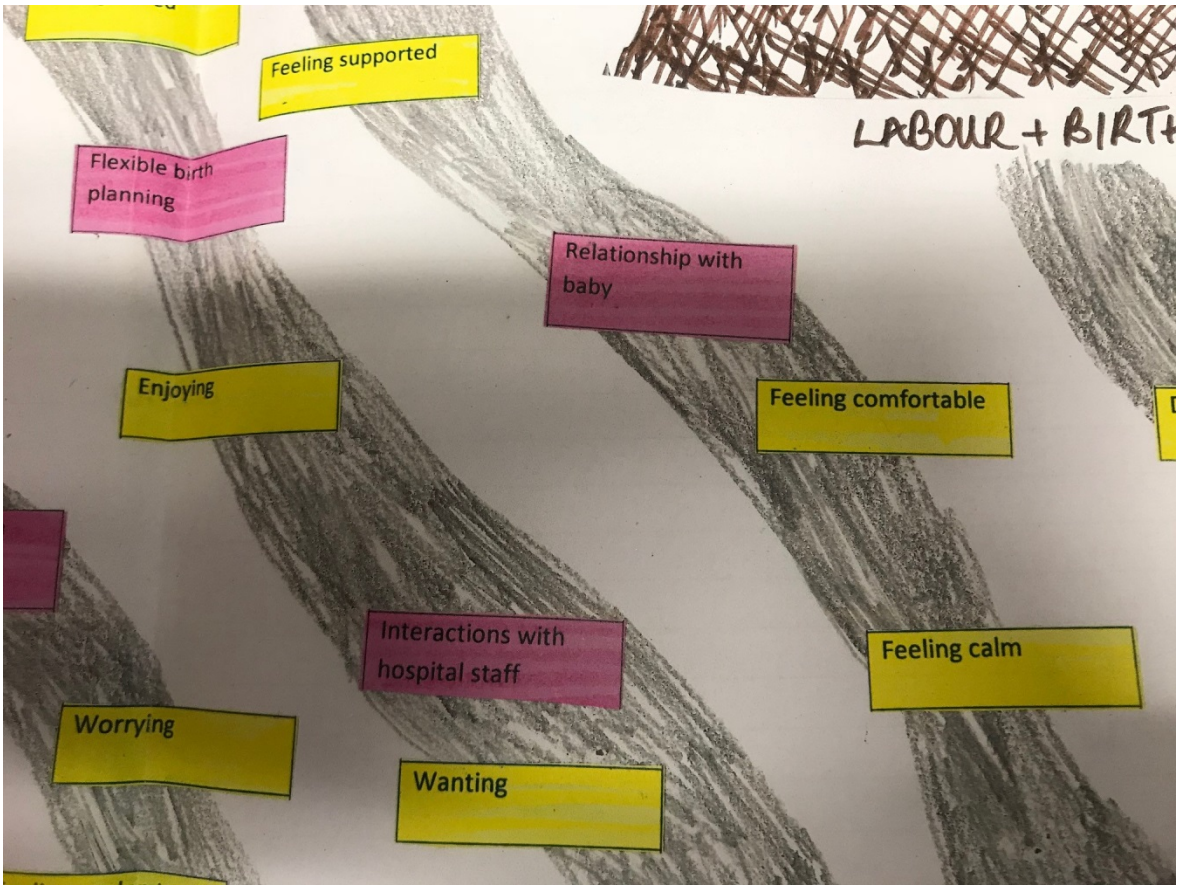


Figure 23: Close up photograph of Figure 22

4.3.10 The development of data analysis in cycle one

Having created the diagram in Figure 22, memo writing helped to be reflexive about how the data was developing. Confidence for birth had become a much more complex concept that I had anticipated. The decision was also made to collect some new interview data to further explore the concepts and the idea of journeying identified in Figure 22.

4.4 Cycle two

4.4.1 Interview participants for cycle two

Having made the decision to focus only on what influenced women's confidence for birth during pregnancy, it felt important to gather more data from women currently experiencing being pregnant. Initially three participants in late pregnancy were interviewed, and then one participant in early to mid-pregnancy was interviewed to gain a different perspective, as illustrated in Table 23.

Pseudonym	Number of weeks pregnant	Expecting first baby?
Alexa	38	Yes
Sophia	36	Yes
Lucy	38	Yes
Ella	16	Yes

Table 23: Characteristics of interview participants in cycle two

4.4.2 Initial coding using gerunds

Each interview transcript was coded by hand, using gerunds. During analysis, it was helpful to sort the codes into action and emotion codes. As with cycle one, memos were written during this initial coding process to encourage me to code creatively. A photograph of writing up the initial codes into action and emotions can be seen in Figure 24.

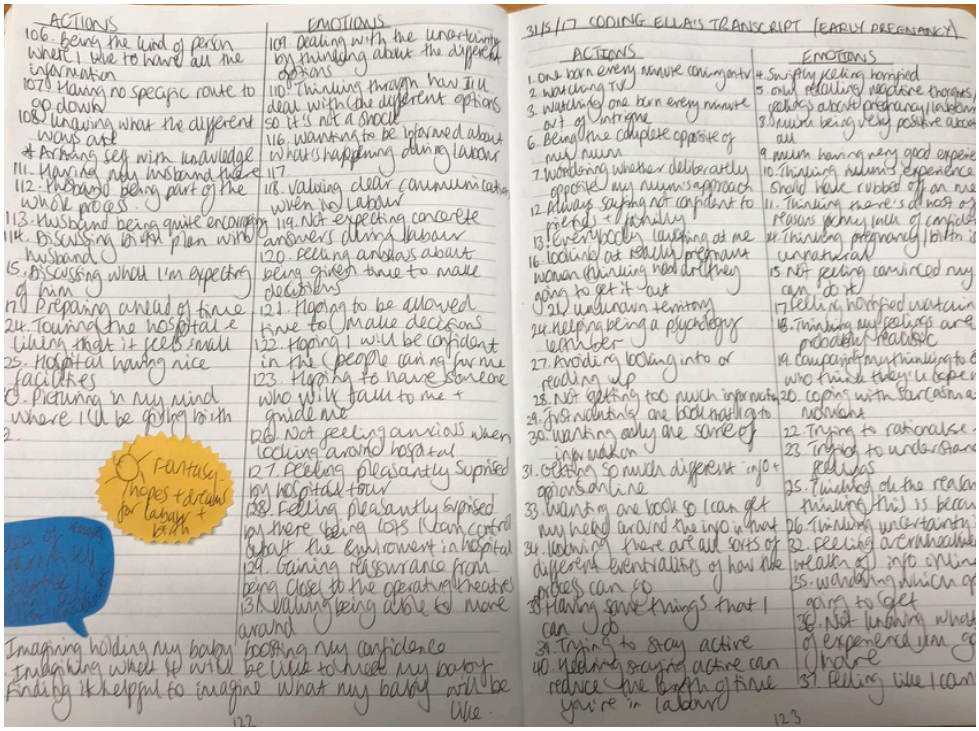
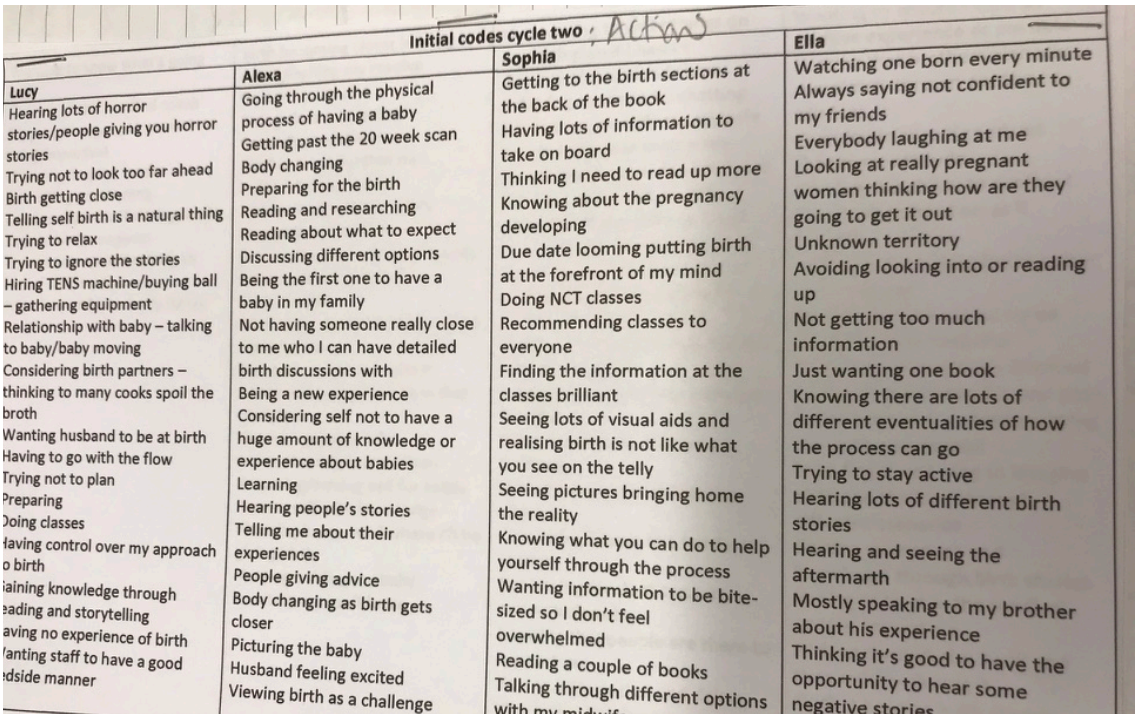


Figure 24: Photograph of sorting initial codes into actions and emotions for each individual participant

4.4.3 Focussed coding collating action and emotion codes

Once each transcript had been coded individually, all the initial codes were collated into separate tables for action codes and emotion codes. Focussing on the codes separately at this stage helped me to make sense of the data and compare the codes from each participant with the data from the other three. A photograph of this process is shown in Figure 25.



Initial codes cycle two : Actions

Lucy	Alexa	Sophia	Ella
Hearing lots of horror stories/people giving you horror stories	Going through the physical process of having a baby	Getting to the birth sections at the back of the book	Watching one born every minute
Trying not to look too far ahead	Getting past the 20 week scan	Having lots of information to take on board	Always saying not confident to my friends
Birth getting close	Body changing	Thinking I need to read up more	Everybody laughing at me
Telling self birth is a natural thing	Preparing for the birth	Knowing about the pregnancy developing	Looking at really pregnant women thinking how are they going to get it out
Trying to relax	Reading and researching	Due date looming putting birth at the forefront of my mind	Unknown territory
Trying to ignore the stories	Reading about what to expect	Doing NCT classes	Avoiding looking into or reading up
Hiring TENS machine/buying ball – gathering equipment	Discussing different options	Recommending classes to everyone	Not getting too much information
Relationship with baby – talking to baby/baby moving	Being the first one to have a baby in my family	Finding the information at the classes brilliant	Just wanting one book
Considering birth partners – thinking to many cooks spoil the broth	Not having someone really close to me who I can have detailed birth discussions with	Seeing lots of visual aids and realising birth is not like what you see on the telly	Knowing there are lots of different eventualities of how the process can go
Wanting husband to be at birth	Being a new experience	Seeing pictures bringing home the reality	Trying to stay active
Having to go with the flow	Considering self not to have a huge amount of knowledge or experience about babies	Knowing what you can do to help yourself through the process	Hearing lots of different birth stories
Trying not to plan	Learning	Wanting information to be bite-sized so I don't feel overwhelmed	Hearing and seeing the aftermarth
Preparing	Hearing people's stories	Reading a couple of books	Mostly speaking to my brother about his experience
Doing classes	Telling me about their experiences	Talking through different options	Thinking it's good to have the opportunity to hear some negative stories
Having control over my approach o birth	People giving advice		
aining knowledge through eading and storytelling	Body changing as birth gets closer		
aving no experience of birth	Picturing the baby		
anting staff to have a good dside manner	Husband feeling excited		
	Viewing birth as a challenge		

Figure 25: Collated initial action codes for all four participants

4.4.4 Focussed coding exploring tentative concepts using memos and diagrams

Following the creation of Figure 25, focussed coding began. First, tentative concepts across the codes were considered using mind maps and diagrams. Figure 26 provides an example of developing the concept of 'meeting the baby' as potentially increasing confidence. In this memo, codes that related to 'meeting my baby' were compared across the four participants from cycle two.

Lucy initial codes:	**Sophia initial codes:**
• Feeling excited about meeting my baby • Baby moving prompting excitement • Looking forward to meeting my baby	• Thinking about meeting my baby making me quite emotional • Feeling overwhelmed imagining meeting my baby but not in a bad way
Alexa initial codes: • Imaging holding my baby boosting my confidence • Giving me the biggest boost • Imagining what it will be like to meet my baby • Finding it helpful to imagine what my baby will be like	**Ella initial codes:** • Thinking it'll be helpful to have an image of meeting my baby when it gets difficult • Considering the pinnacle event to be having the baby in my arms

Memo: Does birth = meeting my baby = increased confidence?

All four women appear to discuss meeting their baby as a key moment when they imagine giving birth. Indeed, Ella describes meeting her baby as the pinnacle event, while Alexa explicitly relates imagining meeting her baby as being one of the biggest factors influencing her confidence. Lucy is less specific in relation to confidence, describing feeling excited, and Sophia seems to feel quite emotional when she imagines meeting her baby. Looking back at memos I made during the interviews, I can see that I made a note that Sophia 'welled up' during this part of the interview.

I think that this second cycle of interviews supports the concept of journeying through pregnancy with the image of the baby being represented as the sun in the distance, with women traveling towards this point through pregnancy… (memo continued overleaf)

… and birth. I think that, as with the data from cycle one, imagining meeting their baby may be an important factor for women during their pregnancy journey and something that I want to continue exploring. All four of these participants' spontaneously told me that they were excited to be pregnant, although Sophia was the only participant to tell me that her baby was not planned. I wonder if this has an influence on confidence as Sophia seemed to be more overwhelmed at the thought of meeting her baby than the other participants. Perhaps, how you feel about actually being pregnant and having a baby influences how you feel about giving birth. This is something that I would like to try and explore further in cycle three, although this feels like a very sensitive topic, I will need to ensure that I approach this topic with care.

Figure 26: A memo developing a tentative concept around imagining meeting the baby

In addition to creating several memos about tentative concepts and comparing codes from all four participants in cycle two, the following photographs (Figures 27 and 28) illustrate the diagramming process, which involved colour-coding tentative codes and concepts to develop the concepts into categories.

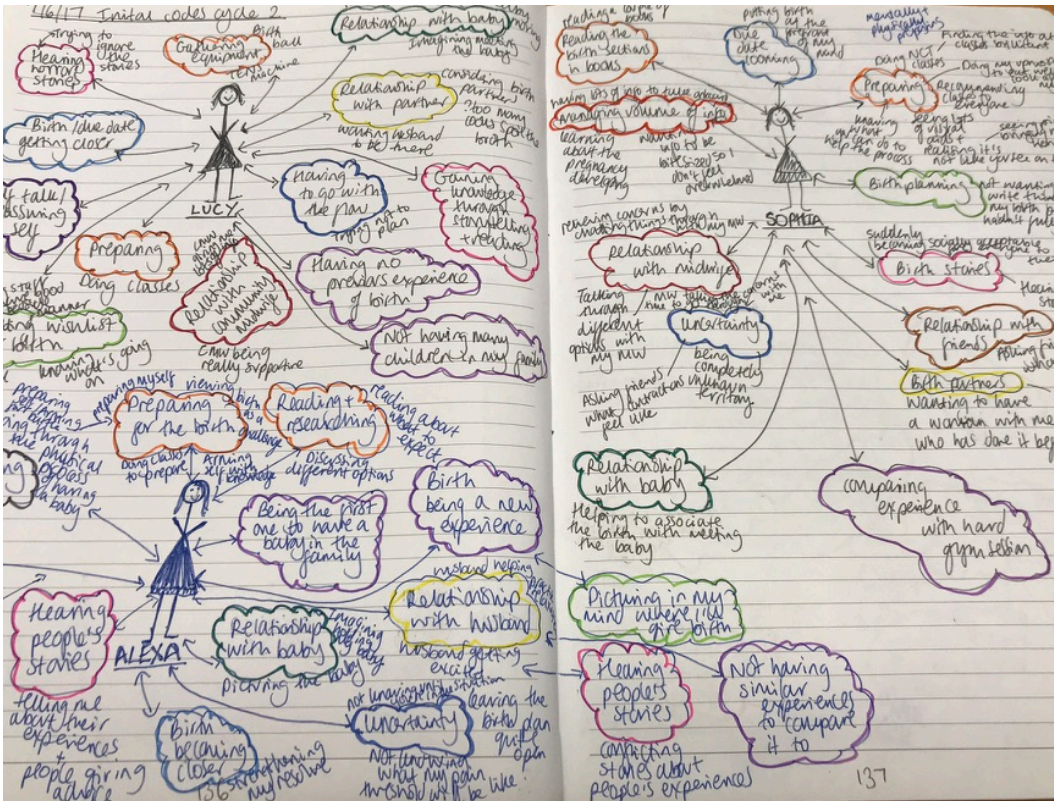


Figure 27: Photograph of memoing initial action codes for cycle two

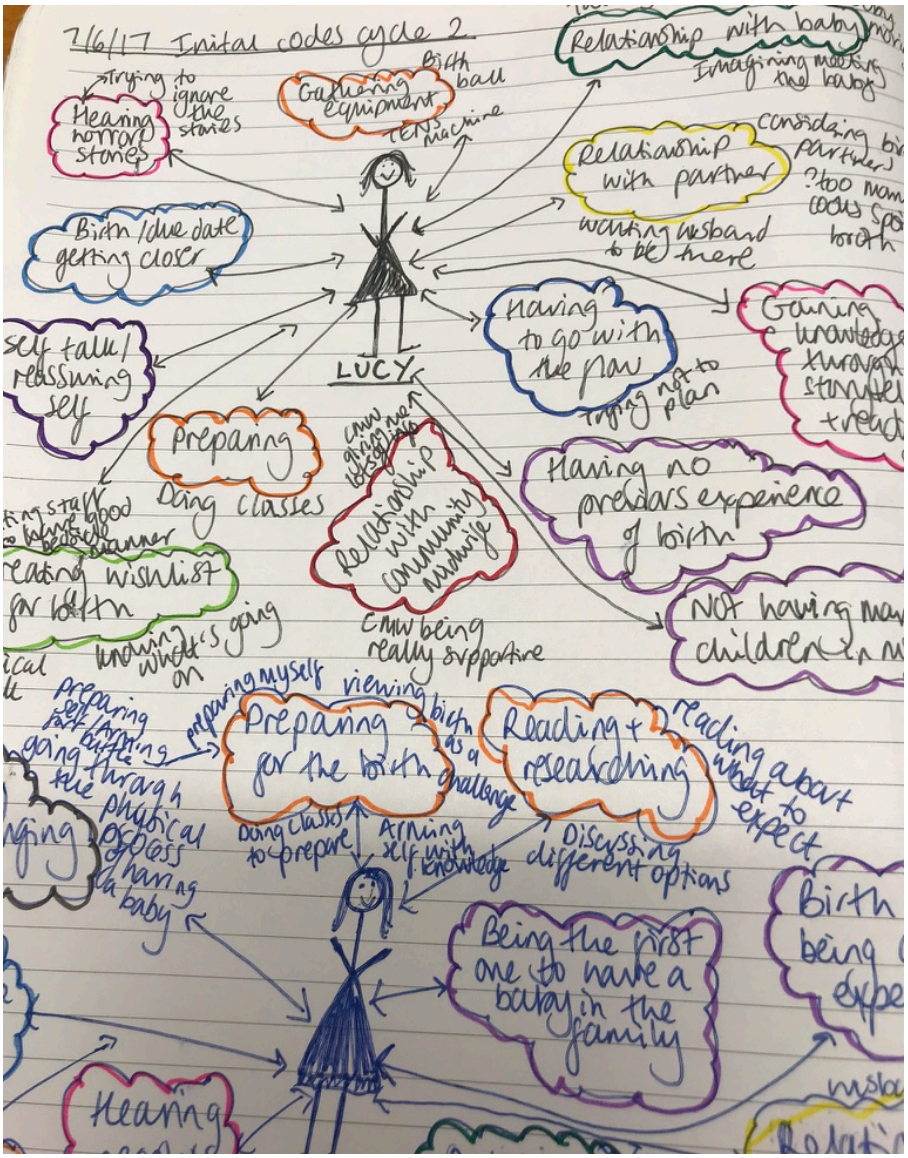


Figure 28: Closer photograph of Figure 27

4.4.5 Focussed coding developing tentative categories

The diagramming process illustrated in Figures 27 and 28 resulted in the creation of the following four tentative categories: ‘information seeking and gathering’, ‘mentally and physically preparing’, ‘intimate relationships’ and ‘physical prompts’. Table 24 provides descriptions for these four categories which captured both emotion and action codes. This felt like a ‘breakthrough’ moment, enabling me to synthesise and start to categorise codes and concepts for the first time in the data analysis process. Until this point it was hard to imagine being able to make the data neat or manageable; rather, it felt as if it the data was continually growing. The categories in Table 24 were changed and refined many times to result in the four categories that were presented in the final model of the theory, but they provided a helpful starting point.

Category	Concepts within categories
Information seeking and gathering	Birth stories, managing information gathering, TV/social media, interactions and relationships with friends and family
Mentally and physically preparing	Preparing, coping with uncertainty, comparing with others' experiences, self-talk/reassuring self, imagining/creating preferences for birth
Intimate relationships	Relationships and interactions with partner being influenced, developing relationship with baby
Physical prompts	Body changing, dates marking points in the journey e.g. 20 week scan and dues date, relationship with own health

Table 24: Overview of very tentative creation of categories and concepts

4.4.6 Focussed coding comparing data from cycles one and two

Following the creation of tentative categories, the data analyses from cycles one and two were compared. In order to do this, Table 25 was created to provide a detailed illustration of the concepts that arose from cycle one only (bold font), cycle two only (italic font) or both cycles of data (normal font). During the process of creating Table 25, it became apparent that although concepts might have been explicit in one cycle and not the other, all the concepts illustrated in Table 25 were relevant to both cycles of data collection. This is not a surprise because the aim of cycle two was to build on the codes identified in cycle one. Creating Table 25 was therefore a very helpful process which prevented me from 'shutting doors' on codes and concepts too quickly; Charmaz (2014) warns that this can be a possibility for inexperienced grounded theorists. If I had not gone back and compared my concepts from cycle one and cycle two, I may have gone on to create oversimplified categories that more strongly reflected cycle two rather than both cycles of data, and which did not reflect the true richness of the data that I had gathered. Going back to thinking of the concepts separately as action and emotion processes was also a helpful process which added depth to the analysis.

Categories from cycle one and two merged		
Category	**Action concepts**	**Emotion concepts**
Information seeking and gathering	**Actively information gathering** Hearing birth stories Managing information gathering Seeing TV/social media Interactions and relationships with friends Interactions with family Interactions and relationships through pregnancy Drawing on previous birth experience/similar experiences **Considering place of birth** **Interactions with community midwives** **Interactions with hospital staff**	Feeling influenced by others' birth stories *Recalling perception of others' experiences* Mum's perspective on birth *Not interested in/feeling horrified by watching OBEM* Not wanting to hear about others' experiences of birth Enjoying and valuing learning about birth Feeling clueless Feeling overwhelmed Thinking it's easier second time round Feeling supported by midwife Feeling safe and comfortable with future birth environment
Mentally and physically preparing	Imagining and creating preferences for birth Preparing Coping with uncertainties Self-talk/reassuring self **Flexible birth planning**	Expectations Being open Coping with managing emotions Imagining/wondering about birth and contemplating preferences – valuing others being in control Protecting self by not writing a birth plan Hoping preparing will be useful Acknowledging and anticipating feelings (worrying, personality/knowing self, feeling uncertain, not worrying, not being able to control birth or control feelings about birth, lacking confidence, anticipating feelings changing) **Feeling confident** **Feeling empowered** **Feeling supported**

Influence of physical prompts	Prompts from body changing Dates marking points in the journey (20 week scan, due date) Relationship with own health	Own health during pregnancy *Enjoying being pregnant* Not feeling ready to learn about birth Looking forward to the birth Realisation dawning Becoming more focused on the birth
Influence of intimate relationships	Relationships and interactions with partner being influencing Developing relationship with baby	Feeling excited to meet my baby boosting confidence Support from partner strengthening confidence Valuing partner's preferences and experiences *Enjoying being pregnant* *Feeling excited about being pregnant* *Feeling excited about having a baby* Feeling fascinated by developing pregnancy and baby

Table 25: Categories developed from data analysis from cycles one and two with action and emotion codes

4.4.7 Focussed coding diagramming to further develop categories

Following the reflection and insights that arose from creating Table 25, more diagrams and memos were created to further refine the data, based on the categories identified in the table. Figure 29 shows a photograph of one of these diagrams to provide an example of this process.

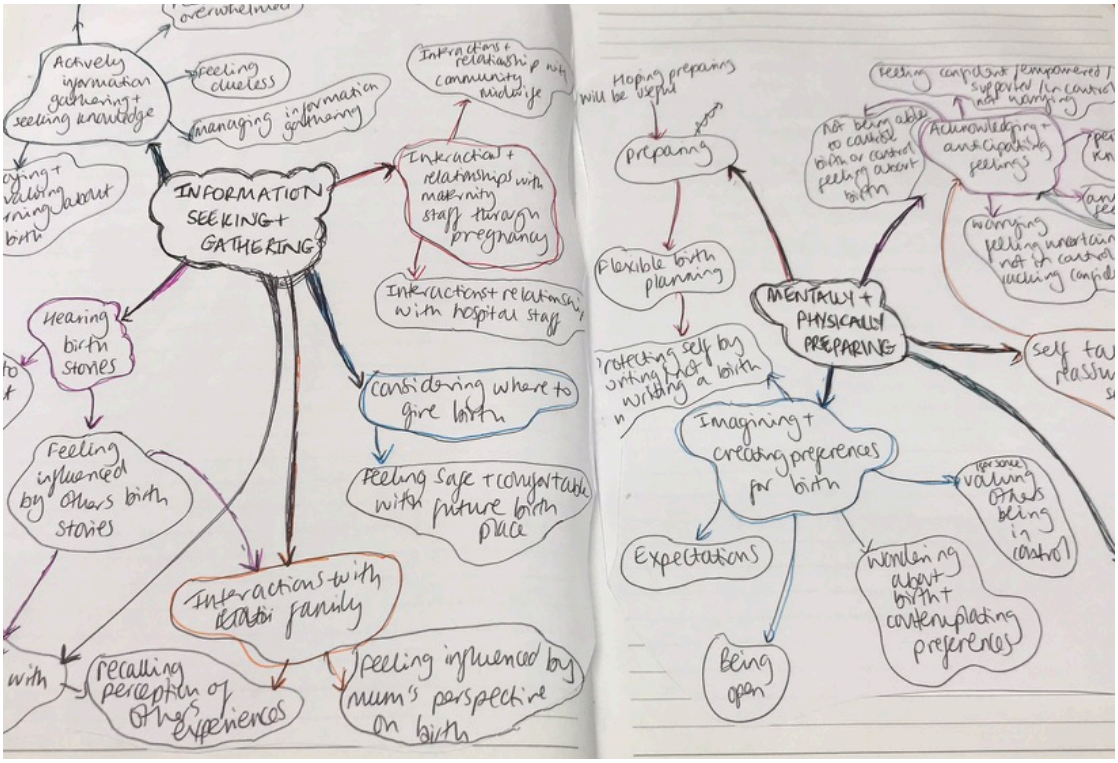


Figure 29: Diagram sorting and further developing tentative categories in cycle two

4.4.8 Focussed coding refining categories and concepts

This period of memoing and diagramming illustrated in Figure 29 led to further refined categories that are explained in Table 26. Cycle three then went on to test these tentative categories and the concepts within them.

Categories from cycle one and two merged		
Category	**Concepts**	**Codes**
Information seeking and gathering	Actively information gathering	Enjoying and valuing learning about birth Feeling clueless Feeling overwhelmed Thinking it's easier second time round Managing information gathering Seeing TV/social media – Not interested in/feeling horrified by watching OBEM
	Hearing birth stories	Feeling influenced by others' birth stories Not wanting to hear about others' experiences of birth
	Interactions and relationships through pregnancy	Interactions and relationships with friends – Recalling perception of others' experiences Interactions with family – Recalling perception of others' experiences, Mum's perspective on birth Interactions with community midwives – Feeling supported by midwife Interactions with hospital staff
	Drawing on previous birth experience/similar experiences	Drawing on previous birth experience/similar experiences – Thinking it's easier second time round
	Considering place of birth	Feeling safe and comfortable with future birth environment

Category	Concepts	Codes
Mentally and physically preparing	Imagining and creating preferences for birth	Wondering about birth and contemplating preferences Being open Creating expectations Creating values for labour (e.g. others being in control) Protecting self by writing or not writing a birth plan
	Self talk/reassuring self	Self talk/reassuring self Acknowledging and anticipating feelings
	Coping with uncertainties	Coping with uncertainties Acknowledging and anticipating feelings
	Acknowledging and anticipating feelings	Feeling confident/empowered/supported/in control/not worrying Personality/knowing self Anticipating feelings changing Worrying/feeling uncertain/not in control/lacking confidence Not being able to control birth or control feelings about birth
	Preparing	Preparing – Hoping preparing will be useful Flexible birth planning – Protecting self by writing/not writing a birth plan

Category	Concepts	Codes
Influence of physical prompts	Enjoying being pregnant	Enjoying being pregnant Not feeling ready to learn about birth Looking forward to the birth
	Prompts from body changing	Realisation dawning that I'm going to have a baby
	Dates marking points in the journey	Due date approaching – Becoming more focused on the birth – Realisation dawning, looking forward to the birth 20 week scan – making things seem more real Not feeling ready to learn about birth yet
	Relationship with own health	Own health during pregnancy
Influence of intimate relationships	Relationships and interactions with partner being influencing	Support from partner strengthening confidence Valuing partner's preferences and experiences
	Developing relationship with baby	Feeling excited to meet my baby boosting confidence Enjoying being pregnant Feeling excited about being pregnant Feeling excited about having a baby Feeling fascinated by developing pregnancy and baby

Table 26: Table illustrating the refined tentative categories from data from cycles one and two

4.5 Cycle three

4.5.1 Analysis process

At this stage of analysis the categories still felt quite underdeveloped, with some categories having more codes and concepts than others. Further data collection and analysis was needed to be able to test the tentative categories of: 'Information seeking and gathering', 'Mentally and physically preparing', 'Influence of physical prompts' and 'Influence of intimate relationships'. The decision was therefore made to interview more mothers who had given birth within the last two years, to try and gain more information about each of these four categories. By conducting more interviews it was hoped to examine whether the tentative categories were indeed the most influential categories on women's confidence for birth. In addition to testing the categories, further data collection and analysis also aimed to provide a more solid foundation for the concepts within the tentative categories.

In total thirteen interviews were conducted with women who had given birth recently (either once or twice before).Two of these participants were also pregnant during the interview. To try to follow the pregnancy journey, the three participants who were interviewed in late pregnancy for cycle two were re-interviewed approximately six to eight weeks after giving birth. These participants' interview guides were tailored towards the specific concepts that arose in their first interview, to see how they felt about the things that were important to them in pregnancy and how their confidence had developed now that they had given birth. By the time that Ella, who was in mid-pregnancy during cycle two, had given birth, it was felt that there was sufficient data so a follow-up interview with her was not required.

4.5.2 Participants in cycle three

Table 27 provides a brief description of the participants who were interviewed for cycle three of the data collection. A '*' symbol in Table 27 indicates the participants who were followed up from cycle two of the study.

Pseudonym	Children who had been born	Currently pregnant?	Type of birth(s)
Hannah	1 x 2-and-a-half-year-old girl	Yes	Unplanned caesarean in hospital
Charley	1 x 15-month-old girl	No	Induction and unplanned caesarean in hospital
Grace	1 x 17-month-old boy	No	Water birth in hospital
Cora	1 x 4-year-oldboy and 1 x 12-month-old girl (approx. age; did not record exact age)	No	1 x vaginal birth at home (first baby) 1 x vaginal birth in hospital (second baby)
Peaches	1 x 6-week-old girl	No	Vaginal birth in hospital (started labour at freestanding birth centre)
Ellie	1 x boy 2-3 years old and 1 x boy approx. 3 months old	No	1 x induction and vaginal birth in hospital (first baby) 1 x vaginal birth in hospital (second baby)
Orla	1 x girl 3 years old, 1 x girl 1 year old	No	2 x vaginal births in hospital
Hazel	1 x boy 4 years old, 1 x boy 2 years old	No	2 x vaginal births in hospital
Sarah	1 x 18 month old girl	Yes	Forceps birth (laboured mostly at home then transferred to hospital because of failure to progress)
Charlotte	1 x 6 month old boy	No	Vaginal birth in hospital
Sophia*	1 x 6-week-old girl	No	Induction and forceps birth in hospital
Alexa*	1 x 10-week-old girl	No	Induction and forceps birth in hospital
Lucy*	1 x 7-week-old boy	No	Induction and forceps birth in hospital

Table 27: Description of the participants in cycle three

4.5.3 Initial coding using gerunds

First, initial coding using gerunds was conducted on all thirteen transcripts using the same process as described in cycles one and two.

4.5.4 Focussed coding categorising initial codes

The initial codes were then colour-coded according to the framework shown in Table 27. This framework was used to provide structure for the analysis of the codes, and care was taken not to force codes into these categories. Figure 30 provides an example of some of Ellie's initial codes colour-coded according to these categories.

Ellie

1. Baby being a surprise
2. Going in for IVF (genetic screening)
3. Timing not ideal
4. Husband not wanting baby
5. Baby having genetic condition
6. Not enjoying second pregnancy
7. Being too busy dealing with other baby
8. Expecting to have a natural birth
9. Feeling confidence as low as a first-time mum
10. Never seeing anyone in labour
11. Going on courses helping confidence
12. Reflecting should watch a second-timer give birth to help confidence with first
13. Feeling determined to follow my birth plan
14. Feeling open minded on the end result

Key for colour coding of categories

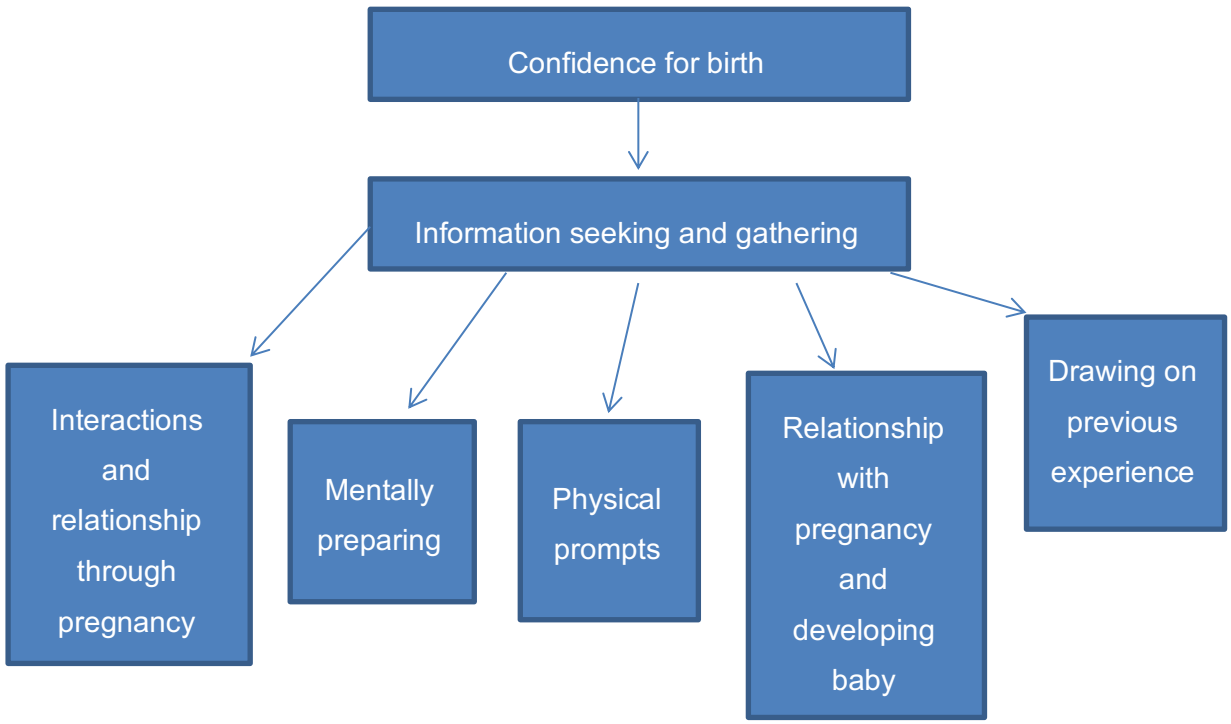
Information gathering
Mentally and physically preparing
Influence of physical prompts
Influence on intimate relationships

Figure 30: A coded section of Ellie's transcript to illustrate the process of colour-coding initial codes according to the framework developed in Table 27

This section of Ellie's interview was helpful because Ellie provided a contradictory response to some of the interview participants, who suggested that you have more

confidence being pregnant and giving birth for the second time. Other participants suggested that women have more confidence for birth second time around because they have previous experience and so know what to expect. However, Ellie's interview helped me to realise the inter-relationship between the categories; for example, Ellie did not enjoy her pregnancy as much second time round, and so reported that she had less confidence for birth than when she was pregnant with her first baby. Ellie's interview also helped me to realise that I needed to make the 'enjoying being pregnant' concept broader because not everyone enjoys their pregnancy.

Categorising all the initial codes in this way enabled 'information gathering' to be identified as a pivotal code, and also helped to further develop concepts within the categories, as illustrated in Figure 31.



Categories not seeming to fit very well while collating cycle three codes. Information seeking and gathering seems to fit into all of the other categories. In fact, it seems like information seeking and gathering is at the centre of the categories and concepts, I think that this is my pivotal code. Having shuffled around the categories. Exercising in pregnancy also seemed to be really important in cycle three with several participants highlighting exercise as a key influencing factor on their confidence for birth. I don't feel like I picked this up as strongly in cycles one and two. Another development of the categories is that previous birth experience doesn't necessarily make you feel more confident about giving birth. It seems like your confidence depends on your interpretation of that experience; for example, if you had an unplanned caesarean and felt that you had failed at giving birth then you are perhaps more likely to feel less confident about giving birth in the future than you did when you were pregnant with your first baby.

Figure 31: Copy of a memo written regarding the development of categories through cycle three

4.5.5 Focused coding data from cycles one, two and three

Before cycle three, ‘information gathering’ was one of four categories. Now there were five categories, and ‘gathering and interpreting information’ became a pivotal category that was embedded through all the other categories. Following the collection of data for cycle three, it was felt that ‘interactions and relationships through pregnancy’ better described the processes occurring in the category that had formally been described as ‘gathering and interpreting information’. Several new concepts within each category were also added. For example, Table 28 illustrates the difference between the category of ‘information seeking and gathering’ before and after cycle three.

Framework before cycle three of data collection and analysis		**Framework following cycle three of data collection and analysis**		
Categories	**Concepts**	**Pivotal category**	**Categories**	**Concepts**
Information seeking and gathering	Actively information gathering and seeking knowledge	Gathering and interpreting information	Interactions and relationships through pregnancy	Hearing birth stories
	Hearing birth stories			Interactions with community midwives
	Interactions and relationships through pregnancy			Being around babies a lot
	Drawing on previous birth experiences/similar experiences			Mum
	Considering place of birth			Interactions with doctors in pregnancy
				Experience with labour line
				Interactions with friends
				Birth reflections appointment
				Relationship and interactions with birth partner

Table 28: Extract from table comparing the differences between categories and concepts before and after cycle three

4.5.6 Focussed coding revising categories

Table 29 provides an example of the revised categories from comparing data collated from cycles one, two and three, for the category of ‘preparing’. The two concepts within ‘preparing’ that are explored in this table are ‘imagining and creating preferences for birth’ and ‘going to classes’.

Categories from cycles one, two and three			
Pivotal code	**Categories**	**Concepts**	**Codes**
Gathering and interpreting information	**Mentally preparing**	**Imagining and creating preferences for birth**	**Not having any expectations of labour** – being open, not being hung up on a particular birth, wanting to be able to go with the flow, wanting to be in a position where I am chilled and open minded **Wondering about birth and creating preferences** – expecting to have a natural birth, wanting to just use gas and air, feeling determined to move around as much as possible during labour, wanting a natural birth for recovery afterwards, not liking the idea of medicalised interventions **Creating values for labour** – valuing others being in control, wanting an up-to-date midwife, having confidence in my midwife being important, valuing clear communication in labour **Feeling like my expectations are realistic** – knowing it's going to be hard, thinking no one goes into labour thinking it'll be easy, being realistic that it'll hurt a lot, having friends with babies helping prevent false expectations, preparing myself that things don't go the way you expect

Pivotal code	**Categories**	**Concepts**	**Codes**
Gathering and interpreting information	**Mentally preparing**	**Going to classes**	**Classes helping confidence** – going on courses helping confidence, doing pregnancy yoga and having quiet time really helping, confidence from classes really helping, doing pregnancy yoga being helpful, hypnobirthing techniques helping with contractions, getting your head in the right place helping, practising contractions at pregnancy yoga, practising caesarean at NCT class helpful knowing what to expect NCT classes helping understand biology, drawing on hypnobirthing like a toolkit, classes making us both clued up, finding confident birthing workshops reassuring, knowing nothing is going to be a surprise **Embracing antenatal classes** – embracing everything that made me feel like I knew more what I was doing **Having no classes to go to** – having no classes for second time mums **Classes taking me out of denial** – feeling like I'd been in denial before the classes

Table 29: Extract from table collating tentative categories, concepts and codes for cycles one, two and three of data collection (full table in appendix J)

4.5.7 Focussed coding refining the framework of categories and, concepts

Having refined the framework, mind mapping helped to visualise and understand the breadth of data collected and how the categories had now developed in relation to each other. At this stage it felt as if the data had become very broad again, as illustrated by Figure 32.

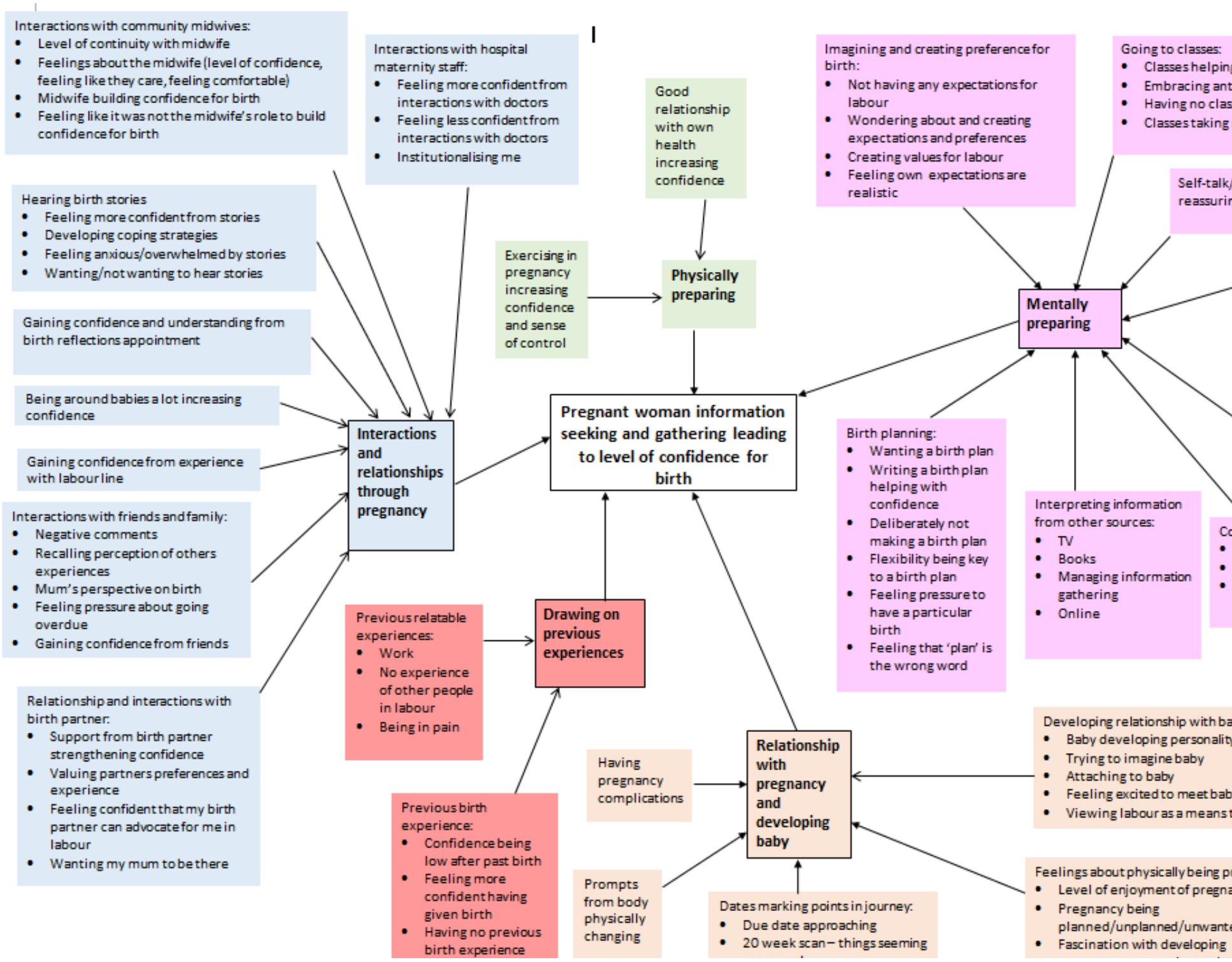


Figure 32: Tentative categories developed from cycles one, two and three of data collection

4.6 Focussed coding to further develop categories

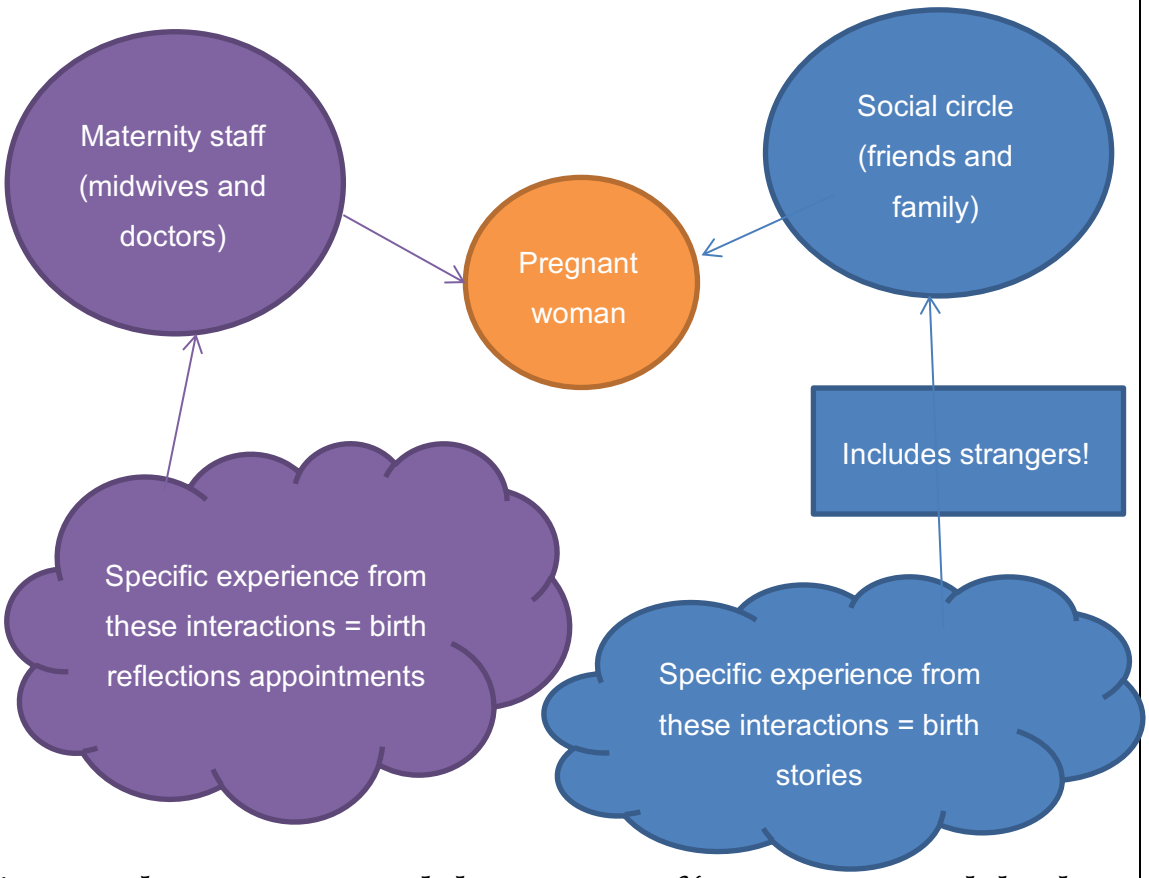
4.6.1 The challenge of knowing when to stop in grounded theory

Following the creation of Figure 32, my supervisors advised me to stop collecting data and analysing data in the way that I had been, and to start writing up the theory. A few months were therefore spent sorting, defining, comparing and refining categories through focussed coding. Memo writing was also utilised to further develop the theory.

At the time that I received the advice from my supervisors to start writing up the theory I was really immersed in the data collection and analysis process, and felt that I had only just scratched the surface in understanding what influences women's confidence for birth. I felt that the data was growing and growing and I was consumed by the enormity of it all. I therefore felt quite reluctant when my supervisors advised me to start writing up the theory. Glaser (1978) refers to this phase of grounded theory as a 'drugless trip', and describes it as the stage when the researcher has lots of different ideas concerning the theory but nothing seems clear. Glaser (1978) also writes that this phase is followed by data saturation, the most important stage of theory development. At this final stage Glaser (1978) reports that the researcher writes down the results of the analysis and make their conclusions. Glaser's description of these last two phases in grounded theory development capture exactly how I felt before I started writing up the theory, and then the clarity that I gained once I had transferred my thoughts to paper. Fortunately starting to write up the developing theory helped to gain lots of clarity about the theory and how the component parts within it fitted together. The memo in Figure 33 provides an example of refining the concepts within 'interactions and relationship through pregnancy' category.

Interactions and relationships through pregnancy

What are the processes and actions involved in this category?



Memo: I have now merged the concepts of 'interactions with birth partner' with 'interactions with friends and family' as the birth partner is either family or a friend, most commonly their partner or their mum. I have also taken out the concept of 'being around babies a lot' as looking through the data, this does not seem to be a key influence (only mentioned in one interview very briefly). 'Interactions with labour line', 'interactions with community midwives' and 'interactions with hospital maternity staff' have all been merged in to one concept, 'interactions with maternity staff'. These changes may not be permanent as there seem to be important differences within these concepts, but the new changes have helped me to get a clearer idea of processes involved with 'interactions and relationships through pregnancy' for the time being.

Figure 33: A memo exploring the processes and actions in a category

When exploring the processes and actions within ‘mentally preparing’ and ‘physically preparing’ lots of overlap was noted – for example, attending a pregnancy yoga class helps to both physically prepare by strengthening muscles but also provides techniques to mentally prepare for coping with contractions and giving birth. Therefore these two categories were merged to create one category of ‘preparing’.

Once the processes and actions had been broadly explored for each category, more detailed questions were asked of the data for the four categories of ‘preparing’, ‘interactions and relationships through pregnancy’, ‘relationship with pregnancy and developing baby’ and ‘drawing on previous experience’. These questions were:

1. What is the name of the category? What does this name mean?
2. What is going on in this category?
3. What are the forms and sources of this category?
4. What are the core features of this category?
5. How does this category relate to the pivotal category of gathering and interpreting information?
6. How does this category relate to the other three categories?

These questions helped to really develop the categories; Figures 34, 35 and 36 provide examples of this process.

Category one: Interactions and relationships during pregnancy

What does this mean?

Definition of Interaction = a reciprocal action or influence.

*reciprocal is interesting; not sure this captures what I'm trying to describe as women don't always want to engage in birth stories.

Definition of Relationship = the way in which two or more people or things are connected or the state of being connected.

'Communication' is a synonym for both interaction and communication. I feel like this captures better describes category one.

↓

Revised title for Category one: Communicating

What does this mean?

Definition of communication: The imparting or exchanging of information by speaking, writing or using some other medium.

*Having defined communicating, I am really happy with this description of the category and think it much better reflects the data.

Figure 34: Extract from memo exploring the category of communicating

Category two: Past experiences

What does this mean?

Definition of past = gone by in time and no longer existing.

**perhaps 'past' could indicate lack of relevance and usefulness of experience… perhaps synonyms of past such as 'prior' or 'previous' will describe the category better, while still emphasising the relevance of the experience.*

Definition of prior = existing or coming before in time, order or importance

Definition of previous = existing or occurring before in time or order

**There doesn't seem to be a substantive difference between 'prior' and 'previous'. However, 'prior' can also mean the head of certain religious orders, which could be confusing. Therefore I think that 'previous' better describes category two, implying that women's previous experiences are still relevant to their current situation better than using the term 'past'.*

Figure 35: Extract from memo exploring the category of previous experiences

Category three: Preparing

What is going on in this category?

There seem to be emotional and physical processes occurring through pregnancy between a mother and her developing baby. It seems like these processes and relationships are too complex to separate out into purely emotional processes and physical processes but are entwined like the lines below.

Furthermore, the relationship seems to be in three phases:

1. *The physical and emotional journey to becoming pregnant*
2. *The physical and emotional relationship with the pregnancy*
3. *The physical and emotional relationship with baby*

Figure 36: Extract from memo exploring the category of preparing

Once each category had been explored using the questions outlined above, it felt appropriate to use the online discussion forum data to further explore the category of communicating.

4.7 Cycle four: Data from an online discussion forum

4.7.1 Collecting the data

As discussed in Chapter 3, using more than one source of data is important for grounded theory studies to advance the emerging theory. When planning the study the intention had been to use social media to search each of the tentative categories to add depth and comparison from the interview data. However, when this method was

attempted, the nature of the way women communicated with each other within the threads was so broad that it was very challenging to add depth to the experimentally defined concepts and categories. Furthermore, this form of analysis also led me to start focusing on the lived experience of the social media participants rather than the actual social processes happening within the social media. After all, social media had been identified as a form and source of communicating in earlier cycles of data collection and analysis. Therefore, this source of data led me to explore the social processes within communicating though social media that may influence women's confidence for birth.

As discussed in section 3.8.3, when searched for threads relating to 'confidence' and 'birth' there were 296 results. These results were sorted in order of relevance to the search terms according to the Google search engine facility within the social media platform. Each thread had between five and 200 individual posts within it, creating an extremely large volume of data. Furthermore, the majority of the threads related to only 'confidence' or 'birth'. Therefore, the 14 most relevant threads were analysed in detail to provide manageable and appropriate data.

4.7.2 Initial coding using gerunds

The threads were analysed using the same process as for the interview data of initial codes, using gerunds. For example, common initial codes included: 'reassuring' or 'reinforcing'. The language used on the discussion forums took some time to become immersed in, because, for example, the discussion forum has its own acronyms, such as:

DC – darling/dear child

DD – darling/dear daughter

DH – darling/dear husband

DP – darling/dear partner

DS – darling/dear son

4.7.3 Focussed coding

Once initial coding had been completed on all 14 threads, the codes were sorted according to those which occurred more frequently or seemed more significant.

Patterns quickly emerged in the data that enabled the category of communicating to be completed. The data source was so rich that a conscious effort had to be made throughout analysis to ensure that I was coding for the processes happening within the threads and not their experiences. However, throughout coding this rich data source no new concepts of categories were identified, which provided reassurance that I had now reached theoretical saturation and my categories and theory were as developed as possible.

4.8 Theoretical understanding of women's confidence for birth

The four cycles of data collection and analysis using the interview data and online discussion forum resulted in the development of the 'journeying through confidence'. This theory aims to provide a theoretical understanding of how women's confidence for birth develops and is influenced during pregnancy. Chapter 5 presents the journeying through confidence theory and explains the categories within the theory in detail.

Chapter 5 Journeying through confidence – the grounded theory explained

5.1 Introduction

The aim of this study was to develop a theoretical understanding of women's confidence for birth. This chapter presents that understanding as the grounded theory of 'journeying through confidence' (the JTC theory). As the scoping review in Chapter 2 identified, the JTC theory is the first attempt to explain and understand what influences women's confidence for birth during pregnancy. Chapter 4 aimed to illustrate the process of how the JTC theory was developed. This chapter now explains the JTC theory itself. In particular this chapter explores the core process of gathering and interpreting information during pregnancy and the four categories of information that are gathered ('preparing', 'communicating', 'relationship with pregnancy and baby' and 'evaluating previous experiences'). This chapter also aims to demonstrate how the JTC theory was grounded in data from 25 interviews and 14 online discussion forum threads. Once discussing these component parts of the JTC theory in detail, the Chapter concludes with an explanation of how the JTC theory it is positioned as a substantive constructivist theory.

5.1.1 The relationship between 'communicating' and the other categories

While reading this chapter it will become apparent that the process of communicating appears to be more complex than the other categories. There are many more forms and sources of communicating in comparison with the other component parts of the JTC theory. The data gathered gave no suggestion that communicating was more influential on women's confidence for birth than the other processes within the JTC theory. However, this will be a useful idea to explore in further research, to test whether or not any categories are more influential and powerful than the others. As part of the grounded theory data analysis process, data were continually compared to each other. This continued throughout all stages of analysis, and therefore once each theoretical category has been discussed individually, the chapter concludes with a demonstration of how the categories may influence each other.

5.1.2 Notes for reading this chapter

Throughout this chapter participants will be referred to by pseudonyms to protect their anonymity. In addition, any place names or other information that could be used to identify participants have been removed and replaced with a description of the identifying feature in square brackets. The theoretical categories have been numbered; this is simply to aid readability, because, as illustrated in Figure 37, the categories do not seem to occur in sequential order.

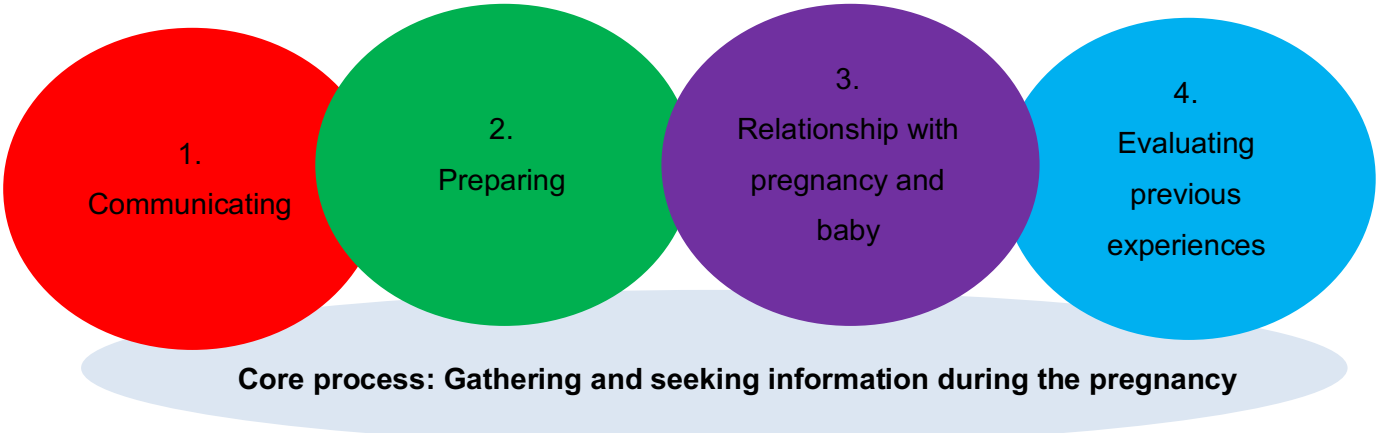


Figure 37: Outline of the processes that influence women's confidence for birth during pregnancy

5.2 Category one: Communicating

The first theoretical category identified 'communicating' as influencing women's confidence for birth, through the imparting or exchanging of information by speaking, reading or using the internet. The two major sources of communication that appeared to impact on women's confidence for birth were spoken communication and written communication. Table 30 illustrates the various forms and sources of communicating about birth.

Forms of communication	Sources of communication	Specific sources of communication
Spoken communication	Maternity care professionals	Community midwives
		Maternity hospital staff
		Birth reflections appointment
	Social circle	Friends
		Family
		Strangers
		Partner
		Hearing birth stories
Written communication	Books	Pregnancy, birth and parenting books
	Internet	Social media
		Other online websites

Table 30: Forms and sources of communication that are perceived to influence women's confidence for birth during pregnancy

5.2.1 Spoken Communication

There appeared to be many different sources of spoken communication that influenced women's confidence for birth. These sources could largely be divided into two groups: staff and social circle.

5.2.1.1 Communicating with maternity care professionals

Healthcare staff providing maternity care appeared to have a large impact on women's confidence for birth during pregnancy. Community midwives and consultant obstetricians were the two groups of healthcare practitioners that participants reported to be influential on their confidence for birth. This is not surprising, since these two groups of professionals provide the bulk of care for women during pregnancy. In the Trust where data were collected participants may also have seen maternity support workers (for vaccines and blood tests), sonographers (for scans) and hospital midwives (if they had any complications during their pregnancy). Perhaps these practitioners did not have the same influence on confidence for birth because they were focusing on a specific task, such as administering a flu vaccine, rather than discussing plans for birth in general.

Most participants saw the same community midwife for the majority of their appointments, with their community midwife leading their pregnancy care. However, some participants with more complex pregnancies saw a consultant obstetrician for two or more appointments, who took the lead in providing their maternity care. On the whole, communicating with community midwives appeared to increase participants' confidence for birth, whereas communicating with consultant obstetricians was more varied and seemed to decrease some participants' confidence. Some participants also made reference to a specific 'birth reflections appointment' with a community midwife as increasing their confidence. These points will now be discussed in further detail, with supporting quotes relating to each of these two groups of maternity care staff.

5.2.1.2 Communicating with community midwives

Most participants described having the same midwife through their pregnancy, and noted that they found this consistency reassuring, particularly if they had a good relationship with their midwife. However, a few participants described having a different midwife at every appointment, so they felt unable to build a trusting relationship with their community midwife. For example, when asked about her confidence, Ellie reported a lack of continuity which inhibited her discussing how she felt about birth. This may have impacted on her confidence for birth:

> "I had a different one every week, or every whatever time, so I never had a community midwife. It probably didn't help what was going on and what to do as I had no one to talk to. It didn't help." (Ellie: 425-427)

In contrast, Emma, who reported good continuity, stressed how comfortable she felt when she was with her midwife:

> "I think I really loved my midwife, like really loved her… She was so lovely that I didn't worry about going and having any of the midwife checks or anything because she just made me feel really comfortable and she was just really nice." (Emma: 359 & 370-371)

As with Emma's experience, most participants described their community midwives as having positive attributes. Several participants also reported feeling like their midwife cared about them and how they got on with giving birth, which seemed to be important for participants. Holly discussed that if she had experienced better continuity with her

community midwife then she may have felt confident, although it was not clear whether this was something she felt at the time or something that other people had suggested to her after giving birth:

> "I think maybe having had more continuity in my pregnancy might have meant that I was maybe more confident in terms of – because you've had that conversation with the same person, because I think at the time I didn't ever think, I wasn't really that fussed that I hadn't seen the same person, but it's not until afterwards where I've talked to people and midwives in the birth reflection where she said, oh, it's really important to have that continuity." (Holly: 281-286)

Some participants provided specific examples of communicating, demonstrating how their community midwife had helped to increase their confidence. For example, Hannah gives the following account, describing feeling worried about the birth and feeling that the questions that she had about her previous birth were dismissed during her consultant appointment:

> "I had a lot of questions and worries after my first birth… So I went back to [name of community midwife] and I said, I've got all these questions, and to be fair, she actually went to the hospital, went through my notes, came back and went through every single question with me." (Hannah: 488 & 492-494)

Ava described her midwife's approach to birth planning as making her feel like her views were important, which helped her to feel empowered for birth and seemed to strengthen her confidence for birth:

> "She asked me to have a good chat with my partner and things like that. So, yes, I was excited, I felt quite empowered because she was really keen that I got my views down and that I really thought it through… She was just really good at talking me through everything." (Ava: 31-34)

Trusting the community midwife seems to be an important factor affecting women's confidence for birth. If the community midwives appeared to be trustworthy and knowledgeable in their communication, this seemed to improve women's confidence. For example, with Cora's first pregnancy she was cared for by a specialist homebirth team of

midwives, and reported that the thorough and clear way in which they communicated with her helped her to trust the midwives. However, she did not have this experience second time around, when she had moved area and had a different community team caring for her:

> "I remember going to see the midwife and saying I wanted a homebirth, and she said yes, that's absolutely fine, again very positive about it, but there was never any discussion about how it would work; who would be involved, who would come, how would I be supported. Whereas first time round it was made very clear how the system would work, I felt very reassured, it just felt very slick… I didn't have the same confidence in the midwife that I was seeing for appointments, so I panicked – would she be the one delivering me? Because I'm not sure that would've worked well." (Cora: 132-138 & 141-143)

Midwives may therefore be able to increase women's confidence by communicating with them clearly and explaining recommended care pathways, such as, in Cora's case, her plan of care for having a homebirth. It seems logical that a woman needs to feel confident in the healthcare professional who will be providing her labour care in order to then feel confident about giving birth. Perhaps continuity of care also influences how trustworthy the midwife is perceived to be, because as illustrated in Emma's and Ellie's quotes above, continuity enables rapport and a relationship to be built between the midwife and the woman.

Alongside continuity and trustworthiness, the structure in which the community midwife is providing care needs to be considered. Both Sophia and Grace reported that they felt like the structure of maternity care prevented midwives from fully discussing birth, inhibiting potential conversations that may have increased their confidence for birth:

> "I think the difficulty with the midwife is that when I see her at the surgery, I'm conscious that someone else has got an appointment booked in after me and I don't want to take up all her time." (Sophia: 98-100)

> "In terms of my normal midwife visits, I don't really know. I guess they impart information, but most of it is about your pregnancy and not about the birth… except from saying do you have a birth plan… so I don't think they addressed the

> birth plan at all. They are there to deal with the pregnancy. That's my perception, anyway." (Grace: 382-387)

From Grace's and Sophia's descriptions, it seems that their community midwife had little impact on their confidence because either they felt that they didn't want to waste the midwife's time, or they perceived that discussing birth was not part of her role. Grace and Sophia also allude to the possibility that if they had felt that the midwife had more time and was able to discuss confidence for birth, this may have helped their confidence for birth. The stresses and time pressure on midwives are currently well documented though social media campaigns and in recent research (Cohen *et al.*, 2017; Fedele, 2017; Pezaro *et al.*, 2017), and perhaps this distress on the part of the midwife is being subconsciously communicated during appointments. As discussed in Chapter 1, a key role of community midwives should be building women's confidence for birth.

In summary, communicating with her community midwife seems to have the potential for increasing a woman's confidence for birth, particularly if she feels that she has a good relationship with her midwife. Good continuity with the same community midwife and clear communication seem to help this relationship, enabling women to feel like they can trust their midwife and discuss birth. However, the structure of how community midwifery care is delivered also seems important in order for the midwife to be able to facilitate care that increases women's confidence for birth.

5.2.1.3 Communicating through a 'birth reflections' appointment

A few participants gave the specific example of communicating with a community midwife (not normally their own community midwife) in a 'birth reflections' appointment as increasing their confidence for birth. This involves a pregnant woman reviewing the notes of her previous birth to debrief and discuss her experience with a midwife. This service is offered by most Trusts across the UK (Sheen and Slade, 2015). 'Birth reflections' is not a formal psychological therapy and it is neither appropriate nor helpful for women suffering from PTSD or postnatal depression, but it can be helpful for women who described their experience as traumatic (Slade *et al.*, 2000). All of the participants in this study who had experienced a 'birth reflections' appointments seemed to feel more confident as a result of gaining clarity and understanding about their previous birth experience. For example, Sarah was pregnant with her second baby and had to transfer from home to hospital in

the late stages of her first labour due to slow progress. Sarah reported that she felt a bit more confident and less worried about birth after her 'birth reflections' appointment:

> "Having done birth reflections I'm now feeling much more positive than I was. I think because in the back of my mind I was worried that the same thing would happen again and I didn't know what had gone wrong… now I feel a bit more confident." (Sarah: 533-555 & 538)

In summary, 'birth reflections' seems to be a helpful resource for some women to use to increase their confidence for birth, if they perceived their previous birth experience as being traumatic in some way. However, this resource is not suitable for women if they have developed a mental illness as a result of their birth experience; these women may require more specialist treatment.

5.2.1.4 Communicating with consultant obstetricians

Overall, communicating with consultant obstetricians appeared to be more negative than communicating with community midwives. This communication seemed to reduce some participants' confidence for birth. Part of this negativity could be because women's confidence is reduced just by being referred to see a consultant obstetrician, because that means their pregnancy and/or birth is considered to be risky or complex by the maternity care staff. However, all of the participants who described their confidence being reduced as a result of seeing the consultant made specific reference to their communication style, rather than the experience of seeing a consultant in itself. For example, Tallulah spoke about her perception that the more she communicated with consultant obstetricians the less in control she felt, because she was 'threatened with a stillbirth' if she did not comply with the consultant's suggestions:

> "I am an intelligent person, like, no I'm not in the medical profession but I do have a degree myself, and maybe if they had said, well, this is the risk of, not just, well, you are at risk so you better do what we say, kind of thing… I guess you feel out of control anyway because you've got no experience, and then when you just feel like more and more control is being taken away from you, I just felt like I was tail spinning really." (Tallulah: 75-78 & 86-90)

Charley described having a pregnancy complication which made her anxious. Charley then described how being given conflicting advice by different consultants further exacerbated her anxiety:

> "They definitely impacted on it, especially the contacts I had with consultants in the last few weeks. I was diagnosed as having excess fluid and then I had extra scans. I was told different things by different consultants when I saw them, and the way they talked about it whether or not it was going to be an issue, so I was told there was a risk of cord prolapse which made me quite anxious, so yes it had an impact on how I felt… I had a couple of consultants tell me I didn't need to be induced, and then I was told that I did, and I don't know if that's just a difference of opinion or because the fluid level had changed but that made me really anxious." (Charley: 276-281 & 283-285)

Hannah, who was a nurse, felt that the consultant dismissed her worries and questions, failing to reassure her following a difficult previous birth experience which she reported had made her feel she had failed because she had an unplanned caesarean:

> "We met up with one of the obstetricians and my husband felt very reassured by him, but I didn't actually feel very reassured because I had a lot of questions and worries, and because obviously what happened with [first child], we had to go and see the obstetricians, so the first obstetrician I felt was a little bit dismissive … didn't go through anything with me, he almost just dismissed all my questions with, oh, it will be fine." (Hannah: 477-450 & 489-490)

Perhaps feeling as if her worries were being dismissed increased Hannah's feelings of failure and further reduced her confidence for birth, because she reported that after her consultation she was 'adamant' that she wanted a planned caesarean and did not want to try for a vaginal birth with her second baby (as had been recommended). However, Hannah then had her questions answered by her community midwife and a different consultant obstetrician and subsequently changed her mind, going on to try for a vaginal birth. If communication can build a woman's confidence for birth and influence her decision about whether she has a planned caesarean or a vaginal birth after caesarean, this could have huge implications for maternity services, with vaginal births being substantially less expensive and less risky for both mother and baby (Fawsitt *et al.*, 2013). However, it is important to note that consultant obstetricians were not always reported as decreasing women's confidence for birth; for example, Fiona, who had an extremely

complex pregnancy, described her experience of communicating with consultant obstetricians as reducing her worries and helping her to feel supported:

> "…just the support from [area where consultant clinic is], because we had consultant care throughout, birth just didn't worry me, I felt like I was in the right place if that makes sense." (Fiona: 27-29)

Fiona had a triplet pregnancy but sadly two of the babies died during the pregnancy. This may have had some impact on the way in which the consultant obstetricians communicated with her. Alternatively, it may be that communication varies according to the style of each individual consultant obstetrician. Either way, communicating with consultant obstetricians seems to have a potentially important impact on women's confidence for birth.

5.2.1.5 Communicating within their social circle

In addition to maternity care professionals, participants reported that communicating in person within their social circle impacted on their confidence. This form of communication appeared to have a larger impact on women's confidence if they had no previous experience of giving birth. Participants also seemed to link how close the person was to them within their social circle, with level of impact on their confidence. For example, birth stories from mothers appeared to have more of an impact than stories from strangers and acquaintances. This distinction was only noted when analysing the data on communication in person and didn't appear to be prevalent when women communicated through the internet, which is discussed further in section 5.7.

5.2.1.6 Communicating with friends

Some participants gained confidence through friends by communicating and normalising their experiences and worries. For example, Holly described gaining positive reassurance and knowledge from friends' experiences after doing a hospital tour because friends had suggested she should chose a different place to give birth:

> "Seeing all the medical equipment around, it just freaked me out a bit. After that I spoke to a couple of my friends that I know had their babies at [midwife-led unit] and I went and had a look round [midwife-led unit]." (Holly: 35-38)

Participants also reported that birth stories were a major source of communication that could influence their confidence for birth. Every participant seemed to describe birth stories as being influential on their confidence for birth in some way. Storytelling through oral communication predates written communication as one of the oldest methods for sharing knowledge (Baker and Greene, 1977). Perhaps this tradition of storytelling is why birth stories had such an impact on women's confidence. Some participants conveyed the lack of control that they felt they had over this communication; for example, Olivia describes being told a barrage of stories:

> "I had lots of friends who had babies before me, so got the usual barrage of birth stories whether I wanted them or not." (Olivia: 13-14)

How the birth story impacted on a woman's confidence appeared to be partly influenced by how positively or negatively she perceived that story. For example, Olivia described one of her friends reassuring her through a birth story during her first pregnancy:

> "I did find that it always feels like the people who are most willing to share are the people with the worst stories. I don't know if it helps them to get it off their chests, but it does feel that way. But there was one of my friends who did sit me down and just say to me, everyone will tell you that, but it's not that bad, because she had two completely normal natural deliveries… I think that was the real reassurance for me." (Olivia: 29-34)

Birth stories were not communicated only by friends but also by family, acquaintances and even complete strangers. While Olivia seemed to accept this, Sophia discussed struggling to manage this when she was interviewed during the last few weeks of her pregnancy:

> "Oh God, the advice! It's more people's experiences, and it's, you know, it sounds awful but I really don't give two shits about other people's experiences… I've literally had someone talk at me for two hours about how their experience of birth was and how they brought up their children. Which never would have been on the cards, before why is that all of a sudden become a socially acceptable topic to discuss at dinner while tucking into your fish and chips? It's just so hard because you don't want to be rude and offend someone, but you know, I have got to a point now where I'm like, I don't want to know about your experience." (Sophia: 127-136)

In contrast, Charlotte describes her thirst for birth stories and how she found it unhelpful when friends were reluctant to share their stories with her. This interest may have been a means of increasing her confidence, or it could have just been a general interest as she was now pregnant herself:

> "I think going back to the whole information thing about having as much information as possible, I found it really unhelpful when people didn't really like to talk about it. Because I've got friends who are really open about their labours, but then other people take the view that you don't want to scare someone, so I won't tell them how horrible my first labour was, but actually I'd rather know how horrible your first labour was." (Charlotte 384-388)

Several participants described the variety and volume of birth stories as being confusing and overwhelming, particularly when pregnant with their first baby. Furthermore, participants seemed to be trying to make sense of the stories by evaluating the source of the story or trying to pick out fact from fiction. Indeed, the use of the word 'story' by participants in itself implies some element of subjectivity and interpretation:

> "My sister-in-law, she's quite dramatic anyway, and she had quite a dramatic birth story, but then she was quite jokey about it. Her exact words were, at one point I thought it's ok because I'll be dead soon! But it was ok, and she wasn't dead soon and she had a lovely baby, but knowing she's very dramatic I kind of took it with a pinch of salt." (Emma: 29-33)

> "I kind of expected people to tell me negative stories, so I tried to ignore them as best as possible… I think the variety of stories were quite confusing because some people were telling me their birth was amazing and some people were going it was absolutely awful, they'd never do it again. It makes it difficult to pick out fact from fiction and also get a proper idea in your head just based on people's stories." (Ava: 58-59 & 61-64)

In summary, birth stories seem to be a source of communicating that participants had little control over. Participants' perceptions of these stories seemed to have an impact on how confident they felt for birth. This perception included an evaluation of how reliable the story was as a source of information – for example, who was the person sharing their story, and trying to pick out fact from fiction.

5.2.1.7 Communicating with Family

Several participants suggested that communicating with their mother or sister may have increased their confidence for birth. This seemed to be particularly helpful if their mother or sister had a positive birth experience themselves. For example, when asked what she felt had helped her confidence during pregnancy, Olivia responded:

> "I was born at home, my mum had me at home so there was that, having had my mum being very calm and it can be done that way helped." (Olivia: 120-121)

This seemed to be a positive experience for Olivia. In contrast, however, Fiona, who had an unplanned caesarean under general anaesthetic, reflected that although her mum's and sisters' experiences made her think birth would be fine at the time, this may actually have been negative. This is because she felt that communicating with her mum and sister did not prepare her for the reality of birth:

> "I guess in your head you have this, like, it's all going to be perfect. My mum gave birth really easily and my sister did the same, so you are just like, oh, it's going to be fine, it will be painful and it will suck, but all the love and stuff that you feel afterwards, and it's just not reality, it's not like that at all or for some people, it's not." (Fiona: 270-273)

For some participants, however the converse was true and their family seemed to decrease their confidence for birth. Tallulah described feeling 'terrified' about having an induction several times during her interview; this seemed to be due to several factors, such as poor communication from maternity staff. However, feeling worried about having an induction also appeared to stem from a comment by her step-mum:

> "They started talking about being induced then, and I got quite worried about it because my step-mum had said, oh, you don't want to be induced, and to be honest from then on I was very, very worried." (Tallulah: 6-8)

Orla's mother was a midwife, and this, she felt, was particularly helpful for ensuring that she had a high level of confidence in herself and that she would not need an epidural:

> "I think that it definitely gave me confidence that I knew what I wanted, and people had said you'll want an epidural once it all starts, you'll get in there and it will be awful. I suppose a lot of it is down to my mum being a midwife for twenty years… I often thought if I didn't have my mum, I think it would have been a lot harder because you don't see loads of your midwife. You have so many questions throughout pregnancy, especially the first time, and I'd had someone on tap that I could ring at the drop of a hat and say, oh, what's this?" (Orla: 316-318 & 346-350)

Perhaps communicating with family is different and has more of an impact than communicating with friends because women assume that they are more likely to have a similar experience to their mother or sister compared to a friend. Alternatively, maybe the relationship a woman has with her family in turn influences how she perceives the impact of communicating with them on her confidence. For example, if she has a poor relationship with her family then she might value communication with her friends, and it might be more influential than communication with her family.

In summary, it seems that a woman's family, particularly her mother and sister, may influence her confidence for birth either positively or negatively by sharing their opinions and birth stories.

5.2.2 Communicating with Partner

Participants gave the impression that communicating with their partner could influence their confidence for birth. This form of communicating seemed to be separate and distinct from communicating with their wider family (mother and sister) and potentially more influential. If participants felt well supported by their partner and felt that their partner listened to and discussed their birth preferences with them, this seemed to be helpful. For example, Olivia, who reported having high levels of confidence during both her pregnancies, describes how supported she felt by her husband through both pregnancies:

> "I think my husband was fantastic through both pregnancies. He is really supportive and always very much he would talk to me about things, and so I think that helped both times round, having him being really, yes, he was happy to listen to me talking about what I wanted, and understand and talk it through with me which was really good, he was really supportive." (Olivia: 39-43)

Most participants had male partners, but Orla was in a same-sex relationship and she raised this during her interview when asked to clarify if she felt having a partner was a supportive influence on her confidence. Orla responded:

> "Definitely. Oh yes, one hundred percent, my partner is really supportive and my partner is female, so whether that makes a massive difference or not I don't know. I'd talked to her about the yoga I'd done, so she would say to me, where is your breathing? Get your breathing going, because they get you to visualise certain things, so she'd say can you, there are all sorts of things about trying to blow out a candle, so she was reminding me all the time the different things." (Orla: 248-253)

Orla also seemed to have high levels of confidence for birth for both of her pregnancies, and on further discussion with Orla about her partner, it was interesting that Orla felt that because her partner was female she was more supportive than some of her peers' partners who were male. Perhaps Orla perceived that her female partner could empathise with her more than a male partner, or maybe knowing that she would have good female support during labour increased her confidence. In England birth has traditionally been women's business; prior to 1960 the prospective father was seen as an inconvenience in the birth room, as he could faint or somehow hinder the woman (Bedford and Johnson, 1988). If participants felt that their partner was not able to support them in the way that they wanted during pregnancy and labour, they discussed needing to find a woman who would be able to support them during labour. When asked what might help her to feel more confident about giving birth in the future, Tallulah responded:

> **"**Next time I think I would want a doula or pay a private midwife just to have, because it wasn't [my husband's] fault, but obviously for a man it's really hard for him to say, and even if I told him what I wanted I think it's quite hard for them to understand, and it's a very female environment, as it should be, and I think to have a woman there who was very knowledgeable but very on your side looking after your interests, that is what I'd want." (Tallulah: 276-282)

Doulas are trained or experienced lay-women who provide social, emotional and practical support to other women during pregnancy and birth but do not provide any clinical care (Steel *et al.*, 2015). A recent qualitative study by McLeish and Redshaw (2018) suggested

that doulas can improve women's birth experiences by offering continuous, empowering, woman-focussed support that complements the role of midwives.

In addition to discussing the importance of feeling supported by their partner, some participants also described wanting to ensure that they took their partners' needs into account when they were in labour. This seemed to be an important consideration because it helped reduce their worry about their partner. For example, Sarah described how she chose to plan a homebirth with her first baby to try and ensure that her husband was calm when she was in labour, and as a result she could be calm herself. Similarly, Ella discussed how it was important for her to feel like her birth environment enabled her husband to be as calm and supportive as possible.

> "My husband sometimes panics in stressful situations… he would be really stressed with the whole idea, the responsibility of taking me to the hospital, and the last thing I need is him stressed, because then I've got to worry about him, whereas if we are at home, actually all he's got to do is fill up the pool. That's a lot easier, and the calmer he is, the calmer I'll be." (Sarah: 134 & 136-140)

> "I'm the host body as such! I think he needs to be part of the decision making, so that feels he was part of the delivery process… I couldn't put him in a non-hospital birth. I need him to be calm and supportive of me, and I therefore need to aware of the scenario and environment I put him in. So it's that kind of, OK, he's thinking of me, and I need to think what's going to affect him so that he can think of me." (Ella: 124-129)

Perhaps some women need to feel confident that their partner will be able to be calm and supportive in order to then feel confident about giving birth themselves.

In summary, communicating with their partners seems to play an influential role in facilitating a woman to feel more confident, either through supportive communication during pregnancy or by the woman ensuring that her birth environment enables her to feel well supported by her partner.

5.2.3 Written Communication

Written communication appeared to have a more positive and less turbulent influence on women's confidence for birth compared with spoken information. Some interview

participants alluded to specific examples of using the internet as a form of communication to gain knowledge and confidence for birth. For example, Mia seemed to have a really poor perception of her previous maternity care experience, to the extent that she had lodged a formal complaint to the hospital. Mia used a fourth degree tear group on Facebook to gain support and advice from her peers during her second pregnancy (see section 5.4.1 for more discussion regarding Mia's tear). Facebook is a large American for-profit corporation and an online social media and social networking service. Facebook has recently developed a reputation for providing a platform and culture of 'fake news' (Kuchler, 2017; Spinney, 2017). This means that information that is either partially or wholly inaccurate or unverified is shared between users and perceived to be credible and reliable information. However, for Mia perhaps it was important for her confidence for birth to feel well supported by people that had 'suffered' from the same experience as her. Mia also described using the internet to try to do some research:

> "So on Facebook there is a fourth degree tear support group which I joined… I've spent quite a lot of time Googling, researching, I've put in freedom of information requests to different Trusts around the region about repeat tears." (Mia: 279-281)

Conversely, Sophia, who was pregnant with her first baby, did not seem to have the same need as Mia to extensively research birth information or join social networking sites to discuss birth options. Indeed, Sophia stressed finding bite-sized information appealing, because otherwise she could feel overwhelmed with the vast amounts of information available through the internet:

> "The NHS website send out weekly emails if you sign up and that's been quite helpful, again it's bite sized so you're not getting, you don't feel overwhelmed with all this information." (Sophia: 69-71)

As with Sophia, Ella discussed using strategies to stop herself from feeling overwhelmed by only using one source of written communication (a book) rather than the internet. This seemed to be because of the overwhelmingly large volume of information available through the internet. The book had been recommended to Ella by her sister-in-law, so perhaps for Ella this information source was also perceived to be more reliable than the internet, and so this may in turn have increased her confidence:

> "I just want one book that I go to, just one place of information, because you've got so much online, so much different information and different opinions that I just

> want one book that I can go to, that's like, OK, get my head around the information in that." (Ella: 29-32)

In summary, the interview participants reported finding written communication, either from books or the internet, a helpful tool that may increase their confidence for birth, if they were able to manage this communication source so that it did not become overwhelming.

5.2.4 Communicating through online discussion forums

Communicating through a social media parenting peer-to-peer forum was also explored directly through collecting social media data. This platform of communication seemed to increase women's confidence for birth by enabling them to post a message asking for advice or reassurance from other mothers. The online discussion forum commonly uses a number of abbreviations, listed in Table 31.

Abbreviation	**Full word as identified by the online discussion forum moderators**
DH	darling/dear husband
DD	darling/dear daughter
DS	darling/dear son
DC	darling/dear child
c-section	caesarean section
G&A	gas and air (or Entonox)
#1	number one
VB	vaginal birth
MW	midwife

Table 31: List of common abbreviations from the online discussion forum moderators

5.2.5 Starting a thread

The thread titles are illustrated in Table 32 and demonstrate the breadth of reasons for participants seeking confidence. For some participants, a specific event such as meeting a rude midwife or having a previous negative birth experience seemed to trigger them requesting help to boost their confidence. Other participants appeared to lack confidence more generally but were now at a stage in their pregnancy where they felt that their confidence needed to be addressed and improved before birth.

Title of thread	Pseudonym of participant who started thread	Number of posts in thread
Lost confidence in natural birth	Amelia	11
Crisis of confidence regarding homebirth	Isla	19
How confident did you feel before going into labour?	Poppy	28
No confidence in my midwife what do I do?	Jessica	28
Pelvis is too small for a natural birth	Lily	15
Lost confidence after painful internal exam	Evie	8
Terrified of labour, first baby!	Ruby	30
Please can I hear some positive birth stories after previous traumatic birth	Chloe	15
Any suggestions on ways to alleviate anxiety of giving birth a second time?	Sienna	17
DH a wonderful husband but a terrible birth partner	Freya	20
Positive birth stories please!! I beg you!	Phoebe	49
No faith in body's ability to give birth – any advice?	Daisy	13
Nervous about C-section after very rude midwife destroyed my confidence	Alice	17
Scared of labour second time round?	Florence	9

Table 32: Title and number of posts in relevant social media threads

For example, Evie described how she was feeling quite confident until she had a painful internal examination, which made her lose confidence in how she would cope with labour. Then, rather than reassuring her, her midwife seemed to further decrease Evie's confidence for birth:

> "I felt quite confident (ish) about labour as I have suffered from hip, back, SPD [symphysis pubis dysfunction] and hernia during this pregnancy – all of these have pushed my pain tolerance level up, so I thought that I would be able to manage labour with the coping strategies I already had in place for my existing problems.

> I started contracting and so went into hospital to be checked, only 34 weeks so was pleased that they were only sporadic and the real thing hadn't actually started. During my check I was given a speculum check and then internal – I found them really painful, as in screaming out painful. This is something that I've always struggled with, vaginal exams have always been painful to me as I seem to have a very tight perineal muscle. Now as the days go by and I find that labour is now really impending I am losing confidence in myself that I will be able to do this. I have spoken to the MW but she basically said I was being a wimp and that if I couldn't handle this then it wasn't looking good for my G&A only planned birth.
>
> Has anyone else had this problem or have any suggestions to help me, as I feel a bit scared to even go into hospital now knowing what is waiting for me. Thanks for the help!!!" (Evie: 5-19)

For Evie, finding the exam painful and then perceiving that her midwife felt she was being a wimp seemed to be specific events during her pregnancy. However, for other participants, such as Ruby, appeared to be prompted to use the discussion forum when she recognised that her pregnancy was progressing and other people were sharing birth stories with her:

> "Hey,
>
> Just wondering how everyone is feeling about labour? Having never done it I'm terrified, especially as i know alot what can and may happen.
>
> I'm now 22 weeks and People have started giving me their experiences which is freaking me out!! The dreaded words 'tear' and 'cut' have been used a lot as well as people saying they got left alone??? I know they mean well but I'm so scared?" (Ruby: 5-13)

Ruby seemed to find that other people sharing negative birth stories impacted on her confidence with her first pregnancy. However, for other participants it seemed that their own previous birth experience was the factor that caused them to feel fearful about giving birth again. For example, Amelia described panicking because she was getting closer to her due date and had not experienced any signs of labour. This panic seemed to be because Amelia perceived herself as failing to go into labour with her first baby and as a result having to be induced, which she found horrific:

> "Pregnancy #1 was very low risk, straightforward etc. However my waters broke (at 40wks) and nothing happened: no contractions, nothing. They gave me 12

> hours to see if anything would start, then got me in on a drip. Took the full force of the drip to make me dilate (they turned it all the way up – the pain was indescribable). 42hrs and many scary experiences later (heartrate didn't recover twice after contractions etc), DD was born. Horrific experience.
>
> Am now 39wks with #2 and am starting to panic that my body is in some way unable to birth my babies. I have had no real signs that labour is near (a few days ago I had some cramping, but it's totally gone away now): feels like I'm likely to be pregnant for a long time still.
>
> I live in fear of my waters breaking, since I'll be induced straight away this time (am in a different country where the rules of how long you get post-membrane rupture are stricter) and I really do not want to relive that past experience.
>
> I just can't imagine contractions beginning slowly and then ramping up like in the 'textbook' scenario: I feel that my previous 'failure' is indicative of how my body can make babies but not get them out. I just have this niggling feeling that my body is in some way unable to get a baby out!" (Amelia: 1-20)

An induction is when labour is started artificially (either because the baby is overdue or because there is a risk to the baby's health) and is one of the most commonly performed medical interventions in childbirth, accounting for up to 25% of births in the most high resource countries, including the UK (World Health World Health Organization, 2011; Jay *et al.*, 2017).

In summary, threads seemed to be started for a variety of reasons, often prompted by a single event or a combination of events that causes the participants to seek confidence through the online discussion forum.

5.2.5.1 Communicating through sharing experiences

Lots of participants on the discussion forums seemed to attempt to provide reassurance and increase the confidence of the participant who had started the thread by sharing their own experiences. For example, here are some responses in Sienna's thread, who asked if anyone had any suggestions for ways to alleviate anxiety about giving birth a second time:

> "I had a bad time with DC1 as well. For DC2 (now 11 weeks old) I had a doula, saw a hypnotherapist and practiced the hypnotherapy recordings she gave me. It

> really helped calm me down before the birth, and the birth itself went very well." (response to Sienna's thread: 13-18)
>
> "I also had a horrendous birth with my DS, and it put me off having another child for quite a while as the thought of going through it again was incredibly anxiety provoking.
>
> Second time around the birth of my DD was more perfect and straightforward than I could ever have imagined. It was a completely different experience.
>
> What helped me with my anxiety in the run-up to the birth was a couple of sessions with an amazing reflexologist who specialised in pre and postnatal women. I found it incredibly relaxing and felt my body was physically being prepared for the birth." (response to Sienna's thread: 39-47)

By sharing their experiences with Sienna, participants may have increased Sienna's confidence for birth by normalising her feelings and helping her to feel as if she was not alone. Also, by providing practical tips about what worked for them to increase their confidence in a similar situation, this might also have been helpful for Sienna to increase her confidence. Indeed, Sienna responds later on in the thread thanking participants for the advice and reporting:

> "Am currently reading about hypnobirthing and have booked a private antenatal home visit next week , hoping to learn some relaxation methods and breathing exercises. Am starting to feel calmer the more I talk it through!" (Sienna: 125-127)

Sometimes it seemed that participants would share their experiences and stories to try to increase the confidence of the participants who had started the thread, either by encouraging or discouraging a belief that the participant expressed. For example, Lily started a thread about lacking confidence because she had an 'emergency section' with her first baby and was worried that this might be because she had a small pelvis. Some of the responses included:

> "The shoe size thing is an old wives tale! I am small 5 2 and wear size 3 shoes but have had 5 babies, smallest 8lb, the others were all 9lb+ and ds4 was 10lb 13oz, all natural normal deliveries, I think positions in labour are important to help your pelvis to open up to its maximum." (response to Lily's thread: 84-86)
>
> "From what I've read/heard (can't vouch from experience – will let you know in a few months' time!), it's unlikely that your pelvis size would prevent a VB. What's

> more likely is that a women isn't in the optimal position or state of mind (relaxed, focused, feeling secure, sufficient support to cope with the pain) to enable the pelvis to open as wide as it needs to." (response to Lily's thread: 94-97)

Both these responses appear to be trying to reassure Lily that her worry about her pelvis being too small is unfounded. However, some participants shared the view that Lily's pelvis may be too small and encouraged her to seek medical advice about this. For example:

> "A very similar thing happened to my mother-in-law during the birth of my husband – G&A, c-section, the works. She had my sister-in-law four years later and saw a consultant who examined her internally and told her that she had a sufficiently narrow pelvis that vaginal delivery should never have been attempted the first time round (she has no hips to speak of either). A c-section was scheduled and she had a lovely second birth, having had to have psychiatric help after the trauma of her first. It may very well be worth your while asking someone to take a look in order to put your mind at rest." (response to Lily's thread: 24-30)

Responses such as these did not appear to be posted with the intention of decreasing the confidence of the participant who started the thread; rather, they seemed to be validating the participant's concerns and making practical suggestions to try and help the participant.

5.2.5.2 Communicating by interacting with other posters

As well as communicating through sharing their experiences, participants within the thread may have influenced a woman's confidence by validating and reinforcing messages in other participants' posts. For example, Phoebe stared a thread as follows:

> "I am 30wks and went to my first antenatal class last night. I came home and cried because I am so afraid of the pain and getting pushed around/completely neglected at the hospital." (Phoebe: 7-8)

Phoebe had lots of responses to her thread, with 49 posts in total and many of the posts seeming to agree with each other. For example:

> "I agree with people above that it's worth spending time getting yourself into a positive frame of mind where you feel like you can cope with any surprises that may come your way. I highly recommend…" (response to Phoebe's thread: 259-261)

> "Like others have said, sometimes it helps not having a perfect birth planned which would be hard to meet... I really didn't enjoy or cope well with DD2's birth as I had not prepared myself and had unrealistic expectations, even though others would consider it a very easy birth." (response to Phoebe's thread: 319-320 & 328-330)

It may be that reinforcing each other's messages helped to further increase Phoebe's confidence for birth, compared to, for example, if all the participants posted contradictory messages. Indeed Phoebe, replied to the responses within her thread saying:

> "Thank you all so much for taking the time to share your stories – I feel really encouraged and will definitely check out hypno birthing, the reading recommendations and some pregnancy yoga/pilates. Also strangely reassuring to know that I'm not the first person to leave an antenatal class in tears! Have a wonderful day  " (Phoebe: 376-380)

It seemed that the responses to Phoebe's thread had encouraged her by normalising her experience and feelings, as well as by reinforcing advice and coping strategies from each other.

5.2.5.3 Communicating by recommending practical actions

Participants often seemed to share practical actions as well as sharing their experiences. For example, Jessica started a thread when she was 35 weeks pregnant with her second baby, posting that she had lost confidence in natural birth because of her previous birth experience, and now that her due date was approaching whe was becoming more anxious. Responses to Jessica's thread included lots of practical advice, such as:

> "Mine was lovely – really empowering, I remember feeling like you though. I would recommend ante-natal yoga – a class not a DVD though. I used all the breathing and visualisations. I would recommended a Tens machine. Make sure you practise putting on the electrodes and have extra electrodes as well as spare batteries. Put it on in early labour to build up endorphins. Paracetamol. You'll laugh but it does work. A flexible birth plan. I really enjoyed the birth pool too." (response to Jessica's thread: 58-64)

Having lots of practical suggestions seemed to help Jessica; she responded later on in the thread to the other posters' suggestions:

> "Thank you all. These responses have got me close to tears. I'll definitely look into those books, and all the support has really helped. Thanks also for the info on…" (Jessica: 124-126)

The online discussion forums appeared to provide a good platform for communicating lots of practical advice from many different women. Perhaps these women sharing their practical advice and describing their positive birth experiences helped participants to feel confident because their experience validated the advice that they were giving, in the sense that the advice was tried and tested by participants' peers, rather than, for example, a childbirth expert who had written a book of tips for birth.

5.2.5.4 Conclusion

Overall, communicating using an online discussion forum appeared to empower pregnant women by creating a community of positive communication and support, boosting women's confidence for birth. The discussion forum provided a platform for women to share their feelings or experiences with other mothers, who responded and provided support through sharing their own birth stories, normalising feelings, recommending actions, dispelling 'myths', reinforcing each other's communication and sharing their own coping strategies.

5.2.6 Summary of 'Communicating' category

In summary women's confidence during pregnancy appears to be influenced both positively and negatively by gathering and interpreting information from communicating with her maternity care professionals or social circle. Figure 38 presents a summary of how communicating can increase or decrease a women's confidence for birth during pregnancy.

Gathering and interpreting information through communicating during pregnancy can increase women's confidence for birth by:

Online communication:

- The process of communicating through online discussion forums can increase confidence for birth by: dispelling myths, normalising feelings, sharing stories, recommending actions and reinforcing each other's communication.

Spoken communication with maternity care professionals:

- Building a positive and trusting relationship with community midwife is likely to increase confidence for birth (good continuity is needed to build this relationship).
- If feel supported by their consultant obstetrician can increase confidence for birth.
- Supportive communication can help to understand/feel more confident about previous birth experience.

Spoken communication with social circle:

- Family and friends can increase confidence by hearing experiences providing positive reassurance and recommending actions.
- Birth stories are likely to increase confidence if perceived as 'factual' and positive, particularly if have no previous experience of birth.
- If have supportive communication with partner and able to facilitate birth environment so partner can be confident this can increase confidence for birth.

Gathering and interpreting information through communicating during pregnancy can decrease women's confidence for birth by:

Spoken communication with maternity care professionals:

- Not trusting or feeling confident in or having a poor relationship with their community midwife may decrease confidence for birth.
- Perceiving communication negatively with consultant obstetrician can decrease confidence for birth particularly, if 'threatened with a stillbirth', receiving conflicting advice, feeling worried or questions being dismissed.

Spoken communication with social circle:

- Family/friends can decrease confidence by sharing negative options or experiences.
- Birth stories if perceived as 'factual' and negative then these can be powerful (as no control over hearing them) and decrease confidence.
- If the woman is worried that her partner will not be able to advocate for her during labour then this can decrease her confidence for birth (hiring a doula can help confidence in this case).

Figure 38: Summary of the way in which communicating can influence women's confidence for birth during pregnancy

5.3 Category two: Preparing

The second category within the JTC theory is 'preparing'. This category describes the process of making oneself ready and able to deal with birth. The process of 'preparing' has two main forms: first, preparing yourself mentally and emotionally through birth aspirations; and second, physically preparing by attending classes and keeping fit. These are illustrated in further detail in Table 33.

Preparing self mentally and emotionally	**Preparing self physically**
Acknowledging and anticipating feelings	Exercising
Birth planning	Going to parent education/pregnancy yoga classes etc.
Considering place of birth	
Imagining and creating preferences for birth	
Going to parent education/pregnancy yoga classes etc.	

Table 33: Overview of 'preparing' category

Overall, participants appeared to have much more control over the process of preparing compared with other categories in the JTC theory. Furthermore, preparing during pregnancy always seemed to help women feel more confident for birth, as long as preparing did not lead to rigid or inflexible expectations. For example, it appeared that if a woman felt under-confident, then the more she prepared, the more she seemed to gain confidence. Each form of preparing will now be discussed in further detail.

5.3.1 Preparing self physically

Participants seemed to physically prepare for birth either by exercising and keeping fit during their pregnancy, or by attending pregnancy classes such as pregnancy yoga or hypnobirthing.

5.3.1.1 Exercising and keeping fit

Several participants conveyed the importance of exercising and keeping fit during their pregnancy. Some participants, such as Peaches, reported preparing for birth through

exercise, describing exercise as helping them to feel in control, which in turn increased their confidence for birth:

> "I think trying to keep quite fit and active through the pregnancy, so I was still doing yoga, Pilates, walking and stuff like that, was something, because I knew I didn't want loads of interventions, I knew that was important, so that gave me something that I felt like I could control, I suppose. My fitness was something I could control, so that gave me confidence." (Peaches: 409-413)

As well as exercising helping women to gain a sense of control, being physically fit during pregnancy also seemed to be important for those participants who prepared for birth using exercise. Feeling physically fit and healthy during pregnancy appeared to increase participants' confidence that they would be fine giving birth. For example, Cora described worrying about having a homebirth because she was an older mum in a conversation with her midwife, and her midwife reassuring her because she was so fit:

> "I stayed very fit and I don't think there's enough emphasis on that for pregnant ladies… every time when I saw [the midwife] they'd say, 'we've nothing to worry about here, you are fit, you are fine', and I think that's really, really important… the best thing is just to stay fit. It made me feel healthy throughout and because I was healthy throughout I thought, yes, this baby is going to come out fine." (Cora: 508-511)

Keeping fit seemed to help Cora to feel healthy and able to give birth. Perhaps midwives themselves have more confidence in a woman's chance of having a normal birth if she has been exercising regularly during pregnancy and is deemed to be fit and healthy. It makes sense that the midwives' own confidence may then rub off on the woman and her own perception of how confident she is about giving birth.

In summary, exercising and keeping fit during pregnancy may help a woman to feel more confident about giving birth by helping her to feel in control and healthy, thereby improving her confidence in her ability to give birth.

5.3.1.2 Going to pregnancy classes

Participants described attending at least one pregnancy class (normally two or three classes) when they were expecting their first baby to help them prepare for birth. Some participants paid for classes, such as National Childbirth Trust (NCT) or Hypnobirthing classes, while others went to free NHS classes. At the time that data was being collected

the Trust was also running new free classes called 'Confident Birthing' workshops (discussed in Chapter 1). Going to classes appeared to not only help women to physically prepare but often involved emotional and mental preparation too. Going to classes has therefore been placed in both categories of preparing in Table 33. The excerpts from Charlie, Sophia and Peaches illustrate a variety of perceived benefits achieved through preparing for birth by attending classes:

> "So I did a pregnancy yoga classes and they did practise contractions, well, where you do the breathing and getting into different positions… that helped really, I know you've got no idea what it's going to feel like, but at least you've thought about breathing through it and using the birthing ball and stuff like that." (Charley: 315-318)

> "Anyone that I come across now that's pregnant, I would say to them to do the NCT classes because the information they give you is brilliant… up until then [attending the classes] we'd been stressing about the house and getting everything ready for the baby, I hadn't really focussed my mind on it [birth]… it brings home the reality, but I'd prefer to know than go in completely blind." (Sophia: 15-17 & 22-26)

> "I think hypnobirthing really helped as well, because I was properly terrified, but that really helped actually with my confidence." (Peaches: 419-420)

Peaches talked directly about the hypnobirthing classes increasing her confidence for birth because she felt terrified about giving birth. In contrast, for Sophia attending classes seemed to be more about focussing her mind on birth, and the classes helped her to feel well informed. Charley seemed to get more practical benefit from the classes, and therefore it seems that classes may help women's confidence in individual ways, according to their needs and the type of class they attend.

Women who reported that keeping fit was important seemed to find exercising helpful in both their first and second pregnancies. However, preparing for birth through pregnancy classes appeared to be more focused on first-time mothers only. With the exception of some participants who attended 'Confident Birthing' workshops, participants did not attend

information-gathering classes during subsequent pregnancies. This makes sense; participants have already experienced birth before and so they may no longer feel that they require the knowledge provided by such classes. However, it is important to note that this is not always the case. Ellie described how, despite having previous birth experience, her confidence was lower in her second pregnancy because she felt she had no pregnancy classes to go to:

> "Obviously with [second baby] because, well, it's second, you can't do anything with second pregnancy, there was nothing to help me with my confidence… my confidence level with [second baby] was lower in that respect because there was nothing; when I was pregnant I had nowhere to go… even the yoga stuff, they'd all be first-time mothers, and you've got your different type of, you are scared in different ways the second time round than you are the first." (Ellie: 515-517 & 523-528)

It is interesting that Ellie had the perception that there were no classes suitable for her to go to during her second pregnancy, because the Trust where Ellie had her baby offered specific classes for second-time mothers to increase their confidence for birth. In the area local to Ellie there also appear to be several pregnancy yoga and fitness classes that advertise themselves as being suitable for both first-time and experienced mothers. Ellie described feeling quite tired and overwhelmed in her second pregnancy, so perhaps a lack of time or childcare had an impact on Ellie's perception of what was available to her. Perhaps Ellie was unaware of these classes, or maybe the way in which the classes were communicated to her made her feel unwelcome as a second-time mother. Normal practice in the Trust where Ellie had her baby is to only offer the standard pregnancy preparation classes to first-time mothers, but if Ellie had asked to attend preparation classes she would have been entitled to do so, and indeed several experienced mothers do, if they have a new partner who has not had children before.

5.3.2 Preparing self mentally and emotionally

The JTC theory identified that women prepared for birth mentally and emotionally through birth planning, acknowledging and anticipating their feelings about birth, considering place for birth, imagining and creating preferences for birth, as well as going to pregnancy classes.

5.3.2.1 Birth Planning

Birth plans have been incorporated into antenatal and intrapartum care provision in the NHS in England for the past three decades (Divall *et al.*, 2017). Birth plans are framed as best practise and part of a commitment to individualised care, involving women in their own care, information giving by healthcare professionals, and enabling women to maintain a sense of control over their birth (DH, 2004; NICE, 2008; NICE, 2014) . The website on NHS choices: Your health (2017) describes a birth plan as 'a record of what you would like to happen during labour and after the birth'. NICE (2014) recommends that this discussion should have taken place between the pregnant woman and her community midwife by her 36-week appointment.

Participants expressed a range of opinions and experiences about birth planning. Generally birth planning was used as a tool to help women prepare for birth, and was helpful for both the first-time and experienced mothers in this study. In particular, participants stressed the importance of flexible birth planning. For example, Sarah, who was pregnant with her second baby, reflected on the rigidity of the word 'plan':

> "It's not your birth plan but your birth aspirations… I guess I've still vaguely got a birth plan this time, because I still have got things I would prefer to happen, if I have a choice this is what I would like to happen, but it definitely needs to be much more flexible… because it's not a plan, otherwise you naively think, I've written that down now and that will be how it's going to go." (Sarah: 475-481 & 465-486)

Sarah raises an interesting point about the notion of choice in birth and whether women really do have choice and control over their birth. For example, although maternity services routinely encourage women to write about their preferences for birth, women also receive recommendations about their care from their midwife or obstetrician. If a woman declines her recommended care during pregnancy, it is normal practise for her to be strongly encouraged to see a consultant midwife (if available), obstetrician or senior midwife. The purpose of this is to ensure that she adequately understands the risks of declining the recommended care, but for the woman it may feel like she is being coerced into care that she does not want.

Birth plans may also give the impression that if a woman writes down her choice then this is what will happen, but from clinical experience this is not always the case. For example,

if a woman writes that she would like an epidural as early as possible in her labour, she is still unlikely to be offered an epidural until she is deemed to be in established labour or at least 4cms dilated. This raises questions about whether by encouraging women to write birth plan we are giving them false expectations about the level of choice that they will have when giving birth, or whether maternity services should adapt to try and facilitate more choice. Given the unpredictable nature of birth, perhaps rather than stressing choice birth plans should focus on flexibility. For example, Charley had an unplanned caesarean with her first baby but described how having a flexible birth plan still enabled her to achieve her wishes:

> "It was helpful to have it. I think writing a plan when you've never given birth before is difficult because you don't know how you are going to cope, but it was helpful to have it, so even though I hadn't planned a caesarean I had put things like wanting skin to skin straight away... that they were able to incorporate." (Charley: 252-258)

For Charley, achieving some of the things that were on her birth plan may have increased her confidence for birth. However, Lin described how she had quite fixed expectations for birth, which led her to lack confidence once she became overdue and during labour because events did not go as she had anticipated. Lin's advice for other mothers to increase their confidence for birth was:

> "I would definitely say don't have fixed expectations of how things are going to pan out, have an open mind about everything to do with birth." (Lin: 429-430)

Although most participants discussed the importance of having flexible birth plans or aspirations, some participants, such as Grace, described deliberately not making a birth plan, which increased her confidence as a self-protection mechanism:

> "We didn't want a plan because we didn't want to disappointed. We thought having a plan, the chances of it going to plan, we thought were probably low, that we didn't want to be disappointed so there was no point in having a plan." (Grace: 363-371)

Overall it seemed that preparing through birth planning and having flexible expectations may be important for women's confidence for birth. Birth planning may be a useful tool to promote expectations of birth and increase women's confidence for birth, if used flexibly.

However, if participants had rigid or inflexible expectations then birth planning seemed to decrease their confidence for birth, particularly if they didn't achieve their birth plans. Perhaps having flexible expectations links with confidence because this protects women from feeling that they have failed or been inadequate at giving birth.

5.3.2.2 Acknowledging and anticipating feelings about birth

While preparing for birth, participants appeared to go through a process of acknowledging their feelings about birth. Participants also described strategies that they had used during the preparation process to tackle negative feelings about birth – for example, sharing their feelings with friends who had recently given birth, or attending classes to gain more information. When participants reported feeling under-confident this tended to be about a specific aspect of labour, as demonstrated in the excerpts below from Sophia and Ella:

> "I don't want to go to hospital and then have to be told, ok, you go home because you're not far gone enough, or I stay without [fiancé], that's a big anxiety… that's the greatest concern for me because I think once I'm in [hospital], I should be in good hands and they'll look after me." (Sophia: 168-170 & 172-173)

> "That scenario of having tried to push and all of that stuff, and then them saying, actually no, we've got a problem, the baby is distressed – that would just freak me out. That would be an emergency, like they say emergency caesarean, and that would really cause me quite a lot of worry and panic." (Ella: 159-162)

Other participants anticipated that their confidence for birth would change through the pregnancy. For example, Lucy discussed anticipating becoming more anxious as birth approached:

> "I don't feel really scared about it at the moment, when it comes to it I'll probably be a bit more anxious, but at the moment I'm just kind of excited about it, really. I'm excited to meet my baby." (Lucy: 50-52)

It may therefore be helpful for a woman to consider her feelings about birth and try to prepare for birth by developing techniques or strategies to help her deal with these negative feelings, in order to increase her confidence for birth.

5.3.3 Conclusion

When asked what advice they would give to another pregnant woman to help her feel more confident about giving birth, almost every participant recommended flexible birth planning. Preparing through flexible birth planning may therefore be an important strategy that can help a woman to increase her confidence for birth. Preparing through exercising and keeping fit, as well as going to classes, also seemed to help women feel more confident for birth. However, some women may feel that they do not have adequate means to prepare for birth, which may reduce their confidence for birth. Figure 39 provides a summary of how women gathered and interpreted information through preparing for birth and the influence this had on their confidence for birth.

Gathering and interpreting information through preparing during pregnancy can increase women's confidence for birth by:

Physically preparing:

- Exercising and keeping fit can increase confidence for birth by increasing confidence in body/sense of control.
- Attending pregnancy classes, e.g. pregnancy yoga are likely to increase confidence for birth.
- Attending pregnancy classes may increase women's confidence with communicating their preferences for birth with their social circle of maternity staff.

Emotionally preparing:

- Creating flexible birth plans may increase confidence for birth by providing an empowering sense that her views matter.
- Acknowledging and/or anticipating feelings about birth can help to increase women's confidence, helping to prepare for and communicate these feelings.

Gathering and interpreting information through communicating during pregnancy can decrease women's confidence for birth by:

- Creating rigid or inflexible birth plans can decrease women's confidence for birth

Figure 39: Summary of the way in which preparing can influence women's confidence for birth during pregnancy

5.4 Category three: Evaluating previous experience

The third theoretical category within the JTC theory is 'evaluating previous experiences'. This is recognised as assessing an event or occurrence that happened before pregnancy and which left an impression. Participants evaluated two different sources of previous

experience which seemed to influence their confidence for birth – either their own previous birth experience(s) or previous experience of watching birth on television, as summarised in Table 34. Participants' evaluations of these information sources appear to be critical when determining their confidence for birth.

Evaluating previous experience of:	
Own birth experience(s)	Watching other people give birth on television

Table 34: Sources of previous birth experience that are perceived to influence women's confidence for birth during pregnancy

5.4.1 Evaluating previous birth experience(s)

Most participants described having previous experience of giving birth as increasing their confidence because they knew what to expect. Furthermore, their confidence was particularly high if they evaluated their previous experience as positive. For example, when asked if there was anything that made her feel less confident with her second pregnancy, Emma responded:

> "No, I don't think so. I think because I had an easy labour last time, I mean, other than I felt like it took quite a long time, nothing went wrong, it was really smooth, it was fine, so I wasn't worried at all about giving birth because I had no negative experience in the past." (Emma: 224-228)

For Emma it seemed that a positive evaluation of her previous birth experience meant that nothing reduced her confidence during her second pregnancy. When evaluating their previous birth experience, some participants reported that their perception of care was the most important factor. For example, when Alexa was asked how confident she would feel about giving birth again, she reported:

> "I don't have any particular, like it didn't upset me and I didn't feel really stressed about, and I feel that my recovery went quite smoothly as well which is good because obviously having a first baby… and not quite knowing what to expect and what it will be like, but actually obviously it's a bit uncomfortable, but it was fine and hasn't put me off in that way, I don't think, and all the care we had was

> good whilst at the hospital and then follow up at the clinic, was all really good. It was a really good experience, and even though it didn't go as I hoped it might go in terms of interventions and stuff, it was fine overall." (Alexa: 272-274 & 275-279)

All four of the participants who were interviewed during their first pregnancy discussed lacking confidence due to feelings of uncertainty because they had no previous experience of giving birth and so did not know what to expect. For example, Sophia reported feeling most worried about knowing when to go into hospital because she had no experience to compare this to:

> **"**Um, so that, that's the greatest concern for me, because I think once I'm in, if anything goes wrong then I'm in, should be in good hands and that they'll look after me and take control, but it's just that initial bit, where you think have, have my waters broken? Or is that a contraction? And how long should I be bearing the pain for? And it's that element that is the complete unknown." (Sophia: 172 – 178)

When Alexa was asked what made her feel less confident about giving birth, she responded:

> "The pain, in the sense, I suppose, luckily I've never had any surgery or any major kind of incident or anything. So I'm kind of, in a way, I'm a bit curious. But in a way it's a bit like, oh, I don't really know what my pain threshold is like, cause because that's something you can discuss with people, but it's a very subjective thing." (Alexa: 194-198)

Alexa seemed to be searching for other previous experiences that she could relate to birth to help her feel more confident about being able to cope with labour. Perhaps if she had previous experience of being in significant pain this would have helped her confidence, acting as a baseline to help her feel like she knew what to expect. However, confidence for birth is more complex than simply having previous experience or not. The crucial factor appears to be how this experience is evaluated, because some participants described their birth experience as making them feel like they had let their baby down, or they were terrified to give birth again. Hannah and Mia were both interviewed while pregnant with their second babies, and both discussed the negative impact of their previous birth experience. Hannah had an unplanned caesarean for her first birth and described losing her confidence in her body's ability to give birth 'naturally':

> "I do think it does have a huge impact on you psychologically as a mum. Like I say, I almost feel like as a woman, I let my baby down because I wasn't able to give birth naturally." (Hannah: 345-347)

In contrast to Hannah, who appeared to place the responsibility for her previous negative birth experience on her body, Mia perceived that she had extremely poor care, and it was this care that resulted in her negative birth experience involving a fourth degree tear. This is the most extensive type of tear that can occur during childbirth, extending to the anus and rectum. Mia reported that she 'kept getting told you're not ready to push' by the midwife, then when the midwife finally examined Mia and confirmed that she was 'ready to push' the midwife needed the toilet, and so:

> "She left me while I was pushing [baby] out and came back to catch him as he was, he was literally out in two pushes. Everyone I say that to, they are horrified that she left, like obviously we've had (birth) reflections and they said that shouldn't happen, but it did happen, she did leave me at that time." (Mia: 180-1865)

Mia's perception of poor care seemed to be further reinforced when she then shared her birth story with other people. Furthermore, as a result of her tear Mia was having a planned caesarean for this birth, and described how she blames the midwife for this:

> "I do put a lot of blame on the midwife, and had she actually been there for the whole time it might not have happened, and because her actions that day impacted on me for, you know, [son] is 21 months and I still think about his birth and we put off having a baby… I'm pregnant again, but we wanted our children close together, and I was like, I shouldn't let her stop me carrying on with my life and my family, but I'm terrified of having a caesarean." (Mia: 331-337)

Therefore, although most participants appeared to feel that having previous birth experience (even if not completely positive or as expected) increased their confidence because they knew what to expect during future pregnancies, both Hannah and Mia had very negative perceptions of their birth experience. They both also discussed having complex and slow physical recoveries from their wounds after giving birth, resulting in them feeling like they had a slower physical and psychological recovery than their friends.

Perhaps a long road to recovery as well as perceptions of poor previous birth experiences lowers women's confidence for birth, regardless of who they blame for this experience.

5.4.2 Evaluating previous experience of watching birth on television

Television also appeared to be a key source of previous experience that participants use to inform their confidence for birth. Television seemed pertinent for participants who had no previous experience of giving birth. The impact of participants' experience of watching television on their confidence for birth was varied and individual. For example, Grace felt that television gave her the impression that birth would be straightforward:

> "I don't think anyone goes into it thinking it is going to easy, but I guess when people talk about it and when you see it on television, they make it seem more straightforward, even if it's got complications." (Grace: 351-354)

However, in contrast to Grace, Ella reported feeling that she really lacked confidence for birth and seemed to partly blame the documentary-style television programme 'One Born Every Minute' (Dragon Fly Dragonfly Film and Televison Productions, 2010) for making her feel horrified at the thought of giving birth:

> "I think probably the whole One Born Every Minute coming on the TV was probably a, oh, what's this? And I remember watching that with my mum out of intrigue, and swiftly followed by horrified feelings… what I'd seen on One Born Every Minute with the screaming and the pain, and it was like, why would you do that to yourself?" (Ella: 2-4 & 12-14)

Participants seemed to use their experience of watching birth on television as an information source to gain knowledge about birth. However, for some participants there appeared to be a certain level of distrust of television as creating unrealistic perceptions and expectations compared to other information sources:

> "You assume maybe from the media that labour does take a certain course, and you imagine when your waters break it's like a big gush, because that's what you see on EastEnders, but it's not necessarily like that so it's good to know other people's birth stories to be realistic about it." (Charlotte: 396-399)

> "I would advise the (sic) to go on an antenatal course because I found that quite empowering especially because most of the time we get our information from TV programmes and 9 out of 10 times they are strapped down on a bed, and they never move, and they scream constantly and all of that." (Ava : 330-333)

Conversely to Charlotte and Ava, who both seemed to view their experience of watching birth on TV with scepticism, Mia seemed to use her experience of watching 'One Born Every Minute' to help evaluate her previous birth, which further reinforced her belief that her poor birth experience had been the result of poor care from an unusually cruel midwife:

> "When I compare with One Born Every Minute… there was no rapport built or anything like that, she was literally just sat on the stool in the corner and then towards the end she was saying, 'have you got any names?', but there was no warmth." (Mia: 201-204)

Perhaps this is partly due to the style of the TV programme; 'One Born Every Minute' is portrayed as a factual documentary on television (despite being highly edited), in comparison to something like 'EastEnders', for example, which is a fictional television soap. It makes sense that in the UK, where women only tend to have their experience of their own birth, watching a documentary with other women giving birth could be seen as a reliable information source for comparison or to inform them about what to expect if they have not had a baby before. However, Grace and Ella's experiences highlight that as with birth experience, it is the woman's subjective perception of watching birth on television that then seems to determine whether this has been a positive or negative influence on their confidence for birth.

5.4.3 Conclusion

In summary, previous experience and a woman's perception of this experience seem to influence her confidence for birth, whether this experience was her own or watching birth on television. Generally, having previous birth experience seemed to increase confidence because a women felt like they knew what to expect. However, if her birth experience was perceived negatively and she had a slow recovery from birth, this previous experience could decrease her confidence in future pregnancies. Furthermore, television may be a useful resource for some women, helping them to feel like they know what to expect.

However, it could also falsely increase confidence by providing unrealistic representations of what birth will be like. Figure 40 provides a summary of how previous experiences (or lack of previous experiences) can influence women's confidence for birth during pregnancy.

Gathering and interpreting information by evaluating previous experiences (or lack of) during pregnancy can increase women's confidence for birth by:

Previous experience of birth:

- If this experience is positively evaluated then this can increase women's confidence for birth.
- Communicating through birth reflections appointments can help to re-evaluate previous experience of birth positively by adding clarity, increasing confidence for birth.
- If have no previous experience of birth preparing or communicating can help to increase confidence

Previous experience of watching birth on television:

- If television programme is perceived as 'factual' and birth is positively evaluated then this may increase confidence for birth.

Gathering and interpreting information by evaluating previous experiences (or lack of) during pregnancy can decrease women's confidence for birth by:

Previous experience of birth:

- If do not have any previous experience of giving birth then this can decrease confidence for birth as have uncertainty about what to expect.
- If previous experience is negatively evaluated then this can decrease confidence for birth, particularly if evaluated their body or the maternity staff as failing them/their baby.

Previous experience of watching birth on television:

- If television programme is perceived as 'factual' and birth is negatively evaluated then this can decrease confidence for birth

Figure 40: Summary of the way in which evaluating previous experiences can influence women's confidence for birth during pregnancy

5.5 Category four: Relationship with pregnancy and baby

The fourth category is 'relationship with pregnancy and baby'. This category involves the physical and emotional connection between a woman, her pregnancy and her baby. Participants highlighted that that although birth is the first time that they will physically meet their baby, birth is not the start of their journey to motherhood or the start of their relationship with their baby. This relationship appears to start with how a woman feels about becoming pregnant, followed by her relationship with the pregnancy, and finally her relationship with her baby. These phases are not discrete and can overlap, as the quotes below illustrate, but for readability the phases are explored individually, as summarised in Table 35. A woman's physical and emotional relationship with each phase seems to have the potential for impact on her confidence for birth.

Phase one	Phase two	Phase three
Physical and emotional relationship with becoming pregnant	Physical and emotional relationship with pregnancy	Physical and emotional relationship with baby

Table 35: Phases of relationship with pregnancy and baby influencing women's confidence for birth

5.5.1 Physical and emotional relationship with becoming pregnant

The participants in this study had varying relationships with becoming pregnant. Some participants reported planning and wanting their pregnancy, while others had an unplanned pregnancy. For example, both Lucy and Sophia were interviewed during the last few weeks of their first pregnancy. Lucy discussed really wanting to be pregnant, and so when she became pregnant she was so nervous about miscarrying that it took several months for her to start thinking about the birth:

> "I've been quite nervous about being pregnant… just from things going wrong… you hear loads of horror stories and that, so I've tried not to look too far ahead and just take each week by week, so probably in the last couple of months I've actually thought about the birth." (Lucy: 7-10)

As with Lucy, whose relationship with becoming pregnant seemed to delay her in terms of thinking about and preparing for birth, Sophia also reported postponing thinking about birth because she was so fascinated with the developing pregnancy and baby:

> "In the earlier days I was fascinated with how everything was developing, you know, there was something new almost every day, um, so yeah, that kind of postponed any anxieties or any thoughts about giving birth. More recently it's come to the forefront because obviously the dates looming and we've done antenatal classes." (Sophia: 8-11)

In contrast to Lucy, Sophia reported that her pregnancy was unplanned and 'a bit of a surprise', but seemed to be very much wanted. Lucy's and Sophia's relationships with becoming pregnant didn't seem to directly decrease their confidence, simply delay them thinking about birth, but Ellie had a more conflicted experience of her relationship with becoming pregnant the second time around. Ellie described her complex emotions when she discovered she was pregnant unexpectedly while waiting for IVF screening for a genetic medical condition that her first child was born with:

> "It was a surprise, [baby] wasn't planned but I found out early with [baby] as well. More of an accident that I found out… When we had the consultation about it, about a day later I found out I was pregnant. Not ideal on that one. It was a good thing that I was pregnant, but wasn't a good thing I was pregnant. My husband didn't want [baby] because of him having the condition. So there was a lot of, what do we do? The second birth is never the same as the first, though. Never have the same experience. Even the pregnancy is never the same. You don't get to enjoy the pregnancy or the second birth because you are too busy dealing with the other baby or working, and then the next thing you know you are 36 weeks pregnant and you've gone off onto maternity again. I just came back from maternity. Work weren't happy!" (Ellie: 140-154)

The difficult timing of the pregnancy in terms of Ellie's work, as well as her husband not wanting the baby because of the high chance of a genetic condition, seemed to impact on how much Ellie was able to enjoy her pregnancy. Ellie reported that she felt:

> "Second time round, when I was in labour, yes, I felt more confident about giving birth, but I was more nervous going into labour." (Ellie: 385-386)

In summary, a woman's relationship with becoming pregnant may impact on her confidence for birth by delaying thoughts about birth if she is worried about having a miscarriage or preoccupied with the fascination of becoming pregnant. However, perhaps the most significant factor that has the potential to influence a woman's confidence is if she feels that the pregnancy is not wanted, either by her or by her close social or family circle. It would make sense that if there have been feelings of not wanting the baby by her (or her partner), and birth ultimately leads to the baby, then this may decrease a woman's confidence for birth.

5.5.2 Physical and emotional relationship with pregnancy

Throughout pregnancy a woman's relationship with her baby appears to continue developing, both emotionally and physically. This includes physical prompts from the baby, for example, kicks and movements, as well as trying to imagine the baby:

> "I get all emotional when I think of L as a little bump, he was amazing. He was an incredible little bump and he had a fabulous little personality inside. We used to call him Spud, and he would do things like he knew voices, and every time he heard us talk he would just, oh, you could feel the [hand gesture representing movements], and I just used to wonder what it will be like, a boy or a girl." (Cora: 468-473)

> "The whole time I was pregnant I just found it incredible that there was a baby inside, that, oh God there's a baby in here, and all the apps and things so you know when the baby is first a foetus, and they are pink and see-through, and you can see all their veins. I couldn't get away from envisaging her" (Holly: 119-123)

Some participants also reported physical milestones, such as the 20-week scan, prompting them to start thinking about the birth:

> "I think probably once I got into, sort of, past having the 20-week scan and that kind of thing, and my body started changing more, it felt a bit more real, I think

> the whole experience and that kind of thing is probably more when I started to actually think about, yeah, my body has to actually do this and it's going to happen." (Alexa: 7-12)

Indeed, most participants described that during their first pregnancy they did not start to focus on the birth until after their 20week scan, because this made everything feel more real. This physical prompt did not seem to be as important for participants once they were pregnant with their second baby, perhaps because they had already given birth once and so birth felt more real form the beginning of their pregnancy.

The extent to which participants enjoyed their pregnancy both physically and emotionally also seemed to impact on their confidence for birth. For example, Emma reported that she couldn't wait to give birth with her second baby as it would relieve her physical symptoms of pregnancy:

> "Having the baby inside and knowing that they are growing and the scans, the scans were amazing, they were the best part of the whole pregnancy, but actually being pregnant I didn't really enjoy. I had really horrific indigestion. I just didn't really enjoy being pregnant, so in terms of thinking about pregnancy and labour, like, the labour didn't really seem to be that bad, because it meant I wouldn't be pregnant any more. I knew that the indigestion would go as soon as he was born, that's all I could think of, so I was like, as soon as he gets here I won't have indigestion anymore." (Emma: 191-200)

For Emma, not enjoying her pregnancy physically seemed to mean that she was looking forward to and couldn't wait to give birth because it would mean that she was no longer pregnant. For Charlotte, her straightforward pregnancy appeared to increase her confidence that birth would be easy and that she would be ok during labour:

> "In my head I thought my labour would probably be easy because I was like, statistically I'm young, I'm fit and healthy, and I guess because I hadn't any complications in my pregnancy… I kind of assumed I'd be ok." (Charlotte: 402-406)

On the other hand, Tallulah reported that she was worried about birth and having a stillbirth (a foetal death at or after 20 weeks of pregnancy) from the beginning of her

pregnancy, but that this worry got worse once she developed a pregnancy complication of diabetes in the pregnancy (gestational diabetes):

> "Do you know what, I could cry now, even, because I really, even [husband] will tell you it really, I was just worried… to be honest it just got worse, because then when I has gestational diabetes they started talking about it [stillbirth] again, and whenever I didn't want to go along with what they wanted me to do they used it as leverage to make me do what they wanted me to do. So I wasn't very happy about that." (Tallulah: 16-17 & 19-22)

In summary, physical prompts such as kicking from the baby or the 20-week scan seemed to encourage participants to think about birth. However, for some participants who were already feeling worried about giving birth, developing complications during their pregnancy seemed to further decrease their confidence for birth. If participants felt that their pregnancy was straightforward and easy, this appeared to increase their confidence that birth would also be straightforward. Alternatively, if participants had a really difficult relationship with being pregnant because of physical symptoms such as indigestion or morning sickness, this seemed to increase their confidence for birth because they were looking forward to no longer being pregnant.

5.5.3 Physical and emotional relationship with baby

Some participants, such as Alexa, described imagining the baby as being one of the most helpful things that boosted confidence for birth:

> "I think that probably one of the most helpful things, when I do get a bit, like, oh, I don't know if I can do this, [laughs] kind of like, what's it going to be like, is thinking about having my, the baby, like as soon as we've had her and able to hold her on my chest, is kind of one of the, I guess biggest boosts, thinking about what it's going to be like and what she's going to look like." (Alexa: 349-353)

It seemed that when Alexa experienced feelings of doubt about how she would cope with labour, imagining meeting and holding her baby was helpful. Emma described how having had a baby already and finding out the sex of her baby at the 20-week scan helped her to imagine him, which in turn meant that Emma looked forward to the birth more:

> "We also found out that he was a boy at 20 weeks, and that was different because, and I think because we knew what he was and we'd already had a baby I could imagine him, so I did imagine having him and we talked to [daughter] about it and she was going to have a baby brother… I think lots of things made me look forward to the birth more, one being that I could imagine him, two that [daughter] was excited about it." (Emma: 208-211 & 216-217)

In summary, if participants were able to imagine their baby, this seemed to help them to look forward to and be excited about the birth, boosting their confidence during pregnancy.

5.5.4 Conclusion

Overall the physical and emotional relationship that a woman has with becoming pregnant, pregnancy and her baby seems to be varied, complex and individual in terms of the impact that this has on her confidence. For some women their relationship with becoming pregnant may decrease their confidence for birth – if, for example, their baby was not initially wanted by their husband. For others, physical interactions with their baby, such as kicks may help to boost her confidence for birth during pregnancy because she is excited about meeting her baby. Figure 41 illustrates a summary of how gathering and interpreting information through the relationship with pregnancy and the baby can influence women's confidence for birth during pregnancy.

Gathering and interpreting information through their relationship with pregnancy and their developing baby during pregnancy can increase women's confidence for birth by:

Relationship with pregnancy:

- Having a 'straightforward' pregnancy may help to increase confidence for birth as can think birth will be 'straightforward'.
- Suffering from pregnancy symptoms, e.g. morning sickness, may increase confidence for birth as means to an end of pregnancy.

Relationship with baby:

- Building a relationship with baby through scans or feeling the baby move can increase confidence for birth as look forward to meeting baby.
- Imagining meeting their baby can help increase confidence for birth as look forward to meeting baby.
- Positive communication with maternity care staff/social circle about the developing baby can increase confidence for birth.

Gathering and interpreting information through their relationship with pregnancy and their developing baby during pregnancy can decrease women's confidence for birth by:

Relationship with becoming pregnant:

- Lack of support from family/friends about being pregnant may decrease confidence for birth.
- If the pregnancy is unplanned then this can decrease confidence for birth.
- If feeling denial about pregnancy or birth then this can prevent preparing for birth, preventing increasing confidence for birth through preparing.

Figure 41: Summary of the way in which relationship with pregnancy and baby can influence women's confidence for birth during pregnancy

5.6 Relationship between the theoretical categories

Throughout analysis it became apparent the theoretical categories did not occur in isolation and could influence the other processes within the JTC theory. For example, communicating during a birth reflections appointment could influence women's evaluations of their previous experiences by helping them to understand and rationalise their previous birth. Alternatively, previous experience may influence women's processes of preparing if they prepare in a specific way to repeat or avoid their previous birth

experience. An overview of how each theoretical category is influenced by the other categories is outlined in Table 36.

	Influencing theoretical category			
Theoretical category that is influenced	Previous experiences	Relationship with pregnancy and baby	Preparing	Communication
Previous experiences		• Doesn't influence previous experiences	• Doesn't influence previous experiences	• Can help to understand and rationalise previous experiences, particularly by doing birth reflections
Relationship with pregnancy and baby	• Wanting/not wanting/planning a baby • Having a baby already can help with imagining this baby • Previous birth experience may result in making birth plans to improve bonding/meeting baby		• Can make birth and baby seem more real – take you out of denial • Practising techniques from classes can result in increased interaction with baby, e.g. movements	• Communication with partner/family can impact on relationship with baby • Communication at maternity appointments, e.g. hearing baby's heartbeat, scans etc., can help relationship with baby
Preparing	• Desire to avoid/repeat previous experience influences preparing	• May influence way in which woman prepares – may be in denial • physical stage in pregnancy may influence approach and method to preparing		• Recommendation for classes from friends/staff /social media influence preparing
Communication	• Influences communication of plans for birth to avoid repeating previous experience	• May influence communication or perception of communication	• Could give rise to new communication with staff	

Table 36: An overview of how the categories within the JTC theory relate to each other

5.7 The JTC theory diagram

Figure 42 presents a summary of the entire JTC theory as a whole. This diagram centres on pregnant women's confidence being in a state of flux as they journey toward birth, with their confidence being influenced by the four key categories of information (communicating, preparing, evaluating previous experiences and relationship with pregnancy and baby).

INCREASING CONFIDENCE

Previous experience of birth:

- If this experience is positively evaluated then this can increase women's confidence for birth.
- Communicating through birth reflections appointments can help to re-evaluate previous experience of birth positively by adding clarity, increasing confidence for birth.
- If have no previous experience of birth preparing or communicating can help to increase confidence

Previous experience of watching birth on television:

- If television programme is perceived as 'factual' and birth is positively evaluated then this may increase confidence for birth.

Physically preparing:

- Exercising and keeping fit can increase confidence for birth by increasing confidence in body/sense of control.
- Attending pregnancy classes, e.g. pregnancy yoga are likely to increase confidence for birth.
- Attending pregnancy classes may increase women's confidence with communicating their preferences for birth with their social circle of maternity staff.

Emotionally preparing:

- Creating flexible birth plans may increase confidence for birth by providing an empowering sense that her views matter.
- Acknowledging and/or anticipating feelings about birth can help to increase women's confidence, helping to prepare for and communicate these feelings

Online communication:

- The process of communicating through online discussion forums can confidence for birth by: dispelling myths, normalising feelings, sharin recommending actions and reinforcing each other's communication.

Spoken communication with maternity care professionals:

- Building a positive and trusting relationship with community midwife to increase confidence for birth (good continuity is needed to build th relationship).
- If feel supported by their consultant obstetrician can increase confide birth.
- Supportive communication can help to understand/feel more confide previous birth experience.

Spoken communication with social circle:

- Family and friends can increase confidence by hearing experiences pr positive reassurance and recommending actions.
- Birth stories are likely to increase confidence if perceived as 'factual' positive, particularly if have no previous experience of birth.
- If have supportive communication with partner and able to facilitate environment so partner can be confident this can increase confidenc birth

CONFIDENCE IN A STATE OF FLUX WHILE GATHERING AND INTERPRETING INFORMATION THROUGH FOU

EVALUATING PREVIOUS EXPEREINCES

PREPARING FOR BIRTH

COMMUNICATING

RELATIONSHIP WITH PREGNANCY AND BABY

Previous experience of birth:

- If do not have any previous experience of giving birth then this can decrease confidence for birth as have uncertainty about what to expect.
- If previous experience is negatively evaluated then this can decrease confidence for birth, particularly if evaluated their body or the maternity staff as failing them/their baby.

Previous experience of watching birth on television:

- If television programme is perceived as 'factual' and birth is negatively evaluated then this can decrease confidence for birth

Emotionally preparing:

- Creating rigid or inflexible birth plans can decrease women's confidence for birth

Spoken communication with maternity care professionals:

- Not trusting or feeling confident in or having a poor relationship with their community midwife may decrease confidence for birth.
- Perceiving communication negatively with consultant obstetrician can decrease confidence for birth particularly, if 'threatened with a stillbirth', receiving conflicting advice, feeling worried or questions being dismissed.
-

Spoken communication with social circle:

- Family/friends can decrease confidence by sharing negative options or experiences.
- Birth stories if perceived as 'factual' and negative then these can be powerful (as no control over hearing them) and decrease confidence.
- If the woman is worried that her partner will not be able to advocate for her during labour then this can decrease her confidence for birth (hiring a doula can help confidence in this case)

DECREASING CONFIDENCE

Figure 42: Summary of the Journeying Through Confidence theory

The JTC theory aims to be dynamic and woman-centred, hence the theory starting and ending with the woman journeying through confidence. A summary of the JTC theory is presented in figure 42. This model aims to demonstrate that confidence is in a state of flux while women journey through pregnancy. The core process of 'gathering and interpreting information' is demonstrated by the large arrow running through the diagram. The four key sources that this information is gathered from are also summarised in the boxes above and below the arrow demonstrating how they influence women's confidence for birth. The whole diagram aims to emphasise that women's confidence for birth is fluid and in a state of flux throughout pregnancy. All of the processes within the JTC theory have been presented in a concurrent fashion and have an overall onward and upward momentum as the woman journeys through her pregnancy towards birth. This chapter will explore the four sources of information (or theoretical categories) in detail. These are: 'a woman's relationship with her pregnancy and baby', 'preparing', 'communicating' and 'evaluating previous experience'. The core process of 'gathering and interpreting information' is embedded within all of these categories, and is therefore evidenced throughout the discussion of each of the other categories. The synthesis of the processes described by the JTC theory appears to enable women to develop their confidence for birth. Furthermore, the data gathered suggests that if any one of the JTC theory's processes is absent or underdeveloped, then there is potential for the woman to lack confidence for birth.

5.1 Positioning of the JTC theory

Having discussed each of the component parts within the JTC theory, it is also important to explore what is meant by the term 'theory', under the grounded theory framework. This includes discussing how the JTC theory is positioned as a methodological framework. There are two different types of theories: substantive theory and formative theory. Substantive theories are considered to have limited generalisability, in that they best describe, or are 'transferable to', individuals drawn from a similar population to that of the study's sample population. A theory can only be described as a 'formative' if it its conclusions are shown to be valid across different populations or as a result of deductive logic that uses validated empirical theories as its basis. The JTC theory is a substantive theory, meaning that it provides a theoretical explanation for the specific context of women's confidence for birth during pregnancy.

Each theory should be approached according to the paradigm within which it was conducted (i.e. a positivist or constructionist perspective). As discussed in Chapter 3, traditional grounded theory adopts a positivist perspective. Positivist theory seeks causes, looks for explanations and emphasises generality and universality. In their original text on grounded theory, Glaser and Strauss (1967) were clear supporters of this positivist approach and devoted a chapter in their book to the issue of moving substantive theory to formative theory. Glaser and Strauss argued that you could move substantive theory to formative theory by rewriting the substantive theory to make it less specific and more generalisable. However, positivist theories have been criticised for decontextualising grounded theories by oversimplifying complex phenomenon and making time-bound events sound more universal and generic than they actually are (Bryant, 2002; Clarke, 2005; Bryant and Charmaz, 2007a; Bryant and Charmaz, 2007b).

In contrast to Glaser and Strauss's (1967) approach, Charmaz (2014) is consistent with advocating a constructionist approach to not only data collection and analysis but also the subsequent interpretation of the theory. A constructionist approach to theory places priority on the studied phenomenon and sees both data and analysis as created from shared experiences and relationships with participants and other sources of data (Charmaz, 2001; Bryant, 2002; Bryant and Charmaz, 2007a; Bryant and Charmaz, 2007b). Constructionists study how and why participants construct meanings and actions in specific situations (Charmaz, 2000; Bryant, 2002; Charmaz, 2008a; Charmaz, 2008b; Charmaz, 2011a; Charmaz, 2014). As a result, the substantive JTC theory not only looks at how individuals view their situation but also acknowledges that the resulting theory is an interpretation. Constructionist grounded theorists take a reflexive stance toward the research process and products (Charmaz, 2009; Charmaz, 2014). It is therefore acknowledged that the JTC theory is a product of the research processes, and is constructed under pre-existing structural conditions that were influenced by my perspectives, experiences, positions, interactions and geographical locations. This is why using gerunds to code for actions (see section 3.9.1) and memo-writing (see section 4.3.5) throughout theory development were integral to try and remain sensitive and true to the data.

In summary, the JTC theory presents the first theoretical understanding of women's confidence for birth, and so the findings from the theory should be applied with caution. The discussion chapter (Chapter 6) explores the strengths and limitations of the JTC theory, as well as some suggestions for clinical practice, in further detail.

5.2 Conclusion

This chapter has demonstrated the complexities of women's confidence for birth by explaining the four theoretical categories within the JTC theory as well as the core process of gathering and interpreting information. Data from interviews with participants and social media have highlighted the impact that each of these processes can have on women's confidence for birth. The process of communicating has been identified as being particularly complex and varied. Generally speaking, the more women prepared and the more positive their relationships with pregnancy and baby, communications during pregnancy and previous experiences were, the more confident they felt about giving birth. However, there was a great deal of variation in how women interpreted all of the information sources and forms within each of these processes.

The discussion chapter (Chapter 6) will now follow. Chapter 6 provides context for the JTC theory by discussing how all the categories within the theory relate to other evidence. Chapter 6 also evaluates the strengths and limitations of the JTC theory and makes suggestions for clinical practice. Future directions of research for the JTC theory are also explored.

Chapter 6 Discussion and implications for practice

6.1 Introduction

Chapter 5 provided an in-depth exploration of the 'Journeying through confidence' theory ('JTC theory'). This final chapter in the thesis discusses the JTC theory in relation to other literature and its relevance for clinical practice. First, an overview of the study background, methodology and methods is presented. Then each of the four categories – 'communicating', 'preparing', 'evaluating previous experiences' and 'relationship with pregnancy and baby' – are explored in relation to other literature. Suggestions for clinical practice from the JTC theory are discussed, including recommendations relating to each of these categories. Then the strengths and limitations of the JTC theory are examined, including a reflection on using a constructivist grounded theory approach to investigate women's confidence for birth. Next, the questions raised about women's confidence for birth that arose from the Confident Birthing workshops, which inspired this study, are readdressed. Finally, future directions and reflections on the PhD process are discussed.

6.2 Overview of the study

The decision to research women's confidence for birth arose because this PhD has been completed as part of a clinical academic doctoral fellowship within an NHS Trust. Being a clinical academic midwife and collaborating with clinical practice has therefore been integral to the PhD. Prior to the fellowship starting, the Trust was running Confident Birthing workshops in an attempt to improve the quality of their care by providing more holistic maternity services. Holistic care (treating the whole person and not just the symptoms of their pregnancy or birth) is an indicator of good and safe maternity care in multiple government reports, maternal death enquiries and the most recent maternity care review (DH, 1993; DH, 2004; DH, 2007; DH, 2010; MBRACE-UK, 2015; NHS England, 2016). However, holistic maternity care can be challenging and costly to achieve due to its broad nature, requiring care of women's spiritual, psychological, social, emotional and physical needs.

Providing pregnant women and their partners with free 'Confident Birthing' workshops therefore seemed like a simple and effective means of providing more holistic care. A service evaluation of 221 pregnant who had completed the Confident Birthing workshops

suggested that their confidence for labour and birth was significantly increased after attending the workshop. The evaluation also raised several questions about women's confidence for birth. However, an appraisal of the literature to further explore these questions found no studies that directly explore women's confidence for birth. Broadening the search revealed 93 studies investigating related concepts such as childbirth self-efficacy, fear of birth and childbirth expectations. This literature suggested that women's confidence for birth is likely to be influenced by many different factors. Furthermore, this literature suggested that women's confidence for birth could impact on their experiences during pregnancy, labour and after birth.

Due to the lack of available literature exploring women's confidence for birth, a constructivist grounded theory study was conducted using Charmaz's (2014) methods. The study aimed to develop a theoretical understanding of what influenced women's confidence for birth during pregnancy. Data from a total of 25 interviews and 270 online discussion forum posts were collected and analysed through theoretical sampling. This resulted in the development of the JTC theory, a grounded theory that presents an understanding of the perceived influences on women's confidence for birth during pregnancy. The pivotal category for the JTC theory was 'gathering and interpreting information while journeying through pregnancy'. This category is embedded in the other four categories within the JTC theory, which are 'relationship with pregnancy and baby', 'preparing', 'communicating', and 'evaluating previous experience'. The findings from these categories and supporting literature will now be discussed in turn.

6.3 Evaluation of category one: Communicating

The key findings within this category were that communication appeared to influence confidence through imparting or exchanging information verbally, by reading or using the internet. Verbal communication was largely via two groups of people – maternity staff or and the pregnant woman's social circle.

6.3.1 Communicating with maternity staff

In relation to maternity staff, the JTC theory suggests that communicating with community midwives can increase a pregnant woman's confidence for birth, particularly if she has a good relationship with her midwife and has experienced continuity of care. This echoes Wilkins (2010), who stressed the importance of establishing a meaningful relationship between a woman and her community midwife to facilitate an enhanced maternity care experience. In their books offering guidance for healthcare professionals, both O'Toole (2008) and England and Morgan (2012) describe the need for highly developed

communication skills in healthcare settings. Indeed, O'Toole (2008) writes that good communication by healthcare professionals is critical if the required effectiveness is to be achieved. However, given that several textbooks have described communication as being important, there was surprisingly scant primary research investigating the impact of healthcare professionals' communication on women's maternity care experiences. The impact of communication by healthcare professionals on their clients therefore requires further research.

The JTC theory also highlighted that sometimes the structure of maternity care can inhibit women from discussing birth with their community midwife. As such, it suggests that any interventions that can adjust the structure of care such that communication is increased could provide significant positive outcomes in terms of the relationship with community midwifes. Indeed, a recent Cochrane review by Sandall (2016), involving 15 RCTs and including 17,674 women, also identified community midwives as being important for women's maternity care experiences. This review compared midwife-led continuity models of care with other models of care for childbearing women and their infants. Midwifery-led models of care are when a midwife, working with the woman, takes the lead in planning, organising and delivering her care from her first appointment in pregnancy through to the postnatal period (Sandall, 2016). Sandall (2016) reported that women who received midwife-led continuity models of care were less likely to experience intervention (including epidural analgesia, episiotomies and instrumental birth), less likely to have a preterm birth or lose their baby, and more satisfied with their maternity care. However, Sandall's (2016) review had a wider scope than this study, looking at the impact of continuity during pregnancy, birth and the first days of parenting. Furthermore, we cannot assume the same benefits apply to women with existing serious pregnancy or health complications, because these women were not included in the evidence assessed by Sandall (2016).

In addition to the relationship with her community midwife, the JTC theory also suggests that continuity of care can help women's confidence for birth. Continuity of care has been at the heart of maternity care policy in England since 1993 and the publication of the 'Changing Childbirth' report, which emphasised choice, continuity and control for women (DH, 1993). The most recent National Maternity Care Review (NHS England, 2016) identified continuity of care as being a key recommendation for improving maternity care across the nation. This aspect of the model therefore fits well within the current direction and focus of maternity care, which also encourages fostering relationships with community midwives and continuity of care.

The JTC theory suggests that communicating with obstetricians is more varied than communicating with community midwives. This form of communicating could decrease a woman's confidence for birth if she perceived that her worries were dismissed, she received conflicting advice or felt out of control. Surprisingly, while this is clearly important, there is scant literature exploring women's experiences of communicating with doctors (during pregnancy and in general). One exception was a study that investigated the experiences of women, midwives and obstetricians when women declined recommended care during pregnancy (Jenkinson, 2017). Jenkinson (2017) found that when women declined recommended care this placed significant pressure on their autonomy (sense of freedom to pursue their own choices). Clinicians appeared to conduct a range of negative interactions influenced by patriarchal conceptions of motherhood (being self-sacrificing and reliant on expert advice), a perception of separate foetal personhood (valuing the baby's wellbeing over the mother's) and medical authority.

While the JTC theory highlights the importance of explicit (i.e. verbal and written) communication, it is also possible that implicit communication (i.e. non-verbal behaviour) such as body language or tone of voice could also influence confidence via the relationship between patients and doctors. Evidence for this observation can be found in a study by Little (2015) which explored the relationship between patients and doctors during consultations, identifying that patients responded to several non-verbal behaviours and non-specific verbal behaviours. This suggests that communication is more complex than simply what doctors say; patients are also sensitive to their doctor's non-verbal communication.

The JTC theory also identified 'birth reflections' appointments as having the potential to increase women's confidence for birth through debriefing. This finding is supported by Baxter *et al.* (2014) scoping review of 20 papers, including nine RCTs. Baxter *et al.* (2014) reported that women's responses to receiving this form of debriefing are generally positive. The debriefing enabled women to have their birth experiences validated by talking about them and being listened to, and by being provided with information. Baxter *et al.* (2014) also highlighted that women seemed to have a strong need for their story to be heard, which may explain why birth stories are such a key source of communication within social circles, as discussed below.

In summary, aside from the research exploring 'birth reflections' debriefing services, there is fairly limited literature available that explores women's experiences and perceptions of the way in which healthcare professionals communicate with them. However, the literature that is available is compatible with the JTC theory's suggestion that communicating with maternity care professionals can influence women's confidence for birth during pregnancy.

6.3.2 Communicating within social circle

The JTC theory identifies birth stories as being very influential on women's confidence for birth. When collecting data to generate the JTC theory, every interview participant described birth stories as being influential on their confidence for birth. Storytelling through oral communication predates written communication as one of the oldest methods for sharing knowledge (Baker and Greene, 1977). Perhaps this tradition of storytelling is why birth stories had such an impact on women's confidence. Kay *et al*. (2017) conducted a hermeneutic phenomenological study of women's experiences of birth stories across two generations of women. Kay *et al.* (2017) findings support the JTC theory's suggestion that birth stories are important. Kay *et al.* (2017) reported that birth stories were found to be problematic and made women fearful of leaving 'the system' and claiming an alternative birth. Kay *et al*.'s (2017) recommends that pregnant women are encouraged to seek out and share positive birth stories, and discusses how powerful these stories can be in reinforcing women's capacity to birth. Munro *et al.* (2009) highlights just how influential birth stories can be, with negative birth stories being cited as a reason for patients opting for a planned caesarean for non-medical reasons. In Munro *et al.* (2009) study, women who had requested a caesarean for this reason drew heavily on social and cultural knowledge gained from birth stories when forming their decision.

When searching the literature, no guidance for maternity care professionals in how to support pregnant women with managing birth stories was identified. Perhaps maternity services have underestimated just how powerful the impact of birth stories can be. MacLellan (2015) identified that telling stories about birth was especially pertinent if the reality of a woman's experience is not as she imagined, appearing to have a healing or cathartic effect for women whose experience has been contradictory, disappointing or traumatic. Perhaps this explains why the JTC theory identifies that most birth stories that are shared with women during pregnancy are negative.

The JTC theory also suggests that communicating with their partner is important for women's confidence for birth. It was particularly helpful for women's confidence for birth if their partner was perceived to be supportive in their communication. The model also identified that some women appeared to facilitate their birth plans and place of birth to enable their partner to feel more confident and be best able to support them during labour. Since the 1960s there has been an increasing global trend in the number of fathers involved in their partner's pregnancies and births (Premberg *et al.*, 2011). However, fathers can find their experience of maternity services leaves them feeling excluded and unsupported by the maternity care system (Fenwick *et al.*, 2012; Widarsson *et al.*, 2012).

A recent literature review of six quantitative and 19 qualitative studies by Poh *et al.* (2014) reported that healthcare professionals and policymakers should make efforts to include fathers when providing care during pregnancy and birth. Poh *et al.* (2014) also recommends that maternity care professionals should first acknowledge the fathers' presence and involvement and engage them instead of focussing solely on the mothers. The literature reviewed by Poh *et al.* (2014) also suggests that maternity care professionals should make efforts to be more empathetic and understanding towards fathers. Similarly, Greer *et al.* (2014) conducted in-depth interviews with 19 women and 19 men and found that fearful parents choose medical interventions in birth as a means of coping with uncertainties of birth and ensuring a safe transition to parenthood. Despite almost all of the women and men in the study (89%) expressing a desire for a normal birth, most participants (86%) also appraised normal birth as risky. The most common fears for men were that their partner's mental health would suffer as a result of a traumatic birth, that they would be unable to provide adequate support during labour, and that their partner or baby would be injured as a result of birth. However, the JTC theory suggests that it is more complex than this, with some participants discussing deliberately choosing a home rather than hospital birth so that their partner would feel more relaxed and confident in their own familiar environment.

The JTC theory also suggests that if pregnant women feel that their partner will not be able to support them during labour, arranging a doula or supportive female relative to be them during labour seemed to increase their confidence for birth. There is a wealth of literature exploring doulas and how this impacts on women's birth experiences, which supports the study findings. A literature review of 48 research papers by Steel *et al.* (2015) identified doulas as having multiple physical and emotional benefits for women. McLeish and Redshaw (2018) conducted a qualitative descriptive study including 19 volunteer doulas and 16 mothers, and found that the doulas played an important role in improving women's birth experience by offering continuous, empowering, woman-focussed support that complemented the role of the midwife.

In summary, reviewing current literature supports the JTC theory's findings that communicating with their social circle can influence women's confidence for birth. In particular this literature related to sharing birth stories, having a supportive partner and the important role a doula plays during labour.

6.3.3 Communicating using an online discussion forum

Communicating using an online discussion forum was highlighted by the JTC theory as seeming to increase pregnant women's confidence for birth. Online discussion forums appeared to enable women to share birth experiences, normalise feelings about birth,

recommend actions to try and build confidence for birth, dispel myths about birth, and share coping strategies.

This relatively recent technology may be valuable since social support for new parents has been connected with better maternal health, relationship satisfaction, child outcomes and parent-child interactions (Salmela-Aro *et al.*, 2010; Meadows, 2011). Some qualitative research has also identified that the internet can help empower women through online communities and information exchange, supporting the JTC theory (Sutton and Pollock, 2000; Miyata, 2008; Hall and Irvine, 2009). McDaniel *et al.* (2012) studied 157 new mothers, reporting that they spend approximately three hours per day on the internet, and that blogging helped new mothers' wellbeing by helping them to feel more connected to the world outside their home through the internet. McDaniel's (2012) findings suggested that frequency of blogging predicted perceptions of social support, which in turn predicted maternal wellbeing as measured by marital satisfaction, couple conflict, parenting stress and depression. Furthermore, Nikki (2015) found that online discussion forums can have a positive impact on women's experiences of pregnancy. Nikki (2015) reports that digital resources can bring women together in a safe online environment allowing them to speak freely, develop practical skills and feel supported as they become parents.

In addition to online discussion forums as a useful source of support, two cross-sectional studies Bjelke *et al.* (2016) and Narasimhulu *et al.* (2016) of 503 and 193 pregnant/postnatal women respectively found that the majority of participants used the internet as a source of information. Reading pregnancy-related information on the internet was seen as positive, but the majority of the women also experienced feelings of worry due to something they had read online (Bjelke *et al.*, 2016; Narasimhulu *et al.*, 2016). Women appeared to cope with these feelings of worry by talking to their partner, relatives and friends or their midwife (Bjelke *et al.*, 2016; Narasimhulu *et al.*, 2016). Current literature therefore supports this aspect of the JTC theory which suggests that online discussion forums are influential on women's confidence for birth.

In summary, current literature supports the JTC theory's substantive suggestion that communicating using online discussion forums can have a positive influence on pregnant women's confidence for birth.

6.4 Evaluation of category two: Preparing

"Preparing" as defined by the JTC theory was described as making oneself ready and able to deal with birth. Women appeared to prepare mentally, emotionally and physically. The process of mentally and emotionally preparing included acknowledging and

anticipating feelings, managing information gathering, birth planning, considering place of birth, creating birth preferences, and attending pregnancy classes such as parent education, yoga or hypnobirthing. Physically preparing also included attending pregnancy classes as well as exercising and keeping fit during pregnancy. The JTC theory suggests that the more women prepare during pregnancy, the more confident they feel to give birth, as long as they prepare flexibly and avoiding creating rigid expectations of birth. Chapter 2 of this thesis reviewed the literature relating to women's expectations of birth in depth. The JTC theory's findings are compatible with Ledford *et al.* (2016) grounded theory study which reported that the flexibility of women's expectations for birth were key to them having a positive experience. This is in contrast to the remainder of the literature which suggested that the more positive women's expectations were, the more positive their experience of birth would be (Slade *et al.*, 1993; Green *et al.*, 1998). The JTC theory therefore provides a different approach to women's birth expectations that may be useful for maternity care professionals to consider. If healthcare professionals are currently emphasising the importance of positive expectations rather than flexible expectations for birth, this may not be helping women's confidence for birth.

The JTC theory identified birth planning as a potentially helpful means of increasing women's confidence for birth, helping pregnant women to feel empowered. However, the theory also highlighted that 'plan' may be the wrong term. The JTC theory suggested that discussing birth plans, rather than, for example, birth preferences, gives the impression that birth can be planned and does not encourage the flexibility required to approach something as unpredictable as birth. Divall *et al.* (2016) conducted a literature review of 35 papers from 33 studies exploring three main themes: 'the impact of birth plans on obstetric outcomes', 'women's experiences and opinions of completing and using birth plans', and 'health care professionals' beliefs about and experiences of the use of birth plans'. Divall *et al.* (2016) identified that some healthcare professionals perceived birth plans negatively, believing that they can increase birth interventions or poor outcomes. As a student midwife I can remember being told by several professionals that women with complex birth plans, particularly for minimal intervention, were the women who were most likely to have lots of interventions. Reflecting back on this, I am not sure where this belief has come from as it is not supported by any evidence.

In contrast, Divall *et al.* (2016) revealed that birth plans appeared to improve women's experiences of labour and birth. In particular, women included in the studies reviewed by Divall *et al.* (2016) believed that birth plans have the potential to enhance a woman's sense of involvement in and control over decision making in labour and birth through opportunities to document wishes and preferences. This preparation and shared approach to decision making might help women feel more confident about giving birth. However, the

challenges of constructing and using birth plans to support women were also identified by Divall *et al.* (2016). As with the JTC theory, Divall *et al.* (2016) emphasised the importance of flexibility, stressing that both the women and the organisation require flexibility and open discussions between women and their care givers. Flexibility was identified as particularly important in the face of unexpected but necessary changes during labour, to help the woman retain a sense of control and have a positive birth experience (Divall *et al.*, 2016). For example, Kuo *et al.* (2010) undertook a single-blind RCT in which the intervention was the completion of a birth plan. These authors found no difference between groups in birth expectations during pregnancy, but a significant difference in degrees of fulfilment, mastery and participation among women who completed a birth plan. Divall *et al.* (2017) conducted a qualitative descriptive study analysing data from two well-known UK-based online parenting forums by posting a series of questions relating to birth plans. Women appeared to have a range of views about birth plans and the benefits of birth planning, included communication with healthcare professionals, potentially enhancing awareness of available options, and maintaining sense of control during labour and birth. However, as also identified by the JTC theory, the idea of birth 'planning' was problematic and some women described reluctance to write a formal plan.

In summary, current literature about birth planning supports the JTC theory's suggestion that birth planning can impact on women's confidence for birth during pregnancy. This literature also supports the JTC theory's implication that birth planning can be challenging and needs to be done flexibly in order to build women's confidence for birth during pregnancy. Furthermore, the literature reviewed also suggests that there are other benefits to birth planning, such as helping women to feel empowered and more in control.

6.4.1 Attending pregnancy classes

The JTC theory suggests that attending pregnancy classes is a helpful means of preparing pregnant women and increasing their confidence for birth. There is some evidence that supports the JTC theory's proposition that from a woman's perspective, pregnancy classes are seen as a source of information that supports their confidence and autonomy (Gibbins and Thomson, 2001; Luyben and Fleming, 2005). The JTC theory is also supported by a recent cross-sectional cohort study by Gottfredsdottir *et al.* (2016) involving 765 pregnant women. Gottfredsdottir *et al.* (2016) found that the majority (87%) of women wanted to be informed about birth in the antenatal phase of care, and 41% reported five to six months after birth that too little time had been spent on the issue by healthcare professionals. Participants in Gottfredsdottir *et al.* (2016) study reported that pregnancy education plays an important role in preparing women for birth. Chapter 2 of

this thesis reviewed literature relating to fear of birth in depth and identified one study by Karabulut *et al.* (2016) which reported that childbirth fear was reduced by childbirth education. Assuming that a reduction in fear is also associated with an increase in confidence, it is possible that confidence may also be increased by attending classes during pregnancy. However, although the evidence from Gottfredsdottir *et al.* (2016) and Karabulut *et al.* (2016) supports the JTC theory , the effects of pregnancy classes still remain largely unknown (Gagnon, 2011). In summary, however, the few studies that have studied pregnancy classes are compatible with the JTC theory's suggestion that they may help to increase women's confidence for birth.

6.4.2 Exercising and keeping fit during pregnancy

The JTC theory suggests that exercising and keeping fit during pregnancy can help women's confidence for birth by increasing their sense of control. Physical activity has substantial benefits for women with uncomplicated pregnancies, carries minimal risks, and is recommended in pregnancy guidelines (Royal College of Obstetricians & Gynaecologists, 2015; NICE, 2017). The benefits of physical activity during pregnancy include improved physical fitness (Kramer, 2010; Ramírez-Vélez *et al.*, 2011; Nascimento *et al.*, 2012), reduced risk of excessive weight gain (Muktabhant *et al.*, 2015), reduced risk of pre-eclampsia and preterm birth (Hegaard *et al.*, 2010; Wolf *et al.*, 2014), reduced anxiety and depressive symptoms (Da Costa and Ireland, 2013), and improved health perception and self-reported body image (Barakat *et al.*, 2011). Forczek *et al.* (2017) reviewed literature relating to 28 RCTs or observation studies, and found that exercising improved maternal psychological wellbeing. It is therefore plausible that exercise may indeed increase women's confidence for birth. The psychological benefits of exercise has also been demonstrated in all adults, not just pregnant women (Plante *et al.*, 2007; Cooney *et al.*, 2013).

In summary, current literature suggests that there are multiple benefits to women from exercising and keeping fit during pregnancy. This is compatible with the JTC theory's suggestion that exercising can increase women's confidence for birth during pregnancy.

6.5 Evaluation of category three: Evaluating previous experiences

The JTC theory identified that 'evaluating previous experiences' could affect women's confidence for birth. These experiences appeared to be relate to either one's own birth experience, or the experience of watching birth on television.

6.5.1 Evaluating previous birth experience

The JTC theory suggests that the way that a pregnant woman evaluates her previous birth experience is more influential on her confidence for birth than the type of birth that she had experienced. For example, if a woman felt that she had previously "failed" at giving birth or if she felt that the maternity services had failed her, this was more influential on her confidence than whether she had previously had a vaginal or caesarean birth. On a personal level I still find it quite upsetting to think that women may have a perception of failing at giving birth. It is difficult to think that some women may start their journey to motherhood feeling that they are a failure.

The JTC theory's finding that women's confidence could be impacted by feelings that maternity care providers had "failed" them in some way is supported by Simpson and (Simpson and Catling, 2016) literature review of 21 papers exploring psychologically traumatic birth experiences. This review concluded that poor quality of provider interactions was identified as a major risk factor in experiencing birth trauma. Similarly, Harris and Ayers (2012) concluded that that interpersonal difficulties with maternity care providers most frequently included women describing feeling "abandoned", "ignored" or "unsupported". Both of these studies support the JTC theory's suggestion that if women experienced negative feelings when evaluating a previous birth experience, this could reduce their confidence for birth.

Guittier *et al.* (2014) identified that a negative birth experience can result in detrimental consequences ranging from feelings of maternal distress to postnatal depression and even post-traumatic stress disorder. The JTC theory also casts doubt on the idea that, as maternity services, we can assume that a positive birth experience is a vaginal birth. Historically, vaginal birth was thought to give women the best chance of a positive birth experience (Salmon and Drew, 1992; Rijnders *et al.*, 2008). However, two more recent studies suggest that women who planned a caesarean section had higher satisfaction ratings during pregnancy if the maternal anxiety or stress level was taken as a reference point (Wiklund *et al.*, 2009; Blomquist *et al.*, 2011). Both of these studies report that we can only speculate as to why this is the case, and further research is needed to understand the reasons (Wiklund *et al.*, 2009; Blomquist *et al.*, 2011). However, with regard to mortality and morbidity for both mother and baby, a vaginal birth is safer than a caesarean (Molina *et al.*, 2015). Therefore, perhaps as a consequence of increasing women's confidence for birth, vaginal birth may will help women to have a more positive psychological experience.

Overall, the current literature is compatible with the JTC theory's suggestion that women's confidence for birth is more complex than her type of previous birth alone, and it supports the finding that previous birth experience can impact on women's confidence for birth during pregnancy.

6.5.2 Evaluating experience of watching birth on television

The JTC theory identified that women's evaluations of watching birth on television are a potential experience that can impact on their confidence for birth during pregnancy. One Born Every Minute (OBEM) (Dragonfly Film and Televison Productions, 2010) is the most high-profile example of birth on television in the UK, and was specifically referenced by participants in the JTC theory study (Roberts *et al.*, 2017). Now in its ninth series, the series won a BAFTA in its first year and regularly attracts three to four million viewers (Hamad, 2016). The JTC theory suggests that pregnant women see OBEM as factual compared to births in soaps and films, which were reported to be unrealistic and criticised for creating false expectations. Furthermore, the JTC theory identified that OBEM was seen as a source of comparison for what birth should be like, even for women who had previous experience of giving birth themselves. The JTC theory suggests that for some women OBEM increased their confidence for birth while for others watching OBEM could lead to them feeling terrified of birth. OBEM is controversial within the birthing community, with some birth activists and midwives calling for the programme to be banned and others expressing concern that the programme may have negative social effects on both women and the midwifery profession (Roberts *et al.*, 2017). As one headline by Hill (2015) announced: 'Love birth? You probably hate One Born Every Minute'. In the article she expressed concern that the programme is having negative social effects on both women and the midwifery profession. Roberts *et al.* (2017) identified 33 commentary pieces about OBEM and identified two common claims made by critics of televised birth: first, that series like OBEM are increasing fear of birth among women, and second, that the show is harmful to the midwifery profession. However, as yet there is scant evidence to support either of these claims, and indeed the JTC theory found that, for some women, OBEM appeared to increase their confidence for birth.

One Canadian qualitative study conducted 17 in-depth interviews with first-time pregnant mothers investigating their reasons for requesting a caesarean when there was no medical reason to have one (Munro *et al.*, 2009). These authors reported that negative depictions of labour and birth on television were identified as an influence on requests for this type of caesarean birth. Munro *et al.* (2009) explored birth on television in general and did not solely focus on OBEM. At a time where few people see birth within their family or community, perhaps television shows such as OBEM have become education as well as

entertainment. In this case, it seems logical that pregnant women's evaluations of watching birth on television could influence their confidence for birth.

Luce *et al.* (2016) conducted a literature review to identify how birth is represented in the mass media and in particular television. Key themes from the 56 publications reviewed were: 'the medicalisation of birth', 'women using media to learn about birth', and 'birth as fast, furious and carrying such significant medical risk that women should rush immediately to hospital when labour begins'. These themes ring true with my clinical experience of patients or their partners often seeming surprised and anxious by the advice to stay at home during early labour.

In summary, there is very little literature exploring the impact of watching birth on television. However, the literature that is available is compatible with the JTC theory's suggestion that a pregnant woman's confidence for birth can be influenced by her evaluation of watching birth on television.

6.6 Evaluation of category four: Relationship with pregnancy and baby

The JTC theory suggests that a pregnant woman's physical and emotional relationships with becoming pregnant, the pregnancy and her baby can impact on her confidence for birth. If the pregnancy was wanted and planned, this could lead to increased confidence compared with if the baby was not planned. The literature exploring women's experiences of unwanted pregnancy in the UK focuses around women's decision making about how to end the pregnancy, either through the morning-after pill or a termination (Bentancor and Clarke, 2017; Pykett and Smith, 2017; Wokoma *et al.*, 2017). However, the JTC theory suggests that some women may continue with their pregnancy even if they do not feel that it is completely wanted or planned. Three studies exploring women's experience of unwanted pregnancy in Asian countries found that women who have an unwanted pregnancy are more likely to suffer from low levels of self-efficacy and perceived social support, as well as showing less engagement with pregnancy care and higher levels of anxiety in pregnancy (Marsiglio and Mott, 1988; Ali, 2016; Shahry *et al.*, 2016). Conversely, there is some evidence to suggest that women who become pregnant through assisted reproductive technology, such as in vitro fertilisation (IVF), are more likely to have high levels of anxiety during the pregnancy and suffer from postnatal depression after the baby is born (Alhusen *et al.*, 2016; MacCallum *et al.*, 2016; Agostini *et al.*, 2017; Vikstrom *et al.*, 2017). This evidence fits with the JTC theory's suggestion that if women have had a more difficult experience becoming pregnant, they may have a lower

confidence for birth. An important aspect of supporting women's psycho-social needs may therefore be to consider her journey to becoming pregnant.

The JTC theory found that physical prompts from the baby during the pregnancy, such as kicks or seeing the baby during an ultrasound scan, could increase women's confidence for birth by prompting them to think about the birth. The JTC theory also implies that if pregnant women are able to imagine their baby, this increases their confidence for birth because this will result in them meeting their baby. The JTC theory's findings are supported by literature that identifies maternal-foetal attachment during pregnancy as important, and something that can be influenced by many different factors either positively or negatively, with the level of attachment increasing throughout the course of pregnancy (Laxton-Kane and Slade, 2002; Alhusen, 2008; Brandon *et al.*, 2009). Alhusen (2008) conducted a literature review of 22 studies that explored maternal-foetal attachment and reported that having an ultrasound scan performed was associated with higher levels of maternal-foetal attachment. Bloom (1995) and Berryman and Windridge (1996) found that prenatal attachment developed with gestation age of the baby, particularly after foetal movements were first felt, typically in the second trimester. Therefore, perhaps there is a link between pregnant women's confidence for birth and maternal-foetal attachment.

If a woman experiences a complication-free pregnancy, this seems to increase her confidence by encouraging her that she will also have a complication-free birth. If the woman suffers from physical symptoms during pregnancy, such as morning sickness, this also appears to increase her confidence for birth, since she views birth as a means of no longer being pregnant.

In summary, the available literature is compatible with the JTC theory's suggestion that women's confidence for birth can be influenced by their relationship with pregnancy and their baby. In particular, this literature focusses on the impact of maternal-foetal attachment.

6.7 Comparison between the JTC theory and Self-efficacy theory

6.7.1 A comparison of self-efficacy and confidence as psychological concepts

The aim of chapter two was to review literature relating to confidence and birth. Scant literature was identified that explored this concept so other similar concepts were discussed which included: childbirth self-efficacy, fear of birth and expectations for birth. Having reviewed the evidence base relating to these concepts childbirth self-efficacy was found to be the most closely related concept to confidence for birth. This discovery led to

a discussion about the similarities and differences between the two concepts as summarised in table 37 below.

Concept	**Definition**
Confidence	'Confidence' is defined by the Oxford living dictionary (2019) as a feeling or belief that one can have faith or rely on someone or something and a feeling of self-assurance arising from one's own abilities or qualities. The concept of confidence is a lay term and was not developed as a result of a psychological theory.
Self-efficacy	'Self-efficacy' is derived from Bandura's Social Cognitive Theory (Bandura, 1977) and was originally defined as being one's belief in one's ability to succeed in specific situations or accomplish a task (Bandura 1977). The concept of self-efficacy involves two expectations: outcome expectancy (that the behaviour, if properly carried out, will lead to a favourable outcome), and self-efficacy expectancy (that one can perform the behaviour properly) (Bandura, 1988; Bandura, 1997). The difference between self-efficacy and confidence in the words of Bandura are: "Confidence is a nondescript term that refers to strength of belief but does not necessarily specify what the certainty is about… Perceived self-efficacy refers to belief in one's agentive capabilities, that one can produce given levels of attainment" (1997, p. 382). In Bandura's (2008) more recent writing he describes self-efficacy as the optimistic self-belief in our competence or chances of successfully accomplishing a task and producing a favourable outcome. It is evident from this definition and Bandura's work in 'An Agentic Perspective on Positive Psychology' (2008) that Bandura's concept of self-efficacy is still heavily focussed on attrition and agency. Bandura argues that the higher your self-efficacy, the more likely you are to pursue a goal and ultimately to be reinforced by the outcome of your efforts. As a result self-efficacy theory is widely used to support, for example, students' motivation to learn (Wäschle *et al.*, 2014), weight loss (De Vet *et al.*, 2013; Armitage *et al.*, 2014) and smoking cessation (Berndt *et al.*, 2013; Ochsner *et al.*, 2014).

Table 37: A comparison of confidence and self-efficacy

The scoping review presented in chapter two identified three studies in relation to confidence for a physiological birth (this is a 'normal' vaginal birth without epidural or spinal pain relief) (Brown 1998, Coughlan & Jung 2005 and Leap et al. 2010). These suggested that women prefer a respectful and connected partnership with their maternity care professional, through which they gain knowledge and confidence for a physiological birth. However, this literature focussed on how to facilitate a physiological ('normal) birth rather than exploring confidence for birth as a general construct.

In contrast to the limited literature available on confidence for birth, the scoping review found a total of 27 studies that explored childbirth self-efficacy. The concept of self-efficacy in these studies was discussed in relation to:

- The influence of self-efficacy in relation to pregnancy, labour and postnatal experience
- The influence of self-efficacy on women's preferences for birth
- The ability to influence women's self-efficacy during pregnancy

Having explored all of the literature discussed in chapter two the concept of confidence rather than self-efficacy was chosen for the focus of this PhD. This decision enabled a broad view of women's perceptions of pregnancy to be captured. Focussing on confidence instead of self-efficacy also facilitated an inductive approach to be taken towards data collection rather than applying an existing theory that was not focussed on pregnancy and birth specifically. The concept of self-efficacy having a heavy focus on attrition was also taken in to account when deciding to focus on confidence and not self-efficacy. Self-efficacy theory may therefore be useful for specific aspects of pregnancy and birth, for example encouraging women to attended antenatal appointments. Whereas attrition is less relevant to giving birth in general as this is not something that pregnant women have a choice about. Regardless of whether this birth is vaginal or abdominal, having to give birth at the end of pregnancy is one of the few certainties about pregnancy. However, given the similarities between self-efficacy and confidence as concepts, now that the JTC theory has been developed it feels useful to revisit these concepts and compare the JTC to self-efficacy theory. This comparison began by revisiting self-efficacy theory before then comparing specific aspects of the two theories in detail.

6.7.2 A comparison of the JTC and self-efficacy theory

One of the biggest differences between the two theories is the momentum within the theories. The JTC theory has an onwards momentum and emphasises the state of flux that women's confidence for birth can be in while they journey through pregnancy towards birth. Whereas self-efficacy theory is linear suggesting that is women have high levels of

childbirth self-efficacy expectancy and high levels of childbirth outcome expectancy than they will have high levels of childbirth self-efficacy and be more likely to have perform and achieve behaviours that will lead to having a more positive birth experience. For example, the quantitative studies that explored the impact that women's self-efficacy had on their pregnancy experiences suggested that if women had high levels of self-efficacy, they tended to have a more positive experience of pregnancy compared to women with low self-efficacy (Sun *et al*., 2010; Beebe *et al*., 2007; Lowe, 2000 and Salomonsson *et al*., 2013b)

The JTC theory gives a more complex picture than this because it encompasses the broader psychology of pregnancy and birth rather than focusing on self-efficacy and attrition. Another key difference is that the JTC theory is imbedded within the context of pregnancy and as such is more detailed and specific to pregnancy than self-efficacy theory.

It is also interesting to compare Bandura's four sources for developing a sense of self-efficacy with the four sources that women gather and interpret information from in the JTC theory. Bandura's first and most important source of self-efficacy is 'personal experience of success'. This is similar to the JTC theory's 'evaluating previous experiences' as both theories include an evaluation of previous childbirth experience and emphasize that having previous experience does not necessarily make you feel more confident or have a higher level of self-efficacy. Both theories suggest that this experience being interpreted as positive or successful is also key. However, an important difference between the two theories is that while the self-efficacy theory suggests that this source is much more important than the other sources of self-efficacy, the JTC theory does not distinguish between one source as being more important than the others. The JTC theory also includes previous experiences of others as well as self by suggesting that watching other women give birth on television can influence women's confidence for birth. Perhaps this is more closely linked with Badura's second source 'observing effects produced by the actions of others'.

There are also some similarities between Bandura's third source of self-efficacy 'social persuasion and encouragement from respected others' and the JTC theory's second source 'Communicating'. However, the JTC theory is much more specific than self-efficacy theory providing different sources within this category. For example, the JTC theory describes the different forms of communicating (verbal or written) and the different sources within these forms (such as, maternity care staff or social circle). The JTC theory also describes how these different forms and sources can influence women's confidence

for birth, providing more detail for practitioners if they want to use the theory to try and improve women's confidence for birth.

Importantly, the JTC theory includes a source ('relationship with pregnancy and baby') that is not found within self-efficacy theory. This aspect of source the JTC theory discusses the physical and emotional connection between a woman, her pregnancy and her baby. Focussing on the relationship with a woman's pregnancy and her baby is unique to the specific context of women's confidence for birth during pregnancy. This highlights that this relationship does not begin at birth but is more complex and can start prior to a woman becoming pregnant. This dimension of the JTC theory is useful because it emphasises the developing fluctuating nature of women's confidence during pregnancy.

In summary several aspects of the JTC theory are similar to Bandura's self-efficacy theory which is reassuring, given that it is a well-established and tested theory relating to a similar psychological concept. However, the JTC theory is more specific and detailed which is to be expected given that the JTC theory focuses on the specific topic of women's confidence for birth. The JTC theory also includes some elements that are not included in self-efficacy theory. The specific nature of the JTC theory allows it to be much more detailed and therefore offers an alternative and perhaps more practical theory for maternity care staff to try and improve women's psychological wellbeing during pregnancy.

6.8 The JTC theory as a unique contribution to knowledge

Section 6.6 has identified that there is a wealth of literature supporting the JTC theory; it is encouraging that the JTC theory is compatible with current evidence relating to women's psychosocial needs during pregnancy. Some literature has already identified several concepts within the JTC theory as being important, such as birth plans, but the JTC theory remains a unique and useful contribution to new knowledge for the following reasons:

1. This is the first research study to focus on women's confidence for birth as a psychological concept, and to explore what influences women's confidence for birth during pregnancy.
2. The JTC theory provides the first model that represents the process of how different concepts can interact to impact on women's psychosocial wellbeing during pregnancy.
3. The JTC theory is the first framework which combines all the factors that influence women's psychosocial wellbeing, viewing them as a whole. Providing a single

theory will be more useful for clinicians than lots of different theories about separate topics.

4. The vast majority of the literature discussed in section 6.6 and the scoping review in Chapter 2 were conducted in countries outside the UK. This limits the generalisability of these findings to pregnant women in the UK, where healthcare is provided in the unique NHS system. The JTC theory therefore provides a valuable increase in knowledge for clinicians in the UK, to better understand women's psychosocial wellbeing during pregnancy.

6.9 Suggestions for clinical practice

This PhD was completed as part of a clinical academic doctoral fellowship, and so a critical part of developing the grounded theory model was to be able to make suggestions for clinical practice. The aim of this PhD was to develop a theory about what influences women's confidence for birth during pregnancy, in order to be able to use this theory to improve maternity care. Given that this thesis has been the first to explore women's confidence for birth, further research is needed to fully understand this concept. However, it is hoped that the following suggestions for clinical practice could help maternity services to start considering women's confidence for birth and ways in which to improve it. Recommendations have been made according to the categories of 'communicating', 'preparing', 'evaluating previous experiences' and 'relationship with pregnancy and baby'.

When considering these suggestions for clinical practice, it is important to note the 'journeying' aspect of the JTC theory. As discussed in the findings chapter, the concept of 'journeying' tries to convey the state of flux that can characterise women's confidence throughout pregnancy. Indeed, the JTC theory describes women's confidence for birth as changing throughout pregnancy. This means that it is important for all the suggestions for clinical practice to be considered throughout pregnancy, not just at either the beginning or end of pregnancy. It is also suggested that healthcare professionals ask women about how confident they are feeling for birth several times during their pregnancy, because their confidence level may change over time.

6.9.1 Suggestions for clinical practice about communicating

NICE's (2017) 'Antenatal care for uncomplicated pregnancies' guidelines recommend that good communication between healthcare professionals and women is essential. The JTC theory indicates that good communication can have a positive impact on women's confidence for birth.

Participants in the study that generated the JTC theory gave examples of how the way maternity care professionals communicated with them could impact on important birth decisions – for example, whether to have a home or hospital birth, or a vaginal birth versus a planned caesarean. The importance of the way that maternity care professionals communicate with women during pregnancy should, therefore, not be underestimated. In particular, the JTC theory suggests that maternity services should value community midwives as the best placed healthcare professionals to help increase women's confidence for birth. This seems to be especially pertinent if the community midwife can build a good relationship with the pregnant woman.

However, the JTC theory also highlights that it is important for the structure of maternity services not to inhibit women from feeling that they can talk to their community midwife about birth. It may therefore be helpful for maternity services to consider ways to encourage pregnant women to discuss and add clarity to their previous birth experiences. For example, the midwife may go through the birth notes chronologically with the woman to explore what happened and why .

Currently there is not enough evidence about the benefits of debriefing services for them to be recommended by national maternity care guidance, and therefore such services are currently offered at each individual Trust's discretion. The JTC theory recommendation is for maternity services to offer (or continue to offer) 'birth reflections' debriefing services for women who wish to have access to them. This form of debriefing service may be a particularly helpful resource to build women's confidence for birth, providing the opportunity for women to discuss and gain clarity about their previous birth experience.

The JTC theory suggests that it is important for maternity services to take into account the impact of a woman's partner's confidence on her own confidence for birth. This includes being mindful that women may make decisions around place for birth to facilitate their partner feeling more confident, with the result that they will be fully able to support the woman during labour. This recommendation fits with NICE's (2017) 'Antenatal care for uncomplicated pregnancies' guidelines, which recommend that the views, beliefs and values of the woman, her partner and her family in relation to her care and that of her baby should be sought and respected at all times. The JTC theory also suggests that it may be helpful to encourage women who lack confidence for birth to consider planning on having a supportive female relative, friend or doula with them during labour. This seems to be particularly important if the pregnant woman perceives that her partner may not be able to advocate for her during labour.

In addition to the above recommendations, the JTC theory suggests that it is important for maternity care professionals to acknowledge that birth stories can have a very powerful

impact on women's confidence for birth. Acknowledging this this could facilitate discussions about how to cope with birth stories that may be negatively impacting on women's confidence. For example, maternity care professionals could recommend resources that provide positive birth stories, such as the Positive Birth Movement – a grassroots organisation that shares positive birth stories and arranges local face-to-face groups across the UK (and several other countries).

In summary, it is important for maternity care professionals to recognise the impact of communication on pregnant women's confidence for birth. For women who lack confidence, it may be helpful to encourage them to consider using online discussion forums, a 'birth reflections' debriefing appointment or a doula. It may also be helpful to discuss the powerful impact of birth stories and signpost women to sources of positive birth stories. It could also be important for maternity services to value and invest in community midwives to enable them to boost women's confidence for birth.

6.9.2 Suggestions for clinical practice about the way women prepare for birth

It may be helpful for maternity services to encourage birth planning using a flexible approach, facilitating open communication between maternity care professionals and women. This may improve women's confidence for birth by helping them to feel empowered, and feel that their views are important. The JTC theory suggests that it may be valuable to explore new ways that birth planning can encourage flexibility to avoid creating rigid expectations. It may therefore be useful to build on NICE's (2017) 'Antenatal care for uncomplicated pregnancies' guidelines which recommend that before or at 36 weeks preparation for labour and birth should be discussed with the woman, including information about the birth plan and coping with pain in labour. The JTC theory could be used to change the culture of these birth plans, promoting flexibility and confidence.

The JTC theory also suggests that maternity care professionals should encourage women to exercise and keep fit during pregnancy. This recommendation that pregnant women should be encouraged to exercise is more proactive than the current NICE (2017) 'Antenatal care for uncomplicated pregnancies' guidance, which recommends that women should be informed that beginning or continuing a moderate course of exercise during pregnancy is not associated with any adverse outcomes. Indeed, the JTC theory and other literature explored suggests that healthcare professionals should be actively promoting exercise during pregnancy. This is because exercise during pregnancy appears to have multiple physical and psychological benefits, in addition to increasing women's confidence for birth.

The JTC theory suggests that it may be beneficial to encourage women to attend pregnancy classes to help prepare for birth (and as a result increase their confidence for birth). This recommendation is more proactive than current NICE (2017) 'Antenatal care for uncomplicated pregnancies' guidelines, which advise that pregnant women should be offered opportunities to attend participant-led antenatal classes. The JTC theory also suggests that 'Confident Birthing' workshops are indeed likely to be a valuable resource for improving women's confidence for birth.

In summary, it would be helpful for maternity services to encourage pregnant women to prepare for birth flexibly and as much as possible, in order to increase their confidence for birth. Recommended means of preparing include exercising, attending pregnancy classes and birth planning.

6.9.3 Suggestions for clinical practice about women's previous experiences

Discussing women's experiences of watching birth on television may be helpful to improve their confidence for birth. The JTC theory highlights the potential impact that watching birth on television can have on women's confidence for birth. OBEM appeared to be a particularly powerful form of watching birth on television influencing women's confidence for birth. An awareness that television shows can influence women's confidence for birth during pregnancy may prompt maternity care professionals to have open discussions about television. For example, it may be helpful for maternity care professionals to note that even documentary-style television programmes such as OBEM are highly edited to ensure that they are entertaining. There is currently no guidance for maternity services with regards to discussing birth on television. There is therefore a need to develop guidance for pregnant women and healthcare professionals on how to manage watching birth on television. Open discussions about the way in which birth is portrayed on television programmes may enable maternity care professionals to help pregnant women have a positive and confidence-boosting experience while they are watching birth on television.

The JTC theory also suggests that it is important for maternity care professionals to have an awareness of the potential impact women's previous experience of birth, or lack of it, can have on their current confidence for birth. It may be helpful for healthcare professionals to discuss and acknowledge the feelings of uncertainty created by women having no previous experience and to try and signpost women who are lacking confidence to positive sources of communication, preparing for birth and imagining meeting their baby. There is no national guidance on supporting women who have had a previous negative or traumatic birth experience. This is surprising given the known psychosocial implications of a traumatic birth, including long-term negative repercussions for self-

identify and relationships (Fenech and Thomson, 2014). The JTC theory suggests that debriefing services such as 'birth reflections' and clear communication with healthcare professionals may help women gain confidence if they have negative perceptions of their previous birth experience. The JTC theory therefore adds weight to the importance of maternity services in ensuring that women have a positive birth experience with their first baby (and then every subsequent birth).

In summary, if maternity services can recognise and discuss the impact of pregnant women's previous experiences, this may help their confidence for birth. This includes discussing women's evaluations of their own previous birth experience or of watching birth on television, as well as acknowledging the feelings of uncertainty if a woman has no previous experience of birth.

6.9.4 Suggestions for clinical practice about women's relationships with their pregnancy and baby

This JTC theory suggests that it may be helpful for healthcare professionals to consider a woman's journey to becoming pregnant and how this impacts on her confidence for birth, either positively or negatively. There appears to be an assumption in the literature that due to the availability of contraception and terminations in the UK, all women who are pregnant have a wanted pregnancy. However, the JTC theory suggests that women's feelings about being pregnant may be more complex than this. Perhaps sensitive enquiry by healthcare professionals may provide women with an opportunity to discuss their own and their partner's feelings about being pregnant. As a result, this could enable healthcare professionals to provide more social and emotional support to women when it is needed.

The JTC theory also suggests that it may be helpful for maternity care professionals to consider the physical impact of pregnancy on how a woman is feeling about birth. Surprisingly, suffering physically during the pregnancy with, for example, morning sickness or indigestion may improve a woman's confidence for birth. This seems to be because these women then look forward to birth, viewing it as a means to the end of the pregnancy (and a cessation of the unpleasant physical symptoms). However, the JTC theory also identified that if a woman feels that her pregnancy has been complex and not straightforward, she could lack confidence for birth. The JTC theory suggests that this is because she may believe that her birth will also be complex and not straightforward. If healthcare professionals offer supportive communication to women who are experiencing more complex pregnancies, this may increase their confidence for birth. It may also be

helpful for healthcare professionals to signpost these women to online discussion forums or groups for support and advice from peers.

The JTC theory suggests that healthcare professionals may also be able to help women increase their confidence for birth by encouraging them to focus on the relationship with their baby and imagining meeting their baby. It is important for maternity care professionals to take into account that as the due date approaches, birth is likely to become more of a reality. This can result in a fluctuation in woman's confidence levels for birth. Discussing how women are feeling about birth at several stages during pregnancy may therefore be helpful. Encouraging pregnant women with lower levels of confidence to access resources, such as the Positive Birth Movement website's online discussion forums, exercising and pregnancy classes, could also help with this.

In summary, if maternity services are able to recognise and consider the impact of women's relationships with their pregnancy and baby, this may help to increase women's confidence for birth during pregnancy. Recommendations from the JTC theory include considering the impact of a woman's journey to becoming pregnant, and recognising how challenging the physical effects of pregnancy can be. It may also be helpful for maternity services to encourage interactions with the baby, to help women focus on meeting their baby and increase their confidence for birth.

6.10 Strengths and limitations of the theory

6.10.1 Strengths of the study

To my knowledge this thesis is the first study to explore women's confidence for birth. This study used a combination of two different data sources which complemented each other. Interviews enabled in-depth exploration of women's confidence for birth, while the online discussion forum hopefully enabled a wider breadth of participants to have their voices heard, enhancing the credibility of this study. Using two different methods for data collection should also mean that they can compensate for their individual limitations and exploit their respective benefits. For example, online discussion forum data counteracted any influence of participants knowing I was a midwife on the interview data. Both sources of data had relatively large sample sizes for a qualitative exploratory study. This should help the transferability of the findings to other pregnant women in the UK.

Efforts were made to enhance the credibility of the study by using midwives as gatekeepers and by advertising the study on the Maternity Service User Liaison Committee. This should have ensured that participants who took part in the interviews were genuinely willing to take part and prepared to offer data freely. Lots of effort was put

into rapport-building with interview participants to try and encourage honesty, and to facilitate participants to be as frank as possible. With regard to the online discussion forum data, participants were unlikely to be posting with the intention that their messages would be analysed by a researcher. Only covert message analysis was conducted on the data and there was no interaction with the online discussion forum participants, which also enhances the credibility of what they were posting.

Including the transparent grounded theory creation chapter within the thesis aims to improve the confirmability and dependability of the study findings. The chapter demonstrated how the theory was built and the specific data collection and analysis process used for this study. Including memos in the thesis also aims to strengthen the study. Memo-writing throughout data collection and analysis facilitated reflexivity, which should in turn enhance the confirmability of the study findings. Another strength of this study is that efforts were made to be as emergent as possible, within the constraints of the tight clinical academic doctoral fellowship timeline and the strict ethical process required to conduct research in the UK.

The planned dissemination event, continuously working in clinical practice as a midwife and involvement from the Trust throughout the PhD should ensure that the findings are clinically relevant. The dissemination event is currently in the planning stages but will be completed prior to the PhD viva exam. Multiple clinical recommendations have arisen from the substantive theory to improve clinical practice.

In summary, aside from being the first study to explore women's confidence for birth, this study has several strengths which enhance the credibility of the study findings. These strengths mean the resulting substantive theory should be relevant, useful and transferable to clinical practice in the UK.

6.10.2 Limitations and considerations of the study

Positivist grounded theorists may argue that a limitation of this study lies in the fact that the JTC theory is positioned as a substantive rather than formative theory. However, if I were to claim that the JTC theory is incomplete, requiring further work to develop it into a formative theory, this could undermine my entire PhD since this view is not compatible with my constructivist methodological position. This is a constructivist position, presenting the JTC theory as a socially constructed theory rather than an absolute truth. A constructivist substantive theory also seems appropriate for the subject matter of confidence, which is a subjective psychosocial construct. Therefore, while I acknowledge the traditional positivist grounded theory positions, I view the JTC theory's substantive

status as a strength rather than a limitation, because I think this adequately reflects the fluidity of women's confidence for birth. Therefore I do not think the JTC theory needs further work before it can be applied to clinical practice.

Another limitation of this study is that interview participants knew that I was a midwife, and this knowledge may have impacted on their accounts of confidence for birth. It is therefore possible that these results, particularly in relation to the importance of midwives for women's confidence, may have been influenced by my position as a practicing midwife. It was for this reason that it was important to collect the online discussion forum data, which did not suffer from this particular limitation. The fact that I am a midwife and was practising as such throughout data collection and analysis may also have influenced the resulting theory. However, since this research aimed to develop a constructivist substantive theory, which necessarily takes the view that our knowledge is constructed through our lived experiences and through our interactions with other members of society, it could also be argued that my experience could be seen as a strength. It is nevertheless important to acknowledge that my world view as a researcher is embedded within and cannot be separated from the JTC theory. As a result, although efforts were made to reduce the impact of my influence on the data, I acknowledge that the resulting JTC theory might have been different if the study had been undertaken by another researcher who was not also a midwife.

Another note of caution when interpreting the substantive theory is that the influences on women's confidence for birth are likely to culturally dependent. Both the interview and online discussion forum data were collected the UK. As previously discussed in Chapter 1 of the thesis, the UK has a unique healthcare system and model of maternity care. There are therefore likely to be some challenges with transferring this theory outside the UK. For example, the model found that community midwives appeared to be very influential on women's confidence for birth, but many countries do not have midwives, let alone midwifery-led models of care. Further research is needed to explore what influences women's confidence in countries outside the UK.

The limitation of collecting data retrospectively should also be considered in relation to the JTC theory as the interview was collected with participants towards the end of their pregnancy or after giving birth. This may have affected how accurately they were able to describe their confidence during pregnancy. Efforts were made to reduce this limitation by only including participants in the interview data if they had given birth within the last two years. Longitudinal studies by Niven (2000) and Takehara *et al.* (2014) suggest that women can recall pregnancy and birth events accurately for at least five years. The internet discussion forum data also largely consisted of women posting who were currently pregnant about their confidence for birth which helped to get some real time data

at several different points during pregnancy. However further research is needed to test out the JTC theory during different stages of pregnancy to check that it applies to all stages of pregnancy.

Finally sociodemographic data was not collected from the interview nor the internet discussion forum participants. It was not possible to collect sociodemographic data from the internet discussion forum participants. It was also felt not be relevant and therefore unethical to collect sociodemographic data from the interview participants. The purpose of grounded theory is to generate theory not generalisability. However now that a theory has been generated, further research is need to check whether or not the JTC theory needs to be adapted according to different sociodemographic groups of women.

6.10.3 Reflections on using a constructivist grounded theory approach

Chapter 3 discussed the importance of memo writing to facilitate reflexivity throughout the grounded theory process. Initially memo writing was helpful to make sense of the data being collected, and was also key to facilitating data analysis. Once data collection and analysis had been completed, memo writing continued to be a useful tool, encouraging reflexivity about the PhD and the research process. Figure 43 presents a reflexive account of my experience of conducting a PhD exploring women's confidence for birth using a constructivist grounded theory approach. In particular, this memo helped me to be reflexive about my own research journey and some of the benefits and challenges of using this methodological approach.

Prior to embarking on this PhD I had no experience of conducting research. Deciding how to carry out this research project therefore felt really overwhelming initially. Once I had completed my scoping review and started to read about research methodologies, it became more and more obvious that grounded theory was the best approach to use. However, I struggled to identify with and make sense of Glaser and Strauss' texts. Then reading Charmaz's constructivist grounded theory book 'Constructing Grounded Theory' was a complete 'lightbulb' moment for me because this approach made sense to me. Charmaz's approach made sense both on a practical level, I could understand her methods, but also at a philosophical level (as previously discussed

in Chapter 3 of this thesis). I identified with her constructivist position and read this cover to cover I felt more confident to start to plan and design my research.

Despite feeling confident about the approach I was using for this study, it has only been while conducting each stage of the grounded theory that I feel I have properly able to understand grounded theory. For example, despite much of Charmaz's writing being dedicated to explaining how to code according to grounded theory analysis, it took for me to have coded the entire first cycle of my interview data to realise that I had coded thematically. I had to reread the grounded theory methods texts and recode that entire section of data, using tools such as gerunds and creating my own thesaurus of codes to help me. This is just one example of how I feel that it has only been by doing grounded theory that I have properly been able to understood grounded theory. One of the most important things that I have learnt is also that grounded theory takes time. I have learnt that in order to produce quality theory you need to allow time to be creative and let the theory emerge. Having the courage and patience required to allow this time has been the most challenging aspect of this PhD. Allowing this time was facilitated by the constant support of my supervisors and through experience, and not something that I was able to learn through textbooks.

Figure 43: Reflections on using constructivist grounded theory for this study

6.11 Future directions

6.11.1 Future directions with clinical practice

Several future directions for the JTC theory have been identified. The first will be to collaborate with maternity services to implement the theory's recommendations for clinical practice. Initially this will be achieved at a local level by:

1. Presenting to senior doctors and midwives in the maternity team at the Trust's clinical governance meeting in July 2018
2. Displaying posters to disseminate the research findings and clinical recommendations to local maternity staff and patients across all sites at the Trust
3. Disseminating recommendations to colleagues through continued work as a clinical academic
4. A dissemination event is also being held in July 2018 where key stakeholders, such as the maternity service user committee, service users, midwives, obstetricians, student midwives and the participants who took part in the study, will be invited to collaboratively develop future directions for further exploring women's confidence for birth
5. Publications in peer reviewed journals discussing the research findings, suggestions for clinical practice and research methods used

In addition to the above plans, recommendations for clinical practice will be presented at local, national and international conferences. These presentations will also aim to raise awareness of women's confidence for birth as an important concept to understand and improve upon (by expanding the JTC theory to include women's confidence during labour and after birth).

6.11.2 Future directions for research

A future direction from this project will be to analyse the data collected about what influenced women's confidence for birth during labour. This was not possible to analyse within the scope of this PhD. Analysing this data (and collecting further data if required) should add value to the model by widening the breadth of understanding about women's confidence for birth. Several participants also identified that their experiences directly after giving birth impacted on their confidence for future births. Therefore, women's confidence during the postnatal period is also likely to be a valuable concept to add to the JTC theory in the future.

Several other implications for further research that were identified when discussing the limitations of the study include exploring the JTC theory in relation to differing sociodemographic populations and exploring the JTC theory in countries outside of the UK.

Finally the JTC theory has not yet been formally tested for future research is now need to test out the JTC theory and the relationships between the categories within the theory.

This could be done for example through semi-structured interviews with pregnant participants to test out how the JTC theory relates to their perception of confidence for birth during pregnancy. Testing the JTC theory will then help to develop evidence based interventions based on the JTC theory that can help to improve women's confidence for birth during pregnancy.

The ultimate aim of all future directions will be to use the JTC theory to inform interventions to improve women's confidence for birth, so that as many women as possible can have a more confident and positive birth experience.

6.12 Reflections on the PhD journey

Figure 44 presents a recent reflexive memo exploring the PhD process as a whole, including reflections on how the PhD is embedded within clinical practice, publication plans, the use of novel data collection methods, how grounded theory has facilitated creativity, and being a clinical academic.

To the best of my knowledge this PhD has been the first study to explore women's confidence for birth. The study findings aim to advance our understanding of the social process of being pregnant and the psychological process of how women feel about birth during pregnancy. Confidence for birth has developed into a much more complex concept than I had first imagined, and needs further exploration to fully understand this concept. However, I think that the large number of clinical suggestions and recommendations highlights that this has been a useful and relevant topic to explore for clinical practice. This project begins and ends with clinical practice and the 'Confident Birthing Workshops', with the study findings suggesting that they are indeed likely to increase women's confidence for birth.

Publications in relation to the study findings, using online discussion forum data and grounded theory, as well as completing a clinical academic doctorate, are now planned, and a HEE Wessex 'Clinical Academic Career Development' award was gained in January 2018 to help achieve the first stages of writing these publications.

Using the combination of online discussion forum data and interviews has been fairly novel and new within midwifery research. This has presented some challenges such as the length of time required to explore the best and most ethical ways to collect data from the online discussion forum.

Due to the emergent process of the PhD research and the complex nature of confidence as a psychological concept, the project has at times felt quite messy, requiring a systematic approach to data collection and analysis. This is partly why the grounded theory process chapter felt so important to include within this PhD to demonstrate the messy and yet systematic process of data collection and analysis.

Completing this PhD has also encouraged me to think creatively and flexibly. Just as the model has identified that it is important not to have too rigid expectations for giving birth, the same has applied for me conducting this PhD. I have had to adjust the design of the PhD on several occasions, including changing the recruitment strategy and having to change my approach to using the data sources. It has also been essential to be flexible in order to allow the emergent process of grounded theory to develop.

On the whole, completing a clinical academic doctoral fellowship has felt like quite an indulgent experience. I have been able to have 3 days per week of academic time while working clinically. This has allowed me to advance my knowledge of research and academic enquiry, not only by completing my service evaluation and grounded theory project but also by having the time to be able to attend local, national and international symposiums, seminars and conferences. The fellowship has provided me with a sense of having a good general understanding of academia that I think would have been very challenging to achieve if I had been working full-time clinically and

completing the PhD in my spare time. I am therefore very grateful to Wessex Health Education England for providing me with this opportunity, and I hope to be able to pursue a clinical academic career in the future.

Figure 4: Reflections on the PhD process

6.13 Final conclusions

This study set out to develop a theoretical understanding of what influences women's confidence for birth during pregnancy. A constructivist grounded theory approach was used to conduct this research, collecting data from 25 interviews with women who were pregnant or had recently given birth in addition to analysing data from 270 online discussion forum posts. A substantive theory and grounded theory model of 'journeying through confidence' was developed from this data, which identified five categories as influencing women's confidence for birth during pregnancy. The pivotal category was 'gathering and seeking information while journeying through pregnancy', which is embedded into the other four categories of 'relationship with pregnancy and baby', 'preparing', 'communicating', and 'evaluating previous experiences'.

This is the first study to have explored women's confidence for birth as a psychological concept. As a result, many clinical recommendations have been suggested to try and improve women's confidence for birth and in turn their pregnancy experience. Further work is now needed to explore women's confidence for birth during labour and the postnatal period. My identity as a clinical academic has been integral to shaping this PhD and I hope to continue working as a clinical academic in the future in order to be able to advance this future research and ultimately improve maternity services so that women can have a more confident experience.

List of Appendices

Appendix A Service evaluation of Confident Birthing Workshops

NHS Trust Logo

Confident Birthing Service Evaluation[1]

Thank you for coming to Confident Birthing. This is a new course being run by [redacted] NHS Trust.

I am a midwife and PhD student. I will be exploring people's views and the usefulness of Confident Birthing. Before I begin the research I am carrying out a short questionnaire to find out how you found Confident Birthing.

If you would like to take part in the evaluation, please complete this form at the end of the workshop. Your feedback will be kept safely and used anonymously.

Yours Sincerely

Emily Young

Clinical Academic Doctoral Fellow

Faculty of Health Sciences

Evy1g10@soton.ac.uk

[1] Information such as the NHS Trust name has been redacted from this document to maintain confidentiality and anonymity of service evaluation participants

1. How did you hear about Confident Birthing? (Please tick)

Midwife		GP		Poster		Other (please describe)
Friend/Relative		Obstetrician		Internet		

2. Is this you're...? (Please circle)

First baby Second baby Third baby Fourth baby Fifth + baby

3. Why did you come to Confident Birthing?

4. Did you come with somebody to support you? (Please tick) Yes ☐ No ☐

5a. How would you rate Confident Birthing? (Please circle)

Poor Fair Good Excellent

5b. Why have you given this rating?

6. What did you like about the course?

7. How could the course be improved?

8. *Before* the course, how did you feel about...? (Please circle)

a. Labour

b. Birth

9. *After* the course, how did you feel about…? (Please circle)

a. **Labour**

Why have you given this rating?

b. **Birth**

Why have you given this rating?

10. **How old are you? (Please circle)**

20 or younger	21-25	26-30	31-35	36- 40	41-45	46 +

11. **How would you describe your ethnic group? (Please circle)**

White	Mixed group	Black or Black British	Asian or Asian British	Other (please describe)

Thank you for completing the evaluation, please feel free to use the blank space below to add any additional comments

Coding framework for 'Why did you attend the workshop?'			
No.	**Code**	**Examples of code**	**Count**
1	Gain confidence for birth	'to gain/build confidence for labour/birth'	
2	Feeling anxious about labour/birth	'feeling scared of giving birth' 'to help with my anxiety about labour' 'I'm very nervous about the birth' 'to remove fears of childbirth'	
3	Enhance relaxation for labour/birth	'to have a calmer birth' 'to learn some relaxation techniques' 'to be more relaxed about birth' 'to stay calm and positive throughout labour'	
4	Optimise birth experience	'to have a good birth experience' 'to make the experience as enjoyable as possible' 'to enable me to feel more in control this time' 'to make my labour easier'	
5	The course was recommended	'suggested by my midwife' 'recommended highly by a friend'	
6	Techniques to help with labour/birth	'to learn skills/ideas to feel more in control this time' 'to find out more about relaxation techniques' 'to learn techniques to help with birth'	
7	Prepare for labour/birth	'to know what to expect during labour' 'to learn from a positive source about the process of labour and birth' 'to gain as much knowledge about birth as possible'	

Appendix B Example of coding framework for Confident Birthing service evaluation

Appendix C Evaluation of databases used in scoping review

Database	Description	Uses	Strengths	Limitations
CINAHL	Produced by National Library of Medline in the United States.	Background research. + One relevant articles found.	Indexes a large volume of journals (3,900). Updated daily	Duplicate articles with MEDLINE and PsycInfo. Focused on USA articles.
MEDLINE	A leading health and medicine database, covering literature from around the world since 1950	Background research. + Some relevant articles found.	Has access to over 13 million records. Can search using 'medical subject headings'. International research is relevant for this project.	Duplicate articles with CINAL and PsycInfo. Difficulty in gaining full text access to some articles.
PsycInfo	Main database for searching the literature of psychology, social behaviour and psychiatry	Background research. + Some relevant articles found.	Includes references as far back as 1806. Includes books, chapters and dissertations	Duplicate articles with MEDLINE and CINAL. Not many midwifery focused articles.
Web of Science	A section from Web of Knowledge. Provides current and retrospective studies from 8,700 journals.	Background research.	International + Uses prestigiou s journals	Difficulty in gaining full text access to some articles.

Appendix D Amalgamation of critiquing tools used for scoping review

The amalgamation of Parahoo K (1997) and Caldwell K, Henshaw L & Taylor G (2011) Models of Critiquing	
Feature of research	**Critique**
Title	Does the title convey the study clearly and accurately?
Author(s)	Are the Authors credible?
Abstract	Does the abstract give a short and concise summary of the following aspects of the study? Background, aim, designs, results, conclusions
Literature review	Is the literature review comprehensive and up-to-date? Is the importance of the study justified? Does the literature review highlight gaps in knowledge which this study seeks to fill?
Aim/Hypothesis	Is the aim of the research clearly stated?
Ethical Issues	Was ethical approval obtained? Are there any other ethical implications?
Philosophical background/study design	Is the methodology identified and justified? Quantitative: Is the study design clearly identified and is the rationale for choice of design evident? Qualitative: Are the philosophical background and study design identified and the rational for choice of design evident? Is this design the most appropriate for the aims of the study?
Population and Sampling	Quantitative: Is the population identified? Is the sample adequately described and reflective of the population? Was there a sample size calculation? Qualitative: Is the selection of participants described and sampling method identified?

Appendix D

Feature of research	**Critique**
Data collection	What are the methods of data collection? Who collected data? Can this introduce bias in the study? Quantitative: Is the method of data collection valid and reliable? Are the methods of data collection constructed for the purpose of the study or do the researchers use existing ones? Qualitative: Is the method of data collection auditable?
Data analysis	Quantitative: Is the method of data collection valid and reliable? Was there a separate section in the paper that explained the planned analyses prior to the presentation of the results? Which statistical methods were relied on? Is it clear how the statistical tests were applied to the data and groups? Qualitative: Is the method of data analysis credible and confirmable?
Results	Are the results presented in a way that is appropriate and clear? Are the results for all the aims presented? Quantitative: Are the results generalizable? Qualitative: Are the results transferable?
Discussion	Is there a balanced discussion? Has all the possible explanations for the results been given? Are the results discussed in the context of previous research? Are the limitations of the study discussed?
Conclusion	Are the conclusions justified? Are there recommendations for policy, practice or further research? Are the results/conclusions helpful for my practice? Are the results generalizable/ transferable?

Appendix E Table of papers included in the scoping review in chapter two

Keys:

Expectations of birth
Childbirth self-efficacy
Fear of birth
Confidence for a physiological birth

Study	Country	Study aims	Methodology/design	Population & sample	Data collection	Key Findings	Limitations
Expectations of birth							
Ayres and Pickering (2005)	England	To examine the relationship during pregnancy between birth expectations and a) symptoms of anxiety, b) subsequent birth experience and the effect on parity and expectations	Prospective questionnaire study	289 women at 36 weeks pregnancy and one week after birth	Questionnaire with measures of expectations of birth and trait and state anxiety at 36 weeks pregnancy and then questionnaire about birth experience one week after birth	Anxiety in pregnancy was associated with expecting less positive emotion during birth, more negative emotion during birth, less control and support during birth. Expectations were positively related to birth experience. Some aspects of women's experience was significantly different to their expectations and differences noted between nulliparous and multiparous women.	Relatively small sample size, given the response rates and separation by parity, therefore increased chance of a type 2 error

Boulton & Malacrida (2014)	Canada	To ask women about their reasons form preferring a particular type of birth, and about their intentions, expectations and actual experience of birth	Qualitative narrative study using a feminist perspective	22 mothers who had given birth within the last three years	Semi-structured narrative interviews	The women's narratives revealed a disjuncture between their expectations of choosing, planning and achieving as natural a birth as possible, and their lived experiences of births that did not typically go to plan. Their narratives also counter assumptions that women, as ideal patient consumers, are driving medicalization.	Sample size is suitable for the in-depth methodology used however further research is needed to be able to transfer these findings to the wider pregnant population
Chattopadhyay et al. (2008)	India	To assess maternal expectations regarding labour and delivery	Quantitative	205 women (the majority were nulliparous) attending an antenatal visit in a charitable non-governmental hospital in India	Structured interviews based on a questionnaire about birth expectations using a five point likert scale to measure level of agreement with statements	Expectation of labour pain was very common and the majority were ready to tolerate it as a natural phenomenon. Nearly a quarter of participants considered a caesarean as a way to avoid labour pain and (99%) perceived a caesarean as being safer for the baby.	Limited to one hospital in India. Possibility of selection bias as participants not chosen at random. Free epidural offered as an incentive for participation, not sure how ethical this is.

Christiatiaens et al. (2008)	Belgium and The Netherlands	To compare the childbirth expectations and experiences of four groups of women: Belgian and Dutch women with a hospital and home birth	Quantitative comparative study, using a linear mixed model	611 women	Two questionnaires were completed, one at 30 weeks pregnancy and one within the first two weeks after birth. W-DEQ	Dutch women have more negative expectations and experiences compared to Belgium women. Women who had a home birth had only slightly more optimistic expectations compared to women who had a hospital birth, but they rated their experiences as more positive.	Completing the postnatal questionnaires so soon after delivery may have meant that women appraised their experience less critically than if they had answered later on. Lack of information about non-respondents may conceal a selection bias.

D'Cruz and Lee (2014)	Australia	To investigate young childless Australian women's stated preferences for future delivery mode and birth attendant	Quantitative	334 single, childless women aged 18–25	Online survey, measures included childbirth preferences, general anxiety and depression scale, childbirth self-efficacy scale, W-DEQ, life satisfaction scale, demographics	Most women expected that they would prefer a vaginal birth and obstetric-led care. Multiple regression showed preference for caesarean birth to be associated with low childbirth self-efficacy, and preference for an obstetrician with childbirth fear and general anxiety. Women referenced fear of birth as a reason for caesarean and 'naturalness' for vaginal birth; and technical expertise for obstetrician-led care and emotional support for midwife-led care.	The study was advertised under the title of 'Childbirth Intentions' which may have elicited a group of participants with a particular interest in childbirth. Strong medicalisation of childbirth in Australia makes limited generalisability to UK maternity care setting and may have affected the results.

Fair and Morrison (2012)	USA	To explore the relationship between perceptions of prenatal control, expectations of childbirth and experienced control in labour	Repeated measures exploratory study	31 primiparous women between 26 and 40 weeks pregnant	Standardised interviews conducted prior to birth to assess levels of prenatal control and expectations for control during birth. Six weeks after birth women were interviewed again to assess experiences.	Experienced control appeared to be a significant predictor of birth satisfaction, with high levels of control correlating with high satisfaction levels. However no correlation was found between birth expectations and birth satisfaction.	Relatively small sample size. All participants were from the same geographic location and attended the same OBGYN practise. All participants were primiparous.
Flykt et al (2014)	Finland	To examine the underlying mechanisms for mothers' and fathers' violated expectations of autonomy and intimacy with the child	Quantitative	743 couples	Couples separately filled in questionnaires concerning their prenatal expectations and two month postnatal representations of intimacy and autonomy with child and Subjective Family Picture Test.	Among mothers the associations with parent-related, delivery-related and infant-related problems were mostly indirect and mediated visa mental health problems. Among fathers, the associations were direct, marital problems. Difference between parity and assisted reproductive treatment versus spontaneous conception.	

Green et al. (1998)	England	To study women's expectations and experiences of childbirth	Quantitative, prospective design	852 women recruited during third trimester of pregnancy	Three self-completed questionnaires (two in pregnancy, one postnatally) including demographic information, women's expectations labour/birth	Most women felt that birth should be a fulfilling experience for them and most women expected this to be so. Experiences of pain in labour were strongly linked to women's expectations of this aspect, and women who were very anxious about pain exhibited less satisfaction with their experience.	*
Gibson (2014)	USA	To determine the differences in the preparation for and experiences with labour pain by women choosing midwives versus obstetricians	Qualitative	80 women (40 had chosen an obstetrician and 40 had chosen a midwife)	Prenatal and postnatal in-depth semi-structured interviews	Women in both groups were concerned with the pain of childbirth before and after their labour experiences. Women choosing midwives discussed preparing for pain through various non-pharmaceutical coping methods, while women choosing physicians discussed pharmaceutical and non-pharmaceutical pain relief.	Very different healthcare system to UK. No discussion about methodological approach used for this study. All women appear to be from same practitioners in Florida.

Melender (2006)	Finland	To describe pregnant Finnish women's perceptions of a good childbirth.	Qualitative	24 pregnant women (half of whom were expecting their first child)	Semi-structured interviews	Five main issues were seen by informants as important in the course of childbirth: 1) unhurried atmosphere, 2) normality, 3) reasonable duration of labor, 4) security, and 5) control.	Small sample size in one cultural setting, however a combination of both primiparous and multiparous women were included in the sample.

Hauck et al. (2007)	Australia	To explore and describe the influence of childbirth expectations on women's perception of their birthing experience and expectations for subsequent birth	Qualitative, exploratory, descriptive design	20 women, 11 primiparous nine multiparous who between them had experienced 31 births.	In-depth individual interviews in two phases: women were pregnant or had birthed in the last 12 months for phase one and then phase two was five/six months after phase one.	The themes in phase one were supported by the themes in phase two. Although women had multiple expectations of birth, specific expectations were regarded as priority. Consequently to perceive a birth as positive, a woman had to achieve her priority expectations. Multiparous women reported more positive birth experiences, having altered their expectations as a result of previous experiences. Women with unfulfilled expectations subsequently adapted their expectations to be more achievable and avoid disappointment.	Different health care system to UK, with most of the sample having private healthcare and the obstetrician or obstetrician and midwife being the most common staff present at birth of sample. Much larger sample size in phase one than in phase two.

Hildingsson (2015)	Sweden	To describe pregnant women's expectations of birth and to investigate if these expectations were fulfilled	Quantitative, prospective regional cohort study (longitudinal)	1042 Swedish-speaking women	Questionnaire about birth expectations in late pregnancy and were followed up with two months after birth	Certain background characteristics were associated with expectations as well as experiences. Statistically significant differences were shown between expectations and experiences in support from midwife, support from partner and midwife's presence. Experiences 'worse than expected' regarding decision making and control were associated with a less positive birth experience.	Only conducted in one region in Sweden. The observational design and large dropout rates between late pregnancy and birth may have affected the findings.

Ledford et al. (2016)	USA	To draw connections between provider communication, childbirth expectations and birth experience appraisals	Qualitative, Grounded theory	36 women that had given birth recently	Grounded theory interviews	Mothers recognize providers' use of patient-centred communication in messages of empowerment, emotional support, explanation, decision-making and elicitation. Findings posit that it is the inflexibility or flexibility of expectations that may determine mothers' appraisals of the experience.	Sample only from one community hospital and very different healthcare system to UK, makes transferability of findings to UK setting limited.
Malacrida and Boulton (2013)	Canada	To understand how informed choice, consumer ideologies and medical influences interacted with women's birth 'decisions' prior to and during birth	Qualitative, Feminist Narrative	22 women that had given birth in the last 3 years	Semi-structured narrative interviews	Women found a disjuncture between their expectations of choosing, planning and achieving as natural a birth as possible and their lived experience of births that did not typically go to plan	Limited transferability of results due to very different maternity care system in Canada. No discussion of limitations of study or demographics of participants.

Martin et al (2013)	USA	To explore the childbirth expectations and sources of information of first time mothers	Qualitative, phenomenological approach	Seven nulliparous women of moderate to low income	Individual in-depth interviews	All participants expected a vaginal birth and had a general sense of the roles of nurses and doctors. All women expected or at least hoped for a healthy baby. No women attended antenatal classes but were able to list multiple sources as forming their expectations, such as, written material, friends and family etc.	Small sample size and very different healthcare system to UK makes generalisability limited.
Moore (2016)		To explore the expectations around birth that are held by women from different cultures	Literature review		SCOPUS, PubMed, CINAHL, Medline, grey literature, ProQuest, Sigma Theta Tau International database	Expectations in childbirth included expectations of one's own behaviour, such as personal control, expectations of support from partner/family/others, expectations of care/behaviour from providers, expectations about the health of the baby and expectations about pain in childbirth	Lack of clear audit trail of systematic searching and refining the literature. Existing tools needed to be translated and validated in different cultures.

Self-efficacy							
Study	Country	Study aims	Methodology/ design	Population & sample	Data collection	Key Findings	Limitations
Abbasi et al (2018)	Iran	To compare the effect of e-learning and educational booklet on the childbirth self-efficacy	RCT	153 pregnant women	The CBSE questionnaire was filled out by the participants before intervention and active phase of labor at 4–5 cm dilatation of cervix.	After the intervention, the mean score of the CBSE in the educational booklet group and e-learning group was significantly higher than the control group. Also, the mean score of the CBSE in the e-learning group had a significant increase compared to the educational booklet group	Study was conducted in Iran which is a very different setting and healthcare setting to the UK and therefore generalisability of the findings are limited to UK
Beebe et al. (2007)	California	To describe levels of anxiety and self-efficacy for childbirth in nulliparous women during the third trimester	Quantitative, Longitudinal descriptive study	35 nulliparous women	Questionnaire during third trimester of pregnancy, pain questionnaire during labour and semi-structured interviews after birth	Prenatal anxiety was significantly related to self-efficacy for birth in late pregnancy, labour pain, number of hours at home in labour and admitting cervical dilation.	Small sample size of women representing a limited range of demographic distribution.

Berentson-Shaw et al (2009)	New Zealand	To determine whether self-efficacy beliefs predict the primiparous labour and birth experience	Longitudinal observational study	230 primiparous pregnant women	Childbirth self-efficacy inventory and cognitive and behavioural constructs at 15 and 35 weeks gestation and then four postpartum measures	Hierarchical multiple regressions indicated that stronger birth self-efficacy beliefs predicted decreased pain and distress in labour. But not pain tolerance. Also, stronger self-efficacy predicted increased birth satisfaction	The effect sizes found in the study were small, creation of composite measures can result in loss in ability to examine and predict childbirth outcomes with precision. Postnatal assessments of labour pain may not accurately reflect measure. Risk of the 'halo effect' surge of positive feelings after birth, altering subjective measure of experience
Byrne et al. (2014)	Australia	To test the feasibility and effectiveness of using a Mindfulness-Based Childbirth Education	Single-arm pilot, repeated measures	12 women	CBSEI inventory	Statistically significant improvements and large effect sizes were observed for childbirth self-efficacy and fear of birth. Improvements for birth outcome expectancies were underpowered.	Very small sample size, lack of a control group.

Carlsson et al (2015)	Sweden	The study aimed to examine how women's childbirth self-efficacy beliefs relate to aspects of well-being during the third trimester of pregnancy and whether there was any association between childbirth self-efficacy and obstetric factors	Cross-sectional design	406 pregnant women recruited at between 35-42 weeks of pregnancy	Composite questionnaires using five different measures, antenatal and birth records	Childbirth self-efficacy was correlated with positive dimensions as vigour, sense of coherence and maternal support and negatively correlated with previous mental illness, negative mood states and fear of childbirth. Women who reported high childbirth self-efficacy had less epidural analgesia during childbirth compared to women with low self-efficacy	Cross-sectional design therefore cannot explain the direction of association found. The sample is only from one part in Sweden. Almost all the women were living with a partner whom they also rated as supportive which may have influenced the findings
Christiaens and Bracke (2007)	Belgium and The Netherlands	To examine multiple determinates and self-efficacy for their association with satisfaction with childbirth in a cross-national study	Longitudinal descriptive	560 women	Mastery, questionnaire completed at 30 weeks pregnant and then two weeks post birth	Women with high self-efficacy showed more satisfaction with self, midwife and physician aspects of the birth experience	Timing of measurement of satisfaction with childbirth. Comparably of the Dutch and Belgian sample can be questioned.

Dilks and Beal (1997)	USA	To investigate whether a relationship exists between the concept of self-efficacy and delivery choice.	Descriptive cross-sectional	74 pregnant women	CBSEI inventory	Women choosing an elective repeat caesarean delivery had lower self-efficacy scores on the instrument.	A nonprobability and homogenous sample limit generalisability of findings.
Gau et al. (2011)	Taiwan	To examine the effectiveness of a birth ball exercise programme during childbirth by measuring childbirth self-efficacy and childbirth pain	Randomised control trial	87 women 48 to intervention group and 39 to control group (188 were initially recruited but only 87 completed)	When cervical dilation was 4cm and 8cm the women completed demographic and obstetric information, childbirth self-efficacy inventory and short McGill pain questionnaire	The birth ball exercises provided statistically significant improvements in childbirth self-efficacy and pain. Specifically self-efficacy had a 30-40% mediating effect on relationships between birth ball exercises and childbirth pain.	Small sample size due to high dropout level, mainly due to emergency caesarean, epidural or preterm labour, as a result balance of randomisation was also lost so it is possible that unmeasured confounding factors may influence the results

Goutaudier et al.(2012)	France	To assess the contribution of negative emotions, childbirth pain, perinatal dissociation and feelings of self-efficacy to development of PTSD symptoms following birth	Prospective longitudinal	98 women	CBSEI inventory	Pain and negative emotions were significant predictors of the intensity of posttraumatic stress symptoms at 6 weeks postpartum. The effect of PTSD is strongest when there is a high level of negative emotions.	The sample is not large enough to take account obstetrical and individual variables that might play a part in the development of PTSD symptoms. Women completed the questionnaires in the first days following childbirth while they were still coping with emotional distress.
Hui Choi et al. (2012)	China	To report a study of the relations of prenatal psychological adaptation, social support, uncertainty and self-efficacy	Cross-sectional, descriptive	550 women during late pregnancy	Locus of control	The four explanatory variable of the psychological adaptation were social support, uncertainty, self-efficacy and commitment to pregnancy. In the established model, which had good fit indices, greater psychological adaptation was associated with higher social support, higher self-efficacy, higher commitment to pregnancy and lower uncertainty.	Limited generalisability to Western setting due to differences in health care system. Uncertainty needs further exploration with both low and high risk pregnancies.

Ip et al. (2009)	China	To test the effectiveness of an efficacy enhancing educational intervention to promote women's self-efficacy for childbirth and coping ability in reducing anxiety and pain during labour	Randomized control trail	Chinese first time pregnant women, 60 in experimental group and 73 in the control group	CBSEI inventory	The experimental group was significantly more likely than the control group to demonstrate higher levels of self-efficacy for childbirth, lower perceived anxiety and pain.	No inference can be made about women who did not attend the educational programme. The sample has limited generalisability as only taken from one regional hospital in Hong Kong. Ratings of pain and anxiety were retrospective.
Isbir et al (2016)	Turkey	To examine the effects of antenatal education on fear of birth, maternal self-efficacy and post-traumatic stress disorder symptoms following childbirth	Quasi-experimental study	90 pregnant women, 44 in the intervention group and 46 in the control group of normal antenatal care	Questionnaire using three measures	Compared to the control group women who attended antenatal education had greater childbirth self-efficacy, greater perceived support and control in birth and less fear of birth and post-traumatic stress disorder symptoms following childbirth	Sample limited to one city in Turkey. Participants were not randomly allocated to the intervention and control groups due to concerns about dropout rates.

Kennedy (2011)	USA	To test for differences in perinatal health behaviours, perinatal and infant health outcomes for women receiving group prenatal care	3-year randomized clinical trail	88 pregnant women in two military settings	CBSEI inventory	Women receiving group prenatal care were six times more likely to be receive adequate prenatal care than women in individual prenatal care and significantly more satisfied with their care	Unable to assess as only had access to abstract and not full text.
Larsen (2001)	USA	To examine the relation between expectancy ratings made after Lamaze training and the subsequent level of labour pain women experienced	Quantitative prospective study	37 nulliparous women	Self-reported pain ratings collected three times during labour- early, active and transitional with the help of labour partner	Self-efficacy expectancies for the early and active phases of the first stage of labour predicted approximately 20% of the variance in pain levels for these phases respectively. However there was no relationship between self-efficacy expectancies did not predict levels of transitional labour pain.	Limited information given on demographics makes it difficult to assess generalisability of findings.

Larsen & Plog (2012)	USA	To determine the effectiveness of childbirth classes for increasing self-efficacy on expectant women and support persons	Quasiexperimental	115 expectant women and 103 support persons prior to and immediately following classes	Proprietary	Childbirth self-efficacy significantly increased self-efficacy scores of both the women and the support person, Support persons had significantly higher self-efficacy scores after the childbirth class than the women. Type of class attended did not affect self-efficacy.	Limited generalisability by using a convenience sample in rural, Midwestern hospital. No information was available on those women and support persons attending childbirth class who chose not to participate in this study
Lowe (2000)	USA	To investigate the relationship between self-efficacy for labour and childbirth fears in health nulliparous women	Quantitative, secondary analysis	280 nulliparous women between 28-41 weeks of pregnancy	Multiple questionnaires	The women in the high fear group were characterized by significantly higher learned helplessness, chance health locus of control and powerful other locus of control and significantly lower self-esteem and generalized self-efficacy	Discussion of findings very centred around context of American obstetric care, difficult to generalise to UK setting due to such a different maternity care system

Rahimparvar et al. (2012)	Iran	Randomized control trail	To determine the effect pf educational software on self-efficacy of Iranian pregnant women to cope with labour	150 Iranian nulliparous women	CBSEI inventory completed 28-32 and 36-38 weeks by participants	After the intervention there was a significantly different mean and median CBSEI score. Also, statistically significant differences existed in the median of outcome expectancy and self-efficacy expectancy after intervention in both stages of labour between the two groups	Limited generalisability to Western setting due to very different healthcare system and educational childbirth classes not being the norm in Iran

Salamonsson et al. (2013) (a)	Sweden	To explore how childbirth self-efficacy i.e. outcome expectancy and efficacy expectancy was associated with fear of childbirth and how efficacy expectancy and fear of birth respectively were related to socio-demographic characteristics, mental problems and preference for caesarean sections	Quantitative, Cross sectional design	423 nulliparous pregnant women	Questionnaires using W-DEQ & CBSEI and information on demographic details, perceived mental health and preferred mode of delivery	Outcome expectancy and efficacy expectancy correlated significantly and positively, FOC correlated significantly and negatively with both outcome expectancy and efficacy expectancy. Women with severe FOC (20.8%) had a significantly lower level of education and had more often sought help because of mental problems. They were more likely to have low-efficacy expectancy and to prefer a caesarean section instead of a vaginal birth.	Sample only included nulliparous women. Low response rate to study.

Salamonsson et al. (2013) (b)	Sweden	To apply and test the concept of childbirth self-efficacy to expectations of the upcoming birth in the context of severe fear of childbirth (SFOC).	Qualitative	17 nulliparous women with severe fear of birth	Semi-structured interviews	Behaviours for coping with labour and childbirth were related to six domains of childbirth self-efficacy: concentration, support, control, motor/relaxation, self-encouragement, and breathing. Most of these behaviours referred to capabilities to carry out (self-efficacy expectancy) rather than to beliefs in effectiveness (outcome expectancy). Five additional subdomains representing defined childbirth self-efficacy were identified: guidance, the body controls, the professionals' control, reliance, and fatalism.	Only explores self-efficacy for nulliparous women with severe fear of birth, limiting transferability of findings.

Schwartz et al. (2015)	Australia	To identify socio-demographic, obstetric or psychological variables associated with childbirth self-efficacy and potentially highlight areas to improve women's childbirth experiences	Secondary analysis, cross-sectional descriptive	1410 women	CBSEI inventory	Self-efficacy was higher among multiparous women. Regardless of parity, women who reported low childbirth knowledge, who preferred a caesarean section and high W-DEQ and EPDS scores reported lower self-efficacy. Multiparous women who's partner was unsupportive were more likely to report low self-efficacy expectancy in both parity groups, as well as low outcome expectancy in nulliparous women only. Fear strongly correlated with low childbirth self-efficacy	

Sercekus and Baskale (2015)	Turkey	To examine the effects of antenatal education on fear of birth, maternal self-efficacy and maternal and paternal attachment	Quasi-experimental study	63 pregnant women and their husbands	Demographic data forms, the Wijma delivery expectations questionnaire, CBSEI inventory maternal attachment inventory and postnatal paternal-infant attachment questionnaire	Antenatal education was found to reduce the fear of childbirth and to increase childbirth related maternal self-efficacy. However antenatal education was found to have no effect on parental attachment	Groups were not assigned at random. Participants only from one region in Turkey
Sieber (2006)	Switzerland	To assess emotional well-being and predictors of birth anxiety, self-efficacy and psychological adaptation in health pregnant women	Longitudinal descriptive	61 pregnant women	CBSEI inventory	The result showed significant changes in emotional well-being, measured by birth anxiety, self-efficacy for labour and delivery psychological adaptation to pregnancy during the third trimester.	All participants visited childbirth classes and participants in the study were unusually well educated and their levels of anxiety were conspicuous and contrary to other study findings, meaning that these results may not be representative of the population

Slade (2000)	England	To assess whether attenders at classes actually used their taught strategies in their labours, whether use was associated with psychological benefits and whether antenatal measures could predict subsequent use.	Longitudinal descriptive	121 pregnant women	Proprietary	Whilst intentions did act as significant predictors for use of posture and relaxation only small proportions of the variance were accounted for and other antenatal measures showed little predictive capacity	Assessment of use of coping strategies was by self-report, limitations with methods of analysis
Soet (2003)	USA	To examine the prevalence and predictors of women's experience of psychological trauma during childbirth	Longitudinal descriptive	103 women form a childbirth education class	CBSEI inventory	The pain experienced during birth, levels of social support, self-efficacy, internal locus of control, trait anxiety and coping were significant predictors of the development of posttraumatic stress disorder symptoms after the birth	Relatively small sample limits the power to find less than moderate effects, information about birth was collected retrospectively over a wide time span, sample is not representative of the rest of that area in the USA.

Stockman and Altmaier (2001)	USA	To study the relationship of self-efficacy to reported labour pain and pain medication usage	Quantitative	43 pregnant women	Questionnaire containing five measures	Multiple regression analysis revealed that self-efficacy significantly contributed to predicating labour pain beyond other relevant variables with (e.g. age, amount of menstrual pain) with barrier self-efficacy the strongest predictor	Sample lacks representativeness as all participants were highly educated.
Sun (2010)	Taiwan	To evaluate a yoga programme provided to primigravidas in the third trimester of pregnancy	Non-randomised experimental study	88 primigravidas at 26-28 weeks, 43 in control group, 45 in experimental group	CBSEI inventory	Women who participated in the programme exhibited higher outcome and self-efficacy expectancies during the active and second stage of labour compared to the control group	Small sample size, of mainly middle-upper class Taiwanese pregnant women, limiting generalisability at one hospital. Potential contamination bias as it was not possible to conceal purpose of research.

Svenson (2009)	Australia	To determine whether a new antenatal education programme with increased parenting content could improve parenting outcomes for women compared with a regular education programme	Randomised control trial	170 women birthing at the hospital, 91 attended new programme, 79 attended regular programme	Self-reported surveys	The postnatal perceived maternal parenting self-efficacy scores of women who attended the new programme were significantly higher than those who attended the regular programme.	Limited generalisability of findings, need further research exploring adolescents, single women and women from minority ethnic cultures
Tilden et al (2016)		To synthesize and critique the quantitative literature on measuring childbirth self-efficacy and the effect of childbirth self-efficacy on perinatal outcomes	Systemic literature review	23 studies published between 1983 and 2015	Searching MEDLINE, CINAHL, Scopus and Google Scholar databases	Increased childbirth self-efficacy is associated with a wide variety of improved perinatal outcomes. Childbirth self-efficacy is a psychosocial factor that can be modified through various efficacy-enhancing interventions.	No inclusion of qualitative studies, focussed on context of childbirth in the United States of America

Williams (2008)	England and Wales	To investigate whether antenatal beliefs about pain management strategies predicted women's intentions to use analgesia during birth	Longitudinal descriptive	100 women in 3rd trimester	Questionnaire, CBSEI inventory	Pharmacological belief assessed by self-efficacy theory did not significantly enhance the prediction of intentions to use any of the medications	Other factors may influence actual behaviour. The use of a self-selected sample may limit generalisability.

Fear of birth							
Study	Country	Study aims	Methodology/design	Population & sample	Data collection	Key Findings	Limitations
Alehagen et al. (2005)	Sweden	To investigate the course of fear, pain and stress hormones during labour	Experimental design	147 nulliparous pregnant women	Urine and saliva samples were collected one day during weeks 37-39 and hourly during labour to measure catecholamines and cortisol and questionnaires used.	The course of fear, pain and stress hormones differed throughout labour in women with and without epidural analgesia. Women who had the epidural had more fear but not more pain before the epidural. Fear and pain correlated.	50% participation rate in study could result in sampling bias. Risk of doula effect with research midwife being in contact with women hourly.
des Rivieres-Pigeon	Canada	To investigate whether asking women questions about their daily life constituted a useful strategy to detect women at risk of developing psychological distress after birth	Prospective study	330 first and second time mothers	Structured interviews 1-2 days after birth and then postal questionnaires 5 months after birth	The interviewers perception of women's mood was significantly associated with the score on the general health questionnaire scale 5 months later. Interviewers perception of mood was a better predictor of psychological distress 5 months later than women's answers to questions about their mood before pregnancy and 1-2 days after birth	Based on secondary analysis of data that was not initially derived to evaluate possible detection of women at risk of further depressive disorder and so did not include validated measure of mental ealth at time of interview.

Fairbrother et al. (2017)	Canada	To further refine our understanding of the various aspects of childbirth fear and assess the construct validity of the CFQ	Cross-sectional study	643 pregnant women	Set of questionnaires, including CFQ and online survey	Gestational age was largely unrelated to fear of birth. Age, income and education were negatively related with fear of birth. Assisted vaginal delivery and episiotomy in previous pregnancy were positively associated with fear of pain.	First study investigating the CFQ and so requires further investigation and calibration
Fenwick et al. (2009)	Australia	To investigate pre and postpartum levels of childbirth fear in a cohort of childbearing women and explore the relationship between birth outcomes	Prospective correlation design	401 pregnant women	Questionnaires including the W-DEQ questionnaire	26% pregnant women report low levels of childbirth fear, 48% were moderately fearful and 26% highly fearful. Surgical intervention and suspected foetal compromise increased levels of postpartum fear of birth	Response rate was 43% which may result in sampling bias reducing generalisability of results.

Geissbuehler & Eberhard (2002)	Switzerland	To examine the intensity and type of childbirth fears among pregnant women in their second or third trimester	Questionnaire study	8000 pregnant women	Postal questionnaires	The most frequent fears mentioned were fear for the child's health (50%) and fear of pain (40%) and fears relating to medical interventions (12%).	Data was collected between 1991-1999 so some data is 27 years old and therefore may lack generalisability to modern day maternity care, given the advances in maternity care in the last 27 years.
Hamama-Raz et al. (2016)	Israel	To investigate the correlation of both intrapersonal factors and interpersonal factors with fear of birth	Quantitative, cross sectional survey, multiple regression analysis	529 women (365 parous women and 173 nulliparous women)	Online survey	For parous women age and intrapersonal factors were significantly associated with fear of birth, namely attitude towards pregnancy and birth, body image and delivery preference. For nulliparous women only intrapersonal factors were associated with fear of birth, namely attitudes towards pregnancy and birth, delivery preference for caesarean.	Online survey has the limitations of a convenience sample with regards to representativeness. Cross sectional design cannot detect shifting in the measured variables as with a longitudinal design.

Haapio et al. (2017)	Finland	To evaluate how extended childbirth education intervention affects first-time mothers' fear of childbirth and its manifestation during pregnancy	RCT	659 first time mothers	Questionnaires	The mothers in the intervention group had less childbirth-related fear than those in the control group. Also fear influenced the mothers in the intervention group less in everyday life that it did the mothers in the control group.	In longitudinal studies possible for confounding factors to arise as a baseline. Participants also had a higher educational status than the average population which limits generalisability for the rets of the population.
Heimstad et al. (2006)	Norway	To assess the prevalence of fear of childbirth and to find possible associations to selected sociodemographic factors	Questionnaire study	1452 pregnant women	Questionnaires, including W-DEQ and STAI	The prevalence of serious fear of birth was 5.5%. The W-DEQ and STAI were positively correlated. Among anxious women a trend towards operative vaginal delivery was noted but not for emergency caesarean.	The estimates may be influenced by selection bias as there was a relatively large non response rate which may result in conservative estimates

Henderson and Redshaw (2015)	England	To examine the associations between young maternal age, worries about labour and birth and postnatal maternal outcomes	Secondary analysis on data collected from a large survey of women's experiences of maternity care	2598 primiparous women who had given birth three months ago (national sample)	A questionnaire about care in the antenatal, intrapartum and postnatal periods, sociodemographic factors and the validated Oxford Worries about Labour Scale	Compared with women aged 21 or more, women aged 20 years or younger worried more about labour and birth. The pain and duration of labour worried all women and those age 20 years or younger were particularly worried about the uncertainty of labour onset, caesarean birth and about embarrassment. However younger age was associated with having a higher likelihood of a normal vaginal birth.	Cross-sectional nature of design, with women having to recall events three months postpartum. Lower response rate from more disadvantaged groups.
Kjaergaard et al. (2008)	Sweden and Denmark	To compare fear of birth among Danish and Swedish nulliparous women	Quantitative cross-national comparison of two distinct studies	165 nulliparous women (55 Swedes and 110 Danes)	Self-completed questionnaire at 37 weeks pregnancy, W-DEQ questionnaire	Severe fear of birth was 10%, there were no differences between the Swedish women and the Danish women who had or had not met the midwife. Fear of birth measured at 37 weeks correlated positively with fear at admission to the labour ward.	Twice number of participants in Danish study, may be some cohort effect as data collected 1996 (Sweden) and 2004-2005 (Denmark).

Kavanagh et al. (2004)	Australia	To investigate whether increasing partner's understanding of motherhood affects postnatal distress and depression in first time mothers	RCT	268 couples expecting their first child, who were in late second or early third trimester of pregnancy	Several questionnaires	A single session to increase partners understanding of motherhood significantly reduces postnatal distress and depression in first time mothers with low self-esteem.	The findings likely do not generalise to multiparous women, women who are not living with a partner and couples who did not attend parent education classes
Larkin et al. (2007)	International	To identify the core attributes of the experience of labour and birth	Literature review and concept analysis	62 papers	Thematic analysis of a random sample of 62 papers identified in literature search	Despite agreement about the significance of the childbirth experience there is little consensus on a conceptual definition. Four main attributes of the experience were described as individual, complex process and life event.	A random sample of the papers has been review rathe than all of the papers that have been identified, therefore some important papers may have been missed in the analysis.

Laursen et al. (2009)	Danish	To examine the associations between fear of childbirth and emergency caesarean and between fear of birth and dystocia of fetal distress	Prospective cohort study	25,297 health nulliparous women in spontaneous labour with uncomplicated pregnancy	Data were collected from computer assisted telephone interviews twice in pregnancy with national health registers	Fear of birth in early and late pregnancy was associated with emergency caesarean section. Fear of birth also increased risk of dystocia or protracted labour but not foetal distress.	Fear of birth was measured from answers to. A single question which did not take into account different .aspects of fear
Leeners et al (2016)	Germany	To investigate whether childhood sexual abuse influences labour experiences when adjusted for clinical covariates	Quantitative, retrospective design	85 women with a history of CSA and 191 controls	Self-reported questionnaire and obstetric data	Compared to controls, women with CSA reported intense fear of delivery considerably more frequently.	Retrospective design of study which may result in recall bias.
Lukasse et al. (2010)	Norway	To examine the association between a self-reported history of childhood abuse and fear of childbirth	Cross-section study	2365 pregnant women	Questionnaire, including W-DEQ questionnaire	Of all women, 566 (23.9%) had experienced any childhood abuse, 10.9% had experienced emotional abuse, 11% physical abuse and 12.3% sexual abuse	There was a poor response rate to the questionnaire which could result in selection bias.

Melender (2002)	Finland	To describe women's objects, causes and manifestations and to identify factors associated with the fears during pregnancy and childbirth	Questionnaire study	329 pregnant women	Questionnaire	78% of participants expressed fears relating to pregnancy/birth or both. Causes of fear were negative mood, negative birth stories told by others, alarming information, diseases and child-related problems. For multiparous women cause included previous negative experiences of pregnancy or birth.	The questionnaire was a new questionnaire that has only been used from this study limiting comparison of findings and only conducted in Finland so generalisability of findings to wider population
MoghaddamHosseine et al. (2017)	International	To examine effective interventions for reducing fear of childbirth	Systematic review and meta-analysis of clinical trials	Ten studies including 3984 participants	Systematic review of 8 RCTs and 2 quasi-RCTs	Educational interventions and hypnosis were effective in reducing fear of birth however educational intervention may reduce fear of birth with double the effect of hypnosis	For some of the studies the relevant data were not available, not all of the studies used consistent measure of fear.
Montgomery et al. (2014)	UK	To inform practice by exploring the impact that childhood sexual abuse has on the maternity care experiences of adult women	Narrative study from a feminist perspective	Nine women	In-depth narrative interviews	The main themes identified were women's narratives of self, women's narratives of relationship, women's narratives of context and the childbirth journey. The concept of silence linked all these themes and aspects of the study relating to it are reported here.	Small sample size limits generalisability to the rest of the population

Neiman et al. (2009)	Sweden	To investigate Swedish women's levels of antenatal fear of childbirth at various gestational ages and factors associated with intense fear and preference for caesarean	Cross-sectional study	1635 pregnant women	Questionnaires, including the W-DEQ questionnaire	The prevalence for intense fear of childbirth was 15.8% and very intense fear (tokophobia) 5.7%. Nulliparous women had a higher mean score than multiparous women. Level of fear of birth was not associated with gestational age. Preference for caesarean was associated with fear of birth, previous caesarean and instrument vaginal birth.	The study was not representative of the whole country and women who knew they were having a caesarean for medical reason may have had difficulty with completing the W-DEQ questionnaire.
Nilsson & Lundgren (2007)	Sweden	To describe women's lived experience of fear of childbirth	Qualitative study using a phenomenological approach	Eight pregnant women 24-37 weeks pregnant seeking help within an outpatient clinic for women with severe fear of childbirth	In-depth interviews	Four constituents were identified: feeling of danger that threatens and appeals; feeling trapped; feeling like an inferior mother-to-be and on your own.	The study was undertaken using a small group of women and so cannot claim to represent all women with severe fear of childbirth in Sweden or other countries

Nilsson et al. (2010)	Sweden	To describe the meaning of the lived experiences of childbirth in pregnant women who have exhibited fear of childbirth as such it has an impact on their daily lives	Qualitative, phenomenological	Nine women who had intense fear of birth and were pregnant with their second child	Interviews	Women described a sense of not being present and an incomplete childbirth experience; not being physically able to/ allowed to participate in birth; feeling things “just happened” to their body; losing or being refused control; connection with body not always obvious; experiencing their bodies as non-functional/incapable of giving birth; lack of support from midwives	Selected only women that had a previous negative birth experience with little justification for this.
Nilsson et al. (2012)	Sweden	To explore fear of childbirth during pregnancy and one year after birth and its association to birth experience and mode of delivery	Quantitative, longitudinal	763 women	Four questionnaires: two in pregnancy and two after birth	Fear of birth during pregnancy in multiparous women was associated with a previous negative birth experience and a previous emergency caesarean section. Associated factors for fear of birth one year after birth were: negative birth experience, fear of birth during pregnancy, emergency caesarean section and primiparity.	Observational study and so can only describe associations between variables. Conducted in a specific region of Sweden making it difficult to generalise findings. Measurement of fear of birth is limited as there is little consensus about definition.

Poikkeus et al (2006)	Finland	To compare the prevalence and predictor factors of severe fear of childbirth and pregnancy-related anxiety in groups of assisted reproductive treatment and spontaneously conceived women	Prospective and longitudinal controlled study	367 ART women and 379 spontaneous pregnancy	Questionnaires, including the FOC questionnaire	The frequency of severe fear of childbirth and anxiety did not differ between the groups	Sample size was not sufficient to detect relatively small differences in prevalence of fear of birth and pregnancy related anxiety.
Rouhe et al (2008)	Finland	To examine fear of birth according to parity, gestation age and obstetric history	Questionnaire study	1400 pregnant women	Questionnaires including W-DEQ and visual analogue scale questionnaire	The W-DEQ and VASE scores were higher for nulliparous than parous women and for women beyond 21 weeks' gestation. Caesarean was preferred mode of birth for women with high levels of fear of birth.	Women only filled in the questionnaire once, fear of birth may change. Did not ask women about indications for caesarean section in previous deliveries or health of prev new-borns which may have influenced fear of birth

Schroll et al. (2011)	Denmark	To estimate the prevalence of self-reported lifetime violence and to assess whether women exposed to any physical or sexual violence had a higher risk of having fear of childbirth before, during or after delivery	Quantitative	2638 obstetrically low-risk women	Two self-administered questionnaires; one completed at 37 weeks pregnancy and one two weeks after birth and data collected by obstetric staff during labour. Demographic information, W-DEQ,	Experience if severe physical violence was associated with increased risk of fear of birth after delivery compared with women who had reported no experience of violence.	Inclusion criteria excluded women with preterm birth and caesarean delivery on maternal request which are both associated with higher fear of birth, hence it is expected that fear of birth was underestimated in this study. Imbedding questions about violence within a larger survey may lead to under reporting of violence. Discrepancy with women rating the violence questions differently.
Stoll et al. (2015)	USA	To understand young nulliparous women's preferences and attitudes toward birth	Quantitative, secondary analysis with cross-sectional design	752 18-24 year old nulliparous women	Online survey	Women with high levels of fear of birth were more likely to be concerned to a higher degree with body changes after birth. Women who reported access to childbirth information, confidence in their level of knowledge about pregnancy and birth and were white, were less likely to have high levels of fear of birth.	Limitations of secondary analysis. Very limited generalisability as from one private college in the USA. The measure of fear of birth was biased towards a vaginal delivery.

Storksen et al. (2013)	Norway	To assess the relation between fear of birth and previous birth experiences	Quantitative, Prospective study	1357 parous women scheduled to give birth in a specific Norwegian hospital	Two self-completed questionnaires between 17-32 weeks pregnancy. W-DEQ, previous overall birth experience and obstetric complications measured using a numeric rating	The association between previous subjectively negative birth experience and fear of birth was high and greater than the association between previous obstetric complications and fear of birth	No established, validated instrument to measure birth experience available. Birth experience and obstetric complications measured retrospectively, which may have caused recall bias

Waldenstrom et al (2006)	Sweden	To investigate the prevalence of fear of childbirth in a nationwide sample and its association with subsequent rates of caesarean section and overall experience of childbirth	Quantitative, Prospective study	2662 pregnant and then postnatal women	Postal questionnaires at 16 weeks and 2 months postnatal	In total 97 women (3.6%) had very negative feelings and about half of them subsequently underwent counselling. In addition, 193 women (7.2%) who initially had more positive feelings underwent counselling later in pregnancy. In women who underwent counselling, fear of childbirth was associated with a three to six times higher rate of elective caesarean sections but not with higher rates of emergency caesarean section or negative childbirth experience. Very negative feelings without counselling were not associated with an increased caesarean section rate but were associated with a negative birth experience.	Study is observational so definite conclusions about the effects of fear of birth or counselling cannot be drawn. Definition of fear of birth was not based on the established W-DEQ questionnaire.

Confidence for a physiological birth							
Study	Country	Study aims	Methodology/design	Population & sample	Data collection	Key Findings	Limitations
Avery et al. (2014)		To examine the research literature for information about prenatal care approaches that increase women's confidence for physiologic labour and birth and tools to measure confidence	Systematic literature review	Six studies	Search of MEDLINE, CINAHL, PsycInfo and Scopus databases. Alongside Normal birth conference papers	Research about enhancing women's confidence for labour and birth was limited to qualitative studies. Results suggest that women desire information during pregnancy and want to use that information to participate in a relationship with a trusted provider	Little generalisability from studies identified to UK setting

Brown (1998)	USA	To explore the relationship between women's search for knowledge, perceptions of self-efficacy and patterns of involvement in the context of childbearing and childbirth	Qualitative: Grounded theory methodology	16 Anglo-American postnatal women	Theoretical sampling and interviews	The story that emerged from within the context of women's narratives reflected a universal search for knowledge related to childbearing, childbirth and early child rearing. Women's search for knowledge was a pervasive concept interwoven into their development of confidence and influenced by the nature of the relationship between women and their health care providers.	Several methodological flaws and limited information about way in which study was conducted, for example, no ethical considerations discussed.

Coughlan and Jung (2005)	Canada	To explore new mothers' experiences of agency during prenatal and delivery care	Qualitative: phenomenology and grounded theory	40 postnatal women	Interviews	Agency is linked to democratic relationships that support women's access to and discussion of relevant health information. While most participants wanted to participate more actively in their care, problematic physician-patient communication hampered their ability to exercise personal agency. This was not true for midwives who have a model of practice that emphasizes education and choice. Different understandings of embodiment affect the development of health care relationships.	

Leap et al. (2010)	UK	To explore women's experiences of pain in labour and relational continuity of care	Qualitative	10 women who had received maternity care with the Albany Midwifery Practise and had given birth in the last four weeks	Semi-structured interviews	Women reflected more positively on how throughout pregnancy and labour their midwives promoted a sense of their ability to cope with the challenge of labour pain. The building of confidence was enabled through a relationship of trust that developed with their midwives and the value of hearing other women's stories during antenatal groups.	Focusses on a specific midwifery caseloading practise therefore findings have limited transferability to UK maternity care

Appendix F Participant information pack[2]

Study exploring women's confidence for birth

Ethics number: 15/NW/0949 Version number: 02 Date: 24/03/15

Invitation

My name is Emily Young and I would like to invite you to take part in this study, which forms part of my PhD.

This study aims to try and understand women's confidence for birth. One of the ways that we are trying to do this is by talking to women about their experiences before or after birth. We will then use this understanding to try and improve care for other women giving birth.

Why have you been invited to take part?

You have been invited to take part in this research because you are either:

- more than eight weeks pregnant
- or have had a baby in the last two years
- And you are having/ have had some or all of your maternity care with [redacted] NHS Trust.

What would taking part involve?

If you decide to take part in this study, the flow chart in this pack shows you what to expect. If you fill out your preferred contact details at www.isurvey.soton.ac.uk/18114 and enter the password: birth (this will take about two minutes). I will then contact you to discuss the study in more detail. Or you can contact me directly on evy1g10@soton.ac.uk or 07523 496 402. With your consent, I will then arrange to meet you at a time and place that suits you.

You can choose to meet at any of these places:

- Your home
- University of Southampton
- [redacted]

[2] Information such as the NHS Trust name has been redacted from this document to maintain confidentiality and anonymity of research participants

The meeting may take up to one and a half hours in total and with your consent, our voices will be digitally recorded. The aim of us meeting will be to discuss your thoughts and experience of confidence for birth. I am interested in your individual experience - there are no right or wrong answers.

The interview will be informal so you will be able to take regular breaks and stop the discussion at any time. If you have a baby, you can pause the interview at any time to care for your baby.

After the interview, I may ask if you would consider being contacted about having another interview with me again to follow-up what we have discussed. If you are offered a follow-up interview you could choose whether to have this over the phone or in person. It is important to note that being contacted again about a follow-up interview is not something you have to agree to and you could change your mind about being contacted at any time.

What are the possible benefits of taking part?

There may not be any direct benefits to you in taking part in this study. However the findings from the study will help healthcare professionals to understand women's confidence for birth. We hope to use this understanding to help women feel more confident for birth in the future.

What are the possible risks of taking part?

There are no direct risks to taking part in this study. This means that we think it is very unlikely that you will come to any harm during the study. If you find that you are affected by talking to me about your birth experience, you can contact the Birth Reflections service offered by specially trained midwives at [redacted] on [redacted] or [redacted]. If you wish to discuss your confidence for birth further after the interview then we recommend contacting your midwife, health visitor or GP.

What will happen to the results of the study?

The results of this study will be published in my PhD thesis. I also plan to present and publish the results in local, national and international journals and conferences to other healthcare professionals.

There will also be a tea and cake event at the University of Southampton in the summer of 2017. If you take part in this study, you will be invited to this event, where I will share the results of the study and discuss how we plan on using the results to help other women. Healthcare staff and students at [redacted] NHS Trust and the University of Southampton will also be invited to this event.

Do you have to take part in the study?

No, you should only take part in this research if you want to; choosing not to take part in the study will not affect your care in anyway.

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

You are free to stop taking part in the study at any time. You do not have to give a reason for not wanting to take part in the study any more.

Will your information be kept confidential?

Yes, all the answers that you give me will be confidential and anonymous. The data will be kept and stored safely and securely in line with The Data Protection Act (1998) and University Policy. This means that other people will not be able to identify you or your answers.

Short quotes from our discussion may be included in publications and you may be able to recognise yourself from this, however other people will not be able to identify you.

Who has reviewed this study?

The study has been approved by the NHS Ethics Committee and the University of Southampton. The service users at the Maternity Service Liaison Committee have also reviewed these information sheets.

What if you have a question or a concern?

If you have a question about the research then please contact Emily Young.

Address: Emily Young, PhD Student, Building 45, Faculty of Health Sciences, University of Southampton, Highfield, Southampton, SO17 1BJ.

Email: evy1g10@soton.ac.uk

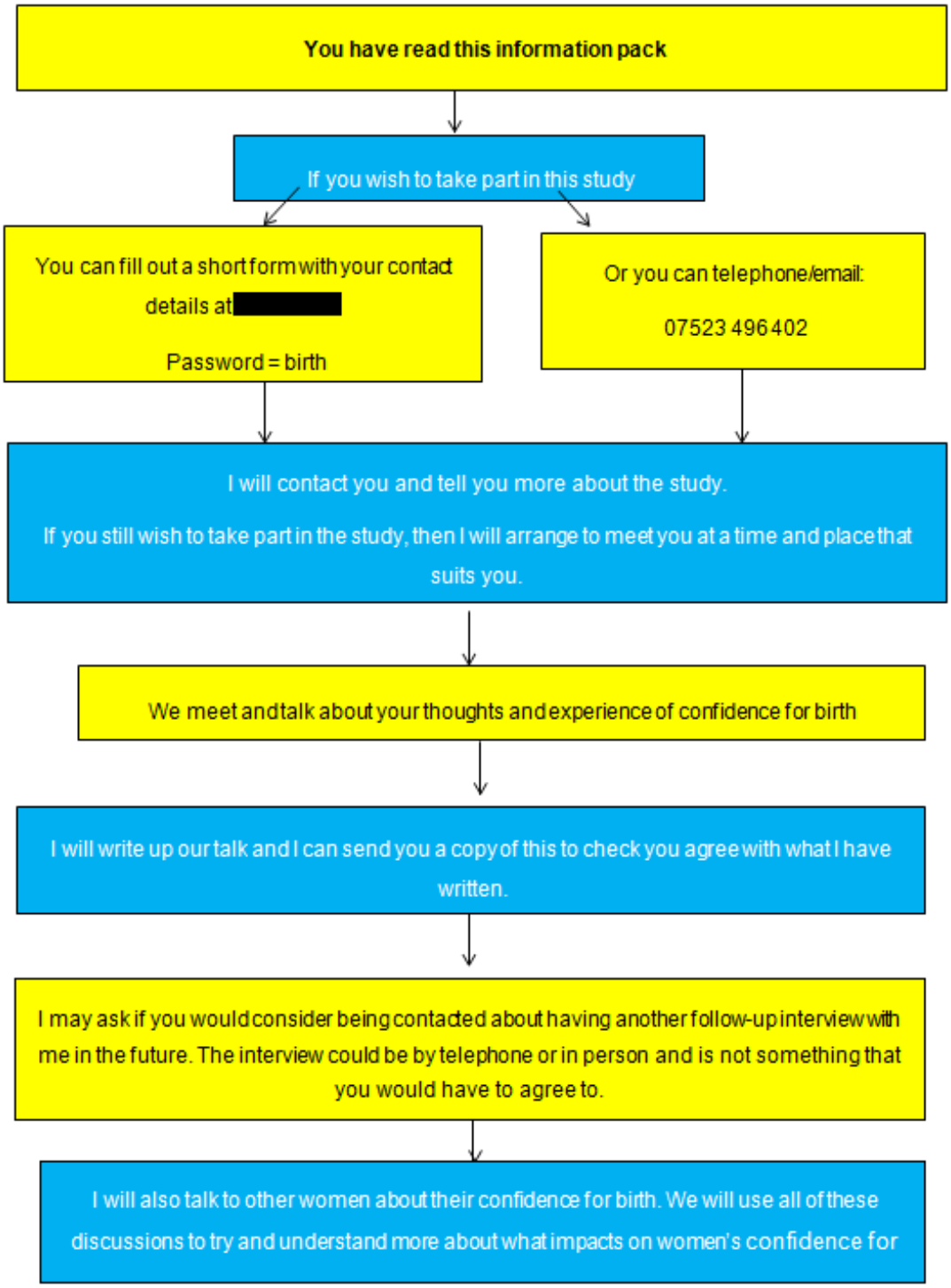
Telephone: 07523 496 402

If you have a concern or a complaint about the research then please contact the Head of the Governance Office, at the Research Governance Office.

Address: Building 37, University of Southampton, Highfield, Southampton, SO17 1BJ

Email: RGOinfo@soton.ac.uk

Telephone: 02380 595058


You have read this information pack
If you wish to take part in this study
You can fill out a short form with your contact details at [redacted]
Password = birth
Or you can telephone/email:
07523 496402
I will contact you and tell you more about the study.
If you still wish to take part in the study, then I will arrange to meet you at a time and place that suits you.
We meet and talk about your thoughts and experience of confidence for birth
I will write up our talk and I can send you a copy of this to check you agree with what I have written.
I may ask if you would consider being contacted about having another follow-up interview with me in the future. The interview could be by telephone or in person and is not something that you would have to agree to.
I will also talk to other women about their confidence for birth. We will use all of these discussions to try and understand more about what impacts on women's confidence for

Appendix G Interview schedule for cycle one

Version 2 Date 18/1/16

CONTENTS

INTRODUCTION/GAINING CONSENT

- Thank you for meeting me today
- Do you have any questions that you would like to ask me about the interview?
- Brilliant, today I would really like to chat about how you are feeling about giving birth, if that's ok with you? My questions are very flexible and I'm really interested in hearing about your individual experience, so there are no right or wrong answers. Feel free to stopthe discussion ortake a break at anytime.
- Also, before we start I always say that, everything that you say today will be kept confidential and anonymous but if I hear anything that seriously concerns me about patient safety then I may have to discuss this with a Supervisor of Midwives. Is that OK with you?
- Great, one of the ways that we protect your identity is by using a pseudo name instead of your name, can you think of a name that you would like to use?
- Do you mind if I use my recorder during the interview so that I can listen back to our discussion?
- Are you still happy to go ahead with the discussion today and if so, please can you read through the consent form. If you agree with all the information on the consent form, please can you initial and sign it.
- OK great, I will turn on the recorder now (start digital recorder).

INTERVIEW QUESTIONS IF PARTICIPANTS THAT ARE PREGNANT:

1. Firstly, do you mind me asking how many weeks pregnant you are? How is the pregnancy going? Girl/boy? What number baby is this for you?

2. Looking back through this pregnancy can you remember when you first started to think about birth?

3. How are you feeling about labour and birth now?

4. Can you think of anything that has made you feel more confident for labour?

5. Can you think of anything that has made you feel less confident for labour?

6. Finally is there anything else that you think I should understand better about your confidence for birth?

Or do you have any questions that you would like to ask me?

Prompts:

That's interesting, could you tell me more..? Can I ask you..? What was..?

If you feel comfortable doing so, can you describe... How did you feel when...? That sounds like it was...

Can you give me an example of what you mean when you say? How do you think that affected you..?

Can I check that I've got things in the right order, so... So what happened when...? So I'm hearing that...?

INTERVIEW QUESTIONS IF PARTICIPANTS THAT HAVE GIVEN BIRTH RECENTLY:

So today I would really like to chat about your birth experience and how you felt about giving birth, if that's ok with you? My interview questions are very flexible and I'm really interested in hearing about your individual experience so there are no right or wrong answers. Feel free to stop the discussion or take a break at any time.

1. Firstly, can I start by asking you how many children do you have? Name, age, what are they doing now?

2. Looking back to when you were pregnant with… can you remember when you first started to think about labour/birth? *(walk through pregnancy)*

3. Can you tell me about how confident you felt for labour/birth? As pregnancy progressed?

4. How about when you were in labour, how confident did you feel then? *(walk through labour & birth)*

5. So I'm hearing that … and … made you feel less confident?

6. And in terms of things that made you feel more confident I'm hearing… and …?

Ending questions:

7. Having been through what you've experienced, if you have another baby, how confident would you feel about giving labour/birth?

8. Finally is there anything else that you think I should understand better about your confidence for birth? Or do you have any questions that you would like to ask me?

Prompts:

That's interesting, could you tell me more..?

If you feel comfortable doing so, can you describe…

Can you give me an example of what you mean when you say?

How do you think that affected you..?

Can I check that I've got things in the right order, so…

Can I ask you..?

What was..?

How did you feel when…?

That sounds like it was…

So what happened when…?

NOTES FOR CLOSING ALL INTERVIEWS

- Thank you for your time, how did you find the interview?

- Remind the participant of the birth reflections service and the contact details for them that can be found in their information pack, should they wish to discuss their birth experience further.
- Send the participant a thank you letter within 2 working days, which includes signposts for participants should they wish to discuss their confidence for birth further. The thank you letter also includes details about the dissemination 'tea and cake' event that participants will be invited to.

Appendix H Confirmation of approval from a website moderator of the internet discussion forum used for data collection [3]

[redacted]

From:

Actions

To:

young, e.v. (evy1g10)

Inbox

09 April 2015 11:51

Hi Emily,

Thanks so much for getting back in touch, and for letting us know the nature of your research process. We're pleased to hear you find [redacted] a useful and valuable source of information.

That sounds fine to us. Please feel free to send us a copy of your research when it's complete.

Wishing you all the best with your study.

Best wishes,

[redacted]

[redacted]

[3] The website moderators name has been redacted to protect confidentiality and anonymity of research participants

Appendix I Full version of table 24

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
Lin	Preparing for birth Reassuring self Feeling supported by midwife	Feeling out of control Worrying Feeling birth is inevitable/unavoidable Going overdue and feeling pressure by friends Feeling scared	Husband reassuring Rationalising midwife's unempathetic behaviour Going with the flow Seeking understanding Trusting midwife's experience Feeling relieved it's over and all fine once given birth	Feeling out of control, Going to hospital to explain self, Receiving conflicting advice, Feeling trapped, Having fixed birth plan/expectations, Not wanting to be induced and being induced, Not wanting to have pethidine, wanting an epidural and having pethidine, Hearing woman screaming, Feeling in so much pain, Uncertainty not knowing pain threshold, Having no experience of birth so feeling unable to ask questions, Comparing and completing with others for worst birth

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
Emma	Seeking information Learning about labour and birth Setting flexible expectations from the start Rationalising and listening to others birth stories Not having a set birth plan Imaging 2nd baby helping looking forward to birth Having an easy previous birth Feeling relaxed because of previous birth Building relationship with lovely community midwife Having same midwife and having confidence in midwife during pregnancy	Being concerned about being actually in labour	Having confidence in medical team Feeling safe and looked after Coping by becoming obsessed with time Feeling really in control Knowing it'd be over soon Having support from someone from someone you know Midwife not being there constantly Baby arriving and feeling great Husband cutting cord and having time just the 3 of us Husband knowing wishes and birth plan Pushing and knowing I could get her out Having very quick birth	Contractions being painful Labour taking so long Becoming really tired Becoming bored, tired and frustrated Midwives being nice but strangers Having different midwives during labour Rationalising actually in labour Being unable to imagine 1st baby Phoning midwife and her being surprised Thinking oh my god I'm going to have this baby on my own Panicking that husband stuck in traffic Speed being

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
Emma cont.	Reminding self all pregnancies and labour are different		Reassuring self and husband will have time Thinking oh great he's here Having a very quick birth Thinking oh great he's here Already knowing what to do with a tiny person Labour being means to end pregnancy, not envisaging pregnancy	overwhelming/ traumatic if 1st birth
Holly	Knowing baby has to come out Talking about labour and things Seeking a less hospital environment Hearing about others experiences Discussing worry with friends	Feeling freaked at by the hospital tour/reality dawning Hospital being an unfamiliar environment Having no continuity in pregnancy	Room facilitating wishes for waterbirth Midwife saying you can do it Having midwife believe in you and believing in self Being able to manage contractions Just chatting inbetween contractions	Contractions being really strong Midwife wanting contractions to be closer together Midwife swaying me about where to give birth Gettign really sharp pain Not knowing what to do with self/ Feeling helpless Birth becoming an emergency

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
Holly cont.	Feeling confident in knowing what options were Envisaging baby Seeking information myself Imagining holding and meeting baby		Husband being there Reassuring that midwife stayed in room Midwife making me feel really confident Feeling so in control Midwife being so calm Doing yoga in labour Feeling so in control Feeling really confident for future birth Knowing had to get her out so not affecting by confidence	Feeling like no one cared about me afterwards Everything being so painful Lots of people rushing in Not knowing what pain was Thinking I'm going to die No one explaining to me what was happening Not being able to see baby's face Being worried about husband being traumatised afterwards Dwelling on her being whisked off Doctor having bad bedside manner Not being offered skin-to-skin

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
Ava	Realising baby has to come out Other people sharing stories Being flexible with expectations Consciously keeping an open mind Trying to ignore negative stories Seeking positive birth stories Avoiding watching births on tv Knowing we are designed to give birth	Finding variety of birth stories confusing Worrying about pain Not knowing when to go in to hospital	Ringing mum and discussing contractions, Pottering around and getting on with things, Using AN techniques to breathe through contractions, Talking control as midwife not believing me, Feeling surreal, Having somebody to talk to/ be with you, Feeling relieved by mum taking control, Putting decision into someone else's hands, Midwife explaining about contractions, Midwife validating and explaining pain, Recommendations going with the flow	Stopping coping Midwife dismissing contractions as not being strong enough Being in a lot of pain Thinking midwife though I was being overdramatic Not being able to do what midwife had instructed Midwife not listening to me Not knowing what to do with self Not know how long left/progress Feeling pushy sooner than expected Feeling like things were starting to go way didn't want them to

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
				Feeling midwife didn't listen to me
Fiona	Others sharing positive experiences Feeling supported by consultant during pregnancy Being in the right place Seeking information Feeling baby moving around Building knowledge	Uncertainty being daunting Everyone having different stories Hearing about people's troubled times Worrying about measuring big Not progressing fat enough	Knowing would leave hospital with a baby, Everyone saying you're doing the right thing, Student midwives being really good at taking to you and being on your level, Student midwives being really upbeat and caring, Rationalising midwives behaviour, Feeling like it's more than just a job to them, Having a stern talking to by the midwife, Midwife being like a mum, Telling me to calm down, Needing midwife to take charge, Midwife taking charge, Midwife staying with me the whole time,	Becoming tired Not getting the physical or mental relief needed Epidural not working as it should Not coping with the pain Getting really severe back pain Worrying about not progressing Being in too much pain to care Never having surgery before Panicking because could feel pain when shouldn't be able to Feeling overwhelmed with all the bright lights Not seeing baby being born Never being able to get experience back

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
Fiona cont.			Doctor reassuring me I've done everything I can, Knowing there was nothing more I could do, Knowing wouldn't be in pain anymore, Seeing a caesarean on tv but not in real life, Making sure partner was alright, Seeking understanding about why had a caesarean, Explaining really well, Midwife helping me breastfeed which was important to me, Having people who are supportive, Hearing others had the same experience, Having continuity of midwives in labour, Midwife not giving up on me, Having someone who's done it before, Feeling had good care, Having confidence to ask questions	Worrying about not being to look after baby afterwards Mum and sisters experience not being my reality

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
Olivia	Trying to be open minded Wanting full range of options available Providing planning a perfect birth Keeping flexible expectations Rationalising story telling behaviours Friend reassuring me it doesn't have to be bad Husband being really supportive Mum's experience giving confidence Feeling husband understands wishes	Getting the usual barrage of stories Not knowing what is coming Hearing different stories from friends	Husband being at home enabling me to relax, Feeling everything is going great, Knowing needing baby to come soon, Seeing baby whisked out of room, Comparing experience with TV, Deciding to have homebirth, Feeling very calm and in control, Using practical coping strategies to feel in control, Confidence being boosted by being able to use the pool, Understanding they needed to monitor my baby, Being able to move as I wanted, Realising it is too late for an epidural and not panicking, Accepting had to do it	Being asked to get out of the pool and not wanting to Feeling scared when baby was born Baby pooping out blueish Struggling emotionally with missing experience Feeling uncertain about how far along I am Getting scared when midwife became worried Pleading to stay in the pool Midwife saying I need to cut you Being told I was only 3cms Deviating from the plan

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
Olivia cont.	Thinking had a straightforward first birth Knowing asking for an epidural came from fear Having mum who had a homebirth Understanding that TV programmes lie Understanding it's rare for things to go catastrophically wrong quickly Being able to set your own atmosphere Wanting to be close to the hospital Trusting in midwives Evaluating risk Having a completely normal pregnancy		without an epidural, Finding it wonderful that baby started to bf Giving us time to adjust, Being convinced I was further along, Disbelieving midwife, Pool making me feel cosy, cocooned and warm, Being convinced I was further along, Disbelieving midwife, Body taking over, Feeling completely confident in what I was doing, Not wanting to be interrupted, Watching water patterns in the pool calming me down, Believing in what I could do, Fitness training helping self belief, Knowing husband and mum where there, Reassuring self midwife is wring, Telling	Thinking I can't do this for 18 hours Hearing conversation with husband about how long it could be Feeling out of control

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
Olivia cont.	Doing lots of reading		myself to trust in my body, Feeling comfortable, Thinking about meeting the baby giving confidence, Previous birth experience giving confidence, Trusting in yourself and your body's ability Reassuring self there's no reason for things to go wrong	
Mia	Knowing mum had a straightforward births Thinking everything will go perfectly Wanting a natural birth Not considering what would go wrong Rationalising that lots of people give birth so it will be easy	Comparing previous experience to TV Worrying about bonding with baby Failing at the natural side	Remembering advice from NCT teacher Asking me what position I'd like to give birth in Having somebody with you Trusting your midwife Body telling me something else Feeling relieved I could stay at hospital Feeling what your body is doing	Dismissing me as it's my first baby Midwife questioning my choice Not feeling welcome Midwife saying that it's my first baby so I'll probably be going home Mum being told they were really short staffed Feeling like an inconvenice

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
Mia cont.	People talking about birth Thinking birth will be magical Others saying they are horrified that midwife left me Explaining my labour was textbook and which bits went wrong Person from customer care team being amazing Discussing birth with others Reflecting midwife was not suited to midwifery Joining a support group on facebook Researching and seeking information Midwife supporting writing a birth plan		Giving me permission to finally listen to my body Being active in labour Listening to how I want to give birth Thinking it will be over soon Managing the pain Husband and mum being supportive	Midwife not having a warm attitude Repeatedly getting told you're not ready to push Midwife being surprised Midwife leaving me while I was pushing Rushing me off to theatre Them being concerned about bleeding Seeing so much blood Feeling that the midwife didn't want to deal with me Intensity of pain making me feel panicky Men being great but not getting it

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
Mia cont.	Having information available feeling community midwife is supportive Midwife spending time taking about what can happen at birth			Feeling like midwife was treating me like a textbook labour No rapport building Not knowing what to expect No one explaining anything Having no idea what happened to me Needing guidance Not feeling in control Having no guidance Not realising you could have a 4th degree tear
Tallulah	Having the confidence to say no in the future Midwife giving me the confidence to stand up for myself	Having GDM prompting worrying about birth Step-mum telling me I don't want to be induced Thinking I am going to have a stillbirth	Feeling like I was doing really well Using hypnobirthing Breastfeeding helping me to recover from bad birth experience	Threatening me with stillbirth Allowing me to go another hour Feeling scared going into hospital Feeling like I have no choice Midwife shouting at me

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
Tallulah cont.	Persuading staff to give me an extra 5 days (overdue) Developing strategies to avoid induction Listening to me Doing all the classes Feeling like the midwife is on my side Wanting an advocate for future Wanting a doula or private midwife Midwife supporting me and telling me I can say no Having a woman with you who is knowledgeable and on your side in the future	Threatening stillbirth to get me to do what they wanted Getting worried about induction Receiving a letter saying I am at increased risk of stillbirth Prioritising baby's safety Trying to get pregnant for 3 years Feeling like I had to do what they wanted Being my first baby Feeling that I am not in control Finding myself pushed into a medicalised birth Not allowing me to assess risk for myself Not explaining their decisions Not understanding why they were so inflexible	Midwife helping me breastfeed Being able to cope	Telling me my breastfeeding wasn't good enough Not being able to move Worrying that I wouldn't know my baby Worrying about not being able to have skin-to-skin Telling me it's too late to have an epidural Feeling so medicalised thinking environment makes no difference Looking like a clinical room Feeling like the midwife is judging me Becoming a mother and your focus changes (feeling like can't be upset about birth, changing identity)

Participant	Pregnancy ☺	Pregnancy ☹	Birth ☺	Birth ☹
	Watching and comparing animal with human births on tv	Treating me like I am not an intelligent person Feeling scared about induction from watching tv Hearing about induction from other people Thinking it's hard for me to be an advocate in a female environment Not being confident enough to say no Not feeling like I have enough medical knowledge or previous experience to say no Not being confident enough to say no Tail spinning out of control Feeling more and more out of cont		Feeling very vulnerable Feeling so out of control Tail spinning out of control Feeling more and more out of control

Appendix J Full version of table 33 with the categories from cycles 1, 2 and 3

Categories from cycle 1, 2 and 3			
Information seeking and gathering leading to confidence for birth	**Interactions and relationships through pregnancy**	**Hearing birth stories**	**Feeling more confident from stories** - Best friend having two straightforward labours, Best friend having really positive birth experiences, seeking and gaining confidence from positive stories **Developing coping strategies –** Ignoring horror stories, trying to pick fact from fiction, making sense of stories, rationalising stories (e.g. overdramatic because my sister-in-law is a very overdramatic person)**,** Thinking people were exaggerating about the pain of contractions **Horror stories making me feel anxious -** Feeling anxious about being induced because I have heard it leads to a lot more interventions, Feeling really scared from what I'd heard about tears, Hearing horror stories about induction **Feeling overwhelmed by the variety of labour stories –** finding variety of stories confusing **Wanting to hear stories-** Finding it unhelpful when people didn't share birth stories, People saying they didn't want to scare me by sharing stories, Feeling like I'd rather know how horrible their labour was, Thinking it's worth knowing different birth stories **Not wanting to hear others stories** – not giving a shit about other people's experiences, thinking just sod off, wanting people to stop giving me tips, having little control over receiving a barrage of birth stories
		Interactions with community midwives	**Level of continuity with midwife** - having a different community midwife every appointment, having same midwife through pregnancy reassuring, going from having a consistent person you've met through out to someone you've never met in labour, learning something new from each midwife,

			Not having confidence in my midwife – not having discussions with my midwife about how it will work, not having confidence in my midwife, not feeling like they were experienced with homebirths, thinking that the midwife was nervous, having an older midwife who couldn't measure properly, **Feeling confident in my midwife -** meeting the homebirth team, being very clear about how the system works, feeling reassured by midwives confidence and clarity, trusting the midwives, **Feeling comfortable with my midwife** **Midwife showing me that she cared** **Midwife building confidence for the birth -** community midwife getting my notes and answering all my questions for me, midwives imparting information during visits, having a supportive midwife making a big difference, midwife helping me realise my choices, relationship with community midwife helping my confidence, talking through situations with my midwife giving me a bit of knowledge, midwife being really supportive and helpful, midwife playing a key role in enhancing confidence through birth planning **Feeling like it's not the midwife's role to deal with birth-** not feeling like midwives addressed the birth at all, perceiving community midwives are hear to deal with the pregnancy not the birth, feeling like the service isn't set up to tell you about in detail what to expect for birth, not having loads of time for birth planning, being conscious that someone else has got an appointment after you
		Being around babies a lot	**Being around babies a lot –** thinking how hard can it be, giving confidence

		Interactions with doctors and hospital staff in pregnancy	**Feeling more confdi3nt from interactions with doctors** - husband feeling reassured by obstetrician, **Feeling less confident from interactions with doctors -** not feeling reassured by obstetrician as had lots of questions, feeling like obstetrician was dismissive, obstetrician not investigating and dismissing my questions, being told there was a risk of cord prolapse by consultant making me anxious, consultants having a difference of opinion making me anxious **Institutionalising me –** doctor and hospital staff institutionalising me and taking my control away reducing confidence, having to explain yourself/persuade staff, treating me like I'm not an intelligent person, threatening stillbirth if I don't comply, Making me feel like my baby is more important to me
		Experience with labour line	**Gaining confidence from experience with labour line -** Labour line being very friendly and reassuring when I had a false alarm
		Interactions with friends/family	**Negative comments** - people telling me I'd want an epidural when it starts, people telling me labour will be awful, family member advising me not to be induced and knowing I might be induced **Recalling perception of others experiences -** realising how much it was for my brother, visiting my friend in hospital and thinking this isn't how it should be **Mum's perspective on birth -** lots of confidence coming from my mum being a midwife, mum being very positive about it all, mum having good experiences, feeling anxious about having mums experience of high blood pressure, mum's experience giving me confidence **Feeling pressure from friends when I went overdue** **Gaining confidence through friends –** communicating and normalising experiences and worries with friends, gaining positive reassurance through communicating with friends, gaining knowledge from friends expereinces

		Birth reflections appointment	**Gaining confidence and understanding from birth reflections appointment** - doing birth reflections helping confidence, interactions with birth reflections helping processing and rationalising of previous birth helping confidence
		Relationship and interactions with birth partner	**Support from partner strengthening confidence –** supportive communication about birth with partner, gaining confidence, talking it through with husband, husband being supportive, chatting with partner **Valuing partners preferences and experiences –** husband feeling more relaxed in hospital, not wanting to ruin the experience for my fiancé, trying to understand husbands perspective, thinking about what's going to affect my husband so that he can support me, finding it good to have a second opinion, Thinking that having a strict birth plan will be more stressful for my husband **Feeling confident by birth partner can advocate for me increasing confidence** **Wanting my mum to be there**
	Mentally preparing	**Imagining and creating preferences for birth**	**Not having any expectations of labour –** being open**,** not being hung up on a particular birth, wanting to be able to go with the flow, wanting to be in a position where I am chilled and open minded **Wondering about birth and creating preferences -** Excepting to have a natural birth, Wanting to just use gas and air, Feeling determined to move around as much as possible during labour, Wanting a natural birth for recovery afterwards, Not liking the idea of medicalised interventions **Creating values for labour** – valuing others being in control, wanting an up-to-date midwife, having confidence in my midwife being important, valuing clear communication in labour **Feeling like my expectations are realistic** - Knowing it's going to be hard, thinking no one goes into labour thinking it'll be easy, being realistic that it'll hurt a lot, having friends with babies helping prevent false expectations, preparing myself that things don't go the way you expect
		Self-talk/reassuring	**Self-talk/reassuring self –** telling myself that lots women give birth every day
		Coping with uncertainties	**Not knowing when I'll go into labour** - Becoming obsessed with when will I go into labour

			Feeling uncertain about what labour feels like - Feeling terrified by every twinge in case labour, Not knowing what the baby/your body is going to do, Never knowing what you're going to have **Coping with uncertainties**
		Acknowledging and anticipating feelings	**Not feeling confident -** Feeling more nervous when I was in labour, Feeling scared in a different way with second baby – worrying about how first baby will cope, Feeling anxious about trying for a vaginal birth and then having a caesarean again, Feeling scared at the idea of giving birth without an epidural, Having so many unknowns, lacking confidence, feeling uncertain, worrying about things going wrong/not being in control, feeling anxious about birth, feeling concerned about being at home and having to make decision, worrying about being rude to people because I'm in pain and no-one wanting to help me, feeling horrified about giving birth, feeling freaked out by thought of baby being in distress, the word 'emergency' caesarean making me feel panicked, only recalling negative thoughts/feelings about pregnancy/labour, not feeling convinced my body can do it, thinking there's a host of reasons for my lack of confidence, not knowing if I'll be able to do it **Feeling confident** - Not being nervous about giving birth, Feeling fairly comfortable with it, Feeling like I know all the stuff, feeling empowered, feeling supported, feeling in control, not worrying **Personality** - Being a personality who likes to prepare, knowing self, being a pessimist, knowing my natural reaction is to bury my head in the sand, liking being in control **Anticipating feelings changing** **Not being able to control birth or feelings about birth –** acknowledging that there are something's I don't have the power to influence, accepting I can't control if things go wrong, not knowing what to expect, dealing with the uncertainty by thinking through different options, accepting that birth is going to happen
		Going to classes	**Classes helping confidence** - Going on courses helping confidence, Doing pregnancy yoga and having quiet time really helping, Confidence from classes really helping, Doing pregnancy yoga being helpful, Hypnobirthing techniques helping with contractions, Getting your head in the right place helping, Practising contractions at pregnancy yoga, Practising caesarean at NCT class helpful knowing what to expect

			NCT classes helping understand biology, Drawing on hypnobirthing like a toolkit, Classes making us both clued up, Finding confident birthing workshops reassuring , knowing nothing is going to be a surprise **Embracing antenatal classes,** Embracing everything that made me feel like I knew more what I was doing **Having no classes to go to -** Having no classes for second time mums **Classes taking me out of denial** - Feeling like I'd been in denial before the classes
		Birth planning	**Wanting a birth plan -** Disagreeing that a flexible birth plan is best, Feeling determined to do what was on my birth plan, Being open minded about the end result, Having a strict birth plan meant I knew what I was doing, Thinking a lot about my birth plan, Not writing a massive birth plan, Not knowing what the baby/ your body is going to do **Writing a birth plan helping confidence** - Finding it helpful writing a birth plan, **Deliberately not making a birth plan -** Knowing people who made rigid plans and were devastated by plan not happening, Not wanting to be disappointed , Not wanting to get my hopes up, Thinking there's no point in having a plan, Thinking chances are of things going to plan are low, Imagining getting really fixated on a plan if I had one **Flexibility being key to birth plan -** Not really caring how baby comes along as long as it's healthy, Difficult to write when haven't given birth before, Feeling happy to go with the flow, Acknowledging that you have to go with the flow if the situation changes, Having a flexible birth plan, Not knowing what to expect, protecting self by flexible planning Leaving the birth plan open as you don't know how you'll find it, gaining confidence by flexible birth planning, valuing midwife communicating importance of flexibility **Feeling pressure to have a particular birth** - Feeling there's a lot of pressure for women to push **Feeling that 'plan' is the wrong word -** Always being told birth plan is an ideal not what's going to happen, Suggesting changing name from birth plan to birth preferences, Thinking it should be called birth aspirations

		Considering place of birth	**Choosing a homebirth to take the stress out -** Knowing I wouldn't have a stressful drive, Homebirth taking the stress out, Not wanting husband to be really stressed, **Worrying about where to give birth** - worrying about choosing a homebirth because that's what I want rather than what's right for my baby **Feeling safe and comfortable with where I'll be giving birth –** feeling like once I'm in hospital I'm in safe hands and they'll look after me, liking hospital environment, feeling happy with my decision about where to give birth, just wanting to be safe, not really caring about the décor if the person around me know what they're doing, feeling like you're in the right place, choice marching preconceptions about where I will give birth, choosing to have a homebirth knowing I can control the atmosphere,
		Interpreting information from other sources	**TV –** Seeming straightforward on telly even with complications, people and telly can't tell you what you'll be feeling like, media making it seem like birth takes a certain course, only having birth stories and TV as birth experience, not interested in watching OBEM, feeling horrified by watching OBEM **Books -** Reading books **Managing information gathering –** feeling overwhelmed, Having lots of information helping me to feel in control, Feeling like I had the knowledge about my choices, Feeling quite informed helping, enjoying and valuing learning about birth, feeling clueless **Online –** feeling overwhelmed by the wealth of information online
	Physically preparing	**Exercising in pregnancy**	**Exercising in pregnancy increasing confidence and sense of control helping confidence -** Doing a lot of exercise helping my confidence, Midwife saying I have nothing to worry about because I'm fit, Staying fit helping me feel healthy and that baby is going to come out, Exercise helping you feel more confident in your body's ability to give birth, Feeling like I can control my fitness pre-birth

		Relationship with own health	**Good relationship with own health increasing confidence** - Thinking labour will be easy because I'm fit and young
	Relationship with pregnancy and developing baby	**Feelings about physically being pregnant**	**Enjoying pregnancy -** Enjoying first pregnancy more than second, Pregnancy being wonderful, Having a perfect pregnancy, feeling excited about being pregnant, really enjoying being pregnant, feeling I will miss be pregnant **Not enjoying pregnancy (can go both ways as either looking forward to birth meaning end to pregnancy or lower confidence for birth) -** Pregnancy being nine long months of stress, Not enjoying second pregnancy or birth because too busy, Feeling keen to not be pregnant anymore, looking forward to the birth **Pregnancy being unplanned or unwanted -** Not feeling ready to be pregnant again, husband not wanting the baby, not being ideal **Fascination with developing pregnancy postponing anxiety about birth**
		Prompts from body changing	**Prompts from body physically changing**- Realisation dawning that I'm going to have a baby, realising this is actually going to happen, becoming real, thinking my body has to do this
		Dates marking points in the journey	**Due date approaching** – becoming more focussed on the birth, realisation dawning, looking forward to the birth, getting more excited about birth as it's closer, thinking I can do this, **20 week scan** – making things seem more real **Early pregnancy -** Not feeling ready to learn about birth as due date too far away, worrying/thinking I might have a miscarriage
		Having pregnancy complications	**Having no complications increasing confidence** - Not having any pregnancy complications, Not having anything that will make me have a bad labour, never expecting a caesarean because I'd had such a health pregnancy **Pregnancy complications decreasing confidence** - Going from 'low-risk' in first pregnancy to 'high risk' in second pregnancy because of caesarean, not expecting a small baby making me anxious, Being told there was a risk of cord prolapse by consultant making me anxious

		Developing relationship with baby	**Baby developing a personality** - Having an incredible little bump, Baby having a fabulous personality, Baby knowing our voices and moving when we talk, Imagining my baby, Feeling excited about having a baby, Feeling fascinated by developing pregnancy and baby **Trying to imagine baby** - Wondering if baby is a boy of girl, Wondering if baby will look like me, Trying to imagine what my baby will be like, feeling overwhelmed imagining meeting my baby but not in a bad way, Not being able to imagine my baby **Attaching to the baby** - Not forming an attachment to second baby during pregnancy **Feeling excited to meet my baby boosting confidence** **Viewing labour as a means to an end to meet baby**
	Drawing on previous experiences	**Previous birth experience(s)**	**Confidence being low after past birth -** Confidence being as low as first time mum second time around, Feeling more nervous about care after having baby than birth based on last experience, Having no-one to talk to about my worries because I'm a second time mum, Having a caesarean really impacting on my confidence for next birth, Feeling like my body let me down, Not being able to give birth naturally, Caesarean Birth having a huge psychological impact on me as a mum **Feeling more confident having given birth** - Feeling future births will be a breeze Feeling really confident to give birth again, feeling familiar with birth now, Feeling more confident if progressed same as last labour, Feeling like I have grounds to ask for things, Previous experience giving you a backing, Past birth experience making me feel more confident, Feeling supported by midwives with first baby, Feeling empowered because of previous birth experience, Giving birth makes me feel like I can do it again, Feeling like I had good care in hospital, Feeling like my recovery went smoothly, Feeling like I had a good experience despite having interventions, thinking it's easier second time around as you're able to judge it a bit more, having prior experience of the event, positively evaluating previous birth, processing and rationalising previous experience helping confidence, **Having no previous birth experience** – reducing confidence as creates uncertainty about it all

		Previous similar experience(s)	**Work -** Seeing horrific things in my job as a nurse (so keeping birth plan flexible) **No experience of other people in labour** - never having seen anyone in labour, Watching a second time mum would give you confidence **Being in pain -** Having no experience of being in major pain/ being in hospital

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