Remembering birth: a narrative inquiry into older women's experiences of birth and their lifelong significance.

By

Helen Muscat

Canterbury Christ Church University

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Dedication.

To all the incredible women I have come to know, and to all of those, I have yet to meet.

Abstract.

While there is an abundance of literature about the women's experiences of birth collected soon after birth, research about recollections of birth across the lifespan is scarce. This narrative inquiry takes a feminist interpretivist perspective to explore older women's birth experiences giving voice to women whose experiences occurred many years ago. As such, it presents a unique opportunity to understand more about the significance of the birth experience over time. Six women in their seventh decade were selected to participate and interviewed. The women gave birth to their children during the 1960-70s and recalled their experiences during two interviews: one unstructured interview and one semi-structured interview. The narratives were analysed using a voice-centred relational method - the Listening Guide (Mauthner and Doucet, 2011).

From the analysis three central and interrelated interpretive findings emerged. The first highlights the importance of context; the stories were shared in a way that exposed the context of living in those times and how this impacted on their experiences. The second highlights the significance of the personal and professional relationships the women experienced during the birth continuum. These involved the midwives who had cared for them and the relationships they had with their mothers and those acting in that role. The third finding has been drawn out of I-Poems and illustrates the enduring emotionality of the birth experience. The poems reflect the sense of fear, un-enlightenment, humour and sadness associated with the women's birth experiences. They also offer empowering advice to younger women who are preparing to birth in the contemporary context.

The research demonstrates the value of older women's perspectives of their birth experiences. Not only does it actively foreground the voices of this group of women, but it also theorises the narratives in a way that reveals the longevity of the complex multi-sensory emotional experience of giving birth. It demonstrates the women's resilience when seeking out female support. It concludes with recommendations to health care professionals, community leaders and policymakers to embrace the wisdom and knowledge of older women and consider how common birthing practices may impact the lifespan of women.

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Glossary

Term used	Definition
Antenatal period	The period of time from conception to before birth
Bilateral renal agenesis	The absence of both kidneys at birth. It is a genetic disorder characterised by a failure of the kidneys to develop in a fetus. This absence of kidneys causes a deficiency of amniotic fluid (Oligohydramnios) in a pregnant woman.
Birth continuum	This is the period of time from pre-conception, throughout pregnancy and the postnatal period up to 42 days.
Episiotomy	Surgical incision into the perineum during the later stages of birth.
Forceps	Forceps are instruments designed to aid in the delivery of the fetus by applying traction to the fetal head. Many different types of forceps have been described and developed. Generally, forceps consist of 2 mirror image metal instruments that are manoeuvred to cradle the fetal head and are articulated, after which traction is applied to effect delivery
Gravida	Referring to a pregnant woman, which is modified by the number of times she has been pregnant, regardless of the number of infants delivered at term.
Hyperemesis	Hyperemesis gravidarum is a pregnancy complication characterised by severe nausea, vomiting, weight loss, and possibly dehydration. Signs and symptoms may also include vomiting many times a day and feeling faint. Hyperemesis gravidarum is considered more severe than morning sickness. Often symptoms get better after the 20th week of pregnancy but may last the entire pregnancy duration.
Lethal fetal anomaly	A fetal condition diagnosed before birth that, if the pregnancy results in a live birth, will with reasonable certainty result in the death of the child not more than three months after the child's birth.
Menses	The periodic flow of blood and mucosal tissue from the uterus; menstrual flow.
Multiparity	A woman that has borne two or more babies
Multigravid	Pregnant at least once or more
Normal birth	Spontaneous in onset, low risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy.

NMC	Nursing and Midwifery Council
Nulliparous	A woman who has never given birth
Parity	The condition of having given birth to an infant or infants, alive or dead, a multiple birth is considered as a single parous experience.
Postnatal period	According to the WHO, the postnatal period begins immediately after the birth of the baby and extends up to six weeks (42 days) after birth.
Supervisor of Midwives	Under the Nursing and Midwifery Order 2001 (the Order), established in 1902, supervision was a statutory responsibility that provides a mechanism for support and guidance to every Midwife practising in the UK. The stated purpose of supervision of midwives is to protect women and babies by actively promoting a safe standard of midwifery practice. This Order was rescinded in 2017, and the Supervision of Midwives ceased.
Toxaemia	A condition in pregnancy which became known as pre-eclampsia 1976 and is characterised by abrupt hypertension (a sharp rise in blood pressure), albuminuria (leakage of large amounts of the protein albumin into the urine) and oedema (swelling) of the hands, feet, and face. Pre-eclampsia is the most common complication of pregnancy
Trimesters	In obstetrics, one of the three divisions of three months each during pregnancy, in which different fetal development phases occur. The first trimester is a time of basic cell differentiation. The second trimester is a period of rapid growth and maturation of body systems. A second trimester fetus that is born prematurely may be viable, given the best hospital care possible. The third trimester marks the final stage of fetal growth, in which systems are completed, fat accumulates under the soon-to-be-born baby's skin and the fetus at last moves into position for birth. This trimester ends with birth.
Primigravid	Pregnant for the first time.

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Prologue

My Mother's story of my birth

Mid-September 1962

Heartbroken again! Another monthly period had started. We had been trying for a baby since we married in October 1961. The family were starting to make comments wondering why there wasn't a baby on the way. The GP was not interested. Many years later, I was diagnosed with endometriosis which, of course, explained the difficulty I had conceiving.

End of October 1962.

I was late! I was late. I'm was too frightened to allow myself to feel happy. I was running to the bathroom to check every hour. Your Dad was beside himself with excitement. The GP won't examine me until I've missed three periods. It seems a lifetime to wait to find out if I'm pregnant.

End of November 1962

I arrived at work and could not stop vomiting. A colleague heard me retching and guessed I must be pregnant. Every morning was hell, and I found it very difficult to eat at all, but still happy to be pregnant.

Mid-December 1962

Thick smog in London, came out of work, and it's snowing hard. The smog made me retch. The bus gave up, so I started to walk home- absolutely petrified. I went to the doctor's surgery – at last a sympathetic GP. Signed me off work and agreed that I was pregnant. The GP wanted to prescribe something for the sickness, but there had been so much publicity about the deformed thalidomide babies I was not willing to take any chances. I was too frightened to take anything at all.

Christmas December 1962

Very excited and happy but still being very sick all have lost lots of weight and look awful. I have a Hospital appointment in the New Year. Dad wanted us to move back to Folkestone before the baby arrives. I'm happy to do that, but we will have to wait for the big freeze to end.

1963

Freezing snow continued until March. I embarrassed myself when I went to Lewisham Hospital for a check-up. I fainted and fell into a pushchair. Luckily it was an empty pushchair.

Sickness finally stopped when I was about 18 weeks pregnant to be replaced by chronic indigestion. According to my mother, that is caused by the baby's hair growing!! I would have been happy to have a bald baby.

Easter April 1963.

We settled back in Folkestone. I registered with my old GP and booked to have a baby in the new Maternity Wing at Buckland Hospital, Dover. Happy with that as I used to work in Buckland Hospital.

My midwife expressed concerns that I had lost so much weight – 7st 9lb and six months pregnant, low weight for me. I was feeling happy but exhausted.

My mother and aunts busy knitting and crocheting the layette. Everyone was happy and excited.

A worrying phone call from GP, apparently, I'm very anaemic. I must take medication and rest, or I will have to stay in hospital. So, I do as I'm told, too frightened to do anything else. I was reading books about pregnancy, giving birth and childcare. Being told many 'old wives' tales' but not many facts, certainly no detailed information. I was starting to get anxious and worried.

10 pm 22.6.63 Saturday evening.

Lying in the labour room all alone, I realised I had seriously upset the midwives by leaving it so late before I came into the hospital. But I honestly did not know I was in labour until a friend called into our shop where I was working and took one look at me and told me off.

At this point, your father started to panic. I was not entitled to an ambulance, so we had to travel to Buckland by taxi.

Of course, the midwives made your father wait in the waiting room whilst they prepared me for your arrival. Not a pleasant experience. Examination, enema, then a bath. Eventually, I found myself alone in the labour room. They allowed Dad to come and say goodnight before sending him home, telling him to phone in the morning.

At this point, I felt not only petrified but also extremely lonely. I remember pressing the buzzer because I had started to vomit. A nurse eventually came in, gave me a dish and told me to get

on with it. She was 'sure I could be sick on my own'. I called her a few nasty names under my breath, of course. Eventually, they did stay with me, and you were delivered at 2.10 am

I had never experienced such joy and happiness. The feeling of love and contentment when you were placed in my arms more than made up for the difficult pregnancy and pain of the night, the months of continual sickness forgotten.

As you had torn me whilst making your entrance, I needed stitches. You were taken away to the nursery, and I was left alone in the labour room. I could hear the sounds of a very noisy party going on. I had a very uncomfortable lonely upsetting night. It was 7 am before a doctor finally arrived to 'repair' me and 10 am before I was taken to the ward and reunited with you. I found the staff in the delivery suite indifferent and uncaring. Their attitude left me feeling lost and deserted. It may have been a new modern maternity wing, but the lack of consideration from the staff spoilt the experience for me. All I wanted to do was sit and cuddle my beautiful baby with her thick dark hair! (My mother was right after all)

2 pm Sunday 23rd June 1963

Visiting time for fathers and grandmothers, so strict, but they stayed for 2 hours. It was considered essential that mothers rested for ten days after giving birth.

The ward was happy and cheerful, and I was grateful for the help and advice the nurses gave me. We were shown how to care for our babies, change nappies, bath and breastfeed.

Because I felt the attitude of the labour ward staff had been so uncaring and indifferent, I swore my next baby would be born at home. Thankfully I was able to give birth to your siblings at home.

July 1963.

Like most first-time mothers, I was very nervous during your first few weeks at home. Constantly checking that you were still breathing, worrying that you were not having enough milk, but with support and encouragement from friends and family, we both survived. The Health Visitor called regularly and gave me useful tips and information. I enjoyed our weekly visits to the baby clinic, and you put on weight and thrived.

Despite the early pregnancy sickness and pain of childbirth, I loved the whole experience. I must have; otherwise, I would not have had another two babies.

Chapter one- Introduction

Birth is a rite of passage of women. Their journey should be honoured, their rights should be fiercely protected, and their stories should be shared.

She Births, by Marcie Macari (2006)

Aim of the chapter

I come to this thesis as a feminist, mother, midwife, lecturer and researcher. During my life's journey, I have experienced and known women's stories of pregnancy, birth and motherhood. I have seen courage, adversity, controversy, joy and grief. The constant has been the story behind and in front of the occurrence, the rite of passage. The opening quote eloquently captures my position and feelings about the essence of this thesis: for a group of older women, their birth stories will be told, explored, understood and shared.

When reflecting on the writing of this thesis, I realised that, as with pregnancy and birth, some of the pre-conceptional plans were more fanciful while others were more pragmatic. As conception occurred, the critical considerations seemed intertwined and interconnected by blurred lines, making decisions and choices challenging. At times, I have referred to this analogy as it signposts my journey. I have used interchangeable words related to the childbirth process, so the reader may feel the terms are poorly defined; however, this reflects the way reproduction is a conjoined, intertwined, physical, psychological and social process. Understanding childbearing as a continuum is influenced by the way women perceive and treat the experience, in that the events that precede and follow the actual birth have a context. Without understanding that context, understanding and appreciating the person is a challenge. Treating pregnancy, birth and motherhood as a continuum instead of individual events has become part of my midwifery practice philosophy and is reflected in my writing. In this reflexive introduction, the discussion about my career pathway, subject matter and my position as a feminist researcher have not been

prioritised. They are fluid and part of a continuum, and I ask the reader to consider this while reading.

This chapter aims to offer a context for this research. It begins with my examination of my reflexive position and how I selected the topic and focus of this thesis. It provides an overview of the research, and its research aims, followed by an outline of interrelated concepts around pregnancy, birth and womanhood. I conclude the chapter with a summary of the organisation of the thesis.

Feminism, birth and me

Many women, if asked when they realised they were a feminist, might say, "I've always felt like that." This is true for me; I cannot remember when I did not appreciate women's rights and the feminist cause. Along with this came the desire to champion them. Midwifery has been an opportunity to do this. It is a job that has women at its very centre, and it is fraught with social injustice, political rhetoric and ever-changing family dynamics. This doctoral journey has helped me explore and define myself within the feminist spectrum, and I comfortably identify myself as a matricentric feminist (O'Reilly, 2016). This type of feminism recognises motherhood as socially and historically created and positions the role of mothering as a way of being as opposed to an identity. Its academic roots lie in the work of numerous feminist researchers (Oakley, 1976, 1986; Gilligan, 1993; Chodorow, 1999; O'Reilly, 2016; Rottenberg, Schonmann and Berman, 2017). It takes the matrifocal journey seriously and embraces the opportunity to be interdisciplinary and multi-theoretical.

Although my journey as a midwife began more than 20 years ago, my professional journey did not start at that point. My career began in 1981 as a pupil nurse, and although it sounds clichéd, I had a strong desire to heal the sick both physically and mentally. I soon realised I was working in a patriarchal hierarchal system (NHS), and I soon came to appreciate that women experienced oppression and subjugation in a variety of settings. As an 18-year-old, I met women who had little personal agency, and their male counterparts, the patients and doctors, firmly orchestrated their own

loci of control. As time passed, I came to understand that women had a powerful sense of resilience and the ability to survive the most awful experiences. I read literature such as "Scream quietly, or the neighbours will hear" (Pizzey, 1979), "Female Eunuch" (Greer and Inglis, 1971) and "Women's Room" (French, 1977) that exposed domestic abuse, rape and inequalities. These fuelled my interest in understanding the concept of social injustice and the power of the women who survived these experiences. This reflection may seem a long way removed from a thesis that aims to capture birth stories. However, exploring this literature was part of my pre-conceptual knowledge gathering. It connects my sense of being a feminist and seeing the injustice experienced by some women when they expected to have a fulfilling, positive, and life-changing experience but experienced anything but that. Some women find they are left with a degree of psychological trauma or, at best, an experience they cannot rationalise or understand (Weston, 2011, 2012; Rottenberg, Schonmann and Berman, 2017). As a clinical midwife and supervisor, I heard women recall their experiences where they spoke of "unkindness," "not being listened to," and "no one told me." Of course, my experiences as a 'sage femme' exposed me to the most wonderful moments, allowing me insight into the positive experiences women and their families could have under the right circumstances.

Intertwined with my developing clinical career was a desire to learn and know more about my profession and the world in which I worked. This eventually evolved into my current academic career. In the 1990s, a resurgence of nursing and midwifery roles was driven by the desire to establish these jobs as highly educated professional roles that used a well-informed evidence base on which to practice their craft. Schools of nursing and midwifery moved from being hospital-based vocational learning into higher educational institutional environments. For the first time, to qualify and be eligible to register as a nurse or midwife, students needed to attain either a diploma or a degree and complete set practice competencies. The programmes validated within university settings were stringently regulated by the General Nursing Council and the Central Midwives Board (now the Nursing and Midwifery Council) (Biley *et al.*, 2017). This new structure of midwifery education

aimed to give the role credibility and firmly place this career pathway on the "profession" listings. During this time, I saw the opportunity to satisfy my need to know more, develop my clinical knowledge and ultimately further my career. I self-funded a conversion course, taking me from State Enrolled Nurse to Registered Nurse (diploma level).

After several successful years of working in acute care services, I decided to change my career pathway to midwifery, which meant returning to full-time education to undertake a midwifery degree. I recall not one specific eureka moment but a cumulative gathering of incidents that led me to that decision. One of the most poignant incidents concerns a young woman I met during 1996. She was in her late 20s, a teacher with two children who had been in a violent relationship. She described how she struggled to end the relationship and maintain any distance from her estranged husband. She justified how she had been coerced into having sex with him and was now pregnant. When I met her, she had decided to terminate the pregnancy; I had been tasked with booking her in for the operation in the Day Surgery Unit. She cried as she related the story, and although her mind was made up, she remained very distressed. I still remember thinking that I should hold her in the moment and be silent, giving her space to tell her story. I made no judgement; after all, this was her experience; I only felt great empathy. She settled down and had the procedure. During her recovery, she thanked me for being kind and taking the time to listen, and we talked about her plans for the future. My reflection on this interaction with her is the paradox that was her sense of disempowerment paired with her resilience. It is difficult to be sure what the significance of chance encounters had on my decision. Perhaps it was the interpersonal connectedness between us that fed into my values and self-evaluative standards, which, in turn, encouraged the development of my personal and professional agency (Bandura, 1982).

During my midwifery education, I was introduced to two books by a midwifery lecturer, both books relating to women's birth narratives. Initially, I was encouraged

to understand the historical value of looking back in order to look forward in the context of how women felt about their birth experiences. Something else that became evident was the ability to use personal accounts to influence political or social change. The first is "Maternity – Letters from working women" (Davies and Women's Co-operative Guild, 1978), a compilation of letters to the author. It is not clear whether the letters were intended for publication or petition. However, the publication of the letters in 1915 was instigated and supported by Virginia Woolf. The publication was received well; it was congruent with the governmental reforms of the times, namely Lloyd George's National Insurance Act. This Act surprisingly proposed that a woman should receive a maternity benefit payment of 30 shillings, held in her name rather than her husband's. Throughout the First World War, the collection of letters continued to be used as evidence in campaigns to improve maternity and infant welfare. The letters discuss the intimate details of the women's experience of pregnancy, birth and motherhood. What is interesting about this book is the women's desire to tell their stories, particularly in a time when such an articulation was socially taboo.

The second book, "The Labour of Love – The experience of parenthood in Britain" (Humphries and Gordon, 1993), was accompanied by a television series of the same name. The book and series aimed to plug a knowledge gap in Britain's social history of family life. Of the book's six chapters, one is devoted to childbirth, another to baby care and a third is titled "Staying alive." In these three chapters, similar themes are identified as in "Maternity – Letters from working women" (Davies and Women's Co-operative Guild, 1978), such as poverty, fear and infant mortality.

When I read these books in the 1990s, I tried to assimilate them into the maternity service and social constructs in which I worked and lived. The most striking realisation was the similarity of the stories, even though they were encountered decades apart. More worrying was that the negative experiences of some of the women could have been transposed into my time and space, mirroring the recollections recalled to me in clinical practice. Of course, there have been vast

improvements over the last decades to the levels of maternal mortality and morbidity. While fewer women die in childbirth, the experience and emotionality of birth appear to have changed little. My initial response was to consider whether practitioners and 'carers of women' had actually learned anything at all; saving lives, of course, was vital and undoubtedly took priority in the service changes of yesteryear. I wondered about improvements to the importance placed on the emotional wellbeing of women during pregnancy and birth. This made me realise that the most significant way to influence and change midwifery practice would be to work with student midwives. After all, they would be the future carers of women and gatekeepers of the profession. Therefore, during the next decade of my career, in both clinical and educational environments, I actively promoted and encouraged positive mental attitudes towards all aspects of birth and motherhood, never losing the impetus to facilitate a positive experience regardless of the birth outcome. Tutors had told me that women would always remember their midwives if the interactions were significant enough. However, I wondered how long these memories would last and what exactly it was that women recalled.

By the time I came to consider this research, my curiosity about the endurance and significance of birth experience memories to women's life span had been sparked. I wanted to hear and understand the stories of those who had had such an experience some 50-plus years ago. In the early 2000s, I was asked to share my expertise as a domestic abuse lead community midwife with students. At this time domestic abuse had become a public concern rather than a private matter. The profession had acknowledged that midwives had a role in identifying and supporting women in abusive relationships, offering them advice and direction and, at times, safeguarding (Muscat, Passmore and Chenery-Morris, 2015). This experience pleasantly snowballed into further ad hoc opportunities to facilitate learning, which eventually culminated in a full-time transition to a midwifery lecturer's role.

Becoming a midwifery lecturer was not without its challenges. In the early days, I experienced imposter syndrome (Pedler, 2011), experiencing an overwhelming sense

of intellectual fraudulence, despite reassurance from colleagues and mentors that my clinical proof of competency was worthy. With some internalisation of the issues, the feelings of imposter syndrome subsided. Interestingly, periodically through my doctoral journey, the feelings of inadequacy associated with imposter syndrome have left me feeling fretful. I have taken solace from "From Here to Maternity" (Oakley, 1986). (The original title of her work, in 1970, was "Becoming a mother.") Oakley offers a level of reflexivity not often seen in research; she firmly places herself as a novice researcher when discussing the research, she conducted in the late 1970s. She positions herself as a naïve researcher, which she felt impacted the way she presented the findings within the first publication. She said she felt she was unable to articulate the discourse behind the women's words. In the second publication, she presents a more critical view of the women's (unchanged) words. Her 'story,' as the researcher reminded me about the significance of the researcher's position when undertaking a feminist narrative study. This type of reflexivity has offered me a valuable perspective on the way I have chosen to include self-reflection in some of these chapters. Even more importantly, it has given me the confidence to be open and transparent when reflecting. Journaling has helped me with this, giving me a place where I can gain perspective on any concerns I might have or revisit and celebrate any successes. I have listened to my own story and debated the complexities of a woman's (my) lifespan narrative. One of the conclusions is that my journey has informed the pre-conceptual thread of this thesis and consequently established my position within it.

The moment of conception of this research occurred during a scheduled meeting with my EdD programme tutor. We were meeting to discuss the focus of my research project. I explained I had often recalled and been enthralled by the two books about women's experiences (Davies and Women's Co-operative Guild., 1978; Humphries and Gordon, 1993). Now in my 50s, I revisited them, considering how I fitted into that scenario of recalling the birth-days of my children. We spoke about 'being seen' as older women and queried whether telling younger generations our birth and motherhood stories was of any value. I realised that I had heard many parts of my

mother's stories of birth but now question whether I had listened to the whole story, after all when I listened to these I had listened as a daughter, nurse/midwife and mother not as a researcher. So, I asked her if she would like to write her memories of my birth. She was happy to do this, and her story has become the prologue of my journey through this work, as it has acted as a catalyst and has implicitly informed some of the choices made and understanding of the time and space of the women who participated in this work. Reading her narrative, I was able to see 'the woman' rather than 'my mother,' by this, I mean that she articulated her thoughts in a way that almost removes me (the daughter) from the story, and this time I listened as a researcher. The story was very much focused on her thoughts and feelings during her journey. Moreover, it raised several questions, I was curious whether others hear such stories, what was heard? What could be heard? and would women benefit from 'listening' to other women's (particularly their mother's) birth stories for no more reason than learning and appreciating their stories and initiating thoughts of what it is to enter the realms of motherhood? Poignantly, I began to see the value of researcher reflexivity and introspection, so combined with a stimulating conversation with my EdD tutor, the seed was sown; the decision was made to investigate older women's memories of their birth experiences and what this might mean to others.

Study rationale – the birth continuum remembered through the lifespan.

The birth continuum as a rite of passage

The birth continuum is universally recognised as a significant rite of passage. Women transitioning from having no birthing experience (nullipara) to having their first (primipara) and subsequent (multipara) experiences. It is steeped in cultural rituals, teachings, activities and behaviours and even has a unique language and terminology. Time has not made this rite of passage passé; in fact, the cultural rituals have evolved, ensuring it remains contemporary and significant.

In 1909, the anthropologist Van Gennep first presented the concept that human beings move through a selection of ritual processes representing cultural life cycle changes of status and position (Van Gennep, 2019). Pregnancy, birth and motherhood were included in this description of events; Van Gennep (1909) skilfully blended the rites of passage of the newborn, who then moves into childhood, puberty and adulthood, extending the continuum to encapsulate the whole life cycle. The passages involve three stages: separation from the current world, transitioning into the new world and incorporating into the new world. The three stages are further defined as follows:

- Separation = pre-liminal[1]
- Transition = liminal
- Incorporation = post-liminal

In midwifery practice, the concept of 'rites of passage' has historically been embraced, and examples of this can be seen in midwifery literature. The birth rites that accompany the birth continuum sit comfortably in the paradigm of birth. Not only does this paradigm include the technocratic, humanistic and holistic models of health care, but, importantly, they are part of the sociological occasion that welcomes a new life into a community (Davis-Floyd, 2003; Hill, 2019). The application of the stages of this birth rite suggests that women move through the process of becoming pregnant, visualising a different lifestyle as a mother (preliminal). The transition stage (liminal) could be defined as the moment of birth when the visualisation verges on becoming a reality. (Côté-Arsenault and O'Leary, 2015) describe this point as 'betwixt and between,' where she sits at the cusp between the liminal and post-liminal stages. The position associated with foetal or neonatal death is paradoxical; after all, birth is one of the most dangerous journeys of our life. The 'incorporation' stage (post-liminal) may not be one of joy, where

[1] 'Liminal' comes from the Latin word *limen*, meaning 'threshold.'

society and communities accept a woman in her new role as a mother, but one associated with grief, bereavement and loss.

The paradigm of birth often does not only include the mother and baby. At various points in the prescribed pattern of events, they frequently fight for priority and attention. The complexities of this dance include both males and females who have a variety of roles as mothers, fathers, sisters and brothers, or the midwives, doctors and obstetricians. The risk of this dance is that women's experiences can be lost or denigrated. The assertion of 'who knows best' has been well documented throughout history. The most considerable tensions are between men (the patriarchy) and women (the matriarchy), with women portrayed as being supportive to others of their gender, while men are portrayed as misogynists needing to control events (McIntosh, 2012). The medicalisation of birth discourse continues into the twenty-first century, and the literature and evidence of the lived experiences of women demonstrate sound arguments for having a better balance to the approaches of supporting birthing (Kitzinger, Paige and Paige, 2005; Cunliffe, 2007; Department of Health, 2016; Ockenden, 2020). This research importantly focuses on women who gave birth in the UK during the 1960s-70s and has made the tension of 'ownership' and 'directorship' of maternity services of this time visible. The situation in maternity services was compounded by the sociological position of the time. The women had birth experiences at a time when women’s rights and patriarchal traditions were arguably at their peak of contention when women were fighting to find their voices and positions in society, yet the irony is that now in their seventies, their voices are muted and hardly heard.

Women, ageing and their ways of knowing

It is acknowledged that rites of passage are transitional points in life that serve as doorways to developing the subliminal self into a post-liminal way of being (Davis-Floyd, 2003; Van Gennep, 2019). Where people can learn from and internalise essential experiences, they have a chance to build their self-agency and discover a

way of being that offers a mature version of themselves. However, birth is a journey fraught with emotional and social complexities, and it is questionable whether the impact of a poor birthing experience could ever lead to a positive post-liminal way of being. Yet, humans can flourish if they have the proper support and facilitation (McCormack *et al.*, 2021). Interestingly, the status of some rites of passage is viewed as having greater consequential value or gravitas.

As women move through their life cycle, they experience the inequity of some of the rites of passage they journey through. For them, birth is not the only consequential woman-focused rite of passage. The transition through puberty, with the onset of menstruation signifying the change from girl to a woman, is often romanticised by suggesting it is a time of discovering one's sexuality, having intimate relationships and reproduction. The importance of being able to procreate is often held up as crucial to female existence, and the implications of infertility leave women feeling excluded from their communities with the topic avoided (Inhorn and Balen, 2002). Later in life, menopause similarly signifies a transition into a woman's 'golden' years. However, unlike the ability to reproduce, menopause is not celebrated as an achievement. It is often not recognised as a landmark that signifies the person has successfully navigated life and survived or as a time that has bestowed wisdom to share with younger generations. More often than not, the topic of menopause is avoided and relegated to the realm of unpleasant or taboo subjects.

Menopause may have become an anathema because the patriarchal view of women's purpose in society is perceived as chiefly related to reproduction. If women can no longer fulfil this role, what is their purpose? In addition to this perspective, poor understanding by the medical profession has made it difficult to manage medically. Attempts to manage the menopause medically began in 1821 when French physician Charles Pierre Louis De Gardanne coined the term *la ménépausie* (Théré and Kramer, 2015). The name (from the Greek words *pausis* ("pause") and *mēn* ("month"), which in itself suggests this rite of passage, is not about moving into a celebrated age; it refers to a 'pause' of fertility and the ability to conceive,

something that needs to be medically treated to un-pause it. Significantly, this time of paused fertility is associated with poor mental health and a time of female weakness (Formanek, 1990). Yet, it could be argued that this rite of passage, unlike birth, cannot be opted out of or delegated to another person, as with surrogacy or adoption. Significant physical changes occur, such as loss of skin collagen, skin elasticity and hair colour, the reversal of which feed into a 56.5-billion-pound beauty industry (Statista, 2020). The hidden impact of this period in women's lives is associated with changes to employment status and opportunity. With so much 'loss' it is no wonder that for some, the perception is that the subsequent rite of passage could only be death! It requires immense strength to travel this rite of passage and immerge positively in the new world of the older woman.

Of course, it would be naïve to proffer that women should not or do not wish to stave off the ageing process. After all, the billion-dollar anti-ageing beauty industry is sustained by its consumers. However, the social construct of women ageing tends to foster a negative image of the process, leading to women feeling marginalised and invisible. This could be rebalanced by exploiting the value of aged intellect (wisdom) and experience and seeing these attributes as a richness in which an acceptance of the life cycle can be shared with families, communities and broader society.

Voices have emerged encouraging older women to take ownership of their place and time of life and be more resilient in their ageing rather than waiting for a societal change (Gattuso, 2003; Jones, Young and Reeder, 2016). Germaine Greer's (Greer, 2018) book 'The Change' attempts to contextualise ageing from an anthropological perspective. As a feminist, she discusses the use of language, medical technologies and fraternities to explain how women find themselves in an unsure position. This book is not a 'how-to guide' that suggests a way forward. It is more directional, suggesting that to achieve requires seizing your power back and finding peace, tranquillity and contentment with the body and mind you have. However, elsewhere, women are taking more pragmatic approaches to redress the issues; they are

creating environments where they are recognised as women of a certain age and disposition in places where their narratives can be heard. Menopause cafés have been started where women (and men) can discuss the impact of menopause on life. In the media, high-profile women are outing their menopause and post-menopausal experiences. Not only does this heighten awareness of an often-taboo subject, but it also suggests that women in this age group are 'worthy' of consideration, making them visible in society (Benjamin, 2018). My research offers an original way of 'seeing' and 'hearing' older women, asking questions about sharing their birth experience stories with younger generations, and trusting that if they have not, asking the question will ignite a desire to do so.

The current generation of 70-to-80-year-olds now represents some of the 10.6 million people in the UK over 70 (Office for National Statistics, 2019). For women, life expectancy has increased over the last decade, from an average of 71 years to 82.3 years. Family units are diverse, either matrifocal, patrifocal, or nuclear rather than traditional extended family groups. Families are often forced into making nepotistic choices when it comes to who lives in the family home due to the cost and availability of housing and the structure of welfare support for the elderly. This familial challenge is reflected in the two million-plus, or nearly half (49%), of all people aged 75 who live alone (Age UK, 2019). Generational discourse raises concerns about the structural changes in families and whether intergenerational family harmony and support are weakening (Keating *et al.*, 2015). A sequence of tensions appears to inform this ongoing discourse; the societal perspective raises concerns about unsustainable health, economic and social care systems with the rising proportions of older people. The women in this study are first-generation 'baby boomers.' They are more likely to have experienced considerable changes in day-to-day living than any other generation. As post-war babies, they are more likely to have experienced parental loss, destabilised housing and home life. Likewise, they have lived through a time that has seen incredible technological and scientific advances (Fingerman, Pillemer and Silverstein, 2012). They have experienced societal

and cultural changes of immense proportions; they have been part of a sexual and reproductive revolution.

Additionally, they have initiated the reinstatement of the common practice of grandparents caring for grandchildren (Fingerman, Pillemer and Silverstein, 2012). Yet, a disparity exists between the numbers of those reported to be isolated and lonely. This seems a missed opportunity for communities to foster intergenerational companionship between families who do not have close family members in their lives. In 'The Age UK report, Loneliness – the state we're in' (Bolton, 2012), the Chief Executive of Age UK introduces the concept of loneliness as a complex web of 'social isolation.' He suggests that the elderly are wrongly treated as a homogenous group allowed to spiral into a life of coexisting morbidities and mortality. This research-rich document outlines potential interventions that could alleviate loneliness, one of which is how the young and old can be bought together supportively. Interestingly, in "Promising approaches to reducing loneliness and isolation in later life" Age UK reported 28 examples of successful intergenerational groups but no examples of pregnancy-related intergenerational interactions, missing a prime opportunity to enrich people's life experiences.

My research will provide a voice to a group of women who are often under-represented within contemporary society and culture, where women complain that they become stereotyped and "invisible" as they pass through middle age and approach their older years (Lemish and Muhlbauer, 2012; Walmsley-Johnson, 2015; Moore, 2016; Good, 2017). Nevertheless, older women offer ways of knowing that are unique to them. Though, as with many people, the social constructs of gender, race, class and patriarchal epistemologies may have shaped a way of knowing, for the older woman, a juxtaposition of interdependency is created. This interdependency is a critical, pivotal component that informs a unique discourse, the convoluted relationship between motherhood, society and self (Belenky *et al.*, 1997). Older women who have mothered may have negotiated the mixed messages and challenging perspectives placed on women in society. Belenky *et al.* (1997) suggest

that the role of motherhood and caring work is ignored by society as irrelevant and contributes nothing, chiefly because it is seen as a 'natural' occurrence, so birth and motherhood should not be revered. This implies that mothers have no agency, yet without this 'natural occurrence,' society cannot thrive. This status quo justifies Belenky *et al*. (1997) assertion of silence as the first of the five stages of knowing. As younger women, the internalisation of this positioning will impact the way knowledge and experiences are shared; after all, why share with those who only wish to oppress you with silence? Women learn to share some narratives covertly with others rather than celebrated with many. Some narratives will be silenced, and others will be communicated non-verbally among only a selected few. My research aims to countermand this by giving agency to women's voices, hearing and understanding what is present and absent in the narratives of their birth experiences.

Overview of the study

This research study represents the development of a unique approach to exploring older women's identity through the lens of birth stories and understanding the endurance of these stories over time. It is based on in-depth narrative interviews carried out with six women aged over 70 in South East England. The recollections of their pregnancy, birth and early motherhood were recounted, and the data were analysed by utilising the 'Listening Guide,' a voice-centred relational method of analysis (Mauthner and Doucet, 1998; Doucet and Mauthner, 2008; Gilligan *et al.*, 2011). The intention of this study was not to document, compare accuracy or even question the 'truth' of the recollections. It was to reveal how after five decades, the women's recollections of birth are remembered and articulated and now contribute to their sense of identity. During the interviews, the women were given space and quiet to reflect on their memories. They were asked to consider how they have shared those memories and reflections over the years. The questions aimed to address the research questions:

1. In which ways do women recollect birth experiences in later life?
2. What are the positive and negative elements of these experiences?

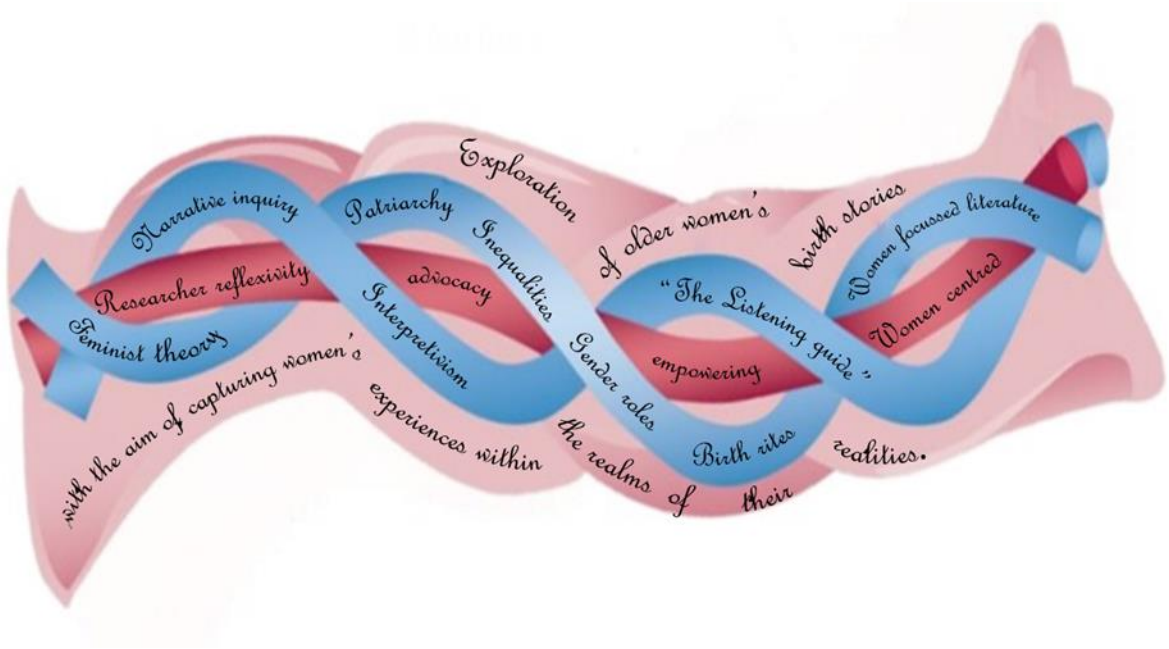
3. How are these experiences transmitted intergenerationally from woman to woman?

Contribution to knowledge, originality, and the conceptual framework.

Two areas of originality are interconnected within this research. The first relates to the conceptual framework (illustration 1.1) I have developed, which will be discussed in greater depth in Chapter 3. It emerged as I rationalised and envisaged how all the aspects of this thesis should fit together. I wanted to include a representation of me as a researcher, midwife, woman and feminist. It was equally important that I not be viewed as sitting on the periphery of the research but as integral to it. I envisioned threads woven together like a quilt, yet this alone did not demonstrate the fluidity of the priorities and felt one-dimensional. Through my mind-mapping, words such as 'importance,' 'continuum' and 'interdependency' prominently appeared. I applied this to the pathophysiology of pregnancy and birth and concluded that the umbilical cord is to pregnancy what a conceptual framework is to a thesis. The alignment began by acknowledging the quintessence of the umbilical cord as the conduit between the mother and the fetus, followed by recognising the interdependence of all features and the need for synchronicity between the parts of the cord to sustain and support parturition.

I embedded words related to the methods and methodology of this work along with one of the arteries (blue tube), the theoretical feminist ideologies and issues through the second artery and wove the personal (me) researcher, midwifery skills, attributes and experience through the centre via the vein (red tube). I ask the reader to imagine these ebbing and flowing through the vein and two arteries, being in a variety of contrasting positions whenever they appear in this work. The research title and questions situated in the Wharton's jelly (the gelatinous outside of the umbilical cord) have encapsulated the conceptual words written in the vein and two arteries. This represents the maintenance of the focus of the questions throughout the thesis.

Illustration 1.1



The second is the unique focus of this research on older women and their recollections of the birth experience. Specifically, it highlights the lifelong recollections of the birth experience of six women in their 70s. This contributes to knowledge as it broadens the understanding of older women's journey through life in a way not seen in other studies. The originality is associated with the analysis of the narratives shared by the women. The analysis throws light on a particular historical time in the women's life journey. Importantly, it demonstrates that they have not just been listened to in a way that records their memories for posterity. A process of radical listening (Clough and Nutbrown, 2012) takes place in the thesis, which elicits unique findings. The theorisation of the women's stories reveals how in the absence of a mother figure, they either developed strategies to seek out support from 'other' females during their birth experiences and transitions into motherhood or experienced lifelong struggles associated with receiving a poor mothering experience.

Additionally, the differing voices revealed through radical listening expose the multi-sensory experience of birth. Grix (2001) advises doctoral students that the

requirement to demonstrate a 'substantial contribution to knowledge' means that an original piece of research must be firmly embedded in the 'received wisdom' of a particular field.' In this instance, the 'received wisdom' is that women often recall their birth experiences at some point. However, the longevity and significance of this have not before been investigated. The 'new wisdom' this research offers is directed to professional practitioners, policymakers, educational institutions, and, most notably, women who might be inspired to tell or hear other women's birth stories, reflexively learning from this.

The organisation of this thesis

This thesis is presented in seven parts, including this introductory chapter. Although the contents are presented traditionally, the data and analysis are not. They are located together, with one immediately informing the other.

Chapter Two offers an insight into the dominant *literature* that engages the discourse surrounding why, how and when women recall their birth experiences. Additionally, threaded throughout, it considers the feminist discourse associated with women's recollections of childbirth.

Chapter Three presents the *methodology and methods* of this research. It explores my theoretical perspective and provides a rationale for selecting narrative inquiry as the methodology. The method is critically discussed, and most importantly, the participants are introduced. The contextual framework is fully presented and demonstrates how the thesis fits together symbiotically.

Chapter Four – Women of their time aims to add context to the women's narrative. It has a perspective on the socio-economic and cultural lifestyle of young women, such as those in this study, who lived through the 1960s and 1970s.

Chapter Five – Personal and professional relationships, focusses on the unique relationships the participants forged with key women in their lives during the birth

continuum. Whether it was their mother, mother-in-law, sister or midwife, the significance of that memory prompted it to be recalled in their narratives.

Chapter Six – The emotion of birth is explored through the use of I-poems, which aim to hear what the women know and say about themselves. It draws out the emotional voices heard during the women's experiences as recalled in their narratives.

Chapter Seven – Discussion draws together the key claims from the analysis in Chapters Four, Five and Six and considers how the research questions have been answered. The narratives associated with birth and the way this is heard in society are discussed. The path of the women's experiences is followed, considering the relationships they had with others and the feelings experienced, bringing them into the now by reflecting on how the experiences might be intergenerationally shared. The chapter concludes by exploring the successes and limitations of the study's methodology and methods and my contribution to knowledge.

Chapter Eight – Recommendations and concluding thoughts discusses those apart from women who influence the way birth is viewed and approached. Suggestions are made on how educationalists and health care professionals can positively impact women's experience by engaging with this study can change the current discourse and policies, helping them work towards a more balanced approach to birthing. This chapter includes justification for the encouragement of women's voices being heard. It concludes with reflections on my journey through this doctorate that consider what this study has given me and how I might move forward.

Chapter Two - Literature review

"For girls and women, storytelling has a double and triple importance, because the stories of our lives have been marginalised and ignored by history, and often dismissed and treated as gossip within our own cultures and families; female human beings are more likely to be discouraged from telling our stories and from listening to each other with seriousness." Gloria Steinem (2020)

The introductory quote by Gloria Steinem (feminist, journalist and activist) typifies for me the importance of hearing, understanding and learning from women's stories and the richness this might contribute to other people's experiences. The literature review was undertaken to consider, compare and understand a body of knowledge related to women's recollections of their birth experiences later in their life. However, it is vital to understand what the discourse already is and what is absent. It quickly became apparent that by undertaking a thorough literature review, the gaps, variables and hidden discourse would be exposed and allow me to bring older ideas and concepts into the 'now' (Ridley, 2008; Kim, 2016). Unearthing the most relevant literature is a complex task, particularly as the number of search platforms continues to grow exponentially.

Knowing that literature associated with birth and the added component of storytelling would yield a large body of evidence, in conjunction with our faculty librarian, I planned a structured search strategy that enabled me to narrow the results substantially, ensuring it was specific and sensitive (Aromataris and Riitano, 2014). The following search terms were used to conduct this search (Table 1).

Population	Boolean operator	Situation	Boolean operator	Doing	Boolean operator	How/What
Mothers OR Women OR Females OR Mum* OR Granddaughters OR Daughters	AND	Prenatal OR Preg* OR Birth OR Confinement OR Childbirth OR Labour*	AND	Story OR Stories OR Narratives OR Storytelling OR Storytelling	AND	Recollection OR Recall OR Memories OR Memory OR Reminiscing

Table 1

I selected the words using common midwifery terms and synonyms noted in an online thesaurus. Truncation or wildcards were used, which allowed the searching of the variants of some words. For instance, preg* extends the search to pregnancy, pregnancies and pregnant. The databases selected reflect those holding literature related to health and social sciences. The Cumulative Index to Nursing and Allied Health Literature (CINAHL), Ovid, BE index, PsycINFO and Medline were accessed through the University Library Search facility. Google Scholar and the British library thesis database were accessed via an internet search engine.

The terms 'storytelling' and 'childbirth' produced thousands of initial responses. To add focus, inclusion and exclusion criteria were applied. I aimed to identify primary studies that focus on capturing the narrative, autobiographical and biographical birth experiences of women of any age other than those in the early teen years or those of 'advanced maternal age' (over 45). This is because of the complex issues associated with birth during those two periods of time. The literature had to be focused on the women's experiences, not midwives, partners, birth partners or students. Studies were excluded where women were engaged with any type of psychotherapy, so the women in the literature should not have underlying mental health issues such as long-term depression, post-traumatic stress syndrome or psychosis.

The literature search was not restricted by year, country, language (although it had to be published in the English language) or culture. Only two pieces of research closely matched the research terms and aligned with my research aims. Both were

found on the Ethos' thesis database (Kay, 2016; Sopakar, 1998) . However, neither primarily focused on women of a similar age to my intended participants, with Sopakar being more closely aligned to my proposed methods and methodology. With this limited amount of specifically focused evidence, I began to consider literature laterally for associated topics such as motherhood.

A 'berry picking' approach was adopted at this point (Bates, 1989). This technique involves 'forward and backward chaining,' where reference lists and footnotes are searched to encourage lateral views (Booth, 2009). Although this technique is often adopted when not much is known about a topic, it was helpful when exact criteria could not be met. Through this technique, key authors and theorists were identified, extending the scope of reading (Bates, 1989). Several of the books identified were written in the 1980s. Some of these represent seminal work by leading feminist writers such as Ann Oakley (1976). The use of personal knowledge was included as part of this 'berry picking' search strategy. I have built on what I know professionally and serendipitously discovered new literature (Bates, 1989; Greenhalgh and Peacock, 2005; Booth, 2009).

After review, 64 sources remained. Bryman, (2016) suggests that when synthesising the literature, the researcher needs to create a story from this evidence to build their arguments. When synthesising the literature, it became evident that, as with the birthing continuum, an entwining, ebbing and flowing process takes place when women tell stories. The diagram below is a visual representation of the reformation of the themes that emerged from the literature. The yellow inner circle became the final subcategories within this chapter. The cog in the centre represents the fluidity and motion of the way each area could be discussed.

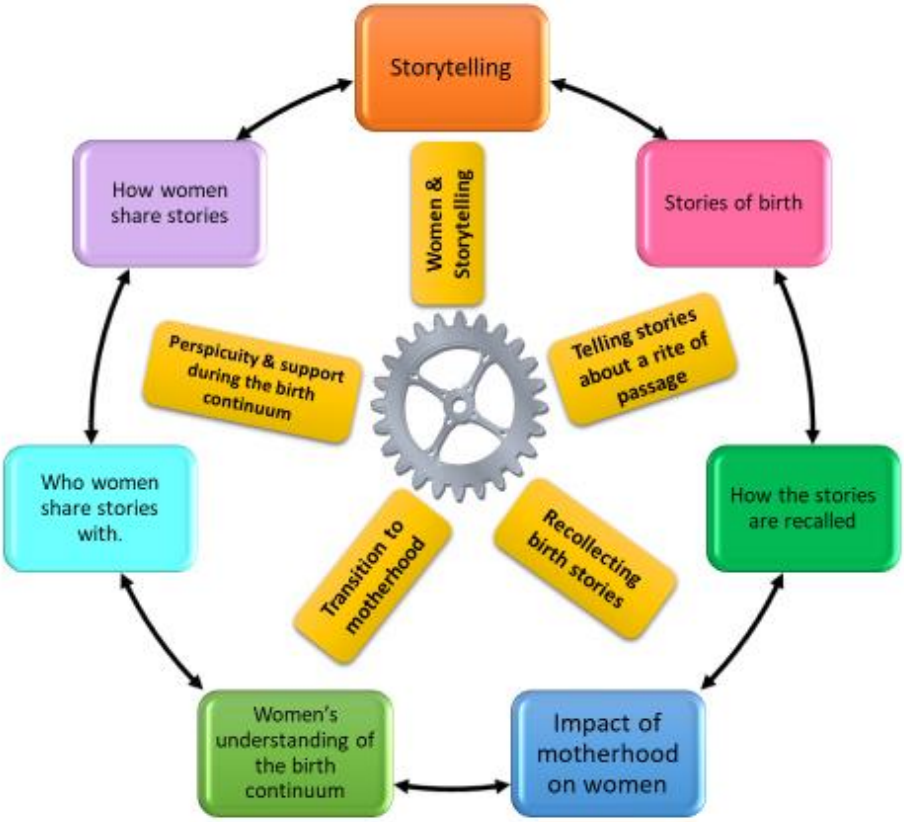


Illustration 1.2

Women and storytelling

Storytelling is both an intrinsic part of what it means to be human and a way of exploring our experiences. It enables us to make sense of those experiences by telling them to those around us. The stories are not always magnificent or significant to others. They may just be tales of daily life that reflect how people function (Baumeister and Newman, 1994). However, they often position the storyteller in their family, community or broader society (Razack, 1993; Pennebaker *et al.*, 2000). Yoder-Wise and Kowalski (2003) suggest it is not just about our position and the strength of that position but how a level of connectedness is created. After all, stories can influence policy and political intent; they can be used to set people against one another, ruin reputations and careers or mobilise people into action in a move to address social injustice (Polletta, 2006). Alternatively, they are used to

teach children life lessons or students in the classroom how to 'be' in their chosen careers. Indeed, in midwifery education, students continually evaluate positively and appear to appreciate the stories of the mentors' and teachers' lived experiences of practice (Weston, 2011, 2012).

According to Gilligan (1993) and Perry (1970) when telling stories, women demonstrate their psychological strength, wisdom when meeting discrimination and stoicism during challenging times. Some women have cultivated and learned to value their voices. Although they have challenges and obstacles to encounter when trying to achieve this, most interestingly, women share a collaborative egalitarian spirit (Belenky *et al.*, 1997). Gilligan (1993) describes this as a 'different voice' that is unique to women. She further explains that women are more likely to be empathetic yet uncomfortable when posed with an ethical dilemma, a view that could be described as a maternal attribute. Gilligan developed her work as a response to the lack of engagement with women in Kohlberg's theory of moral development (Kohlberg, 2008). The feminist criticisms of Gilligan's work relate to the idea that women only have one homogenous voice, and that age, race and class factors do not impact that voice. The discourse adds to the nature-nurture debate by driving women further into the role of caregiver (Weisstein, 1993; Hoff- Sommers, 2000). However, she has remained steadfast in supporting her research findings. Perhaps it is the context of experiences that impacts on the difference of voice and that the voice of women/mothers is unique in themselves. This is true of all gender identities; however, this uniqueness is about the process of reproduction that is a biologically female experience regardless of where a person places themselves on the gender spectrum.

Birth stories as a rite of passage

Women often tell stories of their birth experiences; sometimes this facilitates a process of reflection where the birth journey is unpicked, explored and understood; for others, it is about showcasing the success and bravery of birthing. Mostly birth

storytelling is part of the birthing rite of passage taken by women as they enter the realms of motherhood (Farley and Widmann, 2001). Questioning whether women tell their birth stories and why was the focus of Sopakar's (1998) thesis. By conducting narrative interviews, she found that women did indeed tell and retell their stories, particularly to their female relatives, however good or bad the experience had been. Her findings added an interesting dimension as she noted that only snippets of the birth story were told depending on the audience. The women positioned 'others' in and out of the story, "my mother wasn't there," "my husband was." Sopakar inclusively noted a connectedness between the women and how they spoke about their babies. They imposed character traits and personalities on their newborns that they associated with when they were in-utero, such as moving a great deal and once born not liking to be bundled up in clothing as they wanted to wriggle and move. This suggests that for some women the bonding process begins during pregnancy and extends to the moment of birth and beyond as they get to know their newborn (Redshaw and Martin, no date; Clift-Matthews, 2010). However, this maternal-foetal attachment is dependent on the mother's psychological and physical well-being (Walsh *et al.*, 2013). This does not only refer to the type of traumatic birth experiences some women have; it can be related to births with good outcomes but poor interactions and high emotional stresses.

The phenomenon of women sharing birth stories as part of their rites of passage might be perceived as romantic and portrayed as a beautiful and fulfilling experience. This way of sharing experiences from woman to woman can be an invaluable resource for the next generation of women. Telling birth stories most certainly has positive outcomes for the women; it allows them to process this significant event of their life and be part of a female bonding ritual where the common ground (birth) becomes the meaningful connection (Sopakar, 1998; Formenti, 2014). However, if women are forced into silence by the experiences of trauma and numbing detachment (Beck, 2015; Savage, 2001) this phenomenon could be lost (Formenti, 2014). Complications arise when women are not forced into silence but share the traumatic event without skilful advocates beside them; this

type of sharing may adversely impact other women's understanding of what a birth experience should be (Savage, 2001), leaving them with a sense of fear and vulnerability. To rectify this situation, the associated trauma has to be identified and intervention needs to occur, such as cognitive behaviour therapy or debriefing, to reframe the experience in a way that can be used as a positive learning experience for others (Beck, 2011, 2015; Beck, 2016, 2021; Beck and Watson, 2010; Elmir et al., 2010; Tatano-Beck, 2009, 2011).

The transition to motherhood

Understanding the emotional implications of becoming a mother is crucial as childbirth no doubt changes women's lives. As the landscape shifts over time and place and the patterns of women's lives change, the issues related to motherhood have become more complex and are not universally comparable (Miller 2005). For some women, the experience offers fulfilment and joy, but the transition into motherhood can be fraught with personal and sociological challenges. Other women experience feelings of loss of identity and visibility. The impact of motherhood having underrated importance and status within society and communities can lead to a sense of being devalued (Brunton et al., 1970; Davis, 2013; Miller, 2005; Oakley, 1984, 2016, 1976, 1986) .

Feminist sociologist Ann Oakley researched the 1970s and 1980s (Oakley, 1976, 1984, 1986) with "From Here to Maternity" (Oakley, 1986) revealing that the first childbirth experience intrinsically changed women's lives. This research exposed the contributing factors and catalysts for this. Interviews were conducted twice during the first and third trimester of pregnancy (weeks 14 and 34) and then during the postnatal period (weeks five and 20). The women experienced and had insight into the medicalised maternity services of the time, where the management of the dangers of birth were a priority and the women passing through this service were expected to do as they were told by the medical 'expert.' During this time, little value was placed on the psychological aspects of women's experiences in the context of

birth, and the Victorian attitudes of just getting on with it remained steadfast. The women in Oakley's study were interviewed about their experience of becoming a mother and shared their feelings of being devalued and less important to society. As they became mothers, the women's feelings of social displacement were driven by the loss of employment, financial independence and social isolation that often accompany motherhood. These feelings the women experienced were most certainly underpinned by the constructs of the patriarchal society of the day, one that viewed the role of the mother as a second-class job with little value or autonomy.

American poet and feminist activist Adrienne Rich identified this and challenged the status quo in her book "Of woman born: Motherhood as experience and institution" (1995). She describes motherhood as a patriarchal ideological construct that institutionalises women (Rich, 1995). Rich (1995) discussed the influence of male control over women's ability to regulate their powers of reproduction and the relationships they might have with their children. Written in 1976, Rich aimed to empower women's choices by exploring the power and powerlessness embodied in motherhood within patriarchal cultures. By bringing the motherhood debate into the public domain and creating an intellectual discourse about the topic, she challenges her readers (women) to be active participants in the process of reproduction and birth, increasing personal agency and strengthening the power of birth and motherhood. This text is arguably one of the most important feminist texts about motherhood. Although outdated contextually, the tenet within the text remains contemporary as the status of motherhood remains subjugated.

From a feminist perspective, the view of the disempowerment of women during the transition to motherhood caused by the patriarchal construct is ever-present (Miller 2005). The discourse about women's career progression vs parenthood and how they may not be congruent with one another remains constant. Similarly, the judgement of the working mother vs the role of being a 'stay-at-home mum' is a debate that is compounded by the soaring cost of childcare that reluctantly pushes women out of work and back into the home. Some feminists feel this reflects a

society that does not value women's choices. It is not merely a financial debate about childcare costs; it is about the value of women as mothers and as part of a workforce that contributes to the community in which they live (Christopher, 2012; Glaser, 2021; Gorman and Fritzsche, 2002; Mcintosh and Bauer, 2006; Pare, 2008). More important is the hidden impact on the next generation, not only how they might experience being parented but also how they will perceive women's roles in society as they transition into adulthood (Green, 2019). A cycle of events is seen in this discourse, one that is concerned with the disempowerment and loss of autonomy of women as they pass through one rite of passage into another, which is exacerbated by the medicalisation of birth. The debate concerning the medicalisation of birth remains a controversial issue within the practice of midwifery; contextually, this type of medicalisation has developed. In the past the catalyst was the basic control of birth by the patriarchy; doctors were the experts and women should do as they were told because they were not the expert. Today, the medicalisation of childbirth not only uses technologies to assert the discourse but also appears to have become more about the politics of risk, conforming to underpinning regulation and the unrealistic policy set rather than successful outcomes (Kitzinger, Paige and Paige, 2005; Kitzinger, 2006). This dominant narrative of the day remains patriarchal and will continually need challenging and evaluation.

Recollecting birth stories

Women's birth stories do not stay constant; they evolve relative to time and place. With the author being the actor (Miller 2005), birth stories may alter as a response to the audience; differing levels of emotionality may be embedded into the story as a way of reaching out to the audience (Farley and Widmann, 2001). The level of reflection and emotional processing of experiences may impact the longevity and importance of different aspects of the recollection. When women begin to tell their birth story, they select a few nebulous elements on which to focus (Simkin 1991,

1992). Once told numerous times, these elements become the essence of their stories, with the unnarrated events fading into the background (Davis-Floyd, 2003). This phenomenon may be a combination of the storyteller responding to what they believe will have the most meaning to the women listening and what the most significant issues are to them at that moment, resulting in finding common ground with their peers or a hierarchical position within a peer group.

With reflection and processing, how the experience is understood, and the story is told may become discordant and changeable. The focus of the experience may not be on the timings and process of the birth; although women often recall the time labour started or their waters broke, it is the accompanying psychological and emotional components they recall. It may be that this is aimed at engaging the listener in the story. The findings from Simkin, (1991, 1992) longitudinal study conducted in the late 1960s and early 1970s found that the women recalled humorous stories related to the doctors involved in the birth. These periods of light-hearted humour during a time of stress may seem strange, but this type of gallows humour is a common feature of human behaviour during times of adversity. Simkin noted the extremes of women's feelings; some felt a sense of achievement and elation, while others felt a distinct sense of loss of control and vulnerability. Women have been shown to use humorous metaphors during conversations to lighten the topic and consolidate themselves as a group. Lee, (2015) found that once women had established their relationships after knowing one another for some time, they allowed themselves to have more intimate discussions about their bodies and personal lives. In Lee's (2015) study the example given concerning the size of the woman's pregnant abdomen became the humorous centre of a discussion. The other women joined in to offer comparative perspectives on the differing size of abdomens experienced during pregnancy.

The use of humour is often transformed into humorous or horror stories (Savage, 2001; Romano, 2007; Munro, Kornelsen and Hutton, 2009). While Savage (2001) regards listening to horror stories as detrimental to women's emotional well-being,

others suggest women quite enjoy this aspect (Romano, 2007; Munro, Kornelsen and Hutton, 2009). Professionally, I have listened to many accounts of both humorous and horrific birth experiences. It seems that these vehicles (humour and horror) are used to draw the audience into the story. Of course, the humorous aspects of storytelling are associated with laughter. Laughter is an intrinsic component of human discourse; it crosses the barriers of all languages and cultures. It can be used positively and negatively; humans can 'laugh with' or 'laugh at.' It is a significant part of socialisation (Calman, 2001; Gervais and Wilson, 2005; Lee, 2015; Meyer, 2000; Scott et al., 2014; Tanaka and Campbell, 2014).

Simkin (1992) undertook a follow-up study in 1989 to her previous study (Simkin, 1991). She revisited the same 20 women some 20 years later, aiming to investigate the impact on recollection over time. Overall, it was found that the women mostly had a good recall, and although some changes occurred in their replies, confusion appears between the birth of the first baby and subsequent babies. In general terms, the responses to both the questionnaire and during the interviews were consistent. Notably, the clinical experiences, such as the onset of labour, the rupturing of membranes or dilatation, faded; for some, the order of those experiences had become confused. The women still remembered and referred to the emotionality of the experience. They remembered feelings such as the pain, the humour and, to some degree, the joy. What is evident in the Simkin studies is that the passage of time had allowed women space to make sense of some aspects of their birth experiences. Whether this was related to subsequent experiences of pregnancy and birth or life events such as divorce, death and marriage is debatable, making it challenging to pinpoint the exact "flashbulb" moment. Simkin, (1992) does highlight the issue of the "halo effect" occurring, a process whereby fewer positive experiences are overshadowed by the excitement and joy of the moment. In this instance, the birth resulted in a baby who had grown to be a wonderful adult, which overrode the negatives of the birth experience.

Unlike Simkin's (1991, 1992) research that considers both physical and emotional recollections, a body of literature enquires about the physical experience of birth and the clinical procedures encountered, such as enemas, forceps, episiotomies and caesareans, rather than the "story" of the birth. (Erb, Hill and Houston, 1983; Bennett, 1985; Githens *et al.*, 1993). Women's memories do not appear to be accurate when asked about events such as the timings of cervical dilatation, for example, once six years have passed. (Githens *et al.*, 1993). It is questionable why women would recall such information. Indeed, it would depend on the level of understanding they had about the medical terminology and process of birth, and notably whether this was a priority for them. It is presumed that the health care professional's documentation is accurate, meaning the researchers have assumed that the expert must be correct as they view their findings through a hierarchical patriarchal lens. However, they did add a one-sentence comment that the women may indeed be correct and the doctors not. The approach of Githen's *et al.* (1993) research reduces the usefulness of this study somewhat, especially as many of the questions required a yes or no reply, meaning the chance of answering the question correctly was 50/50. Interestingly, this research asked two groups of women, those who had experienced adversity and those who had not. The psychological aspects of traumatic birth or experience would surely compound the memories and should be considered. When suggesting that the recall is only accurate six years after delivery belittles the holistic experience. Psychologist Elizabeth Loftus describes our memories as the "essence of you" and has become one of the world's leading experts on false memory or misremembering. Although most of her work is related to the justice system and how eyewitness accounts are prone to suggestion and can be unreliable, it provides some insight into the usual process of remembering. She has written widely about the normal function of moving recollections from our short-term memory to our long-term memory (Hyman and Loftus, 1998; Loftus, 1997; Loftus et al., 1987) and how memories are distorted to protect the person and reframe the experience. This implies that the adaptations made when recalling an

experience to others may transform into a version of events with inaccuracies, but at that moment, that version of events is true to the person.

Perspicuity and support during the birth continuum

Although women seem to value embodied knowledge (Romano, 2007; Munro, Kornelsen and Hutton, 2009), little research has been conducted on the transfer of experiences between groups of women, familial or otherwise, as a way of learning about birth. In the research available, women say they want the authenticity of the experience, they want this type of "embodied knowledge" as opposed to "authoritative knowledge" (Romano, 2007; Munro, Kornelsen and Hutton, 2009; Miller, 2017). When drawn together socially, people will attempt to find common ground to focus their conversations on (Lee, 2015). Women will often select marriage, relationships, pregnancy and motherhood as areas of common ground. The participants in the conversation do not have to have experience of these situations but merely know they could if they chose to. Discussion about the transference of birth experiences within broader research pieces about women's relationships relates to their usual focus on relationships' negative and challenging aspects. The intention of sharing experiences through the birth continuum is mainly supportive but it may draw the relationship closer and establish familial relationships, particularly when considering mother-daughter relationships.

The significance of the mother/daughter/sister conversations related to birth often appears as an incidental finding in the literature and is intrinsically woven into chapters that talk about the support the women needed (Oakley, 1986; Davis, 2013). Yet the mother-daughter relationship is powerful and complex and often those who are unmothered, seek mothering all their lives (Rich, 1995). When asked, women often refer to the significant women in their lives, how they informed them about pregnancy and birth and crucially how they influenced their choices and supported them as they transitioned into motherhood. They firmly position them in or out of their story (Sopakar, 1998). For example, in Oakley's research, she described how

pregnancy diagnosis was 'observed' and identified by women's mothers or sisters long before the doctor could confirm the pregnancy. Likewise, when the women were trying to decide whether it was "right" to take maternity leave or resign, their female relatives would exert the view that they should resign. Of course, mother-daughter relationships are not always nurturing and intuitive; they can be significantly complex. They can be full of conflict where barriers are put up between the mother and daughter, resulting in poor communication, in turn reducing support and understanding (Debold, Wilson and Malave, 1993; Caplan, 2002; Bojczyk *et al.*, 2011; Onayli and Erdur-Baker, 2013; O'Reilly, 2016).

Understanding how grandmothers, mothers and adult daughters communicate is complicated. Miller-Day, (2004) defined the aim of her research as "to investigate how mothers and daughters symbolically negotiated their relationships" (p.xii). She adopted a mixed-methods methodological approach in her research. She described this as "descriptive, interpretive, hermeneutic and heuristically layered" (pg. 17) in an attempt to represent the simultaneous voices of the participants. This book provides an invaluable resource for researchers when trying to understand the different levels of communication between female members of the same family. By including three generations of the family the analysis provides insight into the communication, interactions and social dynamics that occur between the women. The three-page section about the connections during pregnancy and childbirth has a sense that the mother and daughter's defining moments in their relationships were when the daughters became mothers themselves. The grandmother and granddaughter relationship is acknowledged as different from that of the mother and daughter – described by one as "special." This comparatively small section about the birth experience offers other supporting evidence about relationships.

When asking about an intergenerational exchange about the significance of birth, Kay (2016) found this did not occur between the generations at either a cultural or spiritual level. Additionally, it gives credence to the suggestion of a silent generation of women (Beck, 2015; Savage, 2001).

Some evidence shows birth stories being shared by the family matriarch to socialise children into their communities; however, the focus is not always related to birth (Archibald, 2008; Reese and Neha, 2015; Taylor et al., 2013). When Reese *et al*. (2008) undertook a comparative narrative study that aimed to test the role of early memory socialisation of two indigenous groups, the Maori and Pakeha (New Zealand Europeans), they found that participants used a reminiscent style of storytelling. The Maori women tell the stories more dramatically, making their children's birth stories richer. The researchers found that this grounded the children in the community and family history. The findings implied that this enhanced their emotional well-being and autobiographical memory.

Now that more grandparents are caring for a grandchild, it might be an opportune time to extended family groups reminiscences with their children and the benefits this offers. In the UK, it is estimated that 80% of grandmothers with a grandchild under the age of 16 provide childcare for at least one child regularly. The aim may be to ease the high cost of childcare for their adult children; however, the other benefits may be associated with the 'kinship' that might grow between the grandmother and grandchildren. Perhaps grandmothers have an aptitude for storytelling because of the nature of their experiences; nonetheless, they are more likely to focus on subjects such as childbirth, love and romance when telling stories (Taylor *et al.*, 2013). As a footnote to Sopakar's findings, she describes the women's interaction as "cross-generational weaving," adding the unique dimension that the storytelling had a sense of reciprocity not often seen in similar research. The notion that a birth story told by a younger person may give comfort or closure to an older person's experience is a unique perspective. In general terms, the lack of reciprocity shown between the generations when storytelling is disappointing and, in some ways, reflects the lack of attention given to ageing and the position of those who are aged (Andrews, 2014). Yet as Andrews (2014) points out, as humans, we all have experience with ageing and know what we have to offer.

Gaps in the research

The key findings from this literature review have shown that birth is a significant rite of passage and that women do tell their stories of birth, especially to other women. They recall the experiences in a way that consistently captures the emotionality and drama of the experience rather than the physicality of birth. As they recollect their experiences, they use humour and horror to add drama and capture the audience's attention.

Women have voiced their loss of identity and status, and where they feel displaced as they transition into motherhood. This is somewhat influenced by the patriarchal societies in which women live, where oppression equals silence. Yet when women share their experiences, it appears they do so in places where they have commonality with the listener and share in a way that makes sense of the transition.

Even within the available evidence, gaps in this knowledge responded to the focus of my study. It is the continuation of women telling the story of their experience through their life span that is absent, with some researchers suggesting that women will not recall the story after more than six years from the event. Having a body of research that explores older women's experiences would provide a catalyst for including the discourse in wider forums such as education and policy development. Additionally, exploring their stories places value on this group of women. It suggests that others want to understand and appreciate the lessons learned, giving voice and visibility to the older women.

The literature reviewed told of older women sharing intergenerationally (mostly grandmother to grandchildren), but the focus was mainly on how women brought the younger members of the family into the community and further fostered their identity within it. If women share their experiences intergenerationally, I am curious to know whether their experiences are shared in a negative or an empowering way.

Overall, the gap in the research raises questions about the longevity of the memory surrounding the birth experience. Moreover, what are the threads that link having the experiences, and recalling them, and what the significant touchpoints with the

narratives are. Finally, who else hears those stories and what are the implicit messages? With this in mind, the following research questions were formulated, knowing that hearing the voices of women is central to answering the posed inquiries. The next chapter will explore and define the design and methods that are used to interpret and discuss the women's stories.

1. In which ways do women recollect birth experiences in later life?
2. What are the positive and negative elements of these experiences?
3. How are these experiences transmitted intergenerationally from woman to woman?

Chapter Three - Methodology and methods

"I keep six honest serving (wo)men (they taught me all I knew); Their names are What and Why and When and How and Where and Who."

Rudyard Kipling

In this chapter, I present an overview of my study design and research methods. It will demonstrate how the research questions were developed through my motivation for the analytical choices. The design of any research requires consideration of many aspects. The design and methods have to complement the research questions, the participants, and to some degree, the researcher. The overall aim of this research is to answer the research questions to create new knowledge and an identifiable way forward. Ultimately this new knowledge will inform contemporary midwifery practice and positively influence the experiences women might have. It could create opportunities to share the outcomes of this study with women and prompt them to consider the way they share their birth stories with others. When selecting the design and methods to explore women's recollections of their birth experiences, it was vital to remain mindful that the topic could be sensitive and that the information shared needed to be treated with respect and dignity throughout.

The chapter begins with a discussion of the conception and development of the conceptual framework (illustration 1.1) I specifically designed for this study. Significantly, this explanation will demonstrate how the components, processes and positions draw together to work in harmony throughout this thesis. It continues by exploring how my epistemological position was established and explores the selected theoretical framework through which this study is viewed - a feminist lens. It discusses narrative inquiry as the chosen methodological approach. This section considers how the rationale for this choice and narrative inquiry complement this study. The final sections set out the research methods, including the recruitment of

the participants in the study and the associated ethical considerations, the collection of the narratives and the method of analysis.

Conceptual framework

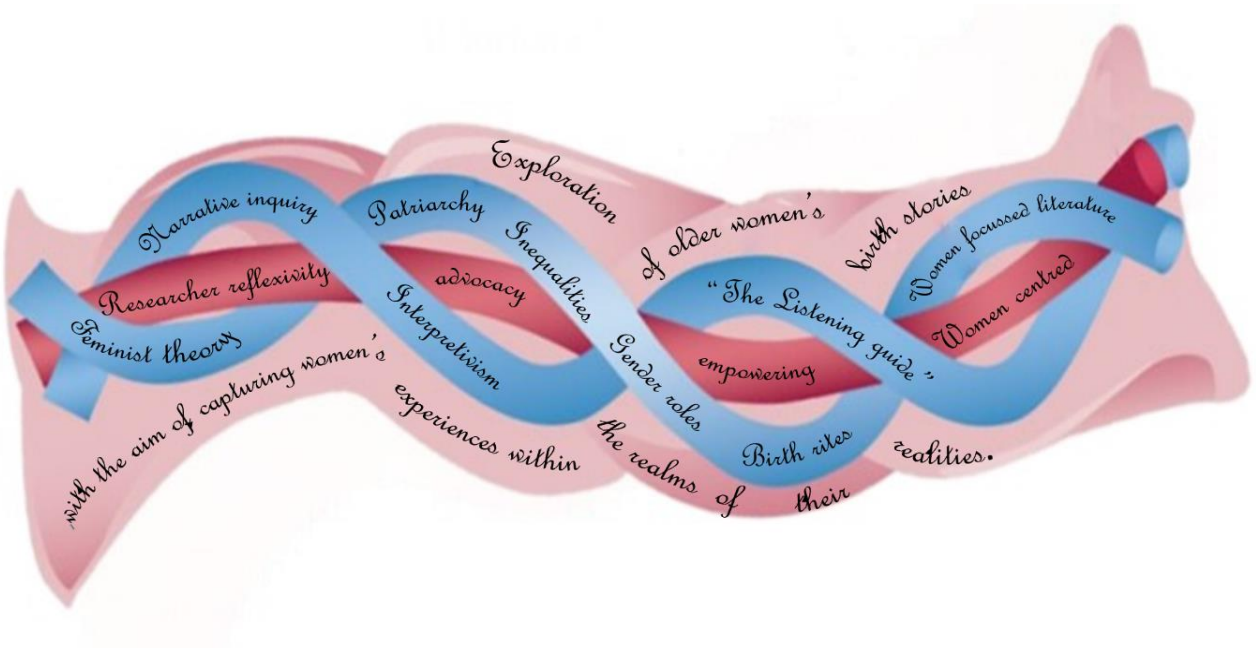


Illustration 1.3 (conceptual framework)

The emergence of my conceptual framework (illustration 1.3) was introduced in the opening chapter. This imagery framework has been an important point of reference throughout the writing of this thesis. Needing a tool to demonstrate the intertwined approach to the reader, I was aiming for one creative enough to add to the originality of the work.

Initially, I investigated the benefits of utilising a conceptual framework to ensure it had the attributes that lend themselves to the nature of my study and enhance my work. I soon established that a conceptual framework could be used to show the path of the research and firmly ground the theoretical constructs. Jabareen, (2009) suggests that a conceptual framework offers soft interpretations related to the study's intentions and serves as a master plan for the work. He indicates that they support the researcher in an understanding of the social unlike others, for example,

the casual nature captured in a theoretical framework. Camp, (2001)attempted to suggest that theoretical and conceptual frameworks are not different, postulating the researchers using the term 'conceptual framework' are referring to a substantive theoretical framework. However, this is a semantic argument because both contain theoretical and positional components; they simply originate from different perspectives. I found using a conceptual framework stimulated the creativity embedded within my frontal cortex of my brain, adding not only the pictorial elements but also it would visually represent the congruence of ontological, epistemological and methodological dimensions (Maxwell, 2013; Durham *et al.*, 2015; Ivey, 2015) originally.

I wanted my conceptual framework (illustration 1.3) to be a reference point that not only complements the work but draws out and helps explain the flow of discourse to the reader (Foucault and Deleuze, 1977; Iser, 2006; Kim, 2016). Deleuze's (1977) suggestion that researchers need to meet 'walls' and only by 'piercing the walls' can practice be improved (p.206) lends itself to my intention to bring the different layers of this research to life for the reader. It needed to be not only aesthetically pleasing but be totally female. The umbilical cord can only be created by females, it belongs to a female biological process that has been oppressed by the patriarchy therefore conceptual the link to this visual representation is intrinsically connected to the core elements of this research. There is a connectedness to the feminist lens, the subject matter and the participants.

My conceptual framework came together abstractly. It began to take form through mind-mapping the position and role of the influences, helping me to consider the right places for discussions and chapters. My thoughts and planning led me to recognize there were multiple threads that influenced my research. The conceptual framework helped me make sense of and organise these in a holistic way so that the syncopation and synergy between all elements of the research can be seen. Therefore, reinforcing the validity and holism within and bringing a well-balanced work to life (Adom, Adu-Gyamfi and Hussein, 2018). The suggested options for

presenting a conceptual framework (illustration 1.1) within a thesis range from diagrams to prose and tables (Grant and Osanloo, 2014; Adom, Adu-Gyamfi and Hussein, 2018). Midwifery is a profession often described as both a science and an art (Baker, 2005; Davies and Davies, 2007), which implied to me that I should not be afraid to embrace my creative side when practising within this profession. I decided to continue with this notion and produce a creative visual representation of my conceptual framework (illustration 1.3) that resonated with both research and the practice of midwifery. My reflections and mind-mapping drew together clear aims and objectives of this visual representation, and I wanted the illustration to show how these components:

- have equal importance throughout,
- the words are carefully selected for their importance to me and the research process.
- are holistically intertwined,
- are governed by the research questions,
- are not compromised by validity or rigour because of the methods adopted,
- have a connectiveness to midwifery practice reflected in this holistic approach.

My epiphany occurred when reflecting on the physiological aspects of birth and questioning what it is that ensures its success. It occurred to me that one of the most significant physiological connections is the umbilical cord, which represents the physiological lifeblood between the mother and fetus. It is comprised of structures such as an outer gelatinous casing called Wharton's Jelly, which holds together the vital two arteries and one vein. The arteries and vein facilitate the flow of blood between the mother and fetus, with the umbilical vein carrying oxygenated, nutrient-rich blood to the fetus and the fetus returning nutrient-depleted blood through the arteries to the placenta and maternal system (Stable and Rankin, 2017; Coad, Pedley and Dunstall, 2019). This creates a physiological connection that

requires a specific set of conditions in order to maintain its functionality or purpose. Being cognizant of this physiology helped me appreciate the budding analogy, in that sound research principles must be present in order to have a positive outcome; they have to be present and functioning to ensure growth. Additionally, like the umbilical cord, while some of the research principles must remain constant, occasional anomalies are present. The presence of such anomalies does not necessarily mean that growth will be limited. Sometimes these unusual or non-traditional elements offer a peculiarity that makes the research unique.

Furthermore, like the blood flow of the umbilical cord, the researcher's (mine and others) thoughts, feelings and activity will ebb and flow when writing a thesis, ensuring that each chapter is nourished with theoretical nutrients. The analogy has an emotional component as both journeys are fraught with emotional episodes of joy, consternation, worry and elation. Symbiosis and synergy exist between the stages of the rites of passage (Van Gennep, 2019), undertaking doctoral studies and the childbirth continuum. It could be said that the preliminal stage of birth equates to the planning and discourse surrounding this research, where I moved towards a new way of looking at situations (preconception) which has challenged, confused and elated me at times. It has challenged my established thoughts and preconceived notions, I have been confused when trying to position myself within the work yet elated when my ideas have come together, as with this conceptual framework (illustration 1.1). The liminal stage is the 'doing' stage, which is represented in the conceptual framework, demonstrating the synergy between all the individual parts of the whole piece (pregnancy) during this time I kept returning to the thought that this must be true to my position and philosophies yet demonstrate change and growth. The post-liminal equates to my postdoctoral position and transitioning into a new way of being. I am sure once the thesis has taken shape into an entity in its own right and the cord is cut (submission), like motherhood, my emotional attachment to this work will be lifelong.

Epistemological position

The activity of questioning and exploring one's epistemological perspectives before adopting a methodology is vital. The decision of which methodological approach to adopt began at the proposal stage (preliminal), if not before. I went through a process of reflection, that included reading, personal journaling, debate and discussion with colleagues about who I am, philosophically and the implication of positioning myself within this piece of research. These activities drew me nearer to deciding what might complement my own personal and professional philosophy to produce new knowledge that would inform contemporary midwifery teaching and clinical practice and positively influence the way practitioners undertake their roles in providing care for women. As a starting point, I used Crotty's (1998) diagrammatic approach as a framework to build, develop and contextualise the process of identifying my pathway within this work. Potentially, this diagrammatic approach could restrict the way a researcher positions themselves and would not encourage critical think concerning their positionality. Therefore, it has been important to add depth to my reflexive activities and curiously move forward.

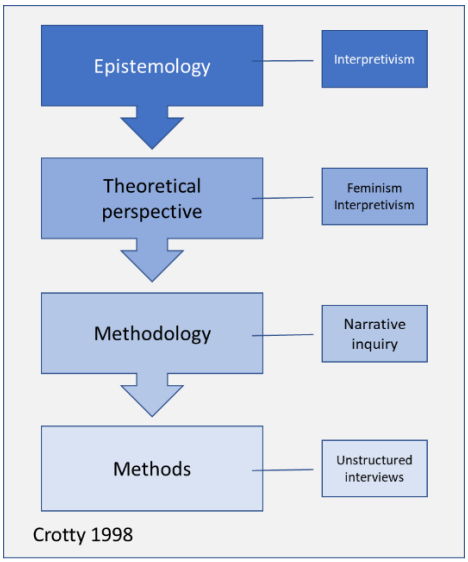


Table 2

During my time of planning, reading and creating a 'thought clouds' I recalled Clough and Nutbrown's (2012) four crucial elements which facilitate the reflective process researchers move through to come to a positional point: radical-looking, radical listening, radical reading and radical questioning. Radical looking encourages the researcher to make the strange familiar. As my reflection evolved and deepened, I realised to come to a decision, I needed to understand how I know what I know.

As a lifelong feminist, experientially, I know that birth is a feminist issue (discussed later in the chapter), at times I adopt a radical or liberal position as a feminist depending on the situation, but always as a matriactivista (mother/woman-activist) (Ricoy, 2022). Equally, as a researcher, I am drawn to topics that respond to the injustice and oppression of birthing women and importantly epistemological perspectives that create an effective way of hearing the voices of that group (Halberg, 1989; Wigginton and Lafrance, 2019). As I moved forward my reading and reflection led me to the concept of interpretivism, an epistemological position that has its historical roots in anthropology. It is in opposition to positivism, which itself contravenes feminist research (Stanley and Wise, 2002; Hesse-Biber, 2011; Hussain, Amir and Asad, 2012; Leavy and Harris, 2018). Interpretivism argues for the idiosyncratic nature of knowledge and truth, as well as it being culturally and historically situated, and based on people's experiences and their understanding of those experiences in the world they exist in. It necessitates researchers understanding human behaviour rather than explaining it, as with positivism (Bryman, 2016), therefore context is everything. Often in studies that adopt this epistemology, deeper meanings emerge towards the end of the research process, meaning that the interpretivist researcher will not be completely separate from their own values and beliefs (Leavy and Harris, 2018; Ryan, 2018).

So, as I reflected on how I am allied to interpretivism and what my biases might be here. I believe that there are two significant areas for contemplation, accountability, and ethics. The notion of accountability is ever-present in my life. This way of 'being' is replicated in my world as a woman, mother, wife and daughter. I am not

suggesting that this life lesson is more prominent in my life than others, but it is the way I can contain this and exercise reciprocity with others that makes it significant. This reciprocity is as important to the role of the researcher as it is that of a midwife, it underpins the principles of both practices.

To contextualise this as a midwife, accountability is both implicit and explicit in the way the midwife is 'with women' through the birth continuum. For midwives, the concept of 'with woman' is deeply rooted in the title 'midwife'. The origins of the word midwife as *mid*, meaning 'with' and *wife*, in the archaic sense 'woman' (Oxford Dictionaries, no date). The responsibility and accountability that is associated with this unique professional relationship relies on honest, reciprocal conversations, which are crafted by a midwife who has a level of expertise within the midwifery practice (Kirkham, 2010).

My ethical code is rooted in my feminist beliefs and again replicated in my professional life, the ethical and moral code of practice set by the Nursing and Midwifery Council (NMC, 2018) is adopted by midwives as they enter the Register of Midwives. Upholding this code is not negotiable and can be transposed when undertaking research, aligning it to the principle of having a duty of care to the participants. Additionally, a duty of candour, openness and honesty are expected; this is evidenced by aiming to understand people's experience and their 'truths'. Of course, this does not imply that other ontologies are any less ethical it merely implies that I seek to prioritise my abilities and specific skills.

Whilst Davis & Khonach, (2019) debate the balance of embracing feminist accountability to positionality and suggest the 'risk' that this might lead to research being devalued by the academic fraternity does heighten my anxiety about positioning myself in this way. I acknowledge that it would be highly unlikely that any research is 'value-free' (England, 2010; Davis and Khonach, 2019) therefore it is the balance of integrity, honesty and reflectivity that I would bring to my work that offers respite to my concerns.

The expectation as a researcher positioning myself in this way is that I would become a social actor who could appreciate the difference between people and present a level of empathy (Dudovskiy, 2018). Interpretivism allows the unveiling of the complexities of women's stories and has most certainly encouraged me to be part of the process. More than this, it reflects my sense of being with people in the moment where I try to understand and synthesise the human experience. I am confident that I have refined my abilities to use the skills of the art and science of conversation, as to foster positive dialogue. To alley times of anxiety and apprehension that my biases may impact negatively, I maintained a high level of reflexivity throughout the study, my thoughts and reflections, therefore, providing a safe space to confront and minimalize them. An example of this can be seen in chapter 4, where I have shared some of my post-interview thoughts and feelings about the women and the experience of being with them.

Selecting interpretivism as an epistemological position does not mean that the researcher does not appreciate the blurred lines of varying epistemologies (Givens, 2008; O'Reilly, 2014). Poth and Creswell, (2018) discussed the pragmatist's position, where no particular epistemological approach is adopted and these 'blurred lines' can be negotiated. Although this initially seemed confusing, the point here is that if there was uncertainty in me being an interpretivist, I should be pragmatic, embrace the moment, reflect and re-position myself back to the original position.

Theoretical perspective: Through the feminist looking glass

As defined and discussed in Chapter One, the research questions gave me a clear sense that my personal and social feminist identity would offer an interesting lens through which to view women's narratives. In this section, I explain how I position myself within the feminist paradigm and explore what the key influencing factors have been. When using a feminist lens, it is crucial to appreciate the impact a patriarchal regime has on the roles of women. The perspective may be regarded during birthing and motherhood as well as professionally when acting as a midwife,

researcher, or activist. In this section, the roles women adopt in life often blend and merge and cannot always be viewed in isolation, so the reader may note that women's and midwives' experiences are often endured in close proximity.

I find that my feminist social identity is "rooted in the concrete, practical, and everyday experiences of being, and being treated as, a woman" (Wise and Stanley, 1983). At times, my feminist stance has been positionally radical, liberal and pragmatic. From my perspective, feminism is a personal political stance that requires me to be present in that moment. In the 80s, 90s, and early 2000s, I was 'present' in the politicalness of my views and activities; now I am present in this feminist research. That is not to say that research is not a political activity; certainly, it is where birth is concerned and the dominant narrative is that of the patriarchy, which means that there will always be a political discourse.

The notion of adopting a philosophy of 'flexible feminism' (Mckenna, 2003) has aided my activism and complemented my teaching throughout my professional life, whether in clinical practice or education environments. I need to acknowledge my understanding of feminism because it has provided me with a view of women's lives through their eyes; I have become a social observer of their experiences with an antenna for misrepresentation, social injustice, and oppression.

Historically, other feminist researchers have worked towards establishing an ontological way of knowing within a regime that valued the superior scientific knowledge of men more than the less useful emotional sense of women. Feminist research methodologies have not always fit comfortably into the dualist hierarchical and political standpoints of philosophers such as Descartes (Enlightenment), Kant, and Rousseau (Cartesian dualism) (Ramazanoglu and Holland, 2002). This was mainly due to the expected subordination of women to male authority. They believed that women did not have the mental ability to 'reason,' so they could not contribute to the development of new scientific knowledge. Theorists and philosophers often placed little value on the experiential knowledge that women offered. Yet contemporary literature reflects that women do have a unique 'way of

knowing,' particularly concerning birth (Brown and Gilligan, 1993; Gilligan, 1993, 2015; Belenky *et al.*, 1997; Miller-Day, 2004; Rottenberg, Schonmann and Berman, 2017). This literature should stimulate the curiosity of modern feminist researchers when they strive to establish that the concepts of 'natural' behaviours are not necessarily predictable and that men are not necessarily authoritative nor are women subordinate to men (Ramazanoglu and Holland, 2002).

Feminist research sits comfortably within the archetype of critical theory as it responded to women's struggles against multifaceted forms of oppression and social injustice. Feminist research attempts to give focus to the world of women even when conducted within the constraints of a patriarchal regime. The most inspirational consideration is perhaps the diversity of feminist research; it often demonstrates inter-, cross-, and transdisciplinary work and is not fixed or rigid in its method (Aune, 2009; Maynard & Purvis, 1994; Wise & Stanley, 1983)(Aune, 2009; Maynard & Purvis, 1994; Wise & Stanley, 1983). This description of feminist research is comparable in many ways to the lives of the women 'researched,' among whom flexibility and collaborative behaviour are critical to their existence and among whom the patriarchal influences on how women experience birth are challenged. Where once the main objective was to exert social control over the 'fairer sex,' this dominance has accelerated to a position where women experience gyno-obstetric violence resulting in a lifelong post-traumatic disorder (Bellón Sánchez, 2014; Garcia, 2020; Chadwick, 2021). Within this traumatic life experience, some women's voices remain unheard, and the midwife's knowledge and skills are still secondary to that of the obstetrician. Now as then, women's experiences are seen as subjective and not authentic, unlike those of their male counterparts, who supposedly produce only 'true' knowledge (Letherby, 2003).

It is well documented that women have traditionally been advocates and carers of women during the birthing process – 'women went to women' (Byrom and Downe, 2015). The women (midwives) developed their skills over time and shared this knowledge and skill through the maternal generational line. In the past, it was a rite

of passage, and they were chosen by their community, coming to understand and know a process that belonged to their gendered group, a woman's world where instinct, intuition, and emotion played an essential part (Borsay and Hunter, 2012).

Nevertheless, men have exerted a position of authority for centuries, using the suggestion that midwives engaged in witchcraft, abortion, and infanticide to throw suspicion on their credibility (McIntosh, 2012). Thereafter, the male fraternity aimed to control the practice of midwifery through divisive types of regulation, which created a paradigm where midwives became highly valued by their clients and communities but restricted by government regulations. Moreover, men relentlessly strived to medicalise birth and exerted their influence on this physiological event in the name of science and risk prevention. The male-dominated medical profession did this under the premise that, because they were male, they had by default a level of superior knowledge and intellect, which afforded them an understanding of the birthing process (McIntosh, 2012). Doctors were facilitated by a society that hierarchically bowed to male privilege and favoured supremacy over female intuitiveness, empathy, and caring (Cahill, 2001). The medical profession of yesteryear brought endangered women's lives by encroaching on their birth experience and bringing dangers from sepsis and infection (Cahill, 2001; Oakley, 1984). Some contemporary obstetric professionals continue to threaten women's health by restricting birth autonomy and their right to self-determination. According to this research, it is not surprising that women's voices are not heard within this monopoly where birth has been misappropriated.

Contemporary midwifery practice continues to suffer as a result of the medicalisation of birth (Johanson, Newburn and Macfarlane, 2002; Kitzinger, 2006). Birth has been politicised through the notion of safety, risk, and regulation, and the positioning of midwives is precariously placed within this situation. Midwives often work in a state of flux, knowing that they have sound knowledge to be 'with women' and intentionally or unintentionally foster feminist ideologies, yet are oppressed by the patriarchal regime. A case in point is the restrictions placed on the options for

women to choose the provider of maternity services. Private midwifery practice in the UK has been stunted due to the legal requirement imposed by the Government to secure indemnity insurance. While insurance undoubtedly protects women and midwives, there is now no right for women to waiver this option or for midwives to work without this, and this type of insurance is notoriously hard to secure and is financially very costly. This means that 94% of all the midwives registered to work in the UK do so within the government-funded NHS and therefore conform to the restrictions imposed on them by these organisations. Moreover, this situation restricts and confines women's choices to whatever services their local NHS provider has available at that time. In the current climate, midwifery-led units and homebirth services are often suspended due to staffing shortages. Women who then choose to freebirth or pay for the services of an independent midwife are often labelled as difficult or non-compliant (Feeley and Thomson, 2016).

There is a political faction within the profession of midwifery that aims to support women's rights to choose. Groups such as the Radical Midwives Association (ARM, 2022) first brought their concerns to public and political arenas in the 70s and were not always viewed favourably by leaders within the NHS. The group was criticised for using the term 'radical' in their name; interestingly, this group still find themselves justifying the use of the word on their website:

> *"The word 'Radical' is used in its literary meaning of relating to roots and origins, and best expresses the hope of that early group, that midwifery could find its way back to a position where midwives' skills were used to the full, while still taking advantage of the benefits of modern technological advances, where these are seen to be in the best interests of the woman and her child. In other words, the hope that the true meaning of midwife ('with woman') will once more be realised in practice."* (ARM, 2022)

However, this explanation does not seem 'political' enough; perhaps it is time to revisit the meaning of "radical" and position themselves in a stronger more assertive radical political position.

Past attempts to bring reproductive autonomy and reproductive justice to the public attention can be seen in existential philosopher Simone De Beauvoir's 1949

publication *The Second Sex* (De Beauvoir, 1974), which aimed to challenge patriarchal systems that marginalise women. This discourse remains as contemporary today as when it was published, particularly in the context of the physiological birth debate. Letherby, (2003) beautifully summarises De Beauvoir's view on the construct and position of 'woman:'

> *"Humanity is male, and man defines woman not in herself but as relative to him; she is not regarded as an autonomous being... she is simply what man decrees... She is defined and differentiated with reference to man and not he with reference to her; she is incidental, the inessential as opposed to the essential. He is the Subject, he is the Absolute - she the other." (p.412).*

In many ways, De Beauvoir's work has influenced my understanding of masculine ideology. De Beauvoir argued for sexual equality by exposing the masculine ideology, which she states exploits the sexual difference between men and women to create social and relational inequalities (Weir, 2011). De Beauvoir's suggestion that the female habitus makes women the weaker sex resonates in midwifery practice, as the medical model of practice uses what should be seen as a 'normal' process of birth to diminish women's self-agency. This can be seen in the words used to describe landmarks within the birthing process that emanate from patriarchal oppression. For example, if labour is slow to progress within an 'authorised' medical model, it is described as 'failure to progress' when, in fact, it is merely progressing at its own pace. Additionally, if the mother is finding it challenging to push her baby out, it is described as 'poor maternal effort.' Both examples belittle the ability of women to know their bodies reducing them to a type of biologism implying that they are no more than "weepy uteruses on legs" (Oakley, 2005). Nor do such terms offer words of empowerment or encouragement. They are based on authorised knowledge cultivated by men of science who neither have nor could have had that experience. Women working within the medical regime find it hard to do anything except accept the derogatory terminology the medical model of practice has imposed on the birthing process, rather than supporting their own gender (Vala Jónsdóttir, 2012). Feminist writer Milli Hill considers the use of inappropriate language and

terminology, and in her book 'Give Birth Like a Feminist' (Hill, 2019) she attempts to reframe the experience of birth and encourages birth autonomy. As Hill's campaign to improve birth experience moved to a more political position, however, she was berated and 'trolled' on social media by both men and women for being vocal about her so-called radical views. The idea that other women find the oppression of their own sex by a patriarchal system unacceptable is incomprehensible, and the lack of female solidarity is disappointing. Weir (2011) explains De Beauvoir's positionality on this point. Viewed through an existentialist lens, De Beauvoir advocated women's liberation through female solidarity, socialisation within their world, and discovering the unique ways in which their embodiment engages with the world. She categorically refutes the liberal and Marxist ideology that to get on in a man's world, a woman must act as a man does.

While this debate could widen the discourse about gender and equality within health care professions and may feature in my post-doctoral work, it is the core principles of these debates that have influenced my understanding of feminism and underpinned this research. For example, the work of feminist researchers such as American philosopher and gender theorist Judith Butler, who has led the debate on gender as a social construct, and sociologist Ann Oakley, who has challenged and developed the concept of De Beauvoir's woman as a second-class citizen, has helped me to add context to the women's experiences analysed in this study (Brunton, Wiggins and Oakley, 1970; Oakley, 1976, 1984, 1986, 2005, 2016; Butler, 1986).

My research questions focus on older women and the recollection of past years when the perception and understanding of gender were different in the 1960s and 1970s. The concept of gender fluidity was not understood, nor was there even a mainstream tolerance of same-sex attraction. The social construct of 'woman' sat firmly in the feminine ideal, and in the 1970s an impetus grew in the academic argument that women learn how to be 'women' mainly by the social requirements of heterosexuality (MacKinnon, 2006). Although this categorised male sexual dominance and female sexual submission, creating an undesirable stereotype, it

confirmed that sexuality and its fight with power was the linchpin of the gender inequality debate.

Feminist theorists have challenged masculine hegemony for decades and demanded that alternative views should be considered (De Beauvoir, 1974; Chodorow, 1999; Kitzinger, 2006). The abutment of Marxism and feminism is a case in point. Both are theories of power and focus on how inequitably it is distributed. Marxism is a male-defined theory that considers class as the vehicle to address society's inequalities by removing the external locus of control that disempowers the masses. However, these best serve the interest of men and do not relate to women's lived experiences within the class construct, particularly concerning the unpaid work of motherhood. Marxist objectives could in principle be fully met without ever addressing the oppression of women within society (MacKinnon, 2006). Of course, Marxist sympathisers might challenge this by suggesting that Marxism is all-inclusive and that women are included in the class war by default. Some feminists sought to align Marxism and feminism, using Marxist ideology to emancipate women through participation in social production and to address the issue of the wage less world of the housewife Federici, (2018). Although it is acknowledged that Marx did not engage with the gender debate and Marxism itself is a theory of class, Federici, (2018) suggests that in the later years of his life, Marx began to reconsider his idealisation of the capitalist industrial development and women's power; however, this is a thought lost in time.

As the twenty-first century progresses, Marxism seems to have retreated, and feminism and postmodernism have in many ways become affiliated (Fraser and Nicholson, 1988; Benhabib, 1995; Fraser, 2017). In general terms, feminist research now aims not only to construct new knowledge (Brayton, Ollivier and Robbins, 2005) but also to address power inequalities in an intersectional way by appreciating the interdependent relationship between social categories such as race, class, and gender, and issues such as power.

As a researcher, I have explored the collision of various standpoints. Fraser, (1995) proposes an attractive position that should be considered by researchers who opt to

view and label narratives or discourses with the intention to be political rather than theoretical. Fraser (1995) explains that once feminist researchers have critically reviewed the Habermassian, Foucauldian, and Lacanian/Derridean perspectives of postmodernism, they should not choose to assimilate one or another of these into their studies; they should select a fourth alternative. Feminist researchers should eclectically regroup the most influential attributes neo-pragmatically to complement the contingent world we live in. This approach offers the production of a feminist counterhegemony that will contest the male hegemony present in many of the theoretical and philosophical standpoints available to researchers. Fraser's proposal provides reassurance that if my study uses male hegemonic theories and literature, its credibility will not be devalued or reduced. This option allows a compromise to work with all the literature yet move forward with the intersectional feminist agenda.

I am cognizant that undertaking feminist research has its challenges. Some of my thoughts about this relate to how I perceive I should behave, how others will behave towards me as a researcher, and how they will receive my work. Bleier, (1986) and Harding and Norberg, (2009) point to the masculism of institutional teachings of what represents authoritative knowledge, where hierarchical, patriarchal practices often place traditional scientific teachings above others. My initial reflexive thoughts about the challenges I may encounter are three-fold. First, I will not adopt the masculine trait of teaching hierarchically. Second, I will be able to oppose masculine hegemonic theories with a feminist research methodology. The third and probably most important challenge is the way I will be able to futureproof my methodology. To achieve these goals, I need to be confident in my way of being and knowing and although I may feel uncomfortable with challenging issues, I need to remain steadfast with my intentions and receptive to new knowledge. The first two points are not just confined to undertaking this research; they are ever-present in my consciousness and related to my self-agency as I move through all areas of my life experiences. When interacting with women I would not find it acceptable to adopt

masculine traits of patriarchal systems to someway 'fit in;' to me, there is strength in the desire to facilitate reproductive autonomy and foster reproductive justice.

The third challenge, futureproofing my methodology, has raised a new state of awareness in me. How this work is planned, undertaken, presented, and disseminated, and how it influences practices could contribute to the way feminist research is perceived and undertaken in the future. Perhaps it will contribute to the longevity, credibility, and validity of feminist research.

When aiming to futureproof feminist research methodologies, their development must not remain static. In many ways, feminist researchers have not remained focused on cis-gender.[2] Although cis-gender is the focus of this study, the participant group may look different if replicated in the future. Feminist researchers might enhance how they include participants from the 'trans' or 'nonbinary' community. As new life choices become omnipresent in society, their life experiences can be socially rebuked and misrepresented, or be underrepresented in research, literature, and social media. As newly defined constructs in society appear, we will more than likely see the emergence of challenging behaviours, oppression, and power inequalities. By considering the intersectionality of contemporary societal issues, we develop a new landscape of epistemology. It is to be hoped that this new knowledge will offer a different perspective on these current-day social injustices.

Overall, I hope my research will offer other researchers insights into adopting a pragmatic feminist lens that has its foundations in both liberal and radical viewpoints and that builds on the work of other feminist researchers such as Oakley, Butler, De Beauvoir, and Kitzinger (Brunton, Wiggins and Oakley, 1970; Oakley, 1976, 1984, 1986, 2005, 2016; Butler, 1986; Kitzinger, Paige and Paige, 2005; Kitzinger, 2006). Importantly in the context of birth, my research moves forward the stereotypical debate of defining the male/female power struggle by providing a

[2] Denoting or relating to a person whose sense of personal identity and gender corresponds with their birth sex.

deeper understanding of women's feelings about their birth experiences and encouraging their own self-empowerment and that of the next generation.

Methodological approach

Understanding the relationship between the methodology and methods provides the researcher with a clear way forward when embarking on the development stages of a project (Ramazanoglu and Holland, 2002; Letherby, 2003). I found clarity in the analogy given by Clough and Nutbrown, (2012) that the methodology might be the reason why you may choose to use a particular recipe, and the methods represent the ingredients of that recipe (p.25). Once the difference between the two has been established, it is the appreciation of how they are interconnected. Clough and Nutbrown (2012) four crucial elements continue to facilitate this (radical looking, radical listening, radical reading and finally, radical questioning). However, it is important to present my delineation of the term 'radical' here. It is not used in the context of extremism or subversiveness but that of an organic deep-seated profound application of looking, listening, reading and questioning.

Using a narrative approach

The objective of this study is to gain an in-depth understanding of older women's stories of their birth experiences. The literature unveiled the significance of both the rite of passage the women experience moving from pregnancy to birth into motherhood (Sopakar, 1998; Farley and Widmann, 2001; Savage, 2001) and the rite of passage experienced as they reach menopause. The commonality is the loss, silencing and oppression of women's voices at these times (Oakley, 1976, 1986, 2005, 2016b; Benjamin, 2018; Greer, 2018). Conducting qualitative narrative research offers a meaningful way for the researcher to witness the uniqueness and commonalities of a group of older women's birth stories (Denzin and Lincoln, 1994)

The consensus is that the true definition of narrative research is complex and multifaceted (Letherby, 2003; Merrill and West, 2009; Andrews, Squire and

Tamboukou, 2013). Tensions within the dimensions of narrative research make it as attractive as it is complicated. It features no given rules about the tools used to tell 'stories,' whether it is spoken, in pictures or written in diaries or journals. Psychologists and narrative researchers such as Bruner and Polkinghorne offer ways of uncovering people's life experiences and histories by adopting a psychological person-centred approach. Bruner explored what the role of the narrative is for people, particularly when associated with random and chaotic events with Polkinghorne, contextualising the way such narratives are constructed. While theorists such as Culler, Todorov, Foucault and Derrida, explored the human experience in the way that it is structured and remembered (Andrews, Squire and Tamboukou, 2013). With their epistemological and ontological vantage points differing in many respects and for some, the link to a feminist cause is tenuous, to say the least, what they do offer to this work is the proposition that by taking aspects of their theories allows me to layer my understanding and approach to conducting a narrative inquiry, creating a poly-logic rather than a mono-logic idea of this methodology (Merrill and West, 2009). Rather than allowing for some bending and bowing as described by Andrews, Squire and Tamboukou, (2013) it is the ebbing and flowing defined in my conceptual framework that adds the fluidity whether it is the 'small' (snatches of conversations) or 'big' (life stories) story that is being told.

However, the overarching success of narrative research is that it enables the researcher to bring together the diversity of people's experiences, thoughts and feelings in a joined-up way to bring differences to the foreground and allow a connectedness to a central theme (Polkinghorne, 1988). Bruner (1990) suggests that the sharing of narratives has a reflexive component as it is a way for people bring to order to their experiences and establish the meaning of an event. Whether it matters that the narrative becomes a representation of the event, not a replica (Sandelowski, 1991; Riessman, 2008) is subjective. When gathering this type of data, the goal is not to seek 'truth.' It is about understanding an experience through the eyes of another person (Letherby, 2003; Woodiwiss, Smith and Lockwood, 2017). A search of the literature shows how women's birth stories evolve, with competing elements

taking priority during the telling of the story depending on when it is told and to whom (Davis-Floyd, 1994; Latva *et al.*, 2008). On some level, this creates data (the narrative) that is fluid, raising questions about its reliability. Pragmatically, however, all research can only be viewed as reliable in a specific time frame due to the subjective nature of human beings' responses to questioning or observation. This fluidity should be seen as a positive consideration as it contributes to what makes us human it suggests that we are present in a moment of time. A narrative that remains rigid and unchanged is cause for concern, as an unchanged rigid account is often associated with trauma or false memories (Loftus, 1997; Hyman and Loftus, 1998), although the listener would need to 'hear' the story many times to come to this conclusion.

Whichever way a narrative is told, visually or audibly, the linguistic connection is inescapable. This connection has to be understood in the context of the narrator's position in time and space. Bakhtin (Holquist, 2003) named this 'chronotope' as it represents a central component of his dialogic theory in which he characterises how time and space are configured in language and discourse (Dimitriadis and Kamberelis, 2006). When the narrator is listened to and heard holistically, it will create a cycle of understanding for the researcher with one aspect informing another. This radical listening should result in an in-depth appreciation of the story being told (Letherby, 2003; Andrews, Squire and Tamboukou, 2013; Woodiwiss, Smith and Lockwood, 2017), one that should create a connection, a level of trust and reciprocity, between the narrator and auditor. Although the researcher should be cognisant that the stories are, as Bakhtin suggests, "unfinalizable" (Dimitriadis and Kamberelis, 2006) and will change and evolve when told to the next person, at that moment as the auditor, you are a witness to that person's existence. Therefore, does it matter if there are inaccuracies, elaborations or diversions from the facts? It's surely about understanding the person's perspective, isn't it? Also, is the way we come to know a person in the moment enough? This debate reinforces to me that radical listening adds a new dimension to the level of responsibility with which I

should see, hear, understand and chronicle the women's stories, capturing that moment in time.

Establishing that I have not employed a narrative methodology to collect a historical account of the women's birth experience but to understand from their perspective as the storyteller, giving credence and context to their life journey (Bailey, 1999), I was drawn to Bakhtin's theory of novelness (Bruhn and Lundquist, 2001) because it attempts to understand human behaviour through human dialogue. Although the translations of Bakhtin's work are incredibly complex, Tappan, (1999) offers a comprehensive explanation of Bakhtin's dialogical position of people's moral identities and the dialogical dimension of self-narrative. Tappan suggests that the premise of Bakhtin's philosophy is that the "authorship" of the narratives people share about their lives is always a function of both self and others. The stories of "self-as-author" are not randomly produced by a monotonic voice; they emerge from a dialogical relationship, which is fundamentally polyphonic. The identity of the 'poly' in my research is multi-layered; I would be able to include myself, bring my own story as a midwife and then researcher, and the influence of others such as midwives, doctors, and partners. It is not Bakhtin alone who offers this type of theoretical understanding of 'voice' in relation to 'self.' Vygotsky (1978, 1987) and Piaget (1932/1965) provide a dialogical perspective on the moral self, showing a commonality in Bakhtin's work. Tappan (1999) presents a persuasive argument that Bakhtin's work "fleshed out" the issues as presented by the others, offering a greater depth of understanding. Although I did not use Bakhtin's work directly it has most certainly added to my thought and creativity by offering another perspective to the multi-dimensional methodology known as narrative inquiry.

Moving forward with the method

Given the interpretative approach of this study and my interest in how older women recall their birthing experiences, the methods of recruitment and data collection comfortably settled on face-to-face interviews. Although a focus group was

considered and may have offered extra data on the way women share stories, I felt a greater richness might be heard during a one-to-one interview. This way of talking to and being with women reflects the way midwives are in clinical practice. Often the most intimate conversations occur when just the midwife and the woman are together. I was in no doubt that interviewing this way might prove challenging. I had to consider the time I had available to meet with individual women; as a full-time lecturer and team leader, negotiating this time away could have been a contentious issue. Other concerns such as how to record, store and transcribe the interviews were considered early on during the planning process. I wanted to ensure the women ample opportunity to recall their birth stories. I chose to undertake two interviews, the first an unstructured interview followed by a semi-structured interview in the following weeks. This approach would provide me with the opportunity to clarify points from the first interview, and develop and build on any significant points. Importantly, it would provide thinking time for the women, who would be able to correct and illuminate pertinent points made previously (May, 2011; Kim, 2016).

Recruiting to the study

Before recruiting to the study, I submitted an ethics review checklist to the University's Ethics Committee, as the study was subject to a proportionate ethical review in line with university procedures. Canterbury Christ Church University granted ethical approval for this study in October 2017, and the narrative collection occurred between January and March 2018. The letter of approval is attached as Appendix 1.

I aimed to recruit six study participants meeting the following inclusion criteria:

- aged over 70.
- had had at least one full-term pregnancy.
- willing to share their experiences.

I adopted a traditional method of snowball sampling for this research. However, the decision of how to recruit to this study occurred in a "convenient way" (Bryman, 2016). Colleagues and acquaintances came to know by word of mouth of my intention to explore older women's recollections of their birth stories. Several women approached me to talk to them in their social groups or individually about the study; this led to a mutual enthusiasm for some to participate. In reporting the pros and cons of using snowballing sampling, Atkinson and Flint, (2004) and Crouse and Lowe, (2018) suggest that although snowballing is useful when the target group is hard to reach, issues related to breaches of confidentiality can arise. This may be due to the type of relationships the participants might have. The target population of my research could not be defined as hard to reach; in fact, it would have been possible to recruit three times as many participants by word of mouth. A type of chain referral occurred from within two separate social groups of women living on opposite sides of the county. I felt satisfied that this would decrease the likelihood of inter-participant conflict of interest.

Additionally, I reflected on the possibility of challenges to confidentiality (i.e. one participant directly asking about someone else's interview or drawing other participants in during their interview). However, I had the opportunity to set out the expectations of maintaining a level of confidentiality at the recruitment meeting. I felt completely comfortable being this open and transparent with someone I had just met, possibly as I have transferred this skill from my professional life as a midwife. I felt assured that I would have a reference point should I need to address any issues and maintain this status quo.

I decided not to limit who could participate in the study based on factors such as the mode of delivery (physiological, instrumental or caesarean), environment (hospital or home) or outcome. I felt that all variations of experience would offer richness to the research findings. The women were not asked about this before being recruited to this study. All participants were provided with a participant information sheet (Appendix 2) outlining not only the confidentiality and data protection issues but also

the interviewing process and the opportunity for further discussion once the thesis had been completed. All participants gave informed consent verbally and by completing the agreed consent form. I was mindful that asking participants to recall their birth experience could possibly include memories of difficult, sad or traumatic times or events in their lives. Therefore, I wanted to ensure complete clarity about my expectations at the point of consent.

Additionally, each participant was given a choice as to where the interview would take place, and all selected their own homes. At the time of their interview, they were given the opportunity to choose a pseudonym. The table below briefly introduces the women.

Name	Year and age (first pregnancy)	Gravity and parity	Place of birth
Nancy	1961 @ 19 years YOB 1942	G2 P2	1 Home 1 Hospital
Elaine	1969 @ 23 years YOB 1946	G2 P2	2 Hospital
Ruth	1960 @ 18 years YOB 1942	G4 P4	1 Community hospital 3 Home
Barbara	1970 @ 24 years YOB 1946	G4 P2	2 Community hospital
Hilary	1966 @ 20 years YOB 1944	G3 P3	2 Hospital
Cordelia	1969 @ 23 years YOB 1942	G2 P2	1 Community hospital 1 Home

Table 3

Collecting the narratives

Today is the first interview. I've checked my equipment, so I'm ready! Remember the questions:

- What is your recollection of your birth experiences?
- What are the most poignant memories related to your birth experience?
- In the subsequent years, have you told anyone this story?

(Reflective Journal January 2018)

The narration and conversation phase (Kim, 2016) of collecting the women's recollections occurred during two activities. The first was the unstructured interview, in which the women were invited to tell their birth stories in their way from beginning to end. The second activity was a short semi-structured interview which provided an opportunity to clarify conversation points from either the woman's perspective or mine. For the first interview, I was welcomed into the women's homes and settled to begin our discussion over a cup of tea; I mention this as I consciously intended to replicate the midwifery idea that you can 'drink tea intelligently.' Tricia Anderson (independent midwife) coined this phrase in the early 2000s when describing how midwives should unobtrusively listen to women, watchfully appreciating what women say and do not say (Seekings-Norman, 2008). I wanted to ensure the women felt comfortable with the way they told their stories, so I plainly asked them to do just that. I had allowed two hours for the first interview; however, on average, they lasted one and a half hours. The women were listened to with minimal interruption, although at some points I found it challenging not to participate more. At times, I steered the conversation back to the topic as some of the women's recollections drifted; however, I only did this when the topic became focused on my role as a midwife. Allowing associated 'ramblings' adds insight into what is important to that person and is worthy of encouragement (Bryman, 2016).

Before the interview, I had been concerned that the women's memories of birthing might have become so faded or distorted that they would no longer remember any significant aspects. Baumeister and Newman, (1994) suggest a typical story consists of interconnected episodes describing human action sequences; people interpret and delete (or forget) facts to make their stories comprehensible These inconsistencies are a way of remembering the story. Delgadillo and Escalas, (2004) call this bias memory, which is a way of building stories into which people fit characters and events together in a narrative form to condense their world and lives meaningfully.

The narratives appeared to be data-rich and transcripts were produced. Once the transcripts were completed, the women were sent a copy, and all acknowledged the accuracy of their recollections. Additionally, after the first interview, I checked in with the participants to ensure they were willing to continue to the second interview. One participant delayed her response as she had been unwell but graciously made contact in response to the second interview in April/May rather than March 2018.

The second activity was a short semi-structured interview. This occurred in the month following the first interview. I intended to give the women time and space to reflect and possibly discuss the first interview with their families or friends and then add any further reflections to their narrative should they wish to. Additionally, it allowed me to ask other questions either to clarify information or to develop the narrative. This semi-structured interview ("conversation phase") was much shorter in length. Again, it took place either in their homes or on the phone and for one woman, by email exchange because she was unwell. Some of the women made small additions and reiterations, and two women had found a few artefacts (pictures and co-op cards[3] to show me. During this conversation, I asked two questions aimed to elicit deeper

[3] Small double-side booklet used to log antenatal, intrapartum and postnatal care, up until the 1990s.

thoughts about their experience. Both asked the women to consider which of their reflections and insights they felt would be valuable enough to share.

- What advice would you give your younger self?
- What advice would you give the younger generation of women?

Data analysis

Selecting the approach of analysing the narratives took many months of searching. I spent a considerable amount of time questioning and seeking out a method of analysis that suited this type of narrative. Kim, (2016) suggested that methods of narrative data analysis offer the researcher an opportunity to "flirt" with the data. This term is not meant in the usual sense of the word, which has negative connotations but is related to Freud's sense of free-floating attention, encouraging the researcher to move away from what they already know. Kim (2016) calls upon Phillips's notion of flirtation as follows:

- Exploiting the idea of surprise and curiosity.
- Creating a space where aims or ends can be worked out.
- Making time for less familiar possibilities.
- "Is there a way of playing with a new idea without letting these new ideas be influenced by our wishes?" (p.g187).

This 'flirtation' offered some reassurance that with proper planning and an open mind, whatever data I gathered, I could find the 'wider story' within the narrative.

As previously discussed, I had begun with the intention of using Bakhtin's concepts, perhaps based on a thematic approach. However, when it came to the point of creating a thematic matrix to capture his principles, I felt that something was lost in this method; the themes seemed one-dimensional. I found that in the 1980s, social scientists such as Bruner, (1986) Mishler, (1979) and Polkinghorne, (1988) questioned the challenges of engaging with and understanding narrative inquiry.

Rather than employing techniques that could have just as easily been captured numerically, they wanted methods that gave insight into the human experience (Hesse-Biber and Leavy, 2006). I found a body of literature that discussed a method of psychological analysis focusing on the voice, tone and relationships within the narrative, a type of radical listening (Gilligan, 2015). A voice-centred relational method (VCRM) called the Listening Guide had been developed at Harvard Graduate School of Education in response to the dilemma preoccupying qualitative researchers - 'how we know others.'

The Listening Guide method comprises a series of four steps within two stages which invites the researcher to hear the polyphonic voice, within and out of the narrative. This polyphonic voice can be heard by those providing the narrative, and it is assimilated into the socio-cultural world in which the narrative is set (Gilligan, 1988, 2015; Doucet and Mauthner, 2008; Gilligan *et al.*, 2011; Mauthner and Doucet, 2011). I used the table below as part of a planning exercise before analysing the women's narratives; it is based on Mauthner and Doucet's (2011) explanation of the stages of analysis when using the Listening Guide.

Stage 1	Process		Application to birth recollection
Reading 1	Read for the plot.	Read twice.	1. Read for the overall plot, consider the people and setting of birth experiences. 2. Consider my responses to the narrative from my professional viewpoint. Challenge presumptions.
Reading 2	I-Poems	Read and extract personal pronouns.	This activity draws out the emotionality of the related birth recollection, and it may present intellectual difficulties in articulating feelings. It may give insight into how the woman perceives herself in the story.
Reading 3	Listen for contrapuntal voices.	Read for relationships.	This may relate to health care professionals, family members and spouses.
Reading 4	Place people within cultural and social structures.	Consider the context of time and space.	Consider the social, political and cultural context of being a woman, mother and wife in this period.
Stage 2			
	Create summaries.	Devise theme matrix.	Create a short vignette of each woman's recollections holistically.

Table 4

This section reflects on the application of the Listening Guide, and I have discussed some of the challenges and successes I met in the initial stages of doing so.

Stage One: Read-through One (Part A) The focus of this read-through is to consider the protagonists and subplots and listen for recurrent words, metaphors and the emotional voice (Gilligan and Eddy, 2017). Here I needed to position the actors and interpret who and what is missing from the story. Gilligan and Eddy (2017) suggest that this is a descriptive activity where the storytellers' words are highlighted throughout the transcripts. This type of analysis is interpretative and has hints of phenomenology and hermeneutics, which are commonly seen in qualitative research. The subtle difference with this framework, and particularly in this stage, is 'hearing' the distinction between the patriarchal voice and the relational voice. In practical terms, I used comment boxes to raise points and questions throughout each transcript.

This activity led me into and at times merged with Read-through One (Part B). This activity required engagement with the research data intellectually and emotionally. Doucet and Mauthner (2008, 2011) challenge the researcher to test their ability to question their biases and relational self in a reflexive way rather than reflectively. Therefore, I would not just consider the activity of collecting the narrative but to position myself as an active participant in that interaction. I found it was not whether I could do this or not but initiating the personal questioning, perhaps this was being able to feel 'free' to do this, needing permission. I worked though this by trying their suggestion of using a worksheet approach listing the participant's comments in one column and the researcher's reflexive thoughts in an adjacent column was one way of achieving this. However, I decided I would not use this as I felt it restricted the way I worked and did not complement my thought processes. I decided I needed time for free-thinking to process my emotional position during the interviews (Taylor and White, 2000); instead, I decided to use journaling activities. I decided to 'allow' myself to write freely, making a safe space to write my inner thoughts. At times I wondered whether I was truly being reflexive as in clinical practice I had seen the

results of others' attempts at this. During the time I worked as a Supervisor of Midwives, supporting midwives through reflective and reflexive activities, I saw that some were able to work through an event or clinical incident reflexively. They showed both intellectual and emotional positioning, accountability and responsibility (NMC, 2018); others believed they were doing this, but in reality, they were not. They merely recalled the events of the incident, therefore, lacking depth and insight. I wondered whether by connecting to the social and cultural environment would be less complicated than mediating my subjectivity, particularly understanding the criticality of the contribution made to an event or phenomenon. Fook, (2007) contextualises the challenges I may meet further when discussing the embodiment of the knowledge or experience, suggesting that my physical well-being and social position may influence the lens through which I view the experience. I concluded that it is the reciprocity of the emotional connection I might have to experience which in turn would influence my thoughts and analysis. I wanted to question and know what I was feeling and imagining as I came to know the inner story of the women, making me an active agent in the process (Etherington, 2004).

As I approached the reflexive activity in Read-through One (Part B) I spent time thinking about and recalling my interaction with the participants. I recalled thinking about my responses to the participants being provided impartially, not influenced by emotive association, I remembered my thoughts when one of the participants cried and found it difficult to begin her story and how this reminded me of older women in my own family, or how the women's behaviours reminded me of my own mother's story. These types of catalysts that prompt deep reflection can be challenging to negotiate, Strømme et al. (2010) refer to this as a 'delicate situation'; although they do not discuss it at length, they acknowledge that recognising bias in yourself can be uncomfortable, or perhaps Strømme *et al.* was insinuating there is the potential to reduce the credibility and reliability of the research findings. Although challenging I welcomed this opportunity to gain insight into my behaviour as a researcher, thus using this awareness positively. I came to see that it was

acceptable to be comfortable with the uncomfortable, a notion that is supported in the literature and gives credence to the challenging of personal emotional and behavioural responses (Hollway and Jefferson, 2000; Jervis, 2009; Holmes, 2014).

Stage One: Read-through Two traces the participant's perception of self through the narrative transcript by locating and drawing out the personal pronoun 'I' (Brown and Gilligan, 1993; Mauthner and Doucet, 1998; Doucet and Mauthner, 2008; Gilligan *et al.*, 2011; Gilligan and Eddy, 2017). The objective of this component of the analysis is to heuristically see the participant's emotionality at the centre of the transcript. It amplifies the moments of high and low emotion (Mauthner and Doucet, 1998), where they struggle to articulate their feelings concerning an event and where they shift between not knowing and knowing (Gilligan and Eddy, 2017). It is this component that differentiates the Listening Guide from other qualitative analytic processes, such as grounded theory. Whereas grounded theory responds to action and interaction and is less concerned about the individual (Strauss and Corbin, 1990), the Listening Guide looks at the 'private' life of the person rather than the public view. It offers insight into the way they associate and dissociate with their world and how their minds work in deep connection with their emotions (Ribbens and Edwards, 1997; Mauthner and Doucet, 2011; Gilligan and Eddy, 2017).

I located and circled the personal pronouns with a coloured pencil. I decided to extend this to include the use of 'you' and 'we;' it allowed for the 'turn of phrase' to be accommodated (Mauthner and Doucet, 2011; Gilligan and Eddy, 2017). At this point, I-Poems can be formulated. Gilligan and Eddy, (2017) suggest the appearance of 'I' (we or you) designates a new line of the poem, and the stanza should break where the 'I' shifts direction,

<u>For example:</u>
I don't know
I wasn't sure
I don't know,
I don't

I didn’t

I couldn't

I

I thought

The section required that I listened and read tenaciously, hearing the poetic cadence, harmonies and discords. Koelsch (2015) describes the researcher’s role at this point as coming alongside the participants as opposed to gazing upon them; this viewpoint resonates with midwifery practice, where the underlying philosophy is that the birth experience belongs to the woman and the midwife is merely an informed, invited facilitator.

While I was engaging with this method of analysis, some of my pre-analysis reflection involved deciding how, if at all, this section would add to the validity of my research, I was sceptical! Negotiating the value of research poetry and positioning the truth (with a small t) within this approach was initially challenging. I needed to come to appreciate that the words were not to be taken literally and accept that the I-Poems reflected the women’s truth of their ‘subjective experience’ at that juncture (Koelsch, 2015). Moreover, the women in this study were offering insight into their way of knowing. Importantly it has come to demonstrate how they view ‘self’ and their sense of agency (Gilligan, 2015; Koelsch, 2015).

It was not until I drew together the poems and reread them several times that I totally engaged with the meaning and could see the potential richness of the content. In Kiegelmann's (2009) interview with Gilligan, she acknowledges that using this method can be challenging and that it requires the researcher to “tolerate the uncertainty of not knowing” (p.13). They should avoid following deductive logic but trace streams of associations leading to great discoveries. She adds sagely, and I would confirm this, that researchers will often not realise this at the beginning of a project.

Stage One: Read-through Three listens for the interpersonal relationships within the narrative, the contrapuntal voice. This can include not only family members and friends but health and social care practitioners. I regarded this as particularly useful as it bought in the midwife as a significant player within the narrative. This section is informed by feminist theoretical appraisals of individualist intellections of agency (Stanley, 1993; Doucet and Mauthner, 2008) and brings together their intrinsic relationality with others (Somers, 1994). This section also helped me to see who is absent from the narrative.

Stage One: Read-through Four exploits this further by placing the participants in the broader cultural and societal context. It frames the narratives by way of the dominant ideologies and power relations. It may locate the tensions between what is expected in the public world and what can be achieved in the women's private world (Gilligan, 1993).

Stage Two: Mauthner and Doucet (2011) draw together the analysed narratives into case studies, themes and vignettes. Their rationale for undertaking this activity relates to how the narrative data is seen and understood as one entity. They describe how they were able to locate themes and subthemes by using computer-based programmes and/or manually creating matrixes. I selected the latter option and created three theme matrixes that identified both differences and similarities. I then wrote small vignettes, intending to draw Read-throughs One, Three and Four together to create a cohesive visual experience for the reader showing the individuality, self and agency of each of the women (Raider-Roth, 2014; Koelsch, 2015).

As I explored how the Listening Guide had been used and applied elsewhere, I came upon the work of Mauthner and Doucet (Mauthner and Doucet, 1998, 2003, 2011; Doucet, 2008; Doucet and Mauthner, 2008). As PhD students, these feminist researchers had worked with this framework and developed it to embrace a widened scope for health and social research, enabling researchers to encircle the duality of social constructs and human agency (Giddens, 1984, 1991). Doucet and Mauthner,

(2008) revisited the tensions between feminist theorists about the positionality of the "subject." This added to the impetus to produce a method that could be used by multidisciplinary groups, which was nonbinary and provided an opportunity to create a rich tapestry of information. Within the literature, they cite the "fierce" argument between feminist theorist Judith Butler and Seyla Benhabib about the "subject." Their disagreement focused on the conditions influencing the "subject" and whether they were chiefly related to power and control (Butler) or whether the poststructuralist environment meant that "self" reflexivity, autonomy and intentionality were lost (Benhabib). This debate raises the question of whether, on a microlevel, the participants in this study are influenced by the power dynamic between a service user and a health care professional during the interview. It may be that after such a long time, the women in this study would not sense this.

Doucet and Mauthner (2008) were most influenced by the work of Liz Stanley, whose theoretical writings about her mother's death phase brought together a notion of seeing the "subject" from three viewpoints and are clearly included in the Listening Guide. The first is "inside," which considers how 'self' exists within the narrative. The second is "outside" the narrative. Stanley describes this as knowing her mother, not just "beyond 'self' but below and behind." Doucet and Mauthner (2008) drew this out of the narrative, especially in the section of analysis described as I-Poems, where the level of emotionality is both explicit and implicit, it can be felt by the reader. The third viewpoint is "how" is where the researcher comes to know the narration and subject. This third activity is reflective and reflexive as the researcher must explore their position and understanding before, during and after the narrative inquiry (Stanley, 1993). This aspect has become an integral part of my research, echoing my theoretical and philosophical perspective, although this phase of the process could be viewed as an epistemological state of flux, with the researcher becoming 'the researched.' What is evident from Liz Stanley's work is the potential when taking a holistic view of 'self' and that just knowing the subject at that moment is not enough to ensure that research has validity, reliability, and credibility.

The strengths of the Listening Guide.

What makes Mauthner and Doucet's (2011)'s version of the Listening Guide attractive is this symbiosis of the researcher, the researched and the conventions of undertaking research. In their writing, they acknowledge the challenges they experienced. It seemed reasonable that I might encounter these during the analysis stage too. They helpfully provided examples of how to work through the complex layers which may be discovered in the collected narratives.

When deciding whether to use the Listening Guide as an analytic approach, there were other influencing factors, I wanted to be confident that the participants had the opportunity to ask, "radical questions" (Clough and Nutbrown, 2012) that would lead me to understand the data as fully as possible. The method needed to facilitate both the discovery of gaps in knowledge and how the answers to those questions could be posed in a way that was morally and politically astute. Although the selection of the analysis tool should not be viewed, chosen and seen as an individual component of a research project (Mauthner and Doucet 2011), selecting the method of analysis and negotiating its processes was most certainly one of the most challenging activities throughout the research process. However, I found it useful to recollect Clough and Nutbrown's (2012) work which encouraged me to have confidence in my choices. This confidence was assured as this analytic approach succinctly blended into my conceptual framework.

During periods of reflection and journaling, I tried to envisage how the narrative and analysis tool might complement one another, and unlike thematic analysis, I became confident that I could apply this method to my chosen area of research, how birth stories are told and shared. More deeply than this I came to see how some women can be invisible within society with their voices being unheard, I began to appreciate the opportunity as the researcher to be the catalyst for giving voice to this group of women

My attraction to the Listening Guide as a method of analysis was ignited by the way it was used in clinical settings when collecting narratives. As seen in my conceptual framework (illustration 1.3) it sits comfortably in the 'arteries' alongside birth rites and women's stories because the focus was on women's ways of knowing. The method has its roots in clinical approaches (Brown and Gilligan, 1993), interpersonal theory, (Belenky *et al.*, 1986; Gilligan, 1988, 1993; Brown and Gilligan, 1993); and hermeneutic traditions (Gilligan, Brown and Rogers, 1990; Brown *et al.*, 2014). Gilligan's 1982 psychological theory and women's development book *In a Different Voice* began in the 1970s as a feminist response to the position of women within a male-dominated debate about abortion, namely the situation of moral conflict and choice within the decision-making discourse regarding abortion. Importantly, Gilligan fosters male and female distinct voices by presenting the book in themes to demonstrate contrasting voices. The commentary acknowledges the social context and power position of the voices. Additionally, it presents two distinct understandings of self and moral development, demonstrating that the female voice had its own agency (Gilligan, 1993). Gilligan's methodology has been highly criticised, and there are allegations that she unrealistically stereotyped males and females, using biology to explain phenomena (Colby, Colleee and Damon, 1983; Nails, 1983; Flanagan and Jackson, 1987). The timeline of her research, the 1970s and 1980s, reflects a time when the debate about the biological predispositions of children vs societal conditioning was gathering momentum – a point that she did not seek to explain – and to some, it may have appeared that she had taken an un-feminist position.

Moreover, she pursued the feminist position of exposing and redressing androcentric bias related to the moral development of girls (Fraser and Nicholson, 1988). Although the criticisms position her research as ideological rather than empirical and essentialistic, it has initiated a long-lasting discourse demonstrating that women were excluded from certain research areas. Importantly, the assumptions about female characteristics that were said to reflect weakness, self-doubt and deference were shown to represent strengths of character – hence a

different voice. The chapter called 'to the reader,' written into the 1993 edition of Gilligan's book, intrigued me further; I wondered what 'voice' I would hear from my collected narratives:

> *"I learned that you cannot take a life out of history, that life history and history, psychology and politics are deeply entwined. Listening to women, I heard a difference and discovered that bringing in women's lives changes both psychology and history. It literately changes the voice: how the human story is told and also who tells it" (p.xi).*

It was at this point of understanding, with Sorsoli and Tolman, (2008), suggestion that this method of analysis,

> *"actively encourages researchers to begin to unravel some of this complexity. Although every person's voice contains multiple melodic lines that can be explored qualitatively, it is often in regard to experiences that are the most complicated, taboo, or awkward to share with others that this method's goal of tuning into" (p.498).*

I became firmly convinced that this was the way I wanted to analyse my participants' narratives and that any concerns about the appropriateness of this approach would easily be resolved as I moved through the process.

To conclude, this chapter has discussed my epistemological position, how and why I have selected narrative inquiry as the methodology and further explored the methods employed to collect and analyse six women's narratives. This chapter has shown how the process of reflecting, questioning and testing the framework allows strategies to be put into place to meet the challenges head-on.

Chapter 4 - Women of their time

.... if you want to start by telling me what your life was like the first time you became pregnant.

Helen interviewing Barbara

This chapter introduces each of the women and the broad context of their lives. Using the term 'birth continuum' within this study encourages the reader to see the women's lives as part of their life's continuum, where one experience informs another. To understand the women's narratives, it was crucial to understand their positionality in that particular time and space (Gilligan, 1988, 1995; Gilligan *et al.*, 2011). Gaining an in-depth understanding of the reality and emotionality of living through the 1960s and 1970s has helped to contextualise the narratives and given insight into the condition of being human. It shows the difference between the historical rhetoric and how this group of women experienced the times and the disparities between the two. Moreover, it highlights the social-eco-cultural priorities of yesteryear, stimulating curiosity about their significance in today's societies. The synopses incorporate elements of the whole narratives as told in their interviews.

Throughout this introduction to the women, researcher reflections (included in an alternative font) are based on my research journal entries and subsequent thoughts and feelings about the interviews and interaction with the women. The inclusion of these reflections responds to the idea of hearing polyphonic voices within a narrative inquiry (Holquist, 2003).

Elaine

Elaine married in 1967; she had met her now-husband at their workplace three years previously, at the age of 19. Once married, they bought and moved into their first house. She described how they saved 'really hard' to have the money to purchase this house and the things to go in it. They decided to try to conceive within the first year of marriage; by the end of 1968, Elaine was pregnant, and the baby boy was born in August 1969 at the local maternity hospital. During her pregnancy, Elaine

had been troubled by hyperemesis, followed by a multi-parity query. An x-ray ruled this out, but it led to investigations for gestational diabetes, followed by pregnancy ailments such as renal colic and pregnancy-induced hypertension. When highlighting these complications, Elaine talked about the loss of her mother at 19, and although she had a strong bond with her sister, she recollected the feeling that she had wanted to talk to her mother about the situation she found herself in.

Elaine's second pregnancy and birth experience occurred in 1972; she had hoped to have a homebirth and a more fulfilling experience; however, her husband was very worried by the thought of this, and she agreed to have a hospital birth. Elaine added that she had gestational diabetes again in this pregnancy. For Elaine, the resounding difference in the second pregnancy and birth experience was the allocation of a student midwife. The student midwife had helped her prepare for the second birth, staying with her throughout the journey.

Elaine was the first person I interviewed. Elaine was an avid journal-keeper and had spent some time before the interview revisiting her journals, particularly those related to pregnancy and birth. She gave me a typed copy of the entries related to the pregnancy, so I could refer to these when analysing the narrative. Elaine was interested in my role as a midwife, lecturer and researcher. She challenged my skill of conducting an unstructured interview because she wanted to hear about me! Yet her warmth and 'motherliness' at points made it easy to reverse the roles, I did manage to keep her focussed and interested in telling her story though.

Barbara

Barbara was married and lived with her husband on the outskirts of a coastal town. She worked as a civil servant in "social security" until her first baby's birth. In 1970, she was aged 24 when she had her first baby in a community hospital; this baby was a girl. Her second baby, a boy, was born two and a half years later in the same

hospital. She included the miscarriages she had before and between the two births when telling her story. Her birth experiences were compounded by having discovered cancerous breast lumps while pregnant, for which she was not treated until after the birth. A prominent figure in Barbara's life was her older sister; she mothered Barbara, supporting her through the challenging times. Although her mother was alive, she describes her relationship with her mother as limited because "she was an invalid."

Barbara returned to paid employment when the children were older. She worked first as a cleaner, then as a school dinner lady, ultimately, returning to her job as a civil servant.

Barbara's narrative left me feeling that a sense of sadness had underpinned her joy. She had several health issues that blighted her well-being during the times she had her babies. I kept thinking of how I might deal with a breast cancer diagnosis when I had a new baby or small children, leaving me with questions about how the human spirit gets a person through those times. Although Barbara's interview included the most challenging health issues, it was the funniest; she interjected great humour throughout the interview, funny stories that poked fun at her younger self that found us both laughing. Barbara was most certainly comfortable with the uncomfortable, she reminded me that role models can be found in unexpected places.

Peggy

Peggy lived in a coastal town with her mother until late in her first pregnancy. She found a tiny flat, which was little more than a bedsit, where she lived with the baby's father, although they were not married at the time. As the story progresses, Peggy explains how "all hell let loose" when her mother found out she was pregnant, and the baby's father was already married. However, they did eventually marry.

Peggy and her husband had two children, both boys; the first was born in a hospital in 1961 when she was 19 years old. Peggy conceived the second baby two months after the first birth; this baby was born at home. Peggy described the support she had from her mother as arbitrary and capricious. For this reason, she concealed the second pregnancy for as long as she could as she feared her mother's reaction. She was in paid employment up to her first baby's birth; she returned to work as soon as she could. Peggy mainly worked as a hairdresser but needed to do several types of jobs to make ends meet.

Peggy found the interview emotional. She found it challenging to start the story; the recorder was stopped and started a couple of times. The relationship she had with her mother featured strongly in the narrative, and it seemed she had not been able to resolve this during her mother's lifetime. Peggy spoke of seeking therapy in recent years and felt any depression she had was related to the way her mother had treated her as a child and young woman. What struck me was the longevity of the feelings; in some ways, she still had that young woman's voice; time had not changed a thing. She spoke of the level of naivety she had quite often felt in her younger years. A sense of sadness and regret was audible in Peggy's voice and seen in her demeanour. Her interview left me feeling sad and reflective amount mother and daughter relationships. I considered my own, not that it is similar in any way, only that as an adult the actions of our parents are seen so differently. Peggy's understanding of those experiences had led her to such a dark place.

Cordelia

Cordelia's recollections began when she was married and lived in a bungalow in a small coastal town with her husband. In 1969, at the time of the first baby's birth,

she was 23 years old. Cordelia talked of the support from both her mother and mother-in-law and often referred to them for advice. She mentioned her family's religious beliefs and how this impacted some of her choices concerning childbirth. She had two children, a girl and a boy. The first was born in the hospital, and the second was born at home. Cordelia had desperately wanted to breastfeed her babies. However, the healthcare professionals' support was not enough to help her get over the problems she met. She persevered for some time, topping up feeds with formula, eventually moving to whole formula feeding.

Cordelia had been in paid employment until her first baby's birth, at which point she left. She returned to paid employment once the children were older, and during this time, Cordelia decided to have a career change and trained as a nurse.

Cordelia gave me the impression that her recollections had been well thought through, and she had a sense of order. Her demeanour and aura were those of a 'hippy spirit.' She did not express any such behaviours; it was just in her sense of being. I suppose my imagination associated her demeanour and aura with my perceptions of this era. Did this mean I was biased? Is it unconscious bias or do I respond to a present bias? Her discussion about the women in her life was central to her narrative. Her mother, mother-in-law and daughter are featured in every aspect of the interview one way or another. My reflection on spending time with Cordelia was one of freedom and openness, which seemed to mean she was comfortable sharing the most intimate details of her birth experiences.

Ruth

Ruth started her story by explaining that she and her then-boyfriend always talked about having six children and were keen to start a family while young. So, in 1959, aged 17, Ruth married, and their first baby was born in the hospital when Ruth was

aged 18 and a half. At the time of their first baby's birth, they lived in an extremely small flat; it had two gas rings and a sink on the landing. In all, they had four children, all boys. The first baby was born in a hospital; the other three were born at home. Although regarding it as "not doing brilliantly," she breastfed her babies for up to seven months and recognised that it had not occurred to her to do anything else. Ruth's mother had died when she was young and she spoke of missing this maternal support. However, she had built a female support network consisting of aunties, sisters, sisters-in-law and friends, and this network remains a constant in her life today.

Ruth expressed her desire and intention to be a stay-at-home mum and had resigned from her job at the "labour exchange" reasonably early in her first pregnancy. She did return to this job; however, not until the youngest child was ten.

Ruth's persona was one of an earth-mother, radiating an almost palpable warmth. She often said how much enjoyment and pleasure she has from being a mother and grandmother, and it was evident from her mannerism and surroundings (keepsakes and artefacts) that these roles were central to her being. She kept a journal and collection of artefacts throughout her pregnancies and shared many of the entries with me. Ruth and I most certainly drank tea intelligently, meaning that over a cup of tea and relaxed conversation she answered my questions with ease, almost not knowing we were doing that. Out of all the interviews, the experience of talking with Ruth was the warmest, she fostered a motherly persona that made the interview easy.

Hilary

Hilary married in 1964, aged 20; with her husband, she moved into a tiny flat in a London suburb. Her first pregnancy and birth experience happened in 1966; she found it difficult to recall much of her pregnancy apart from the fact that she had toxaemia (now known as pre-eclampsia) and a traumatic delivery of a baby boy at

the local hospital. For Hilary, the overriding memories were about becoming a mother. She talked about the challenges of being sleep deprived and not knowing what she was doing with a colicky baby. By the time the first baby had been born, she had moved to a small house in the area where she had previously lived. New motherhood was compounded by feelings of isolation and not having a support network nearby. Hilary described her relationship with her mother as closed to discussions about the body and birth, although she did talk with her sister, who had a young baby, she described her as "not a very chatty person." The challenge of a colicky "bright, very active" baby did not dissuade Hilary from having another baby. She talked about this pregnancy being calmer than the first, and the birth was "good." Even though she required surgery post-delivery, it did not mar her recollection. Two years later, she had another baby boy. Both the second and third baby boys were born in a local maternity hospital which had only been built in 1964, making the surroundings feel luxurious and state of the art.

Hilary had left her place of employment before her first baby's birth, and she did not return to paid employment until the youngest son was at senior school. However, she became an active member of her children's school parent-teacher association.

The interview with Hilary left me feeling professionally concerned; it seemed that some of her memories of the birth were suppressed or unspeakable; her body language told me she did not want to go there! I replayed in my mind, listened to the tape and read the transcripts over and over, as I wanted to test my instinct. Fear and pain were associated with the memories she spoke of and then closed down. Motherhood seemed to be a lonely and challenging role to transition into for Hilary, but she showed a level of acceptance that this was what she was expected to do. Her social circle seemed to be small, and support was fragmented.

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[4] In 1966 a new Maternity Unit with 56 beds and a Special Baby Care Unit with 14 cots opened.

Schooling and opportunities

The women in this study would have ended their secondary education in about 1947. The leaving age had been increased to age 15, between 1958 and 1962. None of them entered higher education; all of them took paid employment. The Education Act of 1944 aimed to create more educational parity between the sexes. Often teachers and parents had limited expectations for girls (Gillard, 2018), assuming their destiny was to be married, have a home and a family to care for, with work just a temporary measure between leaving school and marriage, a sentiment reflected and accepted in the six women's recollections. Although none of the women formally continued with their education per se, Cordelia spoke of deferring her desire to become a nurse, which she eventually pursued once her children were older, and Peggy undertook a hairdressing apprenticeship. However, in the main, the women in this study were not following a national trend in the number of students attending further education and higher education institutions. The societal expectation may have influenced the decision not to pursue this pathway, since further education had chiefly been a male-dominated activity. However, Tables 5 and 6 demonstrate the climb in the achievements of women studying at a higher education institution (HEI). In 1950 total awards for women were 4,200; by the 1970s the figure had climbed to 17,333 (P. Bolton, 2012). This figure represents a population of 2,107,630 women aged between 20 and 24 in 1970.

Learners at further education institutions, England and Wales

Thousands

	Further education institutions			Adult education centres	Total
	Full-time	Part-time	Evening		
1910-1911	26	68	..	558	652
1920-1921	30	90	..	754	874
1930-1931	26	76	..	930	1,032
1937-1938	30	89	..	1,203	1,322
1949-1950	75	284	761	1,263	2,383
1960	151	488	713	877	2,229
1970	363	716	716	1,320	3,115

Table 5 (P. Bolton, 2012)

Students obtaining university degrees, UK

	First degrees			Higher degrees		
	Men	Women	Total	Men	Women	Total
1920	3,145	1,212	4,357	529	174	703
1930	6,494	2,635	9,129	1,123	200	1,323
1938	7,071	2,240	9,311	1,316	164	1,480
1950	13,398	3,939	17,337	2,149	261	2,410
1960	16,851	5,575	22,426	2,994	279	3,273
1970	35,571	15,618	51,189	11,186	1,715	12,901
1980	42,831	25,319	68,150	14,414	4,511	18,925

Table 6 (P. Bolton, 2012)

The significant rise in women attending further education institutions (FEI) and HEI reflects the political and social movement of the 1960s. The modernisation of the workforce offered women an opportunity to pursue a career and achieve self-actualisation (Mills, 2016). However, like the six women in this study, women may have found themselves caught up in the conflict between old and new values and expectations of how their role in society should unfold. The six women did not mention whether their parents leaned towards an equalist forward way of thinking. Interestingly, Hilary and Elaine inferred that they went to work "as expected," and Peggy said, *"I didn't have anybody… I just lived for them (*the children*) and worked,"* explaining the necessity to earn a living. Elaine and Ruth inferred that marriage and reproduction were the natural order of their life journey. However, their gender was not the only contributing factor; (Gillard's (2018) summary of education in the 1960s highlights the role of social class concerning educational opportunities. (Gillard (2018) states that children from unskilled family homes were less likely to attend grammar school even though they may have passed the "intelligence test". Gillard's report further discusses the Government's encouragement of and response to the growing affluence and consumerism of the middle classes. The concept of 'education for all' included introducing and promoting comprehensive schools and the dissolution of grammar schools. The Crowther Report (1959) was aimed at the groups who were least benefiting from the expanding educational services. They included "children of manual workers and those in larger families and because of

deeply entrenched prejudices the female members of the population" (Gordon, Aldrich and Dean, 1991).

Only one of the participants in this study mentioned attending a grammar school. Her description of her lifestyle as a child would be equated to living in an unskilled household. Although she passed the intelligence test for grammar school, she did not continue into further education; instead, she took an apprentice type of employment.

Early family life and housing.

Four of the women, Peggy, Elaine, Ruth and Hilary, spoke in detail about their living arrangements at the time of their first pregnancy and how this impacted their early motherhood experiences. They included in their recollections how their housing improved or changed as their lives moved forward. Their recollections began in the first half of the 1960s, and the poor housing standards they recalled were a continuation of the post-war housing crisis. This crisis saw social housing developments and increased homeownership from 35% in 1939 to 47% in the late sixties (Burnett, 1986). Although more housing was built in the 1960s than at any other time, many people like Peggy, Elaine, Ruth and Hilary were living in towns where large Victorian houses had been divided into small flats. These properties often shared amenities, as recalled by Ruth when she explained, *"We were in a tiny flat at the top of somebody's house, with two gas rings on the on the landing and a little sink*".

The governments attempted to address this by developing residential tower blocks; about 55,000 tower blocks constituting 400,000 homes were constructed in the UK (Burnett, 1986; The NHBC Foundation, 2015). It was hoped that this would be the answer for the 100,000 families, including old-age pensioners, who were still living in poverty, not benefiting from the newfound economic prosperity promised by the 1960s. Promoted as modern living, it was not long before disapproval of tower blocks grew, chiefly due to their poor design and technical insufficiencies, they

became described as vertical slums. In an attempt to improve the quality of new buildings, the Government replaced the longstanding local Bye-Laws for Building with (English) National Building Regulations. At the same time, the Labour Government pushed forward with the 1930's housing act aims to clear the slums. Two further waves of New Towns were selected, Telford and Washington, followed by Milton Keynes and Warrington in the late 1960s (GOV.UK, 2015; The NHBC Foundation, 2015). Although statistically, some improvement in the levels of overall household poverty occurred between 1970 and 1975, the Government did not meet its aims to improve housing and the standard of living for all. By 1975, a million homes remained rated as slums, and 1.8 million were unfit for habitation. Peggy, Ruth and Hilary compared how the lack of basic essential facilities and equipment was different from contemporary living. Hilary gave the example of not having a washing machine,

"Nappies were all in the buckets of Napisan and then they all had to be boiled in the boiler and with the tongs and push them all out. Oh, it was difficult, all that."

At the same time, half a million families shared a home, and as many as 30,000 people were homeless (Burnett, 1986). Dorling et al. (2007) place the household core poor rate during this period at 14.4% and the breadline poor rate at 23.1%.

Social life

All the participants of this study were young women in the 'golden era' of the 1960s and the tumultuous years of the 1970s; they lived in a time of extreme social and cultural change. The women may not have consciously realised they lived in such a progressive era until they lived through it. The 20-something adults found themselves in a technologically advancing period that presented new life opportunities and freedoms, providing they could finance this. They then plummeted into the economic challenges of the '70s, where the women may have needed to call upon their stoicism and resilience to negotiate the strikes and blackouts caused by the Governmental implementation of the 'three-day week' policy (Sandbrook, 2013).

Some of the women in this study expressed an initial desire to take control of their choices and make decisions for themselves. However, for some of the women, this enthusiasm for fighting for independence and patriarchal freedom was curtailed by some less free-thinking adults who perhaps feared for the younger generation's behaviour and moral values. Peggy explained that in order to maintain her relationship with her partner, who was already married, and to keep her baby, she moved out of her mother's house:

"I moved back to this room, erm, at the top of a house in xxxx somewhere, it was about 70 stairs to go up…That's where I stayed with xxxx. My mother was disgusted with me and ashamed of me."

It seems that society was at odds with itself. The war years had shifted society's moral and social compass by giving many a new lens through which to view their future, a position cultivated by the Government's motivation to reward the generation that had contributed to the war effort with financially prosperous lifestyles. However, the Government had conflict among the ministers. It had a party manifest that was laissez-faire liberalist in its ideologies, with a proportion of ministers voicing their anxiety that affluence would undermine society's structure. They had inadvertently created a quagmire by overemphasising family values and behaviours (Morgan, 2006; Sandbrook, 2013).

Employment and marriage and birth

All of the women in this study were in paid work before marriage or cohabitation and the subsequent birth of their first baby. Only Peggy returned to work when her children were young; however, this was rooted in her social status and lack of support from her partner/husband. Although many changes occurred throughout the 1960s and 1970s, the foundations of the world of work for women had been set out in the Beveridge Report (1942) (Beveridge, 2014). This report contributed to the formation of the welfare state legislation, during which Beveridge stated that a restricted role for the married woman in post-war Britain should allow women to focus on their role in the home. It noted that "she (women) should not have the

same attitude to employment as that of a single woman" (p.50). Beveridge had set the scene when he outlined the man's role as the breadwinner and the women and children as mere dependants. He placed no value on any earnings women could bring into the matrimonial home, and the earnings, in general, were not a means of subsistence (Davis, 2013).

Interestingly, there was no reference was made to the social class of women in the Beveridge Report, which in itself is curious as people were still categorised and labelled concerning their class by both Government and society. Spencer (2005) suggests this gives the impression that Beveridge viewed them as a universal group, regardless of class, ability or opportunities, diminishing any worth they may have had to society and the communities in which they lived. As the 1960s progressed, the Government noted that they did not realise all members of society's potential to work in paid employment. They acknowledged that the deficit was the contribution of women. In The Higher Education Report 1963, the Robbins committee summarised why women and girls should be given more career and work opportunities stating:

"It seems possible that the tendency for girls to stay on may gain momentum, and this might become a major feature of the future educational scene. We should greatly welcome a tendency for more girls to stay on at school, if only from the national point of view of making better use of what must be the greatest source of unused talent at a time when there is an immediate shortage of teachers and of many other types of qualified person" (p.66).

Initially, from this statement it seems that the Government placed little or no value on women and girls, wanting only to plug the national workforce gaps. However, on reflection, during this era, this report would have been ground-breaking. It gave a glimpse of what might be possible for women if they were 'officially allowed' to seek opportunities to access education or workplaces that led to a skilled profession.

Although not prominently reflected in the women's recollections in my study, attempts were being made by the media (newspapers and magazines) to reinforce the Government's efforts to increase the numbers of women in the British workforce.

They proffered the idea that women could have careers and be mothers and housewives (Davis, 2013). Davis (2013) discusses the influence of magazines on women in the 1960s and 1970s in her book, which records the oral histories of 160 women's recollections of life from 1945 to 2000. Although women remembered such articles in women's magazines, they did not refer to them as influential. Davis (2013) found it somewhat confounding that the content was contentious and enticing enough to remember yet did not influence them to believe it to be more than propaganda.

Women outside of the Davis (2013) study did begin to question their expectations of what they might achieve. Women began to challenge the social inequalities within their communities, such as the traditional patriarchal model, which expected women to stop work after marriage and then take employment that merely provided 'pin money.' By taking menial jobs, they could accommodate raising children. Ruth explained that she did not want to work and not have time with her children when they were young. Although she acknowledged that today's world is vastly different, she sagely offered advice to younger generations of women:

"Think very carefully before you have children because why on earth would you have children and give them to somebody else to look after and then go straight back to work?"

Most workplaces' infrastructure did not accommodate this new way of thinking and placed constraints on women who wanted to be a career woman and a wife and mother; the option was to choose one or the other, not both. It may have been this that prevented Elaine's pursuit of her expressed desire to become a midwife and which delayed Cordelia from becoming a nurse until she and her children were much older. Furthermore, the same set of circumstances bound Peggy and Barbara to undertake piecemeal part-time employment. Above all, the women spoke of the desire to be married and have children.

Statistically, marriage rates rose gradually throughout the 1960s and 1970s. Of the six women in this study, five were married before the birth of their first child, and the sixth married sometime between the first and second child's birth. By 1972 the

UK's marriage rate was at its highest since 1940, with 426,241 marriages. The average age of marriage in 1960 was 25 years and three months for women and 28 years and three months for men, with only a slight increase of one year in both over the subsequent decade (Office for National Statistics, 2018). Statistically, the six women in this study fell short of this age range. Three who were under 19 and 11 months and the remaining three were over 20 years of age do not conform to the national average during this period. An initial response to these birth and marriage statistics could be that perhaps the post-war values and parental influence won over the Swinging Sixties, the decade of 'free love.' However, the divorce rates for the same period demonstrate the 'freedom' of the 1960s with a significant increase, with 37,785 divorces in 1965 rising to 119,025 divorces in 1972 (Office for National Statistics, 2011). Out of the six, only Peggy divorced, and this was after 12 years of marriage.

During the 1960s and 1970s, a multilateral system of maternity care in England had been created. General practitioners (GPs), local health authorities who employed district midwives, and hospital-based obstetricians all had involvement in pregnant women's care (McIntosh, 2014). With obstetricians exerting power over the Government, the Cranbrook Report (Ministry of Health, 1959) suggested that at least 70% of all women should have their babies in a hospital. The focus of care during this time was on safety. The hospital environment was sold as the safest for both mother and baby, and women were compliant. Understandably, that was appealing to women, as Britain's maternal mortality rate had already fallen from 415/100,000 births in 1935 to 27/100,000 in 1965. However, this was not due to curtailing homebirth but was more likely influenced by medical advances such as antibiotics. Conversely, the 1966 leading cause of maternal death was criminal abortion, with about 100,000 'back street abortions' per year (Drife, 2016).

It is essential to remember that women's voices were not critical to the planning of maternity care. Informed choice and partnership care planning between patients and healthcare professionals were not everyday practices. The Association for

Improvements in Maternity Services (AIMS) tried to raise women's and society's awareness of the negative aspects of birthing in this environment. Writing to the Guardian, the founder of AIMS, Sally Willington, suggested (McIntosh, 2014),

'In hospital, mothers put up with loneliness, lack of sympathy, lack of privacy, lack of consideration, poor food, unlikely visiting hours, callousness, regimentation, lack of instruction, lack of rest, deprivation of the new baby, stupidly rigid routines, rudeness, a complete disregard of mental care of the personality of the mother.' (The Guardian 01-04-1960)

Of the 14 births experienced by the women in this study, five were homebirths. Four took place in small community hospitals, often staffed by midwives and GPs, with the remaining five taking place in an acute hospital setting, staffed by obstetricians and midwives. The 35.7% of the participants who had homebirths exceeded the national rate of 22%. However, this may have been related to the timing and location of those birth. The majority occurred in the 1960s in suburban towns that did not yet have large provincial hospitals.

The feminist movement

It is well documented that the 1960s was the epicentre of the women's liberation movement and the sexual revolution (Escoffier and Rattray Taylor, 2015; Giami, Hekma and Macmillan, 2015). Although the women in this study did not make direct reference to feminism or associated activism per se, it would be remiss not to mention the omnipresence of huge legislative change. The passing of the following key Acts of Parliament set in motion unprecedented changes in every aspect of women's lives and the communities they lived in:

- 1964 The Married Women's Property Act entitles a woman to keep half of any savings she has made from the allowance her husband gives her (Fawcett Society, 2016)

- 1967 The NHS (Family Planning) Act permits health authorities to give contraceptive advice regardless of marital status, and the Family Planning Association (FPA) follows suit. (www.parliament.uk, 2019)
- 1967 Abortion Act (Abortion Act 1967, 1967)
- 1968 Equal Pay Act. Women at the Ford car factory in Dagenham strike over equal pay, almost stopping production at all Ford UK plants. This strike was the catalyst for the Equal Pay Act. (Fawcett Society, 2016).
- 1969 Divorce Reform Act (Divorce Reform Act 1969, 1969).
- 1975 The Sex Discrimination Act makes it illegal to discriminate against women in work, education and training (Sex Discrimination Act 1975, 1975).
- 1975 The Employment Protection Act introduces statutory maternity provision and makes it illegal to sack a woman because she is pregnant (Employment Protection Act 1975, 1975).
- 1976 The Equal Opportunities Commission comes into effect to oversee the Equal Pay Act and the Sex Discrimination Act (Equal Opportunities Commission, 2019).
- 1976 The Domestic Violence and Matrimonial Proceedings Act is introduced to protect women and children from domestic violence (The Domestic Violence and Matrimonial Proceedings Act 1976, 1976).

These nine gender-focused Acts of Parliament listed above aimed to impact women's lives positively. They gave status to married women rather than just being regarded as their husbands' property; they provided women with control over when they might become pregnant and the choice of whether to continue the pregnancy. The Pay Act offered financial equity in the workplace and prevented castigation because they decided to embark on motherhood. Of course, the passing of these Acts of Parliament was the beginning of the journey. The campaigners and their supporters continued to pursue these new laws' enforcement. It is questionable whether the statutes' practical implementation reached the suburbs immediately. Feminist groups successfully created safe havens for abused women and continued to lobby the banking fraternity to allow women to own credit cards and secure mortgages;

however, the most significant challenge was addressing systemic sexism that was ingrained in society. It is this change that probably had a substantial impact on the day-to-day lives of the women in this study, although it has taken decades to alter significantly. It is therefore reasonable that the women in this study allude to sexism, social injustice and oppression in their lives and relate it to the emotionality of living in that moment.

This chapter has contextualised the society that the women experienced at the time of their narratives. It has been shown that the 1960s and 1970s were decades that brought society and communities exciting developments and opportunities but at the same time antagonistically presented many contradictions, particularly for women. Schooling and education offered greater opportunities, yet marriage, reproduction and housewifery were still often presented as a woman's greatest role, rather than a career or profession or indeed both. Compelled by feminist activists, the Government had passed emancipatory legislation, yet society was slow to follow with implementation.

The Government called the 1960's a 'golden era.' Although this was true for many people (male and female), it was not so for all. If they were of a low social class, impoverished and female, it was unlikely that long-term housing and employment prospects would improve, continuing a cycle of inequality, dependence and oppression (Morgan, 2006). Some women in this study, Hilary, Cordelia and Elaine, experienced a more prosperous time. They described that through 'hard work' (employment), they could secure a mortgage on a 'new' home with modern amenities, albeit in their husbands' names. Employment prospects for these households were good, and they were able to purchase some of the new technologies available in these two decades. For others, their choices were more restricted. Peggy and Ruth lived in several different rented properties. The properties were often large-period houses that had been converted into flats without modern conveniences.

While this chapter introduces and outlines the women's 'real-time' world, it is essential to remember that their narratives are underpinned by a backstory that came with a different set of beliefs and behaviours enforced by previous generations.

Extract from my reflective journal.

Bringing the women together, and building a picture of life in the 60s has been absolutely captivating. It has raised a few curious questions with regards to my mum's story. Where does she fit in this picture? was she typical of that era? I know that although she went to a grammar school, she also did not enter into a 'profession' until much later in her life. She gave up work when I was born and did not return until I was at school. Did that frustrate her? Did she like being at home? .....When these thoughts come together, does it mean that I will be influenced by these thoughts as I move toward the analysis?

Chapter 5 - Personal and professional relationships

"She was a pussycat, really." (Peggy)

This chapter explores the nature of the relationships the women had with other significant women during their birth experiences. To recap, the six women in this study had 14 live birth experiences. Five of these births occurred in a primary hospital labour ward and four in community hospitals, which would have been staffed by midwives and GPs. The final five happened at home with a midwife in attendance.

By following the Listening Guide steps of undertaking a series of sequential listening's, the interviewees' contrapuntal, multi-layered voices have been drawn out, mainly in Read-through Three (Gilligan *et al.*, 2011; Gilligan, 2015). During this read-through, the goal was not to see an agreement of commonalities (themes), but more the connectedness and resonance that brings the participants' interviews together or the absence of aspects of relationships that give voice to the contrapuntal element of the Listening Guide. During Read-through Three, two strong themes emerged. The first is the women's relationship with their mother or/and a mother figure or representative. Early on in the interviews, the women positioned women who were either present or absent from their lives. They did this in the context of a supporting role in the pre-conceptual period, during pregnancy, birth and the early days of motherhood. The strongest emphasis was on practical support as they transitioned into motherhood. The second theme focuses on the relationship they remember having with the midwife during their birth experiences.

Both themes were responses to the interview question, *"What are the most poignant memories related to your birth experience?"*

What the women said about mothers, aunties, sisters and the sisterhood

Of the six women in this study, Ruth and Elaine had mothers who had died during their early years. Cordelia, Hilary and Peggy's mothers were alive when they had their babies. Barbara's mother was alive but unwell, and she nonchalantly described her as an "*invalid*."

Cordelia's relationship with her mother seemed to be steadfast throughout her birthing experiences. Although her mother had not discussed her changing body with her much when she was a child, this changed when she married, and as she began to question her experiences, these prompted her mother to share her own experiences:

"When I became a married woman, she was far more open, and she discussed her own birth experiences with me and, erm, I think she probably had quite a bad time, erm, with my brother. She had heart trouble, my mother and, erm, I think she was told that she shouldn't have any more children because it would have a really bad effect on her health that she did. So, she had the three, but she actually gave me lots of stories and as an older woman, women tend to do, she did elaborate rather on me, erm, with the gruesome aspects, … you know, giving birth. But I think, realistically, it is quite a gruesome experience, and it isn't pretty."

Her mother joined in the "scary birth story" tradition that women do to one another. Despite this, she believed her mother was her greatest supporter and advocate, and she mentioned contention between her parents when deciding where Cordelia would have her home birth.

"My mum, yeah, I think my mum… was happy to be involved. My father was difficult and, I wasn't allowed to, coz I was gonna have my second baby with my mum at home, at her home, but my father wouldn't allow that…."

Cordelia went on to have a homebirth in her own home with her mother as her birthing companion. Cordelia spoke with ease about her relationship with her

mother and her confidence in knowing when choosing a homebirth environment to birth her baby that her mother supported this decision. She assumed the role of advocate and mediated between Cordelia and her father, who raised concerns about how safe it was for her to make this choice.

Out of all the participants, Peggy's relationship with her mother appeared the most punitive and unpredictable, and she described the authoritarian parenting style of her mother and the corporal punishments she experienced as a child.

"Erm, and I was never allowed out to play or anything like that. I used to have to stay in and do cleaning the brass at the weekends or the silver or stuff like that...."
"You had trees in the streets in those days...Play rounders and I'd sneak out the gate, and I always remember one day my mother coming down, finding me and dragged me back, and she used to beat me with a tomato cane..."

She attempted to justify the situation by explaining the psychosocial perspective of her mother's situation.

"My mother took in lodgers to make ends meet. She was on her own, and she obviously had me late in life...I think my mother was about 44/45 when she had me."

Peggy became tearful and distressed when she spoke of her mother's harshness and explained that she had only been able to internalise this in recent years (in her 70s).

At the time of pregnancy, Peggy had been in a relationship with a married man (whom she later married), and her mother's reaction seemed expected but emotionally overwhelming: *"My mother was disgusted with me and ashamed of me..."* Her mother made her move out of the home, and she felt very alone. Interestingly, she became pregnant again two months after her first baby's birth, and although she lived with the babies' father at this time, she expressed anxiety at having to tell her mother.

"I fell pregnant again, and I was so scared to tell my mother. I really was so frightened to tell my mother, and I didn't even show hardly at all."

She chose to conceal the pregnancy until she was eight months pregnant for fear of the reaction. Although it seems strange that Peggy was so worried about her mother's reactions to the second pregnancy when she no longer lived with her or relied on her financially, but this enmeshed relationship had continued into Peggy's adult life, leaving her with a poor sense of self and low self-esteem due to her mother's behavioural dominance (Miller-Day, 2004).

Although not described in such depth, Hilary's relationship with her mother appeared to have little reciprocity. While it was common for women to be uninformed or have little knowledge of sex, pregnancy and birth in this era, Hilary presented her mother as a disconnected figure when asked whom she talked to when she wanted to know something about her pregnancy:

"My mum, erm, wasn't that kind of a mum really. Erm, my sister had, had a baby, erm, about six months before me. So, that was quite good, we used to chat."

She repeated this disconnection when talking about her mother's lack of practical support when she was overwhelmed with caring for a baby with colic. I asked her if she felt annoyed that her mother did not want to help her by looking after the baby, she replied: *"No, not really because if someone's really frightened. We were frightened."* This reference to her mother was said with a tone of acquiescence in her voice. Hilary did not elaborate further, nor did she show any greater emotional response to this aspect of the conversation.

Elaine and Ruth had both lost their mothers, who had died before either of them was married. Elaine established the sadness of this early on in the interview:

"My mother passed away in 1966 when I was 19, so [it] wasn't all roses" "... That would be perhaps the most significant part of when you're pregnant is not having your mum."

Further on in the interview, she referred back to her mother's absence and positioned her in a role during both of her pregnancies, births and after. She appeared to have partially reconciled her loss by acknowledging the relationships

she had developed with others, reflecting that "I was very close to my sister but, you know, you just really need your mum sometimes" and "to sort of, you know, put you straight and look after you and things, so that was quite a big thing for me, but I had a really nice mum-in-law and, my sister was very good." Elaine's relationships with her sister and mother-in-law had become a positive source of support and advice.

Ruth acknowledged her mother's death but did not elaborate further about the timing or feelings related to this. She went on to discuss the inflexibility of the NHS services to accept another person in the role of "mother" or female supporter:

"The visiting times were so strict, and my auntie came in to see me in the afternoons when it was mothers and mothers-in-law only, and we didn't tell anybody she was my aunty, but somebody heard me say auntie and they wouldn't let her come back anymore."

When discussing the support mechanisms that surrounded Ruth, she talked about the network of friends that regularly got together, *"Yes, a lot, yes. Oh, we've got a houseful of friends and their children; we were at somebody's house with them. Yeah, we used to do that all the time."* She continued to express how important that was and the type of subjects that they would discuss, *"... yeah, I had discussions on potty training and breastfeeding, cracked nipples and all that sort of thing, you know, agony (laughs)."*

For the women who discussed the absence of a mother figure in their lives, the significance during pregnancy, birth, and early motherhood was evident. Mainly they explained how they compensated for this in their life, often by replacing it with a sister, auntie or female friend, while others spent moments in abstraction, then removed them from the progressing narrative. Interestingly, the women did not talk about their male counterparts in the same way as they did the females. They did not use the same language, intonation or descriptors for the men in their lives. The comments were often cursory or said with humour. Particularly Ruth, whose husband missed most of her homebirths because he was distracted by emergencies or other activities like fixing a fuse, she laughed with fondness and did not develop

the narrative into any criticism. Hilary was the only interviewee who talked about her GP's supportive nature and referred to his supporting role throughout each of her pregnancies.

The relationship between a mother and daughter could be described as one that should endure the complexities of life and human behaviours and interactions. Strong theoretical discourse within feminist literature debates the significance and ramifications of a mother's role in a daughter's life, both positively and negatively (Rich, 1995; O'Reilly, 2016). The challenge is defining and understanding this dyad's relevance and impact when the daughter becomes pregnant and enters motherhood. For the women in this study, it is to understand their expressed desire to have a 'mother' or 'mother figure' as their primary supporter and advocate as they transition through this rite of passage. However, defining the issue is complex because the variables are so wide-ranging and ever-changing that while the mother-daughter role is commonplace, and the principles of love, sustenance, respect and growth reflect the ideal, it is the nuances that make it such an individualised experience. Perhaps it is the expectations and the societal rules of this relationship that fuel the mother-daughter debate, meaning that priority is given to the social meaning and biological changes when considering the nature of this relationship across the lifespan. This is evident within the review of the literature, as the main body of evidence appears to focus on the mother-child relationship with the aim of considering child development or adult daughters as caregivers to their aged mother (Boyd, 1989; Chodorow, 1999; Bojczyk *et al.*, 2011; Fingerman, Pillemer and Silverstein, 2012; Onayli and Erdur-Baker, 2013). Rich (1995) places pregnancy and birth as the pivotal point, for which she presents a juxtaposition stating that as women are born of women, the daughter learns about mothering from the women with whom she has an intimate 'mother' relationship; in essence, she sees the blueprint for her womanhood. Rich (1995) discusses the tenuous link between biology and mothering and that it does not necessarily mean that all mothers are good mothers.

Conversely, during Peggy's interview, she recalled how harsh, unpredictable and unresponsive mothering manifests itself as insecurity and low self-esteem. It appeared to manifest as anxious attachment or attachment avoidance (Mikulincer and Shaver, 2007). Anxious attachment in an adult would present as emotional in their expressions and responses and impulsivity in their relationships (Hazan and Shaver, 1994). At times in the interview, Peggy seemed fragile and vulnerable. Peggy did not sever her relationship with her mother at any point as a method of self-preservation. She continued trying to foster a compliant relationship with her, perhaps placing herself in the 'matrophobic' position (Rich, 1995). Sadly, as Peggy recounted what her early life was like, she cried, particularly when she described her mother's behaviour and explained that it has only been in recent years that she has been emotionally able to reflect and come to terms with her mother's attitude and behaviour towards her. The impact of her mother's lack of empathy and demonstration of love remained a poignant and consistent recollection throughout her lifespan. In her seventh decade, it seems the feelings have not faded, and it remains an emotionally sensitive subject. Although she referred to having a good circle of friends, she did not identify one individual who filled that maternal role in her life. Conversely, she did acknowledge that her relationship with her partner-husband was volatile and eventually ended in divorce. Perhaps the option to end this relationship was not one that she felt able to take; indeed, it is well evidenced that women who live in an abusive relationship take many years to leave, chiefly due to the coercive nature of the abuser (Oliver *et al.*, 2019; Long *et al.*, 2020; Domoney and Trevillion, 2021).

Hilary's impassive emotional response about her relationship with her mother points to an enmeshed relationship, with a sense of one-sidedness to her comments (Miller-Day, 2004; Tartakovsky, 2018; Szepsenwol and Simpson, 2019). When she spoke of her mother's vulnerability and fears, she appeared to have accepted her mother's way of being; of course, Hilary might not have cared to share the backstory with me. It is possible that her mother believed Hilary should manage her own life and that once married, she was autonomous. Debold, Wilson and Malave, (1993) suggest

that mothers often fall victim to this patriarchal developed notion that by cutting some of their mothers' emotional ties, daughters will become independent and autonomous. In fact, some daughters feel abandoned; therefore, in an attempt to empower their daughters, mothers would benefit their daughters by remaining the constant in their lives (O'Reilly, 2016). This is only possible if mothers feel empowered themselves, which can be challenging when women try to exist within a culture where an institutionalised patriarchal structure of motherhood and motherlove is demanded (Caplan, 1990; Rich, 1995). While it is relatively easy to argue that women of today have more opportunities to build their empowerment and resilience due to legislative support and societal acceptance, in transposing this discourse to the inequalities seen in the 1960s and 1970s, it is easier to appreciate the depth of the oppression experienced by women then and later.

Like Peggy, Hilary did not identify anybody who adopted the mother role during her birthing and mothering time. She often spoke about the isolation of motherhood, and although she seemed to be resilient, her story had a sense of loneliness. Ruth, Elaine and Barbara filled the void they felt by the absence of a mother figure with sisters, aunties and, at times, female friends. Barbara's profound admiration for her sister was evident throughout the interviews.

Barbara's sister had adopted a caretaking role not just during her pregnancy but since before puberty. This may have been instigated by their mother's disability and lack of engagement with her parenting role. Miller-Day (2004) describes the relationship between siblings as an enmeshed learned family culture. It is one with a shared history, which can grow deeper with further shared events and life's transitions, becoming a mother being particularly significant (Kuba, 2011). It was not the mothering knowledge her sister had that drew Barbara to use her as her supporter, as she was childless at this point. It seemed the reliability, security and intimacy of the relationship secured Barbara's sister's role; (Bank and Kahn, 1997) describe this as "a connection between the selves at both the intimate and the public levels…it is a 'fitting' together of two people's identities" (p. 15). Barbara's

recollections demonstrated a continuing high level of reciprocity in the relationship with her sister, one caring for the other throughout their lives, and since her sister's death, Barbara has felt deeply bereft.

When Ruth spoke of the women who supported her during her pregnancies, births and motherhood, whether friends or her maternal aunt, she placed them in a position of significant importance in her life. They were integral to family life and how she mothered her children. Her narrative featured an intonation of accession; this group seemed to represent her family life's value-added component. Perhaps this positioning is the consequence of "joining the club" (Oakley, 2005), a concept further developed in Chapter Seven.

What the women said about midwives

A division existed in the way relationships were formed between the women and the midwives. It appears that the hospital labour ward midwives were very clinically orientated and chiefly focused on the outcome, namely the birth. The hospital midwives do not feature in the stories frequently, and the comments are cursory with the descriptor 'midwife' used interchangeably with the word 'nurse.' This may have been because the midwives did not introduce themselves as such or that the memory of the health care professional involved is not significant in the women's recollections.

Their stories have overwhelming similarities relating to their emotional responses, the feelings they recall during their admission and their hospital stay. Apart from Hilary, the women did not directly express their fear of birth; it was the fear of not knowing what would happen to them and their isolation. It was not common practice for men or any birthing companion to be present during a hospital birth in this decade. This meant the women were alone for hours sometimes. Elaine talked about her feelings during her admission, saying, *"I wish this baby rubbish was over and done with but because I felt I was making these midwives or nurses really cross...I didn't feel there was any care...."* Cordelia also recalled the feelings the

midwives approach to her conjured *"(hospital)the midwife was very brisk…"* but she validates this behaviour by adding *"and, erm, very efficient but very brisk."*

Barbara's recollections focused on the isolation she felt and feeling uninformed and uninstructed: *"What I remember of the birth was being not exactly frightened, erm, but a bit isolated. I didn't know who to ask…."* Her recollections of the midwives were more positive, as they made her feel less isolated and relaxed. She did this by asserting, *"… but the midwives were great there."* She then reinforced this statement by telling a humorous story about her admission to the hospital. *"I was really frightened, erm, I can remember I was shaking so much that the midwife said: Oh, we've got a jelly here (laughs), you know, try and make me relax."*

Elaine positively recalled one hospital midwife who had been kind and caring:

> *"There was this one midwife who used to come in, and she was my salvation because she was so kind and so caring…you know, I, I met her a few years late (laughs). We went to a friend's party, and I said to her, 'You've got no idea how pleased I was to see you in those days.'"*

This demonstration of kindness has remained so significant in her memory that she regaled this to the midwife at a social event.

When expressing her fear of childbirth, Hilary found it challenging to recall who was with her during the birth: *"I don't remember a midwife at all. Erm, and the birth was really scary coz I had this toxaemia…"* This was reflected in her recollection of her antenatal care, *"I never had a midwife who I knew by name or anything like that."* During her third pregnancy, she excitedly recalled how the student midwives wanted to be present during the delivery:

> *"There were midwives with me then because, erm, they knew it was a big baby and they all…they wanted it on their records that they delivered a… Apparently, they had to have a big one on there before they could pass their exams."*

The intonation of this recollection was of pride that she had a large baby weighing more than ten pounds, which was worthy of students jostling for the lead position in the labour room.

Barbra shared a story of fear and trauma about a young girl who was in the hospital at the same time as her; she explained:

"She was only 14…Made pregnant from a soldier…, she had had a 13-pound 6-ounce baby…And she, course she was traumatised, so was the baby. He was bigger, he was 3-month size, and his hair stood up like a question mark... I've never forgotten that..., Sister was pretty nasty to her, but the rest of us and the, even the midwives were nice to her, you know coz she was completely traumatised, bless her... But they sent her home, er, very quickly because her baby was being adopted but… I've never forgotten that how frightened she must've been and I felt awful coz nobody was, you know, ….in those days it was, you know, you did not have children out of marriage."

This story has remained a poignant episode in Barbara's memory. It was not only the birth's physicality (a young girl and a large baby) that impacted Barbara. It was the recollection of the social stigma of having a baby outside of marriage and how this was reflected in the Ward Sister's behaviour, particularly how they cared for this young girl.

In contrast to the women's recollections of the hospital midwives, the narrative about their relationships with the community midwives had a different voice. Elaine's story reflected this when talking about her second pregnancy.

"I really wanted the baby at home. So, they then allocated me this lovely student midwife...she was as scatty as anything but absolutely lovely, and we got on really well. Ended up going to her wedding afterwards as well. Erm, and she really, really took care of me…"

She compared the experience of her two pregnancies; she identified the midwife as a friend and unconditional supporter.

"The difference between baby number one and baby number two are so different down to the excellent midwives. So, because I knew, knew her...once I'd met this midwife and she said to me: you know, I'm gonna stay with you now, it was like having a best friend."

Ruth, Barbara, Peggy and Cordelia spoke of the same community midwife, whose attitude was assertive and direct. However, they all appear to respond to her manner and saw beyond this. They seemed to have respect for her position as "my midwife." Ruth, who came to know her through four pregnancies, explained:

"She was a character...My sister-in-law refused to have her because the second time because she said she's too brusque and…But I got on very well with her. She was quite a laugh, really."

Barbara said, *"I did have a good, erm, midwife, and she was a bit of a bully…But she was great."* When recalling the structure of antenatal care, Cordelia similarly explained:

"There was a midwife attached, which at the time of my first pregnancy was a Nurse xxxx... and she was quite fierce. She was actually quite nice, but she seemed quite fierce…"

Peggy had two midwives care for her, one who provided antenatal care and the other delivered her second baby at home; she spoke fondly of the midwife who commented on her attempts to conceal her pregnancy:

"Because I was still wearing the same clothes. Even the midwife said to me: you must have a little rabbit in there… I was under, originally, Miss xxxx but actual, erm, … was delivered by Mrs xxxx and she was lovely but Miss xxxx, everyone was scared of her, but she was a little pussycat…"

Ruth, Peggy and Elaine all spoke of the relationship they had with the community midwife. They defined it as a reassuring friendship. Ruth rationalised the positives of having a homebirth in relation to having this midwife steering the process:

"It was so much better having it at home. Doing things at your own pace with a midwife that you knew that you'd been to see, and she had examined you every month, or every week as it got closer, erm, and they knew you…"

"They'd usually been to your home before you actually had the birth anyway, erm, and you got your family or friends or whoever you needed or wanted around you, and it was just so much better, I think."

Peggy clarified that the partner/husband was not usually in the room with the woman, so having a midwife who you knew enhanced the experience:

"He wasn't with me when I actually had him, gave birth, no one stayed with me. Erm, and it was just as I say: me, me and the midwife and she was fantastic."

Much has been written about the midwife-mother relationship in contemporary midwifery practice and how continuity of care enhances the woman's birth experience for her and her partner and family (Page, 2003; Carolan and Hodnett, 2007; Hunter *et al.*, 2008; Cronk, 2010; Kirkham, 2010). Continuity of care and carer is the current mantra for the midwifery profession in the UK. It suggests that best care can be provided if a named midwife is a consistent feature of the women's care pathway (Department of Health, 2016). This model of practice aims to provide an opportunity for midwives to formulate a relationship with the women in their care, which should result in a better experience whatever the birth outcome. The notion of continuity of care and carer seems reasonable. The question that arises is about the attributes of people who have called themselves midwives.

Historical evidence exists regarding the suitability of women who were supposedly midwives (Totelin, 2019). The Greek physician Soranus of Ephesus wrote a manual for doctors with a section titled: "What persons are fit to become midwives?" His overarching criteria included:

"being literate, having her wits about her, have a good memory, loving work, being respectable and not unduly handicapped, have long slim fingers but with short nails." (Holtz-Carriere, 2017)

The currency of these patriarchal endorsed requisites has remained consistent through time. A midwife today needs to be trained to degree level (literate), respond appropriately to deviations from the norm and emergency (having her wits about her, have a good memory) and meet the statutory requirement of good health and good character (being respectable and not unduly handicapped) (NMC, 2018). Although slim fingers are not a prerequisite, short nails are crucial to infection control.

The women in this study do not recollect the midwives' clinical skills, which they undoubtedly had as qualified practitioners; they just understood the midwife's role as skilled birth attendants, who either worked autonomously in the community or a

hospital setting with a doctor. What was clear was the way they came to know the (mainly community) midwife was 'with woman,' and in most cases, acted as their advocate. The midwives spoke with authoritative knowledge; they were autonomous in the way they structured the women's care. Yet primarily, it was the conscious and sub-conscious knowing, along with the cluefulness (Leap, 2010), that helped them interpret the world the women moved in that had a lasting impact.

Leap describes this way of being as "the less we do, the more we give" (Leap, 2010). Leap means that by facilitating the journey of pregnancy, birth, and early life rather than managing it, women are more likely to be empowered and consider their own choices. Midwives should signpost the journey, providing direction when unpredicted obstacles present themselves, but always instilling confidence and celebrating the triumph of birth. It seems that in the women's recollections, particularly Ruth and Peggy, the community midwife came alongside them, they did not feel judged or pressured into making conventional choices but forgave or saw past the community midwife's hard exterior.

It should be remembered that the hospital midwives have a different challenge to how they form relationships with women at the point of birth. The window of opportunity to tune into the woman's needs and create a trusting relationship is short. The women's narratives show that some did not achieve this and have left a recollection of unkindness, briskness and disengagement. Although the characteristic of briskness or sternness was used when describing the community midwife, the women all saw past this. This shows how the pairing of *"Differenceness and support uniqueness"* in the Swedish research (Lundgren and Berg, 2007) can work reciprocally. Some made attempts to use humour to engage and coax the women into compliance. Mostly the memories were of midwives (or nurses; the words were used interchangeably) in roles that focused on tasks and ensuring that the labour and postnatal wards were efficiently run.

In summary, this chapter has focused on Read-through Three of the Listening Guide. It has outlined the importance the women placed on their relationships with other

women during their pregnancies and birthing experiences. It has shown how the memory of a birth experience recalls the mother-daughter relationship's enduring nature and professional relationship with the midwife. The memories once drawn together by the five senses and neural activity have long since been stored in the women's long-term memories. When asked to recall their birth experiences, their recollections have evoked an emotional response that places these relationships in a significant position in their narratives.

Chapter 6 - The emotion of birth

"If a woman doesn't look like a Goddess during labour, then someone isn't treating her right."

Ina May Gaskin, The Mother of Authentic Midwifery 2015

Whereas the last chapter draws out the women's contrapuntal, multi-layered voices, this chapter responds to the narratives created in the I-Poem section of the Listening Guide methodology. This level of analysis aims to hear what the person knows and says about themselves. As the I-Poem's form into stanzas, the cadence and rhythm of the women's voices can be heard as you move through the poem. The story they were able to portray was overwhelmingly moving; just by using a collection of verbs preceded by the word "I", the emotions of the story emerge and, most importantly, place the women at the centre of the narrative (Doucet and Mauthner, 2008).

I-Poems have five sections. The first four voices heard are the unenlightened, fearful, humorous and sad voices. These voices connect the women's narrative to the emotionality of their experiences. However, it is not only the voice (sound) that draws the reader in; the other senses are present in the emotional recollections. The women's echoic and haptic senses have been stimulated by recounting the memories of their experiences. The fifth section of this chapter has the addition of the second person pronoun 'you.' The poems became You and I-Poems. This allowed me to draw in the narratives from the second interview, which focused on sharing

stories with others and advice the women might give the younger version of themselves. This section of the chapter demonstrates the inner strength and resilience of the women and caused me to recall the lyrics of Helen Reddy's song, "I am woman, hear me roar."

The unenlightened voice

In the previous chapter, the ethos of midwives being 'with woman' was heralded as one of the positive outcomes of the women's narratives. They recollected how midwives were kind and empowering. The difference in how hospital midwives were recalled was evident: they were defined more like the doctor's handmaidens, unlike the community midwives, who were perceived as autonomous practitioners. The women in this study birthed babies in the 1960s and 1970s, a time that saw considerable changes in the way birth was 'managed'. The medicalisation of birth had been underway since the 1920s, with the protagonists suggesting that a hospital birth was the best option to assure women's safety and comfort. In the 1960s and 1970s, the focus of attention shifted. The fetus became all-important, and the women slipped into second place, assuming the position of 'vessel' (McIntosh, 2012), shifting the focus from addressing maternal mortality to perinatal mortality. Women were expected to be compliant and do the best for their babies. They were instructed, and some were coerced into agreeing to procedures. They most certainly did not make patient-centred decisions in partnership with their health care providers. Today's healthcare professionals strive to achieve this through partnership working with service users in the healthcare system. However, knowing that this is a beneficial, fair and equitable way to practice in the moment is very different from understanding the long-term impact that entering any care system has on people's psychological well-being.

Peggy's experience was compounded by her challenging relationship with her mother. She had little knowledge about the changes occurring in her body, nor did she identify that her family or partner supported her emotionally. Her recollections

are of not having information that would have helped her understand. Her I-Poem reflects the isolation and loneliness she felt at that time.

I was living, I got pregnant, I stayed with my mother, I was still,
I went to, I remember that I was very naïve,
I knew, I'd got pregnant, I didn't know anything,
I just said, I can't stop, I travelled on my own, I got to, I got to.

Elaine's I-Poem also reflects a lack of knowledge and understanding of pregnancy and birth. Her recollections are of depression, sadness and fear, and although she had created a network of family and friends, her mother's death became more poignant during her pregnancy. Elaine continued to consider what her death might mean and questioned why she did not ask questions and whom might she ask.

I felt depressed, I just read,
I didn't say, I didn't want to worry,
I think, I dunno, I think you feel,
I kept thinking, I die in childbirth,
I dunno, I missed having, I could've said, I'm just feeling.
I went, I'm sure, I didn't get, I think, I saw, I saw
I don't think, I went anytime, I think in all, I never saw

Health care professionals failed to encourage the empowerment of either of these women during their birthing experiences. An opportunity to develop a more significant locus of control and personal agency was missed. In their need to control women's birth experiences, health care professionals have left an indelible imprint on the women's memories associated with isolation and unknowing.

Other factors occurring at this time were the rise of technologies such as ultrasound and the fetal monitoring machine (Cardiotocograph CTG). These fostered the cascade of intervention during birth through furthering the status position of the Obstetric Consultant within the NHS hierarchal structure by confirming that

obstetrics was a scientific process (Graham, 1986; Oakley, 2005, 2016a; Kitzinger, 2006; McIntosh, 2012). Midwives did not necessarily see themselves as losing part of their role; textbooks encouraged midwives to embrace the technologies and support obstetricians in their procedures (Myles, 1968). They did this in a way that provided circumscribed amounts of information to women throughout the birth continuum. In tandem with the growth of new technologies that provided fetal surveillance was the idea that labour and birth could be controlled and risk mitigated, which would help to ensure better outcomes. Ian Donald, a leading Scottish obstetrician, wrote, *"Nature left to her own devices often fails to achieve the pattern and duration of labour which we now accept as normal"* (Donald, 1979)*: 575.* The first Perinatal Mortality Survey, published in 1963 (Butler and Bonham, 1963), aimed to firmly push birth into the hospital environment as opposed to birthing at home, paradoxically suggesting that:

> *"The very normality of the childbirth process now makes it unlikely that any individual can obtain sufficient experience even in a lifetime, to assess accurately the overall risk of any given complication of pregnancy or labour" (p.10).*

A cycle of intervention ensued where pregnancy and labour were controlled in duration, mode and environment, all in the name of improved outcomes. An unprejudiced mind might suggest that the obstetricians, midwives and women were doing the best for the babies with the knowledge they had at that time. However, the longer-term impact on women could have possibly outweighed the benefits. Women were now expected to be compliant and obedient, and they were to have no voice, with no partnership in the care pathway (Kitzinger, 2006). This can be seen in one of Ruth's I-Poems; she appears uninformed at the time of her third birth experience, and there was little or no discussion that demonstrates informed consent. Nor does it suggest a process of debriefing had occurred postnatally, other than Ruth recalling being told that the baby's cord was around his neck at delivery, thus described as a 'difficult birth.'

I started at 3.30, I dug my fingernails into her hands,
I think it was a bit of a difficult birth, I didn't realise,
I mean, you know it's just a birth, I wasn't aware of the panic,
I don't think.

After acknowledging the complexity of why male medicine came to assume charge over childbirth, Oakley, (2005) argues that the theoretical foundations of patriarchy lay in the denigration of women's biology to ensure their social inferiority. Therefore, as definers of biology, medicine is best placed to impose its interpretations of birth on society with devastating cultural consequences. In real terms, this meant women had to conform to a model of care that consisted of a sterile, depersonalised environment where they laboured alone (no husbands were allowed in the 1960s and 1970s), where clinical procedures were 'done to' them. Doctors assumed a position of being the expert and 'knowing best,' and women's birthing experience and knowing their bodies were discounted. Both Oakley (1986, 2005) and Kitzinger (2006) discuss episiotomy (a cut to the perineum that aimed to open the vagina and expedite the delivery of the baby's head) as a case in point, a procedure developed as early as 1742 that gained popularity in the twentieth century. An advocate for this procedure, Dr Joseph Lee, a prominent Chicago obstetrician, described birth as a "decidedly pathological process" similar to falling on a pitchfork. This description provided clinicians with a justification for preventing such an experience but did not acknowledge the body's built-in ability to accommodate the crowning of the baby's head. By 1978 almost 70% of all women were being cut, some with no consent or anaesthetic. Oakley (2005) describes it as no less than genital mutilation. Kitzinger (2006, 2005) describes this treatment of women as bullying at best and continues to suggest this procedure is a type of paternalistic coercive violence. Even though procedures such as episiotomy have been redefined to support emergency manoeuvres, the consequences and emotional memory last across the lifespan. Within the I-Poems, this 'being done to' can be seen, for example, in Barbara's recollection of her first birth.

I remember the birth, I didn't know who,
I actually, I didn't understand,
I've got to cut, I didn't realise, I remember.

Barbara was uninformed of what might happen to her and, like the other women in this study, had limited information or reassurance provided to them by either a health care professional or family or friends. Cordelia was the only participant who spoke of her mother's openness to discuss topics such as sex, pregnancy and birth, particularly after Cordelia married. Even though her mother loved to share birth horror stories, Cordelia was not prepared for the pain and assault on her senses when experiencing an episiotomy.

During the interviews, the women's medial temporal cortex busily put long-term memories back together that had been scattered around the brain. Part of the medial temporal cortex is the amygdala. It responds to highly-charged emotions and can put these back together to recall senses and neural activity (Rettner, 2010). As Cordelia recalled the episiotomy being performed, the stored echoic (auditory sensory memory) and haptic (touch) memory resurfaced. This demonstrates how recollections and life reminiscences present themselves multi-dimensionally. It is understood that the five senses can trigger both negative and positive memories, such as the smell of certain foods or the sound of a particular piece of music (Rettner, 2010; Concina *et al.*, 2018, 2019), but the endurance of this echoic and haptic memory is quite outstanding. Undoubtedly, the way this memory was processed was compounded by the lack of informed consent and support during the procedure.

I can remember, I did get taken, I can remember.
I knew, I wasn't offered, I had,
I got into the room,
I can remember, I found the pain, I would never,
I can, I can, I can, I can just, I can also.

I found the pain excruciating,
I vowed I would never do it again,
I had an episiotomy; I can remember that visibly.
I can remember the noise of the skin being cut

The fearful voice

It is understandable how some women may be apprehensive about impending motherhood; it is common to have worries and concerns about their ability to perform this role well. However, before the negotiation of the role of motherhood comes the looming process of giving birth and its association with pain, discomfort, morbidity and mortality (Hofberg and Brockington, 2000; Hofberg and Ward, 2003; Saisto and Halmesmäki, 2003; Alehagen, Wijma and Wijma, 2006; Bakshi, Mehta and Sharma, 2007; Nilsson and Lundgren, 2009). A level of fear is a rational response to this life-changing event. Most women can negate these fears and worries by talking them through with either health care professionals or friends and relatives. Outside of the health care professional, women relied on information from family and friends, who may have relished sharing their 'horror stories' and dramatised version of events. Understandably, this may not have allayed fears at all, but merely escalated them (Ryding *et al.*, 2007; Fenwick *et al.*, 2009). Elevated anxiety and fear of birth have implications for both mother and newborn; it may impact the way childbirth is experienced and in the postnatal period how the transition into mothering is navigated (Slade *et al.*, 2019). In extreme circumstances, fear can become irrational and manifest as a paradoxical phobia – tokophobia, the fear of birth (Geissbuehler and Eberhard, 2002). Walsh (2002) suggests this clinical diagnosis is a phenomenon that has been socially constructed, fostered mainly by modern obstetrics and how the focus of childbirth is on the reduction of risk and the removal of pain, implying that for the experience to be 'normal' it should be pain and risk-free. Fortunately, most of the women in this study did not present their fears in such a way that tokophobia was evident; however, fear did featured in the dialogue.

Interestingly, when recalling their feelings, the sensation of fear remained observable and tangible. This feeling, for some, had been reconciled and accepted, allowing them to take a more halcyon position in their narrative. For others, it seemed near to the surface of the memory. However, it was neither accepted as 'normal' nor the trigger of a traumatic memory. It had been counterbalanced within the recollection of their experiences. One participant demonstrated an imbalance regarding the sense of fear as this initiated a shutdown in the recollection. The fearful voice remained present for all participants in one form or another even though the experience occurred more than five decades ago.

Ruth recalled the fear of going to the hospital to have her baby, but she offsets this feeling with the elation felt after. The I-Poem provides insight into the processing of emotions and how her fears were transformed into delight. In this I-Poem, it is possible to see her rite of passage journey. This was central to her explanation that birth was a means to an end, something she had to go through because she wanted many children; she said, *'It is just birth, isn't it?'*

I got married, I had my first baby, I was 18,
I had three more, I've got four,
I was frightened, I thought,
I was absolutely delighted, I could remember,
I eventually went in, I looked as if, I came out.

Ruth had always wanted a houseful of children; this desire had superseded her fear of not knowing.

When Elaine and Hilary spoke about their sense of fear, it was very much a response to a health condition they did not understand. This sense of fear was heightened because they were not included in the discussions about the management of those conditions. Exploring this was the trigger for the reignition of the sensation of fear. Contextually the situation was compounded by the care packages provided during this period. Support for the birthing experience was not seen as a priority; thus,

husbands and companions were not permitted to be present at hospital appointments or the during birth.

I don't remember the midwife, I had this toxaemia, I had this toxaemia,
I can't remember, I was alone, I think that's, I think, I suppose,
I was expecting that, I don't know, I don't think, I must have read,
I think it's just a terrifying thing, I think they didn't, I don't know,
I think I was quite weak; I didn't have him for long.

Hilary's experience was compounded by the removal of her baby from the room. She was not allowed to bond with him immediately after the birth.

I used to get worried, I don't know,
I used to really think, I'm not going to survive,
I had an x-ray, I had the x-ray,
I didn't go, I can remember, I was absolutely enormous
I remember going in, I got there, I think, I was really scared
I had no one, I didn't know, I just felt quite alone, I didn't
I didn't know, I had a midwife, I really didn't
I said, I could hear, I can still remember.

Elaine's lack of knowledge and poor information sharing led her to worry about dying.

I wanted to have him at home, I had to go in, I went in,
I started labour, I said, I started to think, I'd lost him,
I can tell, I can always, I dozed off,
I got into the delivery room, I never heard him, I heard, I was taken in.
I remember, I was more, I don't know, I can remember,
"I told you it'll be a boy, didn't I?"
I was more tearful, I don't know.

Barbara's experience of a late miscarriage remained at the forefront of her mind during her next labour.

Elaine and Barbara spoke of the fear of death during their recollections, Elaine of her death, and for Barbara, the fear that her newborn baby might not have survived. What stands out in the I-Poems is the lack of intervention from the health care professionals to ally the fear, to give perspective to their fears. In this instance, it would be easy to adopt a default position that suggests this was a symptom of the times. However, it is challenging to understand the lack of person-centredness demonstrated by the doctors and midwives. On a human level, why would they not have responded to the women's fears of foreboding? Perhaps the midwives were so disempowered as health care professionals that this superseded their ability to respond appropriately to the women's needs. This can be seen in Barbara's recollection of the midwife's comments about the gender rather than being reassured that the baby had survived the delivery. When reflecting on her 1970's research, Oakley (2005) discussed the attitude and behaviours of doctors toward women as a complex issue associated with a desire to exert social control over reproduction. They achieved this by assuming the position of the 'experts,' a position that denigrated women's instinct to birth. The language used during birth is a case in point; some of the terminology developed over centuries focuses on failure, such as 'poor maternal effort' when trying to birth the baby or 'failure to progress' when a birth does not follow a prescribed pattern (Mobbs, Williams and Weeks, 2018). Even using the term 'false labour' rather than pre-labour has an accusatory tone about it. The stance of this type of language leads to women believing that their biological abilities are compromised in some way, a belief not borne from any evidence (Hill, 2019).

Hilary's I-Poem reflects the beginning of a fragmented recollection of her birth experience. Her fear of the birth was underpinned by ill health (raised blood pressure) and her previous instrumental (forceps) delivery. She was not distressed when telling her story; however, she found it nearly impossible to recall any details of the event. Of course, no clinical diagnosis had been made that explains Hilary's

response. However, the definition of a traumatic birth is related to the person's perception of that event (Beck, 2009, 2011, 2015; Elmir et al., 2010). The subjectivity can include the lack of care and support by health care staff, the fear of dying and the feeling of powerlessness, all of which are reflected in Hilary's narrative (Thomson and Downe, 2008; Beck and Watson, 2010). Abrams (1999) suggests that trauma's insidious nature can create an intergenerational disconnect between physical closeness and emotional silence. Abrams (1999) cautions that the power of this disconnect should not be underestimated.

The humorous voice

The use of humour in storytelling has been written about for millennia, from Aristotle to the present day, much of it relating to the psychological and social aspects of humour and attempting to understand its purpose. However, the study of humour is challenging; as Calman (2001) points out, once the 'joke' or the humorous discussion has been dissected, it is left lifeless and without form. This leads to a strange dichotomy; the academic report is dry and not humorous at all. At times, humour can divide the communicators. It is the more positive aim of humorous interaction that is most attractive. Humour can create a connection between the person telling the funny story and the listener (Meyer, 2000). Humour creates a chemical reaction that evokes a sense of well-being. Biologically, laughter is a stress-relief effect and can bring about feelings of being uplifted. The initial biological response to an act of laughter is an immediate increase in heart and respiratory rate, respiratory depth and oxygen saturation. A period of muscle relaxation follows, with a corresponding reduction in heart and respiratory rate and a lowering of blood pressure (Strean, 2009).

Cordelia began her narrative journey by explaining her visit to the antenatal clinic:

I could remember,

I went along,

I didn't know, I took,

I don't know, I was quite slim, I didn't need,

I had a girdle, I remember, I thought… well.

Cordelia shared a humorous story about her first antenatal appointment. She had not realised that she would need to be examined by the community midwife, and she had a girdle on, which was extremely challenging to remove. This, paired with the fact she had taken a large bottle of urine rather than a small sample, became a comedy of errors as she kicked the oversized bottle of urine underneath the couch.

As we both laughed, a connection formed through the humour of Cordelia laughing at her naivety and inexperience, and as a nurse, she would have appreciated the value of the 'insider' joke. She confirmed this by explaining how the midwife laughed, and the facade of being a stern health care professional was broken down.

Elaine used humour in a similar way of laughing at herself. Papousek *et al* (2017) describe this as bright laughing where the storyteller is 'laughing with' the audience with the intention of bringing pleasure into their lives (Simkin, 1991, 1992; Gervais and Wilson, 2005; Scott *et al.*, 2014; Tanaka and Campbell, 2014; Lee, 2015). By comparison, should the storyteller adopt a dark 'laughing at' position, they may have precisely opposite intentions. This is malicious and often loaded with irony and sarcasm, often perceived as bullying (Papousek *et al.*, 2017). However, by 'laughing with,' Elaine demonstrated how she managed a situation that she was ill-prepared for and in a way that she may not have been entirely comfortable doing.

I can remember her saying, I can remember banging,

I am baa baa black sheep, I didn't, I was awake.

I was in for one night, I was in,

I think, I suppose, I was still young,

I say – the midwives, I think, I can't explain it.

Elaine had remembered being advised to recite a nursery rhyme to help her get through the contractions. She laughed as she told the story of doing this repeatedly and banging on her chest at the same time, which the midwives frantically tried to stop her from doing.

Cordelia's second use of humour was related to the period she was being sutured by the GP, and he commented on the look of the baby.

I knew, I was giving birth,

I remember, I had to be, I hadn't been sutured, I remember, I nearly kicked him.

I remember him saying, I hope this child has brains.

This I-Poem was related to the birth of her second child, who was delivered by the GP at home, with a midwife in attendance. The narrative continued with the GP saying, "as he has no beauty." Cordelia laughed as she explained the moulding of the baby's head just after delivery with the adage that he was now beautiful.

Health care professionals often use humour in their communication with their client group. It can be viewed as a way to bridge the embarrassment of an intimate procedure or create laughter in a sensitive moment (Duffin, 2009; Tremayne, 2014). In contemporary clinical environments, this way of creating a relationship with a client group may very well be at odds with professional codes of conduct. Jokes that disparaged women were commonplace in the 1960s and 1970s, and the use of sexist humour was slow to be reformed. In maternity services, inappropriate tongue-in-cheek comments about women and their babies were commonplace until the early 2000s. I recall as a student midwife being told to use the initials FLK (funny-looking kid) in the paediatric notes as though adding a humorous undertone to the terminology would make it more acceptable. As with Cordelia's experience, this dark laugh or comment at an inopportune time seems wholly inappropriate and insensitive. Cordelia managed this by adding that her son was now a beautiful man to countermand this comment. Of course, she may have agreed with it and joined in this dark humour, but her narrative provided no evidence of this.

The sad voice

Of all the women, Barbara was the only one to discuss her two experiences of miscarriage. Although she described how she had been comforted by her GP and sister, further discussion about the miscarriages was not encouraged. Moreover, the I-Poems below demonstrate how the sadness remains current and is as recallable as her other two children's births.

I had a little flip, I didn't know, I was pregnant,
I didn't think, I'd be pregnant, I thought,
I went, I lost the baby, I suddenly realised, I didn't know.

This was Barbara's first experience of miscarriage. It occurred early in the pregnancy.

I had a miscarriage, I was 4 months,
I had a miscarriage, I was almost 5 months,
I had to go in, I came out, I was really upset,
I wanted, I'd wanted children,
I didn't wait, I should have done.

The second miscarriage occurred later in the pregnancy and required hospital admission. However, she did not see the baby or have the opportunity to say goodbye, nor was a funeral held.

Barbara's I-Poems demonstrate that without an opportunity to talk through, understand and process the experience, the raw emotional response remains present even after five decades. Barbara was encouraged to dismiss the miscarriages and move forward, and although her GP ensured her physical well-being, he referred to the miscarriages as 'nature's way,' which was little or no consolation for Barbara. Without the opportunity to discuss the potentiality of the baby's life, her thoughts have remained anchored at one point throughout her life. Her experience reflects Violet Ring's account of loss in Humphries and Gordon's (1993) *'Labour of Love'*, indicating little or no change in the way women were treated in such circumstances. In today's society, how pregnancy loss is responded to has moved forward positively.

Women are encouraged to have time with their lost baby (particularly with late miscarriage or stillbirth). Midwives help create memory boxes that contain birth data cards, locks of hair and foot and handprints. The options for funerals discussions are facilitated by dedicated people working within the hospital setting. Most importantly, women are encouraged to explore their emotions about the loss of a pregnancy and baby, with specialist counsellors and support groups who tailor their advice to the individual experiences of women and their partners and families (Stratton and Lloyd, 2008; Murphy and Merrell, 2009; Martínez-Serrano *et al.*, 2018; Jensen, Temple-Smith and Bilardi, 2019; Tian and Solomon, 2020).

The intergenerational voice (You and I)

This part of the narrative is drawn out of the second interview, where the women were asked what advice they would give their younger selves and younger generations. Rather than focusing on the 'I,' I have combined this with 'You' and created didactic free verses. These poems show the change in the women's voices. During the interviews, this change was audible; the vulnerability has gone, and they are empowered but compassionate and empathetic to their contemporary womankind.

When asked what advice she would give a modern version of herself, Elaine offered this sage and humorous advice:

Maybe get a career,
something you really enjoy,
something that you can keep up,
go back to after motherhood,
Don't feel guilty about returning to work,
it doesn't seem to me that it affects the children in any way.

Have the family you want,
not what is expected of you.

Make the most of all post and prenatal care,
try and have the birth option that you want,
no choice years ago!!!

Ask questions.
That's what your midwives and doctors are there for,
don't be embarrassed,
knowledge is power.

Find time for yourself and your partner…
I was told when I first got pregnant by an elderly neighbour,
"Always find time for your husband,
as he will be there when your children have grown up and gone."
It's true.
Most importantly
Keep up your pelvic floor exercises,
You will always wish you had!

Cordelia's response to the same question encouraged empowerment and was said with real vigour.

I would have to say, "Fight for what you want, girl.
Don't take 'no' for an answer.
You are grown up now.
You can choose your path in life."

I would, and do, say,
"Be thankful for all the milestones in your life,
and all that they have given you,
but seize each day and stop worrying so much!"

Hilary's response reflects the isolation, vulnerability and fear she felt during her birth experiences.

I would say enjoy yourself,
search out information
so that you can enjoy pregnancy.
Find a midwife who can be with you.
So, I would find a midwife who could be with me.

The two sections of Barbara's response reflect the influence of others and encouragement to maintain a sense of self.

One would be not to panic listening to people's horror stories of birth.
I've found out that some people revel in it,
others are just blasé,
it's better to take the blasé ones,
rather than frighten yourself to pieces.

When you look in the mirror and you think:
God, look at me,
you know you need time out,
go and get your hair done or whatever.

The advice to their intergenerational selves reflects the women's lived experiences of birth and motherhood. The opportunity to share their narrative may have heightened the focus of the advice. In different ways, each of the women has focused on developing self-agency, locus of control and empowerment. Elaine's advice reflects some of the intergenerational advice given to her. As her last communication was via email due to her ill health, she raises a pertinent point humorously by using capital letters and exclamation marks about maintaining pelvic floor health! Cordelia prescribes taking control of the experiences, particularly birth.

It is a reminder that birth is primarily women's business, and the intervention and medicalisation of this physiological process should not be the norm.

The first part of Barbara's thoughts adds to this concept, and it could be that she is suggesting that women surround themselves with friends, family and communities who encourage them to reach their full potential, nurture them, affirm their values and difficult decisions, and are likely to offer a reality check should they be caught in a pattern of negative thoughts. All three women promote the idea that a person's identity should not be lost in motherhood. Their You and I-Poems reflect Oakley's (1976, 1986) research that found women in the 1970s felt a loss of identity and were devalued by society. In this era, the women's experiences were compounded by the convoluted judgements made by society. Employment is a case in point; some described women who had children and did not have outside employment as 'good' mothers, alternatively they were criticised as they no longer contributed financially to the 'home' and society (Oakley, 1976; Simkin, 1991, 1992; Chodorow, 1999; Davis, 2013). However, this does not give credence to the way the subsequent generations are nurtured and developed. Within this argument, little or no consideration is given to women's identity and personal agency. That the desire to have outside stimulus or interests is pivotal to balancing and maintaining healthy mental well-being is not accepted.

You and I-Poems show women who are urging younger generations of women to relax more about their pregnancy and birth journey, counselling them to enjoy this rite of passage.

Extract from my reflective journal.

What are my voices? Certainly, they can be fearful, asking what if I don't do the women's voices justice? What if no one likes this work!! Definitely humorous, I have to laugh about the silly things, humour is grounding, and it relieves stress. What would my I-poem look like from my journal?

I can't
I like this
I didn't
I forgot
I know

Chapter 7 - Discussion

I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.

—Maya Angelou 2003

When introducing my aim for this thesis, I stated that my intention was not just to document or compare accuracy or even question the 'truth' of the participants' recollections but to reveal *"ways women recollect birth experiences in later life"* and consequentially the impact of this on their lives. This research has revealed three key insights about the significance of the birth experience. These areas chiefly focus on the emotional and psychological experiences of the women with their social communities. As this thesis moves into publication there is an opportunity to develop the themes to explore the transformational experiences of the women during their reproductive lives. As the researcher, I have determined the priorities within the narratives and drawn them out for discussion. In my reflexivity, I have asked myself often whether my choices were influenced by my own prejudices and biases. Did I in any way co-opt the findings? Yet I return to the conclusion that my choices were justified by the surprise I felt by how significantly the themes stood out in the narratives, especially the multisensory nature of the recollections. These are not distinct themes; they are interwoven. Therefore, this interconnectedness can be seen in three areas. The first is the endurance of the emotions connected to the event and how the experiences were recalled in a multisensory way, with echoic memories of surgical instruments being used, smells of the environment and newborns. In appreciating the emotional connection to birth recollections, it is evident that the oppression of women's voices, thoughts and *presence* experienced during the birth continuum in the 1960s is not what is expected as the norm in today's society. This leads to a discussion focusing on the significance and benefits of offering a counternarrative to challenge the culturally dominant narrative that steers the birth discourse and devalues the voice of women within it.

Secondly, the research highlights the significance of the female relationships identified within the women's narratives, which ranged from family to professional. The women present these relationships as versions of female solidarity to ensure the women would have their required level of support during their reproductive years. Conversely, this research demonstrates the personal consequences of the relationships that proved toxic or counterproductive in the women's lives. These voices are heard in the women's narratives, indicating further still that the longevity of a birthing experience remains firm.

Finally, despite the challenging aspects of their experiences, all of the women unexpectedly proffered feminist-centric empowered words of wisdom and resilience-building to younger generations of women.

Long-lasting memories of birth experiences

The emotions associated with birth seem to be all enduring, and, incredibly, after 50 years, the women were able to retell their stories so clearly, demonstrating the significance of this life event to them. Using the Listening Guide, the I-Poems technique as a means of analysis allowed the emotional connection to the experiences to be heard and seen through the five voices.

Within the 'voices' heard, one of the most exciting discoveries in this study was that the women recalled their experiences through all five of their senses. Historian Martin Jay (2011) describes this ontology as an "infinite variety of sensual experience that has become a staple of contemporary historical analysis" (p.307) and perhaps is one that needs to be incorporated into the realms of midwifery research. I am reminded that in practice, I commonly heard olfaction recall from the mothers of new mothers when they smelled the newborns, and it reminded them of their own experience and the newness of life. In this study, Cordelia remembered an unpleasant auditory sensation of her episiotomy being performed. Barbara spoke of remembering the sensation of shaking with fear (proprioception - the perception of body awareness).

Each voice had an emotional strength, even within the humorous voice. The women laughed at themselves and the situations they found themselves in and appeared to enjoy the satire and boosted their resilience. This correlates with Kay's (2016) findings where she noted that women enjoyed the drama of birth; this, in turn, lends itself to the findings that multigravida women relish the opportunity to share horror stories with primigravid women (Sopakar, 1998; Savage, 2001; Romano, 2007; Munro, Kornelsen and Hutton, 2009). What makes this interesting is that the emotions conjured up through an experience of birthing, whether positive or negative, endure in a way that those experiences may be transferred to other women. Furthermore, the emotions heard in the '*voices'* could be experiences of women today. The easiest way to describe this is 'the same but different.' They are the same in that women today feel similar emotions to those in this study, whose experiences were four to five decades ago. This sameness is reflected in research about contemporary birth experiences (Ayers, 2007; Ayers *et al.*, 2008; Latva *et al.*, 2008; Bastos *et al.*, 2015; Kay, 2016; Baxter, 2019, 2020). The medicalisation of birth remains constant, and therefore the emotional response from women could be characterised as the same. However, it is the context and causal factors that constitute the difference. The difference between the women in this study and young women today is that they were unenlightened (felt vulnerable) and fearful (afraid) because they were not informed, and consent was not requested for the procedures subsequently enforced on them. However, women today are fearful, but it is framed very differently and worse still it is erasing their identities as women encouraging them to forget who they are and what they are capable of. It seems that they are often comfortable hiding behind the scenery the patriarch has staged for them. They believe they are safe in the protection of this production. Yet often are so overwhelmed by the sheer amount of information they are required to process and accept (Lagan, Sinclair and George Kernohan, 2010; Lima-Pereira, Bermúdez-Tamayo and Jasienska, 2012; Walsh and Devane, 2012; McCarthy *et al.*, 2020; Chen and Wang, 2021) the outcome is very different to the promises made at the start of the professional relationship. They have little autonomy when making choices about

their pregnancy and birth is not as straightforward as initially perceived and they have little or no control over what might happen during the pregnancy (Marteau, Dormandy and Michie, 2001; Thachuk, 2007; O'Hare and Fallon, 2011; O'Brien, Butler and Casey, 2017).

With the knowledge that the memory of the event continues to be significant throughout the lifespan, the aim should be to ensure the birth experiences are owned and understood by women. Where emotions of fear and vulnerability occur, reframing the narrative positively for the women would offer a new voice, one that is associated with empowerment and confidence. The women in this study lived through a time described as a 'golden era,' where historians tell of significant changes to the UK's socioeconomics and cultural outlook. The aim was to ensure that opportunities and the rights of women placed them on an equal footing to their male counterparts. However, the women did not recall newfound freedom and equality. It could be that this had not become the norm in their lives, thus making it less significant in their stories. It could have been that they did not feel included in the discourse of the day due to their geographical location (suburbia) or that they did not move in social circles where activism was an intrinsic part of the group. Women today still experience inequalities of experiences as, while the battle for equality on some levels has improved, areas such as poverty and race remain significant points of discrimination against birthing women. In many ways, the emancipation of birthing experiences has not reached the institutions that covet them. There are politically driven directives that suggest women's experiences would and should be improved (Department of Health, 2016; Ockenden, 2020), but as is often the case, sufficient resources and finances are not provided to ensure the implementation of the grand idea.

A financial cost-neutral way of altering perceptions and behaviours associated with birthing involves the cost of willingness and proactivity. The way forward is to challenge and counterbalance the dominant narrative by radically listening to women throughout the birth continuum. When the participants of this study were

pregnant and young mothers, the dominant narrative surrounding birth was that it should be managed, therefore pathologising this event rather than viewing it as a normal physiological process (Borsay and Hunter, 2012; McIntosh, 2012). This dominant narrative was based on the ideologies of the patriarchal constructs of society, whose position of power determined how birth should be perceived and 'dealt with' within the confinement of the NHS. The women outside that culture would remain unheard, their voices lost, and would certainly not contribute to the improvement of maternity services. In this study, their lived experiences or counternarratives offer resistance and an opposing viewpoint of the experience (Bamberg, 2004; Bamberg and Andrews, 2004; Stanley, 2007).

Most importantly, this study has given a voice to those marginalised by the dominant narrative. After all, history is only as 'true' as those who record, tell and retell it. Therefore, as a feminist researcher, my priority is to broaden the counternarrative discourse (Miller, 2005) to counterbalance the perspectives of the dominant narrative. This research has exposed a counternarrative in the form of a selection of *'voices'* that speak to the importance of recognising the emotional connection of birth throughout a person's lifespan. This contrasts with the dominant narrative that surrounds the medicalisation of childbirth and creates an emotional disconnect from birth. When recalled it evokes 'fearful' and 'unenlightened' voices.

In a TED Talk, Nigerian author Chimamanda Ngozi Adichie warns of the risks of hearing only a single story, the dominant narrative. Her warning is preceded by the suggestion that this behaviour might lead to the creation of a metanarrative, a state that assumes everyone behaves or exists within the parameters of the dominant group. Adichie explained:

> *"All these stories make me who I am but to insist on only the negative stories is to flatten my experience and overlook the many other stories that formed. The single story creates stereotypes. The problem with stereotypes is not that they are untrue but that they are incomplete. They make one story become the only story."*
> (Adichie, 2009)

The advantage of appreciating another discourse offers people a richer insight and deeper connection to one another. Counternarrative levelling can be seen in the women's narratives as they all recalled how they travelled through the birth rite of passage. It is captured in the advice they offer younger women. If a shift in the dominant narrative occurs, younger women, unlike the women in this study, may be less likely to be 'done to' rather than 'done with.'

Examples of counterbalancing the narratives can be seen in practice in both the independent sector and the NHS. The Positive Birth Movement (Positive Birth Movement, 2019), spearheaded by women and midwives, advocates for women to own their birth experiences and invites midwives to come alongside them in partnership. Their manifesto reflects the currency of De Beauvoir's strategy for liberation. It states that they aim to challenge the patriarchal cultural negativity and fear that exist around birth, share positive experiences and empower women to believe that a positive experience should be accepted as part of the unique way women engage with birth (Hill, 2019). Even in the most tragic of situations, this can be achieved. For example, I had known independent midwife Virginia Howes for several years when she approached me to support her in publishing an article about her experiences caring for one particular woman, Natalie. Tragically, at 32 weeks, she was informed that her baby had a lethal fetal anomaly (LFA) called bilateral renal agenesis and that it was highly likely that this condition was incompatible with life. In such situations, the birth and death of this baby would typically be expected to be a medicalised event. However, the midwife fought hard against the constraints of the patriarchal medicalised approach to birth and death to facilitate Natalie's desire to have a homebirth and be able to say goodbye and grieve in her home, surrounded by her loved ones. The outcome was as expected; her baby died shortly after birth, but this was a positive experience for Natalie because she was in control of an event that she could not change (Howes and Muscat, 2015).

In such instances, those who hold power in healthcare systems and imply that they advocate for partnership working could achieve this by genuinely listening and

hearing women's voices. Health care services and professionals could model behaviours that make this type of discourse a commonly practised activity rather than focusing on reducing complaints or addressing trauma. The key message should be that birth for most women is an experience that is physiological and emotional in its processes and is mainly experienced by well-women, not a pathological process that needs managing. The longevity of memories should not be disparaged, nor the experiences relegated to silence. They should be processed, understood and shared within families and communities, perpetuating a positive sense of what is 'normal.'

Relationships

Chapter Five highlights the significance of the relationships the women formed with particular women during the birth continuum. It discusses how they drew in other women, creating a type of female solidarity which would support them when they needed it most. The findings exemplify Maya Angelou's quote that heads this chapter. All of the women identified the significant women in their lives during their pregnancies and birth experiences. The personal relationships were aligned with the need for 'mother love' and the unconditional support and love this brings. The women thought creatively about replacing absent mothers with sisters, aunts and friends. Importantly, they needed to feel comfortable when being asked questions of an intimate nature, with all of them expressing how naïve they were, particularly during the time of their first pregnancies. Suggesting that this was female solidarity and that all women in the 1960s and 1970s naturally gravitated to other women could be viewed as assumptive; however, unlike today, a clear distinction was made between male and female roles when it came to reproductive activities. For the women who did not address the ineffectual 'mother' roles in their lives and create a supportive female network to rely upon, the pain and absence can be heard as part of their backstory. For example, Peggy, now in her late 70s, has embarked on a series of therapy sessions to address the conflict she feels about her relationship with her mother. It is arguable whether a more supportive network would have addressed

entirely the issues Peggy had at home. However, it may have contributed to enabling her to process some of the conflicts.

The women's relationships with midwives (all women) were significant and correlate with the Maya Angelou quote from 2003. The women did not always remember the midwives' names, especially those working in a hospital setting; however, they clearly recalled how they were made to feel. The bond with the community midwife seemed stronger, mainly when the women then had a homebirth. The community midwife had the opportunity to forge a relationship with the women on her caseload and provide continuity of care during the pregnancy and birth would have fostered this relationship.

To a contemporary midwife, it would seem that practising midwifery in yesteryear was undoubtedly not encumbered by the level of attention given to birth-associated risk, data collection and safeguarding as seen today. However, the patriarchal structure was ever-present in the 1960s and 1970s; perhaps the midwives were better at circumnavigating this to provide a more matrifocal type of care for the women. Lundgren and Berg's (2007) secondary analysis of eight Swedish studies drew together six pairs of concepts. The pairs consisted of one aspect from the woman's perspective and the other from the midwife.

Woman	Midwife
Surrender	Availability
Trust	Mediation of trust
Participation	Mutuality
Loneliness	Confirmation
Differenceness	Support uniqueness
Creation of meaning	Support meaningfulness

Table 7

Presenting these pairs in a table shows the reciprocity in the relationship. After all, when reflecting on the many relationships experienced in my life's journey, those that are reciprocal, such as teacher/student, mentor and mentee or employer and employee flourish when the rules of engagement and communication are clear and explicit. The all-important balance in the midwife-mother relationship can be achieved by committing to the partnership; however, the midwife has to be the instigator and strike a balance between allowing women to own their own birth experience while remaining the subject "expert" (Kirkham, 2010). It is somewhat easier to appreciate the reciprocity of this relationship when considering the women's experiences of home birth, especially surrender and availability, and trust and how it might be mediated. The participation and mutuality pairing might be apparent as the woman enters into this relationship as an active participant, knowing she will be heard. The midwife demonstrates mutuality by ensuring openness and shared responsibility of participation. This pairing is pivotal to the woman's and midwife's successful collaboration during the birth continuum. This was particularly pertinent in the 1960s and 1970s when no other lay supporters (husband, mothers) would be invited to the birth, projecting a sense of exclusivity to the midwife-mother relationship. All of the women described this situation in their narratives. They spoke of their husbands either waiting elsewhere in the building, travelling to the hospital alone or being sent home by the midwife. Of course, transposing this to the contemporary midwife-mother relationships introduces a different set of variables, chiefly related to the construct of what is 'family'. It is not unusual for friends and family to be active in the social event of birth, this extends to the parameters of social media 'friends'. This leads to the question of whether the increase in participatory partners has eroded the midwife-mother relationship.

Continuity of care and carer has become a model of gold standard practice that the NHS continues to strive for (Kirkham, 2010; Department of Health, 2016). The benefit of continuity to the woman-midwife relationship is not in dispute. With continuity, women will be more likely to trust the midwife, value her advice, and be

willing to share personal concerns and issues and work in partnership with the midwife and other health care professionals (Kirkham and Stapleton, 2000; Hunter *et al.*, 2008; Cronk, 2010; Leap, 2010; Hill, 2019). It is the relationship with the hospital midwife that is more challenging. The midwife has a very small window of opportunity to create a relationship with women entering the hospital or birth centre environment. They need communication skills on the highest level to assess the woman's psychological well-being and establish a trusting relationship, doing this in an instant before undertaking an intimate physical assessment of someone they have just met. This attribute or ability is compounded by the requirement to work within a medical model. The participant's recollections show that the midwives gravitated to this as opposed to being first and foremost the woman's advocate. Unfortunately, this continues today in an evolved way, as women describe the dehumanising and disempowering effect of being managed or pigeonholed into a risk classification (Kitzinger, Paige and Paige, 2005; Kitzinger, 2006; Hill, 2019).

As advocates for women, midwives have the opportunity to contribute to a counternarrative that facilitates the drive for women to reclaim this experience, moving to a position where they are no longer viewed as a risk category or a condition. The most straightforward starting point is to change the language used. In support of this, the NMC has published two new key documents: The Standards for pre-registration Midwifery Programmes and The Standards of Proficiency for Midwives (NMC, 2018, 2019). The concept of risk has been reframed, and the focus is on universal and additional care rather than high and low risk. The approach would be more holistic, assessing for risk throughout the continuum rather than labelling it as a risk category. However, while the professional statutory body has embedded this notion in its standards for practice, the challenge is to change the long-established culture of the NHS to bring it alongside such an ideology.

Midwives have an opportunity to lead the way and be true gatekeepers of the birth continuum. Being mindful about the language they use when talking to women during the birthing continuum may positively impact the recollection of that

experience regardless of the outcome. Shifting the language in an uncomplex way from a negative disrespectful dialogue to a holistic person-centred language would be a more positive way to practice midwifery. I was reminded of an example of this recently when a fellow Lead Midwife said she reiterates to her students that, pizzas are delivered, but babies are birthed. The connotation of using the term 'delivery' is related to the balance of power at the birth. Admittedly, the midwife is a skilled birth attendant who will observe for any deviation from the norm or emerging emergencies, but it is the woman who births the baby, and this experience is controlled by her body and her passenger, the baby. Women's understanding and expectations of birthing should be that this experience will be facilitated by their body's innate ability (Byrom and Downe, 2015; Hill, 2019). Along with the communication is the attitude of those who support women. Changing the language used during birth may facilitate the reframing of the health care professional's perspectives of birth in a transformational way, as the positivity of words is often reflected in behaviour (McCormack *et al.*, 2021).

Sageness

The women in this study shared the challenging circumstances of their birth experiences and transitions into motherhood. Yet despite this, they not only demonstrated learning and reflectivity, but their message was surprisingly powerful and insightful. On some level, I expected this group of women to be disempowered by the challenges met during the birthing continuum and early motherhood. This misplaced assumption raised the question of whether women who had such experiences would be emotionally positioned to offer words of empowerment to other women during their birthing journeys. However, the second interview completely dispelled this assumption. During the second interview, I asked the women what advice they would give to their younger selves or/and the younger generation of women. Overwhelmingly, they all used encouraging and positive affirmations that concentrated on being informed and in control. They added a feminist-focused confirmation that birth was 'normal' and to go with it, with the

adage that women can have both careers and motherhood. It is essential to remember that age does not deplete the commitment to feminist ideologies (Shaw, 2015). They counterbalanced this with the reassurance that asking for help was acceptable and motherhood should not be a self-sacrificing role; finding time for yourself and your partner is vital to your family's success.

The women's messages to those embarking on motherhood are most undoubtedly positive and wise, raising the question of how the women became wise and whether it is just age that bestows this on them. The definition of wisdom or how one becomes wise seems to be a multifaceted concept in much of the literature (Glück, Strasser and Bluck, 2009a; Matney, Avant and Staggers, 2016; Mitchell, Knight and Pachana, 2017; Swartwood, 2020; Sternberg and Karami, 2021). The models and theories of wisdom attempt to hypothesise how the person's qualities, attributes and experiences must align and be processed to achieve the status of a wise person, which may contribute to better decision-making (Mitchell, Knight and Pachana, 2017; Sternberg and Karami, 2021). It is fair to assume that it takes some time to undergo this process, suggesting that time equals age. The caveat here is that for some people, the experiences and attributes are absent, so levels of wisdom may be minimal. The discourse around the wisdom women gain and can offer others could be drawn into a gender debate. However, with little evidence of a significant difference between the sexes, it may be simply the experiences a person has (Aldwin, 2009; Glück, Strasser and Bluck, 2009). In this case, it is the experiences of birth, not the gender the person identifies with.

In some ways, it is not identifying the sageism; it is the challenge of connecting women with other women and people to share the wisdom. I asked the women whether they had shared their stories with others; they took this to mean daughters and granddaughters rather than those outside the immediate family circle, and the group was somewhat divided. Interestingly, those with female children had shared their experiences, and those with boys had not. However, the women who had

daughters-in-law and granddaughters shared their experiences with these next generations. This level of communication replicates Miller-Day's (2004) research findings, which identified strong communication bonds between grandmothers and granddaughters. Feminist research since the 1970s has identified and explored the complex and often fragile relationship between mothers and daughters. It has been noted as symbiotic and pivotal to developing 'self' (Friedan, 1963; De Beauvoir, 1974; Friday, 1985; Rich, 1995). Still, this complex relationship can be responsible for the oppression of subsequent generations of women and the cause for much psychoanalytical debate (Friday, 1985; Debold, Wilson and Malave, 1993; Miller-Day, 2004). Yet, the grandmother-granddaughter relationship appears to have a different line of communication and a stable relationship status. One of Miller-Day's (2004) participants suggested she "had the fun but not the worry" (p.113). Conversely, the granddaughters felt the comforting, protective nature of their relationship with their grandmothers. While Miller-Day's research is not generalisable to all populations of mothers-daughters-granddaughters, opportunities occur to develop a discourse about the role of older women within communities, especially for those who do not live near or have relationships with a mother or grandmother figure. There is a role of support that could be offered to lonely, isolated or vulnerable women.

The complexities of life in the twenty-first century were absent from the recollections of the women in this study but are pertinent to their roles as older women, perhaps as grandmothers. Social media influences, the diversity of family forms and the social demands of everyday living add a new layer of complexity that impacts how their 'mothering' might be approached. What can be distilled and transposed into this century is the uniqueness and frailty of the mother-daughter relationships where disruptive, toxic and vulnerable power dynamics are at play. The cathexis-typed relationship Rich (1995) defined as 'matrophobic' does not present itself as a fear of mothering or motherhood but fear of becoming one's mother. Building on Rich's seminal work, others have argued that the development of a strong female self can only be cultivated by a strong mother-daughter connection (Caplan and Hall-

McCorquodale, 1985; Gilligan, 1993; Rutter, 1996; Baker et al., 2000; Caplan, 2002; O'Reilly, 2016). In today's society, it could be argued that this must be a significant mother figure, not just one with a biological connection. Nonetheless, Rutter (1996) suggests that girls' high self-esteem is made possible through close relationships with mothers. Rutter writes:

"Mothers can raise girls with a vital, intact feminine spirit…. [The] mother-daughter relationship is the ground for teaching, talking, and sharing the feminine experience, and the more we empower that experience, the healthier our girls will be. We need to secure our daughters' sense of self-worth, in their mind and their bodies, so that they will not turn away from us and from themselves" (2, 9-10).

Whether the components of this 'close relationship' as outlined by Rutter create a causal sequence where the level of human flourishing continues into adulthood is debatable. Questions surrounding whether self-agency and reproductive autonomy can be upheld during experiences of pregnancy and birth depend on the strength of the dominant narrative, which invariably is that of the patriarchal medicalisation of birth.

Intergenerational reciprocity depends on the cultural context of the country. Each society has well-established cultural norms and welfare systems (Pinazo-Hernandis, 2010). However, since the recent pandemic (2020), the UK is in a position to re-evaluate what the new norm is. This reflective time should include the way mothers and grandmothers are perceived and valued, questioning the importance placed on those who are reproducing society's next generations and those whose lived experiences can support them. In Chapter One, in the section titled "Women, ageing and their ways of knowing," I discussed how grandparents practically support their children with childcare and how this could be a missed opportunity to develop greater levels of intergenerational reminiscence, creating a deeper emotional connection. My concern is that since the pandemic, childcare by grandparents and everyday interactions might look very different, with the time spent in the same space being substantially reduced. Therefore, in this time of reflection, how families

can become "warmer" (Thane, 2011) to one another is a priority. There are examples of intergenerational projects that aim to bring people together in a meaningful way (International Child Development Initiatives, 2014; Ageing Better, 2020; Active Communities, 2021). Pregnancy and birth reminiscence activities can be included within these forums, which lack them at present. Communities could look towards the wisdom that may come with age, explicitly value it and utilise it to support younger generations.

The limitations, methodology and methods

When reflecting on this study's limitations and methodology and what the study might offer others; and reflexively consider what I have gained as a midwife, lecturer, researcher and woman. I do this in a way Clandinin and Connelly (2000) describe as '*wakeful*'. This way of reflecting requires the researcher to accept that the critique of the study will be in a state of fluidity, ever-growing and developing. My biases might become more apparent, or I may justify the ones I am already conscious of. Nonetheless, a starting point is required, with the proviso that this stance may alter as the work is critiqued throughout the years. Despite the richness of the findings, I start by considering the limitations of this study. The sample was chosen based on convenience and was not representative of all women birthing in the UK.

The participants were all white women geographically situated on two sides of the same county. Increasing the size of the sample group would increase the power of the narrative. Broadening the dimensions of the ethnicity, race and diversity of the sample group would add specific details of the challenges experienced by these groups. Before undertaking this research, I did not consider the way women might identify with their gender. However, if this research is repeated or continued in the future, the inclusion of participants who have lived through times where their gender and sexual orientation have been acknowledged, ignored and responded to by health care professionals will most certainly yield a differing narrative. Just as the participants in this study told their stories to me as the audience, the next storyteller,

audience and reader will be unique in many ways, yielding a different story (Kim, 2016). How the outcomes are compared and contrasted to this study will depend on the criteria used to judge the narratives. Clandinin and Connelly (2000) suggest this might be supported positively by not squeezing narrative inquiry into a language created for other qualitative research types. They recommend emphasising '*recognisability,', 'authenticity,', 'adequacy'* and *'plausibility'* rather than commonly used criteria of '*reliability,', 'validity* and *'generalisability'*.

Considering the use of narrative inquiry as part of my design, I am confident that this approach was appropriate for this study. It gives the women in this study a voice, and for some, it was the first time this opportunity had been facilitated, a forum where they could share those experiences. By participating in this research, the women might have felt encouraged to start sharing their own birth experience stories with others. This group of women's sage advice is reassuring through the transformational way they have survived their experiences by negotiating the celebrations and challenges. Their levels of resilience and fortitude are heard in the empowering advice they offer younger women. The recommendations from this study include ways of increasing the dialogue with women of this age group both within maternity services and in local communities. No '*epic closure'* should occur (Bruhn and Lundquist, 2001; Holquist, 2003) the multiple voices remain "unfinalizable" and continue to grow (Kim, 2016).

My reflection moves to the process of analysing the narratives. I struggled for several months to find a method of analysing the data in a way that felt right. I did model several ways, such as coding and thematises; however, I did not feel they were compatible with the data or me as the analyst. It is hard to pinpoint the exact reason for this emotional response, could it be as simple as the type of methods did not resonate with my creativity? Or perhaps they did not feel compatible with my authenticity? Fortunately, in my search, I came across the Listening Guide. I went back to the place it originated and read Gilligan's (1993) book *In a Different Voice* and knew this method would do the narratives justice. I felt comfortable with how

the book's ideology offered countenance to my feminist lens and philosophies. While I have come to appreciate this tool wholly, I initially found the idea of I-Poems a little disquieting, I felt that creatively I did not respond to poetry well and that often the hidden means were lost on me! However, once I had fully committed to using this tool, I found the I-Poems gave the most profound results. If asked in the future, I would suggest to other researchers that they embrace methods and designs that sit outside of their comfort zone as the results may be astounding. Becoming attuned to the emotionality of the narratives yielded an unexpected finding: I had not considered that the women's recollection would include sensory elements. I now see the potential for future research that would include sensory details within a narrative inquiry about birth recollection.

My contribution to knowledge

As I move towards the final elements of this chapter, I consider the uniqueness and originality of this study. The originality of this research has two unique aspects. The first is the significance that birth experiences have for women's lives. Some women make the transition into motherhood with a live child, and others, without. Nonetheless, the experience has deep meaning throughout their life span; entry into the motherhood club is a significant event. I believe this study is the only contemporary work that hears the voice of older women's birth narratives, theorises the narratives in a way that reveals the longevity of a complex multisensory emotional experience and demonstrates the resilience of women when seeking out female support. This type of research may prompt society's conscience and encourage those in positions of power to consider the way they lead others to value older people. For health care professionals, this work might offer an understanding and appreciation of the deeper meanings of birth experiences; the practice could be improved and enhanced.

The second aspect relates to my conceptual framework (illustration 1.1). It has a unique relationship to the birthing process, as does this study. It was '*conceived*'

when I was negotiating how all of the elements of this thesis might be threaded and woven through the entire work. When trying to visualise this, I drew diagrams and flow charts to stimulate my creative juices. My eureka moment came when I applied it to the physiology of pregnancy and asked what it was that sustained the pregnancy. I concluded the umbilical cord was the answer. In application, I was able to show how the methodology and methods, the theoretical feminist ideologies, ebbed and flowed alongside the women and me. It is all-encompassing and provides the sense that all components are intertwined, yet each has an individual purpose. As I progressed with writing this thesis (the pregnancy), the conceptual framework (illustration 1.1) has remained an adaptable feature despite the reforming, reconfiguration and editing of this work. As I move towards submitting this work (*the labour*) and the final changes are being made (*first and second stages of labour*), the conceptual framework remains a point of reference that checks the consistency of all the required features *(the health check*). Once submitted (*the birth*), the viva will become the most pivotal moment as I defend the thesis, one that will be full of mixed emotions, as the *third stage of labour* the sense that the end of the hard work is in sight and if successful *the umbilical cord is cut*. This will be followed by the success and trials of the postdoctoral work I might undertake *(motherhood).* Although the cord has been cut, the invisible connection between me and this thesis will remain a feature of my life's narrative, avoiding epic closure (Bakhtin, 1981; Bruhn and Lundquist, 2001; Holquist, 2003).

Chapter 8 - Recommendations and concluding thoughts

This study aimed to answer the following research questions, concerning women in their seventh decade:

- In which ways do women recollect birth experiences in later life?
- What are the positive and negative elements of these experiences?
- How are these experiences transmitted intergenerationally from woman to woman?

The narratives gathered from the questions were analysed to produce findings that contribute and build on a body of knowledge that focuses on women's experiences of the birth continuum. The theorisation of the women's stories revealed that as they recalled their stories, multisensory voices were heard. Additionally, the way women-built relationships with the midwife and those in the mother role had remained a significant memory throughout their lives. In this chapter, the discussion will turn to how this new knowledge might influence policy and practice. While these findings are substantial and unique, it is the way this new knowledge can be used to inform the influencers (educationalists, feminists and midwives) that may become most important. This group of influencers plays a pivotal role in how birth will be experienced by women and supported by others. Should they take the opportunity to engage with this research, a new discourse may ensue which cascades to shifting the power dynamics by reinforcing the counternarrative. The challenge is how to achieve this; some of the possibilities follow.

To midwives: Hear the voices

Midwives and health care professionals are instrumental players in women's birth experiences. This study has shown how enduring the nature of the memories of birth is, and the players should be conscious of the long-lasting impact their behaviours and attitudes might be. Being mindful about the language they use when talking to women during the birthing continuum may positively impact the recollection of that experience regardless of its outcome. Shifting the language from a risk-focused

dialogue to a more holistic person-centred language would be a more positive way to practice. Providing information and assuming that this creates a culture of choice and informed decision-making is a naïve belief; it could foster high levels of anxiety and worry (Barnett *et al.*, 2007). The balance here is much more complex: It has to include inclusion, discussion, and respect and contribute to building a positive client-midwife relationship (Marteau, Dormandy and Michie, 2001; Thachuk, 2007; O'Brien, Butler and Casey, 2017). The adage that women never forget their midwives is not about their names but their '*presence'* and their ability emotionally to contain the experience (Farrington, 1995; Ungar and Busch Ahumada, 2001). Combining this with the continuity of carer, compassionate care and tolerance of difference, the memory of the experience may be positively impacted whatever the birth outcome (Department of Health, 2016).

The political voice of midwives could be strengthened, and they could be encouraged to lobby policymakers and employers (NHS) with the aim to re-establish the necessary professional development since the recent cuts to post-qualification education budgets. Midwives would benefit from having time and space to reconnect with the true essence of midwifery practice, particularly at a time that notes high levels of compassion fatigue and moral distress experienced by midwives (West, Bailey and Williams, 2020). The employer-directed in-house study available to them chiefly focuses on the mandatory needs of the Trust, not the restorative needs of the midwife. In the interest of women, midwives should be steered away from practising like a 'Medwife'[5]; they need opportunities to reconnect to the art and spirituality of midwifery practice (Baker, 2005; Davies and Davies, 2007). It is vital that midwives vehemently protect the title of midwife and conserve and remain the gatekeepers of physiological birth. This role could include the facilitation of the counternarrative regarding birth, as the role of advocacy is in jeopardy without it.

[5] A disparaging term that is meant to denote a midwife who uses medical procedures or heeds traditional medical injunctions.

To midwifery educationalists

As educationalists, we are in a powerful position that allows us to respond to societal and technological changes that should reflect the best interests of the client group, stakeholders and students (Sidebotham *et al.*, 2017). Midwifery curriculums being developed include a regulatory requirement to engage with those who use maternity services and there is a moral responsibility to drive the developments in a unified way that challenges outdated and contrary norms innovatively and entrepreneurially. To achieve this, the service user must be central to curriculum development. At the moment, it is usually only those who have recently used maternity services, a task that is notoriously difficult to achieve, as women who have recently birthed are often trying to negotiate the challenges of motherhood. Engaging with this study provides an opportunity to think more laterally and include those who used maternity services some time ago. This is where their narrative accounts can be listened to, and the long-lasting emotions of that experience might be heard. This longevity of the emotional responses may inform curriculums in a deep and meaningful way.

While developing midwifery curriculums, the use of birth language could be revisited. The women in this study talked of their feelings when they were either excluded from conversations and decision-making or spoken to condescendingly; therefore, the use of a more affirmative and transformational language set should be agreed upon. This should be embedded implicitly and explicitly throughout the curriculum, with the midwifery lecturer's role modelling its use. The implicit message can be seen in the way teaching blocks are named. They should not reflect the classification of pregnancy and birth as a 'risk' category. Categorising women by risk should be replaced with a more non-stereotypical holistic person-centred approach. This research has demonstrated the significance of the value the women placed on the relationship they had with midwives and how this feeling is ever enduring. The student midwives' learning should be focused on experiences, for example *'the childbirth continuum-universal care'* as opposed to *'managing altered health states.'* The content would need to include learning around the actual altered

health conditions, only with the women, not the condition, central to the discussion, remembering that significant changes to the curriculum would not only be related to the physicality of birth.

As a requirement of the NMC proficiencies (NMC, 2019), many midwifery curriculums include political and philosophical aspects, but the need to develop students' clinical skills and meet statutory proficiencies has been known to overshadow topics such as feminism and critical theory. The importance of providing an opportunity for student midwives to explore the feminist matricentric perspectives of birth should not be underestimated. They should have a safe, nurturing environment where they have the chance to debate and consider how they might influence the feminist discourse and align it with the concept of birthing with dignity (Prochaska, 2015).

The role of midwifery lecturers is not confined to the classroom. They often have close working relationships with midwives in practice, which places them in a pivotal position to influence practice. They should act as a catalyst to help create a positive shift in the current culture of many birth environments. The use of positive women-centric language is a simple example of such an improvement. This, in turn, gives voice to the counternarrative as it shifts the dominant narrative of the medical model of care and levels the playing field.

To policymakers and community leaders

This research has shown how the voices that reflect the lifelong memories of birth are muted and they are not held up as a significant contribution to a life course. In many ways, this attitude and positioning of women's experiences can be viewed as passive sexism and ageism. Older women can be seen as less valuable in society because their reproductive and working life has ended. However, often the older woman is the glue that sticks her family together. In this study, the women have taken a lifetime to conclude that they can give empowering advice about birth to the younger generation. Whether or not this is because they have learned other life

lessons that have informed this position, it is perhaps a culmination of years of reflexively revisiting the experience that brought them to this conclusion. Although women can exercise their self-agency and move forward in a well-informed, assertive, and resilient way, policymakers and community leaders can set in motion a cascade of opportunity, autonomy and economic empowerment (Horstead and Bluestone, 2018; Age International, 2020).

The provision of care for women has most certainly improved since the 1960s, as is evident from the comparable maternal morbidity and mortality rates. It would be naïve to believe that all women can safely experience birth without medical or midwifery intervention. Many more women with long-term chronic and acute health conditions become pregnant and sustain that pregnancy due to the advancements in technology and medical care (Department of Health., 2016; Ockenden, 2020; Walton, 2020). However, with a national caesarean section rate of approximately 29% (NHS Digital, 2020), it is questionable whether birth is being 'dealt with' and 'managed' so intrusively that the physiological response to birth is so disrupted that it fails. A move to address the issues is published in reports such as Better Birth (Department of Health., 2016). However, the resources need to be proportionate. The message to health care professionals is one that encourages self-efficacy. Birth should be admired as a physiological process intervention only when absolutely needed (Kitzinger, Paige and Paige, 2005; Kitzinger, 2006). Where intervention does occur, women should still feel they experienced a good birth (Ockenden, 2020)

Like older women, the younger women's voice is lost, but not for the same reason. Younger women are lulled into a false sense of security when they are led to believe that the only way to avoid any risk is to birth in a hospital and that this will ensure safety and a positive outcome (Department of Health, 2016). Worst still, they are led to believe the 'myth' that caesarean section is the safest way to have a baby (Phelan and O'Connell, 2015; Elinion, 2018). Compared with vaginal delivery, caesarean section is associated with a three- to sixfold risk of severe complications. Furthermore, it increases long-term gynaecological morbidity and mortality (Sandall

et al., 2018). These 'myths' surrounding the safety of hospital births and caesarean sections are not grounded in evidence. In fact, for women who have remained in good health during their pregnancy, such interventions can be highly detrimental. Those who can influence this behaviour should make all attempts to act as levellers to ensure the counternarrative is heard and assumes its rightful position in the discourse.

In the context of the working world, news articles (NBC) report that older women 'will rule the world' (Pawlowski, 2018) because of the transferable skills they bring into the environment. Women live longer, they have learned compassion and patience as caregivers and can balance their interpersonal skills. In contrast, the World Health Organisation clearly outlines the health and well-being inequalities experienced by women worldwide (World Health Organisation, 2007). They continue to suggest that older women are seen as a burden to society; therefore, it is no wonder that older women's voices are lost if these perceptions are to be believed. The ideology portrayed by the NBC news article (Pawlowski, 2018) should be the reality that policymakers and influencers strive to achieve. Although it sounds patronising on some level, the transferability and adaptability of women's skills gained during motherhood and 'grandmotherhood' would undoubtedly be advantageous in the world of commerce. However, before this utopic gender gap is filled, older women have to rebalance the inequities and take ownership of their voices. This could be assisted on a micro level within local communities by utilising some of the strategies for intergenerational interactions touched upon in Chapter One. Strategies that build reciprocal relationships between young and old in various settings, including the birth continuum, will only enhance the experiences of all involved (World Health Organisation, 2007; Pinazo-Hernandis, 2010; Ageing Better, 2020).

Final thoughts but not the end

In Chapter One, I outlined the professional journey that led me to this research. I spoke of the significant people and events that formed my thoughts and appreciation of women's birth stories. I think the impact of reaching 55, and now 58, prompted a process of deep reflection on my position in the world and who hears my voice. Since listening to the six women in this study, I have wondered who is interested in hearing the story of my birth experience. As a mother of boys, I know my daughters-in-law listened to my advice but was this because I am a midwife with expert knowledge hidden in the stories we shared? I wonder as I move into my next decade and retirement looms, will my voice become marginalised because I will have lost that 'expert' title, and will I be able to find places to be heard?

I feel that meeting the women and conducting interviews has added richness to my appreciation of the resilience and fortitude of our personal stories. I have come to know that age does not deplete the belief in feminism; it becomes a well-informed way of being. The keenness the women had to participate in this study was overwhelmingly positive. In fact, I could have recruited many more women because as I shared the premise for this study with others, I was often asked if I needed more participants; they would be willing to be interviewed and be part of the research. This has made me consider my direction for postdoctoral work. I want to gather stories and recollections of women in their seventies to share with others; perhaps a modern version of '*Maternity: letters from working women*' (Davies and Women's Co-operative Guild., 1978) or '*Labour of Love'* (Humphries and Gordon, 1993) would be an interesting way to draw older women's recollections together. Some of the topics within this work might be developed should they arise again such as exploring in more depth the power dynamic of women's relationships with their health care providers and female friends, perhaps how this has changed over the last 60 years. Of course, in the twenty-first century, other media can be used to increase circulation and diversity. It would be interesting to understand whether women across the UK have similar recollections and appreciate the variables impacting their experiences and memories.

The experience of undertaking this study has been academically challenging. Working full-time and trying to find ways of studying at this level at times felt insurmountable. Then when I most needed a consistent work-life balance, the world moved into a pandemic as COVID-19 appeared. It would be reasonable to think at this point that this meant working at home, allowing more time to complete this study and write this thesis. However, as the Lead Midwife for Education, I had to respond to the emergency standards from the NMC and remove and relocate midwifery students with minimum notice. I mention this not because I want the reader to feel empathy or sympathy for my struggle but to celebrate how pleased I am to have found the resilience to complete this work. My resilience has been nurtured by my Supervisor Nicola, who has consistently fostered discussions about the women's birth recollections and the creativity included in my methodological approach. The Listening Guide, predominantly the I-Poems, has been a revelation, encouraging me to listen to women's voices differently. I have become open to poetry and not so dismissive, adding a new string to my creative bow. My thoughts and feelings resonate with Andrews (2007) suggestion that:

> *"Listening involves risking one's self, exposing oneself to new possibilities and frameworks of meaning. It is psychologically very demanding of us as it requires a suspension of the aura of certainty that becomes our professional trademark" (p.15).*

During the time I was interviewing the women in this study, I asked my mother if she would like to contribute her story to this thesis. After all, how could I not listen to my own mother's voice? Her recollections of her pregnancy, birth and early motherhood are presented as the prologue to the thesis, they allowed me to test the concept of listening to a story, or more importantly how I heard the story. The story of midwives having a party during my mother's labour has become a family tale that has been repeated throughout my and my sister's pregnancies. My mother is similar to some of the women in this study; she was 19 years old when she married and 20 at the time of my birth.

She recollects humorous points, but along with this, she speaks with an unenlightened and fearful voice. The intergenerational voice is heard but to her from my grandmother; although the advice is not sage, it is present! My advice to readers is to ask your mothers, grandmothers and significant women in your lives to tell their stories. Listen to the range of voices that can be located in their recollections. Open your senses to their experiences as women in their own right and changes the perspective of what was really important during that time.

I believe the questions posed in this study have been explored and answered. The women spent time sharing their recollections of their birth experiences with me. They shared the highs and lows of these times and added context to their memories by talking about the world they lived in at the time. The emotionality of the experiences was ever-present and drawn out through the analysis but without a significant amount of intergenerational sharing about their birth experiences. My research has shown the potential for greater intergenerational sharing as the women were sage in their advice to younger women. The advice they offered had a feminist thread. They suggested women take control of their experiences and assert their desires and expectations that this rite of passage should be a fulfilling experience, not a dreaded, fearful and unenlightened one.

A counternarrative presented in this study should be heard by midwives, health care professionals and policymakers as this may level the dominant narrative. The 'usefulness' of older women should not be discounted or marginalised within communities as they have much to offer. Women themselves should share the counternarrative, using some of the many media platforms available to them. When drawing this conclusion together, I was reminded of the Helen Reddy song, "I am woman" (Reddy and Burton, 1970). This song became the anthem for the feminist movement, but it was inspired by the strength and resilience of Helen Reddy's mother, grandmother and aunts. So, I will end with the final verse and chorus as this resonates with the women in this study.

Oh yes, I am wise,

But its wisdom born of pain.

Yes, I've paid the price,

But look how much I gained.

If I have to, I can face anything.

I am strong,

I am invincible,

I am woman.

Oh, I am woman,

I am invincible,

I am strong.

I am woman,

I am invincible,

I am strong,

I am woman.

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Appendix 1

10 August 2017 Ref: 16/Edu/CL128

Helen Muscat
c/o School of Childhood and Education Sciences
Faculty of Education
Dear Helen

Confirmation of ethics compliance for your study *"Exploration of older women's birth stories. With the aim of capturing women's experiences within the realms of their realities"*

I have received your Ethics Review Checklist and appropriate supporting documentation for proportionate review of the above project. Your application complies fully with the requirements for proportionate ethical review as set out in this University's Research Ethics and Governance Procedures.

In confirming compliance for your study, I must remind you that it is your responsibility to follow, as appropriate, the policies and procedures set out in the *Research Governance Framework* (http://www.canterbury.ac.uk/research-and-consultancy/governance-and-ethics/governance-and-ethics.aspx) and any relevant academic or professional guidelines. This includes providing, if appropriate, information sheets and consent forms, and

ensuring confidentiality in the storage and use of data. Any significant change in the question, design or conduct of the study over its course should be notified via email to red.resgov@canterbury.ac.uk and may require a new application for ethics approval. It is a condition of compliance that you **must** inform me once your research has been completed.

Wishing you every success with your research.

Yours sincerely [redacted]

[redacted]
Email: red.resgov@canterbury.ac.uk

Appendix 2

Canterbury Christ Church University

PARTICIPANT INFORMATION SHEET

My name is Helen Muscat and I am a senior Midwifery lecturer at Canterbury Christ Church University (CCCU), undertaking a Doctorate. I will be conducting a research study titled:

Exploration of older women's birth stories.

Background

It is known that storytelling, immediately after birth and in the proceeding months and years is a constant feature in women's lives. There appears to be general agreement that storytelling is an inherent human attribute. However, there seems to be a missed opportunity to understand and share the recollections of women over 70 about their birth stories. It would be interesting to know how their wisdom and reflections have been shared with their female relatives and friends. It is hoped that this study will be the catalyst for the sharing of knowledge between the generations.

Participants in this study will be required to share their birth stories and then discuss some aspects their experiences.

To participate in this research, you must:

- Aged over 70
- Had a baby

- Be willing to share your experiences

Procedures

I would like to meet with all participants twice. The first time will be an unstructured interview which will be audio recorded and transcribed. I will then send you a copy of the transcript which we will use as the basis for a second semi-structured interview to explore some of the issues raised in more depth. This will also be audio recorded and transcribed. Both interviews are likely to take between 1-2 hours each and can take place in your home or an alternative venue of your choice.

Feedback

Once I have successfully completed the study I would like to send you a summary of my thesis, it would be useful to meet and discuss your experience of participating in this research. I would like to ask you for your consent to use some of the data, this may be through publication or presenting at conferences. Should the opportunity arise, I would also like to offer you the chance to share your stories and reflections with others, particularly the younger generation.

Confidentiality

All data and personal information will be stored securely within CCCU premises in accordance with the Data Protection Act 1998 and the University's own data protection requirements. Data can only be accessed by Helen Muscat. After completion of the study, all data will be made anonymous (i.e. all personal information associated with the data will be removed).

Deciding whether to participate

If you have any questions or concerns about the nature, procedures or requirements for participation please do not hesitate to contact me. Should you decide to participate, you will be free to withdraw at any time without having to give a reason.

Any questions?

Please contact:

Helen Muscat
[redacted]

[redacted]

Appendix 3

ID	Year and age (1st pregnancy)	Gravity and parity	Employment status	Marital status	Antenatal care	Place of birth	Onset of labour & admission	People referred to during labours	Adversity- During reproductive years
1 Peggy	1961 19 years YOB 1942	G2 P2	Employed- returned to work, multiple jobs	Single supported, married later	Absences of menses Urine test confirmation by GP Some GP care Attendance at standalone clinic *Recalled*: MW names.	1 home 1 hospital	G1. SROM- sent in by ambulance G2-spontaneous contractions- MW in attendance	G1- alone G2- CMW by name	Single-supported parent, poor housing Bowel problems Challenging relationship with mother. Domestic abuse
2 Elaine	1969 23 years YOB 1946	G2 P2	Employed- did not return until children older	married	Absences of menses Urine test confirmation GP care at mat hospital *Recalled*: MW name	2 Hospital	G1- ROM- taken in by husband- not allowed to stay in room. G2 IOL- taken in by husband. not allowed to stay in room.	G1- husband sent home G2- CMW by name	Renal colic Breech & ECV Glucosuria X 2 ? multiparity – XRAY taken.
3 Ruth	1960 18 years YOB 1942	G4 P4	Employed- did not return until children older	married	Absences of menses Urine test confirmation by GP Attendance at standalone clinic *Recalled*: MW's names.	1 community hospital 3 Home	G1- IOL- G2- spontaneous contractions- MW in attendance G3- spontaneous contractions- MW in attendance G4- spontaneous contractions- MW in attendance	G1- husband not called. G2-4 CMW x2 by name Sister-in-law, Husband missed 2-3 but in building.	IUGR Hyperemesis ? multiparity G3- unwell 1 child with severe eczema, dermatitis and asthma.
4 Barbara	1970 24 years YOB 1946	G4 P2	Employed- did not return until children older	married	Absences of menses Urine test confirmation by GP Attendance at standalone clinic *Recalled*: GP name	2 community hospital	G2- spontaneous contractions - taken in by husband. not allowed to stay in room. G4- spontaneous contractions - taken in by husband. not allowed to stay in room.	G2- alone G4- husband not present MW not named.	Breast cancer found in pregnancy. Transverse lie Baby in SCBU Reoccurring breast cancer

5 **Hilary**	1966 20 years YOB 1944	G3 P3	Employed-did not return until children older	married	Absences of menses Urine test confirmation by GP Attendance at standalone clinic *Recalled*: GP name	2 Hospital	G1-spontaneous contractions - taken in by husband. not allowed to stay in room. G2- spontaneous contractions, not allowed to stay in room. G3- spontaneous contractions- went by taxi alone	G1-husband sent home G2- alone, student mw mentioned but not named. G3- alone	PIH x1 Toxaemia Traumatic forceps D & C Large baby Episiotomy with poor repair
6 **Cordelia**	1969 23 years YOB 1942	G2 P2	Employed-did not return until children older	married	Absences of menses Urine test confirmation by GP Attendance at standalone clinic *Recalled*: GP & MW name	1 community hospital 1 Home	G1. spontaneous contractions - taken in by husband. not allowed to stay in room. G2-spontaneous contractions- MW in attendance	G1- student MW G2- CMW by name GP by name	Episiotomy PIH Breast abscess