

**NEGATION IN THE CHILDBEARING CONTINUUM: AN IN-DEPTH
EXPLORATION OF WOMEN'S NARRATIVES IN THE UK.**

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ABSTRACT

Background: Negated childbearing is difficult to define, and can include both conscious concealment, and conscious and unconscious denial of pregnancy, labour, birth and the postnatal period and beyond. The phenomena of hidden and unknown childbearing have a historical background but are also present in modern day society and communities, a story which is often played out in the media. With no agreement on prevalence and socio-demographic factors, current evidence indicates that this is an event that although poorly understood, can provoke strong reactions and commentary from within and outside of maternity services. A lack of awareness and a limited evidence base provided a strong rationale for a qualitative exploration of this phenomenon. The storied experiences of women who have been through negated childbearing are largely unexplored, unheard and minimised within the literature.

Aim: A reflexive, narrative research approach provides an alternative and dynamic framework for an in-depth exploration of the distinct phenomena of negated childbearing, through the unique individual and shared stories gathered, in modern day society and communities.

Participants and Data Collection: A sample of six women narrated their individual stories through one question, unstructured, in-depth interviews. The women shared their experiences and stories with each other online, through a unique secret Facebook group, which acted as a virtual focus group and safe space for sharing.

Data Analysis: Narrative analyses of the data from the interviews and the Facebook group were employed, and utilised the thematic (thread), structural and performative strands to knit together and present “matryoshka” narratives which emerged. To give depth, narrative tone and situational lens concepts were employed. Poetry techniques were used as performative analysis, drawing on the threads and story structure.

Findings: Individual stories revealed narrative threads including trauma, dyad, guilt and family and friends. Storytelling and structuring revealed complex plotlines, and a consistent revisiting of storied elements. Shared conversations generated storied aspects and further threads around diagnosis, mental health and future pregnancy. Found poetry provides a powerful, holistic presentation of stories. Broader theories and concepts have been considered and discussed, as they impact upon the contextuality of the narratives in relation to current midwifery practice.

Recommendations: The importance of stories and storytelling, through holding space is important in generating a different discourse, and raising awareness of negated childbearing, alongside the need to improve care using a trauma informed approach. A new proposed definition, model and areas for further research and education are key elements.

DECLARATION

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

DEDICATION AND ACKNOWLEDGEMENTS

This thesis is dedicated to the women who shared their stories with me, and with each other, and for bringing my research to life. The dedication is also shared with my closest family, my husband Paul for believing in me and supporting me, and my children Niamh and Caolan, for being a joy through the difficult times.

There is one person who although she is not here in body, she is with my spirit always, and her photograph sits on my work desk at home. She is my late mother-in-law Mary, who was like a mother to me, and she would have been incredibly proud of my achievement.

I would like to acknowledge the work of my supervisory team: Professor Valerie Fleming as Director of Studies, and Dr Clare Maxwell and Professor Moira Lewitt as supervisors, who have given guidance and feedback throughout my part-time PhD journey. A special mention for Dr Robyn Lotto who helped me with my NHS Ethics application, providing a huge amount of advice and support at this challenging time. Thank you to my midwifery and academic peers for their informal and essential support, being generous with time and understanding, and offering sage words of advice.

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For a girl who was told when she was young that she wouldn't go far, and struggled with maths, to the woman who is completing her doctorate, the work and time taken to carry out this research and write my thesis, has certainly been an extraordinary personal achievement.

CHAPTER 1

INTRODUCTION

1.1 Overview

The presentation of this thesis explores the subject and phenomena of negated childbearing, using a narrative approach. There are a range of definitions of negated childbearing used across the evidence base, and for the purposes of this thesis I have used my own bespoke definition throughout to inform this study:

“The phenomenon of negated childbearing encompasses pregnancy, labour, birth, the immediate postnatal period and beyond - across the whole childbearing continuum. It includes (non-psychotic) conscious concealment, and conscious and unconscious denial of childbearing”

This exploration has been achieved through listening, analysis and presentation of individual stories and shared conversations of negated childbearing across the childbearing continuum. Moreover, the research findings and the presentation and ongoing dissemination of these, seek to raise awareness and increase understanding of negated childbearing. This is particularly important in midwifery and maternity services, but also in the wider healthcare professions who may be involved in care and service delivery for women and families impacted by their experiences.

The journey through this research process starts with a consideration of the core ‘why’ of choosing to research negated childbearing, and how this rationale provides oversight for the driving force for the design and implementation of this study, and influence on the presentation of the findings and further discussion. Next, comes an exploration of my position within the research, and as part of the research process, considering the actions of being reflexive and reflective.

A brief discussion and synopsis of definitions, background and history of negated childbearing, critically considers the challenges of research in this subject, and provides links to gaps in the evidence base, alongside the need for agreement and standardisation of terminology. Lastly, I will provide a short summary of each thesis chapter, to give an overview of how the chapters are structured and linked.

1.2 Rationale and Research Oversight

My rationale for this research study, as well as my passion and interest in negated childbearing, was triggered over twenty years ago from an experience I had as a student midwife on my first clinical placement on delivery suite, which I remember very clearly. I had completed enough birth observations, and my midwife mentor was confident enough to let me lead the intrapartum care of 'low risk' women. Whilst I sat in the office completing notes, a Health Care Assistant (HCA) came in and asked me to help her with a labouring woman who had turned up and was in the car park. She said it looked like the woman was in advanced labour and that we needed to hurry. I left my notes, informed my mentor, who instructed me to go with the HCA, whilst she prepared a room and the delivery pack, so off I went.

We collected a wheelchair and located the woman close to the main entrance of the maternity unit, who was in advanced labour and appeared to be pushing. Acting very quickly, we supported the woman into the wheelchair and headed straight to delivery suite, into the waiting room, where my mentor was waiting. After ascertaining the woman's details, it became clear that she was not booked in, had concealed the pregnancy and had had no antenatal care. After just ten minutes in the delivery room, I facilitated the birth of her baby, and was shocked and unprepared for her response to both the birth and to her newborn:

"This woman turned up at my unit in labour having concealed the pregnancy, it was very difficult to build a relationship with her and following the birth she was very distant and emotionally detached from the baby which she did not want to pick up, hold, look at or engage with". Researcher diary of Jane Rooney (2016).

Up until this point, I had never cared for a woman where negated childbearing had been present and had no knowledge or education around these phenomena. Although I was well supported by my mentor in placement, she also had little knowledge or experience to draw on. This encounter profoundly impacted me, and sowed those first seeds of inquiry, as I had no further input into her care, as she was wheeled over to the postnatal ward. I thought - what was this woman's story? Why did she not come for care? How does she feel? What could we do to help?

As my midwifery career progressed, I gained further experience in caring for women and families where childbearing had either been concealed or denied. However, I felt that there was a lack of sensitivity, awareness and understanding of the issue, with a focus on

the baby, at the expense of almost ignoring the impact on the woman's health and her family. A move to academia prompted me to explore negated childbearing further, and an opportunity arose to apply for doctoral study, and my initial research proposal was accepted.

Whilst my account of negated childbearing as a midwife, reflects some aspects of modern-day midwifery and maternity care, women have negated their pregnancies, labours, birth and postpartum periods throughout human history. Gowing (1997), Carter (2015), Conlon (2006), Madden (1872) and McClive (1999) have discussed that there are accounts and descriptions of negated childbearing from biblical times through to the current day, and that these exist in a range of formats, including historical documents, parish accounts and library and archive collections, for example. Additionally, and more recently, there is reporting and portrayal of negated childbearing through media channels and platforms, including social media, and which is explored briefly as part of this thesis (see Chapter two, literature review).

1.3 Aims of the Research

This thesis focuses on modern day negated childbearing, within a defined time-period in the twenty first century (see Chapter four, methods). Whilst there is a substantial body of evidence to link none and late engagement of maternity services (and therefore negated childbearing) with higher rates and risk of maternal and neonatal morbidity and mortality (Brezinka *et al* 1994, Friedman *et al* 2009, Amon 2011, Knight *et al* 2018), there is a clear lack of research which focuses on the voices and stories from women's perspectives.

Therefore, a different focus and approach to negated childbearing was chosen to address a gap in the small body of research, and to employ a holistic, narrative methodology, with a defined focus on the collection and use of stories to elicit findings and further discussion and understanding. There are four main aims of this research:

- 1) Explore the stories of negation at any stage of the childbearing continuum, from the perspective of the individual woman, and from a collective perspective through shared stories.
- 2) Gain further understanding of negated childbearing as a distinct phenomenon, identifying key aspects and issues.

- 3) Contribute to an alternative research approach, which facilitates deeper engagement with the negated childbearing phenomena.
- 4) Consider care, services and support mechanisms offered, and the effectiveness of this from the woman's perspective.

1.4 Reflexivity, Reflection and Researcher Positioning

I spent time throughout the whole research timeline considering stories and experiences connected to my roles as mother, wife, midwife, educator, researcher, practising catholic and as a woman who lives with depression. At first, I struggled with the concept of acknowledging incredibly personal attributes as part of the research process, but this has enabled me to embed myself in the narratives and stories revealed throughout (Etherington 2004, Joyce 2014). It has also drawn me to think more critically and widely around the threads, which flow from the body of knowledge that are considered in this study.

Acknowledging my role as a mother, and in particular my struggle with postnatal depression and depression, including suicidal ideation, has profoundly changed my sense of self, and has made me the person I am today. It means that I feel an inherent empathy with the women in this study who have all struggled with their experiences of negated childbearing and the motherhood continuum, revealing a changed sense of self identity, and becoming part of who they are.

Reviewing the storied data provided me with the opportunity to see how voices had not been heard, being shut away in the darkness, which resonated with my own traumatic childbearing narratives. I strongly felt a need and a researcher's responsibility to allow for a light to be shed on the darkness of negated childbearing, keeping the stories and the reflexive narrative ethos at the centre.

My experiences as a clinical midwife have also played an important role in shaping this research and provide me with a moral and ethical compass to guide my approach as a researcher, in being open, honest and transparent. It is important to acknowledge the potential influence that my personal experiences in caring for women and families have had, as they form a core part of my midwifery self and my individual story as a midwife.

These influences have collectively shaped my midwifery narratives and are part of the rationale for the approach and processes carried out as part of this study. Gilkison *et al* (2016) explores this approach in their work which considers life narratives and midwifery practice in the context of learning. Furthermore, the emphasis in this study is on the strength of the bond between the ability to develop emotional connections with stories and narratives in midwifery practice, and to improve decision making by enhanced learning through reflexivity (Gilkison *et al* 2016).

Authors such as Koch and Harrington (1998), Greenhalgh (2016) and Engel *et al* (2008) regard this approach as the underpinning foundation for narrative and storied research in nursing and is one way in which honesty and trustworthiness can be applied. The importance and embedded nature of stories and the narratives that are created from them have been identified as being rooted in the midwifery profession (Kinnane 2008, Wang and Geale 2015, Wood and Giddings 2003). As midwives we listen, engage, observe, record and communicate with childbearing stories as actors, narrators and audience, forming a deep core of narrative midwifery understanding. It is these abilities that I have drawn on to build the framework and the foundations of the reflexive, narrative approach.

Developing my skills and experience as a narrative researcher helped to inform and shape my understanding, thought processes and decision making, as I came to terms with the “ebb and flow” of a fluid and continually evolving process. This was not without challenges, and it could be argued that the elastic nature of narrative thought, process and epistemology can elicit confusion, disturbance and sometimes distress for researchers and reviewers (Etherington 2004). It felt difficult not to be defensive when discussing, debating and taking feedback about all aspects of the research, and it became an integral learning curve as a narrative researcher to learn to “lean in” to critical discourse when answers are not always clear or defined, as I built confidence in my knowledge and skills.

Achieving a balance between employing reflexivity and obscuring the aims and ethos of the study, through a potentially multi-layered, unclear and ever widening approach is essential (Koch and Harrington 1998). One way in which I addressed this whilst carrying out the literature review was to keep a researcher diary, and to note my thoughts and feelings. This provided a useful and accommodating private mechanism, to be able to reflexively ‘park’ emotions, and provide informal recognition of my personal potential impacts and challenges. Taking the stance of a reflexive researcher is not without challenge however, and the inherently subjective, and sometimes ambiguous nature, of researcher diary use as part of establishing rigour in qualitative research, has been discussed in studies by Harvey (2011), Finlay (2002) and Gergen and Gergen (1991).

The main issues arise from the use of intimate material, blurred boundaries between researcher and narrator, privacy, clarity, losing sight of the study aims and objectives, and balancing the amount of subjective diary content (Harvey 2011). However, the nature of narrative reflexivity in diary form, which involves the structuring of stories to make sense of “other” and bring understanding and order to difficult experiences and situations, allowed me to create coherence and claim my story, and my voice in this research process (Finlay 2002, Frank 1995).

1.5 Definitions of Negated Childbearing

The current body of evidence for negated childbearing has no agreed set of standardised terminology and definitions for use, which can make research in this area challenging. It is therefore important to highlight the need to discuss and outline definitions, as used in the body of evidence. Furthermore, the variety and use of terminology between authors and research studies, make comparing and aligning data, findings and outcomes from studies difficult. It should also be acknowledged that some words, terminology and their use within studies has potentially negative associations, and may not be considered person or family centred, or an appropriate approach when using trauma informed care approaches (Benton *et al* 2024, Law *et al* 2021, Marsh 2019, and Vimalasvaran *et al* 2021). Additionally, a range of commonly used midwifery and maternity terms and definitions are used throughout the thesis, and a guide to these can be found in the glossary (see Glossary, after Appendices).

The term negated pregnancy was first proposed by Beier *et al* in 2006 in their research study, which brings together data from both concealed and denied pregnancy, that they argue can be classified together from a psychosocial approach, due to similarities in findings. Although Beier *et al* (2006), give an overview of definitions for concealment and denial as individual definitions, it is not the focus of the study. Most other research studies in this area consider concealment and denial separately, and there are various definitions utilised across the evidence base.

Sadler (2002) defines concealed pregnancy as “where a female, through fear, ignorance or denial, does not accept or is unaware of the pregnancy in an appropriate way”. There are many definitions of “denial” (Vellut *et al* 2012, Sandoz 2011, Freidman 2007, Conlon 2006 and Wessel *et al* 2002), and criteria to inform a definition and diagnosis (Beier *et al* 2006). Following a review of the literature, a summary of the main definitions of concealed and denied pregnancy used is presented in table 1:

Author and Date	Table 1: Range of definitions used in the literature for negated childbearing
Vellut et al (2012)	Concealment - aware of the pregnancy but doing everything in their power to hide it. Denial - aware of symptoms but rationalise them to be something else without considering pregnancy which potentially could be due to poor mental health. Persuasive denial - unaware of pregnancy.
Sandoz (2011)	Denial of pregnancy - a woman's subjective lack of awareness of being pregnant. Denial is defined as a primitive defence mechanism found not only in psychotic patients but also in healthy individuals under unusually severe stress.
Friedman et al (2007)	Pervasive denial - not aware emotionally or of the existence of pregnancy. Affective denial - intellectually aware but no emotional or physical preparation for birth. Persistent denial - when woman discovers pregnancy in third trimester but seeks no antenatal care.
Conlon (2006)	Unconscious denial—a woman is not subjectively aware of her pregnancy well into pregnancy, or even to the point of giving birth. Conscious denial—although on close questioning the woman has knowledge of the pregnancy, her behaviour has been totally inconsistent with such an understanding. Concealment of pregnancy—a woman is fully aware of her pregnant state (and indeed will sometimes seek antenatal care) but hides it from her social group until the pregnancy is well advanced, or until delivery, or sometimes not at all. The following were suggested as useful for maternity services to categorise women: Concealment—a full knowledge of the pregnancy, but active measures taken to keep that knowledge from others. Conscious denial—the woman is aware of the pregnancy at some level but does not act (in a way society would expect) on that awareness. Undetected—the pregnancy, when discovered, is a complete surprise to the woman (and those providing her care).
Wessel et al (2002)	Description to provide diagnosis for denial: <i>“Sudden delivery following totally absent prenatal care or the late onset of prenatal care (>20 weeks), women who have no perception of their pregnancy. (Excluding those who haven't attended for other reasons when there was obvious awareness and openness of the pregnancy)”</i>

Table 1: Range of definitions used in the literature for negated childbearing

With no consensus on the use, and standardisation, of language, terminology and definitions in the literature, I have created the following bespoke definition, to inform the overall approach, research process and methodology of this study:

“The phenomenon of negated childbearing encompasses pregnancy, labour, birth, the immediate postnatal period and beyond - across the whole childbearing continuum. It includes (non-psychotic) conscious concealment, and conscious and unconscious denial of childbearing”

This definition aims to highlight the importance of the consideration of the entirety of the childbearing continuum, whilst providing clarity on what definitions are included for concealment and denial of childbearing.

1.6 History and Epidemiology of Negated Childbearing

Negated childbearing has been observed and described throughout human history, and certainly as far back as biblical times, although it may not have been recognised or defined as “negated” at this time. Examples from the bible, such as the conception and pregnancy experience of Elizabeth refer to being in seclusion and hiding from others (Holy Bible 2007, p1163, Craddock 1988).

Further examples are recorded through ancient and medieval history, largely described and linked to criminal behaviour and illegal activity at the time, particularly neonatal abandonment, infanticide and criminal abortion (Mueller 2006). Modern history accounts have been noted through the Victorian era right up to the modern day and have been examined in a variety of formats (Madden 1872, McClive 1999). These accounts include concealed pregnancy and birth cases brought to the Old Bailey, where infanticide is suspected (Williams 2011), historical case histories, (The Scotsman Online 2016), and reporting of “negation stories” in the media (McFadden 2018, Wyatt 2012).

The current body of evidence shows a wide variation in the incidence of negated childbearing, with rates differing between concealed and denied pregnancies, and with studies which consider both. A brief overview of the main studies indicates a range of incidence of between 1:148 to 1:2500, with different measures used for calculation, inclusion and definitions. There is currently no agreement on the rate of incidence for

negated childbearing or taking both concealed and denied pregnancy and looking at these individually.

A similar pattern emerges with studies which have considered the socio-demographics of negated childbearing, concealed and denied pregnancy, which indicate a range of maternal characteristics present in such cases. Other findings also show that it is difficult to predict and generalise characteristics (Spinelli, 2001; Vellut *et al*, 2012; Kenner *et al*, 2015). An overview of the limited information available from the main studies which include data on incidence and socio-demographics are presented in table 2:

Author	Thynne <i>et al</i> (2012)	Jenkins <i>et al</i> (2011)	Nirmal <i>et al</i> (2006)	Conlon (2006)	Treacy <i>et al</i> (2002)
Incidence	1:148	1:475 in denial up to 20 weeks	1:2500 at delivery	1:403	1:768
Negation Criteria	Concealed Pregnancy	Denied Pregnancy (Non-psychotic)	Denied Pregnancy	Concealed and Denied Pregnancy	Concealed and Denied Pregnancy
Location of Participants	Ireland	International	Wales	Ireland	Ireland
Socio-demographic Factors	Primiparous Younger age Fear parental reaction Rural background Low birthweight	Multiparous Early-mid twenties Good social support External stresses Normal birthweight	Multiparous Ages 15-42 Not Included Unemployment Normal birthweight	Primiparous 16-44 Concern parental reaction & good support Employed/ Students Not included	Multiparous Younger Age Not included Unemployed Low birthweight

Table 2: Brief Overview of the Incidence and Socio-Demographics of Negated Pregnancy

This table therefore indicates that there is no evidence to show that women who conceal or deny their childbearing, exhibit certain predicted characteristics, or who fall into

designated population groups (such as within a set age range or financial background). This would suggest that childbearing negation is challenging and difficult to predict, and that as such it can be considered individual to each woman and family, and that the context in which the negation happens, becomes increasingly important in research.

However, given the findings of this study, which indicate the broader importance of trauma and abuse, and which are explored through thread findings and background (for example story precis), and recommendations (around trauma informed care), it is useful to briefly consider their relevance here. It is widely recognised and accepted, that a proportion of women throughout the childbearing continuum, will have a history of, or current background of trauma and/or abuse, including adverse childhood experiences (ACEs) (Bellis *et al* 2017, Cull 2023a, Cull *et al* 2023, Law *et al* 2021 and Wilson 2007).

This has the potential for both short- and longer-term impacts on perinatal health outcomes and well-being for childbearing women and families (Agius *et al* 2016, Bellis *et al* 2017 and Law 2021). Furthermore, aspects of trauma and/or abuse, either as separate influences, or those which occur as a result of negated childbearing, may also be an important contextual element, which contributes to shaping experiences, and forming stories and storytelling across maternity care (Cummins *et al* 2023, Etherington 2007, Gokhale *et al* 2020, Seng *et al* 2002 and Seng and Taylor 2015).

Recent work by Ayers *et al* (2024), Cull (2023), Cull *et al* (2023), and Montgomery and Duckworth (2025), amongst others, have moved the discussion forwards, to highlight the importance and integration of a trauma informed approach in maternity and midwifery care, and how discussions on trauma should be best approached in practice. It is therefore necessary, to highlight negated childbearing, within the context of trauma and abuse, as a group of women and families, who should be included, heard, understood and considered, within further research and evidence-based practice.

1.7 Overview and Structure of the Thesis

This doctoral thesis is presented with seven chapters covering the research process and work carried out about negated childbearing. This introductory chapter gives an overall outline of the reasons for conducting the study, and provides a brief background of negated childbearing, setting the research in context. Additionally, the introduction highlights some important issues around definitions, and the impact this has when appraising the evidence

base. This is particularly pertinent, as it is strongly linked to chapter two, which provides a literature review of negated childbearing.

An outline of search methods used are discussed, and the current evidence base is critically examined and analysed, structured into four main strands of literature, with key findings for each strand. Consideration of grey literature, with a focus on media and social media, is also included, to give a broad and modern-day picture to the literature review. Overall, the literature on negated childbearing constitutes a very small number of studies in the UK, primarily utilising retrospective and case-based studies. Standard generic qualitative methods are mainly employed, with some use of quantitative and demographic data sets, focussing on the third trimester and intrapartum periods. Several gaps in the existing research base are identified and discussed including:- inclusion of the childbearing continuum, postnatal period, lived experience research methods, narrative research and women's voices and stories.

Methodology and researcher positionality are the focus of chapter three, providing the underpinning ontological approach of relativism, through to the philosophical framework of social constructionism. A critical lens is applied as childbearing as a social construct is considered and discussed. Furthermore, a detailed and in-depth deliberation is given to the narrative methodology, including discussion of the history and rationale, and the typology used and applied within health, and in negated childbearing.

An outline of the use of reflexivity and the impact of researcher positionality are also considered in this chapter. Chapter three provides the philosophical foundations and rationale for the next chapter, Chapter four, which outlines the methods, data collection and data analysis utilised in this study.

A comprehensive and critical account is given of all aspects of this phase of the research process including ethics, recruitment, data collection and management (including methods), and data analysis. A detailed and step-by-step account of exactly how the narrative data analysis was carried out is given in chapter three, to provide transparency in the research process, and inform a comprehensive structure and rationale for the findings.

Chapter five is the largest chapter, providing an in-depth presentation of the findings, arising from the analysis of the unstructured interviews and the secret Facebook group. Negated childbearing experiences are represented in two parts, with part one focussing on individual, personal stories from the interviews, based on a story telling, story structuring and performing stories approach, including the use of poetry.

Part two highlights the findings from the secret Facebook group, through the portrayal of shared conversations, from a story telling and sharing aspect, considering the unique nature of social media interactions. Performing shared negated childbearing stories is also included, using the medium of poetry.

Finally, chapter six, concentrates on the discussion of personal stories and shared conversations, in relation to narrative knowing, researcher positionality, and story construction. Contextual influences of childbearing culture, and the broader narratives of self-identity, embodiment and perceptions and duality of normality and abnormality in maternity are imparted and discussed. This chapter concludes with a critical look at the short- and long-term impacts of negated childbearing across the continuum.

The last section of this thesis, chapter seven, considers the overall conclusions and proposed recommendations that are drawn from this research. Important aspects touched on are the role of narratives and stories in midwifery, relationships and holding space and the impact of sensitive subject research. The contribution of this research to the current evidence base is outlined, and a new model proposed for the unknown childbearing continuum. Recommendations are proposed for future and further research, care and clinical practice (including midwifery and MDT), and suggestions for education and training.

1.8 Summary

This introduction to the main chapters of this thesis gives a summary outline of the rationale and subject of negated childbearing, set in the context of the key aspects of definitions, history and epidemiology. A brief precis of each chapter is described, to give an overview of the entire thesis, and present the structure which follows. Setting the scene for this study on negated childbearing, provides an important basis and context for the qualitative research process.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter provides a considered and critical review of the evidence and literature of negated childbearing and the broader aspects of negation as a concept; negated health and health care; and the use of narrative/s in health. The narrative ethos, which forms the linking thread throughout the different elements of this research process, is also a key part of the literature review, including the incorporation of a reflexive approach (Etherington 2004, Frank 2010). This reflexivity informs and develops the narrative thread, which in turn supports the cyclical nature of the review, throughout the study. The details of the research methods used are outlined and discussed, followed by a narrative synthesis of the four main strands of literature, with a focus on strand three - negated childbearing. Finally, an overview is provided, drawing the strands together, setting the scene and providing the background for the design, implementation and resultant findings of this study.

2.2 Preparing the Ground, Considering the Approach: Reflexivity when Reviewing Evidence

Adopting reflexivity enabled me to ‘prepare the ground’ for a narrative literature review, as I realised the importance, impact and context of my research journey, in conjunction with the need to acknowledge, incorporate and understand personal influencing factors as part of the review. Janesick (2000) describes the identification and acceptance of personal perspectives as “owning up” to researcher subjectivity, which suggests something of a confessional nature - an implication of wrongdoing and secrecy. However, researcher reflexivity is a process which can increase honesty, transparency and trustworthiness of qualitative studies, especially those which partially or wholly include lived experiences, stories, narratives and ethnographies (Etherington 2004, Connelly and Clandinin, 1990, Wolcott 2001).

Holloway and Freshwater (2007), acknowledge the strength of reflexivity as rigour, and its relationship to evidence-based practice. As I engage with my emotional self as part of clinical practice, which informs emotional intelligence and empathy, I mirror this approach in my research study, and when reviewing the evidence, I become closer to the literature and develop a deeper understanding of the current narrative strands.

The ability to be reflexive and reflective when reviewing the literature was, at times, a challenge when considering potentially biased or narrow approaches to negated childbearing. It was at these times that I relied on my training and experience to step back, then re-engage with the evidence, to rebalance my critical engagement of the literature and emerging narratives.

The approach and process unfolded throughout the research, and the importance of reflexivity became an inherent part of the literature review. This is noted in narrative philosophy as essential in recognition of the influence and impact of our self-identity, the importance of personal experience and stories in defining the nature and essence of a narrative researcher (Riessman 2008, Tseng and De Fina 2017). Upon further reflection, I was also able to think about the impact of personal subjectivity, and how this may potentially influence and challenge the searching process and subsequent review of the evidence.

2.3 Initial and Continuing Literature Review Approach

In conjunction with the narrative framework of the study (to be discussed later), the literature review has been carried out using the “initial and continuing” literature review approach, as suggested and outlined for narrative work, and is a narrative literature review approach (Glaser 1999, Wolcott 2008). This has enabled me to develop a more pragmatic method towards reviewing, in that the initial review should not be so in depth that it “leads” the researcher (and the study) into a specific or narrow direction; with the potential to silence the direction of the voices of those narratives yet to be told. The overarching aim is to provide a broad ranging review of the current evidence base, through critical evaluation and synthesis, allowing any gaps to be highlighted.

Frank (2010) discusses the importance of not constraining stories in the process of narrative research, and the need for researchers to “let stories breathe” (Frank 2010, p2). However, the review of the evidence needs to be flexible enough to allow a broad consideration of negated childbearing research, and transparent enough without supressing any “untidy” outliers, as in a standard literature review approach. The narrative approach to the literature review is summarised in figure 1:

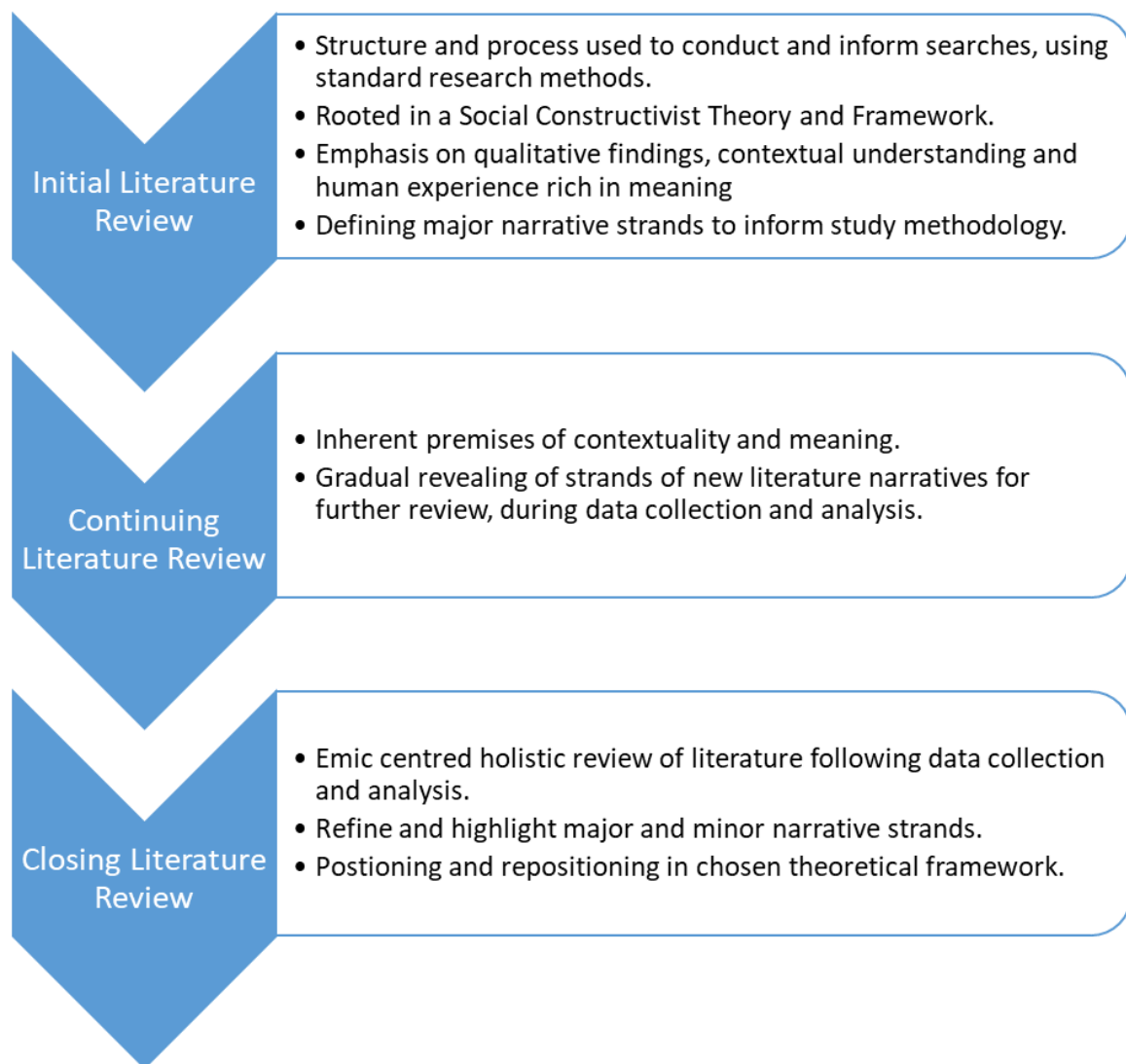


Figure 1: Initial and Continuing Literature Review Approach

An initial exploration was carried out, as detailed in figure 1 above, and informed the research process, allowing me to build the framework for a proposal, and scaffold in breadth and depth as the study progressed (continuing review), and subsequent stories were revealed (Wolcott 2001). In the third and final part of this approach, I closed the literature review by revisiting work carried out after the data collection and analysis (Glaser 1999, Wang and Geale 2015). A holistic view was taken which allowed me to review the main narrative strands, as discussed later in this chapter. This continuing method enabled me to be reactive when potential new strands of literature emerged, but also to consider discounting those strands which were not pertinent to this study (Riessman 2008).

One example of a strand of literature that emerged throughout the literature review process was around “cryptic pregnancy”; a term which is used interchangeably with both negation and denial. With no agreed definition in the literature for negation and denial, the use of the term “cryptic pregnancy” was identified as a condition in which neither ultrasound

scanning, hormone testing, or other commonly used methods could detect or confirm the pregnancy. Indeed, it was the woman herself who identified that she was pregnant (Guidice 2007, Bushra and Shobana 2021). This strand of literature does not then come under the definition of negated childbearing as used in this study and was therefore discounted from the review. It would be more pertinent to include “cryptic pregnancy” under the broader umbrella of ‘the associated phenomena of hidden childbearing’. Other examples of this terminology include “phantom pregnancy” and pseudocyesis - conditions, but not for inclusion in this study.

2.4 Search Approach and Strategy

When considering the use of a searching strategy which would complement the overall epistemology of the study, I decided not to use one of the many mainstream models available such as Patient, Intervention, Comparison, Outcome (PICO), or Sample, Phenomenon of Interest, Design, Evaluation, Research (SPIDER). These models can prove extremely useful in increasing rigour for some qualitative and mixed method approaches (Cooke *et al* 2012). However, an alternative framework was needed to accommodate the narrative ethos. On further reflection, mainstream searching models are not flexible, appear tightly structured and often centre on a medical, truth-seeking paradigm (Schiavenato and Chu 2021), which does not align with, or fulfil, the inherent dynamic nature of narrative research.

After considering and researching several mainstream and some alternative models, I decided that a different approach was needed, and so I developed a narrative searching “toolkit” was devised to increase rigour through a narrative lens. The process for the development of the toolkit, was through the dynamic identification of useful tools, as the search progressed. Specific tools were then highlighted, and incorporated into my toolkit, which I have presented here in Figure 2 overleaf. The toolkit includes using different components; for example, thought mapping, reflexivity and free text searching to allow narrative inquiry scaffolding. This free flowing and dynamic approach of narrative inquiry helped me to consider and identify synonyms and Boolean operators through thoughts, ideas, values and conceptions around negation. A visual representation of the narrative toolkit approach that I utilised is highlighted in figure 2 overleaf:



Figure 2 Narrative Searching Toolkit

The search terms I used were derived from using the combined elements in the narrative searching toolkit, and I identified and defined these as: Concealed, Denied, Negated, Pregnancy, Birth, Childbearing, Narrative and Stories. Following this, I drew out and composed simple Boolean Search Operators, and then used these to refine search parameters, for the concept of negation, adding to the childbearing terminology required to commence the search. These parameters are listed in table 3 overleaf:

Boolean Operator	Identifiable Concept	Search Outcome
OR	Concealed OR Denied Pregnancy	Records containing either term(singular)
	Concealed OR Denied Birth	
	Concealed OR Denied Childbearing	
AND	Concealed AND Denied Pregnancy	Records containing both terms (combined)
	Concealed AND Denied Birth	
	Concealed AND Denied Childbearing	
NOT	Concealed Pregnancy NOT Cryptic	Excludes records containing the second term
	Denied Pregnancy NOT Cryptic	
	Negated Pregnancy NOT Cryptic	

Table 3: Boolean Search Operators for Negated Childbearing

These main search terms and Boolean operators were then used in a systematic way to carry out the initial literature review. Search expanders, descriptors and truncation were not utilised, as the specific terminology related to negated childbearing had already been utilised within the search terms effectively, with related words and terminology appearing in the initial search, for example ‘cryptic pregnancy’. Terms were searched singularly using the Boolean operator “OR” for concealed or denied and combined using the Boolean operator “AND” for concealed and denied, as identified in Table 3.

Supplemental searching techniques were employed to capitalise on potential pathways for new resources, and to ensure the search terms chosen were effectively used. Citation searching was utilised to maximise scope and reach of evidence identified, and databases with a citation index (including ScienceDirect and Scopus) were used with selected literature.

To complement the citation search, author searching was employed, to cross check seminal literature and key texts, for further evidence. Primary source reference lists were then identified and searched for further primary sources not already included, and other grey sources. These have been grouped into headings and can be seen in Appendix (1).

Appraisal of the literature was carried out through utilising the qualitative Critical Appraisal Skills Programme (CASP) checklists (CASP 2018). I decided to supplement this by use of the Consolidated Criteria for Reporting of Qualitative Studies (COREQ) checklist, as a further in-depth tool useful for qualitative evidence and when applied to research using in-depth interviews and focus groups (Tong *et al* 2007).

Moreover, use of the COREQ checklist enabled me to reflect on my study design and appropriate use of methods, thereby strengthening the rationale and approach. Jong *et al* (2021), Thomson *et al* (2011) and Walsh *et al* (2020), identify and outline the importance of quality reporting in qualitative studies, and that addressing the requirements of a checklist thoroughly, strengthens clarity and can provide further confirmation of where methodology and methods need addressing. In the context of a narrative literature review approach, CASP and COREQ were utilised and applied in a flexible, systematic manner for all qualitative research studies (or those that contained elements of qualitative research).

Literature strands one (narratives in health) and two (negation as meaning, concept and philosophy) both relate to philosophy and methodology, and date of publication was not part of the exclusion criteria, as seminal evidence needed to be included. Inclusion criteria for these two strands was literature from Europe and USA, again to include seminal work,

and encompass the broader nature of the subject strands. This includes key search terms as already identified - apart from pregnancy, birth, postnatal and childbearing (Concealed, Denied, Negated, Narrative, Stories) in, or related to, health.

Literature strands three (negation in health and healthcare) and four (negated childbearing) included evidence in the female adult population, within the last forty years in Europe, again with key search terms. Choosing a length of time to include literature from was a challenge, and in this study was led by the need to include as many relevant studies and evidence for consideration as possible, in a relatively narrowly defined subject area. Furthermore, the literature review and inclusion of studies was concluded by 2020, so no studies related to strands three and four have been included for discussion beyond this time period.

This literature review is not a systematic review, but aims to mirror the narrative synthesis approach, to provide a broader qualitative and narrative research focus, rather than summarising data from the evidence (Greenhalgh *et al* 2018, Aveyard and Bradbury-Jones 2019, Sukhera 2022). This approach seeks to include a wide variety of evidence and provides an overarching summary of key areas and themes, with critique and a level of observation and interpretation.

Moreover, the overarching lens used in this study to review the literature is generic narrative, based on the framework and core concepts of social constructionism - including how knowledge is formed, meaning making, the nature of truth and the importance of the self (Connelly and Clandinin 1990, Burr 2015, Neimeyer 2000). Gstrein (2018) and Bryant (2000), also acknowledge the element of integration, in social constructionism, having a role to play in perspective and value, but also highlighting the importance of practical application in research, which can be used when considering complex subjects.

The practice and inclusion of reflexivity in the process of this literature review was challenging, and something which I revisited and reflected on throughout, using my researcher diary to capture this. It is important to acknowledge my potential impact through personal values and beliefs, on the process and presentation of the findings of the review.

Olmos-Vega *et al* (2022), Etherington (2004) and Finlay (2002) echo the importance of reflexive practice, whilst recognising the challenges often faced to embed it into the research process. My professional and educational values as a midwife formed an integral thread throughout the literature review, alongside personal values discussed in the

introduction; however, it is the midwifery values that I needed to revisit and reflect on consistently (Lambert *et al* 2013, Burns 2012, Marshall 2010).

Moreover, there was a need to explore and consider my identity as a midwife, my midwifery knowledge and my first-hand clinical experience of negated childbearing, and the impact that this may have on the transparency and criticality of reviewing the literature. A summary of the methods utilised in the literature review can be seen in figure 3 below. A manual method of recording all relevant literature was used, and reference lists generated according to the four strands identified, which I will be discussing next.

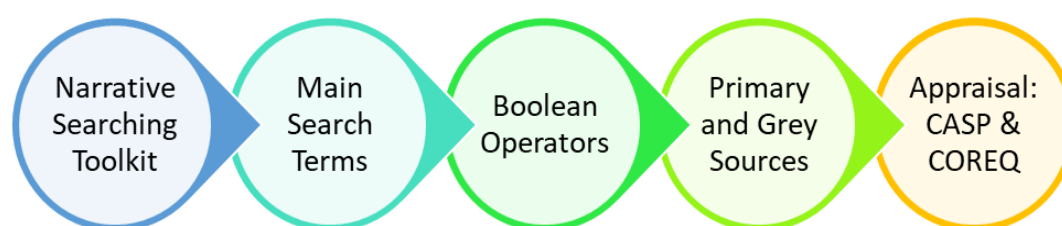


Figure 3: Literature Review Research Methods

Literature Strand 1: Narratives in health

The exploration of narrative within health literature has been examined through a number of studies, with a strong focus on narrative as research methodology (Engel *et al* 2008, Greenhalgh 2016, Riessman 2008). The use of narrative to highlight certain aspects of qualitative research, such as the investigation of stories and storied lives is seen through the work of Leamon (2009) and Wang and Geale (2015), which draws on the work of similar approaches by other studies (*e.g.* Wood and Giddings 2003).

Additional insights into using narrative to elicit personal experiences from storied lives, is further explored in work by Connolly and Clandinin (1990) and Joyce (2014). Although a number of narrative studies use the approach as a vehicle for examining stories of the vulnerable, as seen by Holloway and Freshwater (2007) and Liamputtong (2007), there has been a strong focus on the investigation of sensitive and challenging issues (Marsh *et al* 2016, Montgomery *et al* 2015, Hyden 2013).

As such, these studies highlight a complexity of approaches towards the use of narrative as a methodology within health research, and how the narrative is defined and analysed (Gilkison *et al* 2016, Riessman 2008, Thomson *et al* 2011). Variety can be demonstrated through using narrative to capture everyday storied health experiences (Kinnane 2008, Kleinman 1988), to exploring unusual, difficult or hard to research subjects (Happel-Parkins and Azim 2017, Marsh *et al* 2016, Montgomery *et al* 2015).

Furthermore, there is also the strong focus of the socio-narrative, where the underpinning of the narrative methodology is strongly rooted in the foundation of social sciences. It is the essence of context, which is all important in narrative methodology, and in respect to health literature this relationship is particularly strong. Seminal Works by Kleinman (1988) and Conrad and Barker (2010) illustrate this relationship when they explore the nature of illness, and how we build our stories through the context in which illness is experienced through our social storied lives.

Across health literature, the narrative approach - in all forms - acts as an anchor, a place to start acknowledging the importance of stories in health and research, linking in with the ongoing and different contexts which influence and shape how the stories are made and told, and of their impact. Narrative can be seen as the spark which gives life to stories untold and unheard, often generating powerful and impactful research across many areas of health.

Literature Strand 2: Negation as meaning, concept and philosophy

When I began to consider the origins of the word negation, I was able to think reflexively about the broader context and the implications of the terminology and language associated with the use of the term. In very simple terms, the shortest root of the term negation, stems from the Latin *ne* - meaning *no* (Collins Dictionary 2021).

The Oxford English Dictionary online (2016) defines a longer root, stating a Latin basis of *negatio* (*n-*), which comes from the verb *negare*, to 'deny', and having a base in Late Middle English. Further reading in the use of the word negation in areas such as grammar and logic indicates strong affiliations with meanings linked to other terms including 'denial, contradiction, truth, absence and opposite' (Oxford English Dictionary, 2016). There is an overwhelming sense of an association with negativity - which can be further defined as: 'The absence or opposite of something actual or positive' (Collins Dictionary 2021, Deprez and Espinal 2020). The inherent feel and context of the discourse of the word negation in relation to childbearing, has the potential to impact participant, reader and researcher, drawing attention to the implicit negative connotations.

Furthermore, the essential roots of both the development and use of the word negation, and subsequent branching out into different fields of study, stem from the origins of both the sciences and arts, notably mathematics, physics, psychology, philosophy, and linguistics (Ricouer 1992, Speranza and Horn 2010). The connecting theme between these disciplines is negation in the context of logic - thinking about how the very meaning of negation is applied in and across a range of areas and understanding applied reasoning and developing

theories to support the use of negation (Bhushan 2011, Speranza and Horn 2010). Dahlstrom (2010) makes a case for the ontological importance of the inherent nature and contextuality of negation, stating: “Negation is fundamental to our understanding of what it means to be” (Dahlstrom, 2010, p3). This is further developed through recognising the ontological significance of negation, and its place as a concept and phenomena (Dahlstrom 2010, Van Eeke 2006), leading to the consideration of the use in language and meaning (Kristeva 1982, Van Eeke 2006).

An exploration of the language of words associated with negation was carried out, to reflect the ontological discourse of the word, and use this alongside the literature search. As an element of the narrative searching toolkit (see figure 2), I used the tool of mind mapping as process, to order, identify relationships and provide a base from which to explore negation in the context of language. Mind mapping is a technique or tool which allows a visual representation and organisation of thoughts and ideas which are usually based around a single concept (Buzan 2006, Nolte-Yupari and Santos 2019). Crowe and Shepard (2012) discuss the beneficial use of mind mapping as part of the research process and suggest that rigour and transparency can be increased through the visual documentation of the researcher’s thoughts and application to methods. I also utilised the mind mapping approach to further incorporate reflexivity into the literature review, and one example is presented as a reflexive thought map, as detailed in figure 4 overleaf:

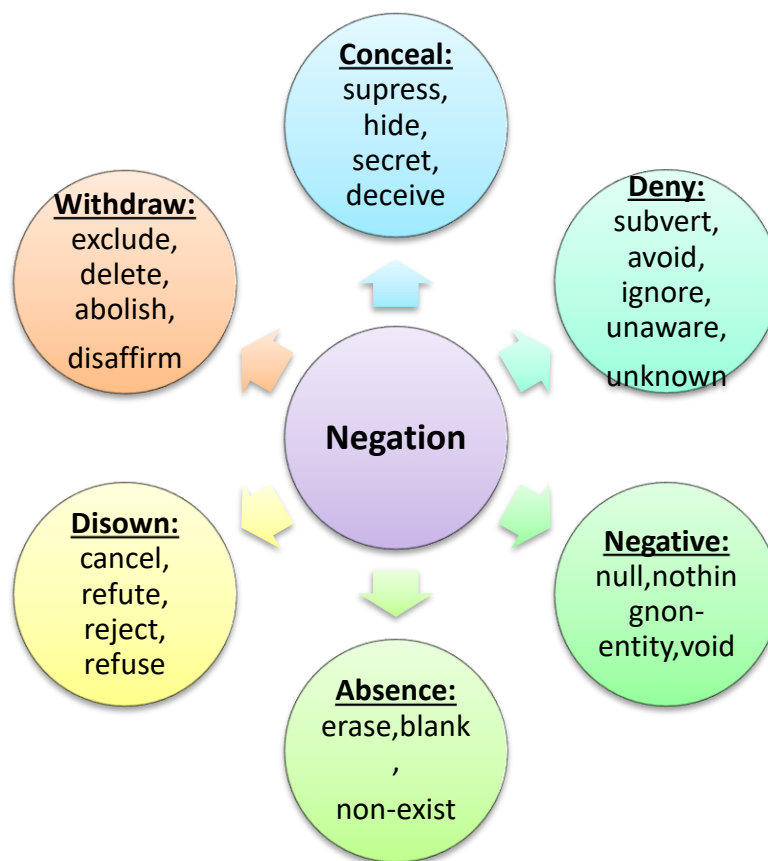


Figure 4: Reflexive Thought Mapping: Negation in Language

Davies (2010) draws attention to the limitations of using the mind mapping technique, as being inherently focussed on the small detail, and unable to reflect a broader view. Further issues may arise from inconsistency in the application and use of mind maps, which may make it more challenging for a reader other than the “mapper” to understand (Crowe and Shepard 2012, Davies 2010, Eppler 2006). Although the mind mapping technique has allowed me to visualise and represent key elements of the word negation, what it does not do is to consider the understanding and use of the word in context, essential to the narrative approach.

Orenes *et al* (2016), Nahajec (2021) and Jordan (1998) explore the philosophical concepts of negation in context/s, highlighting important relationships with discourse, communication and listeners/narrators, and the influence that this has on critical use, developed meaning and understanding, and the literal use of the word as a descriptor. Furthermore, the narrative contextual discourse of negation, and its relationships with overarching themes within the literature, will now be explored further in strands two, three and four.

Literature Strand 3: Negation in health and health care

A core element of the contextual discourse of negation is to consider the use, meaning and integration of its premise in health and health care. There is a particular focus on illness in health negation (unlike maternal negation where this link is not established), with close associations to minimising, hiding or not revealing acute and chronic physical and mental illness (Loney 2018, Telford *et al* 2006). This negated illness focus is underpinned by a social constructionist tradition, which seeks to recognise, appraise and embed the contextual importance of the cultural nature, personal experiences and an alternative to the medical model in health care (Conrad and Barker 2010, Greenhalgh 2016).

Moreover, the social construction of illness is considered an important research area, as it seeks to create awareness, knowledge and understanding of the role that social, emotional, spiritual and cultural influences play in illness narratives in modern holistic health care (Conrad and Barker 2010, Kleinman 1998). It also allows us as nursing and midwifery professionals to reflect and apply this theory of how people cope with illness into evidence-based practice (Bril-Barniv *et al* 2017, Telford 2006).

Research suggests that part of the coping mechanism is to negate the symptoms or illness which may involve actively concealing, non-disclosure or a reluctance to accept and therefore ignore health issues (Beisser 1979, Telford *et al* 2006, Wheat *et al* 2010). Beisser's (1979) work reconsidered data from other psychological studies, which suggested that denial of life-threatening illness could have potentially positive implications for extending survival rates. Several psychological factors which were not fully examined in these earlier studies, were studied by Beisser, and indicate coping mechanisms, as part of a suggested paradigm to include factors for health, of which denial is a key part. However, as Beisser did not fully replicate the original studies, there may be limitations to understandings and new meanings drawn from it.

Across the evidence base, communication in illness denial, is an essential impacting factor. Bruce *et al* (2019), considers the challenges of communication, and the issues arising from concealment and disclosure of illness, from a narrative research approach. In this qualitative study with thirty-two participants, in-depth narrative interviews with people experiencing chronic kidney disease, HIV/AIDS and cancer, alongside case studies, findings were generated suggesting that concealing illness or diagnoses is part of a socially acceptable and normal pathway and is part of a person's right in healthcare decision making.

Furthermore, a study by Defenbaugh (2012), using a personal performative narrative approach, identifies additional impacting factors notably: disease stigma, risk in revealing and appearing well. The importance of communication is again identified in Defenbaugh's

work, which also considers methods used to reveal illness and the potential consequences. Several studies have examined both concealment and denial of health issues and illness as a coping strategy, and mechanism for reducing social, emotional and psychological impact (Beisser, 1979, Bril-Barniv *et al* 2017, Moll *et al* 2012, Bos *et al* 2009 and Schneider and Conrad 1980).

I have focused on two individual research studies: one which considers a common medical condition (diabetes), and another which looks at mental illness (Bril-Barniv *et al* 2017, Hakkarainen *et al* 2018), alongside a literature review and a systematic review of studies in this area (Telford 2006 and Wheat 2010). The studies were selected as the most prominently cited in illness denial literature, covering a range of methods and using and discussing models of health and healthcare with a broader remit. Additionally, I felt these would give a useful and brief narrative synthesis, and an introduction to some of the key themes present in illness and health care negation.

In a Finnish study by Hakkarainen *et al* (2018), a mixed methods approach using a cross-sectional survey of 688 participants and 20 semi structured interviews was carried out, to investigate the concealment of Type 1 Diabetes at work. The study presents a socio-demographic profile of those who are more likely to conceal their diabetes and also pinpoints a range of contributing factors identified through thematic analysis of the qualitative data.

The limitations of the study include a narrow definition of concealment of Diabetes, geographical location and relation to the UK healthcare systems, and use of cross-sectional selection limiting interpretation of causes and contributing factors (Hakkarainen *et al* 2018). Results from the qualitative part of the study indicated that participants were more likely to discuss other people's reasons for concealing illness and diabetes, rather than their own, which impacts upon the reliability of the contributing factors identified from thematic analysis. This may also suggest that negation of illness continues to be a sensitive and challenging issue to research.

When considering the sensitivity of illness negation, an Israeli study used a phenomenological approach to ethically navigate the issues around concealment and disclosure of mental illness (Bril-Barniv 2017). In-depth semi structured interviews were carried out with participants who all had a serious and enduring mental illness of depression, bi-polar or schizophrenia. The study focused on the lived experiences of mental illness and how this influenced decision making around concealment and disclosure (Bril-Barniv 2017). Findings from this suggested that participants made decisions based on potential personal

gains or losses from either concealment or disclosure, and that this was closely linked to a small, identified list of influencing factors.

The research identifies some outcomes and reflects the themes of the importance of emotions in decision making, anxiety in relation to disclosure and the personal cost of sharing illness narratives with others, in line with Hakkarainen *et al*'s work (2018). Weaknesses of the study have been identified as ethics around recruitment and the choice and reasoning for use of semi-structured interviews for data collection which have the potential to impact the rigour and trustworthiness of the data collected.

A further contribution is made in a systematic review of 48 studies (qualitative, quantitative and mixed methods) by Wheat *et al* (2010), also looked at revealing illness in the workplace, focussing on mental illness. The reviewers concentrated on personal beliefs, behaviour in the workplace and again looked at influencing factors (Wheat *et al* 2010). However, it is noted that evidence to support definitive influencing factors was not robust enough to be predictive. Perceptions of those who present as "ill", and the positionality of illness within communities and society, was identified as an important concept in both studies (Hakkarainen *et al* 2018, Wheat *et al* 2010) and examined by Telford *et al* (2006). However, the work does underline the importance of coping mechanisms in mental illness, especially in relation to the workplace, and that illness denial is a key factor in coping.

In a literature review of 60 studies which incorporate illness denial carried out by Telford *et al* (2006), denial is discussed as an essential concept to an altered sense of self within illness and health, linking this with the individual and unique told and untold narratives of the experiences of illness. Moreover, the coping mechanism was influenced by others' perceptions and beliefs of expected and normalised behaviour from those with chronic illness, with Telford *et al* (2006), highlighting that individual stories which were not seen as important, could contribute to a more holistic knowledge of illness denial. Although the literature review methodology used was not as rigorous as a systematic review, there is an in-depth consideration of the narrative context, which is not identified in the other studies (Hakkarainen *et al* 2018, Wheat *et al* 2010).

A common theme through several of the studies reviewed, was that of an emergence of reaching a more positive state, through the challenges that health negation, through denial and concealment brings. This included affirmation, acceptance, healing and adapting to symptoms and illness, often described in the narratives of those who suffered with ill health (Beisser 1979, Kleinman 1998 and Telford 2006). These themes are important in balancing perspectives of negated health and contribute to an increased breadth of knowledge across the literature. The key messages of these illness negation studies are three-fold;

identifying the importance of considering individual perspectives from storied data, the impact of others on decision making of illness denial or concealment, and the perceived or actual impacts and risks to the individual self and life.

Moreover, these are reflected throughout the broader literature of health and healthcare negation, alongside an overarching theme of a changed/changing sense of self, when negation in healthcare is necessary, due to chronic, enduring or life-threatening illness. The consideration of negation in health, particularly in illness, has informed the literature search of negated childbearing, through providing a framework of essential findings and key elements to consider and look out for. There is an expected relationship and overlap with negation concepts, and aspects of health, that I would expect some of these to be reflected in negated childbearing literature.

Literature Strand 4: Negated childbearing

The body of research and evidence concerning negated childbearing is complex and broad ranging, with overlapping subject areas which focus on a range of aspects. Utilising the search strategy outlined, the first section groups together all literature which relates directly to negated childbearing, with four areas highlighted as the ones which are directly relevant to this study. As this is a contemporary study of negated childbearing, historical accounts are not formally included in the literature review.

Furthermore, literature on clinical maternity guidelines and legal/other concerns were also not included for review, as these were not the focus of the study. However, these three areas do form part of the introduction and background to the subject of negated childbearing, and as such, a discussion of these areas has been covered in the introductory chapter one.

The second area of evidence within the negated childbearing literature relates to those where the infant and/child is the focus of the literature and, as indicated in table 3, cover a range of sub-areas, where the focus here is on health outcomes and care of the infant, including safeguarding (Manchester Safeguarding Boards 2018, Surrey LSCB 2014, Hyde 2017, Earl 2000, Green and Manohar 1990). This sub-speciality was identified in the overall search, and is largely concerned with poorer outcomes, related to single case studies, where negation is considered as a potential factor (Hyde 2017). Whilst relevant, this literature does not directly consider or discuss negated childbearing, and so was not considered as part of this literature review, but again does provide some additional information which adds to the background presented in the introductory chapter.

Medical considerations constitute the third area of grouped literature, and here the key aspects as outlined in table 4, were the primary focus of case studies and commentary pieces. Negated childbearing was not the core subject being studied, and once again noted as a potential factor of interest, with no in-depth discussion, so the value of the piece was relatively limited in relation to this literature review and this study (Foster and Jenkins 2018, Kilby and Clubb 1992, Kenner 2015, Brezinka *et al* 1994, Finlay *et al* 2016).

The fourth and final area of evidence within negated childbearing includes those studies and pieces which focus on the epidemiological aspects. The studies that were included as part of this review discussed negated childbearing as a focus, in relation to aspects of epidemiology such as prevalence and socio-demographic factors. These were considered relevant to this review (Friedman 2007, Friedman *et al* 2009, Thynne 2012, Wessel *et al* 2002, 2007). However, studies that were not included in this area were those where the focus was on mothers who did not attend or access midwifery/maternity (they were unbooked), where denial and concealment of pregnancy was discussed, but where other factors may contribute to decision making and choices in attending for care (Friedman *et al* 2009, Weller 1987).

The main aspects are outlined in table 4 overleaf, with critical analysis focussing on the first four areas as highlighted in bold:

Negated Childbearing	• Concealed Pregnancy/Birth • Denied Pregnancy • Negated Pregnancy • Historical accounts • Media and Social Media Reports/Accounts • Guidelines, Policies, Reports • Legal, Criminal, Forensic Concerns
Infant/Child	• Neonaticide & Infanticide • Newborn Abandonment • Adoption • Medical & Health Outcomes • Safeguarding
Medical Considerations	• Obstetric & Gynaecological Concerns • Mental Health • Management • Ethics
Epidemiology	• Prevalence • Socio-demographics • Social background & Culture • Impacting Factors

Table 4 Identified areas of evidence within the literature review

Concealed Pregnancy

Concealed pregnancy and childbearing is a phenomenon in its own right and comes under the umbrella term of negated childbearing, as discussed when I considered definitions and use of terminology in Chapter one. This section of the discussion considers literature which has studied concealed pregnancy or childbearing alone, without other situations such as pregnancy denial. Although the body of evidence on concealed pregnancy is relatively small, it is dominated by studies carried out and largely based within the country of Ireland (Conlon 2006, Tighe and Lalor 2016a, Thynne 2012).

Nirmal *et al* (2006) and Thynne *et al* (2012) carried out retrospective population-based studies of hospital births, focussing on incidence, and aspects of epidemiology and socio-demographics. Nirmal *et al's* (2006) study was carried out over an 11-year period and completed a retrospective review of 24 cases, data being obtained from the Cardiff Births

Survey. The findings generated suggest an incidence of one in 2,500 births for concealed pregnancy, with women who are not married and multiparous more likely to conceal. The findings also noted that concealed pregnancy was notably more likely to happen in the Winter months and carried a greater risk of the baby being born prematurely, with almost a quarter having reduced APGAR scores.

Nirmal *et al* (2006) also note that the women who concealed their pregnancies had no documented follow up in relation to the concealment, and no documented offers of counselling was noted. The study data and findings are compromised by a lack of clear definition and limitations in the inclusion criteria of the cases included, and the terminology of concealment and denial being used interchangeably throughout the study. Case note reviews and comparisons with booked pregnancies were then used to generate the data, although blinding was not used, so again the validity and reliability of the statistical data produced may have been affected.

One major factor of note was identified when reviewing inclusion criteria and data collection for these studies. Both pieces of research studied those women who gave birth in the hospital environment and did not include other birth environments such as Midwifery Led Units, stand-alone birth centres, home births (intentional and non-intentional), or births that occurred in transit (for example in an ambulance, car or by other transport means).

Although many women give birth in the UK in a hospital environment, consideration needs to be given to other birth environments, which may potentially impact study outcomes, and/or generate further findings (Happel-Parkins and Azim, 2017). The focus on hospital birth in maternity-based research, also points to the impact of the dominant medical model of childbearing and the differences in care which may be received in different birth environments (Gilkinson *et al* 2016, Leamon 2009).

Thynne *et al* (2012) carried out a retrospective case control study with a sample of 43 women who concealed pregnancy, matched with 30 women in the control group who had not concealed their pregnancy, over a 2-year period in Galway, Ireland. The identified cases of concealed pregnancy, which had a clear definition in comparison with Nirmal *et al*'s study (2006), were compared with a control group of booked pregnancies, and another control group of identified "crisis" pregnancies (Thynne *et al* 2012). Findings suggested that women who concealed pregnancy were more likely to come from a rural background, were younger in age, had lower birthweight babies, and had concerns about potential negative reactions from parents to a pregnancy announcement. Additionally, the incidence rate in Thynne's study was one in 148 births from a concealed pregnancy.

A crisis pregnancy is defined as one which is neither planned nor desired by the woman and constitutes a personal crisis for her (Thynne *et al* 2012). There is no clear rationale given for the inclusion of using “crisis” pregnancy as a case control, and this appears to be a definition confined to Irish communities, and all the concealed pregnancies had been referred to social services. Both issues may impact the findings, validity and generalisability of Thynne *et al*’s study (2012) and make comparisons between studies challenging. Both studies suggested that women who concealed pregnancy came from a varied and broad social background, with Thynne *et al.* (2012) also indicating a higher prevalence rate (Nirmal *et al* 2006, Thynne 2012).

The key focus of both studies was epidemiological aspects related to the concealment of pregnancy and included a consideration of incidence and socio-demographics. When terminology and definitions are not clearly defined, this has an impact on accuracy of data collected, especially in relation to some aspects of epidemiology and others such as incidence of concealed pregnancy. Cases of concealed pregnancy have no recognised or agreed mechanism for recording - and so some cases may not be identified or identifiable as concealed, and therefore not reported as being concealed, potentially being missed from inclusion in studies and contributing to data collection, especially in a retrospective population-based study.

Furthermore, another key area of epidemiological significance within the body of research, is to see if the incidence and prevalence of concealed pregnancy can be accurately identified and measured. Researching the incidence and prevalence of this phenomena can allow me to see how frequently something occurs, which can be useful in informing and guiding further studies and identifying certain areas for investigation. It is clear when reviewing the literature on concealed pregnancy that there is no agreement on the incidence and prevalence of concealed pregnancy; for example, with Thynne *et al* (2012) indicating a higher prevalence rate than that stated in Nirmal *et al*’s study (Nirmal *et al* 2006, Thynne 2012).

Both retrospective studies suggest that women who concealed pregnancy came from a varied and broad social background, and that no definite conclusions could be drawn regarding characteristics which would indicate a higher prevalence of concealing pregnancy in certain groups. This finding is indicative of other studies which have failed to strongly demonstrate a link between concealment and socio-demographic factors (Friedman 2007, Friedman 2009a, Tighe and Lalor 2016a).

A seminal piece of research on concealed pregnancy was carried out by Conlon (2006) and was also based in an Irish setting - with clear identification of a focus on the Irish history,

context and culture, in terms of the findings and report. Conlon also considers the evidence base for concealed pregnancy, including international studies, concluding that research is limited, and noting a centring of research linking concealed pregnancy with adverse neonatal outcomes and/or serious mental health issues. This is the first study on concealed pregnancy which takes a more holistic approach, and considers a number of other impacting factors (for example socio-demographics) in depth, highlighting it's seminal contribution.

Furthermore, Conlon (2006) also discusses definitions, summarising the variety used in the literature, and acknowledging the difficulty in comparing studies where there is no agreed national or international definition, and so outlining the definition used in her study of women who present for antenatal care past twenty weeks gestation, having not accessed care or revealed the pregnancy to others. However, Conlon does present typologies of concealment in the study, including cases of undetected pregnancy and conscious denial, which is different to other studies carried out.

Using a case study approach, fifty-one women from two sites (rural and city based), were sampled over an eighteen-month period, and mixed data generated from three sources to consider the issue from different perspectives (Conlon 2006). Quantitative data sets were generated from the fifty-one case notes of identified cases of concealed pregnancy. Purposive sampling was then used to recruit a subset of the sample of fifty-one women, and thirteen participants for the qualitative part of the study, in conjunction with Irish social services were recruited for unstructured, in-depth interviews- a method shared with Thynne *et al* (2012).

This method of purposive sampling through social services has the potential to introduce some bias and researcher assumptions into the study - that concealment necessitates safeguarding and thus poorer outcomes. The involvement of the Crisis Pregnancy Agency, and inclusion of "crisis" pregnancies (the same as in Thynne *et al's*, 2012), also points to a presumption of a focus on negative consequences. Moreover, Conlon (2006) indicates the difficulty in recruitment for this subset, due to personal circumstances of some women and ethics of contacting the women in relation to the study. A grounded study approach was used for data analysis, with themes explored as they emerged.

The third source of data which contributed to the study was research across a range of health professionals involved in caring for women with concealed pregnancy, using focus groups and interviews to collect data. A total of eight focus groups, each having between four to ten participants, were held, equally split across both geographical sites. In addition, four individual interviews were conducted with consultant obstetricians and gynaecologists only, again across both sites. In summary, health professionals identified several challenges

when caring for women with concealed pregnancy including limited options available due to the late gestation of presentation, time pressures, intrapartum care and postnatal care, communications and integration of care between services.

Conlon's findings reveal a prevalence rate for concealed pregnancy of between 1.6 per 1000 (1 in 625 births) and 2.5 per 1000 (1 in 403 births), the variation between the data collected from the two sites sampled, the higher incidence rate being from the rural site. Notably, Conlon compares the incidence findings with that of Wessel (2003), who indicated a 1 in 475 births - however Wessel's study considered denial of pregnancy, which again highlights the difficulty of comparison with no agreed definition which varies between individual studies. Conlon also identified that, in her study, many women revealed their pregnancies between twenty- and thirty-five weeks' gestation, with a smaller number presenting between thirty-six and thirty-nine weeks, and a minority at forty weeks, and finally a smaller number presenting in labour. The study identified that the pregnancy was considered revealed when the women presented at hospital for care, as identified from the case note data.

However, this does not consider women who may have revealed to other health services, or the nuanced way that revealing the pregnancy can happen. The women's socio-demographic data was collected where available, and many women were single, in the seventeen to twenty-four age categories, white and of Irish nationality, had completed secondary level education and were either employed or in further education. In comparison to studies by Nirmal (2006) and Thynne (2012), the findings in Conlon's study most closely mirror those by Thynne for socio-demographic outcomes. Additional findings suggest that many women had support from family and friends, and had contact or support from other services, with a small minority considering adoption or foster care as an option post birth. Furthermore, Conlon's qualitative data indicates a wide range of individual behaviours, experiences and reactions across all typologies, too detailed to discuss in detail here, but which indicate some difficult, challenging and distressing experiences, and that concealment was noted as a coping mechanism.

Conlon's (2006) study which generates both quantitative and qualitative data, has some potential limitations including retrospective use of the template on the quantitative data set, differing systems used across both sites to record data, and some missing data across both sites for the quantitative data. In addition, qualitative data includes women with mixed typologies of concealment, with Conlon acknowledging that all the women in her study accessed health services, noting that there are some women who do not access services, and whom very little is known or understood about their experiences. It does provide a useful addition to the limited evidence base, with areas noted for further study

including more reliable data on prevalence, further exploration of a wider range of typologies and the socio-demographics of the women and a need for exploration of health professionals' experiences in providing care.

The most recent work to date has been a qualitative study carried out by Tighe and Lalor (2016a, 2016b) on concealed pregnancy and the association with newborn abandonment. Using a Glaserian grounded theory approach, thirty women were interviewed on up to three occasions, resulting in a total of forty-six interviews, and additionally twenty-two cases cited as public interest with 'tragic outcomes' (for example stillbirth/newborn abandonment) were included as data. Recruitment was carried out via press release from the University of Limerick, as clinicians did not feel comfortable directly approaching women, due to the sensitivities involved (Tighe and Lalor 2016c, 2018). The participants were mostly Irish, although women from three other European countries were also included, indicating study findings may be of limited significance due to the location and cultural context.

Further study limitations include a limited exploration and explanation of ethical issues encountered - two women were actively concealing pregnancies, a further woman revealed an infanticide, and some women expressed suicidal ideation (Tighe and Lalor 2018). No mention was made regarding the use of a Distress protocol or Safeguarding guidance as part of the research process, although counselling was offered to all involved. The timeframe for when the concealment occurred was very broad - from pregnancies which were still concealed to those which had happened up to forty-eight years ago, making it difficult to relate some cases to modern day midwifery practices and service delivery. The emphasis on concealment as trauma and an event leading to poor outcomes, is highlighted by the focus on selecting women (who revealed trauma and/or a significant outcome) from the sample for further interviews (Tighe and Lalor 2018).

There were no significant primary or seminal studies identified in this review of the literature of concealed pregnancy in England. There are a small number of individual case reports in England presented using the medical model, and all are unusual cases resulting in the death of the foetus/neonate (Finlay *et al* 2016, Foster and Jenkins 1987 and Kilby and Clubb 1992). Finlay *et al* (2016) includes a rapid review of literature to date, which include some of the themes already discussed including the lack of agreement on incidence and prevalence and no identified socio-demographic common factors.

Simplistic conclusions are drawn by the authors in relation to the need for safeguarding (input and referral) and increased risk of poorer perinatal outcomes. Safeguarding continues as a recurrent narrative throughout the literature review and can be seen in

sources of evidence including linked case reviews (Earl 2000) and in the production of Council Safeguarding guidelines.

Most of the literature in relation to concealed pregnancy is not primary evidence and can be seen in grey literature sources (Appendix 1), with the occasional conversation piece, such as that by Sadler (2002). Some of these multiple and varied sources are further discussed under the umbrella term of negated childbearing, media and social media. These grey sources provide an interesting and useful contextual aspect to the literature on concealed pregnancy and reveal stories and narratives which are worthy of distinct and separate research but are too complex to include in this review.

The overall key findings of the evidence in relation to concealed childbearing can be summarised as follows:

- There is a focus on the medical/obstetric model of care
- An identified lack of discussion and clarity on the definitions and terminology used, and how this has been applied
- An overreliance on retrospective studies, potentially leading to bias, and a lack of balance in recommendations of outcomes
- Case reports reviewed showed a lack of transparency and clarity, using a range of different methods
- Studies are concentrated on the antenatal period, there is little resource given to concealment in the intrapartum, postnatal period and beyond
- There are a small number of qualitative studies, looking at lived experiences, there are none that use narrative methodology, with some consideration given to women's experiences
- Much of the published evidence is not carried out by midwives, and so this aspect of the profession is often lacking in the conclusions, recommendations and commentary on the evidence
- Overall, there is a negative tone associated with the evidence, and this influences the dominant narratives of concealed pregnancy which are crisis, safeguarding and poor neonatal outcomes
- The overwhelming focus is on the outcomes for the neonate, with very little attention paid to the short and longer-term impacts on the woman, her partner and family, and those health professionals involved in care

Denied Pregnancy

The category and phenomena of denied pregnancy also forms a sub-strand under the umbrella term of negated childbearing and is considered in relation to use of terminology and definitions (see Chapter one). A larger body of literature was evident in this review, with primary evidence consisting of prospective case sampling, case reports and literature reviews, in comparison to that of concealed pregnancy, although a significant proportion overall was grey (see Appendix 1) and not primary evidence.

Jens Wessel is a lead author and researcher on a small number of primary studies, where denied pregnancy is the focus. Wessel and Buscher (2002a) and Wessel *et al* (2002b), carried out prospective case sampling of a population based in Germany, over a 12-month period of 62 reported cases of pregnancy denial in maternity hospitals and practices, located in one German city. The primary aim of the research was to ascertain prevalence, and to consider aspects of epidemiology such as the socio-demographic characteristics of women with denied pregnancy. Discussion around definition of denial is limited, referring to “unawareness” of pregnancy from 20 weeks gestation, highlighting a lack of defined inclusion and exclusion criteria.

The study focusses on quantification of denial, with 37 women being diagnosed prior to birth, and the remainder during labour; however, there is no detail on how this was classified or how the pregnancy or birth was revealed to the woman. Moreover, the authors acknowledge that some case data was not complete, and that as these cases could not be included in the study, the rate of prevalence may be higher than indicated. This further reflects the challenges and difficulties of accurately recording concealed and denied childbearing, making comparisons between studies problematic and complex. Wessel *et al*’s (2002a, 2002b) research provides additional insights, including a prevalence for denied pregnancy of 1:475 (for Germany), regardless of socio-demographic background or characteristics. Furthermore, the study proposes that pregnancy denial cannot be classed as a rare event, and that further studies are needed to provide a greater breadth and depth of the evidence base.

Whilst acknowledging difficulties in predicting prevalence and incidence, the study concludes that pregnancy denial is more common than reported in other evidence (Brezinka *et al* 1994, Speilvogel and Hohner 1995). However, whilst the study provides a sound methodology, there are limitations especially regarding a lack of clarity and awareness of the importance of defining denial, which has the potential to affect the research process, study data and outcomes.

The 2002a and 2002b evidence, provides data and a foundation for further research involving the same author and, in 2003, Wessel *et al* considered neonatal outcomes from this prospective study. Findings suggested that women who were identified as having pregnancy denial were at increased risk of poorer neonatal outcomes; however, the same issues remain regarding definitions and inclusion criteria which could compromise the validity of the findings.

A final linked study in 2007 by Wessel *et al* follows on from this earlier work and takes an in-depth look at the characteristics of women, and the usefulness of these in potentially predicting those women who may be at increased risk of pregnancy denial, utilising data from the initial study data presented in 2002a and 2002b. Cases identified as pregnancy denial were analysed for maternal characteristics and socio-demographic factors, which were compared with the Berlin birth register.

Many women were aged between 15 and 44 years, with a second or subsequent pregnancy, and had a close partner relationship with a minority having an identified serious mental illness (for example Schizophrenia). This study concluded that pregnancy denial affects a wide range of women from different backgrounds, and that characteristics are not predictable of an increased risk of pregnancy denial.

A study by Jenkins *et al* (2011) differs from previous studies on denial, by conducting a comprehensive literature review, and identifying and discussing issues of ethical and legal significance (such as capacity to consent and consideration of best interests). There is a brief discussion of definitions, highlighting a straightforward psychotic or non-psychotic classification, with the potential for subcategories within these. However, these suggested definitions are based on the minimal evidence both available and considered at the time and therefore require further discussion around applicability and comparison across studies.

The authors highlight the main findings of their literature review as an association of pregnancy denial with neonaticide and poor maternal outcomes, for example depression and substance misuse, citing generally poorer perinatal consequences. Furthermore, there was an increased incidence of both precipitous labour and birth, unassisted birth, and giving birth into a toilet, with women who had pregnancy denial. This study by Jenkins *et al* (2011), is one of a minority to mention postnatal care, but the discussion is brief and primarily concentrates on a need for maternal psychiatric assessment and safeguarding of the neonate.

The authors agree that when considering the evidence base, there is no clarity in relation to characteristics and socio-demographic factors which may indicate groups of women who

are more at risk of pregnancy denial. In relation to the difficulty of identifying and predicting pregnancy denial, Jenkins *et al* (2011) suggests that the threshold for pregnancy testing should therefore be lower, in relation to childbearing women who present with symptoms which may be attributed to pregnancy, and who do not recognise that they are or may be pregnant.

This is a new suggestion, which is not identified or suggested in other pregnancy denial research, and adds a useful practice-based recommendation, not identified in other studies. The work draws strongly on evidence from Freidman *et al* (2007, 2009a, 2009b), and Wessel *et al* (2002a, 2002b, 2003, 2007), although due to inconsistencies in definition, and the use of evidence which studies concealed pregnancies, discussion should be used with caution. The study is not a systematic review, and the methodology used to categorise and interpret findings from the studies included is neither systematic nor transparent.

Finally, there are a smaller number of studies which consider specific aspects of pregnancy denial, with a focus on adverse outcomes, including neonaticide (Green and Manohar 1990, Vellut *et al* 2012), psychological aspects (Miller 1990, Kenner 2015, Milstein and Milstein 1983, Giacomo *et al* 2020) and obstetric aspects (Beier *et al* 2006, Brezinka *et al* 1994, Speilvogel and Hohener 1995). Although these were not considered the primary focus of this literature review, the studies are included here with a brief discussion, as denial of pregnancy was a focus alongside the adverse outcome.

Vellut *et al* (2012) utilised data from legal files in France and considered 32 cases of neonaticide over a 5-year period (the majority carried out by mothers with pregnancy denial and/or concealment) and identified that most women in these cases had an average age of 26 years, were employed and were not using an effective contraceptive. However, whilst serious mental health conditions were seen in a minority of women, in line with other studies (Jenkins *et al* 2011, Wessel *et al* 2002a, 2002b, 2007), Vellut's work highlights specific personality traits and behaviours (such as immaturity and poor partner communication), which are not reflected elsewhere. Similarly, research which utilises single case reports of neonaticide (Green and Manohar 1990), illustrate a relationship between neonaticide and pregnancy denial. The suggestion with these single cases is that prevention of neonaticide may be possible and that further research is required.

There were several studies which focussed on the maternal psychological aspects associated with pregnancy denial (Miller 1990, Kenner and Nicholson 2015, Milstein and Milstein 1983, Giacomo *et al* 2020). Research by Miller (1990) considers psychotic denial of pregnancy, which occurs in women who are severely mentally unwell (with diagnosed Schizophrenia) and in which some research suggests there are increased risks of poorer outcomes including

neonaticide, poor maternal mental health and an association with precipitous or unassisted birth and safeguarding (Jenkins *et al* 2011).

Other case reports presented by Milstein and Milstein (1983) describe the reported absence of pregnancy symptoms, attributed to psychotic denial and with an exploration of normal functioning in all life areas throughout the experience. Kenner and Nicholson (2015) present an overview of the literature of pregnancy denial, considering it a psychological and somatic disorder, drawing on forensic and judicial studies and information which provide links with neonaticide, in common with other research (Vellut *et al* 2012, Miller 1990, Jenkins 2011, Green and Manohar 1990).

However, Kenner and Nicholson (2015) also highlight the importance of trauma and the behaviour of dissociation, as key factors in understanding of pregnancy denial. A case report by Giacomo *et al* (2020) also reports an absence of pregnancy symptoms with unassisted birth; factors noted in other studies (Jenkins 2011, Miller 1990, Milstein and Milstein 1983) with a focus on maternal psychiatric well-being and follow up post birth as an important part of care delivery.

A focus on obstetric aspects related to pregnancy denial, was the focus of studies by Beier *et al* 2006, Brezinka *et al* 1994. Pregnancy denial as a reproductive disorder is discussed by Beier *et al* (2006), work also involving Jens Wessel, and considers both forensic and obstetric cases, with a view to proposing a new Diagnostic and Statistical Manual (DSM) classification. The study attributes physical and psychologic aspects of pregnancy denial, which the authors argue characterise the condition and form the basis for a new category in the DSM.

Brezinka *et al* (1994) considered 27 cases over a 3-year period, providing an audit and evaluation of the obstetric history of the women, outcomes and any coping strategies. In many of the cases studied, denial lasted until the third trimester through to labour and birth, with irregular bleeding throughout that time, but no other pregnancy symptoms identified. Furthermore, Brezinka *et al* (1994) acknowledge the individual nature of pregnancy denial, in line with other studies (Wessel and Buscher 2002a, Wessel *et al* 2002b, Jenkins *et al* 2011), whilst noting potential impacting factors for example partner separation (also seen in Vellut's 2012 work) - with the reverse (positive partner relationships) as a factor in studies by Wessel *et al* 2007.

Findings relating to pregnancy denial and absence of pregnancy symptoms, psychological impact and trauma and dissociation (Jenkins 2011, Milstein and Milstein 1983 and Kenner and Nicholson 2015) are also evident in a study by Speilvogel and Hohener (1995). Their

study reviews the literature and utilises case-based reports, suggesting that pregnancy denial is a complication, closely linked to past trauma and acknowledges the difficulty in prediction in women without severe mental illness.

Reviewing the body of evidence on denied pregnancy, there are several common areas shared with concealed pregnancy, and these are identified below:

- Lack of discussion and clarity on the definitions and terminology used and how this has been applied. This has a further impact on inclusion criteria and the validity and reliability of the evidence
- Studies are concentrated on the antenatal period; there is little resource given to concealment and denial in the intrapartum, postnatal period and beyond and where this does happen, it is linked to abandonment, neonaticide and safeguarding
- There are a very small and limited number of qualitative studies; there are no studies considering narrative methodology, with little focus on women's voices and stories
- Much of the published evidence is not carried out by midwives and so this aspect of the profession is often lacking in the conclusions, recommendations and commentary on the evidence
- Overall, there is a very negative tone associated with the body of evidence, and this influences the dominant narratives of concealed and denied pregnancy in the literature
- There is an identified lack of consistency and quality in the approach, methodology and methods used in the case reports, which makes comparisons across the evidence base difficult, with no firm conclusions able to be drawn out

Negated Pregnancy and Birth

Although several studies discussed previously have examined either concealed or denied childbearing, there has not been a strong focus on research which considers both phenomena together under the umbrella of negated childbearing. As a result, the body of evidence on negated pregnancy is very small, with very little primary evidence to review. There is again a lack of clarity on terminology and definitions used when researching negation (See Chapter 1/introduction) and this is something which is common across all negated childbearing phenomena. Seminal evidence in this arena is based on retrospective research outside of the U.K, which includes a study carried out in America for this section of the literature review.

Freidman *et al* (2007) conducted a retrospective record review on 211 women who presented to 1 hospital in 1 American state, over a 6-year period. Although definitions are

discussed and outlined in relation to the cases considered, it should be noted that the studies included women who simply did not access antenatal care and thus may not have concealed or denied their pregnancy. Women eligible for inclusion were those who were in their third trimester, and who presented to the hospital for birth or immediately after giving birth, having not had any antenatal care.

Moreover, the lack of clarity in relation to not accessing care versus concealing or denying pregnancy, raises some challenges with the study methods in relation to inclusion criteria. The authors extracted and analysed qualitative and quantitative data from the records, with a focus on a range of medical and socio-demographic factors.

The results of Friedman *et al's* (2007) retrospective study indicated that, of the 211 case notes reviewed, 61 were categorised as denial, 20 as concealment, totalling 81 women whose case-note data were included in the study findings. The authors present a prevalence rate of 0.26% of all births at this hospital, for both concealed and denied pregnancy. Demographic findings indicate that women who negated their pregnancies were more likely to be in their early twenties or below, living with their mother, living with a partner was not a common factor.

This contrasts with studies by Nirmal (2006) and Wessel *et al* 2002a, 2002b, who concluded that concealment or denial occurred across a wider age profile and was not restricted to women in the younger age categories, although Conlon (2006) and Thynne (2012) do concur with Friedman *et al's* (2007) findings in this respect. However, the study does note that support from family and partners was present and important for a significant proportion of women, and this theme is also picked up in studies by Conlon (2006) and Thynne (2012). Educational background was also considered, and many women had either 'completed' their education up to high school (secondary equivalent in the UK), or were students, which is also reflected in studies by Conlon (2006) and Thynne (2012).

In relation to obstetric factors, Friedman *et al* (2007) noted a minority of women experienced precipitous labour and birth, birthing at home and being diagnosed with a serious mental illness, findings also presented in work by Jenkins (2011), Vellut (2012) and Wessel *et al* (2007). However, those women in the sample who did have diagnosed serious mental illness were at increased risk of significant safeguarding input, including removal of their infant from their care, but with virtually no psychiatric follow up or assessment. The potential impact of these long-term postnatal outcomes is noted by the authors as a complicating factor and represents an area for further study and improvements in care; findings also noted in studies by Finlay (2016), Jenkins *et al* (2011) and Giacomo *et al* (2020).

A subsequent peer reviewed article by Friedman *et al* in (2009a) utilises the data and findings presented in the 2007 work, with a slightly different emphasis which considered a broader reach of lack of antenatal care, the link with pregnancy denial, and the need to consider thoughtful and targeted antenatal care by services. Furthermore, the authors recommend a more systematic approach to mental health inquiry and point to further consideration of safeguarding and mental health referrals following birth, as identified in the 2007 findings.

A second and subsequent peer reviewed article by Friedman *et al* (2009b), again using the findings from the 2007 study, highlights safeguarding implications and found that where substance misuse was indicated (a minority of the cases sampled) that women were more at risk of infant removal than women who did not have substance misuse as a complicating factor in concealed or denied pregnancy. The infants in these cases were also more likely to need intensive care and had lower birth weights; findings also corroborated by Finlay *et al* (2016), Jenkins *et al* (2011) and Wessel *et al* (2003).

The methodological approach in Friedman *et al*'s work (2007, 2009a, 2009b), is like other retrospective studies and provides some insight into prevalence, socio-demographic factors and neonatal outcomes; although the authors acknowledge issues and challenges with the quality of the data obtained, and therefore findings and conclusions should be critically reviewed in the context of available evidence.

A case report by Stammers and Long (2014), examines one case of a woman who presents at a Trust in the South-West UK. A clinical picture of the case is described, with alternative diagnosis considered, resulting in a positive pregnancy test. The woman reporting to be "unaware" that she was pregnant and in labour. As such, this evidence is extremely limited, due to the lack of methodological rigour applied to the case examined. However, the flexible approach needed to consider both concealment and denial when a woman presents with signs and symptoms, and has not accessed antenatal care, is an important insight (Stammers and Long 2014).

Research by Beier *et al* (2006) has been briefly considered under the denied pregnancy section of this literature review; however, it is useful for further consideration in this section as the work refers to both denial and concealment, highlighting definitions and similarities between the two. Moreover, concealment and denial are brought together under a new psychosocial definition of "negated pregnancy" (Beir *et al* 2006). Study methodology is clear and logical, but limitations of collection of epidemiological data and socio-demographic information indicate reduced validity and reliability. The study provides

a perspective on negation as a “reproductive dysfunction”, which could be construed as a negative and medicalised focus.

Ali and Paddick (2009) provide an exploration of the literature on both concealed and denied pregnancy with a focus on grouping cases according to shared characteristics thereby using this as a basis for re-working definitions of concealment and ‘undetected’ pregnancy. The discussion and proposals for definitions is mostly based upon the work by Conlon (2006).

The authors also review evidence from the Confidential Enquiries into Maternal and Infant Deaths (Knight et al 2018), suggesting that concealed pregnancy is associated with increased risks, although a broader scope of women not accessing or engaging with antenatal care should also be considered. Four case studies are included, but these are for illustrative purposes only and have not been reviewed as primary cases. A summary draws the focus to raising awareness of concealed or denied pregnancy with healthcare staff and services and the need to make antenatal services more accessible - which is also reflected in Conlon’s (2006) study.

Furthermore, some additional contemporary references on negated childbearing were considered towards the end of the writing up period, to add currency to the literature review. Recent commentary and studies by AIMS (2024), McKenzie (2022) and Milne (2024), consider issues around capacity, consent and legality, with a particular reference to freebirth. The discussions consider women’s bodily autonomy, and the right to decline maternity care, with a call for a reconsideration of the law which makes concealing a birth a criminal offence (Birthrights 2025a, 2025b).

A holistic consideration of the evidence of concealed pregnancy, denied pregnancy and negated childbearing reveals some additional points summarised below:

- An identified need for an increased awareness and use of maternal mental well-being and psychiatric services and referral pathways in the postnatal period
- The importance of partner and family support in the childbearing continuum
- Lack of engagement with, and access to antenatal care has been identified in some studies as an important factor
- A focus on demographics through an epidemiological lens
- Variable findings between studies, meaning difficulty in drawing firm conclusions or making recommendations for practice

Commentary pieces such as that by Ali and Paddick (2009) draw on the small evidence base of negated pregnancy. However, they have little new discussion or oversight to add to the

debate and can be considered grey rather than primary research. However, there are examples of grey literature which can provide an informative and conversational contribution to the overall review and media and social media will be considered next.

Media and Social Media

Grey literature forms a substantive amount of the overall literature reviewed and, as such, outlining the main narratives from these and consideration of the impact on the context of negated childbearing is useful. The literature search utilised the same basic principles as outlined earlier, including search terms, and inclusion criteria were then altered to the UK only across a ten-year period (2010 - 2020). This change to inclusion was due to time constraints, the large amount of material sourced and the scope and key elements of the literature review, to focus on primary evidence. The grey literature was then manually sorted and grouped into five subject areas which were: safeguarding information, NHS trust and hospital guidelines, commentary pieces from a variety of organisations, reports from organisations (for example MBRRACE) and social media/media information.

Both concealed and denied childbearing have been reported in a variety of media formats including television, radio, news stories and more recently news online. Several high-profile news stories reported in the media follow a pattern where concealment of pregnancy, and sometimes birth, is linked with stillbirth, infanticide/neonaticide (BBC News 2018, Carter 2015, Staveley 2018) and abandonment (McCarthy 2014). Current media cases including those of Constance Martin and Mark Gordon (BBC 2025, The Guardian 2025a), and Joanne Sharkey (The Guardian 2025b), indicate that the pattern of reporting these cases continues.

Tighe and Lalor (2016a, 2016b) consider media reporting of concealed pregnancies and abandonment, highlighting the negative and emotive terminology used in reporting and discussing a lack of understanding of the nuances and differences in individual cases. Media which considers negated childbearing (both concealment and denial) is rarely discussed, but an online research blog by Morelli (2013) attempts to consider some of the emerging narratives around use and consistency of terminology, the lack of evidence around women's experiences and concludes that further research is needed to inform guidelines and improve the knowledge of birth professionals in delivering better care.

In contrast to this, denial is often reported in a different light - terminology such as "surprise" birth (Hosie 2018, Wyatt 2012) describes the event, with signs and symptoms of pregnancy and labour attributed to alternative medical diagnosis such as acute illness (Bucklow 2018, McFadden 2018). This view is underpinned by Maclean (2017) whose work

looks at birth stories in British newspapers - a small section notes “surprises and miracles”, where unexpected birth garners a more positive language.

The contrast between the overwhelmingly negative narrative tone of primary evidence and a potentially more balanced, often positive narrative of denial in grey evidence is worthy of consideration. Primary evidence which is underpinned by a broad range of research process and indicative terminology issues has not been able to capture and share the experiences and voices of those women and families, which are portrayed in the grey sources.

Social media of negated childbearing falls into five main categories, as illustrated in figure 5 below, with the review concentrating on the three areas of professional and lay discussion, alongside personal stories:

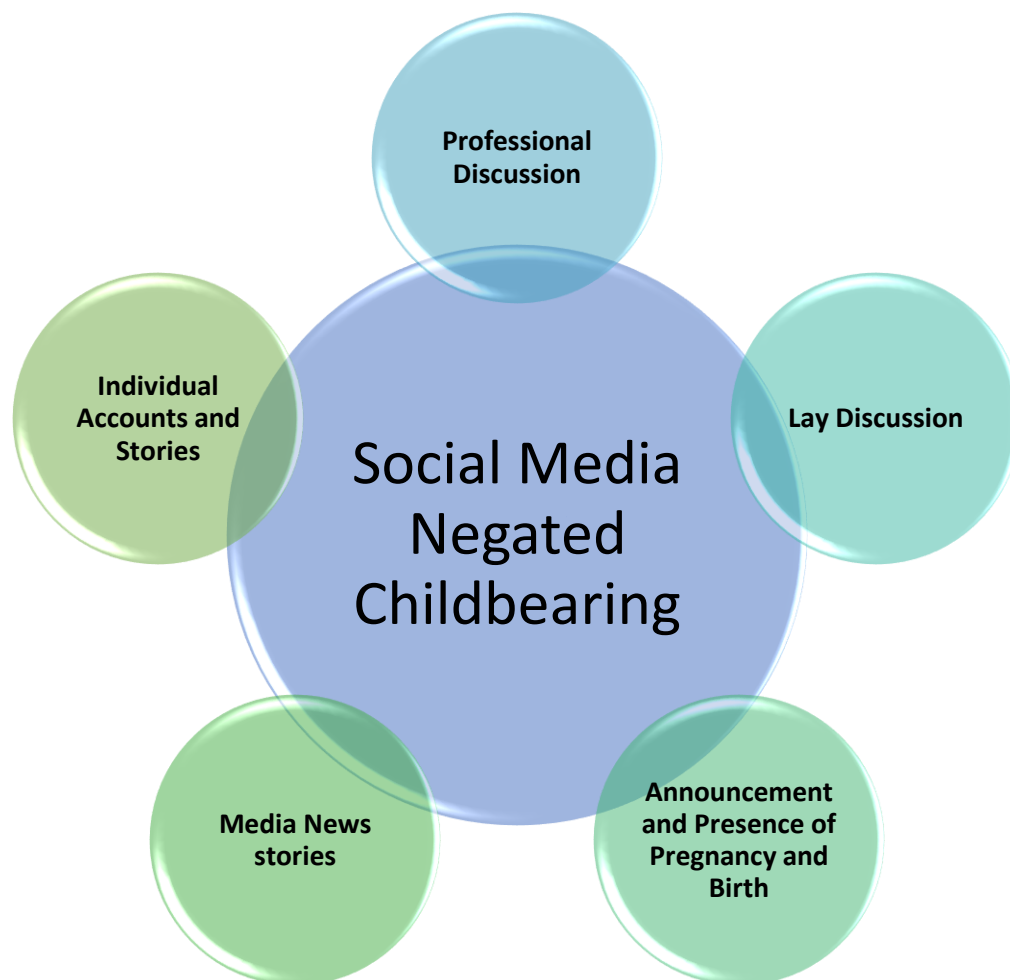


Figure 5: Depictions of the Social Media of Negated Childbearing

2.5 Conclusion

There are too many assumptions made using the lens of the medical and epidemiological models, which fail to consider the holistic picture and ignore the context of the negated childbearing phenomena, resulting in a lack of understanding. A lack of consideration and consistency with regards to the terminology and definitions in the literature review has impacted the evidence base, resulting in research which is difficult and challenging to review and compare.

Furthermore, the use of inclusion and exclusion criteria as part of literature searching and review is largely linked to systematic reviews and use of the PICO framework (Cooke *et al* 2012, Schiavenato and Chu 2021 and Wolcott 2008). Moreover, Bramer *et al* (2018) and Ferrari (2015) acknowledge that, whilst inclusion and exclusion criteria are considered a useful and organised method to refine searching results, that their use as part of the searching process is not always necessary, and that alternative methods can be employed to systematically search.

A research gap has been identified and, within this, the need for inclusion of the voices and stories of women from a narrative approach. A very small number of qualitative studies have sought in-depth data, but none have included both concealment and denial and none have utilised a narrative methodology or collective voice. Therefore, there is a need to add to the body of evidence using a different research philosophy.

Narratives and stories are unfound and untold, and the essence of negated childbearing phenomena remains largely hidden and unexplored. Utilising alternative methods of gathering and understanding and presenting data will enhance the current evidence base through more unstructured and dynamic methods, which have not been seen in other studies.

CHAPTER 3

METHODOLOGY AND RESEARCHER POSITIONALITY

3.1 Introduction

This chapter provides an overview of the research methodology, which has been considered, applied and analysed, in the context of this study. However, the initial discussion and reflection will focus on the potential overlap and confusion between what constitutes methods and which methodology to utilise; this is often highlighted as an issue pertinent to all research and one which the researcher should provide clarity for in relation to their approach and position (Savin-Baden and Howell-Major 2013, Yin 2016).

Clough and Nutbrown (2012), Mackenzie and Knipe (2006) and Mills (2014) discuss the case for methodology as the overarching philosophical approach, which is considered initially at the outset of the research process, and which informs and guides the paradigm choices which align with the study. This ‘methodology as philosophy’ approach aims to provide a distinction between the methods as used to carry out the research (the research tools), which are chosen in context with the underpinning research paradigm and the theoretical ontological foundations. Howell (2013) discusses the issue at length and advocates for a deeper understanding of the inherent challenges of defining methodology and methods, whilst acknowledging their importance in the research study.

Conversely, there is also an argument for considering methods as an intrinsic part of methodology and that it is impossible to compartmentalise and separate methods and methodology, as one underpins the other (Byrne 2001, Kothari 2004 and Patten and Newhart 2018). The strength of the links between method and methodology often means that researchers consider both theory, philosophy and methods together when designing a research study. Moreover, Brink *et al* (2006) and Flick (2015) point to the importance of a broader understanding of methodology, when researchers consider the approaches and tools in context; however, they also emphasise the importance of the position of the researcher - and the positioning of the researcher within a world view - in strengthening and clarifying the research framework.

In relation to this study, ontological influences were the first consideration when writing the research proposal and formed the basis of the development of the philosophical underpinnings for my researcher values and study paradigm. This led to the development of a better understanding of the importance of methodology in this research and the ability

to theoretically embed the approach being taken from the outset. Focussing on the relationship between methodology and methods, as well as identifying what is fundamental to this research process, has enabled a more thorough understanding and application of ontology. Therefore, the approach which has been taken in this study (and embodied in this chapter) is that methodology excludes methods - which are considered in the next chapter - and although separated, connections between the two are identified and acknowledged.

Furthermore, this allowed me to think about and define my position as a researcher in relation to the research and with the subject of negated childbearing and consider the broader position of negated childbearing in relation to big narratives and concepts. In addition, Bowling (1997) and Francis *et al* (2016) highlight the importance of defining positionality in health and social research, facilitating a deeper understanding of social and political frameworks which influence and impact health care and research.

In summary, according to Guba (1990) research philosophy is characterised through a consideration of what reality is or means to individuals (ontology), how individuals know and understand things (epistemology) and then how individuals find out (methodology). The ontology and epistemology of this research study creates a holistic view of how knowledge of negated childbearing is viewed and how individuals see themselves in relation to this knowledge.

This holistic view incorporates personal values and beliefs which together underpin the research design. The methodological strategies are used to discover and uncover the narratives of negated childbearing through the social constructs and the context in which they sit. The awareness and discussion of philosophical assumptions and approaches provides a key framework in increasing the quality of this research and has contributed to the exploration and creativity of the research process, methods, analysis and dissemination overall.

3.2 Research Philosophy: Relativism

From a qualitative perspective, Guba and Lincoln (1994), Byrne (2001) and Flick (2015) outline a range of research philosophies which may be utilised by the researcher to provide the framework for a study. Different approaches were considered in relation to my personal beliefs of knowledge and the potential importance of how the data would be collected. This

was also in conjunction with the sharing and telling of the negated experience from the women's perspective.

Thinking and employing reflexivity - deciding on an underpinning ontological belief for this study - have been influenced by several factors, most notably personal beliefs and values, clinical and professional experiences and career as a midwife, educator and researcher. It was also crucial to the study to ensure that there was a measured and inherent need to allow the women who took part in the study to be empowered and have ownership of their experience and story as it happened to them, in their world; in short, as their own truth of what happened.

The notion or idea that there is no one single, absolute reality or truth of experience has been debated and discussed since the birth of philosophy, and this plays a crucial part in how individuals view and understand the complexities of negated childbearing (Guba and Lincoln 1994, Smythe and Murray 2010 and Walsh 2010). Furthermore, this leads to the view that people as individuals create and develop reality, in which are embedded the many truths of experience (of negated childbearing) in the context in which they are created, and which researchers may be able to see and study (Mitchell and Radford 1996 and Ormston *et al* 2014).

Drawing from these underpinning values, which suggest that life experiences consist of multiple constructed realities and that these may be different for different people, is the underpinning nature of the ontology of relativism and is the philosophical cradle for this study (Berger and Luckman 1967, Byrne 2001 and Guba and Lincoln 1994). In relation to personal values and position, I believe that the reality of multiple social and life constructions can be seen through multiple, individual experiences across different career paths, as well as social, physical, religious and emotional constructs, which impact and emphasise how the world is seen.

Moreover, relativism leads engagement with the subjective stance that individual beliefs - which form part of a person's essence of self and identity - exist only in relation to the context of occurrence; so where the persona and their experiences sit in relation to negated childbearing and the potential to impact the truth as experienced. This importance of the influence of context and occurrence means that the expression of negated childbearing is open and subject to change, according to the individual women and their telling of their reality and also how the reality is collected, analysed and understood (Angen 2000, Clough and Nutbrown 2012 and Hammersely 2018). These influences are explored further in Chapters 5, 6 and 7 of this thesis.

Baghramen and Carter (2015) and Rachels (1998) discuss the practical application of realism to qualitative research and highlight the challenges that truths as expressed by individuals can be difficult to define and benefit from more creative and flexible thought and approaches. This study is not searching for the truth of negated childbearing, but seeking to gather stories and considers the wider narratives of the individual and personal truths of the women who have experienced negated childbearing.

Acknowledging that reality and personal experience is inherently dynamic, shifting and fluid and are influenced by a sense of self, life factors and bigger narratives, helps to make sense of negated childbearing through the lens of context, construction and the umbrella of relativism. Best (2008), Chase (2005) and Howell (2013) also draw out the realist importance of individual life as a changing construction in which realities can be altered at numerous points throughout experiences (such as negated childbearing) and the lifespan continuum. This leads to the consideration of how to appropriately understand negated childbearing through a constructionist epistemology.

3.3 Research Philosophy: Social Constructionism

The meanings applied to the umbrella term ‘social constructionism’ have long been debated but are generally thought to apply to philosophies and theories that highlight the socially created nature of human life (Best 2008, Brink *et al* 2006 and Gergen and Gergen 2003). Social constructionism is one of a range of interpretive approaches to research which uses the importance and location of the contextual environment in which experiences take place, as a key defining element (Angen 2000 and Francis *et al* 2016). Historically, the use of the ideas can be found in the work of prominent American sociologists and philosophers in the 1950s and 1960s, who described this socially created aspect of our lives as a community that we actively participate in (Best 2008, Gergen and Gergen 2003 and Howell 2013).

Moreover, communities, societies and populations are created by individuals through subjective experiences, which form a network of social constructions held together by individuals and groups (Ormston *et al* 2014 and Somers 1994). Berger and Luckman (1967) formalised the use of the term in the sociological world, as they presented a unique and modern approach to formalising the ideas of earlier works by prominent thinkers such as Emile Durkheim. One defining element of this approach (when applied to research) is the acknowledgement and exploration of the involvement and beliefs of the researcher with the participant. Howell (2013) and Hammersley (2018) discuss the importance of relationship

creation within a social environment and context, which can impact and influence the positionality of the researcher.

Thinking about the social construct of negated childbearing, it may be considered as a creation of individual and group experiences, which result in a social reality influenced by human values. Consideration should also be given to the relationship of the woman and the researcher within the event of negated childbearing and the context in which it occurs. These relationships form an inherent role in knowledge generation through research and should include personal values and beliefs which play a role in the social construction of childbearing (De Vries 1981).

The acknowledgement, incorporation and interaction of this element of social constructionism played a central role in the nature and development of this research study and its progression. This has enabled the personal development and understanding of the important concepts of subjectivity, reflexivity and multiple perspectives, giving a depth and breadth to the social construction of negated childbearing. Moreover, Carpenter (2018), Etherington (2004) and Finlay (2002) discuss the influence and impact of personal thoughts, values and beliefs as an essential contributor to the formation and construction of reality and being, in addition to the close links with the “relationship” aspect in the production of qualitative research design, through a social constructionist view.

The complexities of personal and shared experiences and relationships (through the childbearing continuum) consist of many linked and overlapping facets which form personal real-world construction. Through the framework of social constructionism, both myself as researcher, and the women who participated, are intricately involved together in the formation of negated childbearing, through shared knowledge and experience. This belief and process is fundamental to the creation of knowledge in this study and highlights the communal nature of the research methodology. In this way, individuals cannot be anything other than joint creators and constructors of the childbearing society.

Social constructionism, therefore, brings into focus the significance of relationships in this research process through researcher relationships with the women who participated, with those who critique and read the research, and with communities and societies. These relationships and innate subjectivity provide a focus for a greater emphasis on flexible methodologies, such as narrative, and act as foundation for highlighting the influence of personal values and beliefs. Finlay (2012), Frank (2010) and Koch and Harrington (1998) underline the importance of the enrichment of research through a social constructionism approach, which can improve our ability to consider many different perspectives.

In summary, relativism and social constructionism forms part of the interpretive approach to research and, in essence, puts the research firmly within a contextual environment (Francis *et al* 2016); where the subjective view and the involvement and beliefs of the researcher with the participant is not only acknowledged but seen as a central part of knowledge creation (Guba and Lincoln 1994). Taylor *et al* (2015) reinforce this view and conclude that what is real can never be captured in research as the knowledge is an ongoing process of creation between the researcher, participant and the study methodology. The relationships and positions of the research philosophies used in this study are further summarised in figure 6:

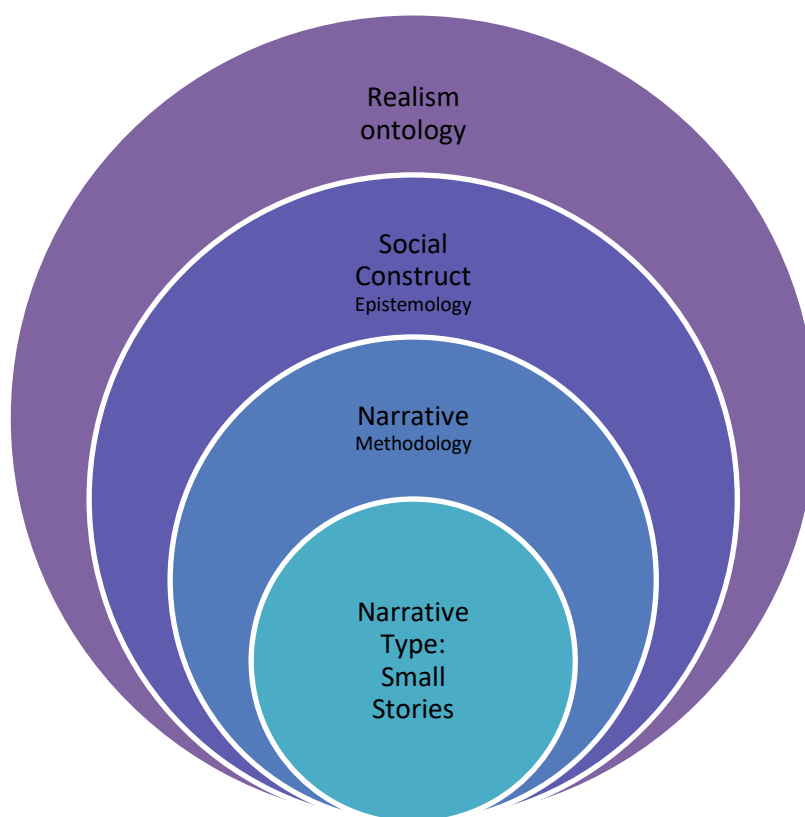


Figure 6: Relationships of Research Philosophy

3.4 Childbearing as a Social Construct

Discussing and understanding the philosophical foundations of social constructionism can help in developing and applying this knowledge to the childbearing continuum; that is, to consider the idea of childbearing as a potential social construct. Davis-Floyd (2001), Oakley (2016) and van Teijlingen (2004) are key authors who have critically discussed the competing paradigms and identified social constructs of childbearing. The three main viewpoints

identified are the technocratic, humanistic and holistic approaches to childbearing, and these in turn feed into the two main defined models of care: medical and social.

When critiquing the evidence of these different approaches, Oakley (1980), Devries (1981), Hern (1975) and Rothman (1977) all identify (in one way or another) the social reality and construct of pregnancy and birth as a key concept, confirming that early discussions pre-date several key texts. Although the physiological, biological, medical and other elements are also considered, childbearing as a social construct implies that the experiences cannot occur in a vacuum and should be considered as more than mere functional processes of the birthing body. However, Walsh (2010) and Shilling (2003) argue that although the approach of social constructionism is a useful one when considering theories applied to childbearing, that it misses the point around the important expression of the body (sociological concept of embodiment) and this has been discussed in detail in Chapter 2.

The view that modern childbearing can be located within a social construct is not new and Hunter and Symonds (1995), Devries (1981) and Graham and Oakley (1986) all discuss the importance and influence of relationships, context and personal value systems on building and maintaining the reproductive construct. The core elements of this construct are based on many aspects of individual and holistic care approaches, with shared values through woman focussed and family-centred ideals. However, the phenomenon of negated childbearing brings an interesting paradox; the acknowledgement that, whilst some elements of the social childbearing construct are shared and common to many women, other elements are not - and are reliant on individual perceptions, which are intertwined with social norms and context, shaping experiences and stories.

France *et al* (2011), Hern (1975) and Walsh (2010) discuss the role of the individual when adjusting to events which may change the social construct of childbirth and identify the potential impact of adjustment on the individual's sense of self and identity within the "new" social construct. Negated childbearing throughout the continuum necessitates the woman (and researcher) to adjust and re-adjust to new definitions of self as the event unfolds and impacts on the usual childbearing construct.

Expected behaviours and attitudes within the usual expected social construct are expected to be transferred to a negated childbearing event and to conform to suitable norms (expected from others). For example, accessing care, focussing on the baby and identifying signs and symptoms of pregnancy are seen as expected childbearing norms. For the purposes of this study, it is more useful to consider negated childbearing itself as an individual social construct, located within the broader socially constructed experiences of

the childbearing continuum. This individual social construct is then influenced and impacted by factors within the broader childbearing continuum, such as the degree to which childbearing is visible, controlled, scheduled and common to others (Hern 1975, Rothman 1977 and Walsh 2010).

Moreover, when considering pregnancy as part of the broader social construction, this potentially offers a framework within which the actions of the individual are interpreted by self and others, and then also society (Graham and Oakley 1986, Hern 1975 and Hunter and Symonds 1995). Pregnancy and childbearing are socially constructed, influenced and driven by the multiple contexts in which they sit (historical, geographical, cultural, religious/spiritual) and are considered normalised aspects of most modern societies, which follow the social norms and values of their time.

Sitting within this is the childbearing experiences of a woman who has lived through a negated event, which are influenced by her, her family and societal context and these contribute towards the social construct of negated childbearing. Whilst acknowledging that childbearing is a socially constructed experience, the context in which the building and construction happens play a pivotal role in defining the character, purpose and scope of the social construct.

Graham and Oakley (1986) and Hunter and Symonds (1995) have clearly outlined the important role that context plays and how it may influence the social construct of the childbearing continuum. The experiences that happen throughout childbearing are social events because they take place in, and are influenced by, social, cultural and other norms within communities and societies. Therefore, the context in which negated childbearing takes place influences its construction and interpretation - impacting research studies as societal values shift and change.

The dynamic nature of communities and societies leads to challenge when researchers seek to draw out meaning and analysis from the social structuring of negated childbearing (Devries 1981, Rosengren 1962 and Somers 1994). In summary, the approach of this study is that childbearing is not an objective state, but a socially constructed subjective and fluid experience which contains numerous smaller and embedded constructs that confront the social ideals and reality of childbirth (Devries 1981, Rothman 1977 and Walsh 2010). When considering an appropriate research approach for small social constructs of negated childbearing, a narrative (small story) methodology which could incorporate multiple and individual realities was chosen and this will be discussed next.

3.5 Qualitative Narrative Approach: Introduction, History and the “Narrative Turn”

The origins of narrative research are rooted in the literary, social and psychological sciences where the term was first used and it has been used as a qualitative theory and research tool since the 1960s, through to the 1970s and early 1980s when Elliot Mishler discussed and made the case for the importance of the narrative interview (Clandinin and Murphy 2007, Mishler 1986). However, Squire, Andrews and Tamboukou (2013) discuss and describe the historical roots of narrative as more complex and derived from two concurrent pathways, which influenced the development of modern narrative research.

The first is considered a post positivist humanist approach, which puts the focus on the individual person and their individual experience as a whole and includes examples from case studies and individual life histories (Hyvarinin 2016, Polkinghorne 1988 and Riessman 2008). The second derives from a post-structural influence with a strong psychological foundation and was interested in the dynamic nature of narrative alongside the discovery of meanings and the importance of relationships in the creation of the narrative (Hyden 2013, Smythe and Murray 2010 and Somers 1994).

Although the two pathways seem to be different, Brockmeier and Meretoia (2014) and Bold (2012) discuss the overlap and argue that the majority of those working in narrative research are influenced by both pathways, possessing elements of both within their work. Squire, Andrews and Tamboukou (2013) emphasise this as key to the foundation of modern narrative, citing examples of this overlap in the works of Holloway and Jefferson (2000), and this can also be seen in illness narratives work by Bury (2001).

The intersections between the two narrative pathways have been used to investigate narrative through the lens of power structures and relationships and the potential impact this has on the sense of self and experiences of those in relation to community and society. This can be demonstrated through the work of Hyden and Brockmeier (2011), Hunt and Symonds (1995) and Mitchell and Radford (1996).

These pathways have been described in popular narrative literature and have been collectively thought of as the “narrative turn” - the influences, ideologies and events which together brought about the movement towards a distinct and modern narrative discourse and research philosophy (Bold 2012, Elliot 2015 and Moen 2006). However, academics such as Hyvarinen (2010), Mackenzie and Knipe (2006) and Smythe and Murray (2010) consider this to be an over-simplification of the timeline and composition of narrative and that a

more comprehensive understanding can be shown through successive waves of impact across different disciplines.

Hitherto, this seemingly innate complexity of narrative highlights the broad range of influences and applications in current qualitative research and the flexible dynamic which allows an often unique but challenging approach to describe and understand. Brockmeier and Meretoia (2014), Bold (2012) and Byrne (2001) also highlight the potential for intersections with alternative qualitative approaches, particularly phenomenology, feminist and ethnography.

Whilst there are shared aspects between narrative and alternative qualitative approaches, stories and narrated experiences focus on elements of (or the whole of a story) as told by the person (Andrews *et al* 2013, Bold 2012, Chase 2005 and Clandinin and Connelley 2000). Furthermore, as identified by Frank (2010), Geogakopolou (2006), Rappaport (1995) and Tuval-Mashiach (2014), it is the emphasis on the core element of the authentic voice and subjectivity of narrative which create assurance and strength in the research findings of narrative studies.

Making sense and meanings from the social construct of negated childbearing, highlights the importance of personal and individual stories, rather than the focus being on theory as the underpinning driver - as is the case with alternative approaches (Clandinin and Murphy 2007, Elliot 2005, Janesick 2000 and Mackenzie and Kipe 2006). It is these core narrative elements of the authentic voice, the importance of the individual experience, and making meaning from these, that encompass the rationale for the choice of narrative over other qualitative approaches.

The capability for potential and actual multiple influences when using a narrative approach can sometimes make it difficult for the researcher and reader to define and critically explain the boundaries of narrative studies when these are, by their very nature, blurred and interchangeable. The ideologies and methodological approach of narrative not only offer challenges as discussed, but also offer different and innovative opportunities for exploring, narrating and presenting research in the childbearing continuum and it is this which is discussed in the next section.

3.6 The Narrative Journey and Rationale

An early exploration of ideologies and theories is a useful way to help identify the potential philosophical framework for the research proposal, incorporating researcher values and guiding an appropriate choice of methodology/analysis in relation to the subject being

studied (Angen 2000, Brink *et al* 2006 and Byrne 2001). Through critical thought, reading and discussion, an initial philosophical framework was developed (see figure 7 below), which formed the basis for the study and shows part of the journey to using narrative, using a simplistic nested form of research relationships:

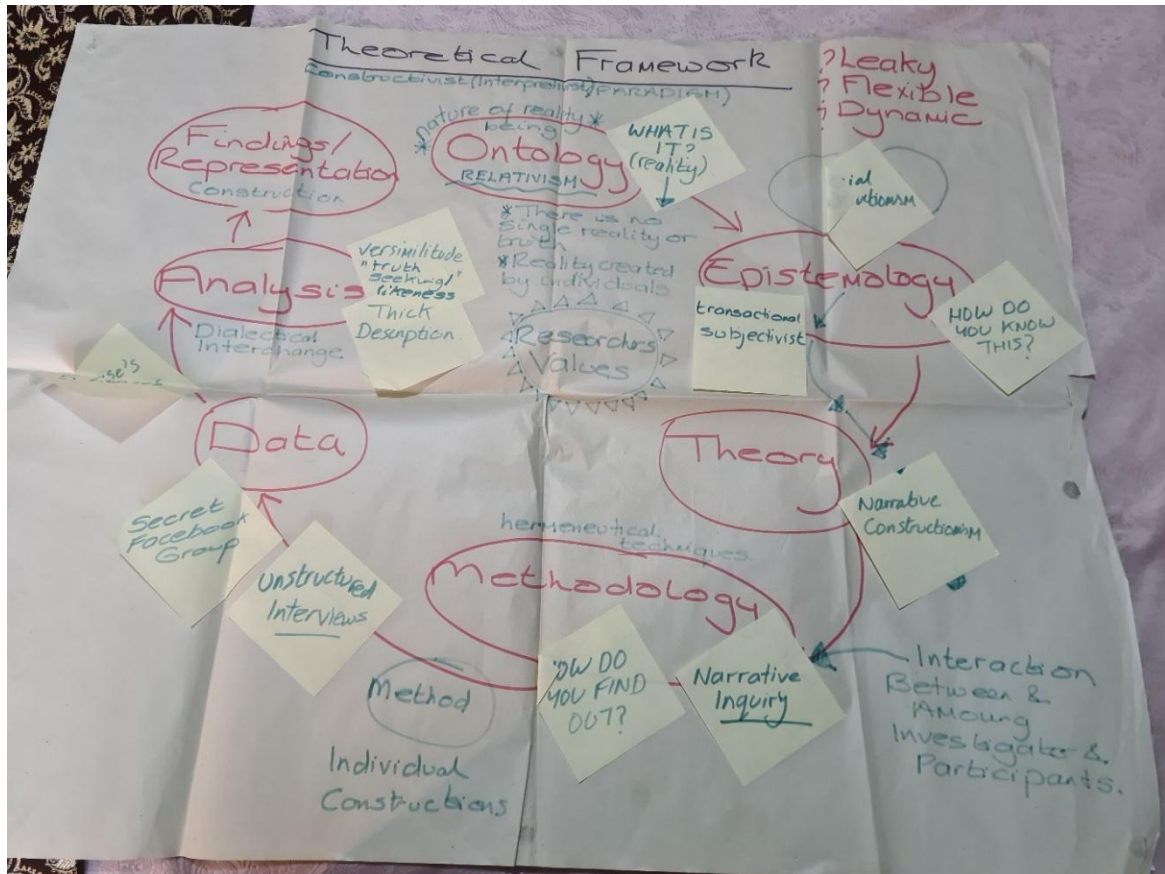


Figure 7: Flipchart diagram of initial exploration of the theoretical framework

The first section of the journey from realism through to social constructionism has already been touched on in the earlier discussion and this was set from the beginning of the study. However, the next part of deciding on a qualitative approach which would encompass the research process was more challenging. The challenges were mainly around the overlap with alternative methodologies; for example, my consideration of if a more feminist approach could/should be used and would be suitable, given the subject being researched.

Chase (2003), Frank (2010), Holloway and Freshwater (2007) and Howell (2013) highlight and discuss the need for identifying the alignment and relevance of narrative to the specific subject being studied. As the underpinning philosophy of narrative research is one of a moral and ethical world view which belongs to everyone, this seemed to fit with narrative approaches taken by other researchers when studying vulnerable groups or sensitive

subjects (Clandinin and Connelly 2000, Dickson-Swift *et al* 2007, Hyden 2013 and Liamputtong 2007). As negated childbearing could be considered as both a vulnerable group and a sensitive subject, narrative seemed to be a potentially good fit and these aspects will be further explored later.

Narrative research has been used to a greater degree in nursing (since around 2000) but seems to still be in its infancy in midwifery and, even now, it is a changing and developing field of qualitative research across many different aspects of healthcare (Holloway and Freshwater 2007, Schneider *et al* 2016 and Thomson *et al* 2011). The move away from a narrow, medicalised paradigm to a broad humanistic paradigm fits perfectly with current drivers in midwifery (Midwifery 2020), which echo the move to emphasise the importance of service user's experiences and stories, in the shaping and development of maternity services and the midwifery profession. This is also echoed and highlighted in recent investigations into standards of maternity care, most recently Okenden and East Kent (Okenden 2022, Kirkup 2022).

A further consideration when choosing narrative was the need to put the participant and their experience at the centre of the research as, following the literature review, this aspect was lacking from the evidence base currently available. Rappaport (1995), Ross (2017), Moen (2006) and Andrews *et al* (2013) highlight a more emic approach as a key element of narrative research and recognise the challenges of etic based qualitative research, which impose (rather than share) the research framework.

The participant takes ownership of their experience, and shares this with the researcher, and this ownership of the narrative continues through the research process. Moreover, using the participant lens as the focus of this research study through narrative, is more appropriate for the negated childbearing continuum and the potential for sensitive and difficult recruitment, data collection and analysis (Bold 2012, Chase 2003 and Frank 2010).

The challenges of researching sensitive subjects with vulnerable individuals or groups is well documented and there are a range of qualitative research approaches which have been used, including phenomenology, action research and historical research (Brink *et al* 2006, Byrne 2001 and Davis-Floyd 2001). However, there is evidence which particularly supports the use of narrative in this aspect of research and authors such as Holloway and Freshwater (2016), Dickson-Swift *et al* (2007) and Liamputtong (2007) discuss the suitability and benefits for both participant, researcher and reader.

One important element of narrative research is the fundamental ability to facilitate experience and storytelling from an individual perspective, which is accepted as the real

and valid personal “truth” (Hunter 2010, Smythe and Murray 2010 and Somers 1994). Furthermore, narrative researchers see the participant as the central and important locus of control, rather than this being the researcher’s standpoint. Brockmeier and Meretoia (2014), Bold (2012) and Chase (2005) discuss and explain the links with power/empowerment of the participant - as they have choice and control over what is said/not said (narrated and non-narrated) and have a greater part to play in decision making of sharing their stories.

Another key defining element of narrative is the importance of meaning, how this is made, described and shared by the participant and the impact of relationships on making meaning (Clandinin and Connelly 2000, Hyden 2013 and Polkinghorne 1988). Although the researcher seeks to describe the meaning of the story (as it is told) to validate the importance of the whole - without selection - Rosenthal (1993), Smythe and Murray (2010) and Squire *et al* (2013) question the practicality of this purist view and advocate for a constructive methodology, which can adapt to the changes in meanings as they occur.

Revealing meanings in narrative research and analysis is a good fit for the subject of negation in childbearing, as it reflects the need to uncover voices and stories of women and start a research dialogue which will enable meaning making and sense making of the picture being presented. Set within a social context and environment of the participant, narrative allows the experience to be understood in the way that it happened, through the eyes and mind of those who have experienced negation through the continuum and social construct of childbearing.

3.7 Definitions and Identity

Defining what narrative research is, is difficult as many authors agree that there is no structured, formal and universally agreed definition. This reflects the complex and comprehensive background to narrative as discussed earlier (Chase 2005, Elliot 2005, Hyvarinin 2016 and Reissman 2008). This is further emphasised in work by Mackenzie and Knipe (2006), Moen (2006) and Somers (1994), who acknowledge and examine the variety of meanings, methods, approaches and disciplines which use a form of narrative in the research process, as part of or throughout, a study. However, for the purposes of this study, it is appropriate to review definitions to provide some structure and boundaries for the narratives of negated childbearing.

Squire *et al* (2014), Byrne (2001), Chase (2003) and Clandinin and Connelly (2000), discuss the broader application and location of the term ‘narrative’ in daily life, emphasising the

range of use and differences in meaning, according to the context in which the term is used. There are numerous ideas and fields of thought proposed, when discussing how to define narrative research, but most of these can be considered in one of two main approaches.

The first approach takes a simple, general approach that narrative research is about collecting stories that humans use to describe their experiences (Bold 2012, Overcash 2003 and Clough and Nutbrown 2012). This can be either studying research materials which are, or contain, narratives so they already exist and/or the narrative is identified or produced as a part of the research process (Squire *et al* 2014).

The second approach takes a more comprehensive view that, to be considered as narrative research, key elements should be present which communicate the meaning/s of the narrative (Chase 2003, Clandinin and Murphy 2007, Hunter 2012 and Reissman 2008). Somers (1994), Smythe and Murray (2010), Rosenthal (1993) and Riessman (2008), examine the need for interchange between key elements as narratives progress and develop and that specific, rather than just general, meanings are produced.

These specific meanings can be individual or shared and are set in the context and construct of society, highlighting those relevant to negated childbearing. This specificity of meanings is important, as it highlights the personal and individual importance which underpins the human and relationships elements (of negated childbearing) as narratives understood in context and it is this which gives narrative research an identity, distinct from other qualitative approaches. It is this approach which has been applied to the study of negated childbearing.

The in-depth nature of this second approach lends itself to the premise that narrative is not simply storytelling, but a research process in which the notion of “stories” (as a part of narrative) may be included (Brockmeier and Meretoia 2014, Bury 2001, and Clandinin and Connelly 2000). In this thesis, the overall narrative approach has been critically analysed throughout much of the research process, but consideration is also given to the small stories of negated childbearing.

The nature of narrative research facilitates a more dynamic research process, which has allowed the stories of negation to unfold, as different elements come into play and are themselves influenced by relationships. Narrative research is deeply subjective, personal and is part of the experience being studied, in the context in which it occurs, and the importance of context will be discussed briefly in the next section.

3.8 The Importance of Context

There is a broad agreement amongst prominent narrative researchers and writers that context and the understanding of this is a key concept in narrative research (Andrews *et al* 2013, Chase 2003, Clandinin and Connelly 2000, Hunter 2010, Hyvarinin 2016, Polkinghorne 1988 and Riessman 2008). However, there is a great deal of discussion and deliberation within the narrative research community as to how context should be defined and used, particularly when analysing narratives, so it is important that a broad approach to narrative context in this study is outlined here. De Vries (1981) provides an initial useful and simple approach to thinking about context in narrative research, in that the term implies both immediate social location and the larger historical setting (linking to small stories and large narratives ethos).

Critically though, this approach to context within narrative is viewed as far too simplistic and may not be suitable for the complexities of narrative research and for the complex subject matter of negated childbearing (Overcash 2003, Smythe and Murray 2010, Squire *et al* 2014 and Tuval-Mashiach 2014). For the purposes of this study, I used a modified approach (see the three steps below), outlined by Tuval-Mashiach (2014), which identifies three main spheres of contexts for consideration:

1. Importance and strength of the relationships between participant and researcher, where small stories or narratives are produced;
2. Negated childbearing acts as the collective social field, where life and small stories evolve, including environment and community;
3. The consideration of big narratives, which may include broader cultural and social influences that contribute to stories and narratives through meaning making and sense giving.

This context approach highlights the multiple and potential complexity of context in narrative research and defines the different contexts at play within this study and negated childbearing. This leads us to consider these spheres of context in further detail, starting with a brief discussion of the commonly used terms big narratives and small stories.

3.9 Contemporary Narrative Research:

a) Master narratives, small stories and storytelling

The definition, identification and application of ‘master narratives’ within narrative research, is central to the understanding and use of the terminology of narrative and story

and different narrative approaches use these terms in many ways. Clandinin and Connelly (2000), Squire *et al* (2013), Rosenthal (1993) and Riessman (2008) provide useful discussion and identify master narratives as those broader themes which help us make sense of our individual experiences of life, impacting and shaping the small stories which are constructed. These 'Master' narratives are often how accepted 'norms' form part of the community and society, providing a framework for guidance.

Some narrative researchers recognise that master narratives may not form discrete categories, which are easily identified from each other, but are often interlinked and permeate into small stories where their influence can be discovered and analysed (Brockmeier and Meretoia 2014, Bury 2001, Squire *et al* 2013). Critically, Frank (2010), Hammersley (2018) and Hunter (2010) have further explored this and highlight the importance of master narratives in shaping the ability of stories to impact life and vice versa, but they also point to the strength of small stories within narrative research.

Small stories and storytelling, as understood within narrative research, have their roots in a seminal exploration of what constitutes a story by Labov and Waletzky (1997). This study focussed on structural elements and how events are sequenced (this will be further discussed in a later section). However, this has been identified by several narrative researchers as too simplistic, although it does provide a useful initial point to think about the 'capability' of stories and how stories and story-telling works (Frank 2010, Patterson 2013 and Tuval-Mashiach 2014).

The evolution of the concept of small stories in the narrative approach is a relatively recent concept, linked to ideas of self-identity and the telling and creation of stories (Frank 2010, Georgakopoulou 2015 and Hyden 2013). Bamberg (2006) and Georgakopoulou (2006), amongst others, discuss small stories as a methodological approach and a potential new turn which enhances narrative research. When small stories are used in this way as a methodological approach, they use the story as a vehicle for discovery and exploration of the narrator's experience and how they express or tell it.

Within this PhD, the methods, data collection and analysis use the 'small story' ethos and I applied this approach for the study of negated childbearing. The approach is centred mainly on the more recent development of the concept (Bamberg 2006, Frank 2010, Georgakopoulou 2015 and Hyden 2013), although I also considered the structure as an important story element (Labov and Waletzky 1997, Patterson 2013 and Tuval-Mashiach 2014). The small story approach is both valuable and beneficial for negated childbearing,

as it can highlight the importance of human conversation and communications in generating new data.

b) Construction and co-construction

Following on from these small stories discussion, Brockmeier and Meretoia 2014, Finlay 2012 and Hyden 2013) highlight the key areas in small stories which facilitate creation, construction (and co-construction), and reconstruction of storytelling, which are the validation of feelings, learning through emotion and meaning making. This enables small stories to acknowledge hidden or new emotions and gives importance to self-realisation and catharsis during the telling, which is also applicable to the women in this study.

During a narrative approach, findings or knowledge are created and constructed as a study proceeds. Andrews *et al* (2013), Clandinin and Connelly (2000), Elliot (2005 and Page (2015) identify that narrative findings emerge through dialogue between story tellers, which can be participant/s and researcher, researcher and participant/s, between participants and between researchers. The dialogue in this study of face-to-face interviews and social media allows for stories to emerge and meaning and interpretations to be conveyed and negotiated among the story telling community identified (negated childbearing). This process, with an emphasis on the small stories of negated childbearing and their place in social constructs, contributes to a more informed and holistic understanding of the phenomena.

However, the extent to which this constitutes 'co-construction' within this negated childbearing study can be critically debated. Frank 2010, Georgakopoulou, (2015), Page 2015 and Shuman (2015) argue that any method within the narrative approach, which ensures an adequate dialogue, can enable co-construction of data and research in stories, in its simplest sense. Moreover, the complexity and relationships between those involved in negated childbearing, as participants and researchers, supports collaborative constructions and allows a meaningful small story reality. Some researchers in the narrative field discuss that this ethos is too broad and that for research to be identified as co-construction, there needs to be a defined and identified input into a story or narrative (Richards 1989, Rosenthal 1993, Ross 2017 and Somers 1994).

One potential example from this study to highlight this debate is the construction of poetry (see Chapters 6 and 7), where the poems were constructed by the researcher using verbatim words and sequence from the women. The question still remains; if this is co-construction or a constructed small story as told to me as researcher? There is no doubt though,

regarding the importance, influence and position of the researcher in this narrative study and this will be discussed next.

c) Reflexivity and researcher positioning

A crucial element of this study is the use and application of reflexivity and which Etherington (2004) neatly describes as how we use our 'self' in the research that we do. The concept of reflexivity is not new and has been used by some branches of qualitative research to varying degrees and in many ways and it is also a core part of narrative research (Andrews *et al* 2013, Brink *et al* 2006 and Byrne 2001).

There are many definitions of what reflexivity is and they vary according to the type of research being carried out. Dowling (2006) and Maulterud (2001) focus on the analytical and systematic consideration of the effect of the researcher at all stages of the research process. This is mirrored in Bowling's (2014) work, which uses the allegory of Plato's cave, where the researcher evaluates their perception of situations critically, aiming to achieve reflective understanding. Awareness and articulation of the choices and interpretations the researcher makes during the inquiry process and evidence of taking responsibility for those choices are also noted as significant and influential (Angen 2000).

However, others such as Gentles *et al* (2014), Etherington (2004) and Finefter-Rosenbluh (2017) take a more general approach, where reflexivity is achieved through the acknowledgement and exploration of the researcher's influence, with the inclusion of positionality and the potential for the researcher to be changed because of conducting the research. It is this second approach and definition which has been used as the basis for this study.

Within an interpretivist and narrative ethos, the researcher's values, morals, beliefs and feelings are inherent in all stages of the research process and cannot be separated out. Furthermore, this close relationship and connection between researcher and research, allows knowledge creation and exchange through dialogue and other means. In this study reflexivity is a thread which forms a part of the whole research process and is demonstrated through various ways including personal perspectives and discussions on research choices and decisions made, keeping a researcher diary, creative method use (poetry) and reflexive points included in this thesis. This multi-faceted reflexivity is highlighted by Olmos-Vega (2022) as a crucial process in qualitative research.

Moreover, Koch and Harrington (1998), Olmos-Vega (2022) and Tuval-Mashiach (2014) discuss the importance of reflexivity in relation to personal, interpersonal, methodological and contextual challenges and themes within the research. This layering of reflexive relationships is important when considering how personal beliefs and subjectivity may have influenced this study and the part this has played in shaping the research journey and process, I have been through. Interpersonal reflexivity relates to relationships as part of the research process and to the position of the researcher. This also acknowledges that researcher positionality changes throughout the research process, in relation to context and with the different lenses that we value and experience.

Etherington (2004), Finlay (2012), Gergen and Gergen (1991) and Mitchell and Radford (1996) identify the foundations of researcher positionality through the seeking out, formation, development and maintenance of relationships within and throughout the research process. They also acknowledge the impact of factors such as social environment, context and life experience of the researcher and those involved in the research, as important when identifying and defining researcher positionality.

Relationship creation as an essential element of reflexivity, which influences the research, and the researcher is acknowledged as a core element of this study. To illustrate my positionality and highlight some of the main relationships and influences which have shaped my position as a researcher in negated childbearing, I have formulated the diagram (figure 8 overleaf):

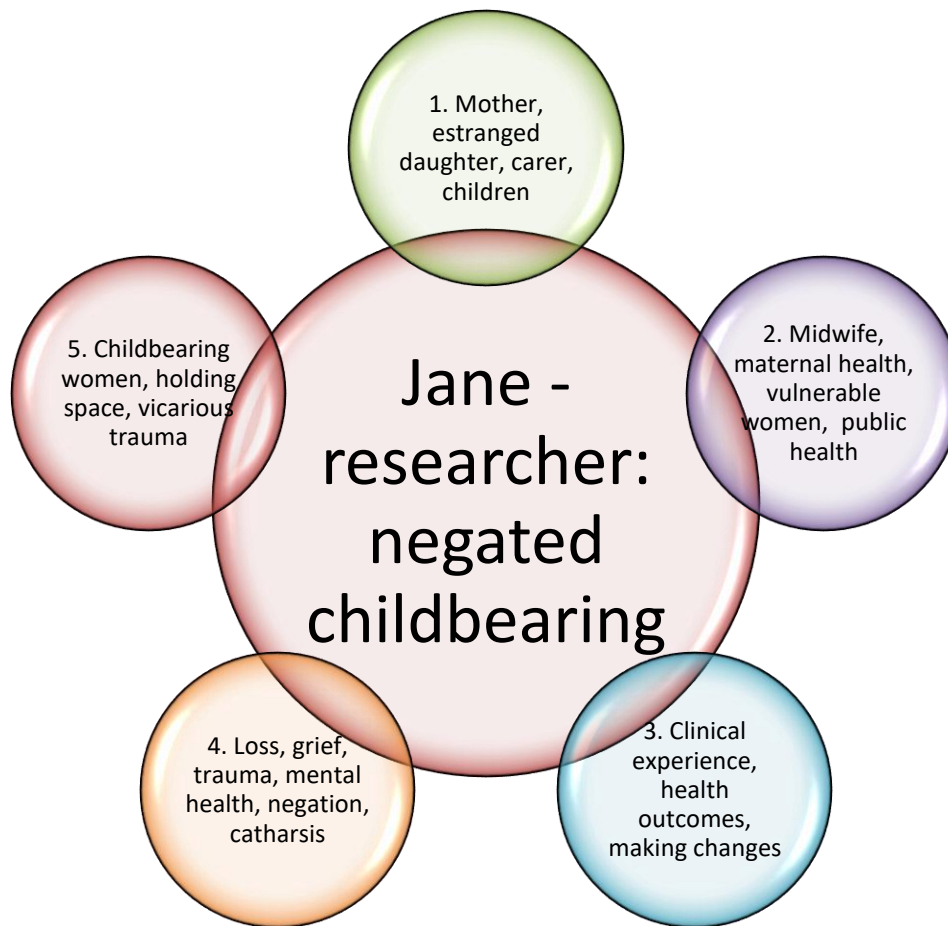


Figure 8: Researcher Positionality and Negated Childbearing

The first area covers my personal and family relationships, and these come with the acknowledgement that they have influenced my values and behaviours and how I think and feel about others in my life. My role as a mother, as estranged from my own mother, my close relationship with my daughter and my son influences how I see things and this also impacts how I feel about this study and the women who shared their stories with me, who have their own challenges with motherhood. The importance of relationships between mother and child (the dyad) is well documented and researched (Davis-Floyd 2001, France *et al* 2011, Graham and Oakley 1986), and I have reflected on this aspect of the study throughout.

The second and third areas relate to my career as a midwife and those influences and interests which have shaped the paths I have taken. These include clinical, education, research and areas of specialist interest. Since training as a student midwife, I have always had a passion for working with vulnerable and hard to reach groups of women and families and this links very closely with my interest in public health (poverty, health inequalities, social determinants of health). My experience of working clinically with these groups and

with women and families who have had a negated childbearing experience, has driven my enthusiasm and provided a lens through which I have used my professional skills and knowledge to inform both the research process and the data collection.

Emotions of loss, grief and trauma are identified in the fourth area and refer to my feelings and those of the women who participated. There was, and is, a huge amount of emotional work which needs to be acknowledged as part of the process of doing a part-time PhD and my own life events (mental health issues, Covid-19, family health, job challenges, being a carer and bereavement) and the sensitive and challenging area of research have impacted how I look at things and changed some of my values and beliefs.

Clandinin and Connelly (2000) refer to this process in narrative as ‘how we become storied as researchers’ (p177) and that during narrative research it often becomes clear that we have our own stories to tell. This is not unlike the women who took part in the study who shared their emotions and personal and family challenges and who also identify with loss, grief, trauma and mental health.

The last area is how I consider myself to be a child-bearing woman, to empathise with their thoughts and feelings and to be able to hold space for them to be able to share, construct and tell their stories of negated childbearing. Although all the women who participated highlighted that this story telling and sharing was beneficial for them, there is an element of vicarious trauma for me as the researcher, repeatedly immersed in sensitive, difficult and challenging data. However, this shared position does help with the narrative research process and with making voices and stories heard - and this will be explored next.

3.10 Health/Social Narrative Research:

a) Exploring quiet phenomena

When the narrative approach is used in health and social/care research, it is often with the intention of studying and exploring subjects which are ‘quiet’ - those which either explore hidden or hard to reach phenomena and/or which remain largely unresearched (Dickson-Swift *et al* 2007, France *et al* 2011, Frank 2010 and Hyden 2013). Furthermore, quiet in the context of narratives can mean phenomena which are hidden, silent/silenced, unspoken, covered, small, unconscious/neglected and contributing to layers of different meaning. It is about making the invisibility of negated childbearing visible - through the narrative process, the data produced, the analysis and how the findings are shared.

Using this narrative research to create a place where the quiet phenomena of negated childbearing can be storied, shared and spoken about, allowed me to consider and understand how or why they have been silenced. Frank (2010), Overcash (2003), Rappaport (1995) and Ross (2017) identify the importance of narrative in facilitating stories not yet told, drawing links with endurance, suffering and trauma which may be excluded or seldom heard.

However, the silence of quiet phenomena can also be seen through other lenses - most notably being a place of personal safety and healing - and used as a protective mechanism in relation to health (Liamputtong 2007, Smythe and Murray 2010, Somers 1994, Tuval-Mashiach 2014 and Walsh 2010). This is further explored in narrative studies where quiet phenomena and silence are explored and the research process forms part of the recognition and recovery of participants (France 2011, Nduna and Sikweyiya 2015, Smith 2015).

Furthermore, the actual process of sharing, telling and creating/co-creating the stories as part of the narrative approach can provide a cathartic sense of release and well-being, especially where the phenomena is difficult and potentially traumatic (da Cunha and Orlikowski 2008, Hovey 2018, Kearney 2007). The potential and actual benefits of storytelling and the links with catharsis are nothing new and have been identified and discussed across disciplines and for many years including in literature, philosophy (particularly the Aristotelean period) and health.

Positive outcomes from difficult and challenging stories and narratives can either be built in consciously as part of the research process and guided by the researcher (sometimes as formal therapy), or they can arise spontaneously as stories are told - as was the case in this study. Research links with psychotherapy show that catharsis and narrative form a naturally embedded part of talking processes and models, which help to understand how creating and sharing stories contributes to therapeutic outcomes (Marx *et al* 2017). Andrews *et al* (2013), Bold (2012), Chase (2003), Ebbs (1996), Hammersley (2018) and Holloway and Freshwater (2007) highlight the importance of catharsis and the resulting need for ethical and responsible research processes which can sensitively deal with storytelling.

b) Valuing and legitimising the narrative voice

Negated childbearing in this research process highlights the phenomena as under-explored and about which very little is understood or known, but it also seeks to give value to, and legitimises, the narrative voice of those women who have experienced it. One problem

which faces people who have been through challenging and traumatic experiences is how they can tell their stories, so they become valued, have meaning and are listened to and accepted in a safe way (Nduna 2015, Rappaport 1995, Ross 2017, Smythe and Murray 2010, Somers 1994 and Squire *et al* 2013).

Framing the value aspect of the voices of negated childbearing had to bring with it a set of assumptions, most importantly those of authenticity, ownership, belief and co-construction. Being believed and authenticity in negated childbearing were embedded values from the start of the research process, that as the researcher I could empower the women to own their stories and that by telling their stories to me and other women, this would give unparalleled access to their lived experience.

Brockmeier and Meretoia (2014), Clandinin and Connelly (2000), Frank (2010), Hammersley (2018) and Holloway and Jeffeson (2000) support this view of inherent values in the narrative approach. In simple terms, for this study, this means accepting that the women who participated, shaped and created their own stories of negated childbearing and added considerable value as a life experience lived and remembered. The stories rely on the memories that women have of their negated childbearing, how they personally experienced it and how they told their stories in the research process. This had the impact of legitimising and validating the story as told, through the premise of the inherent values of belief from the start.

However, there are some who argue for a more critical approach towards storytelling values, highlighting the need to accept issues including favouring the storyteller, the fractional nature of personal stories, memory and recall, and social bias in research interaction (Atkinson 2009, Goldie 2004, Gwyn 2000 and Riessman 2008). Conversely, there is potential for over-simplification of the narrative voice, as identified by Hunter (2010), Hyden and Brockmeier (2011), Moen (2006) and Shuman (2015), if we accept that stories and narratives are co-constructed.

Storytelling, creation and performance relies on those who narrate, those who listen, and those who produce. There is the need to accept that I am as much a part of creating the negated childbearing stories as the women who told them, so the narrative voice does not stand alone, but rather is a part of a joint enterprise. Criticality, reflexivity and researcher positioning are therefore of crucial importance in strengthening this narrative study.

3.11 Summary

The methodology of this study as outlined in this chapter, details the importance of social construction, in understanding the narrative meanings of negation in the childbearing continuum. Generation of meaning and the recognition of the impact of personal values on the study is a key concept in narrative research, which is acknowledged in the shaping of the research process and the data generated. As a researcher, I must understand the socially constructed nature of the world and realise that values and interest become part of the research process. Complete objectivity and neutrality cannot be achieved and, indeed, is not the purpose of this approach.

Narrative has its roots in philosophy and the human and social sciences. The methodology centres on the way in which human beings make sense of their subjective reality and attach meaning to it. This has led me as a researcher to approach people, not as individual entities who live their life in a vacuum but explore individual worlds of negated childbearing within the whole life context across the continuum. This way allows me to make sense of the small stories told and to understand the contextual elements of negated childbearing that form part of overarching narratives, as discussed in Chapter 2.

It is through narrative and stories that many women and families share their childbearing experience with others. Narrative methodology is therefore central to increasing knowledge and building understanding of negation in a comprehensive holistic way. It will give the small body of research depth and sensitivity directly from the participant, owned and validated by the participant, which is currently not explored within the literature.

CHAPTER 4

METHODS

4.1 Introduction: Narrative Research Methods

This chapter will focus on the key elements of the ethics, methods and data collection aspects of the study and will include the rationale and evidence to support my critical decision making and thoughts processes in relation to these. In the evidence base for negated childbearing, the narrative approach had not been employed, and although interviews had been utilised, the technique used in this study had not, and social media was not utilised. The combination of using the narrative methodology, in conjunction with the interview technique and social media to gather the data was a new approach, which would add novelty and consistency to the evidence base.

Therefore, a narrative approach continues to form the underpinning framework for the overall methodological support and guidance, particularly in relation to ethics and the methods and tools selected for data collection and the way in which I chose to use the methods in a narrative framework. A small story ethos was utilised and is elaborated on in Chapter 3 (Bamberg 2006, Beal 2013, Bleakley 2005 and Georgakopolou 2006, 2015). The rationale for the choice of methods, also highlighted in chapter three, is based upon the small story ethos, and the need for flexible, dynamic and participant led story-telling and meaning making (Clandinin and Connelly 2000, Feldman 2004, Frank 2010 and Georgakopolou 2015).

The study design consists of defined strategies for recruitment and sampling, and data collection in two phases, firstly with individual participant unstructured in-depth interviews (using the single question technique), where personal negated childbearing stories are told. Secondly, through utilisation of online research methods, specifically a secret Facebook group, in which all participants join (likened to a virtual focus group), share their stories and make shared negated childbearing conversations. Narrative approaches including situational lenses (Finlay 2012 and Chase 2005), dimensions content (Lieblich *et al* 1998) and Crossley's narrative analysis (Crossley 2000a), have been utilised to provide depth across the methods research processes.

4.2 Ethics: Considerations and Approval

The understanding, consideration and use of basic ethical principles is thought to provide the essential foundation of the research process, regardless of the methodology and methods used. The central tenet of non-maleficence (do no harm) has long been seen as a core pillar of research; however, this is considered by some to be an oversimplification of what can prove to be a complex issue (Borbasi *et al* 2019, Clark and Sharf 2007, Ebbs 1996).

Hammersley and Traianou (2012) Carpenter (2018) and Hofman (2004) take a further step when looking at the concept of non-maleficence and discuss the need to be pragmatic about minimising risk and harm throughout the research process, with an understanding that risk cannot be eliminated completely, but should be identified, understood and mitigation put in place. However, Iphofen and Tolich (2018), and Israel (2015) also identify that not all potential risk or harm can be identified prior to a study, and the ability of the researcher to be flexible and adapt is key in acting upon new and emerging potential risks as a study progresses.

This is especially true of certain methodologies such as ethnography and narrative research, where research of sensitive subjects often sits and where the potential for risk is greater (Josselson 2007, Smythe and Murray 2010). Furthermore, the sensitive and potentially challenging topic of negated childbearing, highlighted the need to consider a range of potential issues and risks throughout the research process, on a moral, ethical and practical level, and these will be discussed next.

4.3 Ethical Considerations

A primary ethical consideration and one which encompasses several others is to ensure that the safety and well-being of the participant is considered, throughout the whole research process. Williamson (2007) discusses several approaches that the researcher may take with regards to the individual participant, according to methodology, but advocates for a general rights-based framework which can provide clear guidance on what researchers should consider.

For the purposes of this study, I undertook an online ethics training module at LJMU, which provided me with a good basis from which to start. The essentials of good ethical practice have been outlined by several researchers and include an understanding of the history and development of ethical practice in research and knowledge of general principles (Bowling

1997, Carpenter 2018, Hesse-Biber and Leavey 2011 and Yin 2016). The broader approach and application to general principles, as applicable to this study and data collection method, will be discussed next.

The inherent potentially sensitive nature of negated childbearing meant that I would be researching an area which could be considered high risk, and which may mean engaging with vulnerable participants and discussing emotive and distressing experiences. This is at the forefront of work by Liamputtong (2007), who discusses many of the issues associated with such research, including the difficulties of defining who is 'vulnerable'.

Clark and Sharf (2007), Corbin and Morse (2003) and Williamson (2007) highlight the importance of application of potential vulnerability to the subject being studied and participant inclusion. In this study, participant vulnerability may mean or include the following considerations: experience of potential or actual harm, risk of poorer health outcomes, subject to stigma/discrimination, are hard to reach, are a hidden population, may be socially vulnerable, and may be less likely or able to participate in research (Hyden 2013, Liamputtong 2007 and Scheff 1997).

Liamputtong (2007) further links the notion of potentially vulnerable participants with the concept of carrying out "sensitive research". The identification of such research is defined as phenomena which is/may be considered private, emotional and be part of a social context which may be challenging (Dickson-Swift *et al* 2007 and McKosker *et al* 2001). Qualitative research provides a foundation and strong basis for sensitive research, as advocated by Liamputtong (2007), Williamson (2007) and Yin (2016) and, furthermore, a narrative methodological approach serves as a postmodern framework for application of general research principles (Chase 2005, Clandinin and Connelly 2000, Hyden 2013 and Josselson 2007).

Returning to the rights-based approach which Williamson (2007) discusses, the principle of the right to be informed will be considered first. Borbasi *et al* (2019), Gray *et al* (2017) and Hammersley (2018) highlight the nuances and importance of information about the research study and how this is given to the participant.

For the purposes of this study, I used a multi-faceted approach - information was given to participants in a variety of formats, in different contexts and covering different aspects of the study. This was to ensure that participants had access to clear, transparent and succinct information, which met national and local ethical requirements, and was accessible and reflected the research study (Hofman 2004, Iphofen and Tolich 2018).

Table 5 outlines how the right to be informed was managed within this study:

	Format	Context	Study Aspect
Research Poster (Appendix 2)	Hard Copy Electronic Copy	NHS Trusts Social Media	Interviews and Facebook group combined
Participant Information sheet (Appendix 3)	Hard Copy Electronic Copy	NHS Trusts Individual contact	Interviews x 1 Facebook Group x 1
Informal Discussions	E-mail Social Media Verbal	Individual contact	Interviews and Facebook group combined
Participant Contact and Support Organisations Sheet (Appendix 4)	Hard Copy Electronic Copy	Individual contact	Interviews and Facebook group combined
Consent Forms (Appendix 5)	Hard Copy Electronic Copy	Individual contact	Interviews x 1 Facebook Group x 1

Table 5: Information given to potential and active participants

The fundamental principle of the right to be informed encompasses gaining participant consent and I proceeded to this, as the next stage in the process (Bowling 1997, Denscombe 2003, Hammersley 2018). I ensured that potential participants were provided with accurate, clear and consistent information and this is a key part of obtaining fully informed consent for participation in a research study. Research ethics and values are underpinned by a need to be open; honest and transparent, and informed consent cannot be gained if the information given does not fulfil basic premises (Williamson 2007, Yin 2016). The fulfilment of basic premises with regards to consent is scrutinised by research ethics committees and for the purposes of this study, I used two consent forms (see Appendix 5).

As there were two methods being used for data collection - the unstructured in-depth interviews and the social media group - a separate consent form for each was provided for each participant. Feedback from the NHS Ethics Review Committee felt that this would help to distinguish the two elements of data collection and would highlight to participants the differences between the two.

As the interviews formed the first part of data collection, participants were given this information first, along with a consent form, to be completed prior to the interview commencing. Following completion of the interview, the participants were given information on the social media group and a consent form for the potential participation in the social media group. Written consent was gained prior to commencement of both data collection methods.

For the right to be informed (as an overarching principle) to be facilitated successfully, the environment and context in which information is given and consent is discussed and gained, also needs to be considered. Hammersley and Traianou (2012), Israel (2015) and Schneider *et al* (2006) discuss the broader issue of the researcher taking the physical environment into consideration when collecting data.

Moreover, the physical place where data collection takes place can impact a number of factors including how safe and comfortable the participant and researcher feel, privacy and dignity, confidentiality, quality of data collected, and the flow or continuity (Dickson-Swift 2007, Ebbs 1996 and Hofman 2004). The women in this study were asked where they would like to be for the interview part of the research, as I felt the decision needed to be with the women as to where they would feel most comfortable and this aspect of decision making in the research process would empower the women to have ownership of participation (Allmark *et al* 2009, Chase 2003, Corbin and Morse 2003 and Dickson-Swift *et al* 2003).

Other factors that were taken into consideration at this point were childcare, presence of family members and pets, knowledge of family and friends of the situation and employment schedules. A date, time and place were agreed with the woman to meet her individual needs and circumstances. For the six women who took part in the interviews, the location where the interview took place were as follows:

- University x 1
- Woman's Home x 1
- Woman's Family Home x 1
- Café/Coffee Shop x 3

The issue of confidentiality is an important consideration throughout the research process and forms an essential part of the rights of the participant and their well-being (Allmark *et al* 2009, Clark and Sharf 2007 and Dickson-Swift *et al* 2007). Williamson (p16, 2007) clearly outlines the premise of the responsibility of the researcher to keep participation in confidence by the researcher, and that this should be a minimum ethical expectation. In this study, this formed part of the information sharing with the woman; through verbal discussion, the participant information sheet and the consent form (see Appendix 5).

In conjunction with consideration being given to confidentiality, is the linked premise of anonymity and both researcher and participant should understand the difference, issues and importance of both (Smythe and Murray 2010, Wiles 2008 and Yin 2016). In the context of this research study, anonymity was addressed through informed discussion and consent, timely anonymisation when data is collected, use of pseudonyms and alternative descriptors in the transcription, restricted access to personal and/or identifiable data and safe and secure storage of data.

However, it does need to be acknowledged that complete anonymity in this study was neither practical or appropriate, so partial anonymity was applied (Allmark *et al* 2009, Arigo *et al* 2018, and Clark and Sharf 2007). The issues around confidentiality and anonymity are closely linked to the emotional well-being of the women and how this might be managed (Israel 2015 and Liamputtong 2007). This will be discussed next in the context of the provision and use of a distress protocol for data collection.

The issues around researching potentially sensitive, challenging and distressing phenomena has been discussed earlier and mitigation and risk management will now be considered. Draucker *et al* (2009) and Dempsey (2016) highlight the importance of utilising a distress protocol, which provides pathway guidance for researchers, advice on managing difficult interactions, protecting potentially vulnerable participants and managing issues of anonymity and confidentiality.

A distress protocol by Haigh and Witham (2013) was selected for use in this study as an evidence-based peer reviewed protocol, which focuses on qualitative data collection, in particular managing distress in the context of interviews, overall interview management and transcription (see Appendix 6). Due to the nature of the phenomena being studied, safeguarding was also considered in the context of the distress protocol. Disclosure by the participant of any potential or actual safeguarding issue was risk managed through using procedures one and two of the distress protocol (Haigh and Witham 2013), my clinical and

educational knowledge, skills and experience in safeguarding, local trust safeguarding contacts and other safeguarding resources (see Appendices 7).

Furthermore, another element identified by Williamson (2007) as part of the rights -based approach, which sits alongside the rights of the participant, is the inclusion and consideration of the rights of the researcher. For this research study, there are a defined set of issues which were identified as part of data collection and throughout the research process, as highlighted in figure 9:

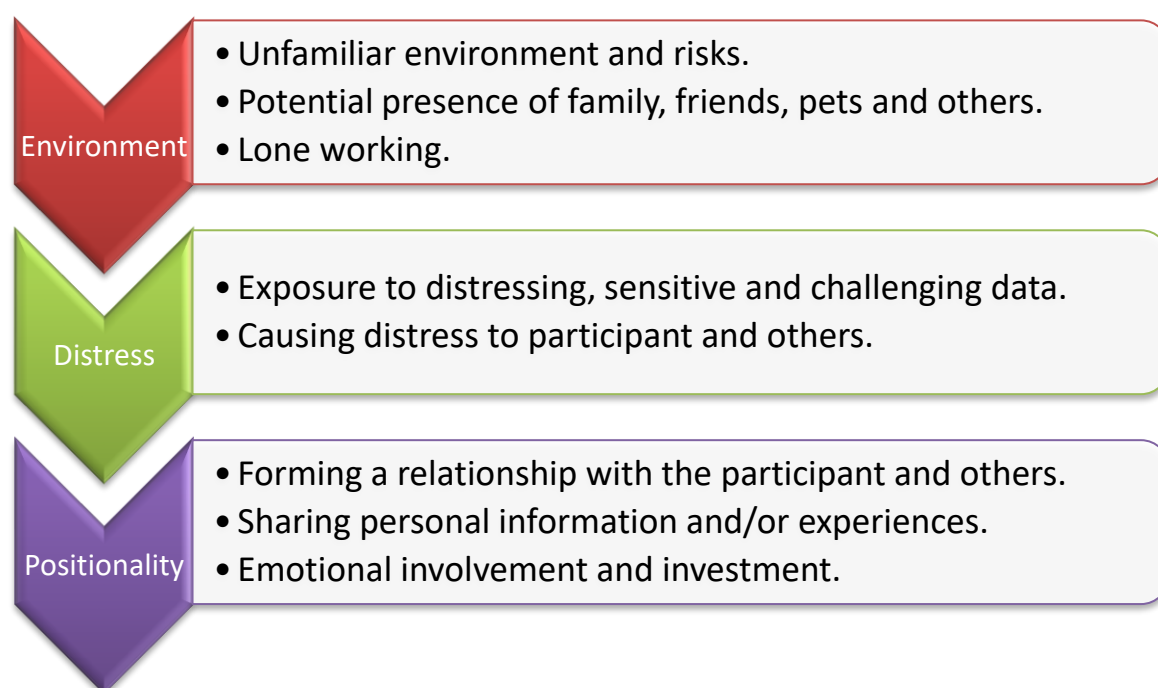


Figure 9 The Rights of the Researcher - identified study challenges in data collection

A multi-faceted approach was taken to risk assess, address and manage the above challenges adopting a good practice stance (Hofman 2004, Johnson and Clarke 2003 and Williamson 2007) including: completion of a research risk assessment, drawing on my previous clinical knowledge and experience, use of a lone worker policy, contact plans for interviews, supervisory team advice and support, reflection through researcher diary, mindfulness and well-being activities and confidential discussions with peers.

Most, if not all, of the rights-based approach can be applied to different types of data collection; however, there are some specific considerations in relation to the use of the netnography paradigm and social media. Overarching guidance for the social media aspect of this study was provided through using the British Psychological Society (BPS) guidance as a baseline (Hewson *et al* 2013). This was further supplemented and updated by work and further guidance from the Association of Internet Researchers (AoIR) by Franzke *et al* (2020).

This guidance was used to develop and inform the research plan for development of the social media group (see Appendix 8), which will be discussed in further detail later.

Arigo *et al* (2018), Eynon (2008) and Grinyer (2007) discuss and highlight the importance of a range of online challenges, particularly in relation to participant recruitment, creation of safe and confidential online spaces, data collection and management, individual challenges of different online functionality and timely monitoring and management of participant activity. Furthermore, Ess (2002) and Sugiura *et al* (2017) note researcher challenges in the online space around ethical decision making and how the use of an online platform for research is perceived by others.

4.4 Ethics Process, Approval and Researcher Reflection

The nature and content of the study meant that ethical approval through the NHS was needed through the Health Research Authority (HRA), followed by ratification from University (LJMU) ethics processes. The study needed “full” ethical approval for the study from the HRA and this was gained by application through the Integrated Research Application System (IRAS) process (IRAS project number 228101). My thoughts are captured through a series of reflections from my researcher diary, which illustrate my journey as a researcher through the approval timeline and by using a process of reflexivity.

The completion of the application through the IRAS process took twelve months from initiation to submission. The length of the process was due to a range of factors including: my unfamiliarity with the process, the part-time nature of the study, completion of several key documents as part of the IRAS process and workload pressures. During this time, I struggled with the requirements of the ethical approval process and to manage this, I again turned to my researcher diary to document my thoughts and feelings on the journey.

Researcher Diary Note 2017: *I have started work on my IRAS form and am already feeling daunted and out of my depth...I find the format confusing and not logical or intuitive. It is taking me a long period of time to get the smallest details completed. Stupidly I had not realised that I need ALL of my documents ready to upload, I feel like I am drowning in forms and not a researcher...I am a fraud and soon someone will come along and say to me that I'm not really a proper PhD student.*

At this point during my study, I began to feel overwhelmed, frustrated and annoyed with myself, that it was taking such a long time to complete the IRAS application and the documents which were needed. Following my IRAS submission, I attended an NHS ethics panel in person to discuss the submission and any issues that the ethics panel may have regarding the study.

Researcher Diary Note 2018: *I feel like running off and crying in a dark corner, I came out of my meeting and said to my DoS that was absolutely horrific, what a terrible experience. It immediately felt like an incredibly personal attack, and I feel that they did not understand narrative research. This was a very low point in the ethical application process and my feeling was that I felt like a failure, looking towards climbing another mountain of changes, alterations and resubmissions. At this point I was in a “big black deep dark hole” which I needed to work out how to bring myself out of it.*

The post panel discussion and debrief with my supervisory team allowed me to re-think and re-consider my approach and position as a researcher and I used the formal feedback from the NHS panel to improve my study, actioning all the recommendations that were made.

Researcher Diary Note 2018: *Renewed energy and vigour is enabling me to attack the list of recommendations and changes that need to be made... I feel like my attitude is you wanted the changes so I am going to do this so comprehensively there will not any grounds for not approving my study.*

An informal small group discussion and reflection with other narrative researchers at a narrative research conference on the NHS ethical process was insightful, the main point being representation of the ethical voice of the participant.

The list of recommendations from the reviewers included some alterations to the inclusion and exclusion criteria, further consideration and explanation of how safeguarding issues could be mitigated and the recommendation of the use of a distress protocol. Completion of all the recommendations made by the panel took another eight weeks and the study was given full ethical approval on receipt and scrutiny of these.

Following the HRA formal approval, the study then went through the ethical approval process at LJMU, which proved to be relatively smooth, quick and straightforward. This was granted approximately four weeks after the HRA approval and after completion of the post panel actions and recommendations. The next step was to apply for local trust access approval, and this was sought from five sites.

Two sites (site A and site B) had granted approval within eight weeks, one other site (site C) granted approval within twelve weeks (by June 2018). One site (site D) changed position and support and did not grant full approval; following further consideration and discussion with the supervisory team, this site was withdrawn. Following discussion and communication with the Head of Midwifery (HoM), the reason cited for this site being unable to fully support the study was given as capacity issues. This was further explained as midwives not having enough time to identify potential participants and not having enough time to discuss the study and give out the PIS (by June 2018).

One further site (site E) also changed position, following initial verbal agreement that the study would be fully supported by the then HoM. A meeting with managers was arranged to discuss the study and give out study materials, but the meeting was poorly attended. Following this meeting, the research department at this site contacted me to say only partial approval could be granted. The reason given was capacity issues; however, no further information or confirmation was able to be gained on the reason for this at this site. The research department at this site now only fully supports portfolio studies, which has impacted on this study's promotion and recruitment as a non-portfolio study. Partial ethical approval was granted for the promotion of the study via posters, and this took 24 weeks (by September 2018). Following discussion with the supervisory team, it was decided to retain this site in the study.

The formal approval process at a national and local level was fraught with difficulties and complications, but the feedback was a valuable aid to review the study and make some useful changes and improve the research. Furthermore, through the incorporation of reflection, I was able to learn and develop as a researcher, increasing my understanding of the ethical approval process and ensure this study was an ethical research process.

4.5 Data Management:

a) Introduction

Data management forms an essential part of any research process and includes privacy and confidentiality, record keeping, safe and secure storage of research information, ownership and sharing of data collected, and more recently general data protection regulation (GDPR) (Lin 2009, Yin 2016). Some of these processes have already been discussed in this chapter, but they will be highlighted here for clarity. Data management formed a key part of the

research proposal and is a key part of this study, seen as essential to participants safety and well-being.

b) Data protection, storage and management

The LJMU (2016) research data management policy informed and guided mandatory and best practice in relation to data storage and data management. Data, which was collected for the purposes of this study, is stored on the LJMU computer system, through my personal file store (One Drive). Data can only be accessed by myself as researcher, through password protected access, which now includes Multi-Factor Authentication (MFA).

A designated draw in a locked filing cabinet was used for the purpose of the research; this was firstly held at LJMU and is now located in my personal office at Edge Hill University, where only I have access and keys to the draw. Audio recordings were stored on a password protected digital recording device immediately following the interview, then as soon as possible were uploaded to One Drive for storage and then deleted from the recording device. All research data is stored for ten years in accordance with LJMU policy.

All data generated from this research study is managed by me, including sole responsibility for all data transcription and analysis, which took place in private and confidential spaces - for example a room at LJMU booked for this reason. The Secret Facebook Group was removed and deleted (Facebook 2017) by me, following completion of data collection and uploading of data to One Drive.

c) Participant Personal Information, Anonymisation and GDPR

For each participant who agreed to take part in this study, basic personal information and simple demographic data only were collected, which consisted of participants name, address, contact details (telephone number and e-mail), date of birth, occupation and parity. This information was gained either prior to the interviews taking place and further information relating to the participant's Facebook profile/status was obtained after the interview if they consented to take part in the second method of data collection (the Secret Facebook Group). For each participant who took part in the Secret Facebook Group, they filled in a separate consent form and shared their personal Facebook profiles/status with the researcher and with the other participants in the Secret Facebook Group.

Details shared on personal Facebook profiles can vary enormously between individuals, but would normally include personal information (as outlined and given prior to interviews), with potential additional information included in the profile section such as: education, place of birth, relationship status (Facebook 'status'), how many followers the account has, how many other Facebook accounts you follow, links to hobbies, list of Facebook 'friends', posts, Facebook 'stories' and visual details such as photographs, videos and Facebook 'Avatars'.

The amount of information available on participants through their Facebook accounts/profiles was not collected and did not form part of this study. The information requested was to ensure preferred method of communication and to allow arrangements for interviews, to ensure the participant met the inclusion criteria as specified (essential and additional). The personal information and demographic data collected prior to the interviews and revealed through the Facebook Group was known only to myself as the researcher and not shared with my supervisory team. Personal data was stored for six to twelve months following the end of the study, using the data storage arrangements as outlined below.

The qualitative, personal and demographic data collected, analysed and presented in this study, is highly individual and descriptive in nature, which may mean that participants or others such as family, friends and organisations and environments in which care was received, may be identified. To minimise the risk of identification, some data was pseudonymised and anonymised; for example, all participants were assigned a pseudonym by myself and other data such as names of others, descriptions or names of places and dates and times were anonymised. This approach of anonymisation is a commonly used method across all types of research.

However, it is not without critical question and the main issues cited focus on perpetuation of power imbalances, depersonalisation and loss of individual self (Heaton 2022, Ferguson 2022, Saunders *et al* 2015). Barusch (2018), Crossley (2001) (2003), Saunders *et al* (2015) and Melton (2011) discuss the need for some level of compromise and simply put this relates to increasing anonymity alongside preserving the integrity of the data, defining the challenge as difficult particularly in subjects which may be considered sensitive or traumatic.

For adherence to General Data Protection Regulation (GDPR), I adhered to national and local guidelines throughout this study. During this study in 2018, GDPR regulation was strengthened and updated through the United Kingdom Government (UK Gov) Data

Protection Act (2018), including implications for research. In 2018, I was contacted by the LJMU Ethics Department (as were all researchers), to review the data management for this study, to ascertain compliance with the revised GDPR regulation and to action any revisions needed, including contacting research participants. I reviewed the data management of this study against the UK Gov (2018) regulation, the LJMU advice and guidance (2018 - available online, web pages no longer available) and the further information provided by the Health Research Authority and National Health Service (HRA/NHS) (2018) and also consulted with my supervisory team.

Following this review, I was satisfied that all elements of GDPR (including the revised sections) within this study were compliant with current and the updated regulations. For the interviews which took place (n=6), the first interview took place prior to the implementation of the 2018 GDPR regulation, five interviews and the Secret Facebook Group took place after changes to the regulation. For all data collection which took place after May 2018 (GDPR update implementation), consent forms for interviews and the Secret Facebook Group were updated with additional paragraphs and information (See Appendix 9), as advised by LJMU.

4.6 Stakeholder Involvement

a) Introduction

The premise of conducting research, and the research process, increasingly needs to consider addressing the balance of power between the researcher and participants (Ebbs 1996, Janesick 2000, Long and Johnson 2007). One way of doing this, which is also considered good practice, is the embedding of Patient and Public Involvement (PPI) at some or all stages of the research. As part of the research proposal for this doctoral study, I thought about how this could be achieved and decided to set up a stakeholder group, at the point of the study design (prior to ethical approval). However, Jackson *et al* (2020) discuss the pitfalls of PPI and the notion that it is often seen as a requirement to be fulfilled, rather than a changed perception of genuine and authentic participant inclusion and decision making in the research process.

Price *et al* (2022), Tolich and Tumilty (2021) and Hammersley (2018) further consider the lack of agreed criteria of what constitutes PPI, challenges of real and effective PPI and how actions and limits are defined around simple involvement through to real co-production of research. For the purposes of this study, the aim was not co-production. I felt the subject

matter may have been too difficult and distressing, but of meaningful input with a flexible approach in mind. The input of the stakeholder group into the study will be discussed next.

b) Structure, function and input

To establish interest in the study, I utilised my midwifery networks through email and social media contacts. Through these contacts, I set up a stakeholder group which consisted of midwives, student midwives, academics, service users, potential participants and researchers. The stakeholder 'NEGCCONT' Group was an email forum which was used to send information to members on the study, ask questions regarding input into the study and act as a conduit for any questions and discussion regarding the study.

Members accessed the research proposal at the commencement of the group, ethics processes/approvals and documents such as blank consent forms, patient information sheets (PIS) and information on the recruitment process. Members of the group were informed that discussions will remain confidential, and suggestions and comments may be used as part of the ongoing research process.

The group made contributions to, and were involved in, the early stages of the research process, up to and including the data collection stage. Furthermore, ad-hoc and informal stakeholder feedback, also occurred from the participants themselves during data collection through the interviews and the social media group. This came in the form of audio recorded verbal comments, notes taken by the researcher at the time of the interview (audio turned off), comments and discussion threads on the social media group and email contact. These two forms of stakeholder input and feedback from the email group and the informal mechanisms are summarised as follows:

- General commentary on the research proposal, including suggestions that a longer timescale may be needed for recruitment and data collection; the overall time taken for the completion of the doctorate and an agreement that the study is worthwhile and aims to address a gap in the current body of knowledge
- Ethics: suggestions for further consideration and mitigation of the potential impact of the study on participants, and on the researcher
- Minor amendments made to the consent form, PIS, and additional information forms
- Additional suggestions and comments made on the recruitment strategy, especially with regards to making best use of social media as an additional recruitment method

- General commentary on the utilisation of social media, in relation to using potential trust channels and platforms, generating interest in the study, and use as a data collection method
- Comments and suggestions on the interview schedule, relating to increasing flexibility and consideration of different environments for interviews, being clear about the use of prompts with the one question technique and explaining the use of the one question technique clearly and concisely

The main challenges with the stakeholder group were sustainability (keeping the group interested over a long period of time - approximately five years), change to and loss of group members (continuity), decision making around what changes to make to aspects of the study and drawing input to a close (completion).

The group aspect of the stakeholders drew to a natural conclusion following data collection, as members became less or non-active with little response or feedback given, so at this point, I formally brought the group to a close. However, input from the participants continues to be an important part of the research process, through discussions made at the time of the data collection and through contact after this.

4.7 Participants: Inclusion and Exclusion Criteria

The inclusion and exclusion criteria were carefully considered and refined initially as part of the research proposal and then further adjusted as part of the ethics application process. By its very nature, the use of including and excluding certain participants from a study will impact the populations and communities who may access the study and therefore affect the data collection and research outcomes (Poth 2021, Williamson 2007 and Yin 2016). Therefore, transparency about the criteria used for recruitment is key and the consideration of groups which are excluded but need to be highlighted for other studies (Miller *et al* 2012; Long and Johnson 2007). The parameters of this study are outlined below:

- **Research population:** Women who have experienced either denial or concealment in the antenatal, intrapartum or postnatal period, for up to five years following the birth;
- **Inclusion criteria:** Women who have experienced either denial or concealment in the antenatal, intrapartum and postnatal periods, infant is up to five years old, singleton or multiple gestation, all modes of birth, foetal loss/stillbirth/neonatal death, ages sixteen and over, resident and had childbearing experience in the UK;

- **Exclusion criteria:** Unable to consent, learning needs, English not the first language, under 16 years of age, infant is over five years old, non-resident in the UK and childbearing experience outside of the UK.

The research population covered all the childbearing continuum, as the literature review highlights a lack of studies across the spectrum of childbirth. It was felt that to keep the experiences relatively current (rather than historic) but give some flexibility for recruitment, including those who had given birth within five years would be a feasible option (with an acknowledgement that memory recall may be impacted).

The reasons for developing the inclusion and exclusion criteria were to focus on gaining ethical, rich and deep data for women in the UK - again, where very few studies have been carried out. The criteria needed to be realistic, in terms of recruitment and for this reason all gestations and modes of birth were included. For practical reasons of consent, the age limit of sixteen was set, along with those women whose first language was not English, due to time, financial and my limited language skills. Furthermore, it is important to acknowledge here that certain groups of women not eligible for inclusion in this study would warrant consideration for further research.

4.8 Participants: Sampling Strategy

The challenging issues around determining sufficient or minimum sample size in qualitative research, is something which has long been discussed and debated. It is generally accepted that qualitative research typically requires smaller sample sizes than that of quantitative research, due to the type of data being collected (Borbasi *et al* 2019, Denscombe 2003, Steen and Roberts 2010).

Ritchie *et al* (2014), Iphofen and Tolich (2018) and Yin (2016) discuss the concept of qualitative research including the premise of a 'minimum' sample size, linking to a positivist epistemology - one which utilises a standardising/scientific approach and one which is often linked to other sampling concepts such as theoretical saturation. The concept of theoretical saturation (Creswell 1998, Glaser and Strauss 1967) (or information redundancy) has been used by some to initiate a cut-off point in recruitment. This is where no new data or themes emerge, even when adding new participants (Glaser and Strauss 1967, Steen and Roberts 2010). Use of this concept relies to some extent on the skill and ability of the researcher in data collection and analysis and so it may be argued that the precise number cannot be predetermined but is a more fluid process which develops as the study progresses (Sandelowski 2008).

However, issues remain with such a generalised approach to sampling in qualitative research, most notably the unsuitability for more interpretive models, the assumption that numerical models are appropriate and an overarching realist ontology (Bold 2012, Chase 2005, Gergen and Gergen 1991 and Finlay 2012). Furthermore, Best (2008), Gergen and Gergen (1991) and Hammersley (2018), highlight the ontological disparity of such an approach, particularly for qualitative research which comes from a constructionist approach, such as narrative.

As such, it can be argued that there is no definitive, one size fits all, sample size for all types of qualitative research, although some researchers have looked at specific types and have suggested numbers, but these are not agreed (Savin-Baden and Howell-Major 2013, Schneider 2016). The minimum number mentioned is often five (Creswell, 1998, Glaser and Strauss 1967, Morse 1995), with some agreeing on between six and ten, for in depth interviews as part of other methods of qualitative research (ethnography and phenomenology), with no agreed number for narrative (Polkinghorne 1998 and Somers 1994).

Considering the challenges of defining sample size for narrative research, I decided that the approach outlined by Sandelowski (1995) would be more appropriate than alternatives and more closely aligned to a constructionist framework. This approach is known as adaptive sampling and the method is flexible, dynamic and can accommodate different types of data. The focus is not on the number of participants which make up the sample size, but on the number of events, experiences, conversations and contexts gathered. Her recommendations on sample size focus on the quality and depth of the data collected, regardless of the number of participants that the data is collected from, and is an approach commonly seen in narrative research (Andrews *et al* 2013, Chase 2003, Clandinin and Connelly 2000 and Josselson 2007).

However, Sandelowski (1995) and Chase (2003) discuss the potential challenges that this creates for the researcher and the need to clearly outline how sample size decisions are made using an adaptive model. The need to provide some indication on sample size for ethical applications and to provide a starting point was also taken into consideration, with an upper limit of ten decided as practical for this study.

Polkinghorne (1988), Riessman (2008) and Sandelowski (1995) provide further clarification and underline the need to reserve judgement on exact numbers needed (of participants and experiences), until the study is underway, which was the path taken here. Further

justification is also provided by outlining factors involved in sampling decisions and in the final sample number of six, as highlighted below:

- Use of inductive methodology to determine depth, breadth and quality of data;
- Paying close attention to the narrative framework;
- Frequent, ongoing and purposeful researcher immersion in data collection;
- Consideration of the number of events, stories and experiences;
- Emergence of the phenomena of negated childbearing and associated overarching narratives.

The method of sampling used in this study was purposive, as dictated by the inclusion and exclusion criteria, and recruitment of this potentially vulnerable group (Liamputtong 2007, McCormack 2004 and Rosenthal 1993). Purposive sampling, where the researcher identifies participants most closely aligned to the subject being studied, was the main method used, with accessibility also an important consideration of convenience. Some participants did suggest others (family and friends) who may be suitable for the study (snowball sampling), but none of those suggested consented to take part, so this third method, although considered for recruitment, was utilised but not successfully recruit participants.

4.9 Participants: Recruitment Strategy

a) Introduction

Recruitment for the study focussed on the regions of Cheshire, Lancashire and Merseyside and through social media for UK wide participants. There was a multi-faceted approach to recruitment of participants due to the uncertainty around prevalence and the inherently sensitive and emotional nature of the research. These were taken into consideration in the development of the recruitment strategy.

Furthermore, when recruiting participants from hard-to-reach groups, it is important to consider an extended timeframe for recruitment, familiarity and knowledge of the recruitment environment and organisations and a partnership working approach (Denscombe 2007, Liamputtong, 2007). The initial plan was for recruitment to take place over 12 months, from ethical approval to completion of data collection, the actual time taken was 18 months, due to several ongoing challenges.

b) Recruitment strategy details and process

I visited some potential areas for recruitment in the local regions, consisting of five sites and provided study recruitment posters for potential participants (see Appendix 2a), verbal and written information to staff and students. The information was also sent as an electronic copy using e-mail to designated contacts within the trusts. Three trusts agreed that the posters could be displayed in identified clinical areas for women and these areas were antenatal clinic, outside ultrasound scanning departments, intrapartum areas (delivery suite, Midwifery led unit) and antenatal and postnatal wards. One trust also allowed the posters to be displayed in toilet cubicles throughout the trust site.

Alongside the participant poster, a poster was also provided to advertise the study to staff (Appendix 2b), along with further written information for staff. Two trusts agreed that this information could be displayed (two out of the three which allowed posters for participants) and this staff information was displayed in staff rooms, near reception desks, next to computer stations, community bases and hubs and in specified clinical areas including intrapartum and postnatal. NHS guidelines and professional guidelines (NMC) regarding confidentiality were followed (Mitchell 2016, NMC 2015). In two trusts, full support was given from research midwives, who agreed to support and promote the study and also identify any potential participants with clinical staff. At the two trusts who agreed to full local ethical approval and active participation in recruitment to the study, written information and instructions were provided for any clinical staff potentially involved, following the recruitment pathway (figure 10):

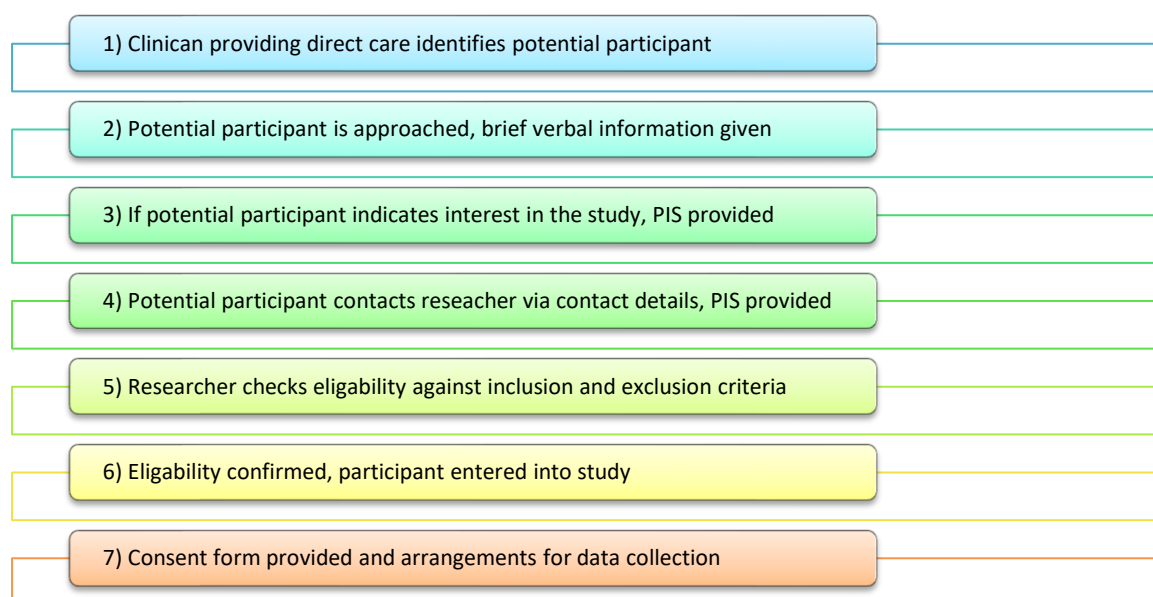


Figure 10: Participant Recruitment Pathway

Social media platforms were also utilised to publicise and promote the study as well as assist with recruitment. The use of social media meant that a wider reach outside of the two designated sites was possible. Two sites involved in the study gave permission for the study details to be advertised on the Trust Facebook page and Twitter accounts - using the research poster and direct text taken from the poster. As the researcher, I also used my professional networks to publicise the study through the following social media platforms:

- Midwifery/Maternity Facebook Groups - MatExp, Secret Community for Midwives in the Making, Women in Academia Support Group, Community Bambis Breastfeeding Support, Research for Midwives, Doctoral Midwifery Research Society, Midwifery Matters, three local RCM groups, Perinatal Mental Health Research Group, Midwifery Education Facilitators;
- Personal Facebook Page;
- LJMU Facebook Page

Potential participants through social media joined the recruitment pathway at step four, making direct contact with the researcher through contact details provided on the recruitment poster.

4.10 Participants: Recruitment Challenges

Several challenges were identified as recruitment commenced and throughout the process, the main ones are identified below:

- A six-month period by some local ethical committees, regarding decision making around the potential for ethical approval;
- Some sites withdrew initial decisions made on support for the study;
- Challenges with consistent communication with maternity and research departments on some sites;
- Challenges with support for non-portfolio studies on some sites;
- Factoring in time challenges with maternity meetings, in getting study information out to all sites;
- Some potential participants, after enquiring felt that they could not discuss their experiences, due to ongoing issues with trauma;
- Challenges with some clinicians to support and/or be involved with the study;

- Some participants changed their minds about taking part, after arrangements were made for data collection.

4.11 Participants: Recruitment Summary

A total of six women were recruited to the study over a period of eighteen months, and all six were successfully recruited through social media platforms. There was an additional number of thirty-five potential participants who enquired or wanted further information on the study, but who decided not to take part. There is the potential that future work in this area could consider a broader recruitment strategy, including formal and structured involvement from third sector and other organisations.

In addition to this, there were a further ten women who wished to take part but did not meet the inclusion criteria and these included women living outside of the UK, women with historical negation (child over five), childbearing experience outside of the UK and under 16 years of age.

4.12 Participants: Data Collection

a) Unstructured in-depth interviews

The use of interviews to collect qualitative, in-depth data in health research, particularly nursing and midwifery studies, has become an accepted and standard method over time (Bowling 1997, Gray *et al* 2017 and Hesse-Biber and Leavy 2011). To facilitate the interview, I utilised a preliminary interview plan (Appendix 10) to ensure a similar process was followed for all participants.

For the purposes of this study and the subject of negated childbearing, the unstructured in-depth interview was considered the best fit for obtaining rich data within a narrative approach. Dempsey *et al* (2016), Dickson-Swift *et al* (2007) and Janesick (2000) discuss the benefits and advantages of using an unstructured approach to interviewing, as opposed to a structured approach, for collecting deep, multi-layered and productive data.

This looser, more flexible method which is the underpinning of an unstructured interview, allows the participant greater autonomy and freedom in which to discuss, describe and elucidate their experiences, with less constraints imposed by the researcher (through structure). Moreover, the premise of utilising a holistic view towards the unstructured

interview, also seeks to include nuances of the spoken word such as tone of voice, pauses and word emphasis, but also other non-verbal elements such as body language and environment, as part of the overall data collection (Kyale 2009, Rubin and Rubin 2005).

Another consideration for qualitative interviews is the concept of neutrality, in relation to the position of the researcher. The need for structured and strict constraints in regards to interviewer neutrality for this research is not methodologically appropriate, and due to the sensitive nature of the subject being discussed, the need to be able to empathise with the participant about their experiences and the need for the interviewer to draw on and constructively use their clinical experience of caring for women and families, should be actively drawn out and discussed as part of the narrative process (Chase 2003, Clandinin and Connelly 2000, Finlay 2002 and McCormack 2004).

Furthermore, Corbin and Morse (2003), Ebbs (1996) and Jones (2002), explore the premise of using the narrative approach to in-depth interviewing and identify the interview as a basis for a conversation between two people - with the participant leading the direction, pace and content of the discussion in the form of them being able to relate the story or narrative of their experience. This is particularly associated with research on vulnerable groups and sensitive subject issues (Allmark *et al* 2009, Chase 2005, Dempsey *et al* 2016).

Elliot Mishler (1986) in his seminal work on research interviews, provides the basis for this within a narrative framework and develops the importance of the concept of context and the co-creation of meaning, seeing the interview as a social encounter. This social context allows for the development of relationship building and transparency of the participant-researcher connection, alongside embedding the narrative approach (Chase 2003, Finlay 2012, Holloway and Jefferson 1997). It is the key underpinnings of context and meaning making, which makes using the narrative approach different to other methodologies.

b) Single question interview method

Building on the open, flexible and dynamic unstructured in-depth interview, the narrative lens sees the participants as narrator - who controls the meaning of what is told and how the stories are structured and relayed (Mishler 1986, Holloway and Jefferson 1997, Hunter 2010). To facilitate this as fully as possible, I decided to search for a method which would allow freedom within the interview process, for the stories and narratives to emerge and be constructed. Lawrence and Sadala (2008), Horsdal (2016) and Holloway and Jefferson

(1997) discuss the use of the single question interview method (SQIM) in facilitating depth in a dynamic way and demonstrating alignment with the overarching methodology.

As part of the interview plan (see Appendix 10) and with the feedback from the stakeholder group, I formulated a discussion precis, to explain to the woman what to expect and how the SQIM works in an interview format. The excerpt is as follows:

“The interview will start with me asking you one question inviting you to talk about your experience. Once this question has been asked my intention is to listen to and record your story as you describe it to me. Once you start to talk, I will not intervene or ask questions of you (unless this is needed to prompt further conversation or asked for by you). This is intended to be a flexible interview, in which you have the opportunity to tell your story in your own words and describe your experiences, thoughts and feelings”

This precis is then immediately followed by the single question:

*“Tell me about your experiences, thoughts and feelings of **hiding/not knowing** about your pregnancy/labour/birth”*

(bold can be adapted according to the individual).

Both the discussion precis and the single question were developed using relatively plain English to be succinct and easily understood. The single question was written to reflect and encompass the aims of the study, but without including the word ‘negation’ and replacing this with the terms ‘hiding/not knowing’. Feedback from the stakeholder group suggested that this word had potentially negative connotations and women may not understand it, so ‘lay’ terms were used to elicit the stories.

In the same way the terms ‘pregnancy/labour/birth’ replaced ‘childbearing continuum’ to keep the whole question as clear as possible, whilst being open ended to allow for storytelling to start. This SQIM uses one main question with minimal (or no) prompts, to allow the participant to tell their story, and to have control over how the story is told (Lawrence and Sadala 2008).

However, although there are benefits to using this method, Allmark *et al* (2009), Brockmeier, and Meretoja (2014) and Corbin and Morse (2003) identify potential issues of reciprocity, risk and ethics, which need to be carefully considered and managed. In this study, good communication with potential participants, use of the interview plan (see Appendix 10), researcher confidence (interviewing, approaching sensitive subjects) and

building a relationship with the women helped to mitigate and manage potential SQIM issues and risks.

c) Interview environment

The details relating to the where the interviews took place have already been discussed in this chapter under ethical considerations and were at a time and place of the woman's choice, by mutual agreement. To reiterate the interviews took place in four different environments: university (1), woman's home (1), woman's family home (1), and a Café/Coffee Shop (3). Autonomy, choice and control over where the interview takes place by the participant, is discussed and noted as an important concern by Chase (2005), Clandinin and Connolly (2000) and Dempsey *et al* (2016).

Moreover, with sensitive and challenging subjects, both the participant and researcher need to feel comfortable for shared and creative storytelling to occur (Finlay 2012, Holloway and Jefferson 1997 and Hordsal 2016). McCosker *et al* (2001), Josselson (2007) and Johnson and Clarke (2003) highlight the comfort, safety and well-being of the researcher and acknowledge the challenges that may arise, and be influenced by the environment, and these are shown in figure 11:

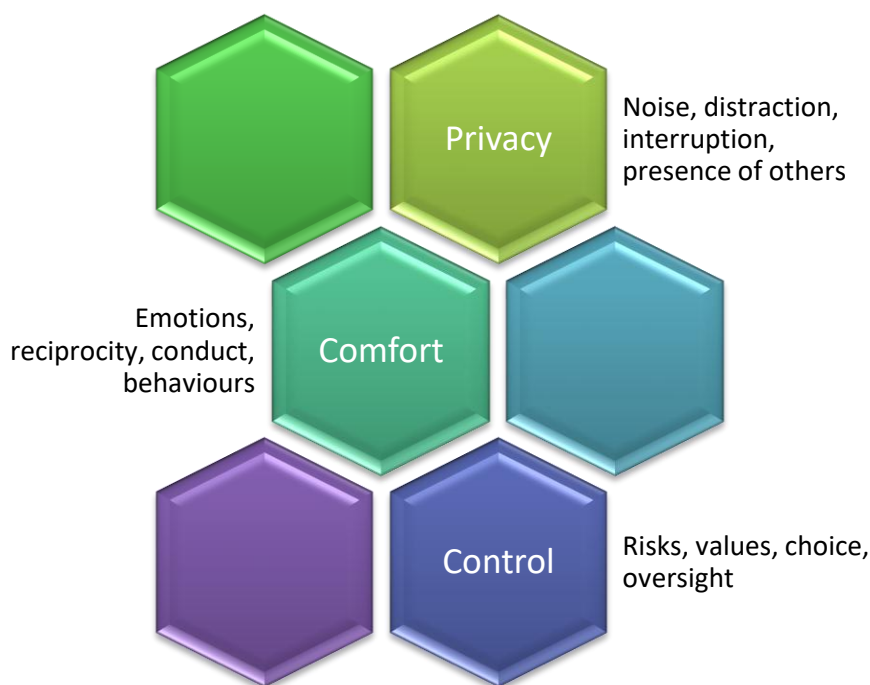


Figure 11 Interview environment challenges

d) Interview process

Following on from the recruitment process described earlier, I commenced the interviews using the interview plan as outlined in Appendix 10. I audio recorded all interviews using a portable, hand-held digital device, then as soon as possible after the interview was completed, I uploaded the recordings onto a secure, password protected computer and then I deleted the original recording on the portable device.

Additionally, I took notes alongside the live interview, recording artefacts such as non-verbal behaviours, presence of others and personal thoughts and reflections. The notes were added immediately after the interview and up to (due to the practicalities of time and workload) one week afterwards, which culminated in the production of a reflective diagram for each interview (for example, see Appendices 11).

4.13 Situational Lens

The concept of a “lenses” approach in qualitative research, is mooted as being a means by which a researcher can theoretically locate and centre their study (Chase 2008, Finlay 2012, Hyvärinen 2016 and Ochs 1979). Savin-Baden and Howell-Major (2013) discuss the importance of research lenses and their application and use throughout the entire research process, but particularly in relation to paradigm, data collection and data analysis.

This use of a lenses approach in narrative research can be demonstrated by McCormack’s (2004) work, where she uses multiple lenses to make sense of data collection in interview transcripts. The type and number of lenses used can vary, can be used across all or parts of the research process and this pick and mix approach is evidenced through work by Finlay (2012) and Hunter (2010), amongst others. Both utilise the model developed by Chase (2005) which is a five lenses approach to inform narratives (Appendix 12), but where one or more lenses may be applied as appropriate to the research process.

a) Theoretical application of the lenses approach

I decided that for the purposes of data collection, in particular the interviews and transcription, that I would utilise a “situational lens”, which is modelled on the work of both Finlay (2012) (Appendices 13) and Chase (2005). The situational lens relates to Finlay’s (2012) approach, which integrates reflexivity into each lens that a researcher uses, and Chase’s (2005) approach of the third and fourth lenses which emphasis voice and communication. The word “voice” in Chase’s (2005) work draws attention to the importance of what the participant narrates and how it is communicated.

Furthermore, Chase (2005) also draws out the contextual and situational elements and locations - the positionality of the participant and researcher. It is this combination of the 'what, how and where' which situates the narration and makes the voice particular. Moreover, Atkinson (2009), Elliot (2005), Finlay (2012) and Moen (2006) identify the need for narrative researchers to use sensitive, flexible and nuanced lensed approaches, which provide and enable recognition of the narrative voice/s drawn out in interviews and through transcription.

I sought to capture the participant's and researcher's "voice", body language, behaviour, demeanour and contextual situation of each interview and transcription, in the form of a "situational lens diagram" (Below, Appendices 13, Chapters five and six). These were constructed after each interview and help to illustrate the complex interactions of participant and researcher as the stories are told and narratives become revealed. This utilises Chase's (2005) lenses approach in a simplified, adapted way by using one "situational lens" to consider the context and environment in which the data collection takes place. All interviews have a narrative reflection and situational lens diagram - as these alongside the original audio recording and the transcription are considered and

further discussed as part of data analysis, and findings (Figure 12).

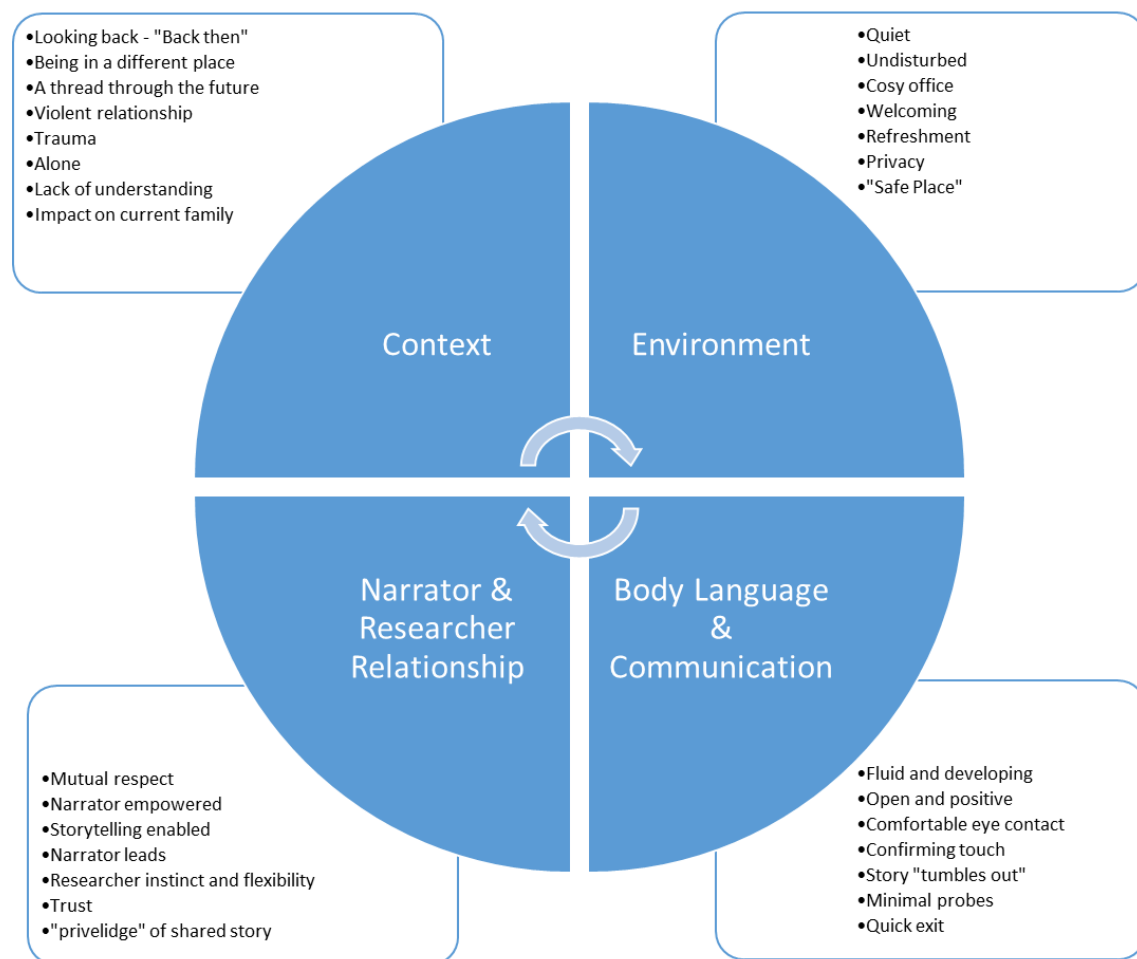


Figure 12: Situational Lens Diagram Example: Interview 1 (Phoenix)

4.14 Participants: Social Media Group

a) Conducting research online

Utilising the online environment for research has been a method which has gradually developed over several years, in line with the growth of the functions and usage of the internet, and various social media platforms and apps (Arigo *et al* 2018, Lee *et al* 2008 and Suigira *et al* 2017). Lee *et al* (2008) and Ess (2018) discuss and define the terminology of conducting online research and note that variations occur, from the widely used phrase online research methods (ORMs), through to the more general internet research, and more specifically netnography (a specific type of qualitative social media research).

For the purposes of this study, I will be using the term ORM, to encompass the use and position of the internet and social media within this study and the methods for recruitment,

data collection and analysis. Increasing use of ORM and development of guidelines for ethical online methods, have meant that ORM have been used throughout all stages of the research process, from development and co-design of studies, through to recruitment, data collection and dissemination of analysis and outcomes (Arigo *et al* 2018, Franzke *et al* 2020 and Price *et al* 2022). As previously discussed ORM were used in recruitment of participants, formed an essential part of data collection and are planned to be a core element of dissemination.

Arigo *et al* (2018), Eynon (2008), and Grinyer (2007) highlight the unique ethical challenges that must be considered when using ORM and these range from simple logistics to more complex issues around care of participants at a distance, data generation and management and identification of new researcher roles. Furthermore, Carter *et al* (2021), Hewson (2020) and Suigira *et al* (2017) discuss specific adaptations that researchers using ORM should make including privacy risks, dealing with engagement and distress and establishing a safe research environment for participants and researcher. In this study, the main challenges identified were as follows:

- Administration, management and moderation of the Facebook group;
- Transparency and clarity of data generation and collection;
- Safety and well-being of participants and researcher during data collection;
- Management and storage of online data.

These were appropriately risk managed and mitigation was put in place and are discussed in the next section, which outlines the operation of the secret Facebook group.

b) Introduction to Facebook (part of Meta Platforms) research

Facebook is the largest online social media network, which allows users to set up profiles and make connections with people globally, through individual and group shared content such as written posts, images, videos and status setting (Hall 2022). Franz *et al* (2019), Hewson *et al* (2013) and Obamiro *et al* (2020) highlight the benefits and challenges of using Facebook in health research and highlight that this is still a relatively new method which has been used for increasing research awareness, recruitment, development of research through PPI, data collection and dissemination and publication of results.

Furthermore, Carter *et al* (2021), Grinyer (2007), Hewson (2020) and Suigiura *et al* (2017) have shown that the use of online social media groups for healthcare research is of particular

benefit when gathering data from the hard to reach and those groups considered vulnerable, or when discussing sensitive issues. Several studies have used Facebook as an effective data collection tool and throughout all stages of the research process (Bonevski *et al* 2014, Kayrouz *et al* 2016, Oliver 2015).

However, Arigo *et al* (2018) and Eynon (2008) highlight the increased potential for harm and distress as ethical concerns, linked to the ‘long-arm’ aspect and physical distance from aspects of the research process. Risk management and mitigation for this study was provided through use of specific guidance on internet research (Ess 2002, Franzke *et al* 2020, Hewson *et al* 2013), developing an internet research plan for ethical approval (see Appendix 6), use of a distress protocol (Draucker *et al* 2009, Haigh and Witham 2013) and utilising a reflexive, narrative methodology as a basis for a sensitive and provenanced approach (Arigo *et al* 2018, Hyden 2013, McCosker 2001).

c) Secret Facebook group operation and process

There are three privacy settings for Facebook groups: open, closed and secret, and anyone on Facebook, existing group member or otherwise, can see the membership of an open and closed group (Nield 2016). Non-members can locate the group, view and see the names of current members. Secret groups, in contrast, are completely invisible to non-members -- they do not appear in search, in the news feed or anywhere else on Facebook unless you are currently a part of, or invited to, the group (Nield 2016). The posts within both closed and secret groups cannot be viewed unless you are a current member, in contrast to open groups, where posts are visible to all. In the case of secret groups, others will not see any news feed stories at all, unless they are also members of the same group (Nield 2016).

As McCosker (2001), Oliver (2015) and Suiguiria *et al* (2017) acknowledge the provision, management and challenges of maintaining privacy and confidentiality when researching sensitive subjects online must be robustly managed, to provide a safe space for sharing and discussion, whilst enabling mitigation of risk. It is for these reasons that a secret Facebook group approach was chosen, as this afforded a greater level of privacy for the participants. Figure 13 details the operation and process for the secret Facebook group:

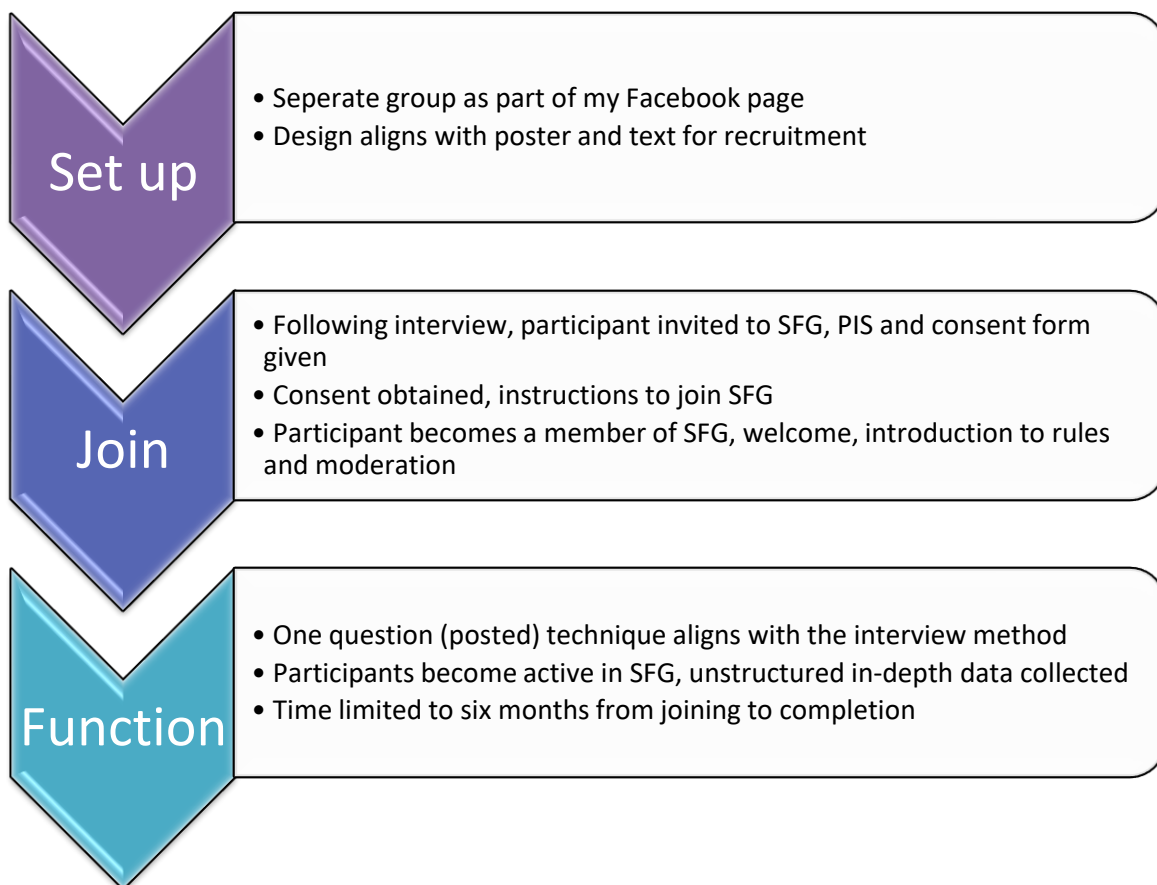


Figure 13 Operation and process of the Secret Facebook Group (SFG) for data collection on negated childbearing

The main objective for the SFG, was to act as an additional method for data collection - to act as a virtual focus group, which may yield new and different data and/or have overlapping areas of experience between participants, shared through an online platform, which would not be possible in a one-to-one interview. The unique aspect of the SFG was bringing the women together to share their stories and generate conversations of negated childbearing.

Due to the sensitive nature of the subject, this would have been extremely challenging in a face-to-face focus group and so the online platform facilitated this sharing and discussion online. The platform allows women to share their stories through an online conversation, in a safe space, whilst allowing some distance and greater control over their input in a sensitive area (Bonevski *et al* 2014, Carter *et al* 2021 and Oliver *et al* 2015). All six women who took part in the face-to-face interviews were invited to the SFG, five women consented and all five actively contributed to the SFG.

Following commencement of the SFG, all data including posts, images, videos, weblinks (all posted content) and additional features of Facebook such as likes and use of emojis were

captured through screenshots, then downloaded into a file on a password protected computer. Data collected was noted and transcribed. The SFG ran for a total of six months, and when no further posts or activity was noted after a four-week period, the members were given notice of a date when the group would close. On this date the group was closed, members thanked for their contributions and the group deleted from the Facebook platform.

4.15 Transcription

a) Introduction and discussion

The art and science of transcribing data, particularly from interviews, is often considered a small and insignificant part of the research process, and separate from data analysis, although some consider it as a stage of analysis (Bowling 1997, Elliot 2005 and Clough and Nutbrown 2012). Azevedo *et al* (2017), along with others such as Silverman (1993) and Wengraf (2001), provide further discussion on this, highlighting the importance and significance of approach and method of transcription and drawing relationships between the process of transcription and narrative analysis. Therefore, the method/s of transcription which are used by the researcher have the potential to impact and influence data collection and analysis and as such should be recognised and clarity provided within the study.

Furthermore, the impact of the person carrying out the transcribing should also be acknowledged. Conversely, Azevedo *et al* (2017), Janesick (2000) and Josselson (2007) suggest that this is a crucial step in the qualitative research process and for narrative researchers is an essential element in strengthening transparency and honesty when taking a more holistic or “naturalised” approach to data collection.

b) The importance of transcription in narrative research

The nature and strength of the transcription and its relationship with narrative data collection, is highlighted particularly by Riessman (2008), Josselson (2007) and Bold (2012). They identify the inherent, interwoven connection between transcription and analysis and that the two can (and should) occur almost simultaneously throughout the narrative research process. Moreover, Patterson (2012) and Elliot (2005) identify the importance of using

transcription methods which align with the narrative approach, in terms of how the transcription was completed, and what methods were used.

Narrative research methods detail two main pathways for transcription - holistic and categorical - although further subcategories may be identified within these two and they may also overlap (Mishler 1991, Riessman 2008 and Holloway and Freshwater 2007). Transcription approaches and pathways were critically considered throughout the research process, alongside the potential impacts on the stories of negated childbearing.

Although Andrews *et al* (2013), Clandinin and Murphy (2007) and Hunter (2010) highlight the seminal nature of Mishler's work, in relation to transcription and interviews (and that it has value to offer in the narrative world), the blanket use of this is not appropriate for this study. Mishler's work provides a valuable foundation in narrative interview methods and acts as a useful starting point for the researcher critically considering different transcription and interview styles. Application to this narrative research study of Mishler's methods was analysed early on and is acknowledged here as an important influence in selecting the methods used.

c) The dimensions content approach

An alternative approach by Lieblich *et al* (1998) is suggested by some narrative researchers as a more holistic, multi-faceted method which allows for the wholeness narrative to lead (Hyvärinen 2016, Riessman 2008 and Squire *et al* 2013). The dimensions content approach seeks to capture the narrative entirely, recording and presenting it as a complete experience, in context, which allows individual stories to be related as part of a broader overarching narrative. Moreover, Riessman 2008 argues that this allows for clarity and honesty in complex data and helps to draw out other narrative elements, such as structure and performance.

However, Hunter (2010), Brockmeier and Meretoja (2014) and Elliot (2005) state that, in the research process, is it very difficult to conserve the entire narrative and that, in practice, it is simply not possible, whatever method is used. It should be noted that the approach of holism in narrative methods and data, is seen by some to be a path to a deeper, subjective and more detailed investigation of the phenomena being studied (Frank 2010, Finlay 2012).

Chase (2003, 2005), Georgakopoulou (2015), and Goldie (2004) argue that the issue of wholeness in narrative studies and works can be achieved through lensed and layered data analysis and also in the way that data is presented. In this way, how the data is presented

leads to consideration of alternative methods, such as the use of art, imagery and poetry to preserve and present a whole story.

For the purposes of this study, I decided to use Lieblich *et al*'s (1998) dimensions approach as I transcribed, using dimension one of the two dimensions identified. In dimension one, during transcription, the transcriber seeks to study the content of the data collected, or the formation of the story. Sometimes both content and form may be considered together or alongside each other as part of the process.

The part that content and form play as part of transcription is usually not determined beforehand, but is revealed throughout transcription, as a fluid process. As transcription occurs, story narrative content becomes explicit to the transcriber - and this is the point at where analysis can, and does, start to occur simultaneously. In this study, content and form were considered alongside each other and this is discussed in further detail in the data analysis section/chapter.

The form, formation and structure of the story may also be identified, as narrative elements of context, coherence, prominence of story characters and plotlines are highlighted. Where this occurs, the transcriber may also be able to elicit complexity, metaphorical discourse and conscious imagery which evoke the essence of the narrative being studied. It is these processes combined that some narrative researchers use to keep the wholeness of the narrative intact, and to aid understanding as a complete phenomenon. As the process of transcription continues, the contextual element becomes increasingly revealed, as parts of the story relate to other parts and are understood in terms of the whole narrative, and it is for these reasons that dimension one was used in this study.

The second dimension identifies a more structured, some would argue objective, method of transcription. Lieblich *et al* (1998) discuss this approach as a categorising process, where data are transcribed as shorter blocks or items. This allows for compartmentalisation early on and grouping together of ideas or themes as they emerge.

In Mishler's work, this second dimension is often used as process, especially in relation to the use of coda, reflecting the positivist epistemology of some of his works and something which does not align with the relativist approach of this study (Clandinin and Murphy 2007 and Mishler 1991). Moreover, this approach uses the premise of imposed structure and a piecemeal method of transcription to inform data analysis and for this reason, it was not utilised in this study (Atkinson 2009, Bury 2001, Chase 2003).

However, it should be noted that although Lieblich *et al* (1998) see the dimensions of transcription as separate entities, some researchers argue that many narrative studies use a combination of different approaches (Elliot 2005, Tuval-Mashiach 2014, Riessman 2008; 2015). This has benefits, as flexibility and fluidity such as this, allows overlap and interaction between one or more approaches and some would argue is the essence of narrative study (Elliot 2005, Riessman 2008).

d) Detailing transcription, narrative meaning

Any transcription can be understood as a compromise of sorts, as none can ever capture the full meaning that has been communicated in the interview experience (Denscombe 2003, Dempsey *et al* 2016), as touched on previously. However, Sools (2012), Nasheeda *et al* (2019) and Crossley (2003), discuss minimising this compromise, by paying significant, consistent and repeated attention to detail throughout the transcription process, which can aid the holistic storytelling and meaning which is part of shared and developed narratives. Transcribing to a high level of detail can be achieved through using a relatively smaller sample size (discussed earlier) and by using an approach where the researcher can fully immerse themselves in the interview data and transcription process (Silverman 1993, Savvidou *et al* 2004, Rubin and Rubin 2005).

In this study, I decided to personally transcribe all the interviews, rather than choosing to outsource this part of the research process. Chase (2005), Georgakopoulou (2015), and Hunter (2010) support this highly personal method note that allows the narrative researcher to understand their position and emerging character within the story and situate themselves in the socio-narrative context.

Furthermore, the nuances of the story which can convey further meaning, such as tone, pausing, emphasis and body language can be captured more effectively (Page 2015, Rappaport 1995, Riessman 2008 and Smith 2015). Conversely, Byrne (2001), Dickson-Swift *et al* (2007) and Goldie (2004) highlight some potential issues with this approach, including the large amount of time needed, blurring of the researcher role and consideration for researcher well-being.

Conversely, Gwyn (2000), Hunter (2010) and Hyden (2013) discuss the challenge of becoming “lost” in the transcription process and being overwhelmed and obsessive with detail. Mitigation in relation to these challenges was put in place by myself by using my researcher diary, taking regular breaks, utilising reflexivity and accessing support.

e) Transcription process and data extraction

The transcription of the interviews was carried out manually by me, initially listening to the complete digital recording twice (without making notes), then using a stop-start-stop method of typing up alongside listening to the recorded interview, to produce a first draft. This first draft was then checked again using the stop-start-stop method and altering, changing or adding to the transcription for accuracy. This produced a second draft, which was checked over again using the same method as described.

Word emphasis (highlighting words in bold where the woman emphasised these in her use of tone) was then carried out, again using the same method producing a fourth draft. Finally, the recordings were listened through twice more, minor amendments were made to produce a fifth draft of the interview.

It is important to note that the transcripts produced were not “cleaned” (focus on the content of what was said, does not include “umm” *etc*) and are inclusive of the nuances of the stories as told by the participants, for example pauses, silences and interruptions. Following completion of the fifth draft, each interview transcript was sent to each participant by e-mail for accuracy, sense checking and verification. All six participants verified their own interview transcripts with no requested amendments, and a final transcript was agreed.

Livari (2018), Nasheeda *et al* (2019) and Bleakey (2005) note that sense checking is an important part of the transcription process in narrative studies and has several benefits including participant empowerment and increased control and participation in their data, improved transparency and clarity in the research process and acknowledging “ownership” of stories. However, challenges including memory recall, trustworthiness and ethical considerations when using sense checking, have also been identified (Carlson 2010, Motulsky 2021, McKim 2023).

The extraction of the data from the social media group was carried out using a different method and this was due to the different data collection method used and data produced. Data extraction was carried out manually by myself; firstly, I read through all the content on the Facebook group in the sequence in which it had been posted by the participants.

I read and re-read the content from screenshots of data taken from the Facebook group in the sequence of posting, copying and pasting the data into a separate word document. This process resulted in a draft data document for the social media group. This document from

the social media group was sent to each participant by e-mail for accuracy, sense checking and verification. All five participants who were part of the social media group, verified the transcript with no amendments requested, and the final document agreed.

f) Reflection on being the Transcriber

Although I have had some previous experience with transcribing interviews, they were not interviews I had undertaken myself and were not as in-depth or sensitive as the ones in this study. As I listened to my audio recording following the first interview, I felt conflicted emotionally. The interview had gone well, the methods had worked, but the detail of the story was harrowing and difficult to listen to.

As I began to transcribe, I knew that I would need to take regular breaks and step away from the transcription for my personal mental health and well-being. Going back and forth over the recording meant I was listening to difficult parts of the interview on multiple occasions, as I followed the transcription process. Words spoken by the participant such as rape, abuse, violence and in other interviews trauma, depression and fear bounced around in my head.

As I progressed with the transcription, and with further interviews, I became attuned to being immersed in the process, withdrawing when I felt things were starting to become overwhelming, and then re-engaging and re-immersing. This meant that the transcription process for each interview was lengthy, time consuming and emotionally challenging and draining. During transcription, and on completion of the first transcript, I could see that this approach and input was extremely valuable as the richness and depth of the data became evident.

I was able to use reflection throughout the transcription process, as a tool to help me cope with the often difficult and challenging stories that had been shared with me through the interviews, and later through the secret Facebook group. Reflection became an integral and essential part of transcribing, and I used it as a tool to refocus on the research process, considering the broader view.

4.16 Drawing on Narrative Knowing:

Relationships between situational lenses, transcription and reflection

As one of the main proponents of narrative knowing, Polkinghorne (1988) provides practical guidance and direction for researchers who want to utilise the data that has been collected in a narrative approach. The building, development and revealing of relationships between elements (narrative knowing) in narrative data collection, is considered an important part of the integrity, trustworthiness and quality of both the process and outcomes of data collection (Andrews *et al* 2013, Bold 2012, Chase 2003, Mitchell and Radford 1996).

Moreover, Josselson (2007), Reissman (2008) and Somers (1994) assert the view that when carried out, this essence of narrative knowing underpins and provides a firm foundation for narrative data analysis. The relationships element, as an inherent part of narrative data collection, is asserted by Polkinghorne (1988) and other narrative scholars as a method of identifying meaning in “small” stories, which allows the “big” narratives to be drawn out (Clandinin and Connelly 2000, Hyvärinen 2016 and Reissman 2008).

However, this view has been refuted by Richards (1989), Jones (2003) and Scheff (1997) as simplistic, lacking in detail and theoretically unsound. Strengthening the argument for the use of narrative knowing, rests with the ability of the researcher to provide clear evidence for the contribution of this approach, in the overall development of the narrative thread (Brockmeier and Meretoja 2014 and Andrews *et al* 2013).

In this study, I used the elemental relationships between transcription, reflection and situational lenses, to provide a detailed underpinning for the stories and narratives as they evolved, and generated narrative knowing and meaning. Work by Andrews *et al* (2013), Carpenter (2018), Ebbs (1996), and Finlay (2012) support the identification of overlap in areas, including researcher positioning, storytelling and story writing.

4.17 Data Analysis

1. Introduction

This section will consider the approach, methods and application of qualitative analysis used on the data gathered for this research study. I will consider, outline and critically discuss the broad spectrum of narrative analysis and how elements of this have been utilised and applied to data collected on negated childbearing. Data analysis applied to the in-depth

interviews and the Secret Facebook Group are outlined and detailed, including singular and joint method data analysis. To conclude, I will examine the challenges and potential limitations of narrative analysis, and how the use of layered narrative analysis can provide a strong basis for rich, deep findings in this subject area.

2. Narrative Analysis

The approach of narrative analysis in research is to examine and interpret storied data and which specifically seeks to understand meaning making, story construction and storytelling/sharing as part of and in relation to, life context and broader narratives (Andrews *et al* 2013, Casey 2016, Hyvarinen 2016 and Moen 2006).

Lieblich *et al* (1998), Polkinghorne (1988), Riessman (1993), Saleeby (1994) and Squire *et al* (2013) discuss and highlight the ‘umbrella’ nature of narrative analysis, as providing a broad framework which encompasses a variety of different methods of analysis, and which aim to capture the form of stories in their contextual setting.

The narrative element is in the use and understanding of the storied forms of data. From this broad framework, I have chosen to apply the broad approach taken by Reissman (1993), which focuses on three layers of narrative analysis; thematic, structural and performative. Although not all narrative research uses multiple layers of analysis, and they can be used separately depending on the nature of the study, a layered approach to analysis embodies the ethos of narrative research and can provide an underpinning strength, which helps with holistic storytelling and context (Beal 2013, Casey *et al* 2016, Clandinin and Connelly 2000, Earthy and Cronin 2008 and Hyvärinen 2008).

In addition, how the researcher uses and applies approaches to narrative analysis can be widely variable so, for example, if thematic narrative analysis is being used there are a few different types that can be used and have different applications. The philosophical framework which forms the basis for this study provides the guiding principles which inform all aspects of this research process, including analysis and so the influence of social constructionism on narrative analysis used in this study will be discussed next.

3. Social Constructionism and Narrative Analysis

With a focus on the meaning making, social construction and performance of negated childbearing stories, uncovering the ‘truth’ was not the point of analysis; there was a move away from the ‘what’ to the ‘how’. This in turn deconstructs the realist position that assumes that life stories can be regarded as ‘mirrors of life events’ and instead emphasises the sense of the ‘told’ story, how the story is told in context and how tellers and listeners

experience stories (Rosenweld and Ochburg, 1992, Saleebey 1994, Sandelowski 1991 and Sools 2012).

Bury (2001), Clark-McGhee and Castro (2015), Neimeyer and Sands (2011) and Williams (1984) have distinguished between narratives of bereavement and chronic illness, that try to make sense of the experiences, including consideration of a changed self. These insights into the purpose of narrative analysis (from other health subject areas), can be applied to many other health/social topics, particularly where the stories being shared may be problematic, unresolved or associated with stigma and when related to the childbearing continuum (Barusch 2018, Carpenter and Austin 2007, Smith 2015).

Moreover, when applied to negated childbearing, these broad narrative insights which informed this study's narrative analysis, uncovered shared elements including development of storied origins, interactions with health professionals, the impact on day- to-day living and changed current and future priorities. It is perhaps unsurprising that the effective use of narrative analysis and it's alignment with the philosophy of social constructionism, can lead to the discovery of overlapping impacts on a person's social role/s and sense of worth, which can be seen through illness and bereavement narratives and also those in this study through the negated childbearing continuum (Frank 1995, Sandelowski 1991, Tuval-Mashiach 2014, Williams 1984).

Likewise, a narrative study conducted by Clark-McGhee and Castro (2015), with people who have experience of a dementia diagnosis, illustrates the way in which people tell stories about their lives (construction), the meanings they attach to them and the context in which they occur. Narrative analysis revealed once more the shared elements as discussed in bereavement and illness stories and as highlighted in negated childbearing.

However, Clark-McGhee and Castro (2015) also reported on the variety of stigma they encountered, such as social stigma, where participants used a focus group or support group, as an opportunity to provide an alternative story of dementia and this is mirrored in work by Bruner (1999), Melton (2011) and Walker (2009) and once more reflected in this study. Similarly, the narrative analysis of these studies was able to draw out the element of, and issues relating to, personal agency and sense of self, in relation social context and identified in negated childbearing (Clark-McGhee and Castro 2015, Bruner 1999, Melton 2011 and Walker 2009). It also highlights the social construction and production/co-production of stories, and the importance of this in relation to the ethos of the narrative approach, which will be discussed next.

4. 'Co-authorship' and Joint Story Making

Instead of viewing stories as simply representative of an individual life, the narrative approach guides us to critically consider the 'joint actions' involved in the creation and production of the story (Bamberg 2006, Clandinin and Connelly 2000, Earthy and Cronin 2008). It also indicates the way in which the meaning of the story and hence its consequences, are to some degree shaped by the social interactions (in the widest sense) between participant and researcher, that encourage and influence the way that stories may be told.

The emotional connection with the narrator as the story is being told, yields a powerful expression of the meanings, influences and context of what is described. I felt this during all the interviews I carried out and, but not as strongly, during interaction on the Secret Facebook Group and this was informally recorded through reflective notes in my researcher diary.

There is a dilemma between wanting to remain professional and wanting to engage and share with the story telling; this signals a confliction between how we feel we should behave as researchers, how we want to behave, and the narrative of what happens as the story is told. Andrews (2013), Bold (2012), Chase (2005) and Crossley (2000a) argue that to adopt a narrative approach is to choose to understand and analyse data from this embedded 'co-production' perspective, rather than focusing solely on the content. This perspective was central to this PhD research and led me to consider the following reflective questions (using my researcher diary), as part of the data analysis:

- Why does the participant tell their story in this way?
- What is the purpose of the story?
- Why does it occur at this point in the conversation?
- How have I (researcher) influenced the story?
- How do the different elements of the story fit together?

Moreover, the framing of questions and signals of interest and encouragement from a researcher (non-verbal as well as verbal) precede storytelling and shapes how the narrative is seen and presented (Bamberg 2006, Elliot 2005, Feldman *et al* 2004, Fraser 2004 and Goldie 2004). Therefore, at a different time with a different researcher (than myself) present, the stories of negated childbearing might be told, created and presented in different ways. This is what is meant when stories are described as being 'co-authored',

although some researchers discuss that a broader concept of joint story-making may reflect the fluid nature of the input of both participant and researcher in a more nuanced way (Hunter 2010, Hyvärinen 2016, Moen 2006, Neimeyer and Sands 2011 and Sandelowski 1991).

Joint storytelling is the ethos which has been identified and acknowledged throughout this PhD research on negated childbearing. This can be seen in the use of the situational lens approach, analysis of the story structure and the use of poetry. Smith (2015), Squire *et al* (2013), Williams and Wong and Breheny (2018) also highlight that topic - for example, those relating to difficult circumstances or issues, and/or closely connected with a person's sense of identity and self-worth (such as negated childbearing) - are likely to foster and promote communication and interaction through joint storytelling and making.

4.18 Data Analysis Process:

a) Steps to, and through, narrative analysis

The practicalities of carrying out narrative analysis were considered throughout this study but took shape whilst I was in the data collection phase, as I became familiar with the data and initial emerging threads from the interviews. As the stories of individual negated childbearing were shared and collected, it became clear that I would need to look at analysis of both the individual (small) stories from the interviews and the shared experiences through the Secret Facebook group which arose, to appreciate and understand the complexities of the phenomena. Bamberg (2006), Casey *et al* (2016), Chase (2005), Feldman *et al* (2004) and Fraser (2004) highlight the importance of letting the data collection inform the approach to narrative analysis, particularly in relation to small story data analysis.

Moreover, elements of the 'life story' were also incorporated, where sections of data are considered holistically in the context of life experience and events, so in context (Barusch 2018, Beal 2013, Carpenter and Austin 2007 and Liebllich *et al* 1998). As the data on negated childbearing emerged, a combination of small story analysis and the life story approach, seemed to be a good fit to gather and analyse the data in an effective, but flexible manner.

This combination of analysis, which is led and informed as the findings unfold, has been used successfully by other narrative researchers and studies, and is seen as a flexible and dynamic means which helps the storied elements and narratives to be perceived. In addition, Bausch's (2018) work illustrates this through story detail of one her participants, in a way which brings the story to life, whilst providing analysis, commentary and discussion along the way. There is a journey of narrative research discovery about the participants' life, eliciting meaning and drawing conclusions, achieved through this analytical narrative.

Andrews *et al* (2013), Bold (2012), Casey *et al* (2016) and Clandinin and Connelly (2000) also identify some practical elements which can work well when using a combined narrative analytical approach; for example considering the potential covert content, which may lie unsaid between the lines of dialogue, highlighted during pauses, unfinished sentences or silence, or alluded to using alternate verbal and non-verbal communications (which was used in this study). These elements were captured during data collection for both the interviews and the social media group.

Crossley (2000b), Earthy and Cronin (2008) and Georgakopoulou (2006) highlight the importance of this element of analysis when comparing stories for similarities and differences in content and style, with Frank (2010) and Goldie (2004) seeing this as essential to enrich and strengthen narrative analysis and interpretation. This unfurling of the narrative study allows the stories to be told and their importance to be revealed as told by the narrator; in fact, Frank (2010), refers to this process as “letting stories breathe”.

Although narrative analysis processes utilised in this study help to maximise the flow and holistic nature of storytelling and sharing, there is also the potential for some stories and narratives, or types of stories, to become difficult to follow, disrupted, distorted and broken, due to difficult or traumatic events. The “disrupted narrative” lens has been identified by some narrative researchers and is associated with elements such as psychological trauma and complicated grief (Honos-Webb *et al* 2010, Savvidou *et al* 2004, Walker 2009 and Wilson 2007), and is further explored by Becker (2023) as a broad concept linking to meaning making through disruption and chaos.

This lens is further explored later in this chapter, using narrative structural analysis - so how the stories were told. As a researcher, I developed my knowledge and skills in managing any noted ‘disruption’ to stories and narratives and became adept at highlighting details and incidents in the stories of negated childbearing that are important, “emblematic events”. These are events which form cornerstones of stories - and can help to identify and reveal the main thread/s through which the story is based on. This helps the researcher to move through the practical aspects of doing the analysis, which is outlined and discussed next.

To strengthen and provide greater depth to the data analysis in this study, I decided that utilising multiple narrative analysis typologies would provide a firm foundation for the data and help with alignment of methodology and narrative research principles. As data collection proceeded, I had considered different methods of analysis and thread analysis

seemed the first and most obvious choice, to identify some of the main threads which were being revealed through data collection.

b) Thread Analysis

Narrative thematic analysis has been discussed and described by several narrative researchers as a type of narrative inquiry which focuses on the content of the data that has been collected - so developing a clear focus through what has been said or told (Bold 2012, Casey *et al* 2016, Earthy and Cronin 2008 and Reissman 2008). A key difference to other typologies is that narrative researchers aim to keep a story whole, when discussing the impact and outcomes of narrative studies, rather than theorising from individual themes. This approach will become clear in the discussion section of this thesis, which follows in the next chapter.

Riessman (1993), Smith (2015), Squire *et al* (2013) and Tuval-Mashiach (2014) discuss the variety and breadth of approaches to narrative thematic analysis and that these vary considerably, according to differences in methodology, research subject and questions, and the definition or position of narrative used in the study and/or by the researcher. There is no 'one size fits all' approach or description to narrative thematic analysis, however as Lainson *et al* (2019) suggest in their work with Braun and Clarke, the traditional 'essence' of thematic analysis can be used effectively in narrative inquiry, where ways of working with narrative data are clearly outlined and applied. In this way, utilising narrative data, common themes are identified as they emerge when data is analysed, and these themes then are set in context with the story as a whole and in this study - as linked to structural and performative narrative analysis.

Hitherto, the concept of the narrative 'themes' was transformed into narrative 'threads' - a more accurate description of using story-based elements, to position the 'telling' of, and experience of the story by the individual or group (Fraser 2004, Hunter 2010, Hyvärinen 2008 and Labov and Waletzky 1997). This provides a link with the use of structural narrative analysis, as it is based on elements of discourse analysis, storytelling and structuring and underlying context, and performative aspects.

The notion that many narrative threads are required to 'make' a story, is a view which is echoed in several key narrative texts (Bamberg 2006, Beal 2013, Clandinin and Connelly 2000, Feldman *et al* 2004, Frank 2010 and Georgakopoulou 2006). It is with this in mind, that the threads analysis concept is a key part of the narrative analysis approach used within this study, and which supports and informs a deeper narrative inquiry.

c) Crossley's Method of Narrative Analysis: theory and application

When I completed an initial review of the data, it soon became clear that the depth and complexity of the stories that had been shared with me, would benefit from a multi-layered approach to narrative analysis, including something which would allow a real sense of expression of the story and the meanings conveyed. Crossley's (2000a) suggested method and approach to narrative analysis is not dissimilar to other steps of narrative analysis, outlined by other narrative researchers such as Hunter (2010), Polkinghorne 1988, Riessman (1993) and Squire *et al* (2013), with the main difference being the inclusion of 'narrative tone', as part of Crossley's approach.

Furthermore, Crossley has carried out a range of research, including health-based studies and more specifically maternity, which align to the social constructionist theory and narrative approach (using narrative tone), and thus I considered Crossley's approach to narrative analysis a good fit for use in this study (Crossley 2001, 2003, 2007 and 2009).

It is for these reasons that I decided it would be useful to incorporate the first four steps of Crossley's method and adapt steps five and six, which would help me to better reflect the emotions and mood of the stories. I applied steps one, two, three and four of Crossley's (2000a) six step process, which details the practicalities of reading and analysis of narratives, to the interview and Secret Facebook Group data. Crossley's method is briefly outlined as follows:

Step 1 - Read each transcript about five or six times to become familiar with them.

Step 2 - During reading, pay attention to narrative tone.

Step 3 - Look for imagery and metaphors

Step 4 - Note possible themes (threads) evident from the reading.

Step 5 - Construct tables for categories recommended from the literature or that stand out in the transcripts, focusing on imagery and themes, to translate into a meaningful narrative.

Step 6 - Include these in the research report.

(Crossley 2000a)

This sets out a way for the researcher to identify what Crossley describes as basic levels of narrative tone from data collected, highlighting similarities and differences, through the first three steps. Narrative tone is identified by the researcher from the data, looking for words, phrases, context, imagery and discourse, and separating the data into categories. Three distinct categories in Crossley's method are utilised: positive, neutral and negative, into which data can be sorted, and which can then feed through into highlighting narrative

threads. The meaning of the three categories from Crossley's method is identified in figure 14:

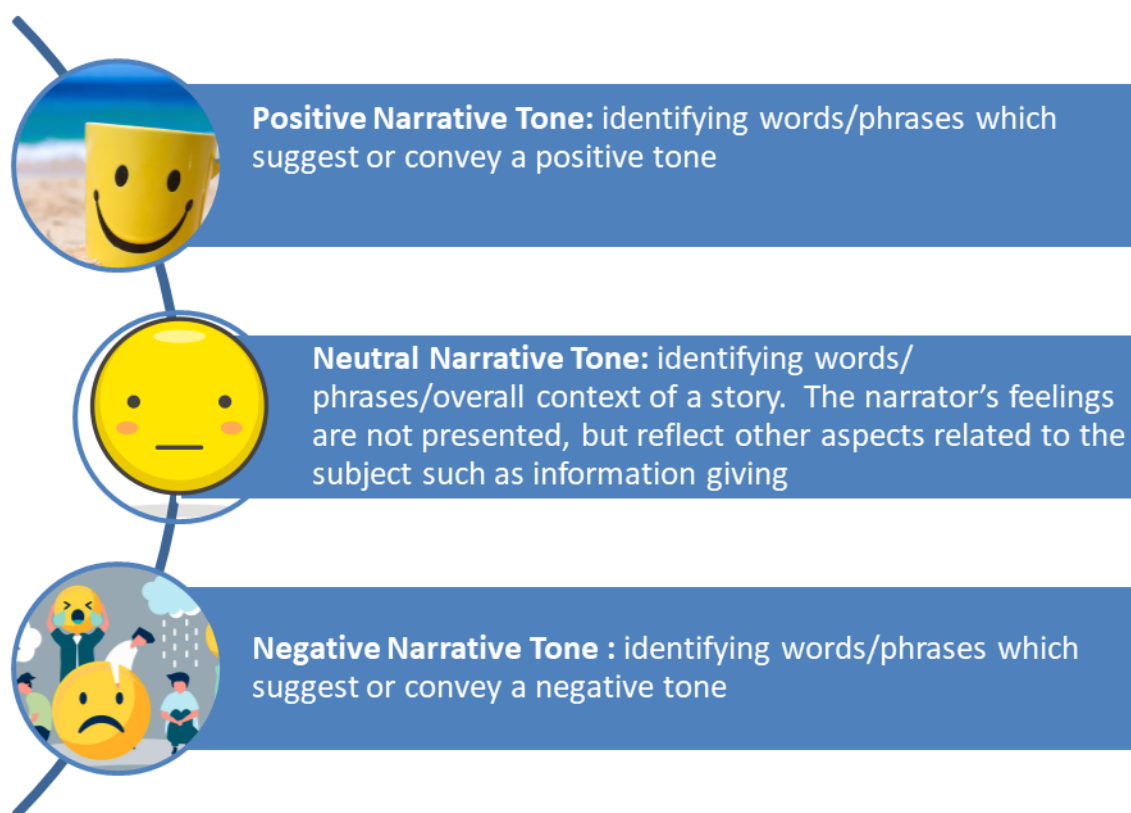


Figure 14: Categories of Crossley's basic narrative tone used in data analysis

Crossley's Method - Step 1

In narrative discourse, the narrator (participant) may use certain language, which can reveal emotions, feelings and attitudes about the subject matter. From the very first interview that I conducted as part of this study, it becomes immediately obvious, during the interview, transcription, and transcript reading and re-reading, that emotions and feelings were very likely to become key in understanding stories and should form the basis for an analytical approach which would do justice to the data collected.

The importance of emotions in narrative analysis has been discussed and identified, and acknowledged as a guiding factor, particularly in narrative trauma and stigma research (Carpenter and Austin 2007, Crossley 2003, Melton 2011, Savvidou *et al* 2004, Smith 2015 and Walker 2009). The act of reading and re-reading facilitates the researcher's connection with the emotion, and thus the narrative tone of the data.

Crossley's Method - Step 2 and Step 3

Narrative tone is described by Crossley as a method which can be used to establish mood within the data and can help to draw out the narrator's use of her own emotion and then to transfer those feelings to the listener (researcher). The tone within data can be created in numerous ways, including in narrative transcription, through figurative language, point of view and word choice.

Expressing behaviour, values and beliefs through storytelling also forms part of narrative tone, as characters in stories are developed through what they say and do, and the language used to describe them (Bamberg 2006, Barusch 2018, Chase 2005, Clandinin and Connelly 2000, Clark-McGhee and Castro 2015 and Fraser 2004). During listening to the interviews, transcribing and reading transcripts, capturing the 'voice', or the nature of the voice (imagery and metaphors), from the data can be challenging, but is essential in identifying narrative tone, as the voice that describes or narrates the events of negated childbearing.

Moreover, Crossley (2000a), Barusch (2018), Carpenter and Austin (2007), Feldman *et al* (2004) and Frank (2010) highlight the necessary importance of analysing attitude within narrative data, and that this can help to understand the emotion from stories which are conveyed to the researcher and readers. I developed my own practical, manual process consisting of five stages and applied this to facilitate steps two and three of Crossley's method (tone, imagery, metaphors), to the data as follows:

Stage 1: Hard copy transcripts were used from the interviews and the Secret Facebook Group, these were physically cut up into words/phrases/context, resulting in a 'pile' for each transcript.

Stage 2: Each pile was then manually sorted out into the three categories of narrative tone as identified in the figure above - a 'first' sort, alongside the complete transcript and the audio recording for context, to aid the process of sorting.

Stage 3: The first sort piles for the three categories was then reviewed by re-reading the piles and using the methods outlined in the previous step, creating 'second' sort piles.

Stage 4: The second piles are used to construct the final three categories of positive, neutral and negative narrative tone, including imagery and metaphors. Within these three categories, main threads emerged.

Stage 5: A manually constructed narrative tone diagram for emerging narrative threads was produced for: each singular interview, all interviews combined (joint/overall narrative tone for interviews) and for the Secret Facebook Group.

Crossley's Method - Step 4 and Adapted Step 5 and 6

Within the six-step model, actioning the fourth step requires the researcher to read their transcripts multiple times, to become familiar with, and then start to identify stories and narratives within (Bright and Du Preez 2023, Crossley 2000a). There is naturally some overlap between step three and step four of Crossley's model, as identified in the practical process carried out in stages, as from stage four narrative threads began to emerge and were identified. As the threads emerged, further listening of the interviews, further reading of the transcripts and data occurred and threads were manually organised into thick threads and thin threads - described as the 'narrative essence' of stories (Clandinin and Connelly 2000, Crossley 2000a and Bright and Du Preez 2023).

The thick threads are the dominant discourses, and the thin threads are the narrative tone, emotion and voice of the story being told. These threads were grouped (see photographs in Appendices 14 for manual grouping), into a table structure for ease of reference - like a section of Crossley's story-map grid (see Appendix 15), and one example of the tables constructed can be seen in Table 6 overleaf):

Thick Threads	Thin Threads
Abuse	Control Social Circumstance Violence Justification Relationship
Dyad	Love Attachment Safety Advocacy Protection Separation
Guilt	Regret Deceit Body Changes/Image Decision Making
Trauma	Mental Health Dissociation Memories Trust Diagnosis
Clinical Care	Choice Information Knowledge Support

Table 6: Narrative Essence: Emergent Threads from Phoenix's Interview

The adaption of Crossley's story map grid was used to simplify the approach and facilitate an in-depth focus on the thread, structural and performative analysis. Furthermore, the imagery and themes, discussed by Crossley in Step five and six, are used as the framework for informing structural and performative analysis, which contribute to small story meaning making, and feed into broader narratives.

d) Structural Analysis - approach and application

Structure is defined in this study as the linear stories that are told about negated childbearing, how the stories are told, and in what order events were shared during

storytelling. Structural analysis in narrative inquiry has essentially two elements, one or both of which may be applied to narrative data, and these have been identified as story building and structuring, and meaning making/meaning conveying (Riessman 2012, Saleeby 1994, Sandelowski 1991 and Sools 2012).

There are several different approaches available to guide structural narrative analysis, most stem either from Labov's work (1972) which focuses on the structure and grammar of the story, or from Bruner's work (1990), which focuses on how stories work to make sense of life experiences - meaning making. For this study, the approach of Labov guided the structural narrative analysis. Moreover, it can be argued that structure influences and impacts meaning making and that structural analysis helps to bring order to traumatic and chaotic stories and make them 'safe' and accessible (Becker 2023, Carpenter and Austin 2007, Crossley 2003, Goldie 2004, Hogan 2006, and Nasheeda *et al* 2019).

By listening to different stories, hearing people tell us about the happenings of their day, we absorb narrative structure. Because of this, we use stories to put events into an order that makes sense to us. Stories are useful to tell others what events happened, to explain why those events are important, and to understand what they might mean for who we are (Somers, 1994). Stories are not just a set of events ordered in time, they are a set of events put into order to convey a particular meaning, to provide an explanation of who we are and how others should see us (Riessman, 2008).

I used the thick and thin threads identified using Crossley's method, to give me a basis for understanding elements of individual stories, and how these were used and structured. I listened to the audio-recordings of the interviews, re-read transcripts and data and from this I absorbed, understood and identified the narrative structure of individual stories, making informal notes in real time.

The structure of each negated childbearing story was written using an adapted version of Labov's approach, without the structural coding system for simplicity (instead using the original transcript), and using a linear sequence to record and present. Each story structure was drawn from notes taken during the listening and reading phase and is presented as story chunks for ease of reference. This utilises Labov's approach of analysing longer sections of data, paying attention to structure and considering the parts that make up the story. Continuing with Phoenix's story, see overleaf the example of the story structure written to illustrate how Phoenix told, organised and presented her story (Table 7):

Story Introduction/Precis →	Personal history and self-identity Life story and background →
Preliminary Plot 1 →	Prenatal and antenatal negation →
Preliminary Plot 2 →	Realisation Looking back, looking forward, signs and symptoms →
Main Event/Core Plot →	Act of Negated Childbirth Physiologic and Psychosocial →
Following Plot 1 →	Postnatal Negation →
Following Plot 2 →	Revisiting realisation Aftermath, looking back, signs and symptoms, here and now, looking forward →
Closing Plot →	Recovery and support Post childbearing, ongoing and continuous process, catharsis →
Terminal Plot	Revisiting personal history and self-identity Assimilation of negated childbearing into self

Table 7: Phoenix's Story Structure

The symbolism that women refer to and use in their negated childbearing story structures, such as embodiment, identity and stigma, help to construct meaning which may not be clear. The women enter negated childbearing as a participant in a broader public childbearing process, in which contextual meanings of the negation are negotiated within community. In this process, the structures and meanings of negated childbearing are not advantageous to the woman, or understood, until they are shared by others. Bruner also

discusses the “private phenomena of secrets” (1990, p13), and that these can be interpreted and elicit pattern, structure and meaning when interpreted in context.

e) Performative Analysis

The third type of narrative analysis used in this study is narrative performative analysis, and it is considered a broad umbrella of approaches which focus on oral stories, utilising some elements of thematic and structural analysis, to add richness and dimension as a complement (Bamberg 2006, Chase 2005, Faulkner 2020, Frank 2010 and Riessman 1998). The ‘performance’ comes from the oral story and how this is produced between narrators or story tellers and ‘others’ (for example researcher, audience, reader), considering the influence of the ‘others’ as well as the teller on how it is interpreted.

Nasheeda *et al* (2019), Smith (2015) and Walker (2009) discuss the importance of the researcher’s influence (power dynamic), the environment or setting in which the story is told and the social context and life circumstances in performative analysis. The ability of this approach to draw on social settings and influence, is a key element which distinguishes it from other analytical types. Furthermore, as stories may be seen as emerging from social construct and told in context, they can shed light on societal norms and values and broader narratives through performance (Hunter 2010, Saleeby 1994, Sandelowski 1991, Savvidou *et al* 2004 and Riessman 1998).

Performative narrative analysis is commonly used to analyse data where there are small numbers of participants, or those that take the case study or biographical approach, where a deeper dive is required, to reflect the complex and detailed nature of the story being studied (Barusch 2018, Bury 2001, Carpenter and Austin 2007, Casey *et al* 2016, Clark-McGhee and Castro 2015 and Crossley 2001).

There are a variety of methods and approaches to narrative performative analysis including: co-production, case study, dialogic performance, role play, life history and poetry, and it is the poetic approach which was adopted for this study. The rationale for using poetry is multi-faceted - it allows deeper engagement with the data, can help to make sense and create meaning in stories and narratives and can create a powerful and emotive connection with research data and studies (Carter *et al* 2007, Clark-McGhee and Castro 2015 and Faulkner 2020).

The use of poetry as a means of qualitative inquiry and research tool, is considered relatively new in research terms and has variously been employed as method, process, analysis,

presentation and dissemination, across a broad range of disciplines with roots in anthropology and the social sciences (Clark-McGhee and Castro 2015, Crossley 2003, Faulkner 2020 and Neimeyer and Sands 2011). It has been utilised across genres such as autoethnography, feminism, participatory research and narrative and in a variety of ways.

Faulkner (2020), Norton and Sliep (2019) and Stenhouse (2013) highlight several core elements which need to be present and applied in the use of poetry in research, namely reflexivity, identification of researcher influences and the importance of subjective understanding. These essential elements can be drawn on across poetic inquiry types and provide the essential underpinning for critical understanding and application of poetry in (narrative) research. For this study, I devised and implemented a simple four step process, which starts with reflexivity determined through re-reading interview notes and reflecting on the narratives. This facilitates an increased awareness and understanding of the impact of myself as researcher and this was determined and captured by making notes in my researcher diary whilst simultaneous reflection occurred.

I then moved on to discerning subjective understanding of the data through a review of items noted in figure 15, including reading the situational diagram and re-listening to the audio recordings of the interviews. The final step is where the poetry was created, focussing on a reflexive approach. The use of the three core elements, and the stepped process for poetry creation in this study (for interviews), is outlined as follows:

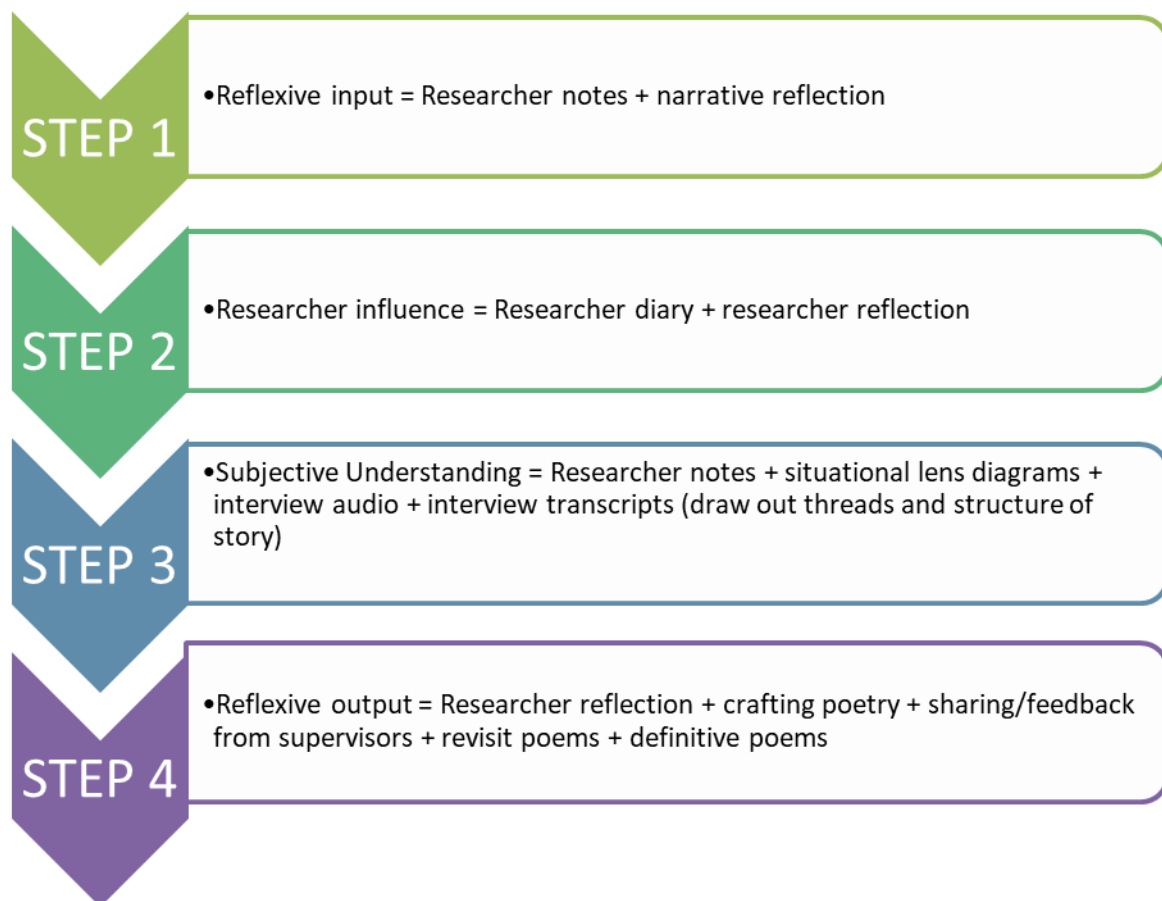


Figure 15: Application of core elements for poetic inquiry in narrative performative analysis: a stepped approach

The type of poetry produced and used during this study is commonly known as ‘found’ poetry and may also be described as poetic transcription (Clark-McGhee and Castro 2015, Edwards 2015, Faulkner 2020). In simple terms, this method of analysis takes data from the stories told (for example, interview audio, interview transcripts, reflections) and the researcher interprets and converts the study data to poetry. In this study, the women’s words from the transcripts were taken and crafted into poems, using the audio recordings and the situational lens diagrams to reflect the style, emotion and essence of their individual stories.

The direct use of transcript words, is a way to enter the life of the storyteller, shaping and presenting meaning and giving ownership of the story to the woman (Faulkner 2020, Frank 2010, Neimeyer and Sands 2011, Walker 2009). Moreover, these research poems give credence to, and highlight the importance and benefits of, oral narrative data, as ethical research process and practice and frame and capture the depth of original, individual holistic performance (Edwards 2015, Norton and Sliep 2018, Stenhouse 2013 and Ward 2011).

The practical method used to create the poems of negated childbearing, is described by Faulkner (p 63, 2020) as “researchers highlighting participants’ exact words and language from interview transcripts, cutting and pasting the essential elements”. I used the one transcript which was produced for each audio recorded interview, to construct a poem for each participant.

Basic ‘guidance’ was followed for the construction of each poem which was that the oral tradition of the participants was followed as closely as possible including: using the closest and/or exact words/phrases taken from the transcript, in the order they were spoken, utilising emphasis and emotion conveyed by the participant and to capture the tone, rhythm and juxtaposition of how the story was told. The ‘cutting and pasting’ was carried out electronically, directly from the transcripts.

The thread and structural analysis of the data further contributed to drawing out the narrative threads and content of the stories, which are reflected in each poem. The different ways in which the stories were told is shown in the variety of structure, stanzas and length of poems. An example of how the poems were constructed using the method described, is shown in figure 16:

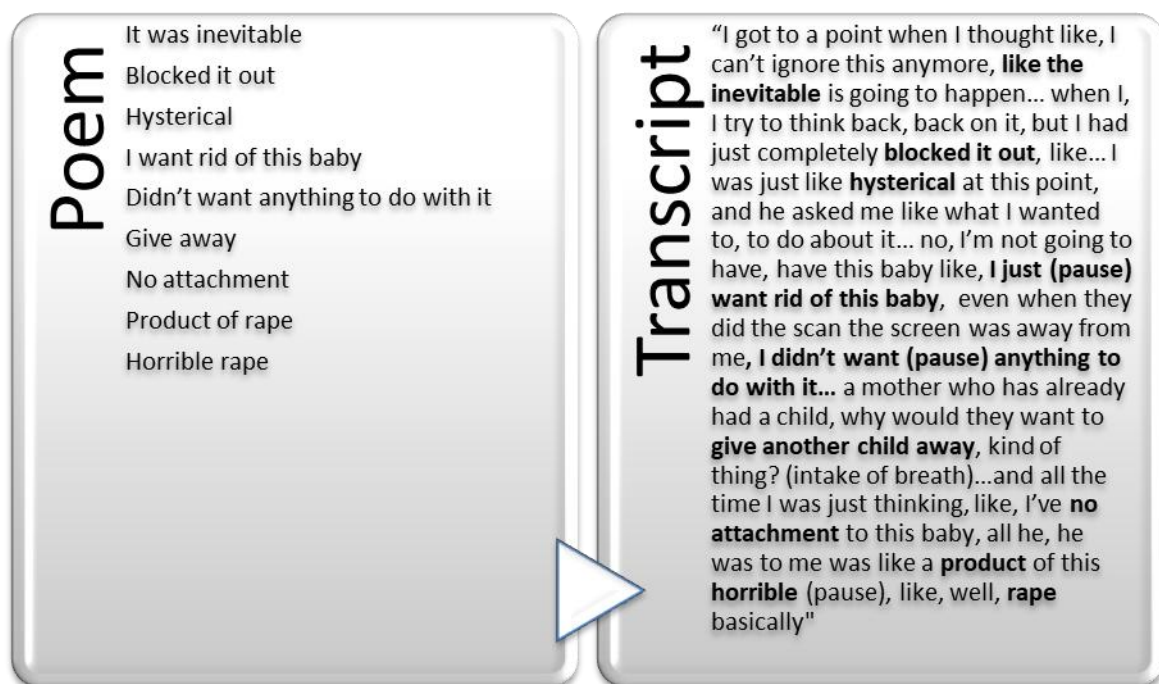


Figure 16: The negated childbearing of Phoenix: Poem sample juxtaposed with interview transcript section

f) Narrative analysis typologies

Weaving the three types of narrative analysis together provides a strength in the findings of negated childbearing. It is also reflective of Reismann's (2008) approach to narrative analysis, where use of multiple typologies is suggested. Reismann (2008) describes four distinct types of narrative analysis in her works (thematic, structural, performative and visual), however with the proviso that boundaries between these are not always distinct and that they naturally overlap and blur during use by the narrative researcher. For the purposes of this study, I used the thematic and structural analysis to inform the performative analysis and the creation and presentation of the poetry.

The rationale, importance and practical application of using three different types of narrative analysis in this study have already been touched on earlier and therefore we consider the potential benefits in this study. The aim of using a variety of different typologies and creating a multi-layered approach to data analysis is to enable a reasoned and in-depth 'picture' of negated childbearing, drawn from the individual case-centred stories, to be presented and disseminated, and this is summarised in figure 17:

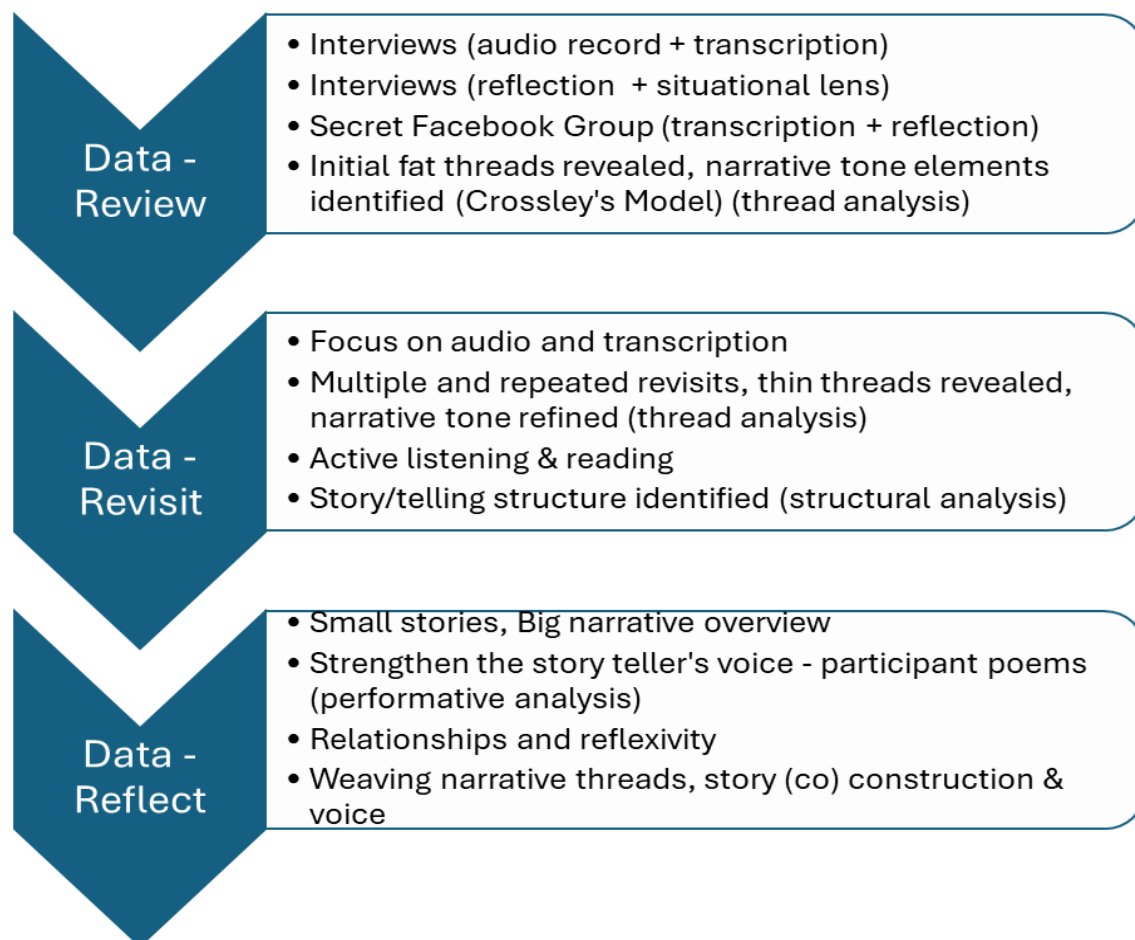


Figure 17 Steps through the stages of narrative analysis

Andrews *et al* (2013), Bamberg (2006), Beal (2013), Riessman (2008) and Saleebey (1994) discuss the significance of narrative analysis, which encourages a deeper understanding of storied data, leading to a wider consideration of narratives.

Furthermore, this can be demonstrated in this study by moving through individual ownership of stories; women telling their own negated childbearing story - to collective and shared stories of negation, and broader narratives such as the childbearing body/embodiment, the motherhood lens and self and identity. When the different narrative typologies are brought together, understanding of negated childbearing can contribute to views and perceptions of the childbearing continuum and how motherhood is seen/heard/understood within that continuum.

g) Challenges and Limitations of Narrative Analysis

The benefits and strengths of narrative analysis as discussed earlier in this chapter, also provide some room for discussion around the potential challenges and limitations of using this approach. Due to the nature and flexibility of narrative analysis, there are a range of quality issues considered to be worthy of exploration and discussion by narrative researchers including validity, truth and trustworthiness, rigour and the ability to make sense of stories, when presenting them to others (Andrews *et al* 2013, Bold 2012, Clandinin and Connelly 2000, Elliot 2005, Hogan 2006, Hunter 2010, Riessman 2008 and Wright 2017). All are relevant to this study, and they overlap and interlink with each other, so they will be discussed fluidly as a group.

Validity and its associated challenges have long been discussed in narrative research and in essence relate to how meaning is created from stories and told to the researcher and how the researcher analyses, interprets and presents the stories (Polkinghorne 2007, Porter 2007, Rolfe 2006 and Sools 2012). Andrews *et al* (2013), Casey *et al* 2016, Chase 2005, Feldman *et al* (2004) and Meraz *et al* (2019) discuss the approach of using multiple methods of narrative analysis to data (such as used in this study), which leads to a strength and depth in interpretation, and aids the sense making aspect of storytelling and presentation.

However, being able to assure research validity in narrative analysis is neither simple nor straightforward and the relative broader context of the meaning of validity as applied to narrative should be considered within the interpretive paradigms in which narrative sits (Bailey 1996, Beal 2013, Earthy and Cronin 2008, Elliot 2005 and Georgakopoulou 2006). This argument is further developed by Iannacci (2007), who discusses and presents a case for critical narrative research which is underpinned by a clearly outlined theoretical

underpinning, essential to ensuring validity. Therefore, the situating of this narrative study within social constructionism is key to addressing the overarching validity issue.

Another aspect of validity that challenges quality in narrative research studies, is that of truth and trustworthiness. Although there are many facets to this aspect, Riessman (2008) highlights and discusses the importance of the storytelling, by both the participant and by the researcher who analyses, interprets and presents the story to others. Squire *et al* (2013), Tuval-Mashiach (2014), Ward (2011) and Wong and Breheny (2018) present the need for an approach positioned within each research study parameters, considered on the nuances of the research process. This thinking eschews the 'fixed' criteria for validity in other research approaches and embraces the dynamic and fluid nature of narrative inquiry.

Moreover, the important aspect of truth and trustworthiness in narrative analysis is then, not do you believe the storyteller, but is more focussed on why and how the story is told (making sense) and why and how the researcher analyses and presents the story in a particular way/s. Essentially as a narrative researcher, I have to make an argument for this study's rigorous narrative research process and present a clear, balanced and ethical route to the storied data and broader narratives (Bamberg 2006, Casey *et al* 2016, Chase 2005, Feldman *et al* 2004 and Riessman 2008).

4.19 Summary

In these previous two chapters, I have outlined and discussed the methods, data collection and analysis elements of the research process, which underpin this research study's contribution to new knowledge and understanding in negated childbearing throughout the continuum. I have outlined and discussed the approach taken to carrying out narrative analysis on the stories of negated childbearing and the practical steps utilised with three different types of narrative analysis. This provides an underpinning framework leading into the next chapter, on the discussion and presentation of the stories of negated childbearing.

CHAPTER 5

FINDINGS AND DISCUSSIONS OF NEGATED CHILDBEARING STORIES

5.1 Introduction

This chapter includes the findings from the data and narrative analysis of the interviews and Secret Facebook Group. The findings are presented and discussed in part one and part two as individual stories and shared stories of negated childbearing. A pattern is followed using the three methods of narrative analysis (narrative threads including narrative tone, structure and performative analysis), which is then further complemented by consideration of the findings of this study in relation to the current evidence base.

This constitutes the ‘small story’ approach of the study as previously discussed. In part three, the broader narratives of the findings and discussion are considered with reference to the current evidence base. The use of pseudonyms was carefully considered, and participants were asked if they wanted to choose their own pseudonym, but none wanted to do this, so the researcher chose alternative names which were felt to reflect an aspect or aspects of the participants story or personality (as seen/experienced by the researcher). The use of pseudonyms also includes ‘others’ mentioned in the stories presented here, including partners, family, friends, pets and places (and referred to in chapter three, section three: ethical considerations).

Part One: Personal Stories of Negated Childbearing

5.2 The Story of Phoenix:

“I didn’t want to admit it, ‘cause I knew where it had come from”

Story Telling

My first participant that I recruited to this study was allocated the pseudonym of ‘Phoenix’, which reflects this woman, who rises from the flames of a difficult and traumatic situation and experience and who has moved on, made a new life and taken some positive outcomes from challenging times. Informal notes were taken at the time of the interview and reflective notes written after the interview, to capture and reflect my thoughts and feelings

as the researcher, of how the interview was conducted. The informal notes are captured and presented in figure 18:



Figure 18: Researcher Reflections on Phoenix's Story Telling

This figure represents the researcher “looking into” the narrator’s story at the beginning, with the image of the corridor providing a visual representation of the start of the interview and story hearing journey. The story of Phoenix’s negated childbearing felt like a long, dimly lit corridor, with patches of light along the way, as my researcher journey moves through the story, with the brightest light shining through at the “end” of the story.

The aspects of light and dark reflect the broad positive and negative narrative tones which I heard as the story was told. The ‘clouds’ represent my thoughts and experiences, which I grouped under three main headings - ‘voice’, ‘silence’ and ‘trauma’. The bullet points at the side summarise the main points from my informal notes, illustrating a story which is rich with emotion and detail, revealing an individual storied account of negated childbearing.

The pauses and silences in the story telling reflect aspects of guilt, trauma and abuse as they are connected to difficult, challenging and negative parts of Phoenix's story. They encompass hesitation to reveal and re-live trauma/s and the enduring feelings of guilt at the situation/s and decisions made, felt long after the concealment and revealing of Phoenix's pregnancy.

To fully consider and capture the context/s and my relationship (and potential influence) with Phoenix, a further exploration of storytelling, using a situational lens diagram (adapted from Chase 2005) was constructed using the informal interview notes. In figure 19 below, four main areas which may impact interviewing and storytelling and hearing are identified as context, environment, narrator and researcher relationship and body language/communication. The arrows within the quarter circles identify the interlinked relationship between the four areas, whilst the bullet points provide the detail of where and how the story unfolded and influencing factors and outcomes:

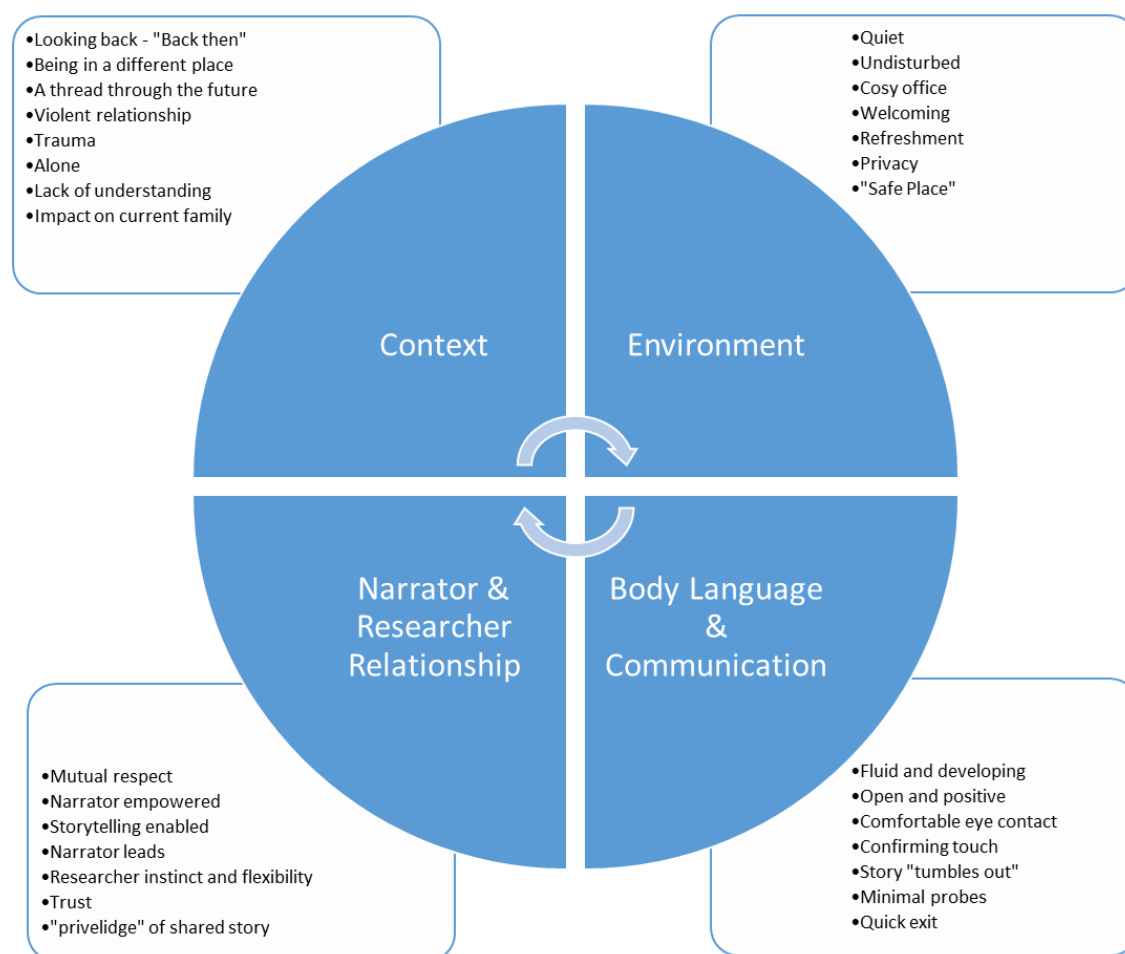


Figure 19: Situational Lens Diagram Phoenix's Interview

Story Precis

Phoenix was employed at the time of her negated childbearing and had one child to her then partner. The relationship that Phoenix had with her partner was rooted in domestic abuse including physical, sexual, emotional, financial, stalking and coercive control, with abuse directed at Phoenix, not her child. Her employment situation was very difficult as she worked with her partner and this made it very difficult for her to leave the relationship, due to financial worries. Shortly after Phoenix was able to leave the relationship, she suspected that she was pregnant, but found it hard to acknowledge, due to the pregnancy being a result of rape by her ex-partner.

From the moment that Phoenix thought she might be pregnant she concealed it from friends, family and work colleagues, avoiding contact with those close to her, wearing loose and baggy clothing to hide her changing shape and ignored her growing abdomen. During this time, Phoenix did not access any maternity services or care until around thirty-two weeks, when she first accessed services and revealed her pregnancy by visiting a clinic - unaware of the gestation of her pregnancy.

From this clinic visit, Phoenix was referred on to her local hospital for care, where a scan revealed her advanced, third trimester gestation. Although Phoenix had revealed her pregnancy to maternity services at this point, family and friends were still unaware and Phoenix was struggling to come to terms with the pregnancy, coping with trauma from her past abusive relationship. Additional assessments and care were put in place, due to concerns around the past relationship and Phoenix's physical health. At the same time, Phoenix was in touch with social services as she was thinking about adoption for her baby; her primary reason being to keep her baby safe from her ex-partner and to be in a safe place.

Social services were also able to help with Phoenix obtaining a restraining order against her ex-partner. Plans were made for adoption and a couple had been selected to receive and care for the baby from birth. At this time, Phoenix also made the decision to request an elective caesarean section, due to the trauma from her past relationship, and how her baby had been conceived.

Her mental health was poor, and she struggled to cope with her pregnancy, did not feel as if she had bonded with her unborn child, and the thought of going through a vaginal birth was very difficult and traumatising. Phoenix's family were unaware of this and did not know of the pregnancy, or the circumstances surrounding it, until after the birth, believing

that Phoenix had been unaware. After her caesarean section, the baby was removed straight away and cared for in the nursery. However, Phoenix felt differently after the birth and wanted to care for her baby but felt conflicting emotions about the adoption and the decision that she had made.

Phoenix did change her mind about the adoption and had to work very hard with social services and the adoptive parents, to work out a plan to get her baby back. A structured plan of supervised contact visits and work with social services, resulted in Phoenix getting her baby back when around three months old.

Story Structuring

The storied nature of Phoenix's negated childbearing is summarised in Figure 16 and will now be explored in further detail. Phoenix began her story telling with structuring the introduction, starting with immediately relaying details of the time-period when she was in an abusive relationship and about the nature of that relationship, including some details of the abuse and trauma that she went through. This part of Phoenix's story forms part of her life story and influences the structured storying of her negated childbearing. She provided me with a logical introduction to what happened, and this precis forms an important underpinning which helps the listener to understand the impact of this background on the subsequent structuring of the rest of the story.

As the researcher/listener this clear and 'expected' introduction provides the beginning to a sequence of events and a way for me and others to recognise the structure familiar to storytelling - that is to start telling the story with a background and introduction given first. The structuring combined with the way in which the story was told, makes for a powerful and emotive experience for both Phoenix and myself, and forms a 'persuading' element to the structuring of this story - Phoenix wants me, the researcher, to believe in what she is saying - in essence that her story is true and that it happened in the way in which she tells it.

Phoenix then moves to what I have identified as 'preliminary plots'; that is initial scenario/s where the story moves, in the first plot, to a brief description of the childbearing negation, prior to and during the pregnancy. This structuring of Phoenix's story helps to 'set the scene' and builds on the need for the story to be believed. It also highlights the lead up to Phoenix revealing her pregnancy and what happened and how she felt during that time.

The gradual building of the story continues with a second plot, where Phoenix structures her realisation of potential signs and symptoms of pregnancy, thinking about what she may

have missed, but also the potential impact for the future. The ‘main event’ in the structure of Phoenix’s story is told next and covers the detail in Phoenix’s story about how the pregnancy was concealed, revealed and how some of the feelings which developed during concealment were carried forward into childbirth. It is at this point in the story structure where details and decision making in clinical care are shared and the struggle to acknowledge the pregnancy and birth fully are outlined.

Notably this ‘core plot’ at the centre of Phoenix’s story, appears relatively soon in the story structure, and highlights both the need to get this part of the story told and believed, and to frame the importance early on. With the early occurrence of negation in the story, this also has the effect of leaving time for sharing other aspects of Phoenix’s story, including what happened in the immediate and longer-term postnatal period.

There ensues next a move to two ‘following plots’ in this story structure, where Phoenix describes in detail what happened postnatally, and this centres on the dyad and the decision-making impact and effects that removal of a baby can cause. There is a second realisation when Phoenix outlines the guilt of concealment, the choices she made for the birth and care of her baby, interwoven with a need to plan a future and coming to terms with a change in her feelings and decisions to a positive determination to build relationship with her baby.

Towards the latter part of the story, Phoenix shares her thoughts about the continual impact the negation has had on her life, including self-care measures such as counselling and the cathartic process of story sharing. The story structure is completed by Phoenix as she revisits some of the earlier story elements (such as personal history and developing a new self), as the story becomes part of her childbearing continuum and acknowledges that her story is an important part of her identity.

Figure 20 is a constructed plotline of Phoenix’s negated childbearing story, and it is a temporal sequence of events which reflects her story as a whole structure:

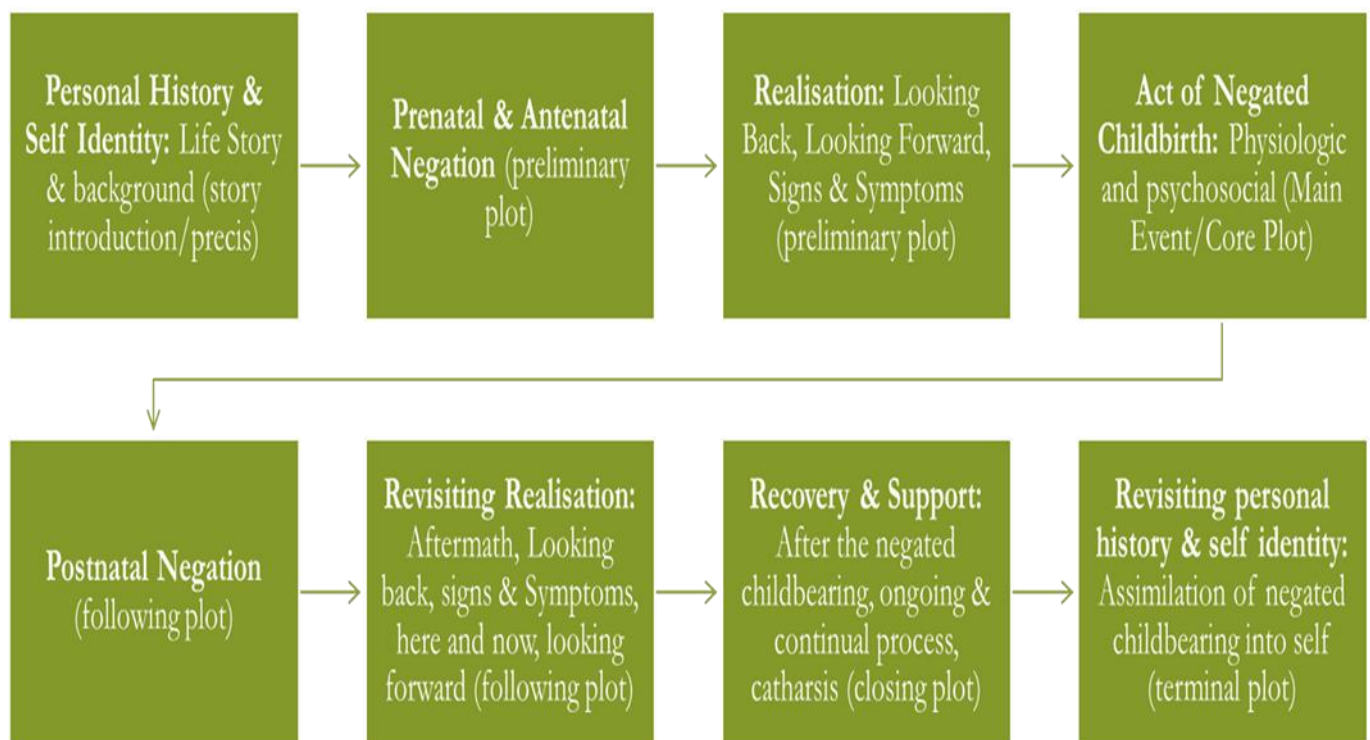


Figure 20: Illustrated plotline construct of Phoenix's negated childbearing story

Story Content Revealed - Fat and Thin Threads

a) Abuse Threads

It became immediately clear to me within a couple of minutes of the interview with Phoenix commencing, that abuse was a big theme in her story of negated childbearing and one which Phoenix describes in detail. The abusive nature of her experience covered many aspects of domestic abuse including financial, physical, sexual, emotional and coercive control and stalking:

"I was in like a, really, like really, really abusive relationship, erm, like physically abuse, like abuse abusive in every, sense of the word basically, he used to like beat me up, would like control my money, used to like force me to sleep with him and stuff, erm, it was just like a really, destructive awful relationship really"

"...and like he knew where I lived and when I did try to, err, like get away from him, he would just follow me and wouldn't leave me alone basically"

These quotes also reflect the thinner threads linked to abuse, of control and violence and the ongoing impact of that past relationship. The consistency and nature of the abuse that Phoenix suffered whilst in this relationship with her partner, ultimately led to the unplanned pregnancy, and had a major impact on how Phoenix felt about and dealt with the past abusive relationship and the pregnancy, leading to her concealing the pregnancy. The thinner threads throughout her story - the violent and controlling nature of the past relationship with her ex-partner and the fact that her unplanned pregnancy was the result of rape:

"I think I knew from the beginning that I was pregnant, but I think I didn't wanna, admit it to myself, 'cause obviously I knew, where it, where it had come from kind of thing"

"When I, I try to think back, back on it, but I had just completely blocked it out, like, so, there was no timeframe there for me if that makes sense..."

"... and all the time I was just thinking, like, I've no attachment to this baby, all he, he was to me was like a product of this horrible, like, well, rape basically..."

Phoenix made some references to her social circumstances at the time the pregnancy was conceived and throughout her negated childbearing experience. She referred to her financial situation at the time and how this impacted her decision making to stay in the abusive relationship, as she already had an infant to care for and support:

"He used to like beat me up, would like control my money"

"I worked with him as well so I felt like I couldn't, leave, because then it would be like losing my job, and I, like, I already had a, erm, a little boy at the time, so like I had the job to support like, me and my little boy"

The thinner thread of justification came about through Phoenix's discussions about her decision making throughout her story and why she made the decisions that she did, but also why she felt the way she did - so a justification of her feelings and decisions which others did not understand, or that Phoenix perceived they did not understand. The justification relates to why she concealed/was unaware of her pregnancy, when she revealed her pregnancy, decision making around birth choices and the impact of the pregnancy being the result of a rape.

"But I didn't realise like, to the extent of how long it had been going on for, because I just, it's just weird to explain now ..."

b) Trauma Threads

The second main thread of trauma in Phoenix's story was also evident from the beginning and throughout her interview, and there is an evident overlap with the abuse thread. The 'trauma' relates to the past abusive relationship and the ongoing impact of this, her difficulty in coping with the unplanned pregnancy, and her birth and post birth experiences:

"I think, it's such erm, erm, it's traumatic, it really was traumatic, it, it was, and like I say I still, still, speak to a counsellor now, about it, and I've probably not even told, said to the counsellor, like everything that I've said to you"

"... and I think I was traumatised from that as well, because even when I had this baby, I was just the whole labour, I was just, because I was induced, and I was high risk"

Furthermore, also overlapping with the fat threads of abuse and trauma, is mental health, which Phoenix alludes to and mentions directly in her interview. She acknowledges occasions when her mental health had been impacted - both by the impact of the abusive relationship and by her negated childbearing experience.

Further links between mental health, abuse and trauma can be seen throughout Phoenix's interview and highlight the behaviour of dissociation (from events/experiences) as a coping mechanism when dealing with abuse, trauma and poor mental health. For Phoenix, the dissociation was from her experiences of the abusive relationship, aspects of care and decision making, the negation - including her unborn child and from her ex-partners connection as a biological father:

"I was just in a place at the time and I just thought, I just can't deal with that, like mental health was just, so bad"

"I think I knew from the beginning that I was pregnant, but I think I didn't wanna, 'cause obviously I knew, where it, where it had come from kind of thing"

Excerpts of Phoenix's interview which touched on issues relating to the revealing of and diagnosis and stage of pregnancy - are reflected in her discussions which relate to her negated childbearing journey, illuminating another thin thread present throughout some sections of the interview. Moreover, the memories that Phoenix has of her negated childbearing, and the memories that were created through decision making, can be seen linked to trauma and diagnosis threads:

“So I think it got to about thirty two weeks when, I got to a point when I thought like, I can’t ignore this anymore, like the inevitable is going to happen...like I’m going to have a baby”

“I think even when I went to the family planning clinic I think even in my head I thought like I’m just trying to, get rid of this baby, I mean I know that sounds awful now...”

c) Guilt Threads

Phoenix alluded to feelings of guilt in relation to her concealment of her pregnancy and we can see that this overlaps with the threads of abuse and trauma and also touches on her decision making and the reasons for her making some of the decisions that she did at the time, particularly in relation to mode of birth and fostering/adoption of her baby. The guilt thread can also be seen in Phoenix’s interactions with others, and how she was made to feel for the very difficult decisions she made:

“I still feel, horrendously guilty about it, so I don’t talk to people about it...”

“Because they were saying, basically making me feel like a terrible person, saying, that, you know, you’ve, you’ve relinquished, that’s what they kept, the word they kept using, like I’ll never forget they kept using that word, re, relinquished, I thought, you’ve got to understand why I did that ...”

Furthermore, the guilt thread can also be seen when Phoenix talks about the health issues that her infant has and that she feels a sense of responsibility for concealing her pregnancy and not seeking healthcare earlier. Interwoven with this fat thread of guilt, and linked with decision making, is the thread of regret which Phoenix expresses:

“He’s got quite, quite a lot of health issues as well, and I do feel guilty about that, ‘cause I think oh, if you’d have just looked after yourself when you were pregnant, if you’d have, acknowledged it and stuff, and maybe he wouldn’t, and that’s something else that I do feel guilty about”

“so my consultant, was a nice man, erm, now looking back I wish he would have talked me out of the caesarean, I wish he wouldn’t have agreed so easily...”

The final two thin threads linked to guilt are deceit and body changes and it is here that Phoenix discusses some of the elements of her negated childbearing, including concealment of her pregnancy and how this shaped her story:

“I didn’t really have anyone to talk to, ‘cause like I said I hid it from literally everybody...like my mum, my sisters, our family, my friends, erm, I used to wear like baggy tops, so no-one could see I was pregnant, erm, I just made a point of not seeing, anybody...”

“I used to feel him, like moving around and stuff, and just said, and said to myself like, no, that’s, that’s just not a baby, like moving around”

d) Dyad Threads

As previously discussed through other threads, there are some very difficult and distressing threads throughout Phoenix’s story, which have a negative tone, but there are some neutral and positive aspects which can be seen, and these relate to the relationship that Phoenix has with her baby, in the dyad thread. The term ‘dyad’ commonly refers to something which has two defined parts, in relationship with each other (Cambridge English Dictionary 2025). In midwifery and maternity, the two parts are normally the childbearing woman and either the unborn or birthed baby (Oakley 1980, 2016 and Hill and Flanagan 2020). The fat thread of love shown as part of the Dyad, can be seen expressed by Phoenix:

“He’s my Jack now, and like I love him to bits”

“Just, love him so much, he’s just, literally the best, funniest little character ever”

Linking to the thread of love is the fat thread of attachment, which highlights some different, nuanced aspects of the dyad. From the previous threads Phoenix struggled to come to terms with her pregnancy, which was largely impacted by the distressing and challenging impact of domestic abuse.

After Phoenix revealed her pregnancy and gave birth, her feelings towards the baby changed, and the tone of her storytelling changed, where she revealed some neutral and positive tone in her narration. This wasn’t seen in the earlier sections of her story, as this was largely negative in tone influenced by Phoenix’s abuse and trauma threads. Phoenix clearly tells me about her feelings towards her baby, and describes their attachment as a dyad:

“As soon as I wasn’t pregnant, I like, it’s so hard to explain, I was just like, felt, like the sure, I was like, I just, I want, I want the baby here with me now”

“There’s still that, that bond there, that special bond, because I knew like, it was just me and him, and like, everything that me and him had been through”

Circling back again to the fat threads of trauma and abuse and again linking very closely with the impact of domestic abuse in Phoenix’s story, the thinner threads of advocacy, safety and protection of the dyad can be heard. Phoenix discusses how she made difficult decisions regarding foster care, which she did because she felt as if she was acting in the best interests of her baby.

Furthermore, the decisions that Phoenix made to advocate for her baby are closely tied to her need to ensure safety and protection - as she was worried about the potential impact of her abusive partner, but also that she felt conflicted in her decisions regarding foster care:

“I wanted to put something in place for the baby”

“I wanted him to be safe and away from, like, I don’t even like saying his dad ‘cause, that, he’s not his dad to me...”

The thin thread of separation can be heard in Phoenix’s story in two different ways, firstly through the concealment of her pregnancy, as illustrated in the fat threads of abuse, trauma and guilt, where a marked separation and dissociation from her pregnancy is illustrated. Secondly, separation is heard through an identified need to be separate - linking with advocacy, safety and protection, and also the difficulty of the physical separation which occurred as Phoenix’s baby was taken into foster care:

“I wanted him to be safe and, just away from that, and even if that meant being away from me”

“I could only see him an hour a day in a contact centre, and I didn’t get him back until he was thirteen weeks old ...”

Performing Stories: Storytelling, Structuring and Presenting through Poetry

To really bring the story of Phoenix to life, and to see where the threads and story structuring overlap and link, telling the story through a poem illustrates and brings together the findings and discussions identified. Presenting the poem also brings out the narrative tone present in Phoenix’s story of negated childbearing and sets it in the context of her

personal history, self-identity and the emphasis that she places on aspects of her story during the interview.

Fat threads of trauma and abuse are clear to see and the importance of the dyad to Phoenix. This approach to understanding, analysing, interpreting and presenting Phoenix's story from her interview, allows me as the researcher to choose aspects of the story which Phoenix identifies and highlights as key in her story telling. Moreover, the dimensional nature of poetry allows a deeper appreciation and understanding of Phoenix's negated childbearing story, drawing out the emotional nature and essence and presenting it in a succinct and meaningful way.

5.3 The Negated Childbearing of Phoenix

In like a really abuse, abusive relationship

Destructive

In every sense of the word

I had my little boy

Control

I left, I finally left

I knew

I was pregnant, didn't want to admit it

Knew where it had come from

Didn't tell anybody

It was inevitable

Blocked it out

Hysterical

I want rid of this baby

Didn't want anything to do with it

Give away

No attachment

Product of rape

Horrible rape

Put me asleep

He was taken away

Straight away

Distraught

*I want the baby here, I want him with me
He should be with me
They took him
Away
I was a big mess
I wanted him to be safe
I will never get over it
If I let him go*

*Had to fight to get him back
Relinquished
You've got to understand why I did that
I had to really fight
I got him back
I got him back*

5.4 Phoenix's Story in Summary

Phoenix's story was the first that I heard and the first interview that I carried out for this study. Her story tumbled out very quickly, almost as if she was ready to share it all and had been waiting for the opportunity to do so. Phoenix shared with me that she had told me details in the interview which she had not shared with anyone, not even her counsellor. As a researcher, I felt privileged to be able to hear and share her story.

The story is a contrast of dark and light - during the initial telling, it felt almost overwhelmingly sad, and the emotionally distressing nature of the story comes across strongly. Gradually lighter elements come through as the story progresses, and this is centred on the relationship of the dyad. The negative weight of the negation lifts following birth and the importance of the postnatal period and beyond, in understanding negation and providing opportunities for support and recovery is identified. Furthermore, the story illustrates a change of heart, the new feelings and positive emotions (but also the guilt), and building the relationship between Phoenix and her baby.

Drawing on the importance of understanding of the impact of the postnatal period in this story on coping with negation, Phoenix tells us about the long-lasting impact of negated childbearing, the regret about feelings and thoughts towards the pregnancy, and the need to protect and hold onto the dyad and it's meaning in Phoenix's life. The need for healing in the postnatal period and beyond and to be understood and believed is identified and

highlighted. What started out as something inconceivable, something awful, becomes changed into something with special and important meaning, and the difficult times create a reason to strive for a better outlook and life.

Moreover, there comes across a uniqueness and individual nature to Phoenix's negated childbearing story, and the telling of it, which is captured succinctly in her words in the found poetry. The poem performs the essence of Phoenix's story, portraying the challenging negative emotional aspects, juxtaposed with the uplifting positive aspects, creating a storied narrative full of meaning.

5.5 The Story of Shell

"I always find it easier to say - she was born on a Monday evening"

Story Telling

Shell was the second woman to share her story with me, through an interview in her home. When thinking about assigning a pseudonym for this woman, I reflected on the way she told her story. The story is shared in a constant ebb and flow of narration and information, mirroring the ebb and flow of how the negation was revealed. The back and forth of the story telling is like the rise and fall of the tide on a beach, and associated with beaches are shells, which are moved by the tide.

Informal notes were taken at the time of the interview and reflective notes written after the interview, to capture and reflect my thoughts and feelings as the researcher, of how the interview was conducted. The informal notes are captured and presented in figure 21:



Figure 21: Researcher Reflections on Shell's Story Telling

The picture represents the concept of cocooning - or creating a cocoon. The creator of the cocoon is the Narrator the researcher looks on and observes as the cocoon is created. The Narrator, through the interview and storytelling, seeks to create, through a purposeful manner, a safe, warm and cosy environment, mitigating the unreality, coldness and trauma of the negated experience.

The cocoon is making a luxurious material - silk - bringing something lovely and tactile to a difficult and traumatic experience, held with lingering guilt. A different part of the story emerges as the Narrator breaks out of the cocoon she has created, and through making a family, builds on the day-to-day reality of the new life.

The 'clouds' represent my thoughts and experiences throughout and post interview, which I grouped under three main headings - 'unreality', 'cocooning' and 'dawn breaks'. The bullet points at the side summarise the main points from my informal notes, and provide the essence of Shell's detailed, purposeful and protective story, once again revealing a holistic and individual storied account of negated childbearing. The practical and

controlled nature of the storytelling, with an attention to small details, is Shell's way of taking control and managing the difficult aspects of trauma and guilt, whilst recognising the positive and important aspect of family, and the creation of the dyad.

To fully consider and capture the context/s and my relationship (and potential influence) with Shell, a further exploration of storytelling, using a situational lens diagram (adapted from Chase 2005) was constructed using the informal interview notes.

In figure 22 below, four main areas which may impact interviewing and storytelling and hearing are identified as context, environment, narrator and researcher relationship and body language/communication. The arrows within the quarter circles identify the interlinked relationship between the four areas, whilst the bullet points provide the detail of where and how the story unfolded and influencing factors and outcomes:



Figure 22: Situational Lens Diagram Shell's Interview

Story Precis

This was Shell's first pregnancy, and her story starts with her talking about the signs and symptoms that she experienced in the run up to the diagnosis of her pregnancy. The timeline for the story is approximately three days from the onset of symptoms through to the birth. Shell did not know that she was pregnant at this point and began experiencing a range of symptoms including back pain and urinary frequency and urgency, causing Shell to think that she had a urine infection as she had had these previously (with similar symptoms).

The symptoms increased and then when blood first appeared in Shell's urine, she saw this as an abnormal symptom and sought medical help through the NHS 111 telephone triage service. Following the advice given by NHS 111, an ambulance was called, and Shell was taken to hospital with a suspected severe urinary/kidney infection, with her partner accompanying her.

On admission to hospital, a range of tests were carried out and Shell's history was taken, during which Shell was asked if she could possibly be pregnant, to which she answered yes. The diagnosis of pregnancy was confirmed by a doctor to Shell and her partner within an hour, and both Shell and her partner said they were shocked. An ultrasound scan was performed, and a diagnosis of an 'early' healthy pregnancy was confirmed. Whilst being scanned, Shell and her partner were informed that she would be within the time frame to consider termination of pregnancy. Shell then talks about her social and financial situation, describing how she and her partner were young, had little money and lived in a flat, in relation to whether they thought about a termination.

Shell was discharged from hospital with pain relief and was told to book in with a GP or midwife, pending consideration of a termination. Shell and her partner went to a local park to get some fresh air, walk the dog and talk things over between the two of them. They thought that Shell was around eight or nine weeks pregnant, following the information that they were given at the hospital, and they discussed finances, their living accommodation, and how they could make things work. They returned home and Shell took some pain relief and slept overnight.

On waking in the morning, Shell then reports having cramping pains - like period-type pains in her stomach; she was coping with these, so her partner went to off to work. When he returned, Shell reports not feeling well and as they had plans to go out with friends, Shell stayed at home and her partner went out as the friends lived close to them and he could

return easily if Shell needed him. Soon after he left, Shell's cramps intensified and she got a hot bath to try and ease them, but they continued to increase. Her partner returned, and Shell once again sought medical advice using NHS 111 telephone triage service and on, describing her symptoms, she was informed she was probably miscarrying.

Shell was taken by ambulance for the second time that weekend to a different hospital, and seen by gynaecology services, whilst her partner went to work. On examination, Shell was informed that she was in active labour and that the baby was, in fact, full term and this was not an early pregnancy as she had originally been informed.

Shell was moved to the maternity unit and on to delivery suite, where she contacted her partner first (who came immediately to the hospital) and then her mum. Shell's mum brought in some items that Shell had requested and then asked a friend to purchase baby items with her credit card. Shell opted for an epidural for further pain relief and required some further intervention at birth, as staff were unable to clearly hear the baby's heartbeat. The emergency buzzer was pulled, and several staff entered the room, with the birth being expedited by a ventouse. Shell was transferred to the ward and tried to breastfeed but struggled and supplemented the feeds with formula as she wanted to go home.

The discharge was delayed as Shell had been brought up in foster care, with social services input, and a referral had to be made to safeguarding due to the past involvement, and the fact that Shell had not been aware of her pregnancy or labour. Following discharge home, Shell continued to have difficulties with breastfeeding and was very ill with mastitis. She also found it hard to talk about her story and avoided going to mum and baby groups and activities for this reason.

A difficult relationship with the health visitor, who felt that Shell had postnatal depression also made for a challenging post birth experience. A few months after the birth, Shell was diagnosed with anxiety and mild Post Traumatic Stress Disorder (PTSD), which she received medication and support for. There is further reflection from Shell on signs and symptoms she experienced throughout her story and that there seemed to be an explanation for them at time. Her story was shared through her partner with a local newspaper and on social media, and some of the comments made were difficult to Shell to deal with.

Story Structuring

Shell's structuring and relaying her story, involves a great deal of revisiting, looking back and reflecting on the events in the pattern that they occurred, as Shell makes sense of her role in the story and the role of others in her story. The focus on sign and symptoms that may have been 'missed', the diagnosis of pregnancy and a very quick transition to the unexpected intrapartum period, form the key aspects of the early part of Shell's storytelling.

The remainder of Shell's story is heavily focussed on the recovery and events in the immediate and longer-term postnatal period, again the thoughts of Shell constantly returning to the negation during pregnancy, and a 'making meaning' of events as they happened. Shell concludes her story by considering how her care could have been different and improved and finally looks to where she is at now and moving forwards with her role in the negation.

The following figure is a constructed plotline of Shell's negated childbearing story, and it is a temporal sequence of events which reflects her story as a whole structure (Figure 23):

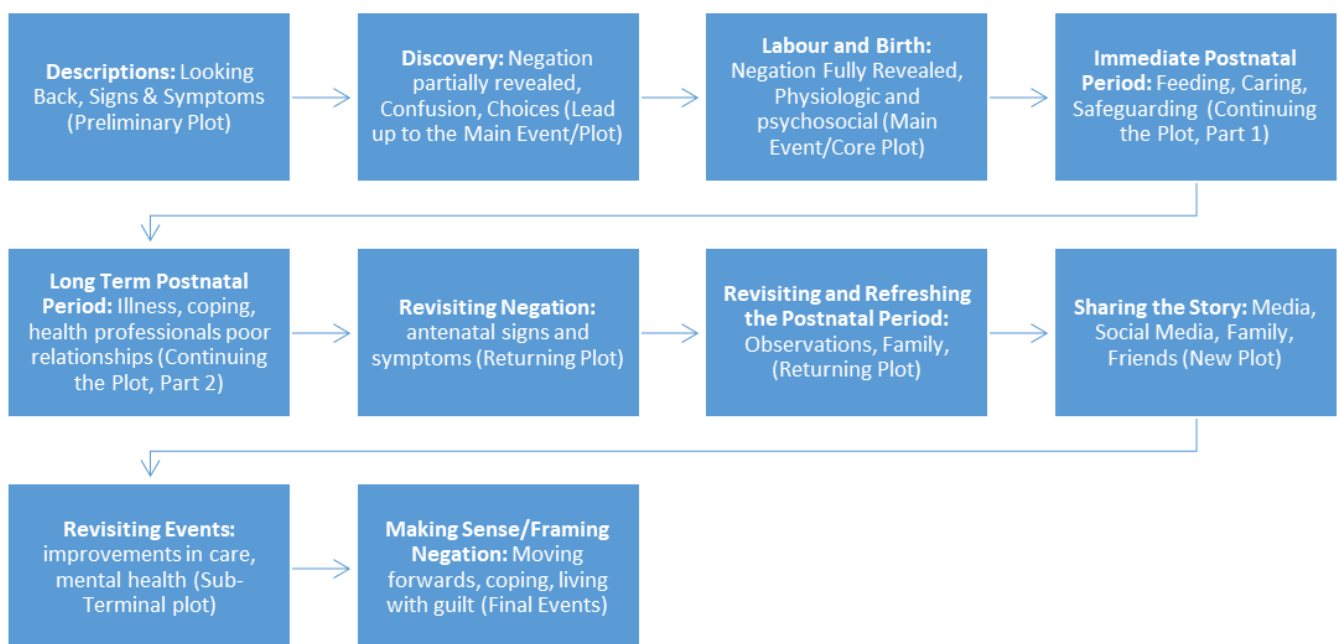


Figure 23: Constructed plotline of Shell's negated childbearing story

Story Content Revealed: Fat and Thin Threads

a) Trauma Threads

Trauma can be seen as a fat thread which runs consistently throughout Shell's story, although this was not immediately apparent as she began her story telling. The trauma thread covers a range of aspects of Shell's childbearing negation; from the diagnosis of the pregnancy and misdiagnosis of gestation, through to the birth and contact with social services. Shell describes through her story, how she developed back pains one evening, thinking it was a severe urinary infection and that, following medical advice, she and her partner made their way to hospital to be checked out. Following a range of tests, including an ultrasound scan, shell and her partner were informed of the 'early' pregnancy diagnosis, which came as a complete shock:

"Maybe forty-five minutes later they came back, and said you're pregnant, and I said okay, we, we were very taken aback, by it"

"We're not really thinking anything right now, we're just a bit shocked"

The trauma of the unexpected diagnosis of the pregnancy, in the early part of Shell's story, is softened somewhat by the early gestation presentation. The next day or so was spent discussing options with her partner and considering the practical and financial implications that raising a child would bring. However, the pain soon returned, and despite using various methods to relieve it, the severity and intensity of the pain gradually increased. Once more, Shell and her partner sought medical advice, and were now going through the trauma of a potential miscarriage diagnosis:

"In agony, and so, again middle of the night, not much you can do, I did turn to 111 again, erm, and, they said okay, erm, we don't mean to alarm you but, this does sound like it could be a miscarriage"

"They sent an ambulance, and it was a lovely lady, and she said I really don't mean, to upset you or scare you, but you need to be prepared, it does sound like you are miscarrying"

Shell was taken to hospital in an ambulance and the situation changed dramatically and very quickly on arrival, with Shell describing what happened as traumatic, when it became clear that she was around full term, and in labour. Shell recalls the events surrounding the birth

of her baby, as a series of overwhelming events, which again happened quickly, as an emergency developed, and the room filled with clinicians, as the birth was expedited:

“She said how, how far along are you, erm I said, I, I don’t know, she said okay, she said you’re three centimetres, like three centimetres dilated, I can see baby’s head, and, at that point, I just burst into tears”

“It was, very err, I don’t really know, traumatic, I suppose, the word I ought to use”

Following the trauma of the birth, Shell reveals further traumatic aspects of her story, and how she struggled to cope in the hospital environment and continued to feel overwhelmed. Further distress added to the way Shell was feeling, as she recalls the delay in her discharge home, which was due to a social services referral, as she was a care leaver. Shell also alludes to her negated pregnancy and labour, as she links this with a potential reason for social services involvement:

“The nighttime, once Danny had gone home, was really quite awful, erm, I was just crying loads, ‘cause everything was just so overwhelming”

“...and so I got very upset then, thinking, well what have I done wrong, you can’t just take my kid away from me because, I didn’t know”

The final element of trauma in Shell’s story is the thin thread of mental health, which becomes apparent and is described by Shell in the postnatal period and beyond. The impact of the negation on Shell’s mental health is further impacted by breastfeeding challenges and the relationship with her health visitor, as the visits are a reminder to Shell of the negation and what followed:

“The health visitor came, the first sentence out of her, her mouth, I mean it probably wasn’t, but what it felt like it was, is, postnatal depression, and she just said it there and then to me, which really put such a downer on things”

“Certainly very high anxiety and, depression, and the doctor also reckons that it’s very mild PTSD, to which they did give me medication”

b) Clinical Care Threads

As Shell was telling her story, she recounted her clinical care to me, throughout her storytelling, and this was clear and consistent. Shell had contact and care from a range of

health professionals including telephone triage (111 service), paramedic input, nursing and medical care, maternity services and primary care services. This indicates the complexities and challenges around the diagnosis of pregnancy and labour, and the ongoing impact longer term.

Hearing the narrative tone in Shell's story, there was a range of positive, neutral and negative aspects in relation to her clinical care. The early part of Shell's story is focused on the signs and symptoms that she had - concentrating on pain, and how this forms a thin thread of her negated childbearing, the timing of how events happened:

"I started getting really bad back pain and, I started going the toilet, really, really frequently, and I kind of just thought it was a water infection going on"

"A bit later on in the evening, the pain got really, really intense"

The timeline of care is tied up with the diagnosis of pregnancy and following an initial diagnosis of urinary issues, Shell was then informed of the pregnancy, and that it was of an early gestation (when she was later informed that she was full term and in labour). This further impacted her choices and options for care, that she thought she had, and added to the overwhelming nature of her negation, which she mentions on several occasions:

"They took a urine sample first of all, and then took my bloods, and maybe forty five minutes later they came back, and said you're pregnant, and I said okay, we, we were very taken aback, by it "

"But basically said that, these pains can be quite normal in the early stages of pregnancy"

An ultrasound scan and hearing the baby's heartbeat provided a positive element to the situation, and as part of the pathway of care at this point, a conversation around choice for a termination of pregnancy was brought up by the doctor. This results in conflicting emotions and feelings for Shell, not least because she tells me that when she told this part of her story to family and friends, that there was a lot of disbelief that this had happened:

"I've told this to a lot of people, and a lot of people go oh, oh what a load of rubbish, putting that politely there"

"He obviously, he had the ultrasound he was scanning me, and he said from what I can see, everything looks okay, however, if termination is something, the way that you wanted to go"

c) Family and Friends Threads

Another constant thread in Shell's story is the role that her partner, family and friends play in her negated childbearing, highlighted with the thinner threads of support, acceptance and provision. Shell mentions her partner early on in her story, although this relates to him accompanying Shell on her hospital visits, but in some aspects of the story, she talks about their joint feelings towards certain parts of the story by referring to "we/our", although the focus is on Shell and her reactions to what was happening.

This connection between Shell's negated childbearing and her partner, suggests a potential impact on her partner, in the early part of her story prior to the birth, however her storytelling focuses on shared feelings, rather than how her partner felt as an individual. The support provided by Shell's partner and family is shared in her story in a range of ways including: their positive reaction and emotions to the situation, buying provisions for the new baby, and dealing with the practical side of things:

"We're not really thinking anything right now, we're just a bit shocked"

"I told him and he was like, it was weird, he was really calm about it"

"She said why what's the matter, I said well I'm in the Hospital, and she said, why, I said I, I'm in labour, she just kind of laughed at that point, she said okay, what do you need"

d) Guilt Threads

The fat thread of guilt in Shell's story can be seen through a variety of interrelated thinner threads, tied up with looking back (retrospection and memories) at what happened, and decisions that were being made at the time. This becomes evident in the early stages of Shell's story, as she describes coming to terms with the fact that she is pregnant, being given information on termination of pregnancy, and discussing the way forward with her partner about whether they would continue with the pregnancy:

"I mean it was always there in the back of my mind, you know we were young and, didn't have very much money"

"Y'know everything that, happened, I do feel guilty, I feel, dreadfully guilty, every single day..."

Interspersed with Shell's storytelling of what happened to her, are some details of the negation, which are revealed through the guilt thread as memories, and retrospective reflection, and allude to the 'usual' signs and symptoms of pregnancy which Shell either did not experience, or she did not recognise them at the time. Furthermore, Shell's guilt thread is also revealed through her telling of, and identification with self-blame and regret, and perceived unhealthy actions as part of the negation, and in the time after it. It is reflected in Shell's need to explain and justify the negation as she told her story, and this also illustrates the ongoing and longer-term impact of negation on her life:

"There were twinges here and there, but, I just put it down to I had gas, or whatever, or was about to come on, because I had periods all throughout"

"...and there's not a day where I don't think about it, and, you know we were really lucky there was absolutely nothing wrong with her"

e) Self-Care Threads

Shell shares the story of her negation partially through a thin thread of how she dealt with pain, and other symptoms, and how she looked after herself (and how those around her looked after her), using a self-care approach. This is threaded throughout her story and forms a core part of her resilience and coping abilities, particularly during the initial negation, early pregnancy diagnosis and during labour:

"I got a really hot bath, thinking that would help, and it did ease it a bit"

"I said I'd really like a towel, I really want to get a shower, and I'm really hungry"

An important thread which Shell shares in her story is her recognition of the negation, during her storytelling, as she shares the physical and physiological manifestations of early labour. This is closely tied with her self-care approach, as Shell acknowledges that the signs and symptoms she highlights, needed to be addressed and that further advice and care should be sought:

"I started, to, bleed slightly when I was weeing which, concerned me, because that's definitely not normal"

"So we woke up on Sunday morning, and, it was then that I started getting like period pain cramps"

f) Dyad Threads

The fat dyad thread can be heard in Shell's storytelling through the positive narrative tone of the demonstration and feeling of love, which is shown by the families, and by how Shell ultimately feels about her negation story. There is an interesting link to Shell's upbringing in foster care, and her exposure to, and practical life experiences of caring for babies and children. The context of this positive and impactful learning journey contributes to a personal desire for motherhood, which is seen by Shell as a natural progression in her life, and one which she initially adapts to well:

"Being brought up in the foster care system, is just taught me, so much, that, I, all I ever wanted to be was a mum"

"I wouldn't, have, my baby, if, if it hadn't happened, and she's the best thing that's ever happened"

When talking about attachment and separation in her negated childbearing journey, Shell discusses these thin threads in a more abstract way; for example, as she hears the baby's heartbeat for the first time, following the unexpected diagnosis of pregnancy, without much emotion or importance attached to this event. Through Shell's breastfeeding journey, she also indicates attachment to her baby through breastfeeding, whilst sharing the practical difficulties of caring due to a severe infection:

"...and so, he scanned me, and they said that the heartbeat, sounds fine, that that was good"

"I got mastitis, quite a bad case of it, a really, really bad case of it, like to the point I couldn't even lift, the baby up"

Performing Stories: Storytelling, Structuring and Presenting through Poetry

5.6 The Negated Childbearing of Shell

To highlight the essence of Shell's story and draw out differences between this and the other women's stories, storytelling through a poem shows the fat and thin threads in a succinct and distinctive format. Furthermore, the structure and telling of Shell's story through poetry, presents the contextual narrative tone of her negated childbearing, which

focuses on the importance and support of family and friends, the positive and more challenging aspects of the dyad, and the enduring thread of guilt.

The structuring of Shell's poem is indicative of how she told her story; in distinct chunks of events, linked together with a central focus on the diagnosis and misdiagnosis of the pregnancy and labour. Additional dimensions of potential birth trauma, recovery in the immediate and longer-term postnatal period and beyond, are also reflected in the poem, identifying challenges around the impacts of negation on mental health, and contributing factors such as breastfeeding challenges and relationships with clinical staff.

Part 1 - Negation Uncovered

*She was born on a Monday
It started on a Friday
Back pain, Intense, Bleeding...
That's not normal
To hospital
Could you be pregnant? Thought... Maybe
I
Am
Pregnant*

*Shellshocked
What are you thinking?
We're not thinking...
Anything
Scan to make sure, early pregnancy, they said
Growing Baby
Heartbeat sounds, looks okay
If termination is the way
Act
Quickly*

Part Two - Coping

*Discharged
Went to the park,
To talk
Didn't know how far along
Thought not the best time... but
Something we could do*

*Plans that night, not going out
Stayed home, In the bath, hot
Tried to sleep, through pain, Intense
On all fours, agony, again
In the ambulance, be prepared you're
Miscarrying
To hospital once more*

Part Three - Labour and birth

*Bit of a blur, a bit of a rush
How far along?
I just found out
Prepare for the worst they kept saying...
Prepare for the worst*

*Gas and air, violently ill
Shouting, can I examine you?
Suddenly, Panic
What the hell... is going on?
Consultant comes, how far along?
Three centimetres she said
I can see Baby's head
Hysterical, crying
Being in labour, traumatising*

*Eventually, Calm
Telling my mum, She laughed
What do you need?
Next minute, she was there, didn't leave
Pressure, Contractions
Urge
To push
A connection, the midwife
Courage and relief, a rush
Closing my eyes
Room full
Overwhelming*

Push!
Shouting and upset
Your baby is facing the wrong way
Getting stuck,
Decided to
Cut
So... she came, Eventually

Part Four - After birth and going home

Up to the ward
Everybody left
Felt like
Passing out
Trying to breastfeed, Struggling
I gave in, gave a bottle
Wanted home, try again

What have I done wrong?
You can't take the kid away,
Because I didn't know
She said,
It's not like that
It has to be done...
I'm scared

Home...
A family cot
A baby chair
Grandkids slept there
Got stuff together,
For us
For her

Settling back in home, comes naturally
All I ever wanted to be
Health visitor said
Postnatal depression
She just said it

*She just expected it
Feel guilty
Lucky nothing was wrong
Still waiting for the penny to drop
It doesn't seem...
Real*

*I'm getting on with it
She's got everything she needs
She's happy
That's it*

5.7 Shell's Story in Summary

The elements of positive, neutral and negative narrative tone present in Shell's poem are dispersed and present a different story of her negated childbearing. The positive elements can be seen through the storylines of the support and importance of family in Shell's life, alongside the attachment and relationship of the dyad, and this is reflected in the thread analysis and seen in the poem.

Neutral elements are related as factual accounts in Shell's story and are seen in the threads and structuring of her story and, to a lesser extent, in the poem. The negative aspects are focussed on three main areas: the misdiagnosis of early pregnancy and the diagnosis of labour, the birth and the challenges of the postnatal period.

Shell's story of negation is one of coping with a series of unexpected events and diagnosis, which culminates in the birth her child, within a very short space of time. The challenges which Shell outlines in her postnatal story, were picked up in all three stages of narrative analysis and indicate that this aspect of negated childbearing is an important area to consider. There is an ongoing impact of negation on Shell's well-being as she struggles to adjust to life with her baby, which is compounded by breastfeeding issues and her mental health challenges.

5.8 The Story of Hermes

“It wouldn’t be that, I won’t be pregnant”

Story Telling

I met with Hermes in a coffee shop at her request, so immediately the interview had a different feel to it, due to the environment. I had some initial concerns about conducting the interview in a noisy, public place, with my main concern being that it would be difficult for Hermes to share her story where others may hear what was being said. I also knew how noisy coffee shops could be, and had a concern that the recorder would struggle to pick up the interview details with enough accuracy. My concern around the story sharing were soon allayed, as the interview began, and Hermes told me that she liked to chat, and felt comfortable in the environment that she had chosen.

As my third participant, Hermes was very keen to share the detail, context and background of her negated childbearing, which provided a rich breadth and depth to her personal story. In choosing a pseudonym for this woman, I reflected on her personal qualities of conversation and speech, and as Hermes is the Greek God of eloquence and speech, this seemed a fitting name.

Furthermore, Hermes’s interview was the longest, and one of the most difficult and lengthy to transcribe - due to the background noise on the recording, but also the level of detail which necessitated use of a long list of alternatives for names, places and other details in the transcription. The contextual and detailed nature of Hermes’s story will be discussed and is reflected in the findings.

Informal notes were taken at the time of the interview, and reflective notes written after the interview, to capture and reflect my thoughts and feelings as the researcher, of how the interview was conducted. The informal notes are captured and presented in figure 24:

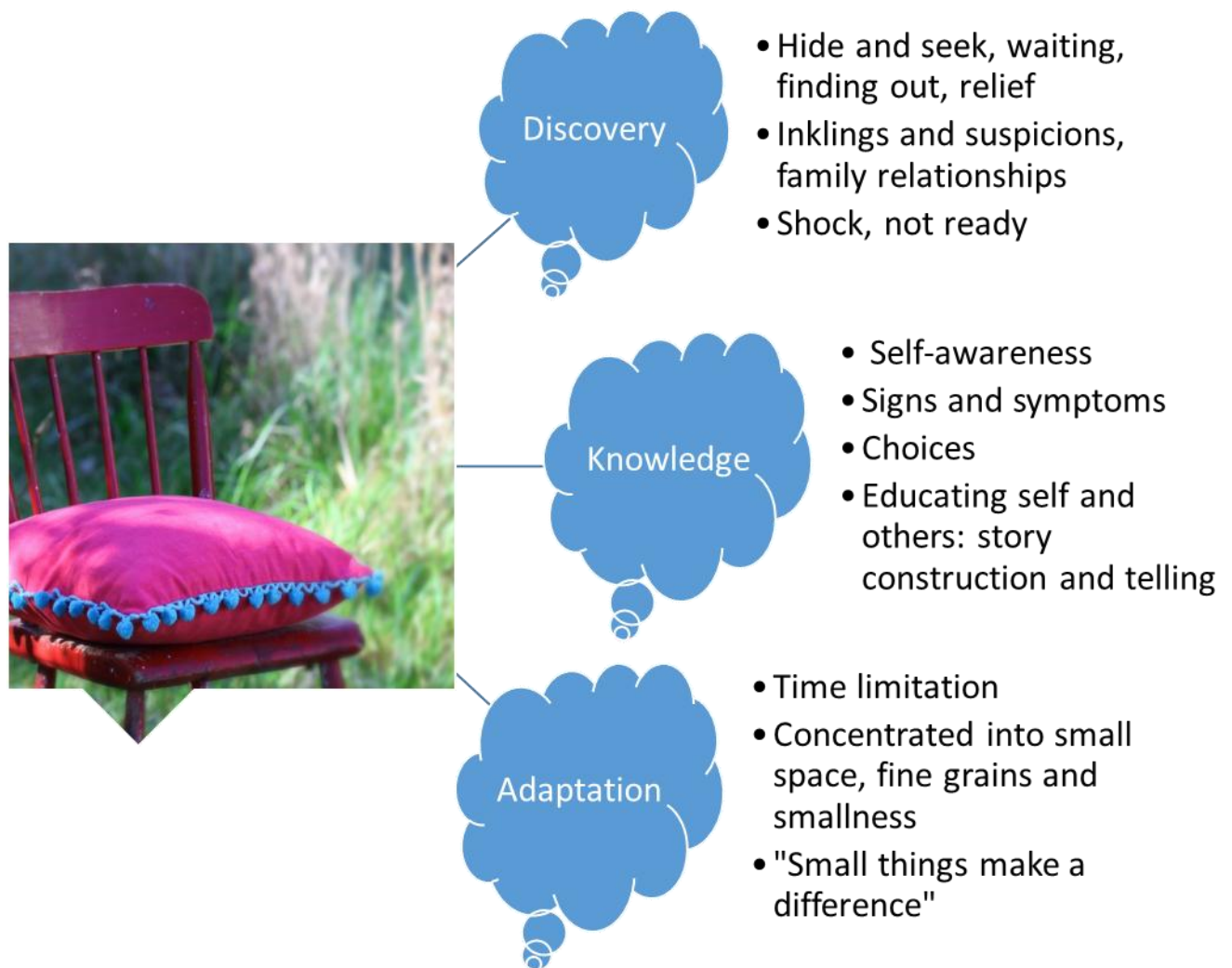


Figure 24: Researcher reflections on Hermes's story telling

The picture represents the ordinary in the chair, providing stability, strength and support, contrasted with the embellished comfort provided by the elaborate cushion, set in an outdoor environment. The narrative context of Hermes's negated childbearing story is much like the chair in the image, and draws together the main aspects of her story, how she told her story and how this can be heard and performed to others.

There is some unconscious recognition of the hard nature of the seat, but the soft barrier covers and hides this, a reference to the suspicions/inklings of a pregnancy, much earlier than the diagnosis. The embellished comfort and the cushion refer to the comforts of a good home and personal life - a loving partner and family, getting engaged, planning a wedding, and being financially secure - providing that practical 'cushion' to cope with life events. Moreover, a stable and solid support is within reach, waiting to be discovered

through the uncovering of the surface beneath. The revealing of the negation, results in unconditional support from Hermes's partner and family, who can provide her with the consistency and steadiness that she needs.

The clouds represent the thoughts and experience of the researcher throughout and post interview, and I grouped these under three main headings - 'discovery', 'knowledge' and 'adaptation'. The bullet points at the side summarise the main points from my informal notes and provide some important aspects from a very detailed and lengthy storytelling.

The detail in the story reflects the open and honest nature of Hermes's story, and the telling of the story, with continual reflection and concentration of aspects - important and relevant to Hermes. The ability and willingness to recount even tiny details - such as being offered jam with tea and toast post birth, show the importance to Hermes of these small acts of kindness, and her story is peppered throughout with these examples. The smallness and ordinariness of acts of caring are a strength, which enables Hermes to deal with her negation and the subsequent additional childbearing experiences which have impacted and influenced her story.

To fully consider and capture the context/s and my relationship (and potential influence) with Hermes, a further exploration of storytelling, using a situational lens diagram (adapted from Chase 2005) was constructed using the informal interview notes. In figure 25 overleaf, four main areas which may impact interviewing and storytelling and hearing are identified as context, environment, narrator and researcher relationship and body language/communication.

The arrows within the quarter circles identify the interlinked relationship between the four areas, whilst the bullet points provide the detail of where and how the story unfolded and influencing factors and outcomes. The diagram reflects elements of outcomes from the three types of analysis, and highlight the importance of where and how the story is being told:

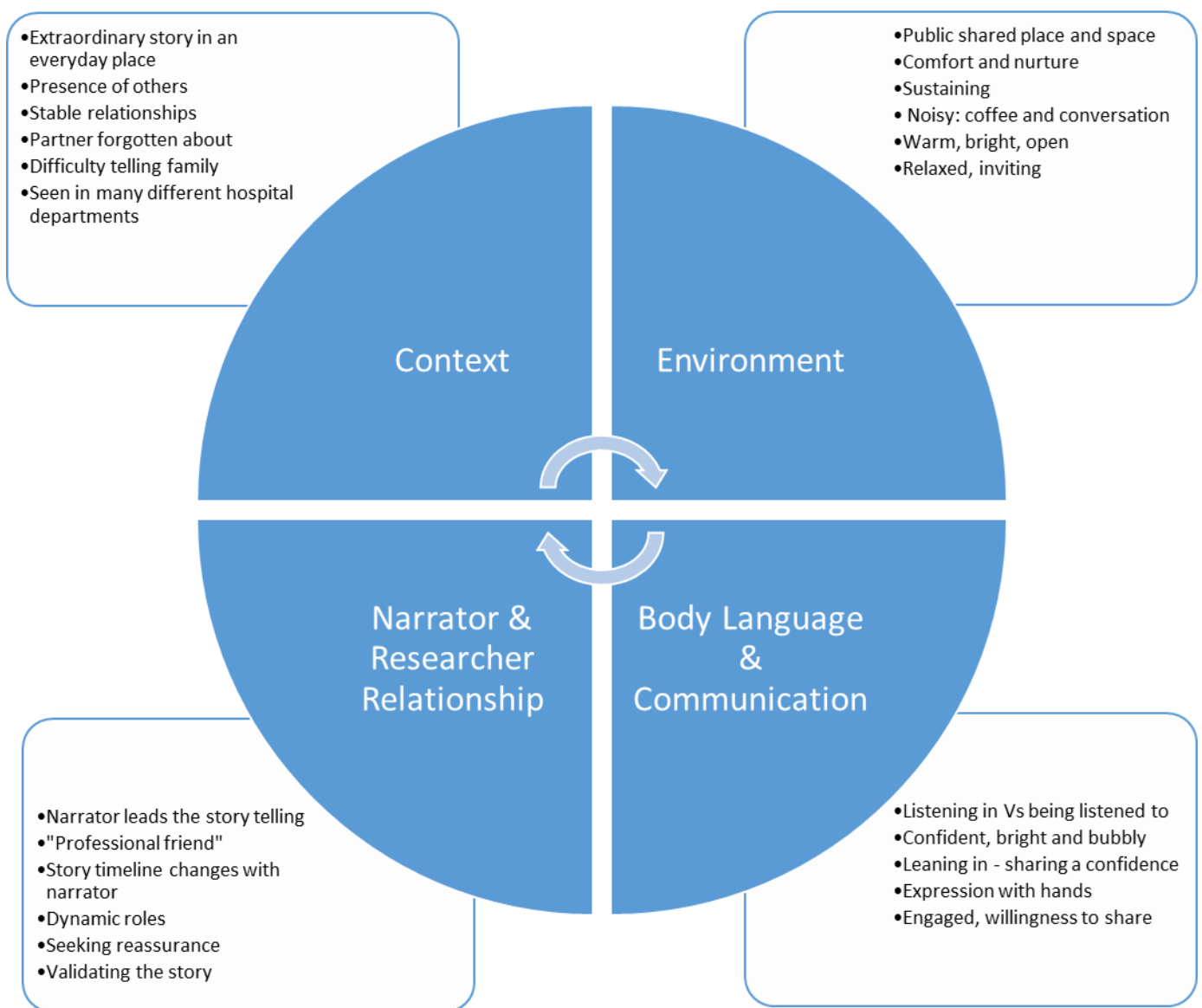


Figure 25: Situational Lens Diagram Hermes's Interview

Story Precipis

Hermes had not been pregnant previously and was in a long-term stable relationship with her partner, whom she lived with. She was in employment at the time of the negation and had experienced some generic symptoms of heartburn and back pain, which she had attributed to IBS, and was also echoed by family and friends when she discussed it with them. Hermes had no 'classic' signs of pregnancy at this stage - she was using contraception, had periods and had no obvious pregnancy bump.

After about a week of the symptoms worsening, Hermes decided to buy a pregnancy test, which she carried out on her own at home and waited until the following day to tell her partner. Hermes was then seen at her GPs to complete confirmation of pregnancy and referral to hospital, and at this point in her story, she did not know how many weeks pregnant she was. Other than her partner, close family and friends did not know of Hermes

pregnancy diagnosis, this was Hermes's and her partner's choice, as they waited a week for an appointment and Ultrasound scan at the hospital, which they hoped would give them further information.

Hermes attended the Hospital appointment with her partner, and on initial examination was informed that she was a few weeks into her pregnancy, and at this point, she was still undecided about her options and decision making about continuing with the pregnancy going forwards, whereas her partner was decided in proceeding with the pregnancy. Further examinations and an Ultrasound scan revealed that Hermes was around twenty-eight weeks pregnant, and it was then that Hermes knew that she would be "keeping" the baby.

Following this appointment, Hermes and her partner informed family and friends and considered the shorter timeframe that they had left to prepare for the baby's arrival. Arrangements were made for midwifery-led care at Hermes's request, with additional anomaly scans booked, due to Hermes booking late for care. A scan and appointment at around thirty-two weeks, indicated that Hermes had a slightly raised blood pressure, and in the days that followed Hermes became increasingly unwell, with family noticing changes in Hermes outward appearance.

Symptoms of headaches, oedema and exhaustion appeared and gradually increased, with Hermes contacting her named midwife for a follow up appointment, as she was worried about the increasing severity of her symptoms. The midwife came out to see Hermes at a home visit, and notes severe hypertension, significant proteinuria alongside the other symptoms that Hermes had described, so an urgent referral to hospital was made due to suspected pre-eclampsia.

Hermes attended hospital with her partner, where further tests were carried out and was then admitted to the antenatal ward - although at this point in her story, there was uncertainty and a lack of communication regarding the severity of Hermes's pre-eclampsia diagnosis. A decision was made to commence induction of labour, and medications including Magnesium were given. However, tests on the placenta indicated some problems, and further decisions were made to expedite the birth, via an emergency caesarean section, with baby going to the Special Care Baby Unit (SCBU), and Hermes going to the High Dependency Unit (HDU) for care.

Initially, Hermes was too unwell to care for her baby, so her partner and close family provided the contact and care, whilst Hermes recovered. A few days later, Hermes was moved onto the postnatal ward and her baby into transitional care, as she focused on breastfeeding, expressing breastmilk, bonding and baby cares. Following an extended stay

due to breastfeeding challenges and issues with the baby's weight gain, Hermes was discharged home, to the care of her named midwife.

The initial postnatal period proved challenging for Hermes as she continued to recover from her caesarean, which restricted her mobility, and this impacted her confidence and ability to attend community activities and groups for new parents. Hermes also felt that she purposely kept her baby in the house, due to the early arrival - that the baby was not yet expected and so "not meant to be here". In the longer postnatal period, Hermes alludes to the difficulties faced by her partner during the hospital admission the birth and afterwards, and her mental health challenges, around a year after the birth, citing exhaustion and postnatal depression, following a visit to her GP.

Story Structuring

The story structuring reveals a depth of complexity and detail, which is further reflected in the threads and in Hermes's poem. The plotline is lengthy, with the main events revealed early in the storytelling, supported by several sub-plots. Hermes revisits the negation twice during the structure of her story - circling back and contemplating the signs and symptoms which were missed.

This 'circling' back in the structure of the story is important, as it provides an indication of what is most important to Hermes. Hermes also shares her story in a logical and compartmentalised format, breaking up her story into chunks, suggesting careful thought and moreover, how Hermes experienced her childbearing negation. The constructed plotline is a temporal sequence of events (story as a whole structure) - described and interpreted as follows:

Lengthy Introduction: Focus on signs and symptoms, telling partner, involving family and friends, revealing negation initially withheld (**Setting the scene**) →

Diagnosis and Acceptance: clinical care, making decisions, life pattern, short time frame (**Preliminary Plot, and lead up to the main event**) →

Short Complex Pregnancy and Illness: Feeling unwell, developing pre-eclampsia, rapid development of illness, strong medication, trauma (**Main Event/Core Plot**) →

Emergency Birth: Caesarean birth, partner shock and distress, quick decisions (Sub Plot 1)→

Separation from Baby: impact on woman and partner, Special Care Baby Unit, breastfeeding struggle, wanting discharge from hospital to home (Sub Plot 2)→

Postnatal Impact: Mental health of woman, partner issues, practicalities of care and struggling to get out (Sub Plot 3)→

Returning to Negation: Considering termination of pregnancy, fitting in with partner and family, unsure of feelings (Returning & Supporting Core Plot)→

Observations on the Baby: strange appearance, separation revisited, worries and concerns about health (Supporting Sub Plot 2) →

Observations on Clinical Care: thoughts on care givers throughout childbearing, behaviours and attitude of midwives, decision making revisited (Supporting the Core and Sub Plots) →

Revisiting and Retelling the Negation Story: Becoming part of a life story, sharing with others, suggestion that other women may need support, family views, partner issues, similar family experiences (Supporting the Core and Sub Plots) →

Future Pregnancies: Worry and uncertainty, history repeating, signs and symptoms of pregnancy (Sub Plot 4) →

Concluding, and Revisiting Conception: Coming full circle, reviewing signs and symptoms of pregnancy, thinking about conception (Final Events)

Story Content Revealed: Fat and Thin Threads

a) Trauma Threads

Aspects of trauma are revealed in Hermes's story throughout her childbearing journey and can be seen particularly through the thin threads of the initial negation and diagnosis of pregnancy, the birth experience and coping through dissociation. Although the quotations

used here may not seem to reflect trauma in the general understanding of the word, the way Hermes told her story, and the emphasis on certain parts of it, suggest that trauma was the overarching feeling. The complexity surrounding the diagnosis of confirmation of pregnancy, and the multiple contexts in which this happens, illustrate the detail shared by Hermes in her story of negation.

There is further complexity in Hermes's story, as she shares that her pregnancy may not have been completely unknown to her (denied), and from the very start of the interview she seeks to tell me why her story is different to other women who did not know that they were pregnant. The suggestion that Hermes may have known that she was pregnant, but chose to consciously ignore/come to terms with the pregnancy, further suggests that our understanding of the negation phenomena is more detailed than at first recognised:

"The difference with me obviously, well, erm, I didn't, I, I had an inkling that I might have been, only from the internet"

"Everyone kept saying to me I had IBS, It'll be something like that, and then I googled it, and I was like, oh, well, it must be IBS 'cause it wouldn't be that, I won't be pregnant, surely to god no way..."

As the symptoms experienced by Hermes continued and increased in severity, she did eventually decide to find out for definite if she was pregnant, by going to buy a pregnancy test. As Hermes was thinking about purchasing the test, she was scared about buying the test, perhaps at this point she was worried that the test would confirm her pregnancy, which she was not yet ready to accept, and furthermore she was apprehensive about how she could buy one discreetly, without anyone knowing:

"I think I waited about a week, and then I was like petrified to buy, buy a test, I don't know why"

"I just don't want anyone to see me buying it, and in loads of supermarkets they tend to be in a box, and you've got to get someone to open them, which was another thing that put me off"

Hermes hadn't told her partner at this point in her story of her suspicions of being pregnant, the increased symptoms that she had experienced, or that she had bought a pregnancy test. She carries out the pregnancy test on her own, when she knows that her partner will be out of the house and shares how she waited until the following day to share the result, which she found difficult. The diagnosis part of Hermes's story is told right at the start of her interview and sets the scene for her experience of negation:

“I think I bought it on the Tuesday, and then, I waited until he, I don’t know why again, went out on a bike ride, and done it, and then obviously it came up positive, which was just, in shock...”

“On the Wednesday, I, what I done on the Wednesday night, he came in from his bike ride... for some reason I didn’t tell him that night, I just kind of, sat, and, and acted all normal, then went into work on the Thursday...”

The context in which Hermes experiences childbearing negation comes at a time in her life when she had returned from working abroad, had started a new job and was uncertain about the future going forwards. The anxiety and apprehension around sharing the positive pregnancy test result, reflect the trauma Hermes feels when she makes the decision to tell her partner:

“...and I didn’t know what I want, I didn’t know how far along I was”

“he was like, why, what’s wrong with ye, and then, y’know it was, I couldn’t, like, for some reason, I couldn’t say it...that I was, erm, and then, finally told him”

The story which Hermes shares around the diagnosis of her pregnancy, sets the scene for the unravelling of the relatively short time-period between the diagnosis of pregnancy, and confirmation of gestation, through to the need to expedite birth due to the onset of pre-eclampsia. This further complicates Hermes’s story as she alludes to trauma linked to the rapidity of the decision to bring forward the birth, and her separation from her baby due to admission to the Special Care Baby Unit:

“They were like, so we’re just gonna take you down, and my partner again was like, for what, and they were like, for a caesarean...”

“I was like, no I’m fine, I have like me mum and me dad with me, and I was like, you look after the baby, do you know what I mean, so, he went and obviously, looked after the baby...”

b) Clinical Care Threads

Hermes’s story in relation to her experience of the clinical care she received during her negated childbearing journey was detailed and formed a fat thread throughout her storytelling. Moreover, the comprehensive nature of this element of her story can be seen woven through the connected thin threads of the diagnosis, choice, information and signs

and symptoms. The thin thread of diagnosis is picked up again here (in addition to trauma), in relation to the context of clinical care and set in the background of potential choices to continue, or not, with the pregnancy.

Further difficulties occurred for Hermes as, although her partner now knew of the pregnancy, the family were still unaware as Hermes and her partner waited for their hospital appointment to book for care, an Ultrasound scan and receive further information. Hermes emphasises that she did not know the gestation of her pregnancy, and thought that she had time to think about what she wanted, and make informed decisions:

“Because I didn’t know how far along, I was when I found out, I thought I had, choices...”

“We had to go and get it confirmed by the Doctors, but then the Doctor said what did you wanna do, and at that point, I still didn’t know if I was weeks, at that point, or, months”

Hermes had alluded to the fact that she may have known that she was pregnant (as discussed earlier) and during her appointment at the hospital she mentioned this again, as she told me about what went through her mind as she waited to be seen, when her partner was with her. This aspect of Hermes’s story was also linked to the thin thread of signs and symptoms, as she reflected during the storytelling about her lack of symptoms. There are some points of contradiction in Hermes’ story, as she recollects what happened:

“It wasn’t like, we couldn’t pinpoint exactly when it was, but, we kind of could, but it was either like really early, and I was like well, or it was then, but that would have been, like, six months ago, and surely it couldn’t have been then...”

“As far as I was concerned, I didn’t have any symptoms, nothing, no sickness, no, you know, no nothing, erm, ‘cause and people always ask me the question, well didn’t you have periods, but, and I, I, I had, I was on the pill, for years, I’ve never, I never ever ever had one...”

The final element of the diagnosis thread is when Hermes and her partner find out the gestation of the pregnancy. There is still some indication that Hermes thinks she is early on - only a few weeks pregnant and again provides a story link to her lack of signs of pregnancy.

The appointment is recounted in detail, especially when Hermes shares her story of the examination, again alluding to the choice thread, and this time including how her partner

reacted. Hermes also recounts the moment of finding out that she was further on than she thought, and the physical separation between her and her partner as they started to process the information that they were being given:

“By that point I knew I was like, god, people have babies at that gestation, do you know what I mean, so already before we walked out of that room, I already knew in my mind, and that was it, like, we were keeping it”

“...and I was like behind the curtain, and I was like why you are bawling, are you there? are you still alive? and he was like yeah...”

c) Family and Friends Threads

The thin thread of support from Hermes's partner, family and friends, was shared at sporadic points throughout the story, and closely tied with acceptance of the situation. From the details given, the relationship that Hermes has with her partner is of a loving and close relationship, with her partner supporting Hermes in her life and career choices. Even with this supportive relationship, Hermes found that she struggled with the idea that she might be pregnant, and with sharing the news with her partner once she had carried out the test, with no reason for why she found this difficult.

Telling her partner and family about the pregnancy was a real challenge for Hermes - to the point where her partner shared the news with family. The support of Hermes's partner right from the start of her story can be seen throughout, in the snippets of his reactions, behaviour and feelings about the pregnancy diagnosis, highlighted through positive narrative tone:

“I was sat in the car and dodged, round it for about a good, hour, erm, and he was like, why, what's wrong with ye, and then, y'know it was, I couldn't, like, for some reason, I couldn't say it, I didn't even, like, I didn't say it to me mum, I didn't say it, to me dad, like, my partner had to tell everyone, for some reason, I couldn't, I don't know why I couldn't, it wouldn't come out my mouth...”

“Then, finally told him, and obviously he was made up, 'cause he's years older than me, and his mums in her advanced years”

The acceptance thread is shared in Hermes's story through her recounting of reactions and behaviours from her partner, family and friends, but again through the suggestion that those

close to her also had a suspicion that she may be pregnant, prior to the pregnancy diagnosis. For Hermes, her acceptance of her negated childbearing, and subsequent short pregnancy journey, strongly relate to the timeline of events, and how she really focused on her story of what she experienced following the diagnosis and prior to birth.

She shares this in her telling of this part of her story as “holding on” to this part and claiming it for her own. The focus for Hermes was the middle part of her childbearing story, and the fact that she felt she had missed out on the experiences of early pregnancy, and of late pregnancy and labour:

“He reckons he knew I was, in that month, two months before I found out...”

“So I do say to everyone, that’s why I do want another baby, because I do feel like I missed out on so much, at the beginning, and I missed out so much on the end, I only got the middle...”

Following the birth, Hermes shares how her partner felt, and struggled with the aftermath of the expedited birth, that Hermes was still unwell and remained on HDU, and that their baby was taken to SCBU. This stressful situation in the context of the negated childbearing, meant that the focus of the clinical care was on Hermes and the baby - the dyad in essence, which resulted in her partner feeling unsure and neglected, in Hermes’s story he is the forgotten partner:

“My partner said, he really struggled, because he felt like he kind of got forgotten about”

“My partner said he just broke down, in the hallway ... everyone was getting looked after, he said it was fine, but, he said but, I didn’t know what I was supposed to be doing, I was supposed to be helping look after you, I was helping look after the baby ...but there was no one, looking after me...”

d) Guilt Threads

As Hermes shares her story of her negated childbearing, there are times when she examines her conscience and thinks about the context of her situation, and her unique narrative. The language that Hermes uses when referring to the negation - that she “got away with” not having any early pregnancy symptoms, suggests regret that she hadn’t experienced these (negative narrative tone). This is further highlighted when other people suggest that she

shouldn't reproach herself for not having the symptoms, as they may not be positive or wanted:

"I have got away with not been pregnant for six months, and not having any symptoms, maybe it's just all hit me d'you know what I mean"

"I only got the middle, but then people like, no, don't do that, don't wish that, you don't want the sickness and the waiting, and the telling"

Furthermore, when referring to her baby in the SCBU, the self-reproach and blame for Hermes comes to the surface again, triggered by her baby's prematurity and appearance - threading the guilt and long-term impact of the negated childbearing through the whole continuum:

"He was like a little alien baby, his legs were so skinny, and his little black, beady eyes, and I said to my partner... maybe he's not meant like, maybe 'cause I didn't find out for so long, and he's ill, maybe I'm not like, meant to like have him, maybe somethings gonna happen"

"That's what I honestly thought at one point, well, don't get attached, because, you didn't know you were having him, and maybe they're like, something might happen to him"

The thinner threads of decision making and termination of pregnancy, are closely woven together and Hermes shares these as she comes to terms with the pregnancy diagnosis, and then the realisation that she is further along than first thought. There are conflicting emotions at play in these early sections of the story, as Hermes struggles with the shock of the positive pregnancy test, and her possible options.

Hermes's uncertainty about continuing with the pregnancy, for an early gestation, and the realisation later at the hospital that there is no longer a decision to be made, is reflected in the negative narrative tone of her story:

"I don't know what I would have done, maybe, if I was earlier...I might of got there, and me sister would of said to me, you're fourteen weeks, and I might of still gone, well actually, for, like the..."

"By that point I knew I was like, god, people have babies at that gestation, do you know what I mean, so already before we walked out of that room, I already knew in my mind, and that was it, like, we were keeping it"

e) Partner Relationship Threads

Hermes's partner features throughout her storytelling, and their commitment to each other and their relationship is clear to see, both through their outward demonstration of behaviours (for example, engaged and planning a wedding) and how they dealt with the negated childbearing and subsequent challenges with the birth and in the postnatal period. Hermes had more uncertainty at the beginning with regards to decision making about pregnancy continuation, but she was supported by her partner. They were at different life stages, and this is demonstrated through Hermes sharing with us that her partner was more settled and felt ready to start a family, accepting the pregnancy diagnosis, and quickly coming to terms with a later gestation, and positive narrative tone. The differences between them set the context for the negated childbearing, and the longer-term impacts for Hermes:

"My partner... was like for it all, all along, 'cause all his friends was years older than him, all their, his friends were all having babies, so he was ready, I almost didn't feel ready..."

"You've got, to think about, yourself first, erm, and, what you want, he's all settled, and he was happy together, but he was more, settled in his life, and I was kind of starting mine"

The thin thread of commitment is also heard through Hermes's partner demonstrating practical care to Hermes and their baby. In the early days post birth, when Hermes was recovering on HDU, and their baby was in SCBU, her partner shows his dedication and responsibility to his family by leading practical cares for the baby, and providing a physical and comforting presence for Hermes during her Hospital stay:

"Luckily enough I was in like, one of those super fancy private rooms, apparently, that had a pullout bed, so my partner got to stay with me, which, if he didn't, I'd, well I don't know what I would've done because, just, he was like, the, I couldn't go to the baby, but he could"

"My blood pressure would go up, every single day, and that's the only reason they wouldn't let me home, and that's because that's what time my partner obviously had to leave"

The question of family planning and considering future pregnancies with her partner, was shared through Hermes's story when she talked about the postnatal period and reflected on

her negated childbearing. She talks about being able to plan conception, and that because of this the early postnatal period with her baby would be more positive. However, this is juxtaposed with the anxiety and worry around a repeat of the negation, and a suggestion that Hermes should know that she is pregnant with a subsequent pregnancy:

“Think if I had another baby, I probably would, I would be able to do earlier”

“So I do say to everyone, that’s why I do want another baby, because I do feel like I missed out on so much”

f) Dyad Threads

The dyad relationship forms early on in Hermes’s story, and some of this is seen through her thoughts and feelings in the diagnosis of her pregnancy, and then finding out the gestation. Initially Hermes has uncertainty - as discussed previously, and there does not seem to be strong dyad bond at this stage in her negated childbearing journey. Following the diagnosis Hermes reflects that although the pregnancy was unplanned, and the timing was not ideal, that it wasn’t something that she and her partner could not manage or cope with:

“It was, what like we always say, it was going to happen, it just happened earlier than, you know, it was in the plan, but it just happened before it was, meant to...”

The development of love and attachment between Hermes and her unborn baby started to develop soon after her hospital appointment, when she thinks about how long she has until her estimated due date before her baby may be born, and also as she started to develop symptoms of Pre-Eclampsia:

“Then, we were like right, some weeks, then some months to prepare, we’ve got a few weeks left”

“You know when they say like before you’re about to have the baby, and nest, and like you’re cleaning, and you do everything, that day I cleaned the house top to bottom, I don’t know why, the night, the night before I had him”

There were further points of separation between the dyad in Hermes’s story, and these are especially evident following the birth, when Hermes was ill and unable to provide physical and practical cares for her new baby. There had to be the initial cares from Hermes’s partner, who provided some reassurance for Hermes that their baby had care from a close family member, when she was unable to:

“I couldn’t do anything, because I was kind of out for the count, so my partner had to go round and, he done his first nappy”

“I kinda thought, I don’t feel like I’m doing anything, but, my partner was, so I kinda felt like, we were still looking after him, if that makes any, sense”

The infant feeding journey following the birth, forms an important part of Hermes’s story, as she shares her challenges and difficulties with expressing breastmilk and breastfeeding her premature baby, whilst separated. Although there were challenges, there were also positive and uplifting parts of the story, and a rollercoaster of emotions for Hermes as she navigated her feeding journey with her new baby:

“That was, probably, me proudest thing, that I got to do that in the hospital, for him”

“They were going to discharge me, they were like, well right, you’re going to go home ‘cause you’re alright now, and I was like, well, I know but I’m expressing every couple of hours, I can’t, live where I live, and get this milk down to you all the time, if that’s going to be the case, I’m not going to be able to do it anymore...”

The ongoing challenges of caring for a premature baby, both whilst in the hospital (in the postnatal ward and in transitional care), and when discharged home further outline the physical separation of the dyad, in the context of building love and attachment. There is continued anxiety and worry about the baby’s well-being, linked to additional monitoring and care measures in place, which also impacts the potential for bonding. The feeding journey as discussed also provides an ongoing storyline, and is linked to a delay in discharge from hospital and wanting to return home for the dyad:

“It was the postnatal ward, but it wasn’t like, with loads, it was me, and it was two other women, whose babies were also in, like, special baby, erm, which I think, I’m glad because I think if there had been another room full of the babies, I would’ve, like, probably been upset a little bit”

“They have to have the alarms round them, don’t they, until I think thirty-four weeks... so you’re petrified every time you pick the baby up, and you didn’t turn the alarm off, and you pestered then, someone was like, robbing him out the cot...”

The story telling of the dyad relationship continues into the postnatal period and beyond, as Hermes recounts how the dyad attachment formed, indicating that the negated childbearing situation had resulted in something that was just meant to be:

"It was so funny the day we walked him home, because I felt like he'd always been there, but I don't know if that's because, I'd spent so time, so much time with him in the hospital..."

"Oh my god look at this baby, but because I already kind of, knew him, he kind of, just slotted in"

"I already remember the midwife going, like, she was like, oh look at him, he's looking, he's looking at you, he's like staring at me..."

Performing Stories: Storytelling, Structuring and Presenting through Poetry

This poem is based on Hermes's Interview, and it is written as whole, with the stanza's organised to reflect the story structure and how Hermes told her story. Hermes's poem has a very different feel, it has emotional aspects which are heard through the descriptions of events and use of certain words, but with a 'matter of fact' feeling. The fat and thin threads are evident and highlight succinctly those elements which Hermes focussed on as she told her story, such as the pregnancy diagnosis, the gestation of the pregnancy, developing pre-eclampsia and the recovery in the postnatal period.

5.9 The Negated Childbearing of Hermes

*I had an inkling
From the internet
Back Pain, IBS, something like that
I won't be pregnant
No*

*I waited a week
Don't know why
Didn't want to be seen
It's positive, in shock... but
Not to be known*

*Didn't know what I wanted
Or how far long
I thought I had choices*

*What's wrong?
He had to tell, I couldn't say
Wouldn't come out my mouth that day
Sent to the clinic
To sit in a room and wait
Was it really early?
Or was it...then, late?*

*No symptoms
No sickness
Periods, I never had one
She said
You're a few weeks on
Behind the curtain
He was bawling
By that point I knew
They wouldn't show me the scan
There's nothing we can do*

*Sixteen weeks to prepare
Then from nowhere
This massive belly appeared
Suddenly
Symptoms all came
Proteins
Blood pressure
Pre-eclampsia it was*

*I can't remember...
Went a bit blank
The baby's coming, a caesarean
That was it
Out for the count
He looked after him
Transitional care
I wanna feed him*

*We walked him home
Felt like he'd always been there
Kind of knew him*

*He just
Slotted in*

*I remember the midwife
Are you alright?
Are you okay?
I'm fine
Went to the doctors
Progressively tired*

*I'm depressed because I'm tired
I'm tired because I'm depressed
Secluded
Couldn't go anywhere
I kept him in the house
He wasn't meant to be there*

*No one can believe it
I still don't believe it
He is here
It was, it is
One of them things
He was always meant to happen
He just happened*

5.10 Hermes's Story in Summary

Hermes's negated childbearing story is one of length and detail, with a focus on the diagnosis, the development of pre-eclampsia, the special care needed due to illness of Hermes and her baby, and the subsequent coping and experiences in the postnatal period and beyond. A diversity of narrative tone throughout the storytelling, which reflects both the positive and negative aspects of Hermes's story, once again signifies the uniqueness of childbearing negation for each woman.

Hermes tells us of the context of her negation, which occurs in a background of stability in her personal, social and financial situations. However, this stability is juxtaposed against Hermes's feeling of shock at her unplanned pregnancy and uncertainty on how to proceed. The complexity of emotions, felt by Hermes and to some extent her partner/family is further

highlighted, when there is a suggestion of a suspicion of pregnancy prior to the diagnosis, but which is not voiced or addressed - and remains silent.

The trauma of negated childbearing (and the aftermath) discussed in Hermes's story is told and shared differently to the other stories; it is less obvious and hidden within the nuances of the physical telling of the story. The elements of negative narrative tone through, for example, tone of voice, intonation and use of language and body language highlight the areas that were/remain difficult for Hermes during her storytelling.

There is a different kind of trauma, for a different kind of negated childbearing story. For Hermes there is clearly a feeling of loss of a normal pregnancy experience, and a holding on tight to the middle - the part that was revealed, recognised and experienced, which again results in conflicting feelings. The precipitate end to the pregnancy, magnifies Hermes's loss - as her pregnancy is shortened even further due to the onset of pre-eclampsia. Coming to terms with the premature baby, separation and feeding formed strong threads and again reiterate the importance of the postnatal period, and ongoing challenges post negation, with the potential longer-term impacts.

5.11 The Story of Rain

"It all started with pain, at home, pain at home"

Story Telling

My interview with Rain took place in a café at Rain's request, in the early morning. I met Rain outside the venue, and she selected a booth for us to sit in, to give us some additional privacy. She tells me that she wanted to meet me in a public place as this is where she felt most secure and safe, this was based on her feelings that she hadn't met me before, did not know me or my character, and wanted to be able walk away safely if she needed to. I assured Rain that I understood her anxiety and being unsure about meeting me, and about sharing her negated childbearing story. I purchased refreshments for us, and we chatted informally, whilst I confirmed the details of the research and consent was discussed again and confirmed. The café was very quiet, and the interview was soon underway

The pseudonym that I chose for Rain is based on the physiological birth event, its quickness, and the impact this had on Rain. It soon became apparent that Rain had experienced a very quick labour and birth, from the onset of her signs of labour to her baby being born,

this is generally known as a ‘precipitate birth’. The watery theme is also seen in the moment of birth, as the baby is born whilst Rain is on the toilet and falls into the water in the toilet bowl.

It seemed fitting that Rain would be an appropriate pseudonym to reflect precipitate (rain is precipitation), in the physical and physiological sense. Informal notes were taken at the time of the interview, and reflective notes written after the interview, to capture and reflect my thoughts and feelings as the researcher, of how the interview was conducted. The informal notes are captured and presented in figure 26:

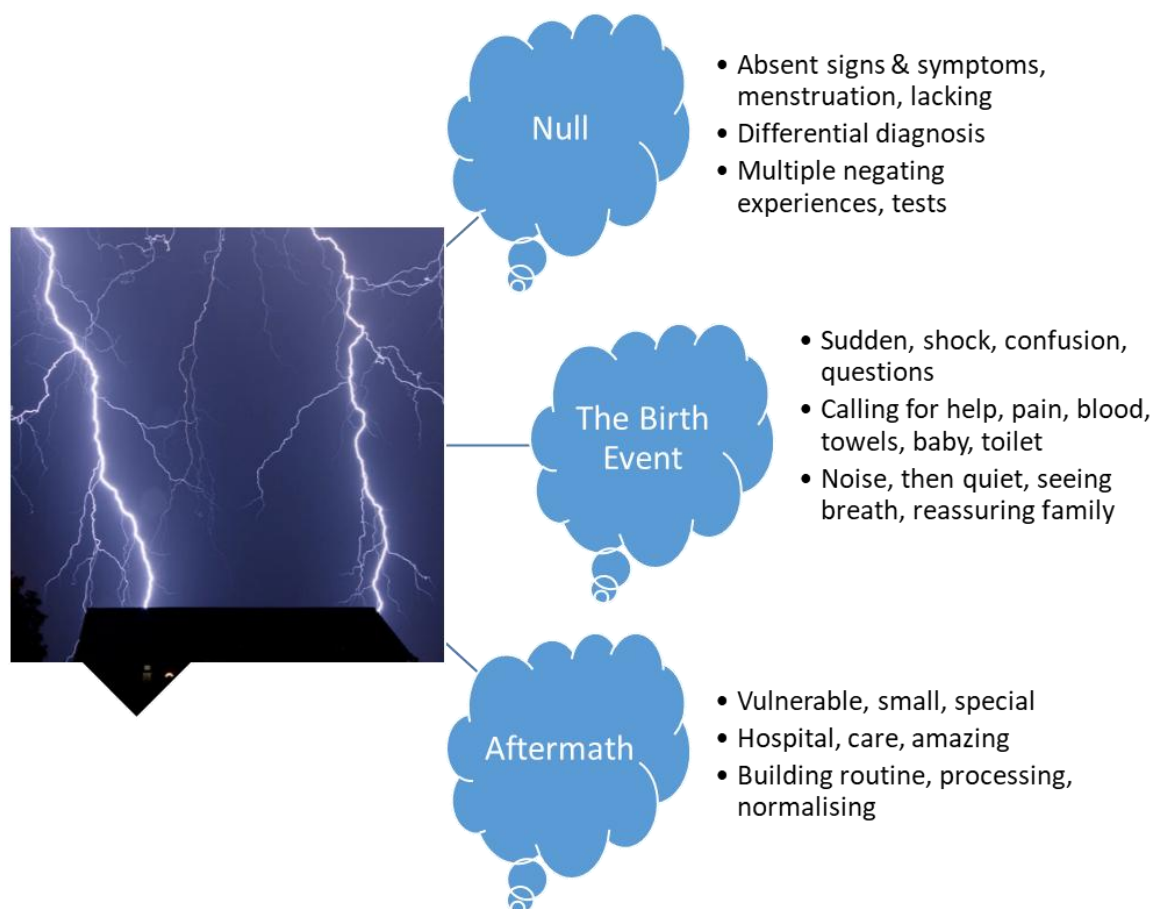


Figure 26: Researcher Reflections on Rain's Story Telling

The dramatic picture represents the intense and vivid suddenness of the experience - and the shock; two lightning bolts one for the physical shock of the precipitate birth process, the other for the emotional shock of suddenly giving birth and Rain being unaware of the pregnancy or labour pains, until the last moments. The lightning strikes the house, illuminating the sense and importance of place, as the sudden experience happens in the home environment. Rain's negated childbearing story is intense, concentrated and very powerful, striking home, and changing the storyline of her life in an instant.

The clouds represent my thoughts and experiences as a listener and researcher throughout and post interview, and I grouped these under three main headings - 'null', 'the birth event' and 'aftermath'. The bullet points at the side summarise the main points from my informal notes, reflection and my researcher diary. The negated (null) aspect of Rain's story came through very strongly, as she clearly told me a little background about the lead up to the unexpected labour and birth, and an absence of pregnancy related signs and symptoms, with no pregnancy diagnosis. This soon was followed with Rain sharing the details of her experience of her precipitate labour and birth, followed by the immediate aftermath and then talking about the immediate and longer-term impacts and outcomes for herself and her new baby.

In order to fully consider and capture the context/s and my relationship (and potential influence) with Rain, a further exploration of storytelling, using a situational lens diagram (adapted from Chase 2005) was constructed using the informal interview notes. In figure 27 overleaf, four main areas which may impact interviewing and storytelling and hearing are identified as context, environment, narrator and researcher relationship and body language/communication.

The arrows within the quarter circles identify the interlinked relationship between the four areas, whilst the bullet points provide the detail of where and how the story unfolded and influencing factors and outcomes. Elements of outcomes from the three types of analysis are reflected, and highlight the importance of where and how the story is being told:

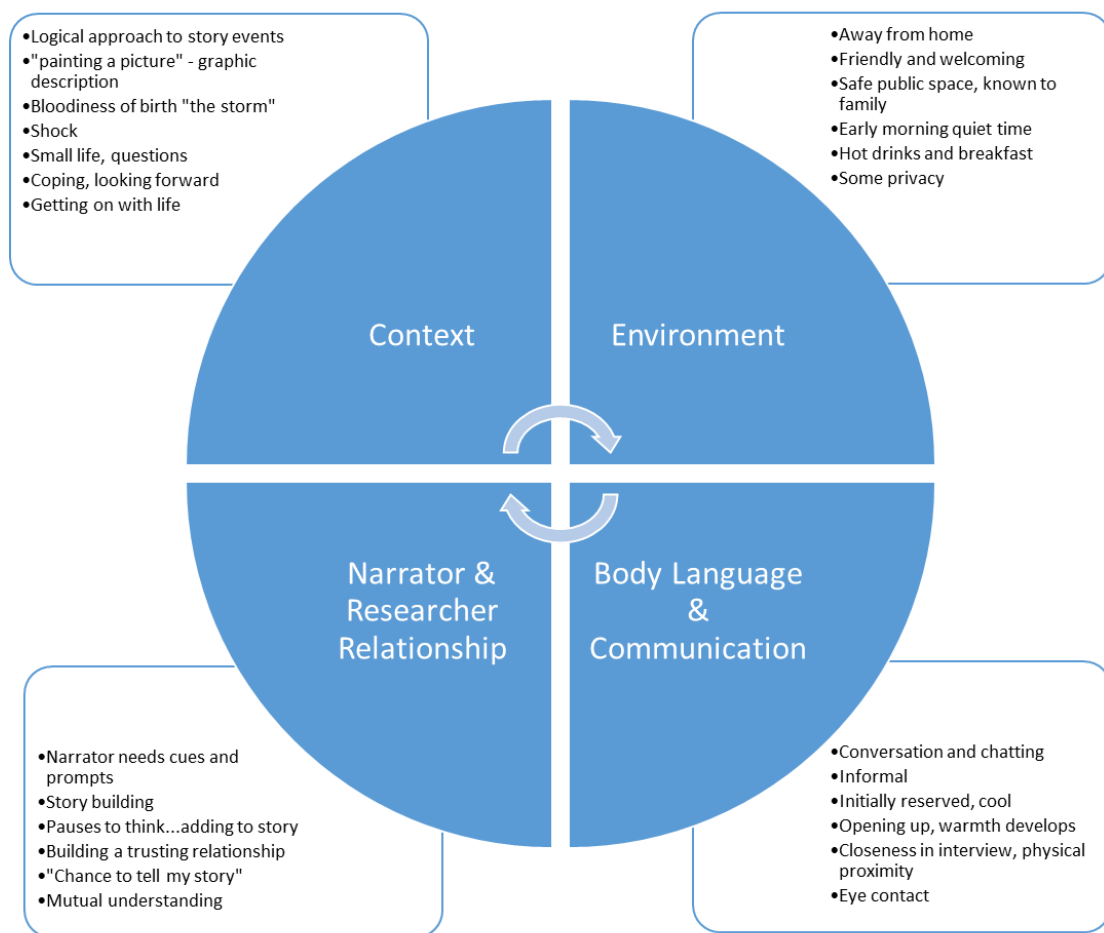


Figure 27: Situational Lens Diagram Rain's Interview

Story Precis

Rain was in good health, employed full time and shared a flat with a family member at the time of her negated childbearing. This was her first pregnancy and Rain revealed that she had had some issues with her menstrual cycle, such as irregularity, and had visited her GP and had been to hospital on several occasions for a range symptoms, but had never had a positive pregnancy test, or experienced any of the classic signs/symptoms of pregnancy. Rain had no contact with maternity services or any antenatal or intrapartum care.

One day when Rain was at home with her family member, she started to experience pain in her abdomen which came on suddenly and became intense very quickly. Rain was upstairs and soon moved to the bathroom from her bedroom, still in a lot of pain, and did not know what was happening to her body. The baby is then born very quickly into the toilet, with Rain shouting to her family member for help, as she got the baby out of toilet.

An ambulance was called for by the family member, who brought Rain some supplies, such as extra towels into the bathroom, whilst Rain cared for her baby. The ambulance arrived and transferred Rain and her baby to hospital, where the baby was taken to the neonatal Intensive Care Unit (NICU), due to his mode of birth and size.

A social services referral was made by the hospital and Rain saw a social worker, who asked her some questions about the birth and the unknown nature of her baby's arrival, with no further follow up or contact deemed necessary, and the case being closed. Rain notes that no additional support was provided for her, and her family supported her following the birth and beyond. The focus seems to be very much on Rain's baby, with Rain advising that little attention was given to her and how she was coping.

Story Structuring

Rain tells and structures her story, through several short, sharp and succinct plots and sub-plots, which form the main stay of her story construction. Although Rain's story was the shortest (interview), these plots are an important indicator of the importance of certain factors and parts of the story for Rain, and the focus that she gives these during her storytelling. The briefest of introductions soon makes way for a short telling of the dramatic and short labour and birth at home, when the negation is revealed. Most of Rain's story concentrates on the immediate and postnatal recovery and experiences, with attention paid to her baby, and recognising the crucial element of family support.

There is a recognition in this telling and structuring towards the end of the story, of Rain's anxiety about future pregnancies, but also a desire to connect with others who have had a similar experience and can understand what Rain has been through. The constructed plotline is a temporal sequence of events (story as a whole) - described and interpreted as follows:

Introduction: Brief description of how the event started, looking back to possible signs and symptoms/menstrual issues (**Framing the Story**) →

Describing Negation: Pain, environment, birth, shock (**The Main Event**)→

The immediate aftermath: concern for baby, emergency services, transfer to hospital (**Sub-Plot 1**) →

The Hospital Stay: NICU experience, prematurity, feeding, social services involvement, family support (**Sub-Plot 2**) →

Postnatal Processing: Discharge, getting into a routine, normality (Sub-Plot 3) →

Revisiting Negation: no signs and symptoms, unaware, normal routine (Returning Plot) →

The views of others: Questioning, disbelief (Commentary) →

Postnatal Processing Revisited: family support, focus on baby, lack of professional support for woman (Revisit and building on Sub-Plot 3) →

Future Pregnancies: Fear of repeated negation, pregnancy tests, consideration of signs and symptoms (New Plot) →

Revisiting the NICU: hospital stay, care given, looking after baby (Returning to Sub-Plot 2) →

Sharing Negation and Concluding: Talking to other women, a shared experience, understanding, wanting the opportunity, coming to terms (New Plot and finality)

Story Content Revealed: Fat and Thin Threads

a) Trauma Threads

Rain does not use the word 'trauma' in her story, but she does refer to traumatic aspects of her negated childbearing, though alternative terminology, use of negative narrative tone and non-verbal communications noted at the time of her interview. There are several references to pain in relation to the birth event, and Rain shares this aspect of trauma in her story, and references the pain in terms of its suddenness, increasing intensity and enduring nature, and that it was unexpected and unknown. In this stage of Rain's story, she remains unaware that she is pregnant and in labour, and did not know what was happening to her body and why:

"The first thing I knew was that I was at home, upstairs, and I had this pain, this sudden pain that just kept increasing, and getting worse, I was doubled over with it, with the pain, and it wasn't going away. I didn't know what it was"

"It was pain in my stomach, it felt like stomach pain..."

The main event in Rain's story centres on her negated labour and birth, and the fat thread of trauma can be heard as Rain shares her distressing and shocking experience from when the pain started to how the negation is revealed and the rapidity of the birth, as a contributing factor to trauma. The physical and emotional act of giving birth, is shared by

Rain as a rapid process, where she explains that she wasn't consciously aware of making an effort to push her baby out, but that the 'pushing' seemed to have happened in a more spontaneous, involuntary way with little control from Rain. This results in a shocking and traumatic birth, as the cause of the pain and the negation are revealed:

"I was upstairs in the bedroom, and then in the bathroom on the toilet, really in a lot of pain, and I didn't know what was happening to me"

"It didn't feel like pushing, but then I must have been as the baby's head came out, then he was born really quickly straight into the toilet, and I was in shock, just in shock then..."

In the immediate period following the birth, when Rain is referred to social services, and had to meet with a social worker to discuss what happened to her (and why) there is a further indication from Rain of the trauma associated with the birth and the aftermath. The questions that relate to the negation, highlight for Rain that she is still in shock, and trying to make sense of what had happened:

"I was still in a bit of a state then just after the birth, still in shock really, I really didn't know what had just happened to me"

b) Clinical Care Threads

There are references to various aspects of clinical care for both Rain and her baby, peppered throughout, and present as part of the sub-plots in the story telling and structuring. As Rain introduces and frames her story, she discusses some health issues in relation to her menstrual cycle, and her contact with her GP and hospital services as a result. This part of the story telling provides a neutral backdrop to the negation, as the narrative tone is neither positive or negative, and is a matter-of-fact description of what occurred. However, Rain does mention that during these episodes of contact with health services and clinical care, when she had pregnancy tests these were always negative, and that she had no signs of pregnancy:

"I was previously admitted to hospital for different issues, for I think periods and have had a negative pregnancy test...I had been to the GP on a number of occasions, for different reasons, different things"

Following the precipitate labour and birth, Rain touches on the arrival of the emergency services, noting that both she and the baby were checked over, and as Rain was still bleeding

and her baby was small. A decision was made to transfer both to hospital, which following a discussion was the hospital nearest to Rain's home. The next section of Rain's story focuses on the specialist care that her baby required due to the prematurity and additional challenges, such as getting to feed established. The positive narrative tone of this story aspect, is strongly heard when Rain refers to 'they' - as the staff who worked in the NICU to care for her baby:

"They were just great with him, brilliant they were, they really took care of him and looked after him, making sure he was okay and doing well"

"The care that he had in the NICU was really great, it was amazing"

As part of the care that Rain received whilst in hospital, a referral to social services was made, due to the 'unusual' nature of the birth, and that Rain had not had any antenatal or intrapartum care. This would have been part of hospital policy and processes relating to risk, governance and safeguarding. There is no negativity or mention of the staff who made the referral, but Rain does share her feelings about how her different situation was viewed by other professionals, who seemed to think that there was a possibility that Rain actively concealed her pregnancy. Rain shared her story with the social worker very soon after the birth, whilst in hospital, and the immediate impact of the negated childbearing on Rain was clear to see:

"So social services were called and they came to see me and asked me some questions, so they were asking me if I really didn't know I was pregnant, and whether I had hidden it or not, but I think when they saw how shocked I was, they knew then that I really had no idea that I was pregnant at all"

"They were apologising and said they had to ask me the questions, but they were satisfied that I didn't know as I was still in a bit of a state then just after the birth, still in shock really, I really didn't know what had just happened to me"

The final thin threads of Rain's story in relation to clinical care, are focussed on the lack of additional support for Rain in relation to her negated childbearing, and the centring of the clinical care and emphasis on her baby. Whilst acknowledging that her baby did need a clinical focus, it is clear from Rain's story that she felt that the impact on her was not acknowledged or attended to, as part of the care post birth.

The dramatic nature of Rain's negation - right up to the point of birth, seems to be ignored - and the distressing and traumatic aspects of her experience are not accepted or recognised:

“I wasn’t offered any counselling or extra support or anything after it had happened, there wasn’t anything extra which might have helped me”

“They didn’t really ask me how I was coping with the situation you know, the midwives and nurses, I think the focus was on the baby, getting the baby well and feeding and things, which is right, but no-one really asked me how I was or how I was doing afterwards, it was a shock, just such a shock...”

c) Family Threads

Rain’s fat thread of family in her story can be heard through the interwoven thinner threads of practicalities, support and belief. In the first part her negated childbearing story, Rain shares the reactions, actions and practical help of a close family member, as her negation was quickly and intensely revealed during an unexpected precipitate labour and birth at home. The dramatic nature of the birth, meant that Rain had to ask for practical help for herself, but conversely also had to provide reassurance to the family member, particularly in relation to the condition of the baby immediately after birth:

“I called for my close family member, I called for some help and towels as I was bleeding, and I just got him out of the toilet”

“He looked quite small but okay, and I had to reassure him you know, my close family member, he was saying he’s not breathing, he’s not breathing, but he was breathing ... I had to keep reassuring him as he was panicking quite a bit, and he was bringing me what I needed in the toilet”

The practical aspects of support provided by family, is heard from the moment of birth, in the enclosed space of the bathroom at home, right through to the postnatal period and beyond, where Rain alludes to family support more generally, but also in relation to financial and practical support to buy what she needed for her baby.

“It was my family that provided the support for me. They really rallied round to get me stuff for the baby to help me out as I didn’t have, y’know anything at all”

We can also hear once more, the emphasis and focus of support being centred on Rain’s baby, not just from a clinical care aspect, but also from a friends and family aspect. This is also tied to a lack of belief in Rain’s story of negated childbearing, and that some of those close to Rain may not be part of her life going forward, due to the circumstances of her baby’s birth:

“I think that although my family were very supportive and really helped me, especially in the early days, it was really hard, I was still coming to terms with what had happened, still processing it, and they didn’t really ask me how I was coping with the situation you know...”

“Some people still don’t believe that this could happen, and I have lost some friends along the way...”

d) Guilt Threads

Rain talks about and describes her feelings of guilt, through the language she uses in relation to be feeling responsible, thoughts of self-reproach and fault/blame around actions and behaviours during the negation. In this part of her story, Rain is revisiting the negation, reflecting on her actions, and giving a reason for why - in this part - she consumed alcohol at her usual levels, whilst unknowingly pregnant. This also forms part of the ‘need to be believed’ element of her story, as Rain states that had she known she was pregnant, she would not have been drinking alcohol:

“I was drinking and everything, and had I know I was pregnant I wouldn’t have been doing that, going out and drinking if I knew I was pregnant. It was because I didn’t know that I was doing that, and I wouldn’t do it again if I knew”.

The enduring guilt of not knowing that she was pregnant or in labour until the birth, forms part of Rain’s story in the postnatal period and beyond, as she shares that she fearful of being in the same situation again - not knowing that she is pregnant. This is heard as Rain explains her reasons for buying multiple pregnancy tests, and keeping a stock available at home, so that if there is any doubt, she can use the tests to check:

“I am really terrified of it happening again, I keep buying pregnancy tests and thinking ooh did I feel that last time, or is that another sign, but then I really didn’t have any of that so it’s really hard to tell, but I always make sure I have some tests at home, just in case, and I am terrified that it is going to happen to me again, so I’m just taking the tests just in case. I keep a supply of them in a drawer at home so I have it there in case I need to take a test again”

e) Shared Experience Threads

Towards the end of her story, Rain shares a thread around the importance and potential usefulness of being able to connect and communicate with other women who have been through a similar experience to her own. This communal ownership and combined story sharing of negated childbearing, resonates with Rain, as she relates to the story telling and story listening aspects of a collective appreciation and understanding by others with lived experiences, and not from healthcare professionals or family. This thread is told considering the potential shared experiences and benefits and opportunity that this could provide, when dealing with and processing negated childbearing:

“I think it would be really useful to talk to someone else who has gone through the same thing as me, you know, because it’s all very well talking to family and friends and midwives and doctors, but it’s not really the same as actually talking to someone who has been through it...”

f) Dyad Threads

Rain’s relationship with her baby begins in an unusual and unconventional way, due to the negated childbearing, and the shock of the precipitate labour and birth. The first time that Rain is aware that she is pregnant and in labour, happens as she is pushing her baby out, whilst on the toilet at home. Her first physical touch with her baby is scooping him out of the toilet and looking at him - focussing on his first breaths and his small size.

The environment which forms the foundation for the dyad relationship, is one of mixed contexts, as we consider the positive tone of the homely, quiet and familiar surroundings of home, with the challenges of the cold toilet water and the hurried need to improvise resources, such as towels:

“I called for some help and towels as I was bleeding, and I just got him out of the toilet”

“... but he was breathing, just barely breathing then, and he looked quite small but okay”

Further challenges to strengthening the mother-baby relationship and bonding are not explicitly shared by Rain in her story, as she recalls her baby being admitted to the hospital NICU for care, due to prematurity. During this time, Rain stayed either in the hospital, or close to the hospital so she could visit and care for her baby, and the story of this aspect of Rain’s childbearing is shared in a neutral, fact giving manner:

“He had to stay in the NICU for a while as they reckoned that he was premature ... they weighed him, and they kept him in for a while for feeding and stuff, to make sure he was okay”

A further aspect of the dyad relationship links with threads evident in both family and clinical care - the concentration of attention being mostly on the baby - which Rain mentions on several occasions throughout her story. Rain's early bonding and relationship with her baby is driven by a need to get back to a more 'normal' pattern of life and get on with the daily aspects of caring for a new baby. This is tempered with rain trying to understand and process what had happened to her, and the unexpected situation that she finds herself in.

The practicalities of a new baby, mean that Rain finds that predictable habits built into her new 'normal' everyday life, help her to process and this in turn forms an important element of the building the dyad relationship:

“I stayed in/close to the hospital and then he was discharged and I just got into a routine really quickly, I suppose I was just processing, trying to process the situation really, to get some normality about it, about the situation and what had just happened, really. So you just really get on with it don't you? That's what I did I just kind of got on with it”

Performing Stories: Storytelling and Presenting through Poetry

This poem is based on Rain's interview, and it is written and organised to reflect the story structure and how Rain told her story. The poem reflects the striking and powerful impact of the sudden labour and appearance of Rain's baby, followed in the bulk of her story of the immediate and ongoing impact that the negated childbearing has in her life. The importance of a routine as part of restoring 'normality' in Rain's life is also heard in the poem, and she draws our attention to the lack of support for her unusual situation and experiences, which support for this was lacking from both health professionals and friends and family.

5.12 The Negated Childbearing of Rain

*It all started with pain at home
Pain and
Sudden pain that kept
Increasing
It wasn't going away*

*Started making a noise
Didn't realise
In the bedroom
In the bathroom
On the toilet
What was happening to me?*

*Baby's head came out
Then born quickly
Straight into the toilet
In shock
Called for some help, some towels
I was bleeding a lot*

*I just got him out of the toilet
Barely breathing then
He looked small but okay
The ambulance came
We got taken away*

*Social services called
Was it hidden or not?
They saw my shock
That I was in a state
They could see
What had happened to me*

*No offer of counselling
Nothing extra to help
Family provided
Supported and rallied
Helping me out*

I had nothing at all

*Got into a routine quickly
To process the situation
To get some normality
You get on with it
That's just what I did*

*In the early days
It was really hard
Still processing
Not asked about coping
Focussing
Getting the baby well and feeding*

*Terrified
It will happen again
Buying tests
Did I feel that last time?
Is that another sign?*

*It was a shock
Such a shock
It still is
Even now
I still think about it
About what happened
To me*

5.13 Rain's Story in Summary

The threads of Rain's negated childbearing story are woven together and present an intense and vivid labour and birth element, which forms the initial backdrop and introduction to the immediate and ongoing experiences and challenges. A variable mix of positive, neutral and negative narrative tone is heard throughout, with Rain using neutral narrative tone as a potential 'coping mechanism' in her story telling.

There is a clear indication from Rain, that she felt she could have been better supported, and that an increased focus on her own well-being, given the nature of the suddenness of

her labour and birth, would have contributed to her being able to effectively deal with and process the negation, and any immediate and longer-term impacts. Rain's story is very much a maternal story - highlighting her experience and feelings, with her baby a small part of this.

5.14 The Story of Margaret

"I found out, simply because I went to get my appendix out"

Story Telling

I met Margaret in a busy and well-known coffee shop to carry out the interview, and after some brief introductions and explanations around consent, Margaret began to share her story with me. She immediately started her story with the reason for the uncovering of the negation and then went back to give the background and detail of what led up to the discovery of Margaret's pregnancy. Further details of her story were shared, including how Margaret coped, and telling me about her situation and circumstances at the time of the negation. Margaret was also keen to tell me about how she felt after she found out she was pregnant, and her story in the postnatal period and beyond, following a complex birth.

When choosing a pseudonym, and thinking about Margaret's story, she did share details around the complications during the remainder of her pregnancy and during labour and the birth. Reflecting this aspect of the story, Saint Margaret is the patron saint of difficult and complicated childbirth, so Margaret was chosen to echo this aspect of her story, which also impacted on the immediate and longer-term postnatal recovery.

Informal notes were taken at the time of the interview, and reflective notes written after the interview, to capture and reflect my thoughts and feelings as the researcher, of how the interview was conducted. The informal notes are captured and presented in figure 28:

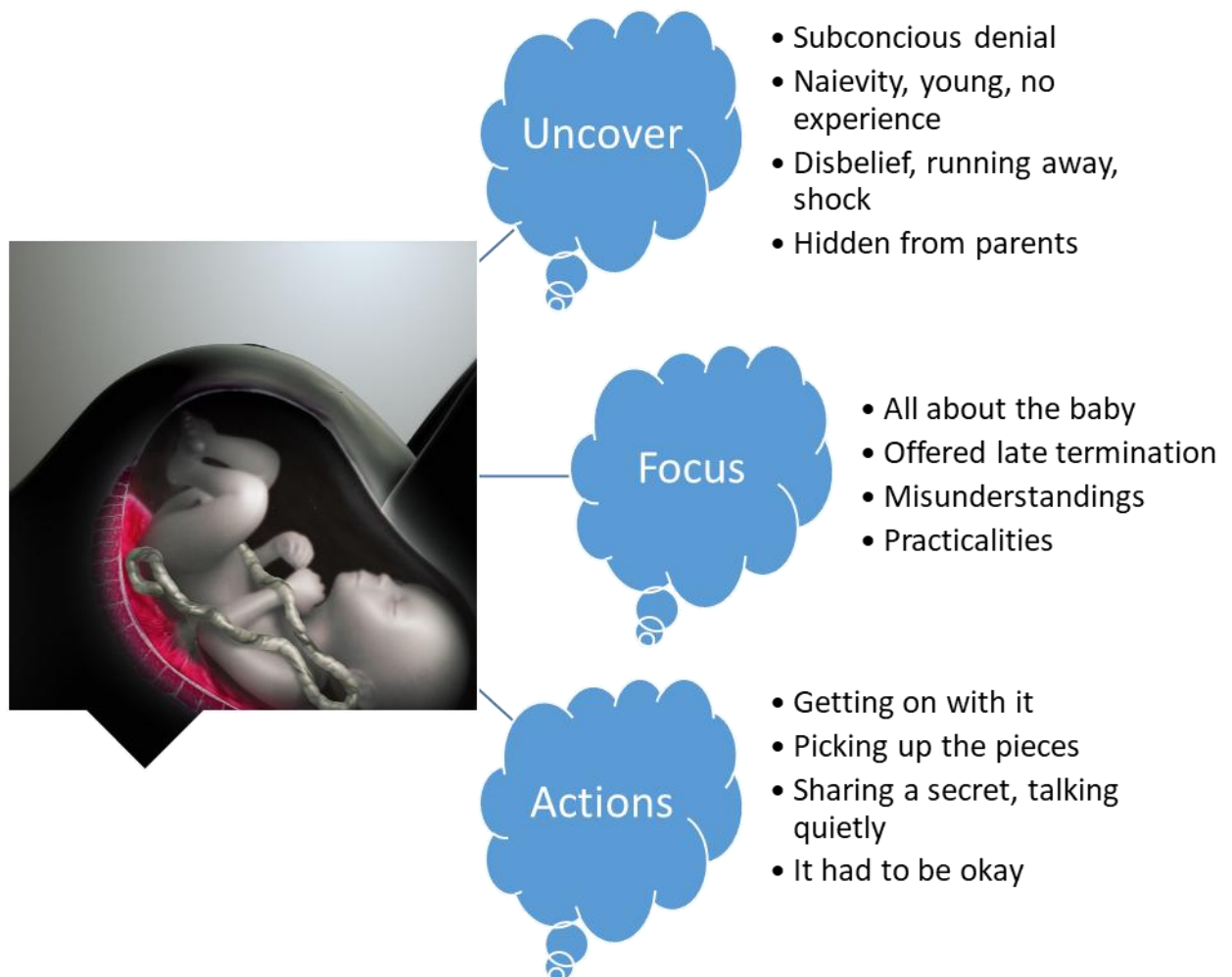


Figure 28: Researcher Reflections on Margaret's Story Telling

The picture represents the complete focus on the baby throughout the story - as described by Margaret, with the pregnant abdomen in darkness, and the lightness and colour of the baby and placenta highlighted and brought to the forefront. For Margaret in her negated childbearing, she felt there was no care or attention about how she felt being in the situation. Margaret indicates that for her there was no confidentiality, she felt stupid and very young, due to a lack of awareness and knowledge about choices and options.

The view of others was that it was all straightforward, and the journey for her was laid out and clearly signposted without her input. The picture also represents Margaret 'looking in' on her childbearing journey, which is concentrated around the needs and well-being of her baby.

The clouds represent my thoughts and experiences as a listener and researcher throughout and post interview, and I grouped these under three main headings - 'Uncover', 'Focus' and 'Actions'. The bullet points at the side summarise the main points from my informal notes,

reflection and my researcher diary. The first two thought clouds relate to the revealing of the pregnancy to Margaret and her family, and what the context and background was to Margaret's situation.

The way in which the pregnancy was uncovered is both shocking and traumatic to Margaret, which then results in challenging and difficult conversations about the way forward and decision making. After the birth, the third thought cloud concentrates on the practicalities of caring for a newborn, but also the emotional practicality and actions to 'get on with it', indicating that for Margaret she felt that there was no other option.

To fully consider and capture the context/s and my relationship (and potential influence) with Margaret, a further exploration of storytelling, using a situational lens diagram (adapted from Chase 2005) was constructed using the informal interview notes. In figure 29 overleaf, four main areas which may impact interviewing and storytelling and hearing are identified as context, environment, narrator and researcher relationship and body language/communication.

The arrows within the quarter circles identify the interlinked relationship between the four areas, whilst the bullet points provide the detail of where and how the story unfolded and influencing factors and outcomes. Elements of outcomes from the three types of analysis are reflected, and highlight the importance of where and how the story is being told:

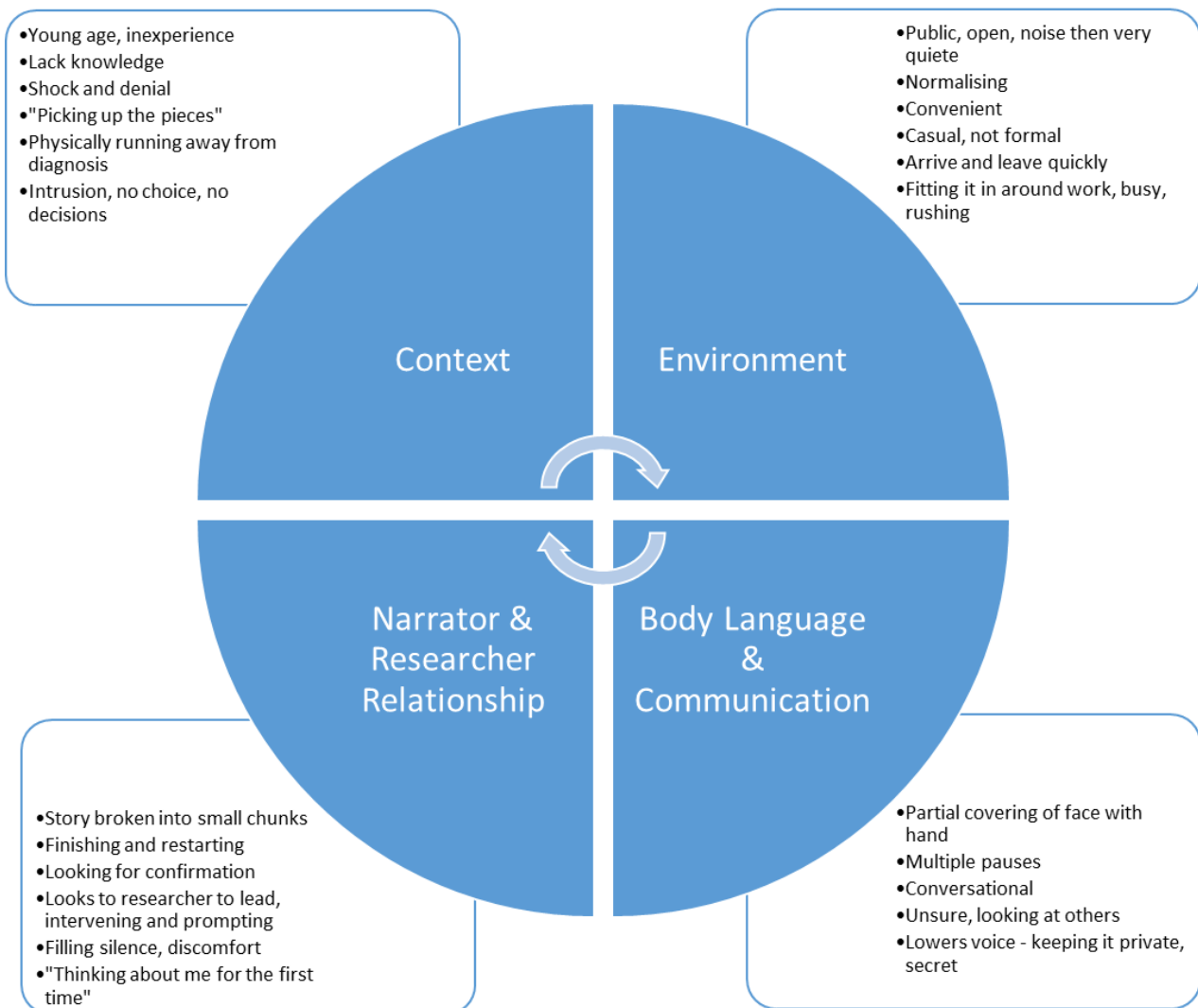


Figure 29: Situational Lens Diagram Margaret's Interview

Story Precis

Margaret was a young woman, attending college and working at the time of her negated childbearing. She lived at home with her parents and had no children and had no previous pregnancies. Margaret had been visiting her GP over a few months for a range of symptoms, including pain in her abdomen and in her ribs and period type pain.

Following another visit to the GP, when the pain returned in her rib area, Margaret returned home after the appointment, thinking it was period pain. However, overnight the pain increased, and Margaret's mum suggested a further visit to the GP, to get things checked out. Margaret attended the appointment on her own as her mum had to go to work and was still in pain.

At this GP's appointment, further assessments were carried out and, as a result, Margaret was informed that the reason for the pain was potentially an inflamed appendix, which was at risk of rupture, and that emergency surgery would be required. Margaret was taken immediately to Hospital, and straight to theatre for emergency surgery on her appendix.

Whilst in theatre, and being prepared - putting on her theatre gown, Margaret was again informed that they thought it was her appendix that was causing the pain, and that it may rupture, so this was the reason for the emergency surgery.

At this point, Margaret was still in a considerable amount of pain, to the point where she thought she was dying. When on the theatre table, they performed an Ultrasound Scan on Margaret, left the room and returned with a different person who carried out another scan. Following this second scan, a discussion was being had between the medical staff, whilst Margaret remained *in situ* on the theatre table. Margaret thought that they had found something on the scan which meant that she was going to die.

One of the medical staff then informed Margaret that she did not need to be gowned up, and could get dressed, and that they would be back to talk to her. When dressed, Margaret waited in the side room, and a doctor came back to talk to her, informing her that they did not need to remove her appendix, that she was pregnant, and at an advanced gestation. Margaret reacted with shock at the unexpected pregnancy diagnosis and walked out of the hospital and back home.

When Margaret's mum returned from work, she told her what had happened, including the pregnancy diagnosis, and that Margaret did not believe it. Margaret was booked to attend her local maternity unit that same day for further scans and assessments, which she attended, this time with her mum. An ultrasound confirmed a pregnancy of around six months gestation, and further discussions followed about options for termination or going through with the pregnancy.

The decision was made to carry on with the pregnancy, and Margaret then developed some complications, which ended in a protracted labour and complicated birth. Margaret returned to work around six weeks after the birth, indicating that she had undiagnosed postnatal depression and struggled to bond with her baby. Her family supported her with childcare, so she was able to go to work, and then on to university.

Story Structuring

Margaret shares her story of negated childbearing in short, sharp bursts, which are told quickly and rapidly in logical succession, of how the events unfolded and occurred. The story is centred around two main events for Margaret - the discovery of the pregnancy and then the complex birth, supported by a number of smaller sub plots. A significant part of Margaret's story is given to reflection and revisiting the negated childbearing, with

reference to specific aspects of this, explored through the story threads. This ‘making sense of’ is highlighted in this story, as an important aspect of story structuring, as Margaret reviews her thoughts, emotions and actions at the time, and how things might have been different.

The impact of context, environment and others, and the part that they play in Margaret’s negated childbearing story, is seen in the story structure, through the bite size sub plots. These reinforce the importance of the minutiae in the detail of story structuring and form the basis for a story told in manageable portions, for Margaret, a way of coping with the telling of the story, but also the content. The constructed plotline is a temporal sequence of events (story as a whole) - described and interpreted as follows:

Brief Introduction: Very short description of the “facts” of when negation was revealed and how (**Preliminary**) →

Illness and Pain narrative: Accessing medical and clinical services, ongoing pain, medical diagnosis of pain, urgent referral, theatre and preparation for surgery (**Sub plot 1**) →

Discovering the Pregnancy: Incorrect diagnosis, trauma, emotional distress, disbelief and dissociation from pregnancy diagnosis, leaving the situation, being young and alone (**Main Event 1**) →

Making Choices: Family involvement, late termination discussions and decisions, gestation confirmation, denial and reality (**Sub Plot 2**) →

Daily Life: Socialising, college course, work life, balancing roles and responsibilities, looking after the baby (**Sub Plot 3**) →

The Birth: Denial, lack of knowledge and understanding, complications, young age (**Main Event 2**) →

Postnatal Period: Mental health issues, going back to work, poor bonding with baby, coping, effects in later life, family support (**Reflection and Acknowledgement**) →

Awareness and Understanding: Lack of education about childbearing and practicalities, young age, essential family support, disappointment and acceptance (**Returning Plot 1**) →

Beyond Postnatal: Future childbearing, society's view, lack of information from care givers, lack of choice, reviewing termination information and decisions (**Further Reflection and Returning Plot 2**) →

Negation Reflection and Revisit: Stigma, not knowing, other family/friends experiences, pregnancy signs and symptoms reviewed, lifestyle behaviour, young age, looking for reasons, further family experiences (**Reflecting and Revisiting Negation**) →

Summarising Negations: Familial history, broader attitudes to negation, discovering pregnancy, getting on with it, family support, mental health (**Concluding Revisitation of Main Events**) →

Fear of Repeat Negation: Worry of further negation, regular purchase of pregnancy tests, irregular menstruation, contraception, family planning and thoughts (**Final Sub Plot 3**)

Story Content Revealed: Fat and Thin Threads

a) Trauma Threads

One of the ways in which Margaret brings to life the trauma of parts of her story, is her telling us how she reacted to certain events in her negated childbearing journey. The revealing of her unknown pregnancy happened in a traumatic way, as Margaret tells us how she felt at the time when she was in a lot of pain, and expecting surgery on her appendix.

At the time, when she was in theatre and prepared for her procedure, following a scan, it was obvious to Margaret that something was not right, and it was at this point that she thought they have found something which is so awful that they cannot do anything about it, and that she was going to die:

"I didn't really understand, thought I was dying, it was one of them..."

"I'm like, must be something they can't fix..."

As Margaret was informed of the pregnancy, and that it wasn't her appendix, she reacted instinctively and was in shock. The trauma of going to hospital, expecting surgery, and then being informed that there was no need for surgery, as it was not her appendix causing the pain, but that she was pregnant, and "far on", was difficult information for Margaret to

take in. At the point she was informed of her pregnancy she was on her own, and couldn't cope with the diagnosis she had been given:

"We don't need to take your appendix out, we don't think it is, you're pregnant and you're far on, and I stood up and said, what you lying for, and I walked out..."

"Crying my eyes out, bawling my eyes out, was just distraught"

Margaret shares her thoughts as a young person, naïve by her own admission in health matters, and that she didn't understand what was happening to her, or the information that was given. This is particularly evident when Margaret was given options regarding termination or continuation of her pregnancy, and the way that the information was given to her was traumatic, and what would happen if she chose termination was traumatic for her. Margaret uses the word 'brutal' on several occasions in her telling of this part of story, when referring to health professionals, her mum, and how she felt the situation seemed to her:

"They were trying to explain to me, you have to go to another city, we'd have to book it, and we couldn't get you a place for another few weeks' time, and you'd have to give birth to this baby, and it was brutal back then"

"Babies are born at this age, and they live, and you kind of just like, okay, this is how you're killing a baby..."

b) Clinical Care Threads

Margaret's thread of clinical care through her story, is focussed on communication, issues around informed choice, confidentiality, decision making and lack of additional support from healthcare professionals. Communication, and the various issues around this, which Margaret shares, impacted how she dealt with, and subsequently feels about her negated childbearing.

The lack of nuanced communication and individual person-centred care meant that Margaret was left feeling vulnerable and unsure what was happening, in the context of an acute theatre environment which was unfamiliar to her, resulting in feelings of heightened anxiety around her condition. The additional impact of the environment on communication, can also be seen when Margaret is asked to get dressed, and wait in a room for the doctor to

come and speak to her. She shares the feeling of being confined in a small, dark space, which adds to her fear and uncertainty, and waiting, alone, to be seen:

“So I’m lying there, I’ve got this gown on, and first they scanned me, and they said I’m just going to leave the room for a minute, I’ll be back in a minute, they come back with a lady, whose scanning again, and they’re like, talking between themselves, and I was like oh my god I’m dying...”

“We don’t need you to be gowned up anymore, just pop your clothes on and I’ll come back in in a minute, and I was like oh, okay, erm, I was just in this room, this dark room, and being so enclosed and thinking, thinking oh my god no-one’s going to cut me open today, but also is it because they can’t save my life”

The issues around confidentiality in Margaret’s story are linked with information giving, informed choice and decision making, and this is heard at the start of Margaret’s story, when she was still in shock at the pregnancy diagnosis. Margaret’s GP had given information to her mum, and booked her in to the local hospital, so a decision could be made about the pregnancy, without Margaret’s consent:

“Mum then rang the GP, who give her all the information, which obviously isn’t allowed nowadays, he give her all the information...”

“He said I had to go to the local hospital, maternity hospital because he’d booked me in that night, me mum could go up and we could make a decision”

Margaret shares her thoughts of what she wanted at the time, but also how her decisions were impacted and influenced by others, including health professionals. There is some reference in this part of the story to how Margaret recognises the pregnancy and that due to the gestation that she knows she will have to physically give birth, but feels conflicted and scared (in her storytelling), because she cannot see herself with the baby as a viable option:

“My decision in my head was just like, I’m having a baby...”

“With my dates ... they scanned me over, and I was just literally, no other, other option than not having this baby...”

The lack of support from healthcare professionals is heard throughout Margaret’s story, from the beginning when the negated pregnancy is revealed, through to the birth and then in the postnatal period and beyond. The overarching feeling of a focus on the baby, and the

‘forgotten mother’ comes across strongly, through numerous references to a lack of help and support, with a negative narrative tone:

“...and I ended up being in labour thirty-seven hours as well, with no help whatsoever, erm, loads of complications”

“I think, going on my experience I’ve had after that, I then realised that actually, so much more should have happened, and there should’ve been someone there to say, actually you might need a bit of counselling there, you might need someone to talk to, shall we take your family out of the situation, see if you really do understand, because, I don’t, I don’t think, I know I didn’t understand”

c) Family Threads

Family and the support that they provided to Margaret, allowed her to cope with her situation, and the practical aspects of this support meant that Margaret was able to be independent, going to college, holding down jobs to support herself and her new baby financially. Margaret acknowledges the importance of the support her family provided after the birth of her baby, and the essential part this played in her postnatal story - one of having to cope with the situation and get on with daily life:

“From there on, I was very lucky, my family stepped in, and I was able to go to work, I was able to go to Uni...”

“My dad, he absolutely supported, he did everything”

Support was a positive aspect of the Family thread in Margaret’s story, but there were also some more difficult aspects of family actions and reactions to the negated childbearing. We first hear this in Margaret’s story after the pregnancy diagnosis, as Margaret is emotionally distraught, and her mum reveals that she had suspected that Margaret was pregnant all along, which then impacts their relationship:

“...and her words to me was, I knew it, so then I wasn’t friends with me mum then, because if she knew and I didn’t, why didn’t she tell me...”

“I was going, no, you could have told me about this and it all could have been solved”

Furthermore, there were also aspects of disbelief and disappointment from some family members relating to the negated childbearing, which Margaret relates to as she shares and reflects on family reactions to her news that she was pregnant. Margaret also alludes to her negated childbearing and the lack of pregnancy signs and symptoms that she had, whilst acknowledging that she may have unconsciously not recognised or realised that what she experienced were potentially signs of pregnancy:

“Like when I had told my family member, he said how did you not know, and I go, my body don’t tell me, and be that be, because I didn’t want to tell my body, be that because I genuinely did not know...”

“But the, the disappointment, I don’t think, was ever overcome, until I had my second child”

d) Guilt Threads

A fat thread of guilt pervades Margaret’s story and is particularly evident through aspects of her negated childbearing journey which touch on her feelings of responsibility, self-reproach and self-blame. As Margaret reflects on how she felt at the time of her negation, she shares how others saw her pregnancy - that it was what she wanted and that she would go ahead with it, even though she may have had different and conflicted feelings towards her pregnancy.

There is also an indication in Margaret’s story of looking back, trying to remember if she missed or ignored any signs and symptoms which may have indicated that she was pregnant, and that were these picked up on, could have changed or prevented the situation that she found herself in. This constant looking back and reflecting, ties in with how Margaret tells her story, and the cycle of revisiting parts of her story. We also see a concern for self and others, as Margaret shares how her family were expected to provide the ongoing support that she needed, and that this is an additional weight of responsibility on them:

“It wasn’t until I had my second, the stigma disappeared, like, it was awful, people just assume, that that’s what you’re doing, and that’s what you want, and, and it wasn’t but, I’d never change it...”

“Or, I had been and ate food, and I couldn’t though, or hungover or, too much alcohol there ... you try and look for things, you do, you do try and look for things...”

“My Mum and Dad were left to pick up the pieces, and then you don’t want that on your Mum and Dad”

Margaret refers to being in denial throughout some of her negated childbearing story through not recognising that she was pregnant through to struggling with how she felt at the time - that she felt guilty about those feelings she had around how to proceed and the choices that she had. These are heard through the struggles as Margaret comes to terms with her pregnancy diagnosis, but also the choice that she faces around termination, and how she really struggled to think about what termination might mean, and the impact it would have on her long term:

“When I think back I think, I was just in denial, completely in denial about, thinking about it”

“The other options, my mum knew I’d never forgive myself for it, if I, done it, ‘cause, you don’t know how you’ll feel at that point, but I know it probably, would have haunted me...for the rest of my life”

e) Everyday Life Threads

As Margaret shares her story, she talks about the activities, actions and impacts that her negated childbearing had on everyday life, but also what she felt, thought and did which enabled her to process the situation and function. There are aspects of the ‘normal’ and familiar in parts of Margaret’s story, both in relation to a lack of signs and symptoms of pregnancy (so there was nothing unusual), and in Margaret’s behaviour and lifestyle, as young teenage woman. The desire to hold on to her normality of life, continues after the pregnancy diagnosis, as Margaret adjusts to her new situation:

“This is like my periods, everything is still, for my state of mind, normal...”

“My decision in my head was just like, I’m having a baby, then, going to a party on Saturday”

Being able to process and accept what had happened to her, along with the newly revealed pregnancy, is Margaret’s approach to managing the negation and brief childbearing, through her own coping strategy. There is a ‘matter of fact’ thread, one which indicates broader societal expectations at the time, but also a more local community pressure to deal with the negation without fuss or challenge:

“...and you just, just get on with it, that was it”

“...and I was just like, if that’s what needs to happen, just, that’s, that’s what happens...”

“What I did back then I could never do now, worked three jobs, looked after the baby and went to Uni, don’t, don’t know how I done it...”

Part of Margaret’s negated childbearing story refers her experience of the stigma, shame and disgrace that she felt at her situation, from health professionals, family and others. This is closely tied with her feelings and actions of having to deal with it both practically and emotionally, and then having to acknowledge and recognise the negation, dealing with the outcomes every day both during pregnancy and following birth:

“...and you feel like it’s, you’ve got to accept it, because of stigma’s and, things people say, even, I think even, even doctors”

“I think, I think it’s just still a stigma, still a bit of a stigma...”

Woven into Margaret’s story and thread of daily life is the lack of attention, focus and support of her well-being. The immediate, short and longer-term impacts of her negation, pregnancy diagnosis, social situation and context all had a profound impact on Margaret, as she reflects on this aspect of her story.

The presumption that Margaret was okay because she was seen to be getting on, and had a supportive and involved family, meant that her mental health suffered. Moreover, a longer-term issue around living with the fear and worry of the negation happening again, became just another issue which had to be dealt with - practically by regular pregnancy testing:

“If I look back now, it was probably handled really, badly, really badly, and there wasn’t anything, no-one ever asked me if I was okay, I think back and I think, that’s the first thing you ask someone, I mean, no-one ever did”

“Definitely had postnatal depression that wasn’t picked up, and I think you pick that up, I picked that up earlier on”

“That’s what I do, I buy them, I buy them in erm, like the six packs, obviously, I just leave them in my draw, I am not regular, I have that issue anyway, I always have them in, it’s not like I’m not careful, I am, that doesn’t matter, I am, I am terrified that it’s going to happen again...”

f) Dyad Threads

The relationship that Margaret has with her baby, throughout her childbearing continuum, is one which is shaped and affected by the negation and the subsequent consequences of the situation. The pressure to show and demonstrate acceptance of the dyad, and absorb the practical and emotional impacts, are further tempered by the manner of the pregnancy diagnosis, and the brief timeframe which Margaret must manage.

The acceptance of the dyad, comes not just from Margaret, but also from family, friends and others, where the negated childbearing has a distinct negative connotation, and which lasts until Margaret further builds her family through active choice:

“I had one neonatal appointment, and then I had a baby”

“...and it’s, thrust upon you, almost, and you feel like it’s, you’ve got to accept it, because of stigma’s”

Trying to make sense of how the dyad came about, through negated childbearing, is something which Margaret reflects on, repeatedly, in the latter part of her story, as she revisits what happened and how it happened. The realisation of the development of the child in the family unit, which was unknown and unplanned, and Margaret’s naivety of how a baby would change her life, and the further life journey, lead her to think about how she did not really understand the choices and decisions that she was asked to make at the time.

This aspect of the dyad relationship, one of disconnection and separation from the reality of birth and baby care, is Margaret’s way of handling the complexity of her situation:

“I think I was just, just got on with it, got to like, years down the line, oh my god, what happened there...”

“Yeah, actually, still wake up now, and think like my child’s, how did that happen...”

The struggle that Margaret had in forming and developing her relationship with her pregnancy and baby, can be heard when Margaret shares the longer-term impacts of her negation. There was a financial need to return to work when her baby was six weeks old, which meant that bonding and attachment were affected as a result:

“I had to go back to work after six weeks, because there was no, like time thing...”

“So, I worked, I went back after six weeks, so, didn’t, I didn’t ever bond, and that’s probably something that showed later on, really, we clash, she’s, she’s not much older than me...”

Performing Stories: Storytelling and Presenting through Poetry

This poem is based on Margaret’s Interview, and it is written and organised to reflect the story structure and how Margaret told her story. There is a striking concentration on, and strength of, Margaret’s own voice and story, which forms the essence of the poem. This reflects the need, as told by Margaret, to bring back the centre of the negated childbearing story to her as the main character, rather than her baby, as happened at the time.

5.15 The Negated Childbearing of Margaret

*Been to the GP
Pain in my ribs
Any sex recently?
Pain was bad
Rushed to surgery*

*They said, appendix
They said, going to rupture
I didn’t understand
Thought I was dying
We’re going to scan you
Nothing unusual*

*Lying there
Gown on
They scanned me
Back in a minute
Scanning again
Talking between
Themselves*

*Pop your clothes on
Back in a minute
Okay then*

*Just in this room
This dark room
Being so enclosed*

*He said
We don't need your appendix
You're pregnant, far on
What you lying for?
Walked out
Walked home
Cried, all the way*

*Mum home from work
Came into my room
Are you okay?
What did the doctor say?
I started crying
I'm pregnant
He's lying*

*I had to go
To the hospital he'd booked
Me mum could go up
We could make a decision
My decision
In my head
Was just
I'm having a baby
Then going to a party*

*We went down there
They said I was six
With my dates
When I'd had sex
They scanned me
Literally
Not having this baby
Trying to explain
To me
You have to go to the city*

*Completely in denial
Thinking about it
Went to the phone
We went home
Spoke to me mum
You're quite far on
A bit of a scary one*

*I didn't know
How you give birth
Complications
Too young to understand
Decisions made for me
Postnatal depression
I didn't ever...
Bond*

*Just got on with it
Got to
The disappointment
The stigma
I had one appointment
Then I had
A baby*

*People don't understand
Don't want to acknowledge
I'm living proof
That it can happen
Terrified
It's going to happen again*

5.16 Margaret's Story in Summary

Margaret's negated childbearing story is challenging and shocking, and invites feelings of disbelief, which she experienced from some of her family members and health professionals. It highlights a lack of support for Margaret as she tries to cope with her extraordinary

situation, and the pressure she feels from society to accept her circumstances and move on, with her life in the short and long term. Margret struggles with decision making, dissociating herself at times, from what information she was given, and what the consequences of those decisions might be.

Margaret's story of her negated childbearing brings back the focus onto the woman, the childbearing woman, who is at the centre of an unexpected and challenging circumstance. Finding herself removed from the point of focus, which was now her unborn baby, Margaret struggles to build the connection in the short time which remains of her pregnancy, and which is further exacerbated after a complex birth and a quick return to work.

5.17 The Story of Ray

"Back pain, stomach pain, take some paracetamol, you'll be fine"

Story Telling

Although I didn't know at the time, Ray would be my final interview, and the last woman to participate in this study. I met Ray at the family home, which she shared with other family members. Ray and her baby were still under the care of health services when I met and interviewed her, she was calm and relaxed in her home environment and had the support of her family.

As Ray started to share her story, she told me how her negation had been revealed, from the point of experiencing pain, right through to the diagnosis of labour and the birth. Ray shared her story readily, recounting how she felt at the time, the reactions of family and friends and how she felt about her baby. The story was shared quickly, with Ray revisiting and reflecting on various elements of her story.

Choosing a pseudonym for Ray was relatively easy, as although she had been through a challenging and difficult time, she was mostly positive about her experience, and her focus was on the love and joy for her new baby. 'Ray' was chosen to reflect this bright, positive aspect of the whole of Ray's story telling (Figure 30).

The brilliant beams of light extending from clouds are often seen during the early morning or early evening when the sun is shining, and these are rays of light. The lightness in Ray's story was heard throughout the story telling and were highlighted by Ray as she shared her

story, through the difficult parts, and this also reflects the time of day when the interview occurred.

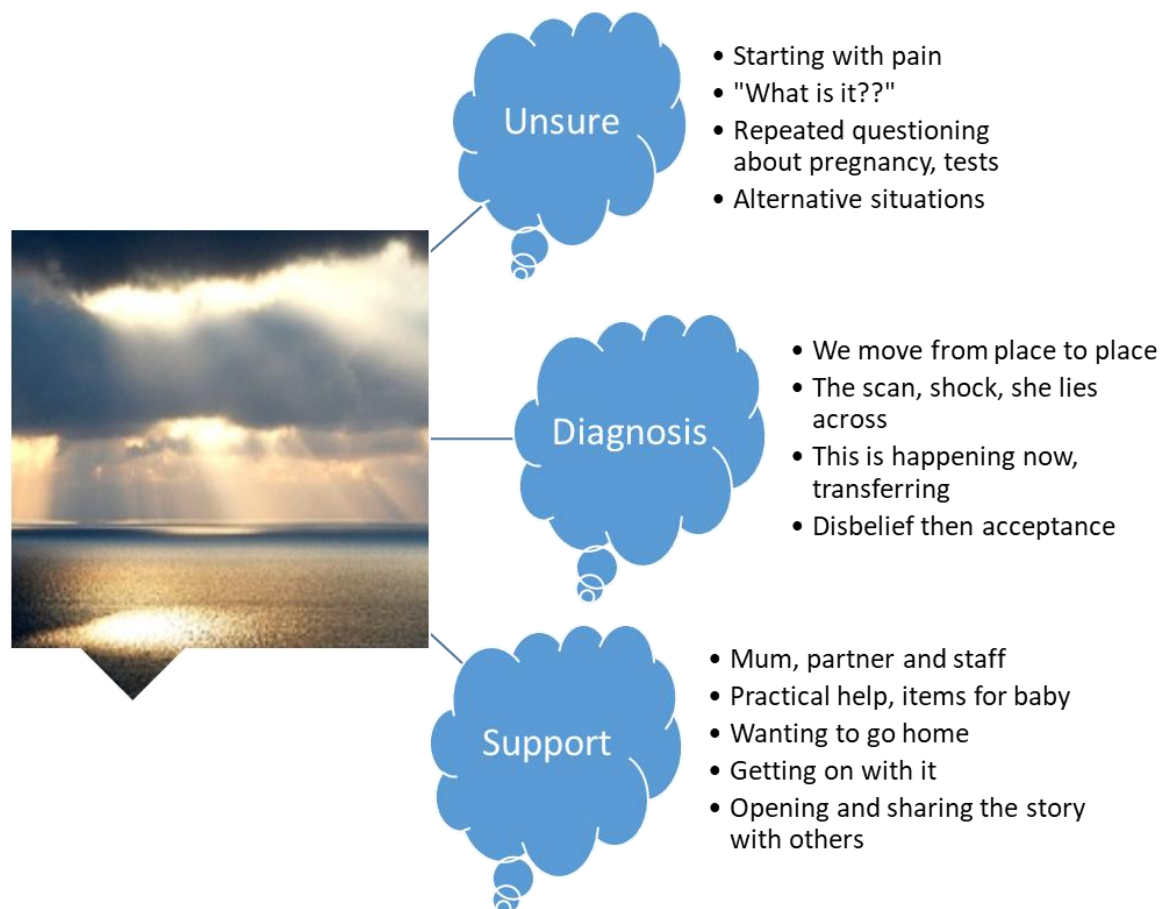


Figure 30: Researcher Reflections on Ray's Story Telling

The picture represents the holistic story and storytelling of Ray - the intensity of the pain and the unknown labour experience, breaking through the clouds when the pregnancy and labour is identified, through to the realisation and shock of the birth. The light of the birth of the baby shines through the pain, surprise and shock of the diagnosis - onto a calm and accepting family story.

Ray's story is likened to the fear of the unknown (the clouds) followed by the bright realisation and birth of the baby as the rays of sunlight breaking through the clouds to create beauty and joy. Rays of light can change direction when they encounter small particles suspended in the atmosphere (scattering), and this aspect of the picture resonates with Ray's personal change of life direction due to the negation.

The clouds represent my thoughts and experiences as a listener and researcher throughout and post interview, and I grouped these under three main headings - 'Unsure', 'Diagnosis'

and 'Support'. The bullet points at the side summarise the main points from my informal notes, reflection and my researcher diary. Rain starts her story with recounting the early part of her negated childbearing, referring to her onset of pain, which could not be managed, and the questioning about what might be happening to her.

Ray visits several healthcare places, before the diagnosis of pregnancy and labour is confirmed, and from the initial disbelief comes a quick and embracing acceptance of the situation. The final thought cloud focuses on the support element of Ray's storytelling, as she outlines the practical and emotional family support that helped her to cope.

To fully consider and capture the context/s and my relationship (and potential influence) with Ray, a further exploration of storytelling, using a situational lens diagram (adapted from Chase 2005) was constructed using the informal interview notes. In figure 31 overleaf, four main areas which may impact interviewing and storytelling and hearing are identified as context, environment, narrator and researcher relationship and body language/communication.

The arrows within the quarter circles identify the interlinked relationship between the four areas, whilst the bullet points provide the detail of where and how the story unfolded and influencing factors and outcomes. Elements of outcomes from the three types of analysis are reflected, and highlight the importance of where and how the story is being told:

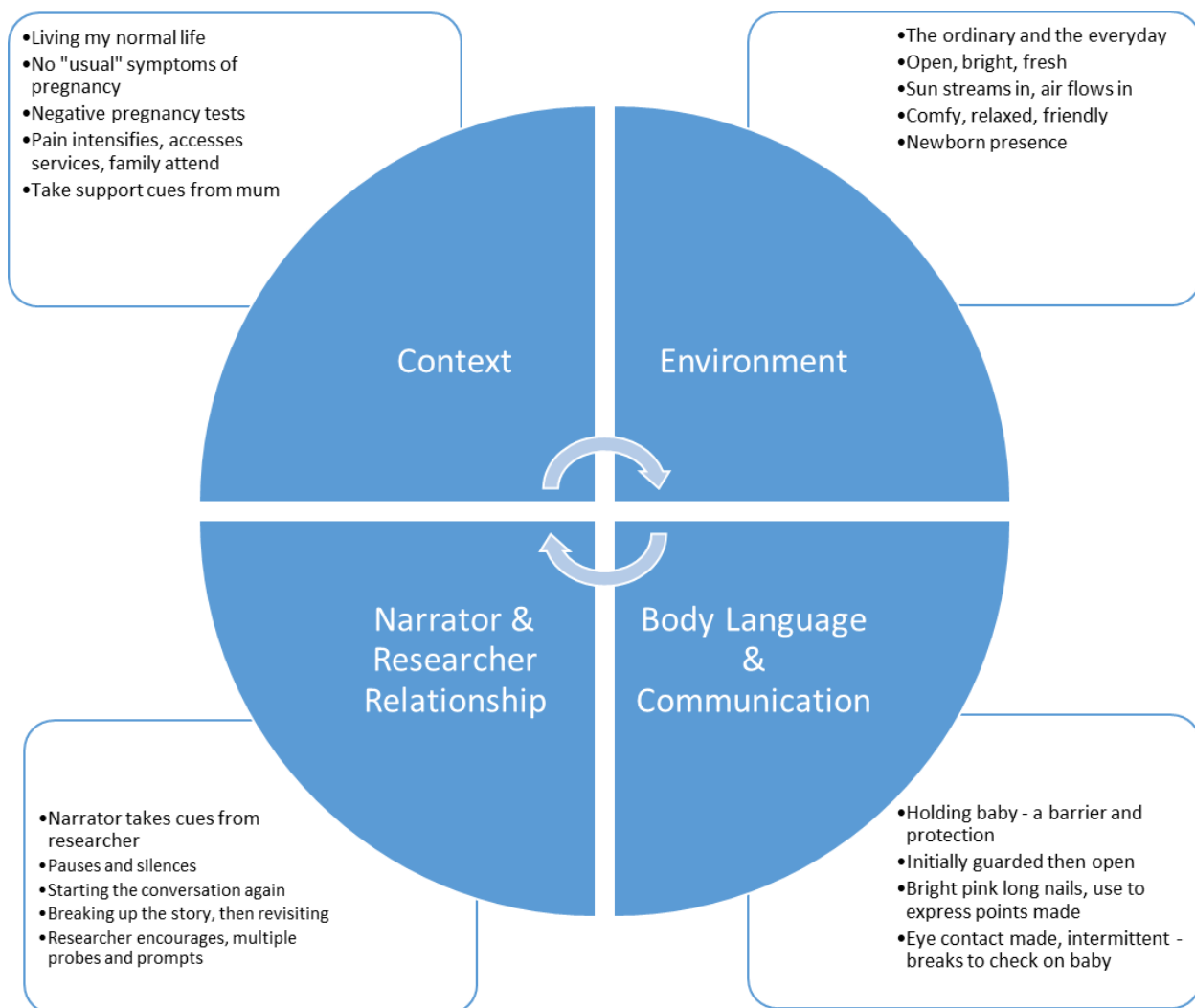


Figure 31: Situational Lens Diagram Ray's Interview

Story Precis

Ray was living in the family home, with other members of her family, and was employed at the time of her negated childbearing experience. This was Ray's first pregnancy. Ray started to experience some back and stomach pain, whilst she was at home, just before the weekend. She talked to her family member about this, who advised taking some paracetamol, which she did, and managed to get some sleep.

Ray woke in the night and again advised by a different family member took some stronger pain relief, to help her cope with the pain. The next day, the pain returned and increased, and Ray took some further paracetamol; however, this didn't decrease the pain, and Ray's family member advised her to contact the NHS 111 service, for some advice. Ray was advised by NHS 111 to attend her nearest walk-in centre, an appointment was made that day, and as part of her assessment a pregnancy test was carried out which was negative.

Ray was transferred to a hospital due to her ongoing pain for triage and was informed that she may have kidney stones. Further assessment at the hospital included an ultrasound

scan and questions about the possibility of pregnancy, which Ray denied, having had no signs or symptoms of pregnancy and had continued to have regular periods. Ray had her partner and her mum with her at the hospital.

After the ultrasound scan, Ray was informed that she was pregnant and possibly in labour, she was transferred to her local maternity unit for ongoing care. Following her arrival at the maternity unit, assessments revealed that Ray was in labour and would have the baby very soon. Ray gave birth just two hours after arriving, following a quick and uncomplicated birth, with her baby being taken to the SCBU for care due to prematurity.

Ray's family were with her for the birth, and additional family members were contacted during this time, and brought in supplies for Ray and her baby. Ray had a lot of support from her partner and family, and was discharged home, whilst her baby continued to receive care in the SCBU. Her baby was discharged from SCBU to the family home, where Ray continues to receive support and input from her partner and family.

Story Structuring

Ray structures her story into small bite-sized chunks, which tell us briefly the main aspects of her negated childbearing story, focussing on four plots, initially sharing three - the uncovering of the pregnancy, the birth and the support of family and friends. The story structuring begins as Ray starts her story with an introduction to how events unfolded, and her journey prior to the pregnancy diagnosis.

There is a portion of the story structure which Ray focuses and refocuses on other elements within her story such as thinking about her lack of signs and symptoms of pregnancy and revisiting and reflecting on the negation. Later in the story structuring, Ray shares the fourth main plot of her story, which touches on her thoughts and feelings of her 'missed experiences' in relation to the negation.

Introduction and Pain Narrative: Brief description of the environment and events, starting with pain, management and medication (**opening the story**) →

Seeking Medical Input and Considering Negation: Continuation of pain narrative, contact with medical services, environment of care and transfer, medical tests, pregnancy testing (**Sub-Plot1**) →

Negation Revealed: Scan and discussion, pregnancy and advanced labour revealed, emotions, family reaction, considering possible missed signs and symptoms (**Main Plot**) →

Birth in Brief: Another transfer - environment and care, quick handover, rapid labour and birth, pain relief, special care baby unit (**Main Plot 2**) →

Family and Friends Narrative: Communication of negation, physical presence, practical support, partner shock, providing the basics, getting on with it, baby becomes part of the family (**Main Plot 3**) →

Revisiting Negation: Reflecting on signs and symptoms, making sense, medical explanations, maternity staff (**Reflecting on the experience**) →

Continuing Neonatal Care: environment and clinical care, commentary on negation, growth since birth, unknown gestation (**Commentary**) →

Revisiting the Pain Narrative: Timeline considered, practical issues, home comforts, medical care and transfer, mode of birth issues, reflecting on negation (**Reflection Continued**) →

Negation Commentary: Long term impact, chance of another negation, family experiences, pregnancy testing, revisiting signs and symptoms (**Returning Plot**) →

Revisiting Neonatal Care: Prematurity and surviving, medical care, staff support, special care baby unit revisited, support at home, discharge (**Detailed Commentary**) →

Postnatal Thoughts: Negation questioned by others, shock lingers, getting back to normal, drawing on family childrearing experiences, baby belongs to family, sorting out employment and finances (**Sub Plot 2**) →

Missed Experiences: Listening to women's pregnancy stories, regret, missed celebratory milestones (gender reveal/scans/baby shower), media reporting negation, family reflections, signs and symptoms revisited (**Main Plot 4**) →

Revisiting Negation and the Pain Narrative Again: Views of family and friends, disbelief, shock, pain relief, pain management, medical care, revealing negation, family support, decision making, home comforts **(Returning Plot)** →

Final Thoughts: Hearing other negation stories, comparison, shared experiences, commonality **(Concluding Discussion)**

Story Content Revealed: Fat and Thin Threads

a) Shock Threads

The manner and the timing of Ray's negated childbearing are told very clearly by Ray in her story, and although Ray does not explicitly suggest or say that her experience was traumatic, she does use the word shock on several occasions when referring to her feelings at the time, a potential indicator of elements of trauma in her story. Ray and her partner and family have no inclination that Ray might be pregnant, mainly due to a lack of signs and symptoms, and this is the main reason for the surprise, upset and distress when the pregnancy diagnosis is given.

Ray refers to feeling shocked after the ultrasound scan, but also when she reflects and revisits the whole experience, in terms of managing and coping with the immediacy and quickness of the diagnosis, labour and birth, and caring for her new baby.

"I'm sorry to tell you but there's a baby, there, so then I started crying"

"Just getting over the shock, like, still think of it like, oh my god like, I didn't know I was pregnant, so it's actually happened..."

A contributing factor to the fat thread of shock in Ray's story, are the feelings of doubt and uncertainty, which relate to both the pregnancy and labour diagnosis. Ray was certain that she could not be pregnant, and that pregnancy could not be the cause of her pain, as she did not experience any usual signs and symptoms of pregnancy or notice anything different in her body. The Ultrasound provides Ray with the definitive proof that she is pregnant, but even then, Ray struggles to understand how this can be the case, with the diagnosis of active labour a further challenge to take on board. In this part of her story Ray finds out that she is pregnant and in labour at the same time, making this situation even harder to process:

“Sorry to tell you but you’re pregnant, and I was like, I really can’t be ‘cause I’ve been on and everything, so I was like, so me head was just confused”

“But when she, they were like, you’re in active labour, I was like, oh my god like, I don’t know what’s going to come to me now, and what’s going to happen ... “

b) Clinical Care Threads

Throughout Ray’s story, she shared details of the clinical care that she received, from contacting the NHS 111 service right through to her care with various healthcare professionals as she was transferred from the walk-in centre to a local hospital and then on to a different hospital to the maternity unit and neonatal unit. This fat thread of clinical care was overwhelmingly positive, and this is reflected in how Ray was treated and asked about the negated childbearing.

Being believed that the pregnancy was unknown to Ray, was an important part of her positive experience, and meant that she felt acceptance and confidence in the information she had given to those caring for her, her story had credence and was validated:

“The Doctor was like, she didn’t know, ‘cause obviously she’s been having a period, and that, and she hasn’t thought nothing of it...”

“The woman that was weighing her was the woman that was on the ward, that where my baby was, so she was like, oh you’re the one that didn’t know you were pregnant was you”

Furthermore, the positive care thread is heard clearly and repeatedly as Ray shares aspects of how clinical staff communicated with her, and the practical and emotional care and support that was provided to Ray and her baby. This positive aspect is also reflected in the positive narrative tone that was present throughout Ray’s interview, and highlights the upbeat and constructive approach to Ray’s challenging situation:

“They were like asking me questions ... but then they were all like, they were boss with me really, like, they were really helpful with me”

“But all the staff that like, dealt with it all, they were amazing like, I couldn’t fault them for nothin’...”

The lack of pregnancy related signs and symptoms that Ray shares, are an important aspect of her clinical care, and this can be heard strongly in the lead up to and during her pregnancy and labour diagnosis. Ray indicates that during history taking and discussion with healthcare professionals, the open and honest communication that she experienced, was instrumental in providing a solid foundation for her ongoing care, giving her confidence that they would look after her:

“They put me on one of the beds, and they said is there any chance you could be pregnant, so I said no ‘cause I was only on last week ... so then they said well we need to do a scan to see, what these pains are...”

“I was walking round with the pains, and he was like, we need to get this, like, sorted out, so then from there, just got taken straight in, and then I got transferred to the maternity unit”

c) Family and Friends Threads

When Ray talks about the positive affirmations and encouragement that she received from her family, it highlights the strength and importance of these relationships in Ray’s story. This is heard particularly as Ray experiences her first pains (unknown labour), and when labour has been diagnosed, a time of vulnerability for Ray as she is still processing her situation.

There is a comforting and supporting aspect to the communication and conversation, and a recognised need to support Ray at this challenging time. The supportive aspects of Ray’s story, are also heard as Ray shares her thoughts around the practical aid and input that she needed, both as a physical presence to aid and assist Ray throughout her short labour and the birth, but also with providing provisions and necessities for Ray and the expected baby:

“...and I was crying to him here, and I was saying to him, I can’t cope with them, and he was like, you’re gonna be fine like, it’s alright”

“She said I’ve had six of yours and I’ve only ever had gas and air, and it helped me, so I know you can do it ...”

“Like people were pass, like passing stuff down ... well all the help and support off everyone, can’t fault no-one for it, that’s it”

The attitude and reactions of Ray's family and friends to her negated childbearing, and to Ray's personal experiences, is one of belief and trust in Ray, that she was indeed unaware that she was pregnant, until the labour diagnosis. As Ray shares this aspect of her story, the positive narrative tone conveys a confidence and faith in the essence of the negation, as Ray experienced it. There is no suggestion that any family member or friend had any thought that Ray might be pregnant, so the situation and outcome was a complete surprise to all who knew Ray:

"Even when me Nan found out I was having her, she was like, but Ray you were here, here yesterday, and there's was nothin' of you, otherwise I would have said to you, Ray don't you think you're, she said but, there's was nothin' for you to show, that you were pregnant, I said I know..."

"Like if I'm walking up the street, they're like whose baby's this, and I'm like, mine, and they're like, but you weren't pregnant, like, and I'm like, I know, but I had her so"

d) Dyad Threads

Ray shares her thoughts and feelings towards her unborn baby, in the early part of her story telling, with particular reference to the negation, and also when the negation was revealed, and her struggles to bond. As Ray did not know she was pregnant, she did not have the opportunity to develop a relationship with her unborn baby as part of a pregnancy experience. Furthermore, Ray was still trying to get her head round her situation, and when Ray is shown her unborn baby through an ultrasound scan, there is an indication on indifference as she looks at the image on the screen:

"Obviously I couldn't enjoy it, because I didn't know I was pregnant ..."

"He turned the scan picture round, and he was like, look, there she is, and she was lying there ..."

The thin thread of bonding continues post birth, but the emphasis and feelings now change to those of wonder and closeness. Although Ray is still thinking about the negation, she reflects on the positive relationship she now has with her baby, and that the dyad has grown stronger, as Ray becomes used to her baby's presence in her everyday life:

“Then I sit there, and I’m like, I didn’t even know I was having you, like, looking at her like ...”

“I hate leaving her like ... I’m used to having her, like, by me now, so like, when he’s like I’m having her, I’m like, oh god”

When Ray shares aspects of her story of coping in the postnatal period with the practicalities of caring for a new baby, there is an expression and feeling of there being no other option, than to get on with the situation that she finds herself in. We hear of Ray’s previous experiences of caring within her extended family, and how this helped her adjust to a new daily life, in both a functional and emotional way:

“Everyone’s just like oh my god I can’t believe it ... I’m just like, neither can I still, just like, just got to get on with it, now that she’s, she’s here”

“You just have to get on with it like, go with it so, because I’ve got Nieces and Nephews I’m used to it, so it weren’t that hard like, it was just like, getting me head round it, she’s my baby now ...”

Alongside the challenge and the joy of having her new baby, in the immediate postnatal period, Ray struggles when she meets other mothers, who share their ‘normal’ pregnancy experiences whilst on the postnatal ward in hospital. It is these conversations between the other women, that led Ray to revisit her negation, and that she did not have the opportunity of celebrating pregnancy milestones such as scans, gender reveals and baby parties. This is Ray’s lost pregnancy experience:

“When I got out onto the ward in the nighttime, there was other women on there, and then in the morning time like, they were all speaking about theirs, and I was like, I never had that, I didn’t have that opportunity of finding out the gender, having a baby shower, going through all the scans and everything, I didn’t, get that”

Throughout the latter part of Ray’s story, she shares her thoughts on her increased awareness of other women’s negation stories, and that she realises that she is not alone in her experiences and situation. Ray describes this comprehension and recognition of the wider negated childbearing community, as an incredible collection of stories, which resonate with her personal journey:

“now that I’ve been through it I know, like, oh my god, like, there’s a few people out there that didn’t know they were pregnant ...”

“it’s just amazing how many stories are there now, since, I’ve had her...”

Performing Stories: Storytelling and Presenting through Poetry

This poem is based on Ray's Interview, and it is written and organised to reflect the story structure and how Ray told her story. It is a succinct and matter of fact telling of a negated pregnancy and labour, which is revealed shortly prior to the birth. The poem reflects a shocking and challenging situation, one which Ray and her family have to get used to very quickly, as the dyad relationship continues to develop.

5.18 The Negated Childbearing of Ray

*Home with my mum
Got really bad pain
Take some paracetamol
You'll be fine
In the morning time
Crying
Pregnancy test, negative
Transferred to hospital
Put me on a bed
Any chance
You could be pregnant?
No, I said*

*After the scan
Any chance
You could be pregnant?
No, I was on
She said I'm sorry
To tell you
There's a baby there*

*Crying again
Me mum come in
Why didn't you tell me?
The doctor was like
She didn't know, obviously*

You're in labour

*She's coming today
I can't do it
I don't know
What's going to come
Gas and air
Within two hours
She was here*

*Mum was ringing round
Telling everyone
Didn't know what was happening
I had nothing
So they brought loads
Then from there
Just, get on with it*

*Asking me questions, and so
An appointment, weighing her
Oh,
You're the one
That didn't know
You were pregnant*

*Every weekday I go
This time seven weeks ago
We were sitting there
I didn't even know
I was having you
Looking at her, like
I'll never forget*

*I've been fine
Walking up the street
Whose baby is this?
I'm like, Mine
But you weren't pregnant
I know
But I had her, so*

Just getting over the shock

*Still think of it
Oh my god
I didn't know
It's actually happened
Go with it*

*I'm used to it
It weren't that hard
Getting me head round
She's my baby now,
And so*

5.19 Ray's Story in Summary

Ray's negated childbearing story, although remarkable due to the timing and situation, sheds a positive and life affirming aspect on negation, and this can be heard throughout the majority of Ray's story. We hear the thoughts and feelings of a young woman, who coped with her experiences with the support of her partner and family, and by drawing on her own knowledge and familiarity with caring for younger family members. The strength of the relationship of the dyad post birth, grows, as Ray focuses on being with, and caring for her new baby.

Part Two: Negated Childbearing Conversations - Sharing Stories Online

5.20 Introduction

In this section, I will present the findings from the Secret Facebook Group, through the online storytelling and sharing conversations between the women who participated. The group acted as a safe space, where women could interact with each other - other women who had been through negated childbearing, in the context of a situated research dynamic.

5.21 Story Telling and Sharing

In this online space, each woman had her own personal story and chose to share or not share all or part of this in the group. Some of the story content reflected the story content in the individual interviews, but some was new content to the study, or shared in greater detail. Each woman who joined the group participated in some or all the posts, threads and conversations, and some women were more active, or posted more than others.

As well as individual stories, story sharing between the women generated some communal and collective story constructs - through thread conversations. These were seen both synchronously and asynchronously and were expressed through a range and variety of content posted in the group.

The types of content shared (see Appendix 5, table 5), forms part of the individual and collective storytelling and is presented here as part of the conversation threads. Expressive content such as emoji's, Facebook 'likes' and reactions and posting of photographs and links to You Tube videos, were used by the women for a number of reasons.

The emojis and Facebook 'likes' and reactions were shared the most, to express what they feeling to show support for story content and sharing, and to emphasise certain elements of conversations. The use and sharing of this expressive content, regularly, and as part of their conversations, shows how the women valued the mutual understanding in the group, and were able to hold space for each other to express their thoughts and feelings.

5.22 Story Conversations and Interactions

a) Negated Childbearing Conversations

The stories and conversations that the women shared around their negated childbearing, were told through revisiting their personal experiences, in small succinct chunks of text, and using emojis to express their feelings about their stories. The conversations are centred on the negation of pregnancy and birth, and include storied aspects of diagnosis, termination of pregnancy and the timing and environment of the birth. The nuanced differences in the individual stories can be heard, alongside some shared aspects, such as the shock when the negation is revealed, and the uncomfortable and self-conscious feelings that come to the surface:

“I had awful stomach pains one night and ended up in the hospital only to be told I was pregnant. They scanned me and told me ‘I had all options open, including chemical abortion if that’s the route you want to go down as you look a little shell shocked’ (Shell)

“He’s my first also and I had no clue. Even to the point of the birth I didn’t know what was happening until I felt his head! 😂 X” (Rain)

“tbh I’m still quite embarrassed by the whole situation, it makes me feel all awkward and upset even 2 and a half years down the line. Not sure that feeling will ever go away ... “(Shell)

One aspect of negation, which forms a conversation thread, is the minimal or absence of ‘normal’ signs and symptoms of pregnancy, which also provides a link to a late or mis diagnosis. There is comparison and sharing of this aspect, with revisiting and reflection on what may or may not have been mistaken or attributed to causes other than pregnancy or labour. For some women there are questions about their journey, and if it could have been different if they, or someone else had picked up on some of the symptoms they had:

“Did you have any other symptoms looking back? I found out I was 24 weeks and then had to deliver at 32 weeks due to pre-eclampsia.. I always wonder if I hadn’t of got would have I found out at all or maybe would I have gone into labour at the end?” (Hermes asking Rain)

“I went to A & E ... for severe stomach pains and they did a pregnancy test and felt all around my stomach and the test was negative and they told me I’d pulled the

lining of my abdomen ... Other than that nothing! You possibly might have!” (Rain answering Hermes)

Hermes posted a link to a news article about a woman who thought her contractions were IBS and did not realise she was pregnant or in labour until she gave birth: “another case in the news I wonder on average per month/year how many people deliver unknown pregnancies 🤔 “ (Hermes) “It’s crazy because people actually think it can’t happen 🤡” (Margaret) (Rain and Ray respond with the Facebook thumbs up reaction)

Moreover, the women discussed other’s reactions to their negated childbearing, related to the signs and symptoms conversation, but focussed on a projection of disbelief - both negation as an event (how is this even possible?), and also of an absence of inward and outward pregnancy signs. This is a shared and storied experience for the women in the group, as they relate their individual feelings and shared thoughts and support for trying to deal with this in the short and long term:

“People always say to me oh you must have known but I’ve never felt a baby kick before or been pregnant before so I wouldn’t know 🙄.. “ (Hermes)

“I always get people question how I didn’t know, but I felt nothing! Had no bump, monthly’s were all as they should be everything!” (Rain)

“I’ve lost count of the “how could you not know” comments - it’s boring after a while and I just adapted a jokey approach to it all ... I somehow get pleasure out of reminding the “I can’t be pregnancy I have my period” girls that “stranger” things have happened 🤡 ” (Margaret)

b) Trauma, Mental Health and Coping Conversations

The women discussed the traumatic impact of negated childbearing on them and reflected on how they felt at the time of the negation, and also how this continued to impact them after the birth. The impression that going through such an unpanned and shocking experience has had, can be heard through the sharing of the women’s experiences.

Feelings of longevity and constancy - that negation remains a story which is part of their lives, that it isn’t something which can be forgotten about, but something which must be managed. Furthermore, there is the suggestion that if mother and baby are physically well,

that the emotional short and longer-term impacts of negated childbearing, particularly on the woman, are not being considered or addressed - this emphasises the 'forgotten mother', and the coping expectations in these story conversations:

".. I still don't think I have gotten over the whole thing to this day either.. "
(Hermes)

"Hermes absolutely. Nobody ever says "this is weird and shocking, how are you feeling mentally" you are just assumed ok, were women after all 🧐 xx " (Margaret Responding to Hermes)

"As women, we are just expected to "get on with it" (Margaret)

The lack of awareness and understanding of negated childbearing, and its potential impacts, are further emphasised in the story conversations about mental health. Some of the women were not asked about their mental well-being, with the focus being on the health of their baby, and even when they were asked (in the broadest sense), it was difficult for them to talk about their situation and what had happened to them.

There was a sense that those women who had talked to health professionals about their negated childbearing, felt that due to the lack of knowledge and understanding of their situation, that no one they spoke to really understood what it had been like, and what they were still going through:

"Yeah I was saying to Jane the other day when the midwife came and said oh how are you doing I was like oh fine. inside I was like WTF is going on in my life right now this tiny baby has just appeared from Nowhere 🤔 I only started to talking to the doctor last year and still haven't fully got into yet with her." (Hermes) (Shell, Rain and Ray respond with the Facebook thumbs up reaction)

"Its so difficult though because they can advise you of things but without them going through it I don't think I could ever fully explain how I feel or felt" (Rain)

The unplanned, challenging and surprising nature of the women's negated childbearing stories meant that some women struggled to process their situation, which to them seemed unnatural and illusory. This dichotomy of the physical reality of the pain, the blood and the baby is juxtaposed with a surreal unreality which questions what has happened and trying to make sense and meaning of it:

"It was such a struggle to come to terms that it was real" (Rain)

“I was left with a baby in a room on my own after going through 36 hours of labour, very traumatic labour too, sat on my own blood, thinking “what is that” is this real xx” (Margaret)

Alongside the difficult and challenging aspects of the stories and conversations, were some humorous exchanges between the women. In the conversation and interaction between Rain, Shell and Hermes, we can hear the shared sense of humour at certain aspects of giving birth for example, and how this links with a mutual sharing of experiences, feelings and coping together, enabling support:

“That’s so crazy! I’m glad you both made it to the hospital before the birthing part, my poor little ones first view of the world was my toilet basin 🚽” (Rain) “wow, that’s one big 🚽” (Shell) “😂😂 that’s genuinely what I thought I needed 🚽 the best 🚽 of my life lol” (Rain) (Hermes responds with the laughing Facebook reaction)

c) Support and Care Conversations

Conversations around the care that the women, their babies and families received, were centred on care during labour and post birth. There were reciprocal discussions around the good care that their babies received, and some shared storied experiences of babies being in the SCBU, for some of the women. The positive feelings and reflections on the neonatal care, is somewhat at odds with what the women shared about their care during their negated childbearing continuum, where some felt dismissed and did not get the attention, care or support that they needed:

“Were either of your babies in special care?” (Hermes) “Hermes, yeah my little one was in NICU for 3 and half weeks, they were absolutely fantastic with both of us” (Rain) (Hermes responds with the Facebook ‘loved’ reaction) “Hermes we spent 3 days in on the ward together as I was struggling breast feeding but apart from a little jaundice after leaving hospital everything was perfect x” (Shell) (Hermes, Rain and Ray respond with the Facebook ‘loved’ reaction)

“Was sent home with some pain killers and told to book appointments. 36 hours later the pains started again and were much more intense, ended up in the hospital and upon my examination was told I was 3cm dilated! I gave birth about 15 hours later” (Shell)

The collective feeling regarding a lack of support, was echoed in several conversation threads. As the women discussed how they felt at the time of the negation, they related once again the focus on the baby, and that as mothers in a difficult situation they were forgotten about. This has close ties with, and touches upon emotional and mental well-being throughout negated childbearing, with the women agreeing that there was a lack of support - targeted and specific support for women who have been through negated childbearing, to help with the emotional impacts immediately and in the longer term:

“I was near 6 months when I found out I was pregnant. Not till today did I ever really think about how unsupported I actually was ... “(Margaret)

“I agree with the feeling unsupported, the hospital were great with the baby but not once was anyone sent to speak to me in the whole 4 days I was in there they just kept a check on my bloods” (Rain)

“I mentioned to Jane the other day girls in our situations should have had a sit down or chat with someone at least to ask how we were the only person who asked me was I ok was my midwife and you...” (Hermes)

d) Future Pregnancy Conversations

One of the identified long-term impacts, which occurs as a direct result of negated childbearing, is the collective fear of the situation occurring again. There is an anxiety and worry that is shared in conversation, of the women not knowing that they are pregnant or in labour, resulting in extremely close monitoring of menstruation cycles and unhealthy behaviours.

Furthermore, an additional outcome of these heightened feelings of repeat negation, is the recurring sourcing, purchase and use of pregnancy tests. Sometimes, the pregnancy testing is not enough to allay fears, and additional medical help is sought to give further reassurance and confirmation of the absence of pregnancy:

“My little one is almost 4 and I’m still paranoid that I’m pregnant and that it will happen again...” (Rain) (Hermes responds with the Facebook thumbs up reaction)

“I do tests on a weekly basis but I’m scared the same that it’s saying negative and I actually am 🤪 “ (Hermes) “Hermes, I’m not weekly but a lot more than I’d like! I still panic if it’s negative and I’ve been to the doctors and requested scans if I’m

really unsure” (Rain) “I’ve deffo calmed down on the testing but I do still do them every no and again. I track my periods and ovulation etc like mad now, a little obsessive really 🏠” (Shell)

Reflective conversations on how the women felt about ‘missing out’ on knowing that they were pregnant, can be heard in the discussions about the lost opportunity to enjoy and prepare for their baby and to enjoy knowing and being pregnant, was important to some women in the group. There were mixed feelings about planning for or wanting another baby, and the reasons for this.

Some women felt that they craved the focus and attention of pregnancy, and that this was their reasons, their main reason for wanting another child - and for this they felt guilt. Other women shared how they knew others who were pregnant, and again that they struggled with their feelings - wanting the best and being happy at the good news, whilst at the same time feeling conflicted because they didn’t have that happy experience, and for them the negation meant things were very different:

“I’m a little broody as my two best friends, ones just had one and one is pregnant but part of me thinks the only reason I want another is because I want a normal pregnancy. And to me that’s totally selfish 😞 😞 “ (Shell) “ Yeah I said to Jane the other day I almost feel cheated missing out on the majority of it” (Hermes) (Rain and Margaret respond with the Facebook thumbs up reaction)

“Even when friends and relatives fall pregnant as much as I’m so so happy for them but I can’t help feel sad seeing them get so excited and prepare for it all. It’s so strange” (Rain) (Hermes and Ray respond with the Facebook thumbs up reaction)

5.23 Sharing Stories and Storied Understanding Conversations

One important aspect of the Secret Facebook group was the facilitation of a safe, private space, where the women could tell and share their personal stories, with other women who had also been through negated childbearing. The catharsis of storytelling in the group, is heard through the conversations, and the use of ‘expressive items’ (such as photographs, emojis and links to media articles), as a mechanism to show support to each other. This supportive and welcoming nature of the group and the content posted, acted as a basis for the women feeling safe to share their unusual experiences with complete strangers online.

The importance of the women being able to identify similarities in storied aspects of negated childbearing, meant that they felt their feelings and storytelling was valued and validated. There is a collective and collected appreciation for conversations with others, who have lived knowledge, understanding and familiarity with negation, and the expression of storied feelings and emotions:

“Its so nice speaking to people who have been through something similar” (Hermes)

“Yeah definitely is, it’s refreshing!” (Rain)

“It is lovely to talk to women who have been through similar emotions! X” (Shell)

“Unless you’ve been through it I don’t think anyone would ever understand how it makes you feel and that’s the difficulty in talking about it” (Rain)

5.24 Performing Shared Story Conversations: Storytelling and Presenting through Poetry

This poem was constructed from the voices of women who participated in the Secret Facebook Group. With the same premise as used with the individual stories, the women’s words have been used verbatim and following a pattern of conversations as they were posted. The poem represents the shared conversations of negated childbearing stories, with a focus on the similar and communal threads which were discussed.

A ‘Collected’ Voice of Negated Childbearing

I had an unknown pregnancy

In the early hours I woke

Giving birth

Within an hour

At my home

Any symptoms, looking back?

People question

How I didn’t know

No bump

No clue

What was happening?

Thought I needed a poo

*When life wants to come
You can't stop
Feel awkward and upset
Don't think anyone
Would understand it, yet*

*How are you doing?
Oh fine
What the fuck is going on in my life
This tiny baby
Just appeared
From nowhere
Only started talking last year*

*Paranoid I'm pregnant
It will happen
Again
Tests on a weekly basis
Scared the same
Still panic, unsure, obsessive
Plays with my mind*

*A little broody
Want a normal pregnancy
To me, it's selfish
Feel Cheated
Missing out the majority*

*When friends fall pregnant
I feel so happy
But sad
It's strange
As women, expected
Just get on with it again*

*Nobody explained anything
Assumed that I knew
Can openly say now
I struggled to bond too*

*Coming to terms
With this life changing thing
Left with a baby
In a room on my own
Sat on my blood, thinking*

*Is this real?
Nobody ever says
This is shocking
How are you feeling
Mentally
You just assumed okay
We're women, after all
At the end of the day*

5.25 Summary - Individual and Collective Voices

The findings presented here give voice to the individual and collective/shared stories of negated childbearing, through narrative threads, storytelling and performance through poetry. The strength and uniqueness of women's voices and experiences has been highlighted through the findings and drawn together in powerful individual and collective found poems. The depth and breadth of data reveals new insights into negated childbearing across the continuum, adding new evidence to the current literature base.

CHAPTER 6

DISCUSSION OF PERSONAL AND SHARED STORIES

6.1 Introduction

This study has explored and investigated an under-researched area within midwifery and maternity of the negated childbearing continuum; from the perspective of women who have been through this experience. A narrative methodology was utilised throughout the study, focussing on storied data/finding threads, story structuring, and meaning making from individual women's stories and collective and shared story conversations.

Furthermore, the storied data/findings are presented and performed through found poetry, illustrating the key aspects of these stories in a dramatic and impactful way. The findings of this study contribute new knowledge and have important implications for midwifery and maternity practice going forwards.

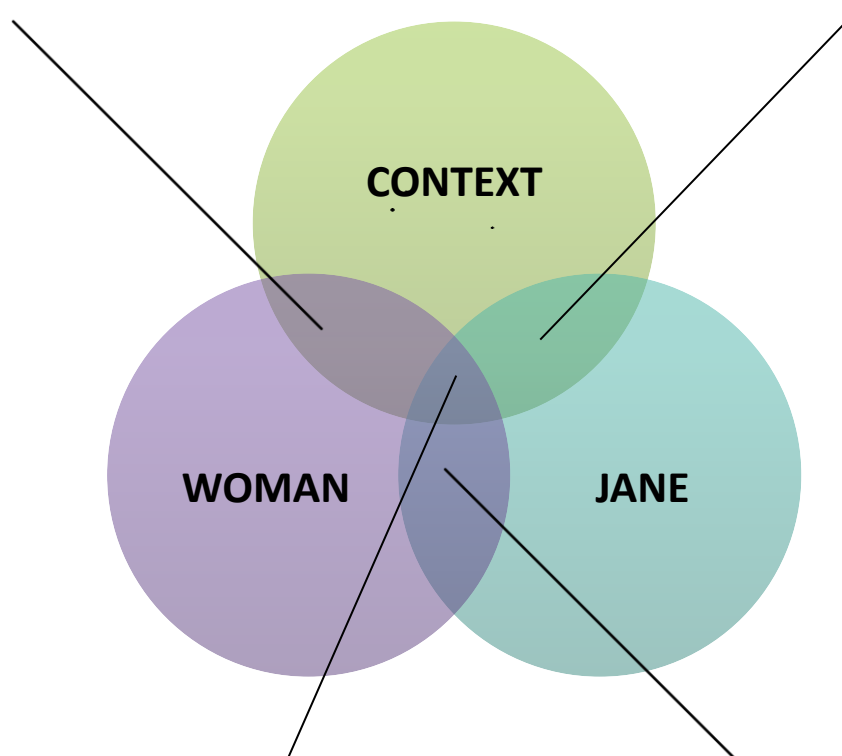
6.2 Narrative Knowing and Researcher Positioning

The importance and value of stories, and the information which arises from their telling, sharing and presenting, can be seen in this study, and forms the new knowledge gained (narrative knowing) of negated childbearing as a phenomenon along the continuum. The emphasis is on the ownership of the story, storytelling and structuring, from each woman's perspective, (individually and collectively), which is impacted and influenced by the context in which story happened and is told, and the bearing and position of myself as researcher, analysing and presenting the stories.

This acknowledges that stories are not created or told within a vacuum, and that the context and position of the researcher should be acknowledged and explored (Bamberg 2006, Polkinghorne 1988 and McCormack 2004). This perspective is presented in figure 32 overleaf:

STORY TELLING

RESEARCHER POSITIONING



NARRATIVE KNOWING

STORY CONSTRUCTION

Figure 32: The Relationships and Creation of Narrative Knowing in Negated Childbearing

Moreover Sandelowski (1994), Beal (2013) and Gilkinson *et al* (2016) identify the relationship between the production of narrative knowing and acknowledged influences, and the situational aspect of stories for the storyteller and those who receive and present stories. Stories of negated childbearing in this study are told by each woman in the context that they occurred at the time, but also these stories are told in a 'new' context - after the event. Furthermore, the impact of myself, as researcher, provides another influence, which may contribute to the shaping, construction and telling of stories.

Clandinin and Connelly (2000) and Neimeyer and Sands (2011) further develop this concept, and focus on story reconstruction, rather than construction/structure, whilst acknowledging external influences and the deep embedding of the researcher in the narrative process. Indeed, this understanding and value placed on the position, impact and relationship of the researcher with their research, forms a key element of the turn towards narrative (Narrative Turn) and away from complete objectivity (Bruner 1990, Chase 2005 and Etherington 2004).

During the time of carrying out this narrative study, reflexivity was a key part of the research process, facilitating my generative thought and structuring of personal influences and self-identity, and contribution to the findings. I felt I had a very personal connection with each woman who participated, through all aspects of the research, and I felt that I owed it to them, to share and present their stories - as worthy of being heard, believed and understood. I became immersed in each story, and the experiences that they shared, and I embraced the challenging and messy subjectiveness of the data that emerged.

As I listened to the women, individually and through their collective conversations, I saw the inherent worth and value in their individual and shared stories, and that making sense and meaning of negated childbearing through narrative, would make an important contribution to understanding of this phenomenon. This is further emphasised in work by Happel-Parkins and Azim (2017), Rappaport (1995) and Riessman (2008), who highlight the necessary contribution of the researcher, and their experiences and identity in narrative research.

6.3 Storytelling and Construction

The concept of storytelling as part of the narrative approach, is reliant upon the basic premises of who tells and shapes the story, who are the main characters in that story, and how is the story formed and structured (Crossley 2003, Goldie 2004 and Leamon 2009). The skill and construction of telling stories, can elicit interest or disinterest depending on the storyteller themselves and the nature of the story they are sharing.

Negated childbearing as a subject has inherent potential as an area of significant interest and curiosity in midwifery and maternity and thus suits the vehicle of storytelling as a means of researching the phenomena. However, Worth (2008) further develops the discussion, and highlights the storytelling approach as forming the basis for narrative knowing but identifies the importance of stories which are judiciously told and crafted.

Conversely, Frank's (2010) approach discusses the importance of not constraining stories, by imposing expectations on them, and accepting stories as they are, and as they are told - potentially imperfect, but nonetheless valuable in our human understanding of life. It is this unconfined philosophy which informed the use of methods in this study - to allow each woman to be at liberty to tell personal stories as freely as possible, facilitating empowerment and ownership of the negated childbearing narrative, which is supported by Ross (2017) and Williamson (2007).

Enabling ownership and telling of negated childbearing stories, was crucial to the success of the study, and was in large part due to gaining and building a safe and trusted relationship with each woman alongside my belief in their experiences and my professional midwifery knowledge and experience of the phenomena. Barusch (2018) and Carpenter and Austin (2007) echo the facilitation of story ownership as a positive measure.

However, Shuman (2015), Smythe and Murray (2010) and Clark and Sharf (2007) urge us to consider the moral implications of attributing ownership to stories and storytelling, including that the notion of story ownership can be challenged. In this study, ownership is defined as each woman's right to tell her personal negated childbearing story, accentuated by the research process and acknowledging the importance of interaction with others, in storytelling and construction.

Another important aspect of storytelling, which is clear in the findings is the aspect of the cathartic nature of the individual and shared telling of negated childbearing. Crossley (2001), Da Cunha and Orlikowski (2008), Engel *et al* (2008) and Honos-Webb *et al* (2010) amongst others, highlight this as a pillar of narrative research, which serves to act as a therapeutic process as a story is recounted.

Moreover, this study has also unearthed new and hidden emotions in some personal stories and facilitating sharing feelings and parts of their stories which they had not shared with their family, friends or health professionals. Furthermore, Grassley and Nelms (2009), Page (2015) and Kearney (2007) explore the view of catharsis from storytelling as a means of validation, attaching importance and of sense making to feelings which story telling elicits.

In this study, each woman indicated that they found telling their individual stories beneficial, but also that sharing those stories with each other through the vehicle of the Secret Facebook Group, was also important. Collectively, women relayed the importance of speaking to others who had been through a similar situation, and that this generates understanding and belief of their negated childbearing stories, through shared conversations.

Facilitating a different type of sharing, discussion, storytelling and conversation through online spaces, has been identified as a key aspect and benefit of using online methods for data collection, especially for sensitive subjects and hard to reach participant groups (Grinyer 2007, Hanna 2018, Kayrouz *et al* 2016 and Oliver *et al* 2015). Moreover, Arigo *et al* (2018), Enyon and Schroeder (2008), Grinyer (2007) and Sigiura *et al* (2017), discuss the importance of geographical distance and space when participants connect virtually, allowing relationships and communication to be managed by everyone.

The use of conversations to generate data in narrative research, is largely linked to the use of interviewing, as discussed by Holloway and Jefferson (1997), McCormack (2004) and Jovchelovitch and Bauer (2000). Furthermore, Page (2015) Oliver *et al* (2015) and Grinyer (2007), consider the use of social media in relation to conversations and catharsis (sharing with like-minded people), highlighting the benefits for both participant and researcher.

This approach has not been utilised in published research, for negated childbearing prior to this study, and as such the shared conversations, in a safe online space, allowed for new and further data generation in an area which is highly sensitive and potentially difficult for women to discuss and share with others.

Bringing women together who have experienced negated childbearing, is an important contribution to facilitating catharsis, as a positive outcome of the study. The creation and construction of stories in narrative research, provides an important basis for a more holistic understanding of a subject, encompassing details of key characters, plot development and place, and the situation and context which shapes the structure and story construction (Feldman *et al* 2004, Leggo 2004, Riessman 2008 and Wood and Giddings 2003).

Data on narrative story construction in negated childbearing, has not been addressed in the current body of research, although elements of 'story' construction, for example social and cultural influences, reflection and sense of self can be seen in some studies, including Tighe and Lalor (2016a, 2016b, 2018), Stammers and Long (2014) and Conlon (2006). The exploration of negated childbearing story structuring within this study, has allowed a deeper analysis of a complex subject, and which helps to reveal the storied phenomena and its construction.

This approach allows identification of key elements within negated childbearing stories, consideration of commonalties and helps to unravel complexities, generate meaning and focus understanding. The following story outline, illustrates these key elements:

6.4 The Structure and Construction of Negated Childbearing Stories across the

Continuum: shared aspects

The importance of structure in forming, shaping and understanding stories, to generate meaning, has been clearly defined and utilised by Beal (2013), Becker (2023) and Riessman (2008), amongst others. By exploring the structuring of individual stories, shared or common aspects of how negated childbearing stories are told, have been identified - highlighting the order, arrangement and key elements in the structure. This is outlined in

the structural sequencing figure below, where, despite the diverse and varied nature of the individual women's stories, there are five core elements shared by all storytellers, giving an archetypal story outline, which links back to the fat and thin threads. One example of the effective use of this narrative approach is from Robichaux (2003), who applies this in nursing research to strengthen analysis and meaning making generated by the stories (Figure 33).

Scene Setting (Story Framing, Precis, Preliminary Plot) - Linking connection to all interviews is inclusion of looking back at the experience of negation for the narrator. This starts to "frame" the story and telling of the story. There are many different versions to introducing the story, including different elements of the individual narratives. For example, describing signs and symptoms, and family roles →

Core Plot (Main Event, Main Plot) - Sometimes identified as one main event, or can be more. Centred around the physical act of birth. Psychological sequelae. Rooted in discovery and trauma →

Sub Plot (Following Plot, Continuing Plot) - Seen as additions to the main or core plot - stories within stories. For example, baby care/baby becomes focus/family and friends. Concern of future pregnancies →

Revisit (Returning Plot, Revisiting) - A cycle of returning to the story, or elements of it: Revisit, Reflect, Return. All revisit negation experience at least once. Reflecting on the postnatal period and beyond. Processing negated experiences. Coping and normalising, alongside catharsis →

Final (Closing Plot, Terminal Plot, Final Events, Finality, Concluding) - New and changed "self" emerges, acknowledged this is the result of negation. Making sense of the layers of storied elements. Living with guilt and fear. Desire to share experiences with others in a similar situation.

Figure 33: Archetypal structural sequencing of commonalities in negated childbearing stories

Furthermore, identified within the 'sub plot' is the addition of the concept of a story within a story, and this was evident in this study, highlighted by the examples given above. Herod *et al* (2007), Graff (2012) and Scanlon (2014) variously identified this concept with the Matryoshka nesting dolls analogy, which can be utilised in different ways in research to highlight numerous other small stories which sit inside negated childbearing. The Matryoshka effect is an analogy which relates the conceptual picture of the Russian nesting dolls, both in physical representation of multiple entities fitting one inside the other, or

stacking, and a theoretical use of the concept to depict phenomena which have multiple “others” within them (Herod *et al* 2007, Kilpatrick *et al* 2013) (as seen in stories of negated childbearing).

The concept has been used in many different disciplines including psychology and sociology but is, however, seldom used or seen in health research and midwifery. The phenomena of negated childbearing can therefore be seen as a complex and deep narrative, which houses multiple small stories within stories, each nesting inside each other, and forming a nuanced, individual story for each woman. The Matroyshka may also be used as a metaphor in negated childbearing to the uncovering hidden meanings, feelings or emotions, which have been recognised in this study.

6.5 Presenting Stories through Poetry

Once stories have been shared, a key element of narrative is the consideration for the researcher of how to embody them in research findings. In this study both individual and collective conversations and stories were collected and analysed, and thought given to presenting, representing and re-presenting the stories of negated childbearing. For this under researched subject, and women in a potentially vulnerable population, it is essential to ensure that stories are heard and made more visible (Barusch 2018, Boland 2021, Bonevski *et al* 2014 and Carpenter and Austin 2007) and poetry was utilised as a means of addressing this.

The use of poetry in qualitative research, as a stand-alone method or alongside other creative arts has becoming increasingly accepted and influential, with Faulkner (2016, 2020), MacDonald (2015) and Butler-Kisber (2002) emphasising the important role poetry plays, particularly in relation to sensitive, complex and/or emotional experiences. Moreover, this approach is further highlighted in work by Stenhouse (2013), Edwards (2015) and Gallardo *et al* (2009), who use poetry as part of the research inquiry process in challenging areas of health research. Furman (2006) identifies and establishes how use of poetry provides a distinctive and diverse approach, especially when used to consider data from in-depth interviews.

The poetry created in this study is characterised by what Faulkner (2020) identifies as having encapsulated a deepness and richness of human experiences and phenomena, in a succinct and powerful format. Furthermore, Oiler (1983) and Harmon (2011), argue that poetry can provide a vehicle for feelings and meanings to be more fully revealed, and that this

contributes to a more holistic understanding of that experience. Poems of negated childbearing constitute an important part of this study, through the truth and reality of personal stories and shared conversations, and highlight the emotional and sensitive aspects of negation, which has been identified in other studies (Ali and Paddick 2009, Boland 2021, Conlon 2006, and Tighe and Lalor 2016a, 2016b).

However, according to Ratner (2002), poetry can be used most effectively and demonstrably, when researchers respect the participants' reality and are able to accurately grasp and understand storytelling, construction and the context in which stories are formed and told. Wulf-Andersen (2012) takes the concept one step further by discussing the process/es of creating poetry and poetic representation, as a form of meaning making and knowledge creation. This is reflected in this study as the poetry created mirrors some of the fat and thin threads, confirms important structural storytelling elements, and provides a vehicle for deeper, holistic narrative knowing (Faulkner 2020, Ward 2011 and Worth 2008).

6.6 Influences of Context and Culture on Childbearing

Social constructionism forms part of the interpretive approach to research, and in essence puts the research firmly within a contextual environment (Berger and Luckman 1967 and Francis *et al* 2016), where the subjective view and the involvement and beliefs of the researcher with the participant is not only acknowledged, but seen as a central part of meaning making and knowledge creation (Gergen and Gergen 2003 and Guba and Lincoln 1994).

The contextual elements of negated childbearing include aspects across medical, midwifery, maternity, social, economic, political and health paradigms and construct continuums, as part of the overarching social narrative discourses. Broadly speaking De Vries (1981), Hunt and Symonds (1995, 1996), Oakley (1980, 2016), Shorter (2017) and Walsh (2010), amongst others, discuss childbearing as an essentially socially mediated experience, which is shaped and reliant upon societal constructs and influences, and which can also be applied to negated childbearing.

Rosengren (1962) and De Vries (1981), amongst others, outlines and discusses the inherent physiological and biological scientific nature of childbearing, and outlines the importance of the individual, family, community/media and the expectations which exist, and which govern how childbearing is seen, heard and understood by others. Moreover, and more broadly, the importance of social context and culture in health has been identified and

understood as a key aspect to the holistic approach across many aspects of healthcare, as demonstrated by Conrad and Barker (2010), Greenhalgh (2016) and Quinn (2005).

The importance of the influence and impact of social context and culture on negated childbearing throughout the continuum, is reflected in personal stories and shared conversations gathered and analysed in this study. Cultural norms and expectations of childbearing are projected onto, and become part of the negated childbearing continuum, as each woman shares her story of not being believed, and because the personal stories and shared conversations do not fit neatly into the social and cultural norms that society is accustomed to.

Hunt and Symonds (1996), Van Teijlingen (2005) and Rothman (1977) further identify that these norms naturally shift and adjust, as societal morals, values and ethics change in response to a range of influencing factors. However, what society considers usual/expected/normal in childbearing is heavily influenced by the dominant medical model of care and service organisation in midwifery and maternity, the increasingly risk-averse culture in maternity and a recent number of high-profile investigations into failings in maternity services around poor care and safety failings (Okenden, Crossley 2007, Davis-Floyd 2001).

However, the social construct of negated childbearing, and how the phenomena of concealed and unknown childbearing is understood by individuals, communities and society has remained largely unchanged, as our knowledge and understanding of it remains limited. This lack of knowledge and understanding is also seen in this study - from each woman as they struggle to cope with the impact of negation, family and friends who express doubt and uncertainty about the reality of the negation, the maternity team and health professional's approach and attitude to women and their experiences, and the care guidelines heavily focussed on safeguarding and risk.

Furthermore, De Vries (1981), Graham and Oakley (1986), Hern (1975) and Oakley (1979) identify the role of the individual, and how the women's behaviour, actions and values are formed, mediated, influenced and interpreted by family, community and society, contributing to the social construction of negated childbearing. The elements of diagnosis and misdiagnosis, conforming to expected norms and care pathways, and patriarchal values of female coping ability in difficult or challenging circumstances heard in this study, reflect the impact of individual woman to transition and adjust to negated childbearing, resulting in a new and changed sense of self, identity and place as a mother.

Moreover, what this study has shown is the lack of understanding and neglect of the impact of negation in the long term on the individual woman's sense of who she is, and her place and how she is now viewed in society. It reinforces the view that whilst some consider childbearing (particularly birth) as a transitory and temporary experience, the phenomenon of negated childbearing has the potential for permanent impact on the women who have experienced it, evidenced through personal stories and shared conversations.

6.7 Construction and Reconstruction of Self-Identity through Negated Childbearing

The potential permanent impact of negated childbearing on a woman's personal sense of self and identity, leads us to consider behaviours of construction and reconstruction of the nature of negated childbearing for individuals. The ability to share, record, identify and analyse how self is structured, in relation to sensitive, difficult and challenging experiences or life events, has been studied through narrative, and in particular the use of stories to illuminate how and why self-construction happens (Bonevski *et al* 2014, Crossley 2000b, Elliot 2005, Fraser 2004 and Georgakopoulou 2006). The use of stories in this study, as individual stories and shared conversations, has demonstrated an insight into the influencing factors and process of self-identity construction when negated childbearing occurs.

The women in this study shared stories and experiences of the emotional and sometimes traumatic nature of negation, and how this affected and changed them, their new sense, understanding and appreciation of negation, and how they were now viewed differently by others. By telling and sharing stories of their negated childbearing each woman was able to describe how the experience happened, the context in which it occurred, and how they felt personally and collectively changed in themselves.

For some women, the process of taking part in the study, through interviews and on Facebook resulted in further identity reconstruction and of validation of self-identity through shared conversations. The potential powerful impact of the storied and narrative approach in the research process in this way, has been discussed by Sermijin *et al* (2008), Rosenwald and Ochberg (1992), Leggo (2004), Holloway and Freshwater (2007) and Frank (2010). The shift from a woman's self-identity prior to negated childbearing, to construction of a new identity and sense of self both during and following negated childbearing, and further reconstruction over time and/or through the research process, can be seen in the stories and conversations, how stories are structured and succinctly and potently through the poetry produced from this study.

Furthermore, also drawn out of this study were each woman's changed views and perceptions of self and motherhood, self-belief and self-worth in relation to the dyad and negation. The concept of the dyad and the importance of the relationship between the woman and her foetus/newborn has been discussed and acknowledged for decades, alongside the need to consider the mother's needs in balance and in equal measure to the baby (Hill and Flanagan 2020, Ustuner *et al* 2020, Karter 2010). Research by Conlon (2006) Morelli (2013) and Tighe and Lalor (2016a, 2016b, 2018), give full agency to the woman's role in the dyad, and suggest that sometimes in cases of negated childbearing the needs of the woman are easily pushed down the priority list, in favour of the baby. This study echoes these findings and strengthens the argument that the balance of the dyad in negated childbearing is unequal and unhealthy, with potential poorer sequelae and outcomes for both mother and baby. The potential is then for the mother herself to feel and become negated, as the baby becomes the central focus of care, resulting in a loss of self and identity, and the need to reconstruct a sense of self to understand, manage and incorporate the childbearing negation into the new and changed life.

Individual stories and shared conversations of negated childbearing highlighted those women said they felt forgotten, less important, and uncared for following birth, reporting a feeling of being left alone, assumptions being made that they would 'get on with it', and that they were fine following the negation, despite not being asked. This was a common thread throughout the findings, and the positive benefit of this study and the research process was once again, shown to have a positive catharsis.

Each woman shared with me aspects of their personal story that they had not shared with anyone else (including counsellors, partners, family and friends), some women acknowledged that only myself as researcher, or other women in the study were the only people to ask in a genuine way if they were really okay and offer signposting and support, and that they felt by sharing their story in this way they felt heard and acknowledged.

6.8 Embodiment and the Negated Childbearing Body

The social paradigms and theories which consider the values, position and influence of the body, and embodiment in our society are many and varied, and rooted in sociology, psychology, anthropology and philosophy (Miller 1978, Lakoff and Johnson 1999 and Boreo and Mason 2019). In this study the influence of social valuation, culture and theory (social

constructionism) is considered in relation to the negated childbearing body, and how embodiment forms part of stories and the narrative experience.

Siebers (2001) and Shorter (2017) amongst others, acknowledge the impact, influence and challenges that the childbearing body can present, and discuss the approach that childbearing physiology and biology inherently co-exist alongside the mind and a sense of self, which in turn is affected by society, resulting in a socially constructed childbearing body. Furthermore, Triechler (1990), Suleiman (1986) and Rodgers *et al* (2024) highlight the unique and exceptional nature of childbearing embodiment and discuss the need to consider both positive and negative aspects, which are influenced and shaped by social context.

The feelings and expressions of the negated childbearing body can be seen throughout this study, in a narrative approach via storytelling and shared conversations. Each woman shared how they felt about their pregnant body, through active concealment of pregnancy, and retrospectively reflecting on and sharing details of possible signs and symptoms that they felt they (and friends and family) had not picked up on, or consciously recognised. Active concealment was linked to trauma and abuse, and a need for the woman to distance herself from a sexually violent event, by shrouding and hiding her changing body shape with loose clothing (as one example), to cope emotionally with her difficult situation.

Individually and collectively, many of the women retrospectively felt guilt that they did not have a 'normal' pregnant body shape, and other body changes such as an increase and differences in their breasts. This meant that their pregnant body was also negated - made invisible and sitting outside of the socially constructed norm of pregnancy in modern day maternity culture, where the shape of the pregnant body is known, seen and celebrated.

Martin (1990), Shorter (2017), Walsh (2010) and Spaegele *et al* (2024) echo the potential challenging aspects of childbearing embodiment and make the link with the development and embedding of an increasingly medicalised model of care, and power and domination of the childbearing body through scientific, medical and technological means. However, this study indicates women who have experienced negated childbearing, have unintentionally and partially reclaimed their pregnant body from the power of medicalised care, due to the hidden nature of the phenomena (until the childbearing is revealed) (see findings).

This reclamation of pregnant and childbearing bodies from the dominant medical discourse, can also be seen in work by Triechler (1990), Hodgkinson *et al* (2014), Young (1984) and Siebers (2001). Continuing the theme of 'reclamation' from a dominant discourse, we can also consider the presence of disembodiment in the negated childbearing continuum, and

the links with dissociation. There are multiple theories and applications of concepts to the presence and understanding of disembodiment, and in childbearing impacting factors such as cultural influences and expectations, the lens of 'others', subjugation to norms and a rebirth of a new self (Alleva *et al* 2023, Piran 2016, Lupton and Schmeid 2012 and Akrich and Pasveer 2004).

The narrative performance of disembodiment in negated childbearing, is heard in this study through the women who shared experiences of creating distance from their physical and emotional bodies and selves (see findings). During episodes of clinical care and at certain points in their stories, some women actively sought to disengage with clinical procedures, processes and healthcare professionals, indicating that this separation and detachment was needed to cope with their changing bodies.

For example, some women talked about not seeing or believing scans of their unborn baby and finding the images on the scan difficult to process, of challenging conversations with healthcare professionals who did not acknowledge the difficulty of negation - seeing their body as the vessel for the baby, and the shock of sudden body changes which they struggled to manage.

Moreover, each woman's relationship with their body was challenged through their experience of negated childbearing, resulting in a changed and new sense of body, self and identity, as a number of the women said - "I will never be the same again", "I have changed as a result of this experience" or "I still cannot believe what I went through, and that I didn't look pregnant".

Furthermore, Siebers (2001), Triechler (1990) and Akrich and Pasveer (2004) discuss the inequality of the value of bodies within childbearing, that is that some childbearing bodies are more valued than others, and that can contribute to disembodiment, and a need to then use dissociation as a coping mechanism. Some women felt that their bodies were considered 'less than', 'abnormal', 'risky' and 'unusual' as a result of negated childbearing, and that this was a direct contest to the status quo of childbearing bodies, of what healthcare professionals, some friends and family and society in general understood or were used to.

This aspect of a perceived imbalance in how negated childbearing bodies are understood and valued, directs consideration of moving from disembodiment to re-embodiment, as part of the negated childbearing continuum. Work by Lucas *et al* (2021), Young (1984), Tighe and Lalor (2020), Shilling 2003 and Walsh (2010) discuss the importance and place of re-

embodiment across the childbearing continuum, and as something which is impacted by cultural and societal influences.

Each woman in this study highlighted a number of factors which played a positive part in their re-embodiment of their negated childbearing bodies, including the acknowledgement of the enormity and challenge of their stories, an opportunity to share their experiences of negation and have conversations with other women, to be believed and finally, negatively, because they had no choice but to ‘cope’ and move on with their new and very different lives as this was what was expected of them. Furthermore, the need and process for re-embodiment in negated childbearing, should also be considered in the broader context of postmodern childbearing, motherhood and feminism, where women sometimes struggle with medical, societal and cultural norms and expectations across the childbearing continuum.

6.9 Perceptions of Normality/Abnormality in (Negated) Childbearing

Threads of the perception, context and experience of normality in (negated) childbearing, are heard throughout the findings of this study. White (2022) discusses the timeline of the changing definitions and use of ‘normal birth’, whilst in essence ‘normal’ in the context of childbearing refers to physiological process and progress without intervention, there is a substantial range of variation nationally and internationally as to what is included or excluded. The concept and understanding of normal/normality in childbearing are central to underpinning definitions of the role and scope of a midwife, and therefore midwifery (and areas of maternity and obstetric) care, practice and service delivery (Anderson 2003, ICM 2019, WHO 1996).

However, in recent years, there has been increasing discussion and debate regarding the use of terminology and definitions related to childbearing, in particular use of the word ‘normal’ - when applied to labour, birth or childbearing (RCM 2022, WHO 2018). Furthermore, criticism of an over reliance and unsafe focus on a normal centred childbearing model of care, revealed through recent high-profile investigations and reports into maternity and midwifery care, have highlighted the challenges and issues surrounding the place and use of ‘normal’ in childbearing (Department for Health and Social Care 2015, 2020, 2022).

In relation to negated childbearing, it is useful to consider the normal narratives of childbearing, and the significant impact that this has on perceptions, values and beliefs of

negation across the continuum, as heard in this study. There is an extensive body of research in the area of normality, birth and childbearing, and this includes the Salutogenesis approach, which incorporates prioritising and valuing a move away from the medical, disease and risk lenses and models which are said to dominate modern midwifery and maternity practice and service design and delivery in the UK (Downe 1998, 2004, 2008, Downe *et al* 2022, Kitzinger 2000, Page 2000).

However, the debate has moved forward with Ely *et al* (2020), RCM (2022), Ferguson *et al* (2014), and Darra (2009) amongst others, discussing the importance of the experience and concept of normality as individual to each woman, but which is also affected by the environment, context, culture and society in which childbearing takes place.

For each woman in this study, their individual stories and shared conversations of their negated childbearing, have revealed a broader non-normative/abnormal perception of negation across the continuum. Women shared how ‘others’ (health professionals, friends, family, community and society) reacted to and understood their childbearing negation as something which was, variously, unbelievable, impossible, risky and extraordinary, and therefore could not be considered ‘normal’ (see findings).

Moreover, each woman talked about their feelings of not having a usual childbearing experience, that they had not had the opportunity to have a positive experience, and that this resulted in a loss of ‘normal’ for them. This led to some women expressing feelings of wanting a non-negated pregnancy, so they could access and retrieve normality, through experiences and activities such as feeling foetal movements, having a baby shower and simply enjoying and celebrating pregnancy, labour, birth and the early and continued postnatal period (see findings).

This longing for normality in a subsequent childbearing experience, led to feelings of guilt but also feelings of disappointment and frustration when some women encountered secondary fertility challenges and were struggling to conceive beyond the immediate postnatal period (see findings).

The articulation of the concept of normality in childbearing, in what is considered abnormal, or which sits outside of what might be considered ‘normal’, has been explored in work (related to specific issues) by McWhorter (2014), Berg (2005), Way (2012) and Davis and Walker (2011), using the motherhood lens to frame the restrictions of the medical model, and identifying normality as something dynamic, with a range of outlooks.

The underpinning finding from these works is similar threads of self/identity, and retrieval of normality for women to cope, and which is also seen in this study of negated childbearing. Furthermore, some women in this study self-identified that they felt their negation was unusual, strange or weird, and expressed their individual views, but also, they acknowledged the broader influencing factors of the media, society and maternity/health care on their feelings, perceptions and stories.

The context and culture in which negated childbearing takes place, shapes values, expectations and behaviours around normality, and has firmly restricted society's view and understanding of normality, meaning that negation is currently seen and experienced as abnormal. Additionally, this is reflected in much of the current evidence base of negated childbearing, with a focus on the abnormal, negative aspects, potentially poorer outcomes, safeguarding issues and risk management in negated pregnancy (Friedman 2007, Jenkins 2011, Milden *et al* 1985, Neifert and Bourgeois 2000, Nirmal *et al* 2006, Sadler 2002, Speilvogel and Hoehener 1995, Stammers and Long 2014, Thynne 2012, Wessel *et al* 2002, 2007).

6.10 Short and Long-Term Impacts across the Childbearing Continuum

The current body of evidence which considers negated childbearing, is focused on the study of the antenatal period, with little thought given to intrapartum, postnatal and beyond, and even less thought given to the study of negation within the whole of the childbearing continuum (Ali and Paddick 2009, Conlon 2006, Friedman 2007, Milden *et al* 1985, Morelli 2013, Neifert and Bourgeois 2000, Nirmal *et al* 2006, Speilvogel and Hoehener 1995, Stammers and Long 2014, Wessel *et al* 2002). Studies such as those by Boland (2021), Sadler (2002) and Tighe and Lalor (2016c, 2020), take a more holistic approach and identify the potential for both short and long-term public health outcomes for the mother. Critically however, these are not discussed in detail, and there is a need to understand further aspects of the experiences and potential implications of negated childbearing across the continuum, therefore the timeline included in this study is of significance.

The importance of the inclusion of antenatal, intrapartum, postnatal and beyond periods for women who have experienced negated childbearing, was highlighted through the individual stories and conversations shared. Each women's personal story and the structuring and telling of the stories, identified several important threads not seen in the current evidence base.

Findings of these story threads indicated challenges around labour and birth, including shock due to unexpected and quick births, misdiagnosis of labour, birth trauma and other complications in the intrapartum period. Although several studies have indicated that trauma around labour and birth, is an issue and something which needs further insight, this hasn't previously been linked to negated childbearing in such a clear way, as identified in this study by each woman (Watson *et al* 2021, Uddin *et al* 2022, Delicate *et al* 2020 and Thomas 2024).

Moreover, it is also clear in the findings that the trauma thread goes beyond birth and is evident throughout the childbearing continuum in negated childbearing, heard through individual and shared aspects of revisiting signs and symptoms of pregnancy, immediate postnatal care and the enduring mental health impact. The need to revisit and reflect on the antenatal period, was a common thread in how each woman told and shared personal stories, and when they had shared conversations with each other. They were able to share details, feelings and experiences of their negation, with most rationalising why things had happened as they had, and ultimately some understanding of why the negation had occurred.

Studies on birth stories by Sanders (2019), Callister (2006), Olafsdottir and Kirkham (2009) and Pollock (1999) reveal that the element of revisiting and reflecting in 'sharing' stories was important in contributing to a more holistic understanding of childbirth, and that this aspect of research can make a valuable contribution to the evidence base. Furthermore, when aspects of childbearing are sensitive, challenging and emotionally difficult, such as with negation, the value of storied data and meaning making within the narrative approach which is generated, is strengthened (Soparkar 1998, Farley and Widmann 2001, MacLellan 2015 and Mahdavi *et al* 2022).

Considering the immediate postnatal period and beyond in negated childbearing, is an aspect of the phenomena which is rarely touched on, in any detail, in the current evidence base, aside from a handful of studies identifying broader public health impacts mainly in relation to concealed pregnancy (Tighe and Lalor 2016c, 2018, 2020, Boland 2021). The individual stories and shared conversations in this study revealed a range of impacts for each woman, their partners and families post birth, with the most significant being mental health and well-being (see findings).

All the women who participated in this study shared their stories of personal challenges with mental health in the immediate postnatal period and beyond. For some women, their experience of negation had impacted them to such an extent that they required additional

support from services such as their GP, counselling and community based mental health services (see findings). In the period directly after birth, each woman told of their shock, confusion and vulnerability due to the negation, which they felt unprepared for and unaware of the potential long-term impact that the negation would have.

Furthermore, most women also felt that the focus was on the health and well-being of the baby, and that they felt ignored, forgotten and unimportant, additionally they also identified the expectations of others that they would 'cope' and felt they had to 'get on with it' - in essence their stories and experiences were unrecognised and minimised, they were unable to validate their negated childbearing experience when they needed to. This experience affected each women's ability to understand, process and manage their emotional and mental well-being, and to start their journey of recovery.

The importance of women's mental health in the postnatal period, and beyond has been supported by a broad body of evidence (for example: Howard *et al* 2014a, 2014b, Megnin-Viggars *et al* 2015 and Shaw *et al* 2006) and specifically in relation to challenging or difficult childbearing scenarios (Turkmen *et al* 2020, Simpson and Catling 2016, Coates *et al* 2014 and Agius *et al* 2016). However, negated childbearing has not been considered either as a potentially traumatising event, or an experience which is identified as potentially impacting mental health and well-being, leaving women and their partners adrift of acknowledgment and services which could support them.

Indeed, each woman in the study also identified that they (and their partners/family), would have benefited from some form of additional care, support, services and signposting during the postnatal period and beyond.

Although women's stories were the focus of this study, it is clear from the findings, that there was also a significant impact of negated childbearing on partners and other family members. Studies by Taylor *et al* (2019, 2020), Howard *et al* (2022) and Davis *et al* (2020) emphasise the needs, roles and impact that partners and wider family have in the extended period after birth, and that understanding their experiences is key in supporting the dyad at this crucial time, for addressing both short and long-term broader health outcomes.

This study indicated that following negated childbearing, partners were and felt, ignored, left out and unimportant, by healthcare professionals, even when some were visibly and emotionally distressed. Moreover, this impacted women who were then further anxious and worried about their partners reaction and how they would cope with the unexpected and new situation - having a baby they were unaware of - and this added to their emotional challenges immediately post birth.

Conversely, the mental well-being of fathers/partners has been studied, and evidence supports the recognition, identification and targeted services for partners to support their mental health in the extended postnatal period, and that this approach is important in family centred maternity care (Ruffell *et al* 2019, Mayers *et al* 2020, Atkinson *et al* 2021). These findings highlight the importance of the consideration of the continuum when studying negated childbearing, but also the crucial importance of postnatal and healthcare services could play in providing holistic person, woman and family centred care.

6.11 Summary

It is through narrative and stories that many women and families share their childbearing experience with others (Barusch 2018, Griew 2023, and Callister 2006). Narrative methodology is therefore central to increasing knowledge and building understanding of negated childbearing in a comprehensive holistic way. The narrative findings give the current small body of research depth and sensitivity directly from the participant, owned and validated by the participant, which is currently not highlighted within the evidence (Georgakopolou 2015, Hyden 2013, Bamberg 2006).

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

The findings and discussions of this study indicate that contemporary childbearing negation itself is a narrative; the stories and conversations of which are told in the immediate context of midwifery and maternity care, the broader contexts of community and society, and that they are impacted by broader narratives of self and identity, embodiment and normality. Personal stories and shared conversations reveal threads, structures and the performance of women's stories, which together create meaning and build new knowledge and understanding of the phenomena of negated childbearing.

In this concluding chapter, I will consider the impact of the use of narrative and stories in midwifery research, reflect on the influence of relationships within the research process and the effect of researching sensitive subjects. I will then move on to discuss the broader impact of the research findings through identifying the contribution of this research to the evidence base, the strengths and limitations of the study, recommendations for further research and clinical practice, completing the discussion with an outline of the dissemination of research findings.

7.2 Narratives, Stories and Midwifery

Navigating the landscape of narrative and stories and discerning their relationship with midwifery and the childbearing continuum has been a complex research journey, encompassing the individual and flexible nature of the narrative approach in uncovering negated childbearing stories. Use of narrative methodology throughout this study has enabled the research process to pivot and flex, which has been particularly useful along my part-time doctoral timeline, and a strength in studying a sensitive midwifery subject.

Narrative inquiry utilised in this study facilitated expressed behaviours and values of negated childbearing across the continuum, through individual stories, storytelling and shared conversations. Small stories are set in the context of big narratives around self-identity, embodiment and normality and rooted in a variety of childbearing cultures.

Embedded small-negated childbearing stories have been collected, analysed and presented using a variety of methods, highlighting thick and thin narrative threads, whilst also considering the ‘how’ of narrating and telling of these stories, through an exploration of small story structuring (see Chapter four, five and six). Included in this study to give richness to the stories, is the incorporation of the temperament of each woman, using narrative tone to identify and establish mood.

Individual and shared emotions become important storied elements of negated childbearing, and these are identified in this study through close attention to metaphorical language use, behaviours, values, beliefs and attitudes, and use and choice of descriptive words (see Chapter four and five). The importance of language and expression of language gives a sense of how story tellers tell their stories and why, and it gives a clear sense of characters, plot development and storylines within negated childbearing. Moreover, performing negated childbearing stories through use of poetry presents a complementary dimension to the findings, and is a powerful tool to increase the individual and collective voice of women.

The use of stories and storytelling in midwifery has historical roots, and it is part of the rationale for using a narrative approach in this study. However, the understanding, application and use of a narrative research approach for knowledge and findings generation in midwifery research has been limited, with a perceived emphasis on more defined and precise methodological approaches (Barnsley 2022, Gould 2017, Muscat 2021 and Olafsdottir and Kirkham 2009).

Studies by Feeley *et al* 2019; 2022, Greiw *et al* 2023, Kennedy *et al* 2004 and Muscat 2021 demonstrate the broad value of narrative and stories in midwifery research, through the creation of new research findings, to the use and application in midwifery and maternity care and practice.

Furthermore, use of the narrative and story-based approach in midwifery research encourages and facilitates consideration of childbearing outside of the ‘norm’, where the challenges pushed onto women from an unequal and distorted lens of the medical model can be analysed and represented (Feeley 2019, Hundley *et al* 2019, Kennedy *et al* 2004, and Siebers 2001). The identified broader narratives within this study of self-identity, embodiment and normality link into the wider discussion around the normalisation of childbearing, the childbearing body/identity and motherhood, and the stigmatisation of unusual or different childbearing experiences and less heard voices (see Chapter five, Cummins *et al* 2023, Feeley *et al* 2023, Mahdavi *et al* 2022, Oakley and Siebers 2001).

There is disbelief from others about childbearing negation - the women's stories in my research were seen as untrue (for example by family and friends), sometimes unexplainable, which can lead to the feeling of stigma of the experience (see Chapter five). Moreover, by not meeting the 'normalised' and expected standards of childbearing, women who experienced negation try to "fit in" to this agreed societal pattern by normalising after the experience. This can be heard through the individual and shared experiences of dissociation, minimising the experience to 'others', and a feeling of coping - with little choice to do or feel anything else (see Chapter five).

The expected, normative experience of childbearing has been taken away, removed, and women identify and discuss the "lost pregnancy", feeling deprived of a 'normal' childbearing experience due to the negation (see Chapter five). This can be seen along the whole childbearing continuum and is brought into sharp focus in the postnatal period and beyond, where women have expressed that negation forms part of personal identity, and they become "changed" women because of the negation experience (see Chapter five).

Women's experiences of negated childbearing do not fit the expected and normalised childbearing continuum, instead offering a different and challenging narrative which disrupts individual, community and societal perceptions of usual and accepted predictable patterns along the reproductive pathway.

7.3 Relationships and Holding Space

The importance of relationships and the context in which they sit, develop and change is a key element of this narrative research. Three aspects of contextual relationships are highlighted as part of negated childbearing - my relationship with the study/research process, my relationship with the women who participated (and those who did not), and the concept of 'holding space' for stories and storytelling to be enabled.

a) Researcher relationship with the study

Being cognisant of the developing and changing relationships that I had as a researcher with all aspects of my research, and along the entirety of the research process, was developed through narrativity, reflexivity and reflection. Mooney-Doyle and Deatricks (2023), Sato *et al* (2021) and Lavoie (2021) highlight that 'relationships' form an integral part of qualitative research, and that recognition of this by the researcher forms the basis for transparency in

research studies and was essential to this study. This is not to be confused with researcher positionality, which has been discussed, although there may at times be an overlap between the two.

As a part-time doctoral student, my relationship with the research process throughout the timeline has been a long and enduring one, taking place over nine years, and encompassing two periods of pauses due to my sickness and workload, due to COVID. Working full-time during the duration of my part-time doctoral studies has been one of the most challenging and testing aspects of my research, as at times I struggled to keep momentum going. The increased stress noted particularly during a part-time doctorate, has been acknowledged by Murphy (2024), Massyn (2023) and Castello *et al* (2017) and the main contributing factor of achieving a work/life balance whilst making research progress is cited as difficult to juggle.

Moreover, a study by Block (2023) indicates several issues including reduced satisfaction, increased likelihood of non-completion and a lack of understanding and support from Universities. During my time as a part-time doctoral researcher, I developed a range of coping strategies, mostly related to support and informal advice from academic peers and family, and taking time out for personal well-being and health activities. This enabled me to retain a healthy relationship with my research and to accept and manage the pauses or delays along the way.

Furthermore, this also facilitated me to self-reflect and to understand my personal transformation as part of the research process. Acknowledging the research knowledge and skills that I have gained, the emotional work involved in sensitive subjects and populations and the ability to do ‘justice’ to the findings for the participants, are the highlights of my research journey, and the key elements of the relationship with my study.

b) Researcher relationships with the women

An important facet throughout my research journey, has been the relationships that I had with each woman who participated in this study. I feel incredibly grateful and humbled, that each of the six women generously gave their time to share their individual stories and be part of shared conversations of negated childbearing. The small number of women who agreed to take part, meant that I got to know their stories on a deep, individual and personal level.

The level and importance of these relationships became more explicit as the research progressed, and was made particularly clear during the data collection, data analysis and

writing the findings. I felt as if I had made an important connection with each woman as an individual, and this connection was initially like a lightning bolt - it provoked an emotional reaction, especially during the interviews when I first heard the stories as they were told, and then again through the shared conversations on the Secret Facebook Group. The feeling is very similar to experiences I have had as a clinical midwife, when women have either confided in me or disclosed something significant, which is troubling them or making them anxious. The connection which we forged - the women and myself - was often the sustenance I needed to keep going, when the research process was hard.

Conversely, I was also conflicted, being aware of my ethical duty as a researcher to remain professional and acknowledge the potential impact of relationships on the data and study outcomes. The consideration of the ethics of relationships between participants and researchers, particularly in qualitative research, have been identified as an important part of the research process, and highlighted in work by Eide and Kahn (2008), Guillemin and Heggen (2008) and Yassur-Borochowitz (2010).

Common reflections on consent, suitability of methodology and methods, potential or proposed benefits of a study and how to define limits in the researcher-participant relationship have been identified and this is particularly applicable in research with sensitive or challenging subjects and were also considered in this study (Newton 2017, von Benzon and van Blerk 2017, Liangputtong 2007 and Yassur-Borochowitz 2010).

Of these four common reflections, consent and suitability of methodology and methods have been considered and discussed in this thesis, and potential benefits are discussed later in this chapter (see Chapter three and four). Focussing on the 'limits' of the researcher-participant relationship, was something that I thought about throughout the research process. I utilised my knowledge, skills and experience of my midwifery career, both clinically and in education, alongside my research ethics training and upskilling myself, to navigate my way through ensuring an ethical relationship with each woman who participated.

The concept of 'respect' in framing my relationships with each woman in this study, was the key underpinning approach throughout the research process, and is highlighted in work by Eide and Kahn (2008), Guillemin and Heggen (2008), Lavoie (2021) and Mooney-Doyle and Deatrick (2023). Through a continuous, ongoing and developing cycle of an ethical and respectful approach to participants, I utilised my researcher diary, private contemplation and confidential peer to peer discussions to engage with and apply the respect approach (Figure 34 overleaf):

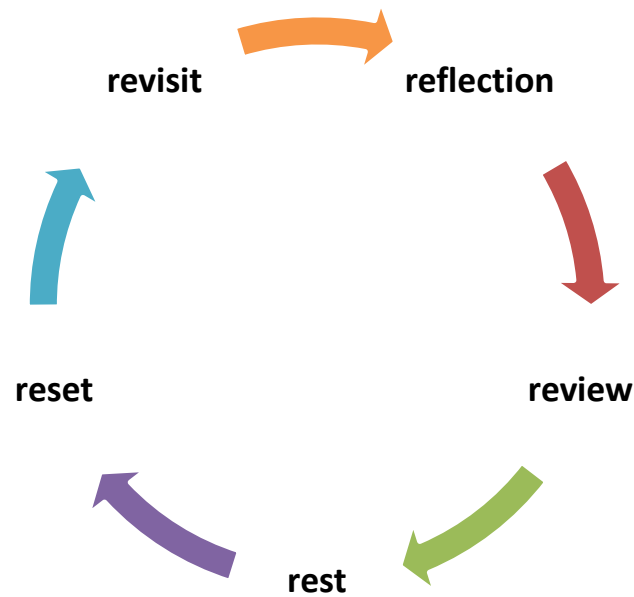


Figure 34: Ethical participant respect approach cycle

This enabled me to think proactively about the potential for issues which may arise in my relationships with each woman participant, and how these might be minimised, mitigated or avoided. One example of an issue which arose during the study was what I would do if a woman asked me to be a ‘friend’ through Facebook. This happened with two of the participants, following the social media aspect of this study. Using the respect approach cycle, I concluded that I would contact each of the women via messenger, and politely turn down the request, with a brief explanation of potential conflicts of interest and boundary setting. Each woman accepted the explanation unequivocally, and that was end of the issue.

c) Holding space

The concept and approach of holding space originates from psychology, mental health practitioners, well-being practitioners and has roots in spiritual and cultural practices (Epstein 2024, Kealy and Hebron 2024, and Plett 2015). To hold space, means that a person ‘holds space’ for another person, or group of people, where they are able to freely express themselves, without judgement from the person holding the space, and where their expression results in a feeling of being listened to and heard, and being in control of their expression (Pollack *et al* 2024, Plett 2020 and White 2022).

Moreover, Plett (2020), Epstein (2024) and Lucero and Roubideux (2020) identify the application and importance of the holding space concept to research, with particular significance in improving trust with participants and communities, and in research with potentially challenging subject matter. The concept has been used in health-related research, as examples from Kealey and Hebron (2024), Pollack *et al* (2024) and Suddick *et al* (2021) illustrate, and across qualitative methodologies.

In addition, there are examples of the proactive and planned use of the intention to hold space in maternity research, as work by Pollack *et al* (2024), Lee (2020) and Lemay and Hastie (2017) demonstrates. There are parallels that I have identified between the narrative approach of small stories and storytelling, and the concept and facilitation of holding space when applied to the study of negated childbearing. The facilitation of freedom to share, expression of experience, telling of stories and redressing control can be seen and heard in this study, and fulfil many of the qualities needed to fulfil the holding space concept.

Likewise, methods used for data collection of the unstructured in-depth interview using the one question technique, and the Secret Facebook group also facilitate holding space concept qualities (see Chapter four and five). The holding space concept was not a main premise for conducting research into negated childbearing but was considered in relation to researcher positionality as identified in Chapter three, and storytelling.

Reflecting on the research process and looking at the study retrospectively, the individual stories and shared conversations findings, highlight space held during the study (see Chapter five). One example of where the holding space concept can be seen in this study, is through freedom of expression, in relation to post negation fear. An element of fear pervades life post birth in the postnatal period and beyond - fear of the repetition of negation, fear of getting pregnant, fear of not getting pregnant, fear of feeling a fool for concealing or being unaware, and a fear of not being believed (see Chapter five). Feeling safe, and in a safe space, has allowed the women who participated to express their feelings, and share their and tell their stories to myself as the researcher and to each other.

7.4 The Impact of Researching Sensitive and Challenging Subjects

There is a wealth of evidence which considers the impacts of researching sensitive and potentially challenging subject matter, for both the participant/s and the researcher/s (Serrant-Green 2010, Komaromy 2022, Mallon and Elliott 2022 and Silverio *et al* 2022). What is or is not considered 'sensitive' subject/research varies, and has been critically debated

between individual researchers, methodological standpoints and the subject area being studied, so there is no overarching agreed definition.

However, there are some generally agreed principles suggested in the evidence base for consideration, as highlighted by Dickson-Swift *et al* (2007), Liamputtong 2006 and Serrant-Green (2010). This provides the case for moving beyond basic ethical issues (considered in chapter three), and towards a holistic view of sensitive research, of positive and negative outcomes, which include emotional work, behavioural aspects, catharsis, safety and protection and short- and long-term effects on participants and researcher/s.

7.5 Participant Impact

Considering the impacts of researching negated childbearing across the continuum for each woman who participated, the primary concern was individual well-being throughout the research process. Acknowledgement of the potential impacts of sharing stories and joining conversations about negated childbearing, formed a key part of my research process, and was initially triggered by reading Liamputtong's 2006 book on researching the vulnerable, which includes a discussion on sensitive research and methods.

A systematic review by Alexander *et al* (2018) on participant experiences in sensitive nursing research topics, found overall positivity in relation to taking part, but with some reports of distress and discomfort reported. These findings are supported in work by Crowther and Lloyd-Williams (2012), Liamputtong (2006), Newton (2017) and von Benzon and van Blerk (2017), who highlight safe and effective management of potential emotional and negative aspects of sensitive research, whilst acknowledging the potential positive benefits, also identified in this study, particularly catharsis (see Chapter five). As part of the ethics process, to minimise negative impacts, and to support women's well-being in this study, tools such as a distress protocol (Appendix 6/see Chapter four), signposting information sheet (Appendix 3/see Chapter four) and certain research methods were utilised.

There were no issues identified with the women who took part in relation to distress or identified negative impacts throughout the timeline of the research process, and longer-term impacts may not be known. However, the impact of research on participants can be much more subtle. For example, during storytelling, use of terminology, pauses and silences, story structure and context can all indicate uncomfortable, emotional or distressing aspects, which can be difficult to identify (see Chapter four and five, Liamputtong 2006, Silverio *et al* 2024, Serrant-Green 2010 and McKenzie and Spoel 2014).

Evidence from Alexander *et al* (2018), Crowther and Lloyd-Williams (2012), Dickson-Swift *et al* (2007) and Guillemin and Heggen (2008) indicates that participant impact from researching sensitive subjects is a balancing act, which involves weighing up potential and actual benefits, versus managing risk, safety and negative aspects, and often involves giving credence to experiences and voices which have not been heard or understood.

7.6 Researcher Impact

There is evidence which highlights and discusses the potential impacts on the researcher involved in studies, which concern sensitive subject areas (Fenge *et al* 2019, Mallon and Elliot 2019, 2022, Silverio *et al* 2024, Hanna 2018 and Watts 2008). Recent work by Mallon and Elliot (2019) focuses on, and gives weight to, the overarching concern of emotional risk, which was identified by the researchers in their work, and the depth, breadth and type of support available to them.

Emotional risk was seen to be managed and mitigated by researcher professionalism, and the inherent requisite to produce meaningful and impactful research. Furthermore, studies by Fenge *et al* (2019), Hanna (2018) and Newton (2017) indicate that it is difficult to predict researcher reactions and behaviour with sensitive research, and that support offered is not flexible, proactive or specialised enough to effectively address researcher needs.

However, it is important that as a researcher undertaking potentially sensitive research, that a plan for management and mitigation of researcher emotional health and well-being is put in place. Sherry (2013) discusses the overarching approach of self-care and how this helped in both looking after and protecting them during the research process.

Protection of the researcher is also considered a key area in work by Micanovic *et al* (2019), where emphasis on the emotionally challenging aspects of sensitive data collection is highlighted, with strategies for management (for example, keeping a personal diary). When I put together the initial proposal for this doctoral study on negated childbearing, my well-being as a researcher was not a formal part of the research process, personal strategies developed organically as I moved through the various stages of the study.

In the early stages of the study, prior to data collection, I drew on my professional background in midwifery, to reflect on different and challenging aspects such as gaining ethical approval and completing a literature review, which is also discussed in work by Mallon and Elliot (2019). As I commenced recruitment and data collection, and it became clear that I would be exposed to difficult, challenging and emotionally affecting stories, and

that I would need a personal strategy to manage the impact on myself. I utilised a range of mechanisms during this phase of the study which included: regulation of emotion during the interviews, a period of immediate quiet and contemplation following the interview, allowing space for private expression of emotion following the interviews as needed, starting a personal journal for reflection and expression of feelings, and some discussion with my supervisory team.

Furthermore, during data analysis (including transcription), I found that repeated re-exposure to elements of the negated childbearing stories, was impacting my personal mental health and well-being. To manage this, I took regular breaks from transcription and analysis, once again allowing space for personal quiet time and reflection. Finding and accessing safe spaces for emotions is an important aspect of sensitive research, and ideally should be planned from the outset (Mazetti 2018, Etherington 2007).

7.7 Contribution to the Evidence Base

This study contributes to narrowing the gap in the literature around negated childbearing, by exploring women's experiences of negation during the whole of their childbirth continuum, utilising a narrative methodology. The focus of this research to include both denial and concealment throughout the childbearing continuum, is additionally an unusual and unique approach, with only a very small number of studies which consider both within the same research process.

Strengthening the qualitative evidence base and expanding the body of knowledge, contributes to diversifying research in this area, and applying a narrative focus which has not previously been explored. Moreover, specific contributions through methods used in data collection - the one question interview technique and social media group, to elicit small stories and shared conversations of negated childbearing, are unique to this study, providing fresh and new insights.

The narrative small story approach has enabled and facilitated new and further understanding in key areas such as changed self and identity for women who have experienced negated childbearing, the domination of the dyad discourse and focus on the baby as the centre of care and the impact of the 'normality' motherhood lens in the negated discourse. Negated childbearing is seen, heard and explored as storied phenomena, which reveals a range of complex and multi-layered aspects which vary between individual women, but which also share some commonalities in emotional and mental health impacts.

The current body of evidence focuses on the antenatal period, with little thought given to negation (particularly denial) in the intrapartum and the immediate postnatal period and beyond. Overall, the scope of this study enables a more holistic and broader exploration of negated childbearing, encompassing the continuum of childbearing, including time periods which have previously been given little or no weight.

7.8 The 'Umbrella Model' of the Unknown Childbearing Continuum

Throughout the research process, particularly when looking at the literature and evidence, I identified several associated conditions which, although not considered in detail as part of this study, could contribute to a further broader understanding of what I have termed the 'unknown childbearing continuum' model. The suggested model is outlined in figure 35 below:

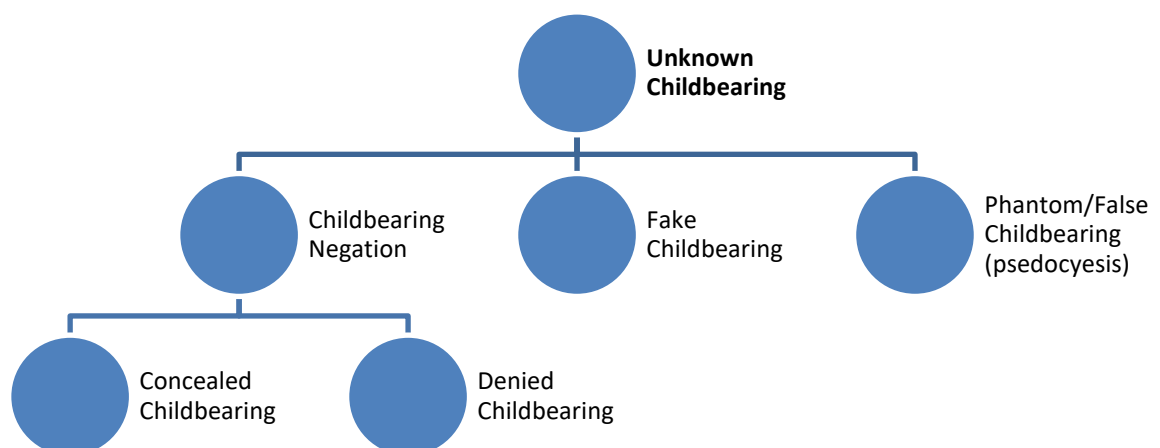


Figure 35: A new proposed umbrella model for conditions of unknown childbearing in the UK

The new model proposes an overarching approach to conditions of unknown childbearing, which has the potential for further research, and to increase awareness and understanding throughout healthcare professions. The new model is a contribution to the current evidence base and is intended to facilitate discussion and critical thinking around potential shared understanding between conditions, and consideration of changes and improvements to clinical care.

7.9 Study Strengths and Limitations

The main strengths of the study can be aligned to three core aspects: methodological and methods use and application, story ownership, depth and quality of the findings and the potential and pertinent use of the findings to clinical care and practice across healthcare professions (which will be discussed separately). The positive outcomes of using a narrative approach to research negated childbearing, has been discussed and critically considered in this thesis (see Chapter three).

The ability of the methods used to generate rich and meaningful small stories, which sit in the context of large narratives, has resulted in new understanding of identified small story threads, story structuring and the performance of stories in an impactful and powerful manner. Additionally, by using social media through a secret Facebook group, shared conversations were generated as women discussed their negated childbearing experiences online, chatting to each other about individual and shared aspects of their stories.

The shared conversation over social media provides a particularly unique aspect of this research, contributing new threads and adding depth of data to the overall findings (see Chapter four and five). Moreover, the concept of story ownership is reflected throughout, the women who participated told their own story, through the narrative approach, giving privilege and insight into negated childbearing.

I have reflected on the limitations of the study, the research process and the findings, and identify some potential areas for further consideration and improvement. It has already been noted and discussed that recruitment for the study was difficult and challenging, and ideally a larger sample size could have yielded further insights and data.

Furthermore, the sample of women who participated in the study were not fully representative of the childbearing population, and inclusivity could have been improved. For example, there were no women from the global majority, disabled women or those with different gender experiences. Additionally, although the study set out to include both concealed and denied childbearing, the ratio could have been improved to include further cases of concealed childbearing, which may have impacted findings and data generated.

Furthermore, the decision to include both concealed and negated childbearing in one study, could be seen as a strength (shared aspects of experiences), but also a limitation, that separate conditions could benefit from a more focussed approach when generating evidence. Finally, an acknowledgement that increased input from service users, and a

better application and use of PPI, could also have positively impacted the design and research findings.

7.10 Recommendations for Further Research

As the current body of evidence around negated childbearing remains relatively small, there is the need to consider further areas which would benefit from research, that have been identified as part of this research process. I have critically considered the areas and have listed them here:

- Work around standardisation of terminology and definitions, both nationally and internationally
- Further studies around prevalence of concealed and denied childbearing
- An increase in the quality of quantitative research studies
- Increased use of mixed methods and varying types of qualitative research not yet explored (for example action research)
- Inclusion of women from the global majority, disabled women, a wider range of social and economic backgrounds and from different and transgender communities
- The experiences and impact of negated childbearing on partners/significant other/s
- The experiences and impact of negated childbearing on family and friends
- The perspectives, understanding and experiences of health professionals involved in clinical care and service delivery
- The experiences of student health professionals involved in clinical care
- A comprehensive review of the media portrayal and information sharing of negated childbearing (including social media/apps)
- Research which includes a more holistic and comprehensive approach towards involvement of service users and PPI
- Potential for development of the proposed new umbrella model of unknown childbearing
- Further and more in-depth studies on the short- and long-term health impacts of negate childbearing

These could be implemented by health professional researchers, including those based clinically, those in HEI's and those in third sector and other organisations. A broad approach including joint collaborative research studies, increasing applications for bids and funding and utilising research networks would be a useful starting point.

7.11 Recommendations for Care and Clinical Practice

The findings and outcomes of this study, suggest that there is room for improvement in the care of women and families who experience negated childbearing (see Chapter five). Women reported a range of care experiences, within individual stories, and through their shared conversations, of very good to poor care (see Chapter five). As care should be guided by the best available evidence, and relevant and current clinical guidelines and care pathways, these two areas should be the initial starting point to guide improvements in service delivery and care.

Current NHS guidance relating to negated childbearing varies between NHS Trusts and organisations (for example safeguarding boards/local council guidance), and is reliant on a range of terminology and definitions, with different expectations in relation to ‘access to antenatal care’ (Holland 2023, Knowsley Safeguarding Children’s Partnership 2019).

To encompass the issues with a lack of standardised terminology, and differences between NHS trusts and other organisations, I suggest the following list of recommendations which would help to improve the overall approach to negated childbearing, and which could be applied across departments that may deliver care:

- An individual, holistic approach, rather than a safeguarding for all cases approach
- An MDT, collaborative approach to care and service design and delivery
- Improved clinical care for women utilising a trauma informed approach, with an increase focus on maternal health and well-being, especially around mental health
- Improved acknowledgement and care of partners, family and friends
- Involvement of those with lived experience, and service users in the potential to review care pathways, clinical guidance and to redevelop and redesign services and responses to negated childbearing

These could be implemented using a variety of approaches including focussing on one main NHS Trust regarding guidelines review (with a view to cascading to other trusts), working with professional bodies such as the Royal College of Midwives (RCM), Royal College of Nursing (RCN) and the Royal College of Obstetricians and Gynaecologists (RCOG), and linking with third sector and charity organisations such as The Birth Trauma Association. Other networks such as patient voice groups and key contacts, for example research midwives, consultant midwives, clinical/medical leads, Heads/Directors of Midwifery and others would be approached for input.

7.12 Multi-Disciplinary Team (MDT) Care and Practice Outside of Maternity and Midwifery

Following on from the recommendations for suggestions to improve the overall approach to negated childbearing in clinical and professional practice, the need for a consistent and comprehensive MDT care package is required. These can be utilised across clinical departments and areas of care, professions and organisations who may be in contact with, or provide care and services for those who have experienced negated childbearing.

Teams should identify specific needs of the woman and her family, taking a person centred and family-based approach to care provision. Furthermore, a key aspect of care provision for the MDT is the recognition of the potential input of specialists, and the involvement of maternity services as soon as practically possible, including rapid and appropriate referrals.

NHS Trusts and other organisations should consider areas where negated childbearing may present other than maternity and develop appropriate care pathways and guidance to inform and support staff involved in care delivery. Examples of such areas include:

Accident and Emergency, Walk-in Centres, GP's Practices, Social Work Practice, Ambulance Services, Children's Centres, Gynaecology wards and services, Sexual health services, Ultrasound/Scanning Departments, Main Receptions, Community Delivery Hubs, Public Toilets, and Local Council Amenities.

Alongside these, appropriate support for a wide range of staff who may be involved in the care of those experiencing negated childbearing should also be implemented and embedded.

7.13 Maternity and Midwifery Care and Practice

Taking on board my suggested recommendations to improve the overall approach to care, there is also a need to review, audit and refresh guidelines and care delivery for midwifery, and maternity services. Midwives should lead the development of holistic assessment for care needs, to determine if women and families require universal or complex care pathways. Additionally, the following suggested changes should be considered when looking to make improvements to service delivery and care:

- An acknowledgement of the increased need for awareness, understanding and knowledge and skill development for maternity staff, of negated childbearing throughout the entire childbearing continuum
- An MDT approach towards care should be taken, including timely and appropriate referrals as required
- A review of prenatal care and support, which could be offered to those who have experienced negated childbearing
- Guidelines for negated childbearing should include: care in future pregnancies (post negation), appropriate safeguarding consideration, specialist midwifery and obstetric input as appropriate, provision of immediate postnatal care, potential for extended postnatal care, collaborative handover to services involved in longer term care of the woman and family
- Care Pathways for negated childbearing should be developed, alongside guidelines review, to ensure consistent and comprehensive approaches to care
- Where possible, women and families should be offered continuity of care and carer, in order to build relationships and avoid repeated explanation and storytelling, which may trigger or re-traumatise women
- There may be the need to offer specialist maternity input and services as appropriate, for example with a Consultant Midwife/Obstetrician or Perinatal Mental Health Midwife/Service, this should be considered and offered
- Increased contact and visits should be offered in the immediate postnatal period
- Extended postnatal care (beyond ten days), should be considered and offered on an individual basis, potentially including joint visits and handover with health visiting services

7.14 Raising Awareness, Training and Education

A key recommendation of this study, is that awareness and understanding of the phenomena of negated childbearing across the continuum, needs to be increased and improved, and that this could be actioned through training and education. Consideration should be given to embedding bespoke teaching and learning activity across all relevant undergraduate and postgraduate (pre-registration) teaching programmes, and across healthcare professions (tailored as appropriate). Sessions could be delivered as stand-alone specifically on negated childbearing or could form part of a broader approach of personalised and/or trauma informed care. The delivery format could include a focus on case-based and scenario focussed activity, utilising examples from professional practice as appropriate.

Moreover, I plan to develop a bespoke training package around negated childbearing, which would ideally be accessed online, potentially through an online information hub (either new or pre-existing), a Massive Open Online Course (MOOC), or a pre-recorded session. There may also be collaboration opportunities with organisations such as the Royal College of Midwives (RCM), the Royal College of Nursing (RCN), Social Work England and Regional Ambulance Services (for example North-West Ambulance Service NWAS), amongst others, to develop and make available learning resources for staff and members.

7.15 Dissemination of Findings

Some aspects and initial findings of this study have already been presented, discussed and disseminated locally, regionally, nationally and internationally, at a wide range of workshops, events and conferences (see Appendix 19 of events attended). These include the terminology and background of negated childbearing, methodological approach, methods utilised, application of narrative and analysis and early findings.

Further presentations through oral and poster submissions will be planned post-doctoral completion. Plans also include developing articles for publication in a wide range of journals, preparing commentary pieces for appropriate media and increasing professional networks to widen dissemination.

7.16 Closing Summary and Thoughts

From sowing the seeds of inquiry from my first clinical experience and exposure to negated childbearing, to growing the green shoots of findings, these have been both the rationale and my personal passion for the design, implementation and outcomes from my doctoral research. Considered and reflected throughout is the essence of holism, the importance of the individual, and an inherent worth of context and situation, which form the core of the research approach. Listening, understanding and presenting stories of negated childbearing from the narrative approach, makes a new and significant contribution to a more comprehensive evidence base, which is needed to improve care and service delivery across maternity and health care.

The findings contribute to a deeper understanding, provide a spotlight on the woman's experience, and gives a voice to an invisible and vulnerable population, (Holloway and Freshwater 2007, Liamputtong 2007, Oakley 1981). The impactful narrative research

process is seen throughout the findings as cathartic and powerful storytelling and sharing, through a vehicle of a listening ear via interviews and social media. Space is held for the women's stories, conversations and experiences, to illuminate negated childbearing, with the focus on personal truth and voice.

I advocate to privilege the woman's experience as the basis for developing a sensitive, client-focussed response that considers the wider social context of people's lives as well as the medical aspects. Moreover, negated childbearing research continues to emerge as a complex, dynamic and challenging subject, where much more work is needed both to improve the evidence base, and concurrently improve the lived experiences of women and families.

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Literature Type	Source Type	Source Used	Findings
Primary Academic	Database	Medline, Pubmed, The Cochrane Library, Cinahl, NHS,	Journal articles Journal commentary and notes Scholarly Essays Key Authors
Primary Academic	Textbooks (hard and electronic versions)	LJMU Library Service LJMU Discover	Nursing, Midwifery, Medical, Sociology, Philosophy, Research books
Academic	Reference Lists from identified primary sources	Google Scholar	Journal articles Conference Address Textbooks Key Authors
Grey	Online	Google Scholar Open Grey	The British Library - Theses Royal College of Midwives (RCM) Department of Health (DH) National Childbirth Trust (NCT) National Health Service (NHS) National institute for Health and Care Excellence (NICE) Royal College of Nursing (RCN) Office for National Statistics (ONS) World Health Organisation (WHO)

Literature Type	Source Type	Source Used	Findings
Grey	Media Social Media	Facebook Twitter Blogs Discussion Forums	BabyCentre BBC News Online Centre for Maternal and Child Enquiries (CMACE) Independent Online Mamamia Online MBRRACE-UK Multi-agency guidelines Mumsnet Netmums The Conversation Online The Guardian Online The Lily Online
Grey	Online groups, communities, organisations: childbearing continuum support and advice	Google Facebook Discussion Forums	Association for Improvement in Maternity Services (AIMS) Birth Trauma Association (BTA) Open and Closed Facebook Groups



DID YOU HIDE YOUR PREGNANCY OR BIRTH?

WERE YOU UNAWARE OF THE PREGNANCY OR LABOUR?

INTERESTED IN SHARING YOUR STORY AND WHAT IT WAS LIKE FOR YOU?

Women's experiences and stories around hidden and denied childbearing are poorly studied. There is a lack of awareness and knowledge about the impact and issues involved, and a need to provide individual care and support to women and families. This research aims to explore these issues using interviews and social networking.

You may be eligible to take part if: your experience of childbearing was hidden or you did not know, your experience happened within the last 5 years, you are aged 16 or over, you are resident and had your experience in the UK.

If you are interested in being part of this research: "NEGATION IN THE CHILDBEARING CONTINUUM: A QUALITATIVE STUDY", please contact the lead researcher below, who can give you further information.



CONTACT: JANE ROONEY, LJMU, SCHOOL OF NURSING & ALLIED HEALTH, 19/7/17
07970175149, j.s.rooney@ljmu.ac.uk, IRAS PROJECT: 228101, POSTER V2,





NEW RESEARCH STUDY

Negation in the Childbearing Continuum: A Qualitative Study

Women can present to health services at any stage of pregnancy, when labour has commenced, or following the birth in the immediate postnatal period. If negated, the partial or entire childbearing process may be denied or concealed by the woman, and unknown to those around her. There is a strong body of evidence to suggest that negation during childbearing is more likely to incur poorer outcomes for mother and baby, compared to those where childbearing is revealed.

Women's experiences and stories around negation are poorly researched. This qualitative narrative study aims to explore these stories using in-depth interviews and social networking.

Inclusion Criteria: Women who have experienced negation in the antenatal, intrapartum and postnatal periods, infant is up to 5 years old, singleton or multiple gestation, all modes of birth, fetal loss/stillbirth/neonatal death, ages 16 and over, resident and had childbearing experience in the UK.

Exclusion Criteria: Unable to consent, learning needs, English not the first language, under 16 years of age, non-resident in the UK and childbearing experience outside of the UK.

IRAS Project ID: 228101 (Poster V2) 19/07/17



INFORMATION FOR STAFF

Can you help to
identify potential
participants?

If so, please
contact the
researcher below

Further
information for
staff & women
available

RECRUITING
2017-2018

JANE ROONEY

PhD Student-Research
Lead

LJMU, School of Nursing &
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Research mobile:
07970175149

j.s.rooney@ljmu.ac.uk



LIVERPOOL JOHN MOORES UNIVERSITY

Title of Project *Negation in the Childbearing Continuum: A Qualitative Study (Interviews)*

Mrs Jane Susan Rooney, School of Nursing and Allied Health, Faculty of Education, Health and Community

"You are being invited to take part in a research study. Before you decide it is important that you understand why the research is being done and what it involves. Please take time to read the following information. Ask us if there is anything that is not clear or if you would like more information. Take time to decide if you want to take part or not."

1. What is the purpose of the study?

To find out about denial or concealment (negation) during childbearing, from your view, and in your own words. In simple terms a 'concealed' childbearing process is one in which you are aware of and understand that you are pregnant, in labour, giving birth and have delivered a baby (and actively hides this process). In simple terms 'denial' of the childbearing process is one in which you were unaware/unable to recognise that you were pregnant, in labour, giving birth and/or had delivered a baby.

Due to the denial or concealment, part or all your childbearing may have been unknown to you and those around you. This study aims to explore your experiences using in-depth interviews to gather data and increase awareness and knowledge of this issue.

2. Do I have to take part?

"No. It is up to you to decide whether to take part. If you do you will be given this information sheet and asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw will not affect your rights/any future treatment/service you receive."

3. What will happen to me if I take part?

- *You will be involved for approximately 1-2 hours for the interview, which will be audio recorded.*

- You will be asked to take part in an interview and discuss your personal experience of denial or concealment during childbearing.

4. Are there any risks / benefits involved?

The main potential risk is that you will become upset when discussing your experiences or following the interview. Interviews will be flexible and led by you, so you are in control of the discussion. The interview may be paused at any time or finished to minimise any further upset. The researcher also has a guideline to follow in this situation so advice and support can be provided as needed, including after the interview is completed.

The researcher has professional and personal experience of dealing with emotionally difficult and sensitive situations. An information sheet will be provided with a list of support organisations with contact details, and referrals can be made as needed.

5. Will my taking part in the study be kept confidential?

As the childbearing may not be revealed to your family or friends there will be processes in place to protect your confidentiality and dignity. You will be approached about the study when on your own, in a safe environment. Interviews will be in a place of your choice and can be away from home if needed. The researcher will follow Local Trust guidance for any issues which may arise to keep you and your family safe, and where information may need to be shared with other professionals.

If you decide to leave (no longer take part) the study at any point during the interview/s, you have the option to have any data collected up to the point of anonymization withdrawn, and no longer used as part of the study.

Any personal information will only be known to the researcher and will only be used to contact you for the purposes of the research, and to collect simple data details (for example where you live, and what your job is). You will be given a pseudonym (different name) to protect your identity. These details will be stored on the researcher's LJMU computer, which is password protected, and only the researcher has access to. This data is stored for 6-12 months.

Audio records will be deleted from the recording device on completion of the analysis of the data. Notes taken at the time of the interview, and the writing up of the interview will be stored for 10 years in a locked draw in the researcher's office at LJMU. The audio recordings and notes taken at the time of the interview will be transcribed (written up). This process will be carried out by the researcher (Jane Rooney). These notes and transcripts will also be anonymised and use a pseudonym.

The writing up of your interview will be sent to you to read through and check it is an accurate record and so you can comment on it, and if you wish you can be kept informed of the study results.

Contact Details of Researcher: Jane Rooney, LJMU, Tel: 0151 231 4312, j.s.rooney@ljmu.ac.uk

Contact Details of Academic Supervisor: Professor Valerie Fleming, LJMU, Tel: 0151 231 4017,
V.E.Fleming@ljmu.ac.uk

If you any concerns regarding your involvement in this research, please discuss these with the researcher in the first instance. If you wish to make a complaint, please contact researchethics@ljmu.ac.uk and your communication will be re-directed to an independent person as appropriate.

LIVERPOOL JOHN MOORES UNIVERSITY

Title of Project *Negation in the Childbearing Continuum: A Qualitative Study (Online Social Media Group – Secret Facebook Group)*

Mrs Jane Susan Rooney, School of Nursing and Allied Health, Faculty of Education, Health and Community

“You are being invited to take part in a research study. Before you decide it is important that you understand why the research is being done and what it involves. Please take time to read the following information. Ask us if there is anything that is not clear or if you would like more information. Take time to decide if you want to take part or not.”

1. What is the purpose of the study?

To find out about denial or concealment (negation) during childbearing, from your view, and in your own words. In simple terms a ‘concealed’ childbearing process is one in which you are aware of and understand that you are pregnant, in labour, giving birth and have delivered a baby (and actively hides this process). In simple terms ‘denial’ of the childbearing process is one in which you were unaware/unable to recognise that you were pregnant, in labour, giving birth and/or had delivered a baby.

Due to the denial or concealment, part or all your childbearing may have been unknown to you and those around you. This study aims to explore your experiences and those of other women, in your discussions together, using an online social media group to gather data, and increase awareness and knowledge of this issue.

2. Do I have to take part?

“No. It is up to you to decide whether to take part. If you do you will be given this information sheet and asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw will not affect your rights/any future treatment/service you receive.”

3. What will happen to me if I take part?

- *You will be involved for approximately 3-6 months in the online social media group.*
- *You will decide how much time you spend in the group, and how often you take part.*

- *You will be asked to take part in the online social media group to discuss your personal experience of denial or concealment during childbearing with other women who are part of the study and have been through this.*

4. Are there any risks / benefits involved?

The main potential risk is that you will become upset when discussing your experiences online or following your involvement in the online social media group. The online discussions are flexible and led by the women in the study, so you are in control of how much you take part and what you want to say. Your involvement in the online group and discussions can be paused at any time or finished to minimise any further upset. The researcher also has a guideline to follow in this situation so advice and support can be provided as needed, including after the online group has finished. You may contact the researcher during the period of the study if needed.

The researcher has professional and personal experience of dealing with emotionally difficult and sensitive situations. An information sheet will be provided with a list of support organisations with contact details, and referrals can be made as needed.

Guidelines will be followed for safe conduct of online research. The researcher will be responsible for administration and monitoring of the group, including issues around inappropriate posts, confidentiality and safeguarding and other issues which may arise. The rules of the group must be followed and will be made available on the group site.

5. Will my taking part in the study be kept confidential?

As the childbearing may not be revealed to your family or friends there will be processes in place to protect your confidentiality and dignity. You will be approached about the study when on your own, in a safe environment. You can take part in the online group discussion at a time and place of your choice and can be away from home if needed. The researcher will follow Local Trust guidance for any issues which may arise to keep you and your family safe, and where information may need to be shared with other professionals.

If you decide to leave (no longer take part) the study at any point during the online social media group, you have the option to have any data collected up to the point of anonymization withdrawn, and no longer used as part of the study.

Any personal information will only be known to the researcher and will only be used to contact you for the purposes of the research, and to collect simple data details (for example where you live, and what your job is). You will be given a pseudonym (different name) to protect your identity as part of the social media group. These details will be stored on the researcher's LJMU computer, which is password protected, and only the researcher has access to. This data is stored for 6-12 months after the group has finished.

All other data collected from the Online Social Media Group (discussions and comments, notes taken) will be stored for 10 years. Data will be stored electronically on a secure LJMU password protected computer, which only the researcher has access to. The online social media group will be deleted by the researcher, following the time-period of use (3-6 months).

You will take personal responsibility for your posts and discussions on the online social media group, and for risk of identification should this occur, but the steps noted above will minimise this risk.

The writing up of the discussions from the online social media group will be sent to you to read through and check it is an accurate record and so you can comment on it, and if you wish you can be kept informed of the study results.

Contact Details of Researcher: Jane Rooney, LJMU, Tel: 0151 231 4312, j.s.rooney@ljmu.ac.uk

Contact Details of Academic Supervisor: Professor Valerie Fleming, LJMU, Tel: 0151 231 4017,

V.E.Fleming@ljmu.ac.uk

If you any concerns regarding your involvement in this research, please discuss these with the researcher in the first instance. If you wish to make a complaint, please contact researchethics@ljmu.ac.uk and your communication will be re-directed to an independent person as appropriate.



LIVERPOOL JOHN MOORES UNIVERSITY

AIMS (Association for Improvement in Maternity Services)

Emotional support and encouragement as well as information about choices and rights. Working towards normal birth, providing independent support and information about maternity choices, raising awareness of current research on childbirth and related issues, protecting women's human rights in childbirth.

<http://www.aims.org.uk/>

ASSIST (Assistance Support & Self-Help In Surviving Trauma)

A support organisation and specialist treatment centre for people suffering from PTSD. ASSIST recognises that many individuals and their families/carers may need support as they struggle to come to terms with the effect that PTSD has on their lives and the lives of loved ones.

11 Albert Street, Rugby, Warwickshire, CV21 2RX

Helpline: 01788 560800

www.traumatic-stress.freesevice.co.uk

Birth Crisis Network

The Birth Crisis Network is a UK help line for women who want to talk about a traumatic birth. The website gives details of the network and has links to articles.

The Manor, Standlake, Witney OX29 7RH

Helpline: 01865 300266

email: birthcrisis@sheilakitzinger.com

www.sheilakitzinger.com/BirthCrisis.htm

The Birth Trauma Association

The Birth Trauma Association (BTA) supports all women who have had a traumatic birth experience.

Holly Tree Farm, 92 Crosshill Codnor Ripley, Derbyshire DE5 9SQ.

General enquiries: 01264 860380

<http://www.birthtraumaassociation.org.uk/>

Care for the Family

National charity which aims to promote strong family life and to help those who face family difficulties. They provide parenting, relationship and bereavement support through events, resources, courses, training and volunteer networks.

General Enquiries: (029) 2081 0800

General Enquiries: mail@cff.org.uk

<https://www.careforthefamily.org.uk/family-life/parent-support/parent-support-organisations>

Counselling Services

Counselling aims to help you deal with and overcome issues that are causing emotional pain or making you feel uncomfortable. It can provide a safe and regular space for you to talk and explore difficult feelings. The counsellor is there to support you and respect your views. They won't usually give advice, but will help you find your own insights into and understanding of your problems. This NHS Choices website has a range of resources to assist you.

<http://www.nhs.uk/conditions/counselling/pages/introduction.aspx>

MIND (for better mental health)

We provide advice and support to empower anyone experiencing a mental health problem. We campaign to improve services, raise awareness and promote understanding. They have specific campaigns for example: postnatal depression and other perinatal mental health issues, including possible causes, sources of treatment and support, and advice for friends and family.

<https://www.mind.org.uk/information-support/guides-to-support-and-services/>

<https://www.mind.org.uk/information-support/types-of-mental-health-problems/postnatal-depression-and-perinatal-mental-health/#.WV9RiljyuUI>

NHS Choices

The online 'front door' to the NHS, and is the country's biggest health website and gives all the information you need to make choices about your health.

<http://www.nhs.uk/pages/home.aspx>

PALS (Patient Advice and Liaison Services)

The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers. You can find officers from PALS in your local hospital.

<http://www.nhs.uk/chq/pages/1082.aspx?CategoryID=68>

[http://www.nhs.uk/Service-Search/Patient-advice-and-liaison-services-\(PALS\)/LocationSearch/363](http://www.nhs.uk/Service-Search/Patient-advice-and-liaison-services-(PALS)/LocationSearch/363)

PANDAS Foundation

Pre and postnatal depression advice and support. They have a variety of different support services available, all run by a trained team of volunteers.

PANDAS Helpline: 0843 28 98 401

PANDAS Email Support: info@pandasfoundation.org.uk

<http://www.pandasfoundation.org.uk/>

Patients Association

Information on a wide variety of issues, ranging from finding local support groups, NHS services, provides information on what patients are entitled to, making a complaint and listening to patients' experiences.

National Helpline: 020 8423 8999

<https://www.patients-association.org.uk/>

Perinatal Illness – UK

A registered charity for women and their families who have any type of Perinatal Illness (PNI). These include antenatal depression, postnatal depression, puerperal psychosis and birth trauma.

PO Box 49769, London, WC1H 9WH

General enquiries: 01530 560645

www.pni-uk.com

Solace for Mothers

Organization designed for the sole purpose of providing and creating support for women who have experienced childbirth as traumatic. Traumatic symptoms resulting from childbearing experiences are real and can even result from a seemingly “normal” birth experience.

<http://www.solaceformothers.org/>

Further Advice and Support

May also be available from your General Practitioner (GP), or if you are under the care of Maternity Services your Midwife, or if you and your family are under the care of Community Health Services your Health Visitor.



LIVERPOOL JOHN MOORES UNIVERSITY

CONSENT FORM

Negation in the Childbearing Continuum: A Qualitative Study (Interviews)

Mrs Jane Susan Rooney, School of Nursing and Allied Health, Faculty of Education, Health and Community

1. I confirm that I have read the information sheet dated: 26/01/18 (Version 5) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights. If I withdraw, I have the option to have any data collected up to the point of anonymization withdrawn, and no longer used as part of the study. ☐
3. I understand that any personal information collected during the study will be anonymised and remain confidential. ☐
4. I agree to take part in the above study (*which includes participation in an interview/s*). ☐

This part of the study involves the use of audio recording of interviews, where there is a possibility that verbatim quotes from participants may be used in future publications or presentations:

5. I understand that the interview/s will be audio recorded and I am happy to proceed. ☐
6. I understand that parts of our conversation from the interview/s may be used verbatim in future publications or presentations but that such quotes will be anonymised, and pseudonyms will be used. ☐

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Note: When completed 1 copy for participant and 1 copy for researcher



LIVERPOOL JOHN MOORES UNIVERSITY

CONSENT FORM

Negation in the Childbearing Continuum: A Qualitative Study (Online Social Media Group)

Mrs Jane Susan Rooney, School of Nursing and Allied Health, Faculty of Education, Health and Community

1. I confirm that I have read the information sheet dated: 26/01/18 (Version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights. If I withdraw, I have the option to have any data collected up to the point of anonymization withdrawn, and no longer used as part of the study.

☐

3. I understand that any personal information collected during the study will be anonymised and remain confidential.

☐

4. I agree to take part in the above study (*which includes participation in an online social media group*).

☐

This part of the study involves the use of recording discussions from the online social media group, where there is a possibility that verbatim quotes from participants may be used in future publications or presentations:

5. I understand that the online social media group discussions will be recorded, and I am happy to proceed.

☐

6. I understand that parts of discussions from the online social media group may be used verbatim in future publications or presentations but that such quotes will be anonymised, and pseudonyms will be used.

☐

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Note: When completed 1 copy for participant and 1 copy for researcher



Distress Protocol for qualitative data collection

Professor Carol Haigh
&

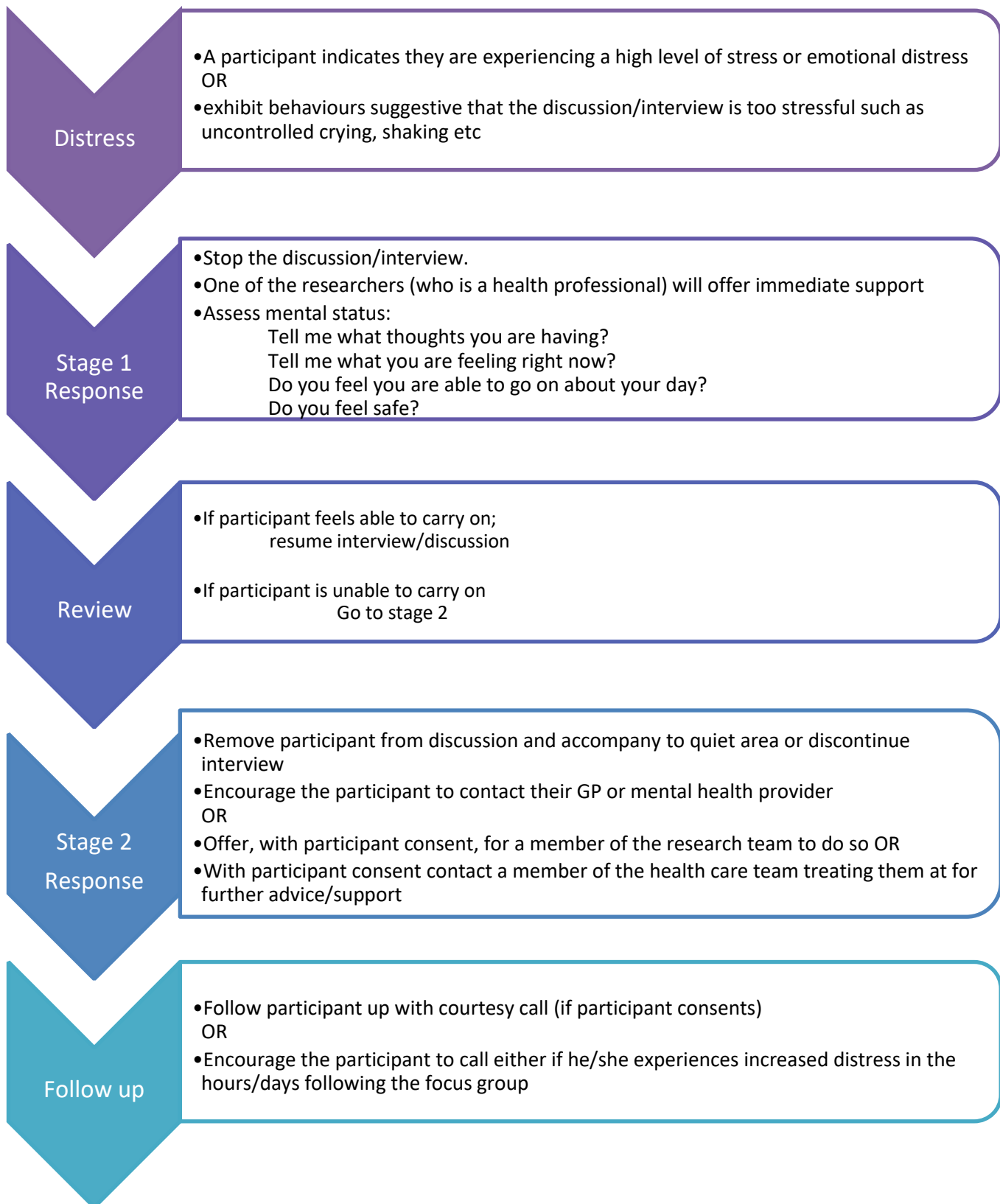
Gary Witham

Department of Nursing MMU

Review date 2015

Distress Protocol 1: The protocol for managing distress in the context of a research focus group/ interview

(Modified from : Draucker C B, Martsof D S and Poole C (2009) Developing Distress Protocols for research on Sensitive Topics. *Archives of Psychiatric Nursing* 23 (5) pp 343-350)



Distress Protocol 2: The protocol for managing distress in the context of a research focus group /interview management

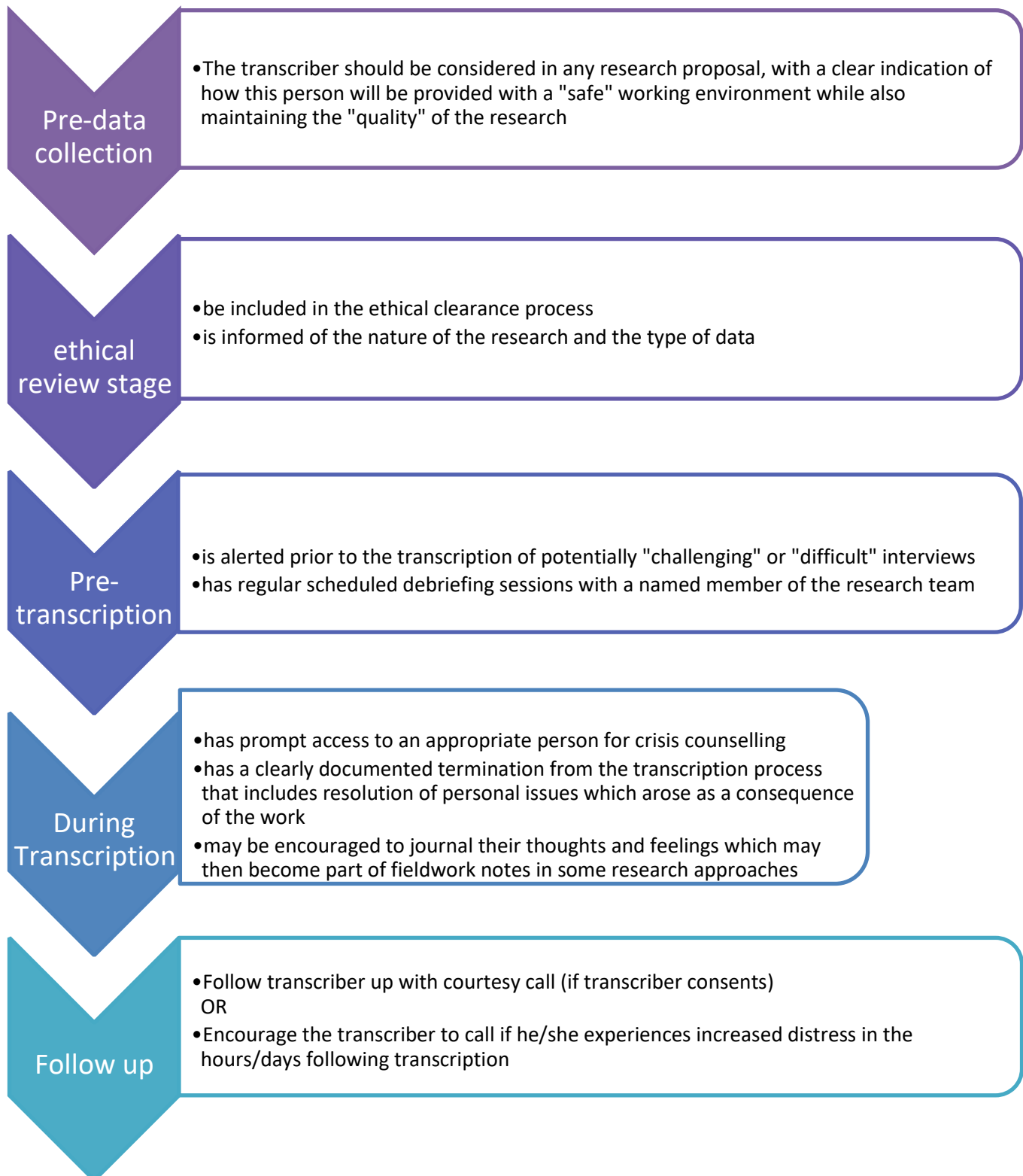
McCosker, H. Barnard, A. Gerber, R. (2001). Undertaking Sensitive Research: Issues and Strategies for Meeting the Safety Needs of All.

Forum: Qualitative Social Research, 2(1)



Distress Protocol 3: The protocol for managing distress in the context of a research focus group /interview transcription

(Gregory, D Russell, C Phillips, L (1997). *Beyond textual perfection: transcribers as vulnerable persons*. *Qualitative Health Research*, 7(2), 294-300.)



Appendix 7 NHS Safeguarding Resources Bundle:

- a) [NHS Safeguarding Adult Pocket Guide](#)
- b) [NHS Safeguarding Accountability and Assurance Framework](#)
- c) [NHS Safeguarding Policy](#)
- d) [Working Together to Safeguard Children 2023](#)

Information and Plan for Development of the Online Social Media Group

Rationale & Background:

Recent research has shown that the use of online social media groups for healthcare research is of benefit when gathering data from hard to reach and those groups considered vulnerable, or when discussing sensitive issues. This approach is still new when used as a research method, but recent studies have used this as an effective tool (Ahmed *et al* 2013, Oliver 2015).

General information:

There are three privacy settings for Facebook groups: open, closed and secret. Anyone on Facebook, existing group member or otherwise, can see the name of a closed group. Non-members can locate the group and view name and current members. Secret groups, in contrast, are completely invisible to non-members -- they do not appear in search, in the news feed or anywhere else on Facebook unless you are currently a part of the group. The posts within both closed and secret groups cannot be viewed unless you are a current member, in contrast to open groups, where posts are visible to all. In the case of secret groups, others will not see any news feed stories at all, unless they are also members of the same group.

References:

Ahmed, OH, Sullivan, SJ, Schneiders, SJ, Anderson, Paton, C and McCrory, PR. (2013). Ethical Considerations in Using Facebook for Health Care Support: A Case Study Using Concussion Management. *PM & R*, 5, 4, pp 328-334. Available at: <http://www.sciencedirect.com/science/article/pii/S1934148213001160>

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Goals and Objectives:

This will act as a ‘virtual’ on-line focus group - the sensitive nature of the issue means that participants can discuss and share negation experiences informally in a safe and confidential environment. This will yield further qualitative data. There may also be the potential to use the Secret Facebook groups as part of the first phase if recruitment proves difficult. This will be considered by the researcher as the research progresses.

Criteria for invitation to join:

All participants who have been interviewed will be invited to take part in the Secret Facebook group, which will act as a “virtual” discussion forum. Other participants who do not want to be interviewed but wish to take part in the research will also be invited to join.

Methodology:

Design, launch, running and monitoring of a time limited (3 - 6 months) Secret Facebook Group, with the researcher as administrator. The design and testing of the group will take place concurrently as the interviews commence. The launch and monitoring of the group will take place following the first 4 interviews, to allow enough participants for a discussion. Participants will be asked to discuss and share their stories on negation. Information shared as part of the group will be transcribed in the form of comments, quotes and discussions.

Safety Considerations:

The British Psychological Society Guidelines will be followed for safe conduct of online research.

The researcher will be responsible for administration and monitoring of the group, including issues around inappropriate posts, confidentiality and safeguarding and other issues which may arise.

Methods:

Purposive sampling: Sample Size 8 - 10.

Online Social Media Group (Virtual Focus Group): Platform will be a Secret Facebook Group.

Problems Anticipated:**Recruitment/Consent:**

There is a multi-faceted approach to recruitment of participants due to the uncertainty around prevalence, and the inherently sensitive and emotional nature of the research. When recruiting participants from hard-to-reach groups, it is important to consider an extended timeframe for recruitment, familiarity and knowledge of the recruitment environment and organisations, and a partnership working approach (Baird and Mitchell 2013, Bonevski *et al* 2014). These have all been taken into consideration in the development of a recruitment strategy.

In terms of recruitment and gaining consent this study acknowledges where stigma and fear of exposure is an issue then a proposed solution is use of online focus group and interview research (Bonevski *et al* 2014).

Ethics:

NHS Ethics through IRAS, Project Number: 228101

Consent:

Formal consent gained following the LJMU template.

Consent will also be confirmed on entry to the Secret Facebook Group.

Additional Information from updated LJMU PIS (June 2018) with regards to GDPR

Information to be read verbally to Participants for study: Negation in the Childbearing Continuum: A Qualitative Study (IRAS ID: 228101)

Information will be added to the consent form at the time of consenting.

14. Data Protection Notice

The data controller for this study will be Liverpool John Moores University (LJMU). The LJMU Data Protection Office provides oversight of LJMU activities involving the processing of personal data, and can be contacted at secretariat@ljmu.ac.uk. This means that we are responsible for looking after your information and using it properly. LJMU's Data Protection Officer can also be contacted at secretariat@ljmu.ac.uk.

The University will process your personal data for the purpose of research. Research is a task that we perform in the public interest.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained.

You can find out more about how we use your information by contacting secretariat@ljmu.ac.uk.

If you are concerned about how your personal data is being processed, please contact LJMU in the first instance at secretariat@ljmu.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: <https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/>

Interview Plan

Settling in:

Informal welcome and introductions if needed.

Participant and interviewer to make themselves comfortable.

Interviewer to make the necessary preparations for the interview to commence.

Informed consent for Interview discussed and obtained using the consent form.

General questions will be asked to help the participant relax - for example, asking them about their journey or their job.

Introduction script:

If we start by just confirming the purpose of the interview, which is that it will form part of my PhD study on Women's experiences of hiding or not knowing about the pregnancy, birth and the period following this (to be adapted as needed according to individual circumstances). The interview today is about you sharing your story and experiences of the situation that you have been through. The interview will be tape recorded, and I may make additional written notes during the course of the interview.

Socio-demographic characteristics:

- Participant Name
- Participant Address
- Participant DOB
- Participant Occupation
- Number of Children
- Participant Pregnancy Gestation and/or Weeks delivered and/or age of infant (as appropriate)

Discussion Guide Precis (SQUIN Method):

The interview will start with me asking you one question inviting you to talk about your experience. Once this question has been asked my intention is to listen to and record your

story as you describe it to me. Once you start to talk, I will not intervene or ask questions of you (unless this is needed to prompt further conversation or asked for by you). This is intended to be a flexible interview, in which you can tell your story in your own words, and describe your experiences, thoughts and feelings.

The Single Question Interview (SQUIN Method)

“Tell me about your experiences, thoughts and feelings of hiding/not knowing about your pregnancy/labour/birth”

(adapt according to individual)

Follow-up Questions and Probes (if needed):

You said... when/why/who was that?

Can you tell me more about...?

In what way...?

Clarifying Questions:

So do you mean...?

Is it correct to say that....?

Interview Conclusion:

Thank you for taking part in the interview for my research project.

Next Steps:

The recording of the interview will be transcribed, and along with my notes, a transcription of the interview will be produced. A copy of this transcription will be sent to you for verification and comment.

The second part of my PhD research is to gather further data using an online social media platform - a Secret Facebook Group, which you are invited to join. The purpose of this group is to encourage women to discuss their experiences together, using a virtual online environment. I will send details and instructions' on joining this group later.

Informed consent for Online Social Media Group discussed and obtained using the consent form.

Do you have any further questions to ask me about this interview, or the research process?

The researcher will make sure any data collected (on paper or in recordings) is stored safely for transport. Equipment used will be packed away.

Narrative Reflection on Interview 1

Narrative notes were taken by the researcher, to reflect on the experience of conducting and being a part of Interview 1, immediately following and one week after the interview was conducted.

These notes are visually presented and represented in the following diagram:



The picture represents the researcher “looking into” the narrators’ story beginning, as told by the narrator. It feels like a long, dimly lit corridor, with patches of light along the way, as the journey commences through the story, with a light shining through to the “end” of the story.

The clouds represent the thoughts and experience of the researcher throughout and post interview.

Meaning revealed by narrator NOT revealed meaning by researcher.

Narrative Reflection on Interview 2

Narrative notes were taken by the researcher, to reflect on the experience of conducting and being a part of Interview 2, immediately following and one week after the interview was conducted.

These notes are visually presented and represented in the following diagram:



The picture represents the concept of cocooning - or creating a cocoon. The creator of the cocoon is the Narrator, the researcher looks on and observes as the cocoon is created. The Narrator, through the interview and storytelling, seeks to create, through a purposeful manner, a safe, warm and cosy environment, mitigating the unreality, coldness and trauma of the negated experience. The cocoon is making a luxurious material - silk - bringing something lovely and tactile to a difficult and traumatic experience, held with lingering guilt. A different part of the story emerges as the Narrator breaks out of the cocoon she has created, and through making a family, builds on the day-to-day reality of the new life.

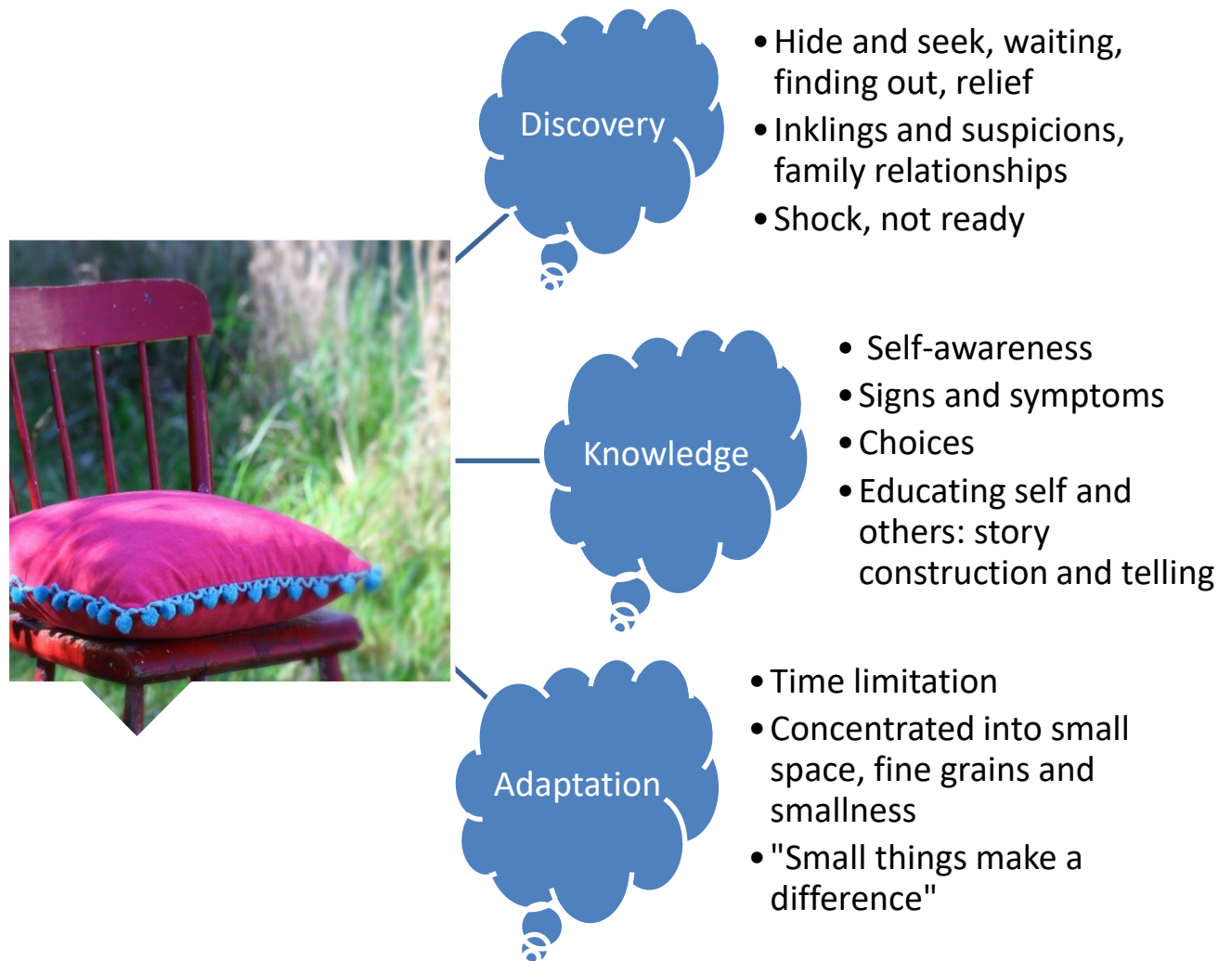
The clouds represent the thoughts and experience of the researcher throughout and post interview.

Meaning revealed by narrator NOT revealed meaning by researcher.

Narrative Reflection on Interview 3

Narrative notes were taken by the researcher, to reflect on the experience of conducting and being a part of Interview 3, immediately following and one week after the interview was conducted.

These notes are visually presented and represented in the following diagram:



The picture represents the ordinary in the chair - providing support, but with embellished comfort provided by the elaborate cushion. There is some unconscious recognition of the hard nature of the seat, but the soft barrier covers and hides this. A stable and solid support is within reach, waiting to be discovered through the uncovering of the surface beneath.

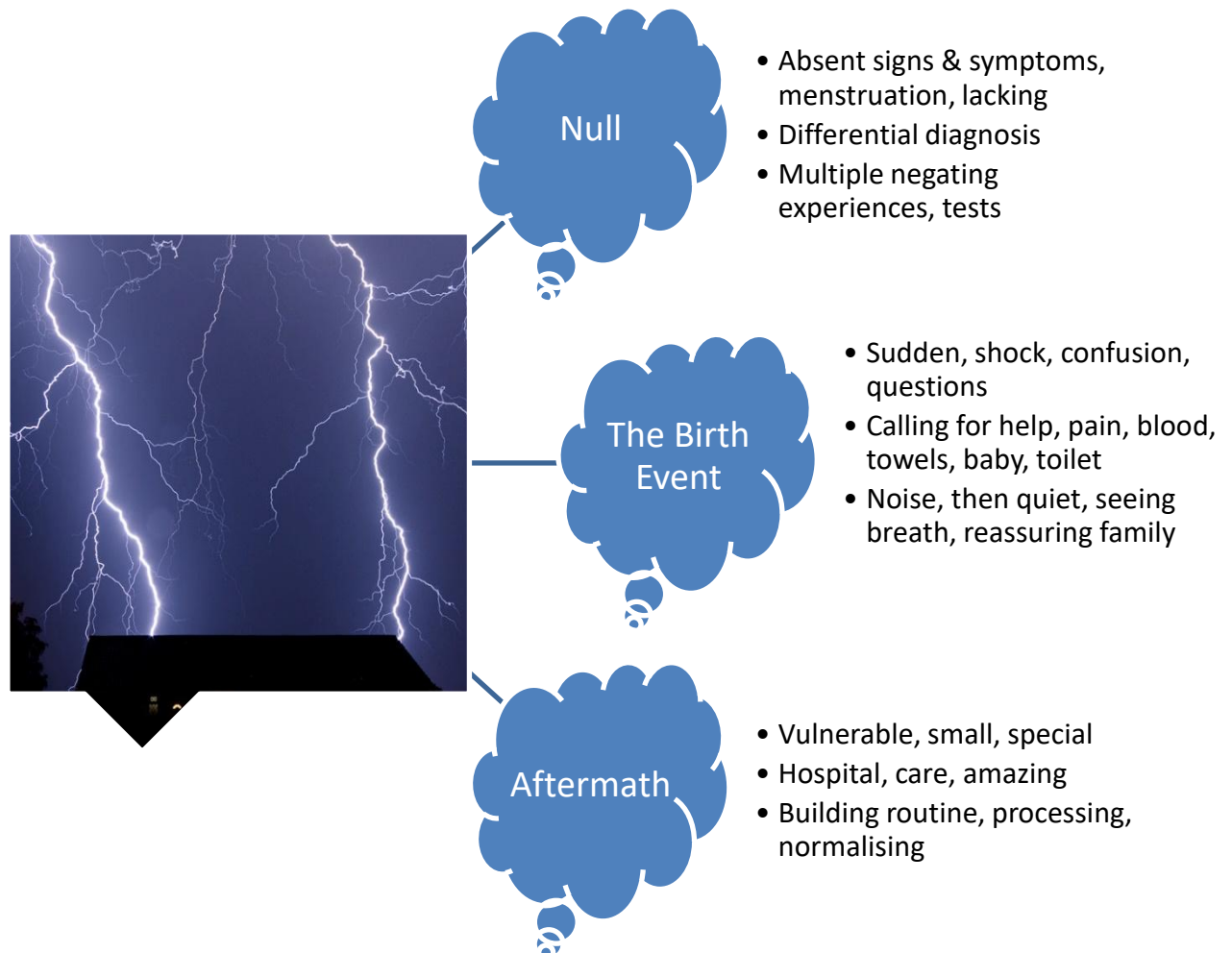
The clouds represent the thoughts and experience of the researcher throughout and post interview.

Meaning revealed by narrator NOT revealed meaning by researcher.

Narrative Reflection on Interview 4

Narrative notes were taken by the researcher, to reflect on the experience of conducting and being a part of Interview 1, immediately following and one week after the interview was conducted.

These notes are visually presented and represented in the following diagram:



The picture represents the suddenness of the experience - and the shock, two lightning bolts one for the physical shock of the precipitate birth process, the other for the emotional shock of suddenly giving birth being unaware of the pregnancy or labour pains. The lightning strikes the house, as the sudden experience happens in the home environment. The story is intense, concentrated and very powerful, striking home and changing the storyline of life in an almost instant.

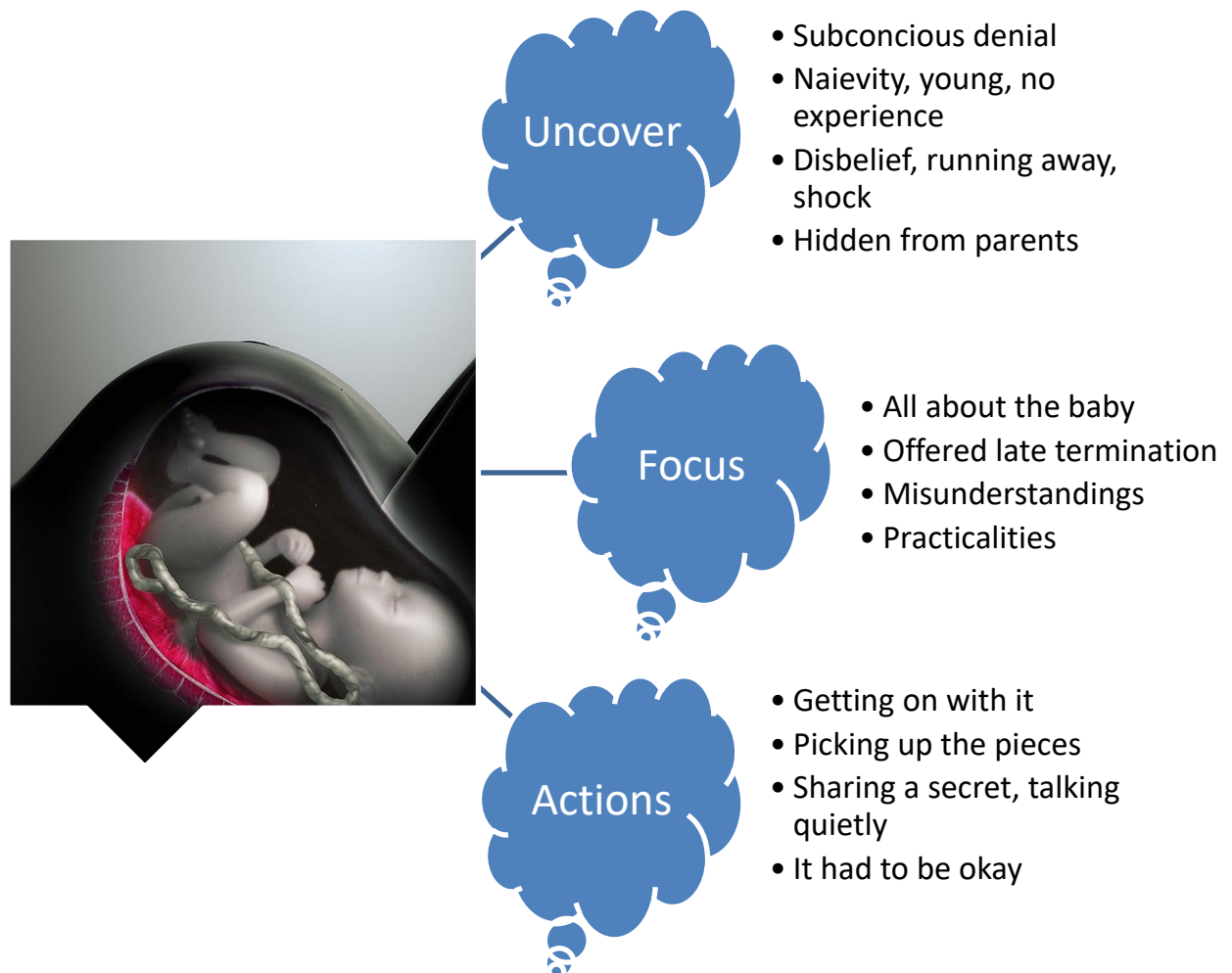
The clouds represent the thoughts and experience of the researcher throughout and post interview.

Meaning revealed by narrator NOT revealed meaning by researcher.

Narrative Reflection on Interview 5

Narrative notes were taken by the researcher, to reflect on the experience of conducting and being a part of Interview 5, immediately following and one week after the interview was conducted.

These notes are visually presented and represented in the following diagram:



The picture represents the complete focus on the fetus throughout the story - as described by the woman, she felt there was no care or attention about how she felt being in the situation. There was no confidentiality, she felt stupid and very young, due to a lack of awareness and knowledge about choices and options. The view of others was that it was all straightforward, and the journey for her was laid out and clearly signposted without her input.

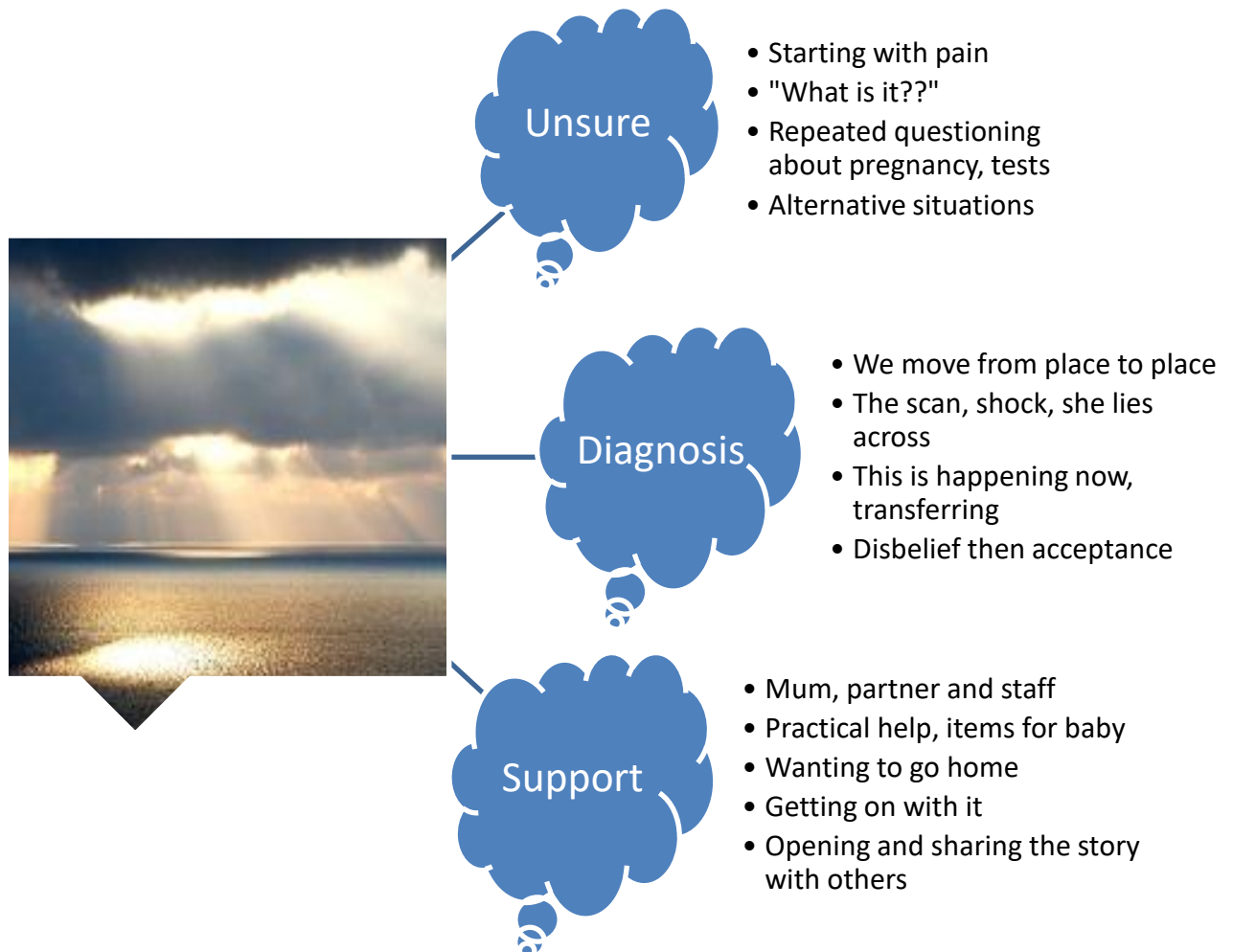
The clouds represent the thoughts and experience of the researcher throughout and post interview.

Meaning revealed by narrator NOT revealed meaning by researcher.

Narrative Reflection on Interview 6

Narrative notes were taken by the researcher, to reflect on the experience of conducting and being a part of Interview 6, immediately following and one week after the interview was conducted.

These notes are visually presented and represented in the following diagram:

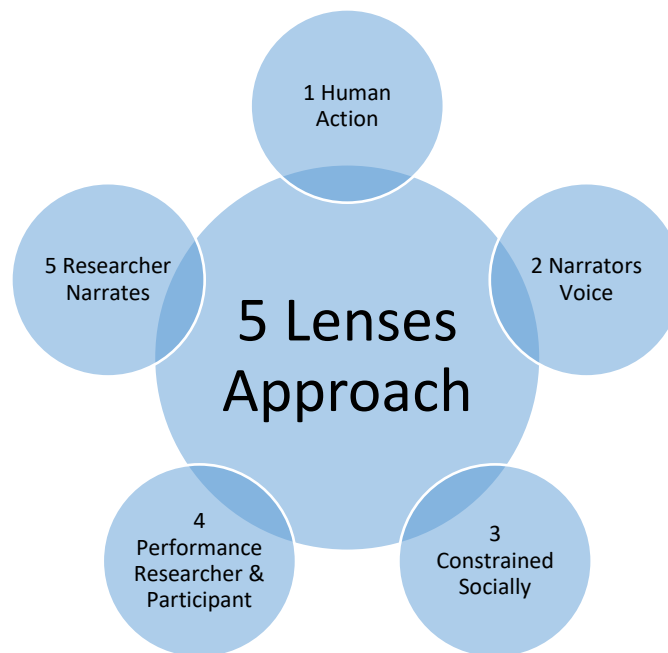


The picture represents the holistic story and story telling of the narrator - the intensity of the pain and the unknown labour experience, breaking through the clouds when the pregnancy and labour is identified, through to the realisation and shock of the birth. The light of the birth of the baby shines through the pain, surprise and shock of the diagnosis - onto a calm and accepting family story.

The clouds represent the thoughts and experience of the researcher throughout and post interview.

Meaning revealed by narrator NOT revealed meaning by researcher.

Chase's 5 Lenses Approach (Chase 2005)



1. **Human Action:** This refers to the consideration of the unique experience of the researcher (JR) in their ethical journey in relation to the study. The reflection of the action and inaction of the ethical process is summarised.

2. **Narrators Voice:** The narrator in this example is the researcher (JR), who challenges the structure, processes and framework of the standardised ethical process. The challenges are multiple and relate to use of narrative methods and methodology, the inherently sensitive subject matter, proposed methods for data collection and analysis. The conventional norms are not considered to be a useful approach for the overall epistemological direction of narratives. It relates to the researchers (JR) projection and performance of self as own voice within the ethical process, and a reflection of the importance attached to the voice.

3. **Constrained Socially:** The ethical process is inherently constraining, due to the guidelines and considerations of the HRA as the overarching organisation. The researcher (JR) considers the impact and influence of both internal and external factors to the action and inaction (reduction) of the ethics process. The reductionist approach is seen as the locus of control of the ethics process which has the potential to impact the narrative study paradigm of a more holistic view. This approach also does not align with Constructivist Paradigm of the study.

4. **Performance researcher and participant:** The “participant” is the researcher (JR), and the “researcher” is the ethics process. There is an acknowledgement of overt influences such as environment, social, political, historical and other contexts which influence the ethics process. The researcher (JR) has identified that there are covert influences and contexts linked to the ethical process but in particular: assessment of the study within the designated ethics committee, the meeting at which the research was

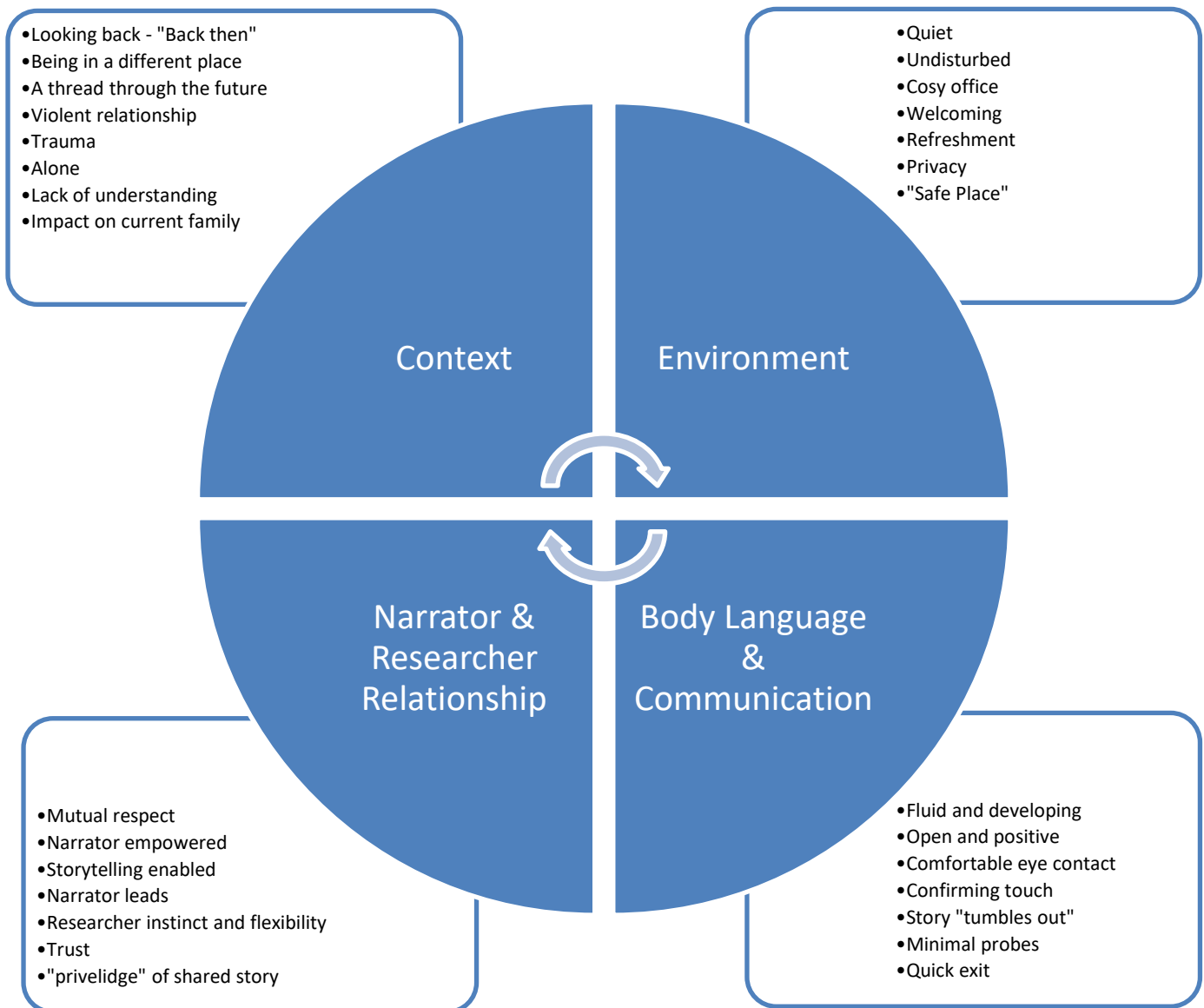
discussed, the formal decision and language of the ethics committee, and the follow up procedures regarding ethical approval.

5. Researcher narrates: The researcher (JR) is integral to this story of going through the ethics process. This ethical process narrative forms part of the overall ethical narrative and this then forms part of the overall study narrative - a demonstration of the Matroyshka effect.

Appendix 13a

Situational Lens Diagram: Interview 1

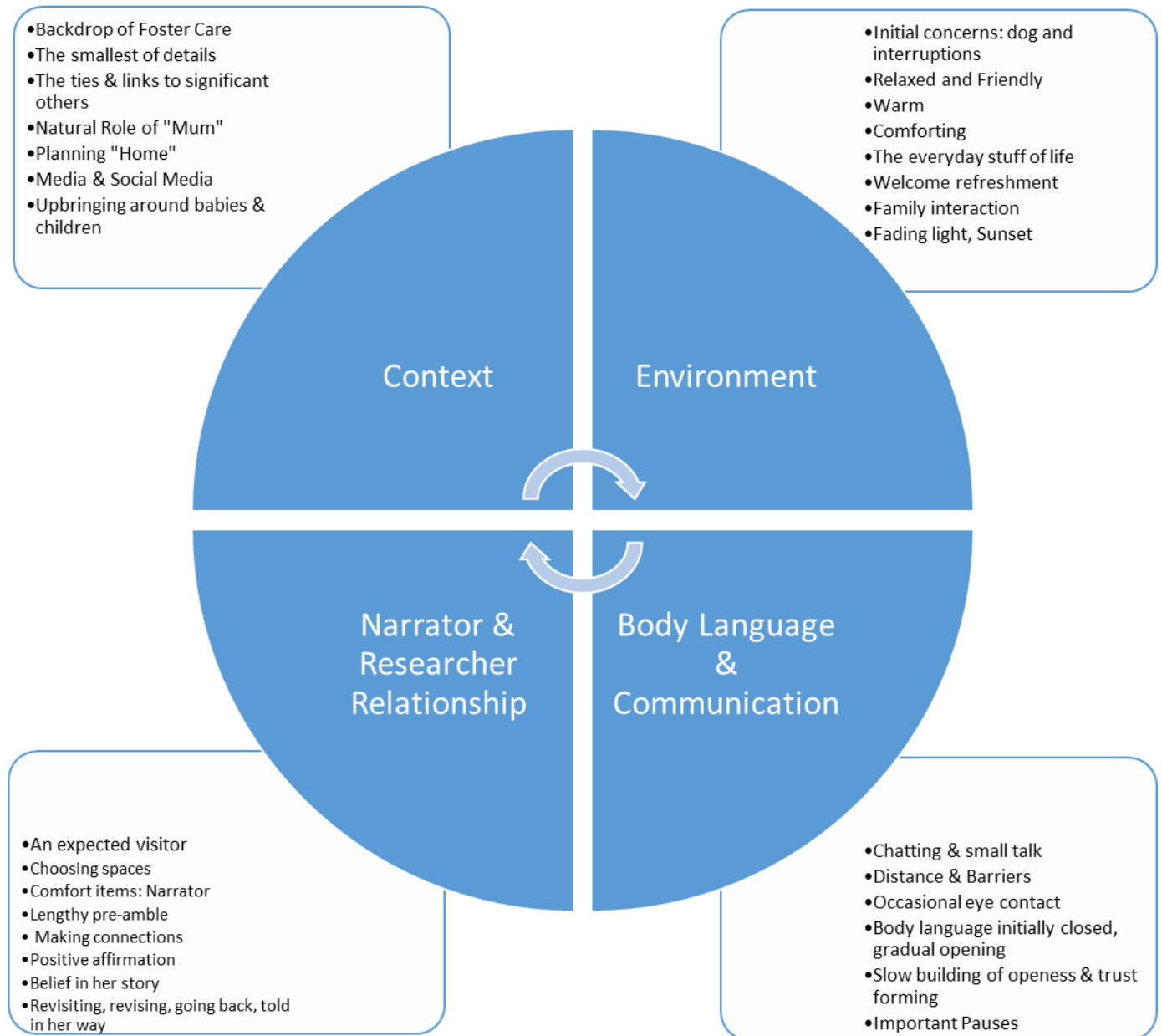
(31/10/18) Jane Rooney



Appendix 13b

Situational Lens Diagram: Interview 2

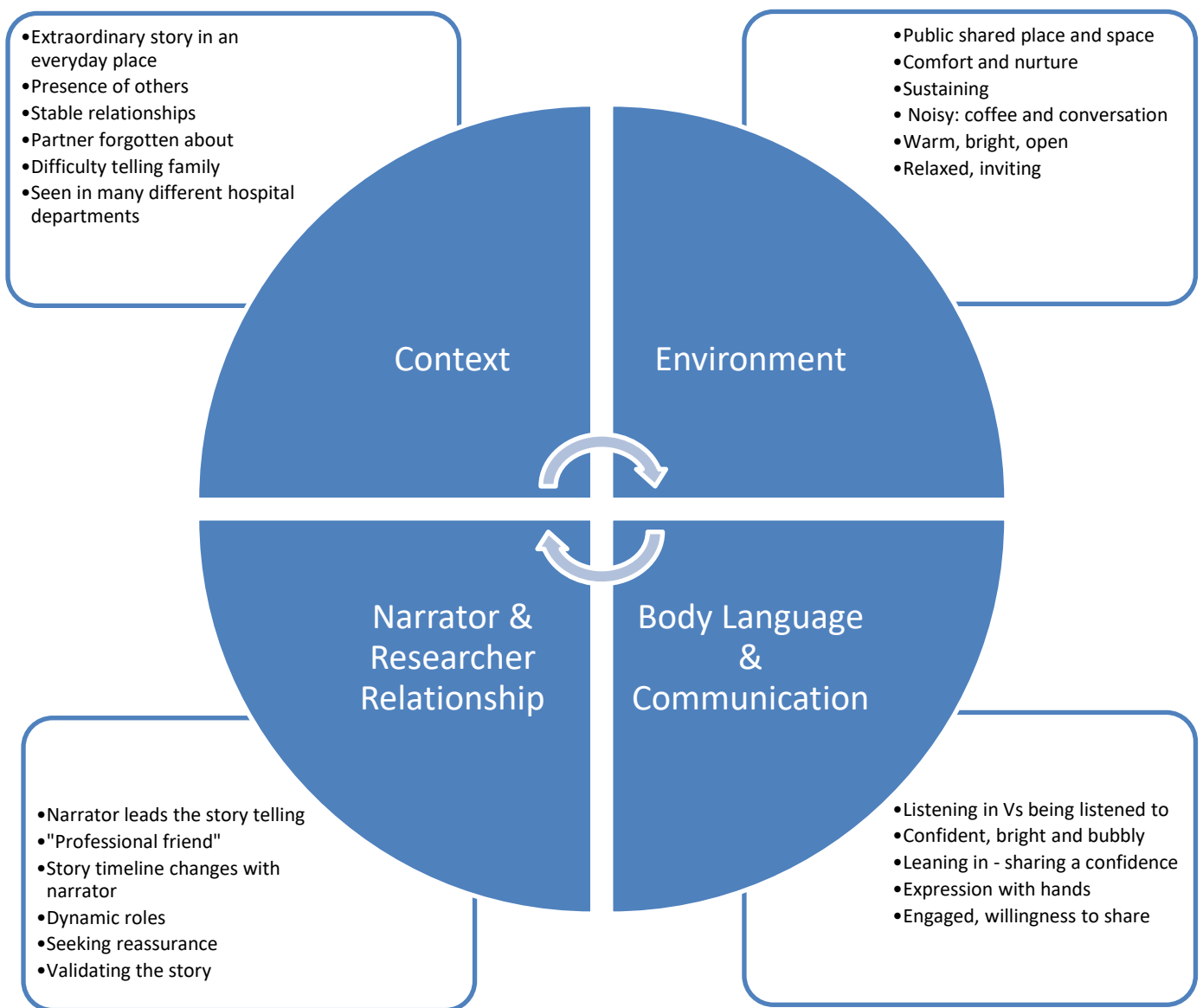
(30/11/18) Jane Rooney



Appendix 13c

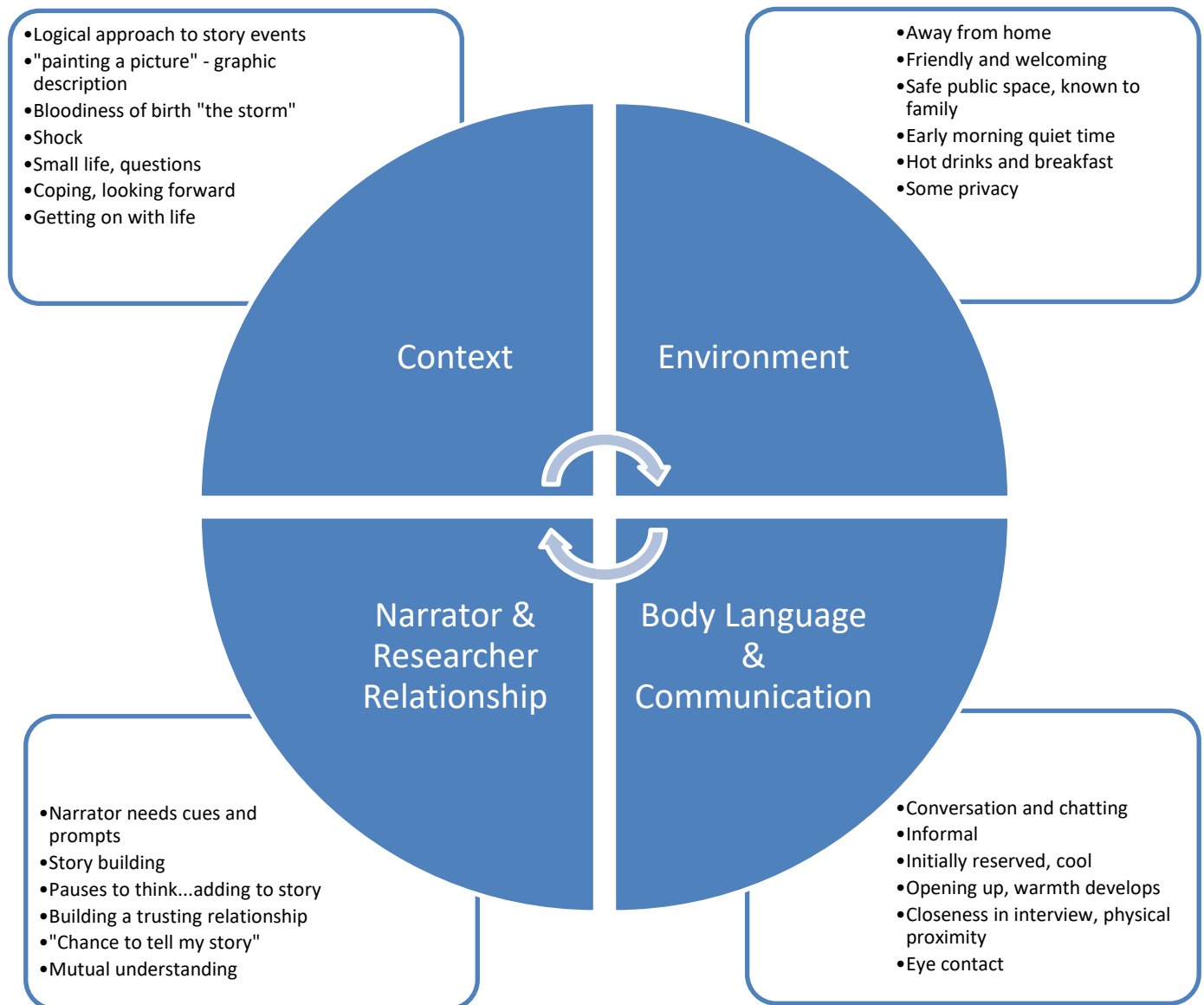
Situational Lens Diagram: Interview 3

(30/04/19) Jane Rooney



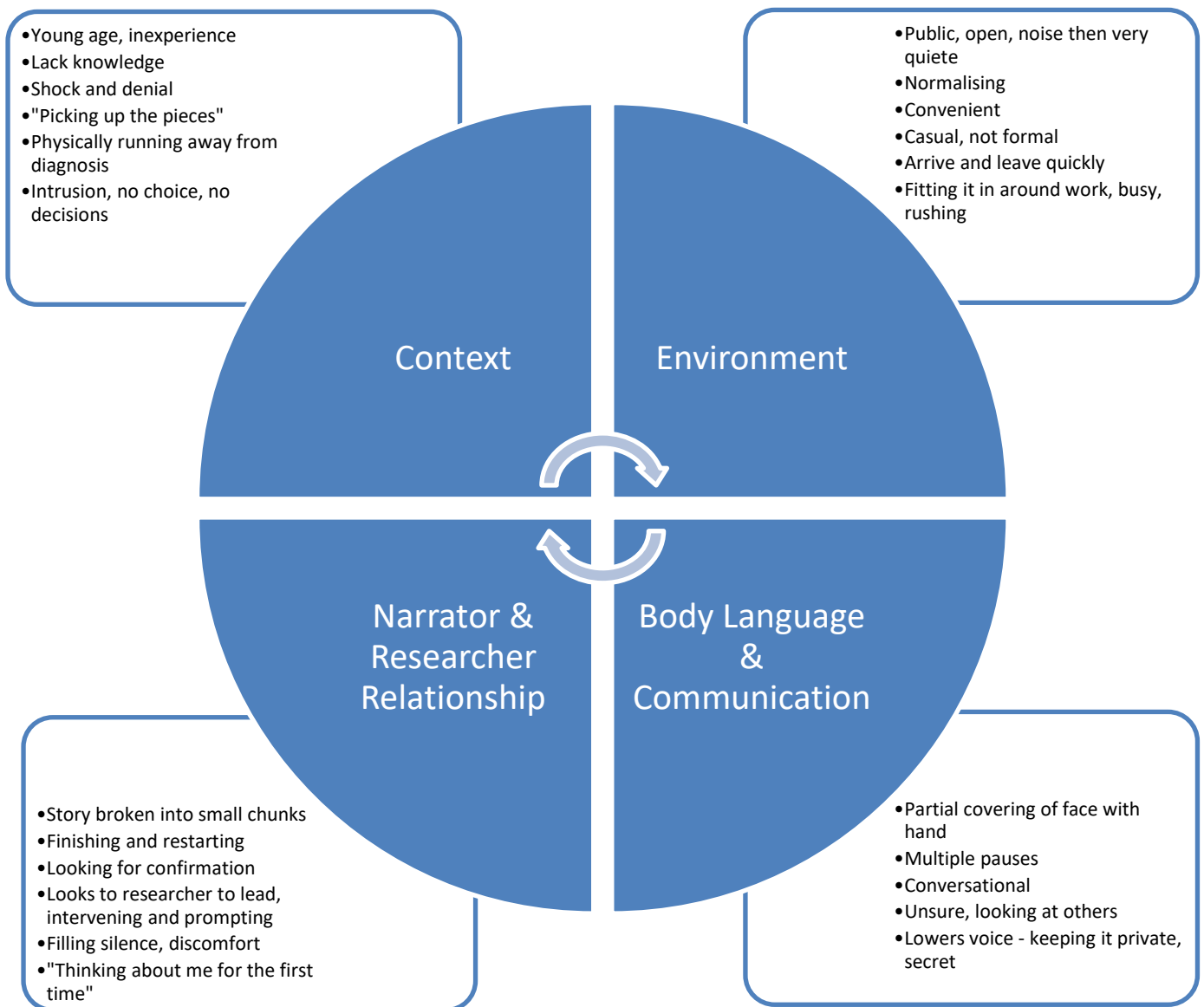
Situational Lens Diagram: Interview 4

(30/04/19) Jane Rooney



Situational Lens Diagram: Interview 5

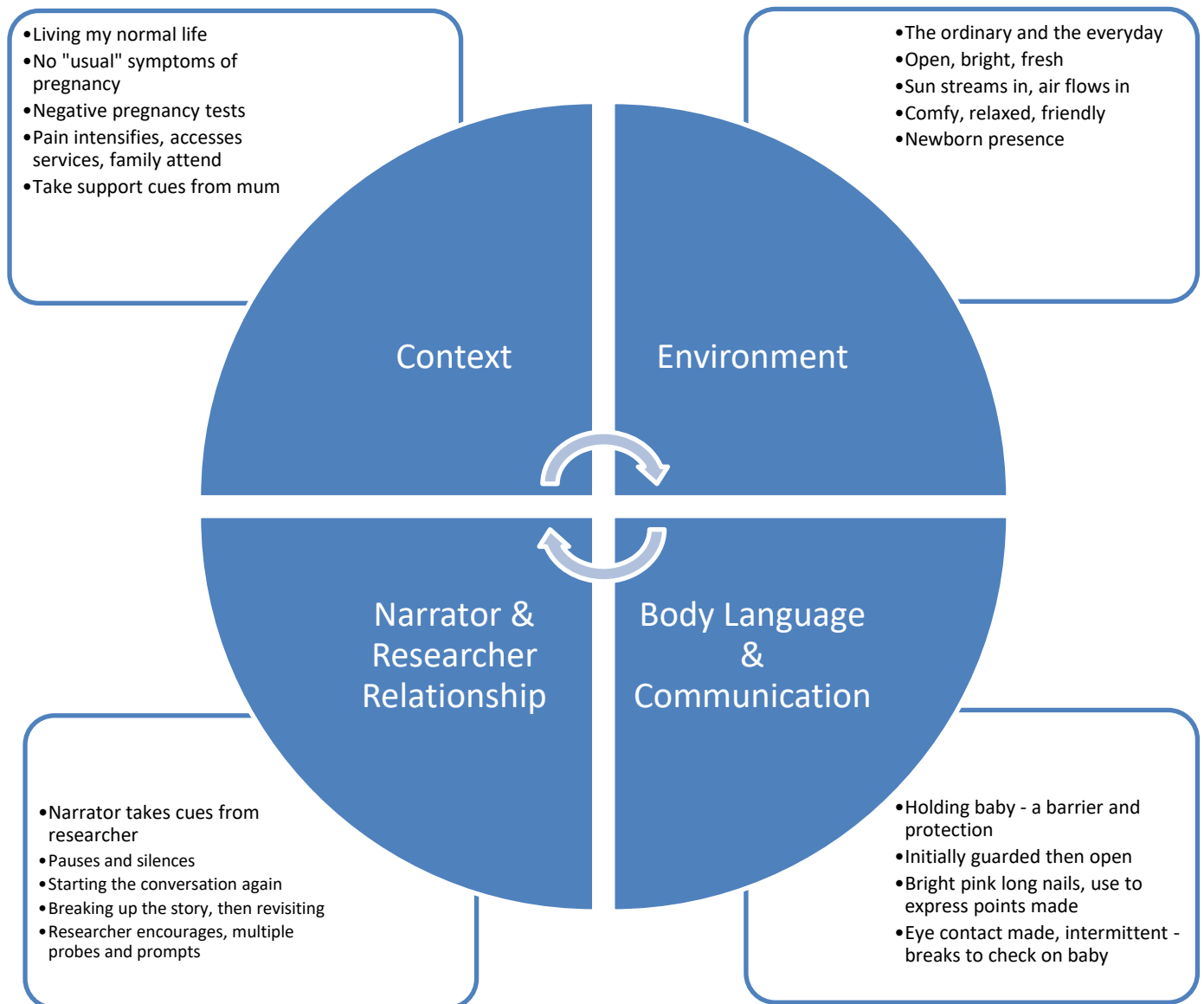
(08/05/19) Jane Rooney



Appendix 13f

Situational Lens Diagram: Interview 6

(13/05/19) Jane Rooney



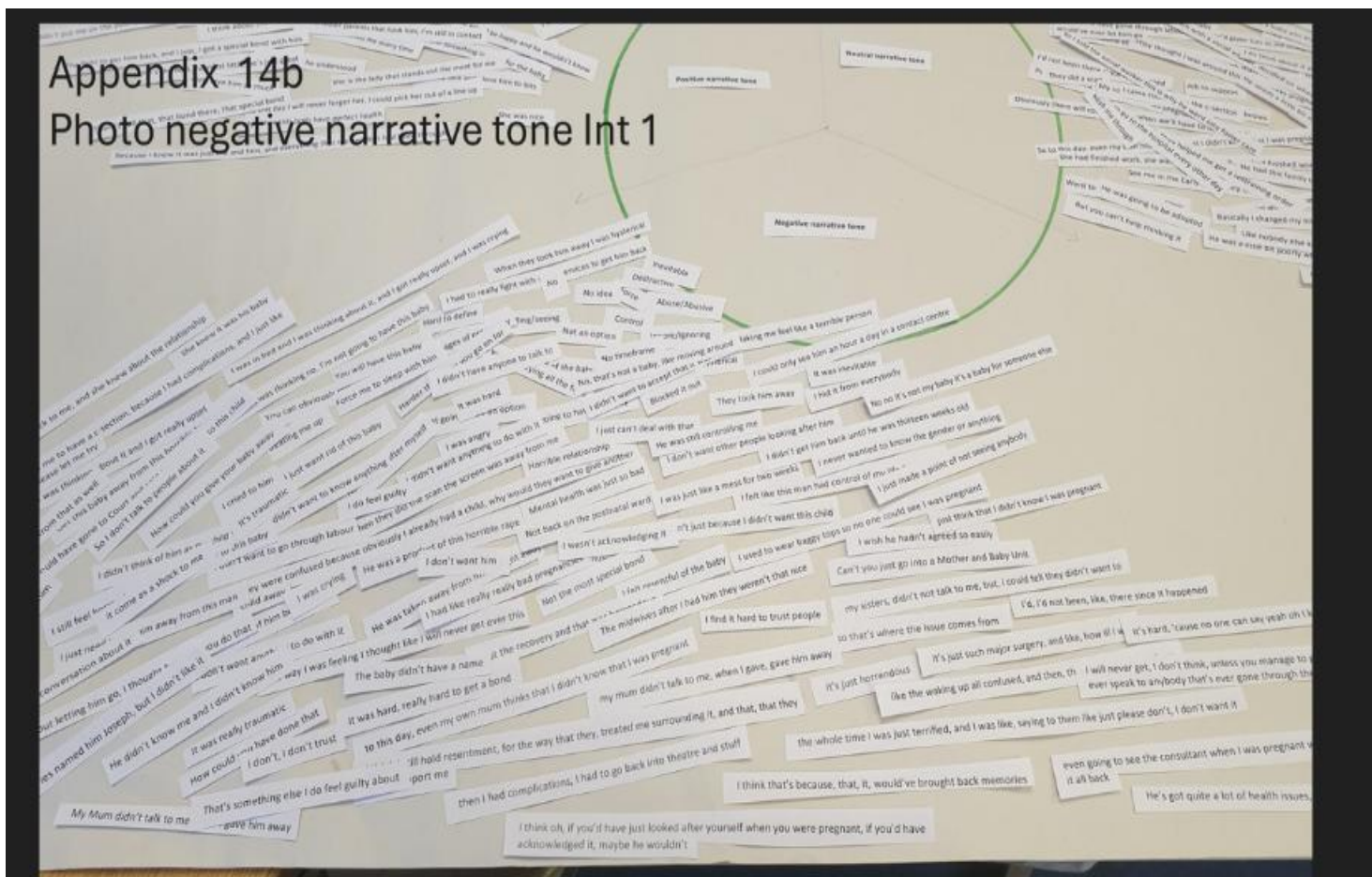
Appendix 14a

Photo construction of narrative tone Int 1

Interview 1 Data Analysis Step 2 Identification of Tone, Imagery and Themes
Using Step 1 of Cressey's (2008) in step analysis model
Identify important concepts to look for (positivity, tone, imagery and themes)
Think about construction of a timeline point? Using the essential elements of narrative tone to tell the story
Narrative Tone



Photo negative narrative tone Int 1



Appendix 14c

Photo neutral narrative tone Int 1

Even like his Doctors and Paediatricians...
The foster couple that took him, they were an...
I wish that there would have been something, just that one person could've said, this is what we can...
I've thought about it so much since I've been in...
The baby didn't have a name, he was born near Christmas, so the midwives named him Joseph...
I still speak to a counsellor now about it...
I wasn't w...
The baby was...
I think if I'd have...
away, I don't think I would've...
I've probably... even told said to the counsellor, like everything that I've said to you...
It's a different bond with...
I think it's because, my partner now has brought him up, as his own, and he calls him Daddy, even...
time he thinks that Darren is his dad...
There's going to have to be some sort of involvem...
Being in the hospital and having him and everything, and having Darren with me, I...
different experience...
It just feels like it's somebody, it feels like it's...
It's just really hard to explain...
I think if I'd have gone through labor...
would've ever let him go...
So I told the social worker...
I'd not been there...
Pe... they did a scan...
Obviously there will co...
I don't me through...
Went to... He was going to be adopted...
But you can't help thinking it...
See me in the Early...
She had finished work, she wa...
So to this day, even my...
They helped me get a...
at I didn't...
He had this family they had...
He was a...
Like nobody else knows...
He was a...
He's not allowed to contact me or Jack...
If there should have been some cross communication with them, it could have made it easier...
I wish he'd have talked me out of the caesarean...
The foster couple that took him, they were an elderly couple...
I've thought about it so much since I've been in contact with you...
I called him Jack after them...
I'm...
Maybe I wouldn't have let him go in the beginning...
That midwife I wonder if she thinks about me...
If there was some sort of intervention now...
Being asleep and coming round, and being confused...
I have never told anybody that...
Years after I still go for coun...
Basically I changed my mind...
He was a...
Like nobody else knows...
He was a...
He's not allowed to contact me or Jack...
If there should have been some cross communication with them, it could have made it easier...
I wish he'd have talked me out of the caesarean...
The foster couple that took him, they were an elderly couple...
I've thought about it so much since I've been in contact with you...
I called him Jack after them...
I'm...
Maybe I wouldn't have let him go in the beginning...
That midwife I wonder if she thinks about me...
If there was some sort of intervention now...
Being asleep and coming round, and being confused...
I have never told anybody that...
Years after I still go for coun...
Basically I changed my mind...
He was a...
Like nobody else knows...
He was a...
He's not allowed to contact me or Jack...
If there should have been some cross communication with them, it could have made it easier...

Appendix 14d

Photo positive narrative tone Int 1

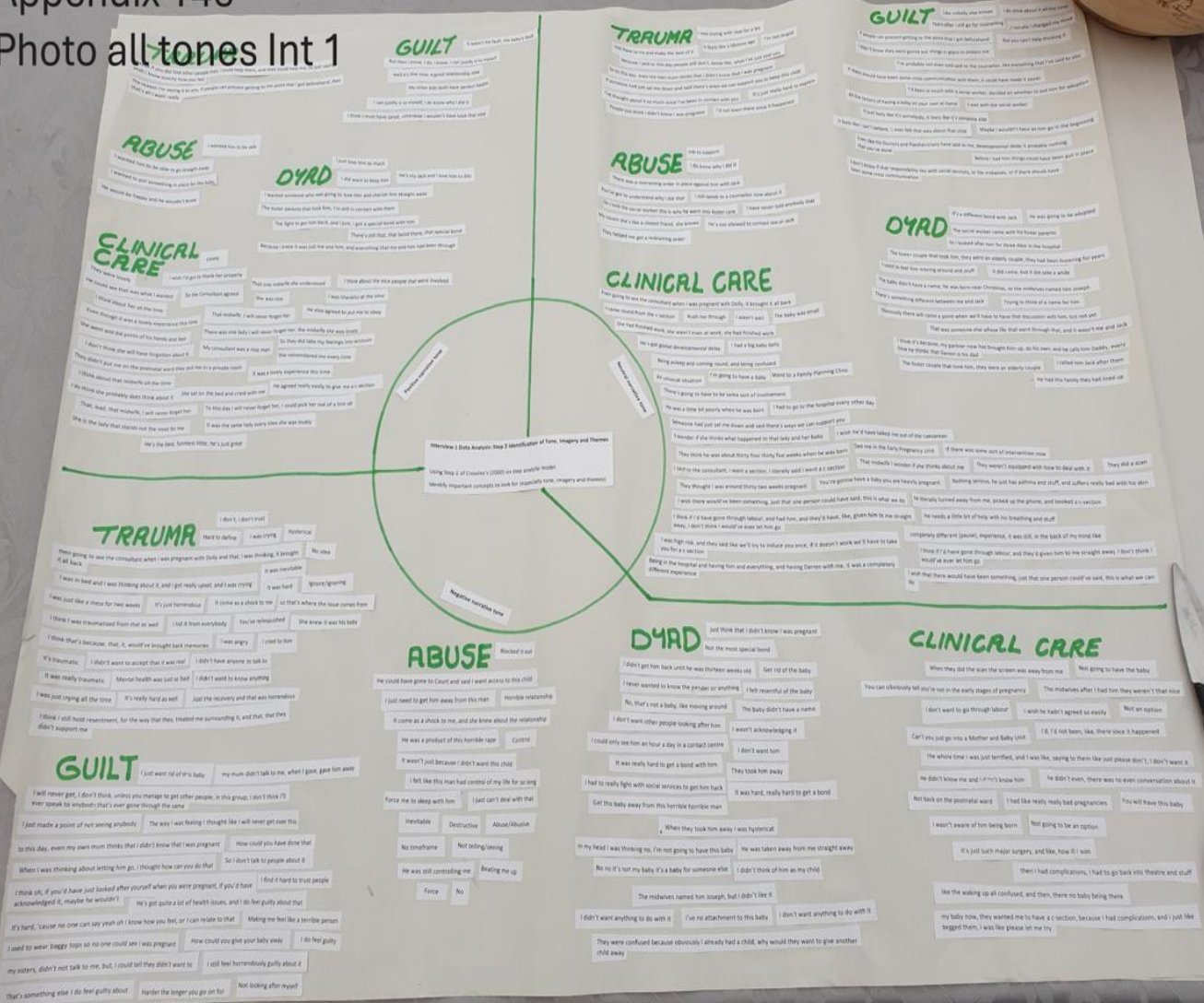
Using Step 2 of Crossley's (2000) six step analytic model:
Identify important concepts to look for (especially tone, imagery and theme)
Think about construction of a timeline poem? Using the essential elements
the story

Narrative Tone:

Maybe if you did find other people that, I could help them, and they could help me, by just saying.
yeah I know exactly how you feel
that's all I want really
I do think she probably does think about it
well it's fine now, a good relationship now
I think about her all the time
Lovely
So the Consultant agreed
It was a lovely experience this time
I know, I do, I know, I can justify it to myself
The lady I will never forget her
She went and did prints of his hands and feet
He could see that was what I wanted
I can justify it to myself
The foster parents that took him, I'm still in contact with them
at midwife all the time
I can justify it to myself
He also agreed
I wanted
Even though it was a lovely experience this time
That, lead, that midwife, I will never forget her
He also agreed
I wanted him to be safe
So they did take my feelings into account
I wish I'd got to thank her properly
I was thankful at the time
I wanted him to be safe
She sat on the hard bed in a private room
I think she will have forgotten about it
I think I must have cared, otherwise I wouldn't have taken that step
I think about the foster parents that took him, I'm still in contact
He would be happy and he wouldn't know
I put me on the postnatal ward they put me in a private room
I think about the foster parents that took him, I'm still in contact
He would be happy and he wouldn't know
The fight to get him back, and I just, I got a special bond with him
He's the best, funniest little, he's just great
he understood
She is the lady that stands out the most for me
for the baby
just love him so much
There's still that, that bond there, that special bond
this day I will never forget her, I could pick her out of a line up
My other kids both have perfect health
Because I knew it was just me and him, and everything that me and him had been through
She was nice

Positive narrative tone

Photo all tones Int 1



Appendix 15

Crossley's Holistic Form Focussed Story-Map Grid

Taken from: Bright and Du Preez (2023)

Working research topic			
Which philosophies are reflected in the narratives of school counsellors who use strength-based counselling approaches as part of their professional practice?			
Themes from literature (Clandinin, 2007, Clandinin and Connelly, 2000, Crossley, 2000)			
Narrative essence (heart)	Narrative voice (identity)	Narrative style (genre)	Narrative significance (message)
What is the story about? What are the narrator's assumptions?	Who is telling the story?	What kind of story is this?	What can we learn from this story?
Themes recognised in transcripts			
Practice stories Relationships Counselling outcomes Adolescent narratives Occupation narratives Deficit narratives	Archetypal image Tone (conveys emotion) Metaphors Personal ideology	Key events during counselling: Past experience Present realities Future hopes Plot structure Archetypal story/genre	Core message

Appendix 16

Overview of data taken from the Secret Facebook Group

Quantitative data relating to SFG

Secret Facebook Group: Data	Number
Total Number of Text Posts: Participants	74
Total Number of Text Posts: Researcher	7
Total Number of Text Posts Combined	81
Posts other than Text: Photographs	4
Posts other than Text: Video	1
Posts other than Text: News Story Links	2
Total Number of Posts other than Text	7
Total Number of Posts Text & Other Combined	88

Facebook Emojis and Reactions used as part of the Secret Facebook Group

<https://emojipedia.org/facebook/>

05/09/19

Facebook emojis appear for users of the Facebook website, Messenger for web, and Messenger for Android. Facebook apps for iOS and Android use native emojis for their respective platform instead of Facebook's own emoji images.

Facebook Emojis

Emojis from Facebook 3.1 in order of use.



Anxious Face With Sweat

Unicode name: Face with open mouth and cold sweat

Category: Smileys and People

A face with open eyes and a small, open frown. Its eyebrows are furrowed, with a single bead of cold sweat dripping down, and its forehead is pale blue, as if experiencing a cold flash. Samsung's design shows upper teeth and tongue.

Meaning widely varies, but commonly conveys such feelings as sadness, disappointment, fear, and anxiety. Similar to Sad but Relieved Face, but with a blue head and larger frown.

Anxious Face With Sweat was approved as part of Unicode 6.0 in 2010 under the name “Face With Open Mouth and Cold Sweat” and added to Emoji 1.0 in 2015.



Two hearts

Unicode name: Two Hearts

Category: Smileys and People

Two pink love hearts. One larger than the other. Can be used to display that “love is in the air”.

Two Hearts was approved as part of Unicode 6.0 in 2010 and added to Emoji 1.0 in 2015.

Grimacing Face

Unicode name: Grimacing Face

Category: Smileys and People

A yellow face with simple open eyes showing clenched teeth. May represent a range of negative or tense emotions, especially nervousness, embarrassment, or awkwardness (e.g., Eek!).

Grimacing Face was approved as part of Unicode 6.1 in 2012 and added to Emoji 1.0 in 2015.

See-No-Evil Monkey

Unicode name: See No Evil Monkey

Category: Animals and Nature

The see no evil monkey, called Mizaru (Japanese for “see not”), one of the Three Wise Monkeys. Depicted as the brown Monkey Face with tan or pinkish hands covering its eyes.

The Three Wise Monkeys represent the proverb see no evil, hear no evil, speak no evil, frequently interpreted as a call to discretion or figure for willful ignorance.

Often used as a playful way to convey a laughing, disbelieving, or cringing I can’t believe what I’m seeing! or I can’t bear to look!

Rolling on the Floor Laughing

Unicode Name: Rolling on the Floor Laughing Face

Category: Smileys and People

A yellow face with a big grin and scrunched, X-shaped eyes, tilted on its side as if rolling on the floor laughing (the internet acronym ROFL). Sheds two tears and tilts right on most platforms. Often conveys hysterical laughter more intense than a Face With Tears of Joy.

Rolling on the Floor Laughing was approved as part of Unicode 9.0 in 2016 and added to Emoji 3.0 in 2016.

Pile of Poo

Unicode Name: Pile of Poo

Category: Smileys and People

A swirl of brown poop, shaped like soft-serve ice cream with large, excited eyes and a big, friendly smile.

May be used to represent faeces and other bathroom topics as well as stand in for their many related slang terms. It also enjoys a wide range of idiosyncratic applications, such as conveying a sense of whimsy or silliness, given its fun, happy expression.

Pile of Poo was approved as part of Unicode 6.0 in 2010 and added to Emoji 1.0 in 2015.

Face with Tears of Joy

Unicode Name: Face with Tears of Joy

Category: Smileys and People

A yellow face with a big grin, uplifted eyebrows, and smiling eyes, each shedding a tear from laughing so hard. Widely used to show something is funny or pleasing.

One of the ten most popular emojis between 2014-2018 and was named the Oxford Dictionaries 2015 Word of the Year.

Face With Tears of Joy was approved as part of Unicode 6.0 in 2010 and added to Emoji 1.0 in 2015.

Grinning Face With Sweat

Unicode Name: Grinning Face With Sweat

Category: Smileys and People

Has the same grin and eyes as Grinning Face With Smiling Eyes but with a single, blue bead of sweat, usually over its left eye. Intended to depict nerves or discomfort but commonly used to express a close call, as if saying Whew! and wiping sweat from the forehead.

Grinning Face With Sweat was approved as part of Unicode 6.0 in 2010 under the name “Smiling Face With Open Mouth and Cold Sweat” and added to Emoji 1.0 in 2015.

Blue Heart

Unicode Name: Blue Heart

Category: Symbols

A blue heart emoji.

Blue Heart was approved as part of Unicode 6.0 in 2010 and added to Emoji 1.0 in 2015.

Flushed Face

Unicode Name: Flushed Face

Category: Smileys and People

A yellow face with raised eyebrows, a small, closed mouth, wide, white eyes staring straight ahead, and blushing cheeks. Intended to depict such feelings as embarrassment, but meaning very widely varies. Other senses include flattery, surprise, disbelief, admiration, affection, and excitement.

Flushed Face was approved as part of Unicode 6.0 in 2010 and added to Emoji 1.0 in 2015.

Face with Monocle

Unicode Name: Face with Monocle

Category: Smileys and People

A yellow face with furrowed eyebrows wearing a monocle. Usually depicted with a small, intent frown and head slightly upturned, as if in careful inspection.

May show that someone is pondering, considering, or questioning something, sometimes with a sense of sceptical or ironic observation or encouraging a closer look at some content. May convey a sense of sophistication or smug intelligence, e.g., smarty-pants.

Face With Monocle was approved as part of Unicode 10.0 in 2017 and added to Emoji 5.0 in 2017.



Confounded Face

Unicode Name: Confounded Face

Category: Smileys and People

A yellow face with scrunched, X-shaped eyes and a crumpled mouth, as if quivering in frustration or holding back tears. May be used to represent being overcome with various emotions, including irritation, frustration, disgust, and sadness, as if to the point of defeat.

Confounded Face was approved as part of Unicode 6.0 in 2010 and added to Emoji 1.0 in 2015.



Neutral Face

Unicode Name: Neutral Face

Category: Smileys and People

A yellow face with simple, open eyes and a flat, closed mouth. Intended to depict a neutral sentiment but often used to convey mild irritation and concern or a deadpan sense of humour.

Neutral Face was approved as part of Unicode 6.0 in 2010 and added to Emoji 1.0 in 2015.



Face With Steam From Nose

Unicode Name: Face With Steam From Nose

Category: Smileys and People

A yellow face with closed eyes, furrowed eyebrows, broad frown, and two puffs of steam blowing out of its nose, as if in a huff or fuming.

May convey various negative emotions, including irritation, anger, and contempt. May also convey feelings of pride, dominance, and empowerment.

Originally named Face With Look of Triumph, and the steam from its nose may derive from a visual shorthand for frustration or disdain in anime and manga.

Face With Steam From Nose was approved as part of Unicode 6.0 in 2010 under the name “Face With Look of Triumph” and added to Emoji 1.0 in 2015.

Smiling Face With Smiling Eyes

Unicode Name: Smiling Face With Smiling Eyes

Category: Smileys and People

A yellow face with smiling eyes and a broad, closed smile turning up to rosy cheeks. Often expresses genuine happiness and warm, positive feelings.

An emoji form of the ^^ emoticon.

Smiling Face With Smiling Eyes was approved as part of Unicode 6.0 in 2010 and added to Emoji 1.0 in 2015.

Woman Facepalming

Unicode Name: Woman Facepalming: Medium-Light Skin Tone

Category: Smileys and People

The Woman Facepalming: Medium-Light Skin Tone emoji is a sequence of the Face Palm, Emoji Modifier Fitzpatrick Type-3 and Female Sign emojis. These are combined using a zero width joiner between each character and display as a single emoji on supported platforms.

Woman Facepalming: Medium-Light Skin Tone was added to Emoji 4.0 in 2016.

Slightly Smiling Face

Unicode Name: Slightly Smiling Face

Category: Smileys and People

A yellow face with simple, open eyes and a thin, closed smile. Conveys a wide range of positive, happy, and friendly sentiments. Its tone can also be patronizing, passive-aggressive, or ironic, as if saying This is fine when it's really not.

Slightly Smiling Face was approved as part of Unicode 7.0 in 2014 and added to Emoji 1.0 in 2015.

Face With Hand Over Mouth

Unicode Name: Face With Hand Over Mouth

Category: Smileys and People

A yellow face with a hand covering its mouth. Apple and Facebook feature simple, open eyes, suggesting someone gasping Oh my! in serious surprise, shock, concern, or apology.

Other platforms depict a face with smiling eyes and/or blushing cheeks, suggesting coy laughter or embarrassment, as if cheekily saying Oops!

Face With Hand Over Mouth was approved as part of Unicode 10.0 in 2017 under the name “Smiling Face With Smiling Eyes and Hand Covering Mouth” and added to Emoji 5.0 in 2017.

Grinning Face With Big Eyes

Unicode Name: Grinning Face With Big Eyes

Category: Smileys and People

A yellow face with smiling eyes and a broad, open smile, showing upper teeth and tongue on some platforms. Often conveys general happiness and good-natured amusement.

Similar to Grinning Face but with taller, more excited eyes.

Grinning Face With Big Eyes was approved as part of Unicode 6.0 in 2010 under the name “Smiling Face With Open Mouth” and added to Emoji 1.0 in 2015.

Face Blowing a Kiss

Unicode Name: Face Throwing a Kiss

Category: Smileys and People

A yellow face winking with puckered lips blowing a kiss, depicted as a small, red heart. May represent a kiss goodbye or good night and convey feelings of love and affection more generally.

Face Blowing a Kiss was approved as part of Unicode 6.0 in 2010 under the name “Face Throwing a Kiss” and added to Emoji 1.0 in 2015.

Astonished Face

Unicode Name: Astonished Face

Category: Smileys and People

A yellow face with open eyes, raised eyebrows, and an open mouth, as if gasping in shock or surprise. Often depicted showing its upper teeth. May convey a wide range of emotions, including awe, amazement, admiration, disbelief, excitement, or concern.

Astonished Face was approved as part of Unicode 6.0 in 2010 and added to Emoji 1.0 in 2015.



Smiling Face With Hearts

Unicode Name: Smiling Face With Hearts

Category: Smileys and People

A yellow face with smiling eyes, a closed smile, rosy cheeks, and several hearts floating around its head. Expresses a range of happy, affectionate feelings, especially being in love. The number of hearts (three or more) varies by platform.

Smiling Face With Hearts was approved as part of Unicode 11.0 in 2018 under the name “Smiling Face With Smiling Eyes and Three Hearts” and added to Emoji 11.0 in 2018.



Thinking Face

Unicode Name: Thinking Face

Category: Smileys and People

A yellow face with furrowed eyebrows looking upwards with thumb and index finger resting on its chin. Intended to show a person pondering or deep in thought. Often used to question or scorn something or someone, as if saying Hmm, I don't know about that. Tone varies, including earnest, playful, puzzled, sceptical, and mocking.

Thinking Face was approved as part of Unicode 8.0 in 2015 and added to Emoji 1.0 in 2015.



Eyes

Unicode Name: Eyes

Category: Smileys and People

A pair of eyes, glancing slightly to the left on most platforms. The Google version of this emoji previously showed only a single eye, despite the name of this character being eyes (plural).

Sometimes used to indicate ‘pervy eyes’ to indicate approval of an attractive photo posted online; or ‘shifty eyes’ to convey a deceitful act.

Eyes was approved as part of Unicode 6.0 in 2010 and added to Emoji 1.0 in 2015.

Woman Shrugging

Unicode Name: Woman Shrugging: Light Skintone

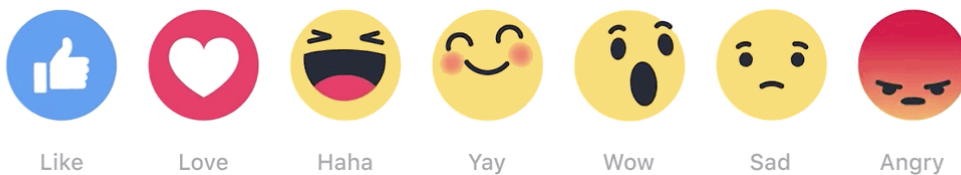
Category: Smileys and People

The Woman Shrugging: Light Skin Tone emoji is a sequence of the Shrug, Emoji Modifier Fitzpatrick Type-1-2 and Female Sign emojis. These are combined using a zero width joiner between each character and display as a single emoji on supported platforms.

Woman Shrugging: Light Skin Tone was added to Emoji 4.0 in 2016.

Facebook Reactions

Facebook provides animated “emoji” reactions to posts. Reactions do not correspond to specific emojis in the Unicode standard but approximate these characters.



Like - Thumbs up

Love - Heart

Appendix 18

Sources of data for narrative data analysis within Secret Facebook Group.

Filters	Data Included
Timeline	User generated and user directed posts
Posts	Text generated by the user
Posts tagged in	Posts where others tag the user/s
Photographs	Photographic images posted by the user
Videos	Videos or links to You Tube videos posted by the user
Emojis	Facebook emojis used by the user in a post or tagged post
Likes and reactions	Likes and reactions using Facebook animated emojis
Articles read or shared	Articles mentioned, read or shared by the user
Television programmes watched or shared	Television programmes mentioned, watched or shared by the user
Backgrounds	Coloured or illustrated backgrounds to short posts by the user

List of dissemination activities

Maternal Health Research Symposium (**May 2024**). Edge Hill University, oral presentation (**Rooney, J.**) Using Facebook for data collection in maternal health: hard to reach groups and negated childbearing.

Northern Maternity and Midwifery Festival (**July 2023**) Manchester, Oral presentation. **Rooney, J.** Fleming, V. Maxwell, C. and Lewitt, M. (2023). Researching stories of unknown childbearing: narrative themes and threads. Presentation by Rooney, J.

Rooney, J. (2023) Chapter Communication in Public Health Midwifery In Staras, T (ed.). Communication in Midwifery: theory and practice. Elsevier: London. (Utilising narrative and story)

Maternal Health Research Conference (**May 2022**) Hosted by Edge Hill University. “Performing Poetry: the narratives of unknown childbearing” Presentation **Rooney, J.**

Virtual ICM 32nd Triennial Congress: Midwives of the World: Delivering the Future (**June 2021**) “Negation in the childbearing continuum: an in-depth exploration of women's narratives” Oral Presentation **Rooney, J.** Fleming, V. and Maxwell, C (accepted presentation abstract).

Rooney, J. Fleming, V. Maxwell, C. and Lewitt, M. (2021). ICMBALI-0046 - Negation in the childbearing continuum: an in-depth exploration of women's narratives. International Confederation of Midwives 32nd ICM Virtual Triennial Congress - Abstract Book

LJMU Research Seminar Series (**February 2021**). “Unknown Childbearing, Narratives and Poetry” Presentation **Rooney, J.**

Rooney, J. Fleming, V. and Maxwell, C. (2020). Negation in the Childbearing Continuum: A Narrative Study of Women's Experiences. Poster Presentation: Royal College of Midwives (RCM) Research Conference (11th March 2020).

LJMU Research Café for International Women's Day 8th March (**2019**). “Negation in the Childbearing Continuum - a narrative approach” Presentation **J. Rooney.**

Northern Maternity and Midwifery Festival (**2018**) “Secrets and the Unknown: A different approach to Negation in Childbearing” Presentation **J. Rooney.**

Faculty of Education, Health and Community Research Day: Building a Successful Team (**2018**) “Secrets and the Unknown: A different approach to Negation in Childbearing” Presentation **J. Rooney.**

University of East London, Centre for Narrative Research Conference (**2018**) “To Think is to Experiment”. Presentation “ Secrets and the Unknown: A Narrative Approach to Looking at Negation in Childbearing” **J. Rooney.**

LJMU School of Nursing and Allied Health: Maternity Research Day (**2017**). “Negation in the Childbearing Continuum - Project Overview” Presentation **J. Rooney.** Organised by J. Rooney.

LJMU Graduate School Conference (**2017**). “Keeping motivation and momentum going during a part-time PhD” Part Time Researchers Panel Member **J. Rooney.**

LJMU VC Scholarship funding for part-time PhD studies “Negation in the Childbearing Continuum: An in-depth Exploration of Women’s Experiences” **J. Rooney** (2016). Funding Body: Faculty of Education, Health & Community, School of Nursing & Allied Health, LJMU.

GLOSSARY

An introduction to key midwifery and maternity terms and definitions used within the thesis. This is not intended to be an exhaustive list, but a guide to the most understood terminology.

Anomaly Scan - an ultrasound scan performed normally at around 20 weeks of pregnancy, which screens for physical conditions in the foetus.

Antenatal - the period from conception to the start of labour.

APGAR Scores - a method of assessing the health of a baby following birth, usually at one minute and five minutes, the score being based on five indicators: **A**ppearance, **P**ulse, **G**rimace, **A**ctivity and **R**espiration.

Childbearing Continuum - a period which includes the prenatal, antenatal, intrapartum, postnatal and beyond, across all aspects and stages of childbearing

Cryptic Pregnancy - identified as a condition in which neither ultrasound scanning, hormone testing, or other commonly used methods could detect or confirm the pregnancy. Indeed, it was the woman herself who identified that she was pregnant. Also commonly confused with unknown or denied pregnancy. There is no agreed definition.

Dyad - the term 'dyad' commonly refers to something which has two defined parts, in relationship with each other. In midwifery and maternity, the two parts are normally the childbearing woman and either the unborn or birthed baby

Elective Caesarean Section - a planned surgical birth, performed through an abdominal incision/s.

Emergency Caesarean Section - an unplanned surgical birth, performed through an abdominal incision/s.

Epidural - a method of pain relief used during labour, through a regional anaesthesia administered by an anaesthetist into the epidural space in the lower back.

Fake Childbearing - a woman deliberately pretends to be pregnant, in labour or given birth to a baby, including faking related events.

Fetal Loss - an umbrella term which refers to the death of a foetus during pregnancy, including both miscarriage and stillbirth.

Freebirth - the practice of giving birth without the presence or assistance of a midwife, or other registered healthcare professional, usually in an out of hospital environment, in a planned manner.

Full Term - a pregnancy that has reached between 37 and 42 completed weeks, which is considered the optimum time for birth, as foetal body systems are considered to be fully developed, enough to survive outside the uterus.

Gestation - the period in which the foetus develops inside the uterus, commonly referred to as pregnancy, and is measured in weeks.

Gynaecology - a branch of medicine focussed on the health and conditions of the female reproductive system.

Hypertension - high blood pressure.

Induced/Induction of Labour - often referred to as 'being induced', induction of labour encompasses a range of methods which aim to artificially enable labour to commence.

Infanticide - the intentional killing of an infant, by a woman/the mother of an infant aged twelve months or under.

Intrapartum - the period from when labour commences, to and including the birth of the baby and placenta.

Mastitis - an inflammation of breast tissue, causing signs and symptoms within the affected breast and sometimes in other body systems.

Menstrual/cycle/periods - usually occurring each month following the onset of puberty, the menstrual cycle is a series of changes within the female reproductive system, including the discharge of blood (periods) from the uterus through the vagina.

Midwifery-led care - a model or pathway of maternity care, where midwives are the lead caregivers during the childbearing continuum.

Miscarrying/Miscarriage - the spontaneous loss of a pregnancy/foetus prior to twenty-four completed weeks.

Multiparous - a woman who has given birth to one or more live infants.

Negated childbearing - "The phenomenon of negated childbearing encompasses pregnancy, labour, birth, the immediate postnatal period and beyond - across the whole childbearing continuum. It includes (non-psychotic) conscious concealment, and conscious and unconscious denial of childbearing"

Neonatal/neonate/newborn - a baby in the first twenty-eight days of life

Neonaticide - the intentional killing of a baby within the first twenty-four hours of life, can be considered a form of infanticide.

Oedema - swelling in body tissues, usually caused by a build-up of fluid.

Obstetric - a medical speciality which deals with the childbearing reproductive system and health.

Perinatal - usually refers to the time-period from the conception of pregnancy until around one year post birth.

Phantom Pregnancy/childbearing - also known as pseudocyesis or false pregnancy, considered to be a rare condition where a woman believes they are pregnant, has signs and symptoms of pregnancy, but no foetus is present.

Postnatal/Postpartum - the period following the birth of the baby and the placenta.

Precipitate labour/birth - commonly a very quick labour and birth, usually involving rapid and intense contractions, followed by a quick birth, within three hours.

Pre-eclampsia - a complication of pregnancy with associated signs and symptoms, normally in the second or third trimester, which usually requires medical intervention.

Premature/Prematurity - a baby is considered premature if born prior to thirty-seven completed weeks of pregnancy.

Prenatal - in the UK commonly refers to the time before conception/pregnancy (pre-conception), can be used interchangeably with antenatal.

Proteinuria - higher than normal levels of protein in urine.

Stillbirth - the birth of a foetus who is dead after twenty-four completed weeks of pregnancy.

Termination of Pregnancy - commonly referred to as an 'abortion', usually a medical procedure to end a pregnancy through medication or surgery.

Trauma Informed Care - a person-centred holistic approach to care, which considers the potential impact that exposure to trauma may have on a person's health and well-being and incorporates this approach into care planning and delivery.

Trimester - a period designated as three months, usually alluded to the three trimesters of pregnancy.

Unassisted Birth - sometimes used interchangeable with freebirth, this is birth without the presence or assistance of a midwife, or other registered healthcare professional, usually in an out of hospital environment, and can be planned or unplanned.

Ventouse - also known as a vacuum extractor, is a specific range of devices used to assist a woman in vaginal birth, usually a cup like device using suction and manual pressure to facilitate birth along with maternal effort.

Vicarious trauma - a range of signs and symptoms which can be experienced by someone who directly or indirectly witnesses or hears about the trauma of another person/people, and which can result in adverse mental health symptoms.