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Hannah Moore

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Life-threatening complications in childbirth: A discursive analysis of fathers' accounts

Hannah Moore

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Investigators

Name: Hannah Moore, Trainee Clinical Psychologist

Location Details: University of Hertfordshire

Contact Details: hse_moore@hotmail.com

Name: Wendy Solomons, Clinical Lecturer/ Research Supervisor

Location Details: University of Hertfordshire

Contact Details: 01707 286322

Name: Lizette Nolte, Research Tutor

Location Details: University of Hertfordshire

Contact Details: 01707 286322

Table of Contents

Abstract.....	5
Background and aims.....	5
Methodology.....	5
Findings	5
Introduction and literature review.....	7
Trauma following birth	7
Men’s birth experiences	10
Men and emotional distress following birth	13
Complicated and “Near Miss” experiences	16
Methodology.....	20
Theoretical Position	20
Social Constructionism and discourse analysis.....	20
Discourses of Masculinity and Fatherhood	22
Rationale for study	24
Research Questions	26
Aims.....	26
Methodology.....	26
Analytic Approaches	27
Data.....	33
Participants.....	34
Recruitment.....	35
Inclusion/Exclusion criteria.....	36
Analysis.....	36
Ethical issues	38
Ethical Approval:.....	38
Confidentiality of Participants	38
Informed Consent.....	38
Psychological Harm	39
Conflicts of Interest	39
Criteria for Quality Assurance	40
Analysis.....	41
Individual Narratives	42
Rich:	42
Chris:	44
Dave:	46

John:.....	48
Major Interpretative Repertoires	50
Normal Birth	50
Medicine.....	50
The Brink Of Death	51
Emotional Distress	51
Masculinity.....	52
Motherhood	52
Separating the strands	53
Failing birth narratives	53
Being a Passenger.....	57
Medicine: Like something out of Dr Who.....	61
Negotiating the power.....	65
Being a Man	72
Falling apart and getting better	76
Conclusions.....	84
Summary of analysis	84
Clinical Relevance.....	87
Methodological considerations.....	89
Future research	90
Personal Reflections.....	91
Bibliography	93
Appendix 1 – Ethical Approval	104
Appendix 2 - Participant Information Sheet & Patient Reply Slip	117
Appendix 3 – Transcription Key	123
Appendix 4 – Sample of transcript analysis	124
Appendix 5 – Interview Schedule.....	127

Abstract

Background and aims

The current British cultural norm for men to attend the births of their children raises the potential for them to experience birth as traumatic. Existing qualitative research conducted by Hinton, Locock and Knight (2014) focuses on the content of men's accounts of their experience following a birth in which the mother experienced a medical "near-miss". They highlight feelings of exclusion and powerlessness, difficulty in dealing with the new baby and issues around support, communication and recovery in men's accounts.

This research aims to add a further dimension to the exploration of men's accounts, viewing those accounts as influenced by the discursive environment in which they are constructed. Using a sub-sample of the same data, this study aims to consider how fathers who report lasting distress following these births construct their accounts, considering the discursive resources influencing their construction and the actions their accounts perform, with the aim of using that understanding to assist in the reduction and management of distress.

Methodology

Under the umbrella of discourse analysis, features of discursive psychology, the discursive action model and narrative analysis were used to consider 4 interviews with men whose partners experienced a "near miss" event at the birth of their child. Using secondary data in the form of audio recordings and transcripts of semi-structured interviews, the discursive features of the accounts were examined.

Findings

Analysis of the stories presented by the men suggests they positioned themselves as seeking predictability in the process of birth, and it seemed difficult for them to make sense of their "near-miss" birth experiences without ready access to

alternatives to a “normal” narrative of birth. In accordance with existing research, communication difficulties with medical staff were described, with men constructing language and knowledge as serving to separate the categories of medical practitioners and laymen. Further, medical processes and practices were constructed by men as categorically different to the more human constructions of themselves and their “lifeworld”. These separations interacted with issues of power, agency and the construction of identities as men, husbands and fathers within the context of birth becoming a medical emergency. The accounts men gave suggested their positioning of their partners as “Mother” was easily achieved within discourses of parenthood, but a position of “Father” as primary carer was less accessible. The analysis highlights men’s efforts to resolve dilemmatic issues regarding their identity as men and their emotional distress arising from the crises, with men utilising a discourse of self-reliance within their families to construct their path to recovery. Understanding how men are able to talk about and make sense of their experiences offers beneficial insights for health professionals working with men during and after a crisis during childbirth and provides fresh avenues for facilitating sense-making and recovery.

Introduction and literature review

This introductory section will outline the rationale for the current study with reference to the understandings existing research has generated in the area. I shall start by considering the potential for giving birth to lead to emotional traumatising in women, before discussing the experience of birth for men in the UK, for whom it is currently the norm to attend the birth of their child. I shall then consider the current understanding of men's potential emotional distress following the birth of their child, before discussing the significance of those births in particular which are considered "near miss" events in which there was serious risk to the life of the mother.

Trauma following birth

The experience of giving birth has the potential to be experienced as emotionally traumatic or causing lasting distress. Estimates of the prevalence of Post-Traumatic Stress Disorder (PTSD) amongst women after birth vary between about 1.5% (Ayers & Pickering, 2001) and 6% (Menage, 1993), and this may be mediated by the historical context of the women as well as events at the birth itself. 1.7% of women in Wijma, Söderquist, and Wijma's (1997) sample of all (1640) women giving birth in one year in Linköping, Sweden met the criteria (assessed by the Traumatic Event Scale) for PTSD. These women had a greater history of psychiatric counselling, more negative appraisals of previous births or no previous births, and a more negative experience of delivery staff.

Estimates of prevalence of symptoms of trauma that do not meet the diagnostic criteria for PTSD are much higher, with 34% of 103 women recruited from antenatal classes in Atlanta reporting some symptoms of trauma when interviewed four weeks after birth (Soet, Brack, and Dilorio, 2003). In Creedy, Shochet, and Horsfall's (2000) study 499 women were interviewed by telephone following their births. 33% reported experiencing an event they perceived as traumatic during birth and struggling with at least 3 symptoms of PTSD. Again, factors beyond the nature of the birth itself influenced the reporting of symptoms of trauma. PTSD symptoms were associated with dissatisfaction with care received, pain and fear for the lives of mother or infant.

While many studies looking at traumatic distress following birth utilise measures of Post-Traumatic Stress Disorder (PTSD) as definitive markers of distress, even within these studies it is evident that lasting distress following birth can be perceived by parents with or without the presence of diagnosable PTSD. What health professionals may consider a traumatic does not always correlate with what parents consider a traumatic birth in terms of their felt experience. Beck (2004) used descriptive phenomenology to analyse the stories of 40 women in New Zealand, America, Australia and the UK recruited through the charitable trusts Trauma and Birth Stress, concluding that births could be perceived as traumatic even when viewed as routine by healthcare professionals. It is this perceived, self-defined trauma, influenced by the individual history, contexts and expectations of each person, which is likely to be the best predictor of ongoing distress following birth. Where “trauma” is used here without qualification, it refers to self-perceived lasting distress on the part of the parents following birth.

Ayers (2004) suggests that subjective factors such as perceived support and control are more important in determining the likelihood of PTSD following birth than objective factors such as type of delivery, with factors such as additional stress in the period after birth, support or coping style impacting upon outcomes. Ayers (2007) interviewed 25 women with and 25 without PTSD symptoms matched for events during birth. They reported women with PTSD symptoms following birth described more panic, anger, thoughts of death, mental defeat and dissociation during birth, had fewer coping strategies focused on the present and more memories and rumination. Olde et al. (2005) used a prospective design following 140 women in the Netherlands for the first three months after delivery. Reporting a prevalence rate of 2.1% for PTSD and 21.4% reporting traumatic birth experience, they concluded negative emotional reactions and dissociative reactions reported during and shortly after childbirth were strong predictors of subsequent PTSD symptoms. Allen (1998), in a qualitative study of 20 women, concluded that alongside beliefs that the baby would be harmed, pain and previous experiences of labour preceded a perception of a traumatic birth. Access to more than one source of social support and a belief that one should not admit to not coping were positive and negative mediators of lasting distress respectively. Rowan, Bick, and Bastos (2007) suggest that it may be appropriate to offer women an opportunity to discuss their experience, though they

caution against the use of formal debriefing, a sentiment echoed within National Institute for Clinical Excellence (NICE) guidance (NICE, 2006, 2007) as evidence does not lend support.

The conclusions drawn by these studies suggest women do not report distressing emotions based simply on the events of the birth, but also on how they construct the experience in light of their histories and social contexts. This suggests the potential importance of an understanding of distress following birth in which accounts are seen as part of a sense-making process influenced by the cultural and temporal context of the teller.

That sense-making is a socially embedded process is further suggested by evidence that support from a partner served as a moderator in the reporting of trauma or depression symptoms after a subjectively negative birth experience (Lemola, Stadlmayr, & Grob, 2007). Allen (1998) also draws attention to the important role of partners in constructing birth experience, reporting that women who perceived their labour as distressing mediated their felt lack of control by seeking reassurance from partners as well as medical staff. Keogh, Hughes, Ellery, Daniel, and Holdcroft (2006) reported that mothers' fear levels during labour were mediated by the level of fear of their birth partner.

Emotional distress in the period following birth can have significant ramifications for the wellbeing of both parents and children, making it an important area of investigation. Studying the effects of parental post-traumatic reactions after premature births, Pierrehumbert, Nicole, Muller-Nix, Forcada-Guex, and Ansermet (2003) concluded that the intensity of these reactions as measured by the Perinatal PTSD Questionnaire (PPQ) were a predictor of later parental reports of sleeping and eating problems in children independent of the actual perinatal risks to the child. They recommended suitable interventions be developed to improve outcomes for families of premature babies. Using semi-structured interviews with 6 women who reported clinically significant PTSD after birth, Ayers, Eagle, and Waring (2006) concluded that traumatic birth experiences impacted upon women's attachment style, mood, physical wellbeing, and relationship with their partners, and where psychological symptoms are left unrecognised there is risk of depression and social isolation. Similarly, long term impacts on a couple's relationship and parents' bond

with their baby were described by Parfitt and Ayers (2009), for whom 126 women and 26 men (of whom 22% and 12% respectively fulfilled diagnostic criteria for PTSD) completed questionnaire measures of PTSD, depression, relationship quality and parent-infant bond. Nicholls & Ayers (2007) interviewed six couples in which at least one partner (five women and three men) had clinically significant PTSD symptoms following childbirth. The extent to which findings such as these suggest a causal relationship between distress and relationship difficulties, or a more complex picture of ongoing sense-making narratives of distress and difficulty, is unclear. However, though these studies selected participants on the basis of having found birth traumatic, they highlight not only the long term impact distress following birth may have on a family, but also the potential for trauma following birth amongst men.

Men's birth experiences

The NHS reports a 98% attendance of male partners at births (TNS System Three, 2005). The ways in which men experience attending birth may be significant. In a correlational questionnaire study, Fortier (1988) found that though the type of birth (vaginal or caesarean) did not correlate with a father's caretaking activities, his presence at the delivery and his early contact with the baby predicted greater caretaking activities. Peterson, Mehl, and Leiderman (1979) reported that fathers' attendance at and attitude towards the birth were the greatest predictors of paternal attachment with the child, and Leonard (1977 in Chandler & Field, 1997) found that the higher a father rated the birth experience, the more child-care activities he subsequently participated in. The importance of fathers' involvement with children as a positive element in the long term outcomes for children is recognised by the National Services Framework for Children, Young People and Maternity Services (Department of Health, 2004).

NICE recognises the importance of communication between health-care providers and women and their partners, the involvement of partners and the need to "assess and, where appropriate address" the support needs of partners (NICE, 2006, 2007, sec. 1.1.1.5). Understandably, the structures put in place around birth centre around the interactions between women, their babies, health care professionals and medical

equipment. The primary aim of that interaction is a safe delivery for mother and baby. Thus there is the potential for men to feel excluded from this process even in medically straightforward scenarios, and when emergencies arise, consideration of the father may become peripheral.

In a literature review of fathers' experience of childbirth, Dellmann (2004) concluded that most men describe finding childbirth both wonderful and distressing, but frequently not living up to their expectations. They often indicated confusion about their role. Dellman reported helplessness to be the most common feeling fathers describe (Nichols, 1993 cited in (Dellmann, 2004), using semi-structured interviews, Vehviläinen-Julkunen and Liukkonen, 1998, using questionnaires) and cited Chapman's (2000 in Dellmann, 2004) description of the distress men tell of in semi-structured interviews at "losing her", when their partners "turn inward". This echoes Von Sydow and Happ's (2012) conclusions, drawn from a content analysis of interviews with 30 men one month before and six months after birth, that men describe experiencing both intense positive feelings (joy, relief) and negative feelings (fear, anxiety, shock, helplessness, disgust, flight impulses), with the baby itself also evoking both joy and feelings of helplessness and alienation. Interestingly Von Sydow and Happ also found that though all men in their study reported wanting to be at the birth, 13% indicated that it was not a choice for them to say otherwise, showing the impact of cultural expectation on men's understanding of their role, and potentially also on what they report in interviews and questionnaires. Dellmann (2004) recommended an increased focus on men's specific needs during antenatal classes and in hospital practices, would improve both maternal and paternal satisfaction. This recommendation fits with Somers-Smith's (1999) conclusions, following an ethnographic approach to identifying themes in semi-structured interviews with 8 men, that men are better able to deal with their feelings of helplessness when they felt more equipped to offer appropriate practical and emotional support to their partners.

Looking at fathers' experiences of attending birth relative to their expectations, Chandler and Field (1997) interviewed 8 fathers before and after birth using initially unstructured interviews with increasing structure as they identified themes from previous interviews. They also interviewed a further 6 fathers who contacted the researchers after their children were born, using these interviews to validate the

researchers' interpretations. They reported that fathers had expected to be treated as part of a labouring couple, but described feeling unsupported by staff in that role and not included in care. Additionally, though saying they had been confident they could support their wives, they found labour to be harder work both physically and in terms of offering psychological support than they anticipated, and felt dissatisfied with their own performance providing comfort. They also described becoming fearful of the outcome and feeling helpless, saying they felt they had to hide those fears, as well as feelings of anger and surprise about the care received, from their partners. The men reported that fear did not persist after delivery, being replaced by positive emotions such as relief and joy. Similarly Leonard (1977 in Chandler & Field, 1997) reported that men said they felt helpless during labour. After the birth, they described their attention shifting from their wives to their new babies, however all the men reported a greater respect for their wives. Recommendations from this study were to include fathers in labour plans as well as offering them support for their role as "coach" for their wives, especially when their wives experience pain. Encouraging fathers to attend to their own needs for breaks or food, was also suggested. Thirty five years later, in a metasynthesis of 23 papers published between 1999 and 2010 regarding fathers' encounters with pregnancy, birth and maternity care in high resource countries, Steen, Downe, Bamford, and Edozien (2012) concluded fathers felt themselves to occupy an undefined emotional and physical space between patient and visitor, leaving many feeling excluded and fearful, and that fathers themselves need support, inclusion and preparedness for the realities and uncertainties of pregnancy and childbirth in order to support their partners.

Though not focusing on the birth itself, de Montigny & Lacharité (2004) used a critical incident technique to interview 13 men about what moments during the early period following birth were significant for them. Of the incidents father's identified, 60.9% were described by fathers as having a negative impact on them. They suggested from their analysis that highly involved fathers, as categorised by fathers' own appraisal of their involvement and the time spent with their babies while they were in hospital, did not seem to feel supported in engaging with their babies by hospital policies, that they "deplored" not being addressed by nurses and wanted their involvement recognised by health professionals. Garten, Nazary, Metze, and

Bührer's (2013) study of the experiences and needs of fathers of very low birth weight infants in neonatal intensive care recommended that while men considered bedside support from unit staff to be satisfactory, they desired greater facilitation of father-specific non-bedside support such as peer education about the practicalities of caring for their babies, or chat rooms for peer support. Both these studies could be seen to suggest that new fathers feel that hospital and health professional practices marginalise their early parenting support needs in favour of a focus on mothers, and would value support and recognition of their role not just as partners of new mothers, but specifically as fathers.

Men and emotional distress following birth

It is increasingly recognised that new fathers can have mental health needs in the period after birth, and that mental health problems may have consequences not only for the men themselves, but for their partners and children too. New fathers have been found to have depression rates up to double the national average for their non-parent peers in Denmark (Madsen, 2006 in Burgess, 2011) and the US. As with mothers, fathers' depression is associated with infant difficulties in both the short and long term (e.g. Ramchandani et al., 2008; Dudley, Roy, Kelk, and Bernard, 2001; Smart & Hiscock, 2007; Davé, Nazareth, Sherr, & Senior, 2005; Ramchandani, Stein, Evans, & O'Connor, 2005) as well as impacting upon their parenting and attachment behaviour (e.g. Roggman, Boyce, Cook, and Cook, 2002; Buist, Morse, & Durkin, 2003; Sethna, Murray, Psychogiou, and Ramchandani, 2009; Wilson & Durbin, 2010). In a review of paternal post-partum depression literature, Schumacher, Zubaran, and White (2008) recommended that assessment of fathers during the postnatal period be conducted, particularly when their partners are depressed, to facilitate prompt treatment and improve outcomes for the whole family.

There is also evidence that men can and do find birth traumatic. Johnson (2002) found that men who attended delivery demonstrated higher scores on the Impact of Events Scale than would be expected in a non-psychiatric population 6 weeks after birth. Though the studies outlined above (Parfitt and Ayers, 2009; Nicholls and Ayers, 2007) deal with small numbers of men, further studies also suggest that

sufficient men struggle with negative emotional responses to birth to render it worthy of investigation. Using established questionnaire measures of traumatic experience, infant-parent bond and couples' relationships with 64 couples 9 weeks after childbirth, Ayers, Wright, and Wells (2007) found similar prevalence rates of PTSD amongst men and women, with 5% (3 men and 3 women) showing severe symptoms. PTSD symptoms were also strongly associated within couples, and associated with similar factors, including complications of delivery and emotions during birth. However, contrary to previous research, lack of control or support during birth was not associated with PTSD in these six parents. Recruited through a London hospital, these parents were self-selected and a low response rate of just 64 out of 207 eligible couples was achieved, suggesting the sample may not be representative. However, the authors suggest people are less likely to participate if they have more symptoms of PTSD (Weisaeth, 1996, in Ayers et al., 2007) and therefore this, and indeed the other studies here looking at incidence and experience of emotional trauma, may underestimate prevalence and underreport experience. Additionally in this case, couples were not considered eligible if their baby had been stillborn or transferred to the neonatal unit, thus excluding couples who may be more likely to experience emotional trauma.

Bradley, Slade, and Leviston (2008) undertook a preliminary investigation of PTSD prevalence rates in men. 199 men recruited in the 72 hours after birth at a UK hospital were followed up 6 weeks after the birth and asked to complete questionnaire measures of post-traumatic stress, anxiety and depression. While no men reported clinically significant symptoms on all dimensions of PTSD, 12% reported clinically significant symptoms on at least one dimension, with hyperarousal most reported. Higher levels of PTSD symptoms were associated with trait anxiety, fewer children, unplanned pregnancy, being present at the delivery, and feeling less confident and prepared and more distressed during the childbirth process. The authors suggest that men's distress after childbirth might be better conceptualised as adjustment and anxiety than trauma, a suggestion which perhaps draws attention to the limitations in the discourses available to men regarding their responses to birth. Also worth considering is that of 447 men, 340 consented to participate and just 199 filled in the second set of questionnaires, with those not returning being more likely to have not planned the pregnancy and to have reported more distress at labour and

delivery. Again, with avoidance being a dimension of PTSD, this attrition may have moderated the results, and the inclusion of fathers of babies requiring care in the Special Care Baby Unit may have altered the conclusions that could be drawn. Of course, in addition to sampling limitations, these questionnaire studies strongly constrain the information parents are able to communicate. It is possible however that such information is also constrained by the discourses parents are engaged in.

One criticism of existing literature on men's experience of trauma or distress resulting from attending birth is that men's experiences are largely discussed in relation to those of their partner or child (Dellmann, 2004). For example, fathers being available to support mothers during and after birth, particularly where the mother experiences emotional difficulties, can impact greatly on mothers' experience of birth (e.g. Anderson and Standley, 1976, Gibbins and Thomson, 2001, Tarkka, 2000 and Enkin et al, 1995, all cited in 'Fatherhood Institute Research Summary: Fathers Attending Births', 2007; Burgess, 2011) as well as her longer term mental health, which in turn influences short and long term outcomes for children (see Burgess (2011) for review). Klein, Fohrell Gist, Nicholson, and Standley (1981)) and Spiby, Henderson, Slade, Escott, and Fraser (1999) found that women rated the father's presence during labour as more helpful than that of healthcare providers. The comparative paucity of research focusing on men's experiences in their own right not only limits our understanding of those experiences, but also serves to perpetuate a repertoire in which men's emotional difficulties, particularly in relation to the female activity of birth, need not be addressed. This in turn may make it harder for men to talk about those difficulties, leaving them potentially underreported and underestimated in their significance.

Nevertheless, there are qualitative studies of men's distress following birth. Johnson's (2002) longitudinal study of 53 men suggests that fathers' stress and fear during their reproductive experience peaks during the birth process and can become very high, especially where labour is prolonged or excessively painful, where complications arise, or where men do not feel they fulfilled their role expectations or felt pressure to be at the birth. Around 3% of 40 men responding to a questionnaire in Berry's (1988) study indicated worry their partners may die, but reported spending more time trying to hide their feelings and worrying than they did actually coaching their partners, suggesting the importance of discourses of what is expected of men

and their perceived role in determining how they are able to interact with the birth experience. Harvey and Pattison (2012) used semi-structured interviews with 20 men (17 within the first 28 days after birth) recruited within an NHS hospital to explore fathers' experiences of the resuscitation of their baby at delivery, an experience likely to be distressing to most people. They reported that predominantly negative feelings remained vivid after delivery, with several fathers describing feeling they had not yet recovered, some showing symptoms of PTSD. Fathers in this study also reported feeling a lack of opportunity to discuss what had happened with health care professionals afterwards. They also told of wanting to go to their baby but feeling they should stay with their partner and not impede resuscitation, feeling they were not "allowed" to go to their babies. Reports that behaviour was constrained by the perception of their roles suggests that such perceptions may shape behaviour throughout the reproductive process but also the ability to process and communicate experiences. Koppel and Kaiser (2001) set out to investigate the experience of 18 fathers of babies on a German NICU using semi-structured interviews. Men instead wanted to talk about their distress at having been excluded from attending caesarean deliveries when things started to go wrong, and their fear for their wives as they waited with scant information. The authors call for a re-think regarding father's needs when their child's birth becomes complicated.

Complicated and "Near Miss" experiences

In England, at 1.2% of births the mother will experience a severe, life-threatening obstetric complication (e.g. haemorrhage or sepsis) requiring emergency medical intervention to preserve life (Waterstone, Bewley, and Wolfe, 2001). In 2011 this would have amounted to over 8600 families experiencing life-threatening "near misses" each year, which could leave significant numbers of people with lasting distress. Those who experience "near misses" are likely to undergo significant disruption to their lives, characterised by Storeng, Murray, Akoum, Ouattara, and Filippi (2010) in their longitudinal interview study of 64 women who survived "near miss" events in Burkina Faso, as "a household crisis" affecting physical, economic and social domains. Though conducted within a very different cultural context, where issues around obstetric complications as well as discourses of childbirth, parenthood

and masculinity differ, this study draws attention to the complexity of the disruption a “near miss” can create. Souza, Cecatti, Parpinelli, Krupa, and Osis (2009), interviewing 30 women who survived severe complications of pregnancy in Brazil, dubbed the stress women experienced following a near-miss “maternal near-miss syndrome”, suggesting care provision must encompass the multifaceted physical, psychological, social and spiritual aspects of women’s health. Interviewing 21 women who responded to advertisements for the study placed in public places such as pharmacies and childcare centres in Australia and experienced severe postpartum haemorrhage followed by an emergency hysterectomy, Elmir, Schmied, Wilkes, and Jackson (2010) reported that women feared not only for their own lives, but also for the futures of their children and partners. Nine experienced flashbacks, and the time elapsed since the event did not for some lessen their emotional response recalling it.

These studies again focus on women’s experience of their own near-miss. However, Snowden, Elbourne, Forsey, and Alfirevic (2012) undertook an interpretative phenomenological study using semi-structured interviews with nine women and six of their partners regarding their experience of postpartum haemorrhage. While identifying communication difficulties, disempowerment and information-deprivation as themes common to men and women, they suggest that information and support needs differ between men and women. Men placed particular emphasis in their accounts on their experience of waiting while the crisis was managed, especially with scant information, and their shift to powerless bystanders, or indeed their removal from events. The authors suggest reconsiderations of the presence of partners during obstetric emergencies as some couples may find it beneficial, and pointed towards the need their interviewees articulated to make sense of events through discussing them. All six men in this study were interviewed with their partners, producing co-constructed accounts of events. Under these conditions it is unclear to what extent men contributed to those constructions, and while an interesting point for analysis in itself, they were likely to have been significantly influenced by their partners’ presence in the accounts they were able to produce.

An increasing interest in the experience of men is emerging however, with widespread media coverage of a recent National Institute for Health Research funded study undertaken by Oxford University researchers from the National

Perinatal Epidemiology Unit in which semi-structured interviews were conducted with 35 mothers, 10 fathers and one lesbian partner (some individually, some as couples). An interpretative thematic analysis suggested that life-threatening complications in pregnancy can impact fathers as well as mothers (Hinton et al., 2014). Several men described feeling powerless, being sidelined and inadequately communicated with by healthcare professionals. However, small elements of thoughtful care from healthcare professionals, such as showing the waiting father a photograph of the baby or providing a monitor so the baby's heartbeat could be heard, were reported to make a big difference to how couples coped. Some men reported difficulty recovering from seeing their wife in a life-threatening emergency, and while some men do not report feeling lasting distress, others describe PTSD symptoms or depression. Several described difficulties obtaining emotional support.

As the voices of men become more heard, it seems prudent then to consider not just the content of their accounts, but the action of accounting. The studies outlined above have sought both quantitative assessments of prevalence of emotional issues and their correlations with other factors, and qualitative understandings of the experiences behind those numbers. These depend on participants' reporting of their experience, whether within the constraints of questionnaires or in written or spoken narratives. Within this, two epistemological positions are seen: either a broadly "realist" position, in which reports are taken as concomitant with the "truth"; or broadly "critical realist" approaches which, while acknowledging that personal accounts are inevitably partial perspectives, nonetheless accept the content of participants' accounts as a representation of their underlying "experience". However, these epistemological positions may be challenged (e.g. Gergen, 1985) by critical, social constructionist readings which argue that personal accounts cannot be seen as a straightforward window onto an underlying "real" or "true" experience. This study will take a constructionist approach in which our understanding of our experiences and identities are viewed as constructed through our talk, and within our contexts.

The discourses available to men to communicate and process their emotional responses to childbirth, and the identities available to them, may constrain how they are able to portray their experience, both in research into that experience and in how professionals, family and friends are able to respond to their stories. Thus it seems

critical to consider the importance of the communicative construction of those experiences, the interaction between what men think they SHOULD be and how they are able to talk.

Methodology

In this section I will outline the theoretical orientation of this research, leading to a statement of the research aims. I will then describe, based on the theoretical orientation, the methodological approach which will be taken.

Reflexivity, the explicit consideration of how the researcher influences the research, is a key concept in a qualitative methodological perspective in which knowledge, including the understandings generated by this research, is viewed as socially constructed. Horton-Salway (2001) suggests that authors of social research who take this stance cannot transcend their own constructive practices and thus must maintain reflexive awareness. (Tracy, 2010) sees reflexivity within research as one means of improving the rigour of qualitative research and I make use of the story of how I have come to this research in describing my chosen methodological approach.

I will then go on to describe how my data was obtained and analysed, and the steps taken to ensure rigour in this research.

Theoretical Position

Social Constructionism and discourse analysis

Counter to a positivist or realist epistemological perspective in which social research purports to uncover truths or evidence about reality, social constructionist research is founded in an epistemological position in which 'knowledge' is viewed as an understanding situated within a cultural context. Knowledge accumulated by research activity is subject to both the bias of the researcher in everything from choosing a topic to interpreting the data, and the filter of the action of communication on the part of the researched. Similarly, the phenomena under investigation is itself socially constructed, with our contexts influencing what we experience as "traumatic" in this case, as well as how we are able to talk about it. This will also interact with the constructs we apply to ourselves, such as "being a father" or "being a man". Thus research yields argument rather than evidence of stable properties of our world.

Burr (2003) suggests that social constructionism can be seen as the family group encompassing several approaches to understanding human beings as social animals which are underpinned by a critical stance towards taken-for-granted knowledge, a belief that the ways in which we understand the world are historically and culturally specific, and that current knowledge is sustained by social processes, including language use. In this way, the way we talk about our understandings of the world can be seen as both subject to the cultural position we inhabit, and purposeful in creating that position. The understandings we utilise about the world can therefore be seen as socially created constructs. These social constructs will in turn affect the way we experience and make sense of our world, including such notions as “traumatic” or “normal”, “father” or “man”. In addition to sculpting our experience, the constructs each of us has available given our particular circumstance (social position, gender, era, etc.) will direct us towards ways of talking about those experiences, which will in turn also shape the ongoing social constructions of these concepts.

Discourse Analysis holds with this “theory of language as an active, performative realm” (Potter & Wetherell, 1987), viewing language as a key social tool in constructing the social world and our experience and action within it. It is how we share our thoughts, how we reconstruct events and how we create our histories. Within this perspective, accounts of childbirth experience given by men are seen as acting to mediate and construct their experience as well as others’ experience of their experience, and they are doing that within the complicated contexts within which they are told. Discourse Analysis views the language we use to account for our selves not as “a clear, pure medium through which our thoughts and feelings can be made available to others” (Burr, 2003), but as more active in structuring our experience and thus our sense of ourselves. It follows from this position that there are possible alternative constructions of the self and of events in our lives. However, the linguistic framework available to us and the discursive actions we take with these are not unlimited; within particular cultural and historical contexts, one cannot talk about events or experiences however we choose, and expect to be understood (Wetherell, 1998). The linguistic conventions available to us will hold considerable sway over how our experience and consciousness are structured (Burr, 2003).

Within discourse analysis, the focus of research becomes an exploration of the constructive action of the discourse within its cultural context, rather than its explicit content. By analysing talk within this framework, the links between individual accounts and wider cultural contexts can be considered; how they draw on (and resist) particular interpretative repertoires or wider discourses; what enables one to say about particular events, while maintaining acceptable social identities. Given the highly gendered nature of childbirth, partnership and fatherhood, constructions of masculinity were considered to be of particular interest to the present study.

Discourses of Masculinity and Fatherhood

Discourses of masculinity are numerous even within the bounds of English cultures. From a notion of masculinity as something inherently linked to biological sex to the notion of masculinity as purely socially constructed, even the aetiology of the concept is debated, and the content of it no less so. (Edley, 2001, p192) argues that “gender comes to be something that is ‘done’ or accomplished in the course of social interaction”, with some ways of constructing an object, including gender or masculinity, becoming more culturally dominant such that they “assume the status of facts” (p. 190). As such, the normative characteristics of masculinity become culturally accepted. Edley argues that to a discursive psychologist, masculinity is seen as a “consequence” of the way we talk about men and their behaviour, rather than being the cause of the behaviour. There are advantages to engaging with this dominant discourse, and one consideration of discursive psychology is the politics or power associated: who benefits from a particular discourse’s dominance? Equally, dominant discourses may be constrictive for some. Edley suggests the avoidance of men’s construction of themselves as emotional in Western culture has both been advantageous in retaining individual group membership and wider group empowerment, and disadvantageous when the situation “demands” an emotional construction. He suggests that “‘emotion talk’ represents a form of discursive activity which is not part of many men’s everyday, practical routine” (p.195).

The discourses of masculinity men draw from and feed into will impact upon the discourses of fatherhood with which they interact. Nixon, White, Buggy, & Greene

(2010) cite research by Marsiglio and Hutchinson (2002) suggesting it is not the creation of a child but the subsequent role played in the child's life on which men evaluated their manhood, particularly the role of provider. Marsiglio and Cohen (1997 in Nixon et al., 2010) suggest this role is so central to cultural notions of masculinity that young fathers who may struggle to fulfil it are likely to shy away from the responsibility of their families rather than risk being "emasculated" by failure.

A 2009 study of fathering in Britain suggested that "an observer might be forgiven for imagining that "good parenting" is the common cure for all social ills" in light of the attention and state resources parenting has received in recent years (Hauari & Hollingworth, 2009, p.6), citing policy documents from the Home Office, the Department for Education and Skills, Department of Health, Department for Children, Schools and Families and Sure-Start issued between 1998 and 2005 as giving particular advice on improving the involvement of fathers in their children's lives in order to improve social, educational and emotional outcomes.

Interviewing fathers from four ethnic groups in England, Hauari and Hollingworth's (2009) study suggested that while articulated societal beliefs and attitudes about the father's role now lean towards less differentiated roles for mothers and fathers, many traditional stereotypes persist in reality, often at odds with stated attitudes. In particular, interviewees still reported seeing fathers as providers and protectors, discipliners and play-mates. These conclusions are similar to a 1999 study in which men described experiencing difficulty and discomfort in meeting the social expectations of being simultaneously provider, guide, household help and nurturer (Barclay & Lupton, 1999). Sunderland (2000) suggested the continuing presence of a dominant discourse in which the father was a part time parent while the mother was the main parent. These ideas about what a father should be, or should do, form discourses of fatherhood with which all members of a family interact.

In addition to these broader discourses about fatherhood, there are also discourses about the transition into fatherhood. A literature review of this transition spanning the two decades between 1989 and 2008 (Genesoni & Tallandini, 2009) suggested that while the period of pregnancy involved significant re-organisation of the sense of self, and the postnatal period was most interpersonally and intrapersonally challenging, birth was experienced as the most intensely emotional period, with

fathers reporting finding birth unexpectedly demanding on them, feeling out of place, vulnerable, unprepared and in need of support, as reported in many of the studies around men's birth experience already discussed. Yet despite the significant emotional impact of fathers' birth experience, little consideration has been given to how men are able to construct that experience through engagement in discourse about it.

Rationale for study

It is evident that the presence of men at births in the UK has become culturally normal, and appears in most cases to have a positive impact on the birth experience of the mother, and the father's attachment to the child. However, where births are perceived as traumatic, there is scope for men to become distressed, and this distress may impact negatively not only on themselves, but also on their partners' mental health and recovery, and their parenting of their children. Research into the experience of men present at a birth they perceive as traumatic is a developing area, and has highlighted interesting and useful points, but has mainly focused on the content of men's self-report. As potentially beneficial as it is for clinicians working with men during and after birth, as well as family members, to better understand how men experience difficult births and what factors could improve outcomes in these situations, the present research holds that these accounts are not windows into a discoverable truth, but discursive actions influenced by and contributing to the discourses that surround them. This perspective may be helpful to healthcare professionals as they listen to what men do and do not say about their experiences, assisting in offering appropriate and acceptable care to those who may struggle with emotional trauma. Thus an examination of the actions and functions of the accounts of men who report their child's birth as difficult would seem an important adjunct to our understanding of men's experience of traumatic birth within the current discursive environment, as well as potentially highlighting a wider range of discourses around fatherhood and birth available to (and resisted by) men who may be struggling with distressing birth experiences.

Research Questions

How do fathers narratively account for their experience of life-threatening complications in childbirth?

Aims

To explore how fathers construct their experience of a potentially traumatic birth through their spoken accounts.

To consider how men's construction of their accounts draws on relevant cultural discourses.

Methodology

Ultimately, the motivating desire of this research is to improve the experience of men when the birth of their child is experienced as distressing. Previous research, as discussed, has concluded that some men do experience distress, and there are trends in their reporting of the feelings evoked by attending a difficult birth. In addition to quantitative methods assessing prevalence rates and correlational factors, qualitative studies have utilised phenomenological and thematic approaches seeking to illicit an understanding of men's experiencing of birth. However, as stated above, the present research takes the view that the conclusions reached in existing studies must be tempered by a consideration of the active, constructive work being done as men produce their accounts. Further, it sets out to explore possible trends in the way men seem able to construct their experiences, stories and sense-making through talk, and how existing interpretative repertoires or discourses may be seen to operate within this talk. This is not to imply suspicion of the motives or intentions of the men, but to recognise that their accounts, like all accounts, are constructions influenced by contextual factors.

Analytic Approaches

While numerous qualitative methods aim to examine the personal experiences of individuals, discourse analysis stands out as examining how the accounting for experience shapes the perception of that experience and how that accounting is shaped by context. However “discourse analysis” has become “an umbrella term for a wide variety of different analytic principles and practices” (Edley, 2001, p.189). Many of these principles did not seem a good fit for this research. Critical Discourse Analysis and Foucauldian Analysis both take a top-down approach to discourse, often taking a political perspective in analysing the data and seeking to expose and challenge the power imbalances implicit in discourses. While issues of social power are clearly relevant, to minimise the imposition of my own power as a researcher, I wanted to adopt a more bottom-up approach, seeking patterns in the data as they emerge.

The interest in sense-making and identity formation through narratives of narrative analysis, and the concept of socially active and socially constrained constructions of discursive psychology both seemed appropriate for this research.

Edley (2001) suggests that while discursive psychology (DP) may be construed as a strand of discourse analysis, it is in itself “a complex field” with many strands, yet retains a central focus on the “action orientation” of people’s discourse. Horton-Salway (2001) describes DP as a reconceptualization of cognitivist understandings of psychological phenomena. Accounts are analysed as discursive practices and constructions rather than as representations of events, and discourse is seen as performing actions. This is not to say people are purposefully manipulative or untruthful in their accounting, but that the accounts they perform are active in constructing identities and social understandings.

Horton-Salway (2001) makes use of a Discursive Action Model of DP, in which analysis is concerned with what constructs such as remembering or attribution DO in terms of producing a version of events, objects and people. She focuses on how people attend to issues of agency, accountability and perceived factuality in their accounting. In particular, she looks at the discursive techniques people use to accomplish credible versions of events, for example, using the corroboration of

others or managing the risk of anticipated scepticism pre-emptive presentation of counter-argument. Additionally, she focuses on the discursive practices people use within their accounts to attend to issues of agency and personal accountability. The deployment of these features impacts the identity people are able to construct, and this research will consider these features within the data.

However, the Discursive Action Model, rooted in a conversation analytic approach in which analysis is restricted to what is presented within the data, does not account for the wider context in which the discourse studied occurs. Edley (2001) describes a critical discursive psychology approach in which discourse is embedded within historical contexts. He argues that a culture supplies a range of ways of talking about or constructing things, and people make contextually appropriate choices what constructions of events or objects to use from this repertoire. However, within that cultural context, some constructions will be more “available” than others, as some ways of understanding the world become more dominant, accepted as truths, or “hegemonic”, at different times. Thus critical discursive psychology is concerned with how historical and cultural context impinges upon and is altered by the performance of accounts, and how that impacts our subjective experience of events. As people are viewed as simultaneously the products and the producers of discourse, it aims to examine how identities are produced through discourse in the local context of the particular situation of their production and in the wider context of history and culture.

Edley (2001) makes use of three key concepts in analysing data. Firstly, “interpretative repertoires”, common-sense building blocks of social interaction- the library of ready-made constructions we use in our accounts, creating shared social understanding. We can use these flexibly and creatively as the situation demands, but conversations are seen as comprising a coherent sequence of these constructions.

Secondly, “ideological dilemmas”. These occur when these units of common sense we make use of so flexibly are inconsistent or contradictory. Edley (2001, P203) gives the example of the contrary notions “look before you leap” and “he who hesitates is lost”. Discursive psychologists view this fragmented, contradictory nature of discourse as part of our situational flexibility, but also as the seeds for social

argument, for the reciprocal development of alternative, competing repertoires and the foundation for personal and cultural shifts.

Thirdly, “subject positions” refer to the possible positions or identities available to people according to the discourses in use, such that our wider cultural contexts as well as our particular local context at any given time determine the identities we are able to adopt or assign to others. This carries with it the notion that as the discourses in use change, so too will our identities.

While this research makes use of each of these features in analysing the data, and I will return to illustrate these features further as I consider my own discursive context in producing this research, I want also to make use of the attention to the sequential organisation, the longitudinal aspects of sense-making of narrative analysis. Taylor (2007), answering criticism that discursive approaches fail to account for our perception of continuity in our construction of our identity across different occasions of talk, assimilates the notion that in addition to being positioned by available discourses, we are also positioned by who we have already constructed ourselves to be. Our narratives, while constructed anew to serve in a particular circumstance of telling, will be constrained by what we have said before, and each version we present will become resources for future talk.

Finally the concept of canonical narratives, the stock of possible story lines in a culture, characterised by Phoenix (2013, p.74) as “narratives of how life ought to be lived in the culture”, though similar to interpretative repertoires in their facilitation of shared social understanding, add a longitudinal element to considering the sense-making process of the men in this study.

As discussed above, within social constructionist approaches to research there is a commitment to the practice of reflexivity. Thus, before we come to the stories of the men themselves, my own story must be acknowledged. As Bruner (1987, p.709) says, “mind is never free of precommitment. There is no innocent eye, nor is there one that penetrated aboriginal reality. There are instead hypotheses, versions, expected scenarios.” In short, I am biased. I come to this research from within my contexts and I bring the constraints and repertoires of those contexts to bear on my approach to research. I have chosen a topic of interest to me, a way of viewing that topic which meshes with my ontological view that reality is not a discoverable

constant but a fluid construct, and a way of asking questions about that topic which meshes with my epistemological view that knowledge is not an objective truth, but a subjectively constructed understanding.

When I tell you I am female, a mother, and a psychologist, like a broken outline glimpsed through trees, you will fill in the gaps to construct a fuller picture based on similar shaped things you have seen before. As I flesh my story out, your understanding of me will become more sophisticated. But it will never become true. Because my story is subject to both my telling and your understanding, and both of those are subject to factors more complex than facts.

As I tell my story, I make use of “interpretative repertoires” to do so. Potter & Wetherell, (1987) explain an interpretative repertoire as “a lexicon or register of terms and metaphors drawn upon to characterize and evaluate actions and events” (p. 138), though there are clear in making no “grandiose claims accompanying the notion” (p.157). However, for the purpose of examining the “limitations that exist for the construction of self and other” (Edley, 2001, p.201), and by implication, the limitations in how we are able to construct our own accounts and sense making of events, I feel this notion that “when people talk (or think) about things, they invariably do so in terms already provided for them by history” (Edley, 2001, p.198) is a useful one to apply. When I tell you then, that my own first experience of childbirth was a natural, drug-free home-birth, that I laboured over a birthing ball and later in a birth pool, my partner in attendance throughout, I make use of a “natural birth” interpretative repertoire which evokes discursive resources which I assume are already also available to you regarding approaches to childbirth, enabling you to understand something of my own approach. This notion of interpretative repertoire however also encompasses the idea that I have, to some extent, chosen my childbirth experience off the rack.

Similarly, Narrative Analysts may suggest that when I, or any member of a culture, come to tell our stories, that we make use of “a stock of canonical life narratives” and “combinable formal constituents” from which we construct our own life narratives (Bruner, 1987, p.694) in accordance with the prevailing cultural conventions about the possible sequences and trajectories of a life. In this way, we make believing we are more or less understanding of and understood by others possible. When we

begin to draw from mismatched canonical narratives for our telling and our understanding, we experience alienation from one another. As such, when I tell you about the late night walks I took with my father as a 9 year old insomniac, and the discussions about the boundaries between reality and perception we had on those walks, I begin a story in which my current position studying clinical psychology and adopting a constructionist approach to my enquiries can be quickly recognised as a commonly understood sequencing of a life – it makes sense as story to most anticipated readers, because again, we both understand how stories are told here and now.

My use of these common discursive resources also helps you to fill in that picture of who I am. But these re-tellings are not only for your benefit. Bruner (1987, p.694) suggests that “eventually the culturally shaped cognitive and linguistic processes that guide the self-telling of life narratives achieves the power to structure perceptual experience, to organize memory, to segment and purpose-build the very “events” of life. In the end, we become the autobiographical narratives by which we “tell about” our lives”. And this makes the telling important. Because if I now tell you that I laboured for 107 hours without sleep, that, without pain relief, the corkscrewing slow turn that my son made against my spine over many hours was almost unendurable pain endured because my fear-addled mind could perceive no possible escape, that after my first birth, I felt an ongoing distress at recalling it which only resolved after my second, healing, natural homebirth, and that without my partner’s constant, steady, faithful presence, I don’t know how I would have come through it, that repertoire I had been using previously is transformed. I could tell the story differently. There are two issues I want to discuss with this.

The first issue is that there is a clash. On the one hand, I want you to see me as an “earth mother”, who birthed her children as all my fellow mammals have birthed theirs in dens and hollows, in fields and under trees for millennia before me. On the other hand, I am telling you it was Hell. Awful. That human evolution is freakishly out of step with basic reproductive tenets. Do these accounts marry well? Billig et al. (1988, in Edley, 2001) suggested that “lived ideologies”, made up of our cultural beliefs, values and practices, differed from “intellectual ideologies” in that they are not coherent or integrated but inconsistent, fragmented and contradictory. Lived ideologies present us with “Ideological Dilemmas”, when our constructions do fail to

hang together well. However they give us the ability to use them flexibly to make sense of the myriad scenarios we face in our complex world, to argue, to take differing positions about the same subject. We can use different repertoires depending on the different rhetorical demands of the immediate context (Seymour-Smith, Wetherell, & Phoenix, 2002).

The second issue I wish to discuss with regard the two versions of my birth story is the role of telling it on how I understand it. While closely entwined with the issues discussed above, I want to make distinct the idea that how I tell that story will inform how I feel about my experience and who I am. Just as my ability to adapt to my birth experience is different when I tell myself as a helpless slave to my biology or as a strong, phenomenal woman, the men in this study are likely to adapt differently to their own experiences depending on how they account for them, and how they account for them is likely to be limited by the discursive resources of their contexts. Discursive psychologists utilise the concept of “subject positions” – the “identities made relevant by specific ways of talking” (Edley, 2001, p.201). Davies and Harré (2001) suggest through learning about discursive categories and taking a position within categories, we begin to see the world from the vantage point of those positions and the metaphors and story lines which are made relevant by them. The extent to which our positioning is culturally determined, ingrained deeply in our consciousness by the equivalence of talk and thought such that they seem natural and inevitable (Billig, 2001) or used actively and flexibly according to our chosen position and the function of our discourse in its context is debatable.

I hope that looking for these features within my data, the ideological dilemmas, interpretative repertoires and subject positions of critical discursive psychology, the micro-features attending to credibility and identity of the discursive action model, and the longitudinal sense-making aspects of narrative analysis, will serve my research aims of exploring how fathers construct their experience of a potentially traumatic birth through their spoken accounts and considering how men’s construction of their accounts draws on relevant cultural discourses.

That my partner might have basic needs, let alone an emotional response beyond elation, to his baby's birth by the way, was acknowledged by no medical professional, no family, no friends. Which leads me to my research topic.

Data

Because this study aimed to make an in-depth exploration of fathers' constructions of experience of the significant life event of the birth of their child during which the mother developed life-threatening complications as opposed to generating statistically generalizable claims, a qualitative design was chosen. Although, as noted above, many advocates of discursive analysis would privilege the use of "naturally occurring data", the nature of the topic makes this largely impractical, and while focus groups could have been used, interviews can form a good compromise in the case of sensitive topics. Therefore in-depth semi-structured interviews were analysed to examine the discursive actions of men's talk about these experiences.

This study undertook secondary analysis of interview data collected by Lisa Hinton of the Health Experiences research group at Oxford University. The interview schedule used to guide interviews is included as appendix 5. This data was compiled for the patient website www.healthtalkonline.org by Oxford University researchers from the National Perinatal Epidemiology Unit and the Department of Primary Care Health Sciences, funded by the National Institute for Health Research Programme Grant and led by Professor Marian Knight. 35 women who experienced a life-threatening complication during childbirth, ten fathers and one lesbian partner were interviewed regarding their experiences and the long term impact of those experiences.

In line with the promotion of qualitative data sharing by bodies such as the Economic and Social Research Council, who now make it a condition of their funding awards that researchers both demonstrate that their primary research cannot be conducted using existing archived data sets and that researchers make their data available for archiving for future secondary research, this study utilised a sub-sample of the data gathered for Health-talk-online described above.

While there may be concerns regarding the "fit" of data gathered for another purpose to a secondary research question (Heaton, 2008), particularly as qualitative data

may be gathered in an iterative or evolving manner, there are also advantages to re-using data where there is sufficient “fit”. (Long-Sutehall, Sque, & Addington-Hall, 2010) make the case that appropriate secondary analysis can be a valuable method for exploring sensitive issues with an “elusive” population, a scenario which could easily describe men struggling with trauma or distressing feelings following comparatively rare pregnancy and birth events. The “fit” of the data, which was gathered using reasonably open interviews in which men were permitted to give free flowing accounts, works well with a methodology seeking to analyse how a phenomena is spoken about. While the primary research sought to gain an understanding of what was difficult for men and how they might be better supported by healthcare providers, the same data is used in the current study to investigate how the discursive context of the same event shapes and is shaped by the experience of that event, and how wider cultural and psychological processes may interact with that experience. Though the discourse to be analysed is likely to have been shaped by the purpose of the original study, the secondary use of that discourse when addressing a research question regarding the action of that discourse has the advantage of providing data in which fathers’ accounts have been created without conscious awareness of the possible analysis of the actions of their accounts.

Additionally, concerns may be raised about the intimate understanding of the context of the data so valued in qualitative research being removed by secondary analysis. However, Long-Sutehall et al. (2010) point out that this may be partially mitigated by the use of audio or visual recordings of the data, as in the current study where high quality audio-recordings were used alongside detailed transcriptions.

Participants

In line with the in-depth approach of this study, I planned to analyse 3 to 6 interviews. From the ten interviews with men, a subsample of six were chosen, purposively selected for having described lasting distress within the interview excerpts publically available on Health-talk-online. However, on obtaining the full interviews, it became evident that two of them were conducted jointly with their

partners and this was considered likely to significantly alter how the men constructed their accounts. Indeed their accounts within those interviews were relatively short and contributed to significantly by their wives. Demographic data provided on Health-Talk-Online ('Father's/ Partner's experiences in hospital : Healthtalkonline', n.d.) for the remaining four interviews which were used is presented here.

Pseudonym	Age/age at birth of child	Ethnicity	Previous births
Rich	34/29	White British	2
Chris	48/48	White British	0
Dave	43/40	White British	4
John	43/40	White British	0

Recruitment

The original sample of ten male and one female partner of mothers who had suffered a condition which threatened their lives during pregnancy or childbirth was recruited by the researchers described above and consent for secondary analysis was sought by the primary researchers. Recruitment packs (see Appendix 2) were distributed via the National Childbirth Trust, the social network forums Mumsnet and Netmums, newspaper advertisement, intensive care clinicians contacted through the Intensive Care National Audit and Research Centre, an advertisement in the UK Obstetric Surveillance System newsletter and word of mouth. Not all those who volunteered were interviewed. Volunteers were selected in an endeavour to include a wide range of conditions and times since the events, as well as socio-economic diversity. As the primary focus of the study was on women, data saturation was considered to have been achieved at 11 partners. The men were interviewed in their own homes by the primary researcher, Lisa Hinton, a senior qualitative researcher in the Health Experiences Research Group, having signed a consent form, and a semi-structured

interview guide was used. Men were offered the choice of video or audio tape. Secondary data was made available on audio tape and as transcriptions for all four men in this subsample.

Inclusion/Exclusion criteria

For this secondary research, a small sub-sample of the original data set was selected, based on those who were interviewed alone, whose child survived and who described ongoing distress. Those who described experiencing ongoing distress were chosen in line with the research question regarding how men construct their distressing experiences. At the time of requesting the data subset from the primary researchers this constituted 6 participants which was considered an appropriate number for a discourse analysis within the context of a research project forming part of a larger submission for a doctorate in clinical psychology. However only four proved appropriate, and the process and agreement for obtaining a subset of the data was not conducive to renegotiating additional access within the time frame available. However, analysis of those accounts in which lasting distress was not reported may have formed an interesting comparison to those where it was.

Analysis

Analysis in discourse analysis is not a proceduralised affair. In their paper about learning to use discourse analysis, Harper, O'Connor, Self, and Stevens (2008) note that the absence of discussion about how to actually conduct a discourse analysis may be both surprising and mystifying to the novice user. Edley (2001, p. 198) refers to it as a "craft skill rather than being something that one can master from first principles", and one that develops through practice. Edley's guidelines for seeking instances of interpretative repertoire, ideological dilemmas and subject positions were applied to this data, with instances of phrases or ideas that repeat between or across interviews, evidence of competing or contrary themes, and consideration of who is implied by what is said respectively. Having received these first, familiarisation began with an initial reading of the transcribed interviews. The audio

recordings of each interview were then listened to with the aim of hearing the stories as they were told, in their entirety before commencing analysis. A further listening with simultaneous reading of transcripts was conducted to identify any differences between the two mediums, and this exercise was repeated as segments which stood out or repeated patterns within each story were noted and annotated, after which an overview of each individual account was written. Continuing to work from the audio recordings colour coding and highlighting on the transcripts segments showing evidence of use of discursive techniques, interpretative repertoires, canonical narratives, ideological dilemmas and subject positions of the men (see Appendix 4 for sample), similarities and differences between the stories were addressed. This helped to highlight recurring discourses which were treated as themes or distinctive strands within the stories for the purpose of arranging the analysis. As analytic strands began to emerge, coding and notes were modified and refined as the audio-recordings were listened to again. This process was refined and elaborated over several more listenings. Examples fitting and deviating from these strands were then sought as thematically orientated segments of analysis were developed. These extracts were re-transcribed in greater detail (see Appendix 3). Increasingly transcripts became more relied upon than audio-recordings due to the capacity to search for key terms easily. However, it was apparent that this resulted in increasing distance from the data and analysis was suspended while the data was listened to once more before resumption of using transcripts as an adjunct to audio-recordings. The functions and effects of the features identified in the interviews were then discussed with reference to the research questions.

It is worth noting that throughout this research, the term “story” is used not to refer to a fictional or untrue tale, but in line with Sarbin’s (1986a, cited in Crossley, 2000, p.532) understanding of a story as “a symbolised account of actions of human beings that has a temporal dimension”. The accounts performed are seen not as calculated manipulations of the truth but as constructions embedded in the context of their own telling.

Ethical issues

Ethical Approval:

Ethical approval was granted for the project by Berkshire Ethics Committee (protocol number 09/H0505/66) from 05/09-09/12 and NRES Committee South Central (Berkshire) (REC reference number 12/SC/0495) from 09/12 to the current time (see Appendix 1). These approvals were inspected by Prof. Richard Southern and accepted as compatible with University of Hertfordshire standards (see Appendix 1)

Confidentiality of Participants

An initial sub-sample of the data based on the criteria above was assessed for suitability for a smaller sub-sample for analysis, and any data not to be used was returned to the primary researchers immediately. All data has been kept securely on password-protected computers; any paper or audio- information has been securely locked away. Each participant retains the pseudonym provided with the data and already in the public domain ('Father's/ Partner's experiences in hospital : Healthtalkonline', n.d.). Access to this data will be limited to the investigator and primary supervisor only, without the prior agreement of the primary researchers with reference participants' original terms of consent.

Informed Consent

Informed consent for both the primary research and the use of data for secondary research was obtained by the primary researchers.

Fisher and Anushko (2008) suggest that within a changing social and political context, the validity of consent to archive data for future use may be questionable if data is to be used for research questions "inconsistent with the consent understandings of those who initially agreed to participation and preservation". They draw particular attention to data collected from oppressed people or collected in an ethically questionable manner. However, in this instance, the data collection and the participants' consent to archive use of the data occurred very recently and changes

in the social and political landscape are unlikely to be significant. Further, the ethical considerations of the primary research have been subject to the guidelines of a major academic institution (Oxford University) and a major research funding body (National Institute for Health Research Programme). It must also be noted in this instance that participants have consented to the use of their raw data in the form of video, audio and transcript excerpts on a website designed for broad public use and as such have shown a commendable willingness to share their stories with a wide audience who may receive them in a myriad of ways in order to improve the support others with similar experiences are able to access. Bishop (2005), writing in response to a critique of qualitative data archiving by Parry & Mauthner (2004) discussing the issues of whether consent can be valid even within a reflexively changing qualitative research process, let alone in considering the long range possibilities for archived data use, views issues such as these as challenges in a developing and important field rather than reasons to desist in the archiving and re-use of qualitative data sets.

Psychological Harm

By using secondary data rather than recruiting and interviewing men regarding their distressing experiences, it is hoped that further risk of psychological harm could be avoided. Issues of informed consent as discussed above may result in conclusions being drawn which were not anticipated by participants when consent was initially given; however, as the men involved have already consented to the inclusion of raw data on a website for use by the public, there will always have been an additional risk of their information being received by others in unanticipated ways.

Conflicts of Interest

There are no conflicts of interest to be stated.

Criteria for Quality Assurance

Research conducted in a positivist tradition in which a discoverable truth is sought, utilises the notions of validity, reliability and replicability as measures of the quality of research- does the research examine the phenomena it purports to, are assessments consistent and the results replicable. However founded in an epistemological belief in the constructed nature of knowledge as opposed to knowledge as truths discovered, these notions cease to have evaluative applicability. Discourse analytic research results are viewed as contextually situated and reflexively produced by a researcher who brings their own contextual factors to their enquiry.

Taylor (2001) outlines a number of criteria for the evaluation of discourse analytic research. Firstly, positioning the research in relation to previously published work is standard practice in producing a literature review and methodological description, as performed above. She argues research should be coherent or rigorous, dependent on presenting an argument founded in a systematic analysis of the data rather than simply reproducing it as if its intrinsic value is equivalent to academic analysis, an aim I have endeavoured to fulfil as I conducted my analysis by applying a technique of coding in line with discursive psychology concepts as outlined above before developing thematic arguments through the examination of coded data and highlighting instances of inconsistency within those thematic areas (Potter & Wetherell, 1987). In line with Taylor's suggested possible methods for ensuring rigour, I have also attempted to provide richness of detail in the data presented such that readers can evaluate the coherence and utility of my argument. The utility, fruitfulness or pragmatic use (Potter & Wetherill, 1987 and Riessman, 1993 cited in Taylor, 2001) of my research is also given consideration in my discussion and conclusions regarding the applicability of this study to clinical practice and to future research. Additionally, (Nixon & Power, 2007) propose a six point framework for establishing rigour specific to discourse analysis research:

1. Clear research question appropriate to DA?
2. Clear definition on discourse and species of DA
3. Effective use of theoretical framework – clarity and explicitness in epistemological and ontological positioning

I have endeavoured to attend to these features in my rationale for the research questions and, though I have chosen to draw from more than one “species” of DA, the pertinence of the strands of DA I have chosen to use.

4. Transparency in analysis methods and application of theory to the analysis
5. Clarity in selection of talk/texts
6. Concepts/criteria/strategies to guide analysis

I hope that through outlining my own relationship both to the research and the data itself, including how that is impacted by my secondary use of the data, I have facilitated a transparency that will aid the trustworthiness of my analysis. I have also sought to outline the strategies used in my analysis and utilise a good range of extracts from the data to represent each of the men and demonstrate the credibility of my arguments.

Analysis

I begin by presenting an overview of each of the separate stories I heard such that a sense of the work being done by individual narratives can be gained. It is worth noting that these overviews are constrained by word limits and what is presented has been constructed by the researcher as important or pertinent. I have also tried to avoid excessive repetition of material analysed across narratives.

Following this I have separated out those strands appearing across the data set which were striking in terms of how men spoke about or made sense of their experiences. This was made difficult due to the interwoven nature of the features discussed. How these men positioned themselves within discourses about medicine plaited into how discourses of masculinity positioned them in terms of being cared for, which wound its way around how men interact with discourses about emotional difficulty, and so on. In line with the constructionist ethos of this research, I have situated my analysis in the academic discursive context of surrounding literature rather than presenting this as separate to the analysis I have performed.

Individual Narratives

Rich:

Rich's wife was diagnosed with placenta praevia at 32 weeks into her third pregnancy. Hospitalized for the rest of her pregnancy, she haemorrhaged during a planned caesarean. Doctors performed a hysterectomy to save her life. Their baby was taken into special care. Rich tells how after his wife and baby came home, he reduced his work hours as a stock room manager to take care of his family. After four weeks Rich was hospitalised himself for two nights with nervous exhaustion, and due to *"a few little things"* such a *"breakdown(1) er diagnosed with(.) posttraumatic stress(.) depression as well(.) and agora(.)phobia"* Rich was unable to continue working.

Rich is cued by the interviewer to begin his story by describing his wife's first two pregnancies. He glosses over the second pregnancy as *"smooth as smooth"*, crediting this to Rich and Sarah's own decision following their first, emergency, caesarean, to have a planned caesarean because *"we didn't want to go through that(2) again"*. This was contrary to his voicing of the doctor's uncertain protestations that *"Oh it might not happen, it might(.) yu, you know(.) it's just one of"* which he overrules with his own more decisive *voice saying "Whatever', we said, 'we're not even going to chance that"*. Rich positions himself as seeking and taking more control over childbirth following his first experience.

His description of the previous emergency caesarean introduces early in his narrative his prior experience of *"before and after"* hospital maternity care as being *"a bit pants(.) really(.) to say the least"*. He relays the account in an angry tone, setting the scene for his more recent experience and response to it. He also strengthens his claim to credibility in this judgement by drawing on the voices of *"lots of complaints from(2) lots of mums that Sarah knows about the care that you get there is(1) is next to none"*. This corroboration is reinforced by a specific example from Sarah's sister, after which *"even she noticed that(.) they just don't really give a monkey's"*. Later in his narrative Rich draws a stark contrast between *"amazing"*, *"different breed"*, *"unsung heroes"* medical staff on the neonatal and intensive care units and *"stupid"*, *"insincere"* and *"cold"* maternity and obstetric staff, the two pictures serving to throw

their counterpoints into relief, but also positioning Rich as someone with the experience to judge between good and bad care and not a habitual complainer.

Rich positions himself in a caring role, stepping in to take responsibility for his wife as he recounts how *“Huh(.) went down to speak to the doctor about it because Sarah’s quite sick in herself”*. He suggests both tenacity and flexibility in describing how *“you’re try it nicely, an’ you’re trying the begging and then you have a temper tantrum”*, implying the ubiquity of the flexible use of discursive patterns according to the context with the generalising use of *“you’re”*. This *“you’re”*, together with the step-up through progressive levels of trying to influence a decision position Rich as a reasonable person, both caring and agentive. However, he describes being dismissed by the consultant who *“left the room(.) and that was the end of our(.) consultation”*, thus beginning an ongoing presence of a discourse regarding disempowerment in medical scenarios, a position which may also carry with it a reduced personal culpability for what happened.

Following Sarah’s surgery, Rich describes how a nurse takes him to see Sarah, telling him the *“hearing is the last thing to go(.) and then shut the door behind me.”* Rich describes interpreting this comment, incorrectly in this instance, in line with cultural connotations of a person nearing death, highlighting how recourse to an interpretative repertoire which a speaker did not intend to reference can lead to dramatic miscommunications. As Rich points out *“what else’re you gonna to think?”*

Following Sarah’s discharge from hospital, Rich presents his struggle balancing his *“traditional”* role as breadwinner and this new *“not actually my role”*, of caring for his family, as well as his own emotional distress. Rich explicitly positions himself as *“traditional”* in his understanding that *“men are men and women are women”*, an influential position in his sense-making, and one I shall examine in more detail in the following sections.

Rich tackles the dilemmatic subject positions of being a *“traditional”* man and struggling with emotional distress by drawing on repertoires of male mental illness. He obtains a diagnosis of PTSD and describes his primary symptom as flashbacks, drawing analogy with PTSD in soldiers first by describing Sarah’s wounds as requiring treatment more usual on *“the battle(.) front”* for *“a gun(.) wound”* and later by saying of his flashbacks *“I didn’t believe when soldiers come back saying”*. This

idea of prior scepticism regarding flashbacks also serves as stake inoculation (Potter, 1996, cited in Horton-Salway, 2001), defending against the risk of suspicion that Rich has a particular interest to be served by his claim on mental illness.

Rich assists the perceived validity of his narrative in several ways. He builds an identity as a reasonable man, tempering assertions of wrong doing with the idea that *"I appreciate"* the challenges others face. In line with Horton-Salway's construction of factuality and authenticity as discursive accomplishments, he highlights his own incredulity, prefacing stories with *"just beggars belief with me"* or *"you're not going to believe this"* pre-empting accusations of implausibility. As well as attesting to the particular accuracy of key elements with *"his exact words"* or *"I remember as clear as day"*, he immediately confesses *"I tell a lie"* when he needs to change a detail, demonstrating his transparency in much the same way as I endeavour to demonstrate mine in establishing the validity of the account offered.

Rich weaves into the latter part of his story a strong trans-generational family narrative of resilience and self-reliance, that *"as a family, we've fixed ourselves"* and creates a progressive trajectory of improvement in their situation, though he says *"I don't think I'll ever(.) properly get over it"*. His narrative is co-constructed with the interviewer who asks questions which direct him to certain areas, but of course most fundamentally, direct him to talk about his experience at all, something he says he was unable to find an opportunity to do previously despite having sought support, *"a difficult decision to make(1) especially coming from like what I said earlier(.) where men are men in my family"*. Perhaps it is poignant then that his interview is terminated by the entrance of his wife, and her agreement with the female interviewer that the interview is finished as it is time for the practicalities of picking children up from school.

Chris:

At 37 weeks into her first pregnancy, Chris's wife became very ill with suspected obstetric cholestasis. Labour was induced but an emergency caesarean section was required to deliver their twins. Chris, a software engineer, tells how during intubation for the anaesthetic, food matter passed into Mary's trachea, creating an emergency.

With the shortest interview of the four, Chris seems unsure what he is expected to talk about, struggling to begin. When asked if he could tell “your side of the story”, he offers a relaxed sounding “*Yeah(.) sure*”. After four seconds silence, the interviewer prompts him to talk about the pregnancy. Chris also asks “*do you want me to talk(.) all the way through that?*” regarding his wife’s induction, peters out mid interview with “*I don’t know what else to say now*” and clearly indicates the end of his story with “*I can’t say any more*”. Chris may not be used to creating a narrative of his experience, but he may also be hesitant to revisit that story. Chris describes his emotional responses to his experience, “*getting very excited*”, “*very upset*” and at one point telling the interviewer he was trying not to cry. Edwards (1997) suggests use of emotion in narrative can help account for behaviour as contingent upon temporary context rather than indicating lasting characteristic of identity. Chris positions himself as subject to temporary impairment anyone might struggle with, rather than as unable to process information as a general rule when he says he “*Didn’t really pay that much attention to be honest cause(.) I was(.) a little bit on the(1) freaked side*” and “*when they’re talking and you’re not hearing(.) cause(.) and(.) I was trying to stop myself thinking bad things(.) and trying to listen to what they were saying. I just just couldn’t understand what they were saying to me*”.

Chris also sets the tone regarding his experience of medical staff early on, reporting feeling “*a little bit let down*” and “*very upset*” by a misdiagnosis as his wife became ill. His descriptions of medical staff set up two categories of “*them and us*”, a gulf between doctors who “*might as well have been talking Chinese*” and “*laymen*”, constructed linguistically and physically, when he describes “*standing on one side and they were like surrounding the other side*” of his wife’s bed evoking a sense of being isolated by membership of a different category.

Chris’s narrative has a number of turns. Many of these are marked by the phrase “*turned round*” preceding voiced speech, as in “*they turned round and said...*” Frequently Chris reports verbal communications to be pivotal actions in changing his understandings of events; however, it is his report of a non-verbal action which conjures an interpretative repertoire regarding procedures in dying which sets Chris wondering “*how am I going to cope(.) without Mary*”. When Chris sees a nurse removing Mary’s rings he concludes she is dead and being held on life support.

Chris volunteers another non-verbal action in corroboration of the interviewer's co-construction of his experience as a "stressful time?" telling of his subsequent decision to have a vasectomy. Initially he says "half of it's probably the experience we went through." However, following accounting for the reasoned nature of that decision, it becomes "absolutely(.) yeah(.) hundred percent" attributable to his experience. This illustrates how his own narrative may be shaping his understanding of what has happened as he talks in the interview. Indeed he says he and Mary "still talk about it(1) so we haven't(.) quite put it behind us", illustrating how this sense making is a shared, social endeavour. Chris finishes his interview in a position of positivity and hope, in praise of his "wonderful(.) children" and "absolutely amazing" wife, before sealing this ending with "I can't say any more".

Dave:

When Dave's wife's labour with their fifth child was induced, she developed a rare condition, Amniotic Fluid Embolism. She haemorrhaged and had to have a hysterectomy to save her life. Dave describes how his wife was "losing blood from(.) everywhere. Sort of basically eyes, nose, mouth, ears, everywhere. It's coming through her skin" and describes how a "particular drug", which is not widely available was used to stop the bleeding. Having used their supply the hospital "flew another one in(.) on helicopter or motorbike", and Dave constructs a vivid picture of how the hospital was "pumping blood in(.) and basically it was coming out. She lost all her blood and they were just pumping everything in". Dave recounts being told that "all you can do is pray. There's nothing the hospital can do".

Dave never tells us whether or not he prayed, however processes beyond human control feature several times in his narrative. Dave differs from the other interviewees in that he is almost consistently praising of hospital staff, overtly attributing their success to three factors. First, he describes "the experience and the knowledge that they actually have", secondly he tells how it is "instinct total with them people", and third, that "luckily" the right doctors had talked about the right drugs recently in the right hospital. Luck, or some power beyond human control features highly in Dave's narrative, using numbers such as his daughter's birth time and weight on his lottery

ticket, feeling *"like I'd won the lottery"* as his wife prepared to come home, and wondering if he is *"cursed"* after two troubled birth experiences. This repertoire of fate, fortune or prayer encompasses the construction of doctors as *"being like a god in my eyes"*, and manages a dilemma between medical impotence and the relinquishing of responsibility, and masculine potency by creating an inevitable position for any powerlessness Dave experiences. Dave seems to position himself less in a position of discordance relative to doctors, but more as a willing disciple. His deification of them as *"a god"* also serves to mystify that power. At the same time however, Dave uses the familiar *"bloke"* to reference doctors, implying group inclusion. Dave seems to further align himself with staff by describing how he knows *"everything about (hospital) [interviewer laughs]. You know(.) I know where all the doctors and nurses go for sneaky fags and stuff like that [interviewer laughs]"*. Perhaps it is through constructing a narrative in which Dave positions himself within the fold of the powerful that he is able to maintain his position of empowerment as a man in a discursive environment where men retain control. Thus he moves construction of his masculinity not into conflict with the power wielders of this reified social order, but into collaboration with them.

Dave constructs his wife, with whom he has had four previous children, as the type of woman who *"gets it over and done with as normal"* when approaching birth. She is positioned as strong, straightforward, robust. When the doctors run out of things to do, Dave voices their handover with *"There's nothing else we can do(.) it's down to her"*. The strength of Tia appears to be a fourth factor in her recovery, but also in the recovery of a family to whom she is central. It is when *"Mum stepped through the door"* that the family is constructed as beginning to heal.

Dave positions both himself and his wife as *"normal"* in extraordinary circumstances, such that what happens, and their responses to it, are not reflections on their enduring identity. As things move away from a canonical narrative of *"normal"* birth, Dave continues to construct if not his experiences, then his responses, as normal. His critically ill wife is *"not a nice sight" "for anyone"*. When the interviewer sympathises that he had a lot to manage, he informs her *"But you would manage with it(.) as well"*. When discussing whether he should have told his wife their baby was unwell he invites his audience, real and imagined, to ask themselves *"what would you do?"* His family *"have feelings(.) you know(.) we laugh(.) cry(.) joke just*

like anybody else(.) you know(.) normal family". Dave makes scant reference to the emotions, tiredness or confusion the other men may attribute their responses to, removing them from the more permanent, stable identity they build from themselves and placing them within the realm of the transitory and understandable. However he does seem to make use of a more overarching concept that any of us would do the same, perhaps both avoiding the necessity of detailing his emotional responses as they are encompassed in a "*what would you do*" repertoire of "*normal*" responses, and casting his ultimate "flashbacks" and "*visions*" not as a personal failing, but as understandable, because they are normal.

John:

After caesarean delivery of John' first child, his partner developed Amniotic Fluid Embolism. John tells of being "*escorted out of the theatre*" with the baby and described at one point understanding that Cheryl had a 50/50 change of survival. He tells how Cheryl was placed in a medically induced coma for 24 hours and he was told to go home and rest, leaving his baby on the children's ward. The following day Cheryl was awake before expected and soon after the family were moved onto the maternity ward. However, after two or three days, Cheryl had to be moved into isolation on a different ward and John was suddenly sent home with his daughter.

John elects to begin his story in the run up to labour saying "*what the first thing was that(1) um(.) due date was my birthday [interviewer laughs] and(.) I was doing some extra work at the time(.) working evenings as well(1) um(1) I was sort of er(.) always had my phone with me sort of expecting this call*". Very quickly, John constructs an identity for himself in which he is hard working in his job as a counsellor, perhaps even positioning himself within a discourse of masculine roles in the family, but also conscientious in his family role. His reference to "*expecting this call*" and how his birthday came and went and people at work he was "*not expecting to see for a while*" started to ask "*no baby yet?*" gives the sense things are already deviating from the canonical narrative of birth. At the end of the first minute of his story we reach the beginning of labour. Once here, John positions himself as part of a patient unit and a couple noting how "*we*" went in to hospital. He then points out at this early stage of

his narrative that “*cause of course(1) we didn’t sleep for(2) a very long time*”, constructing his perceived failings as short term and situational rather than lasting features of his ongoing identity.

The prominence in John’ story of the practical difficulties he faced in the early weeks of fatherhood, while his partner was in hospital and he was at home with his baby, left little space for talk about his partner. At the end of his story, my personal response was a questioning of what had happened to Cheryl. This may reflect my own adherence to a birth narrative in which the mother’s story is central, even in the context of an interview requesting the father’s. John discusses how he tells himself “*you can deal with emotions when(.) people have(.) survived*”, normalising this approach by reference to seeing clients at work use the same technique. This “*practicalities first*” approach may be part of a wider discourse in which people do what they need to do to survive trauma.

Though he starts his story using “*we*” and “*our*”, positioning himself alongside Cheryl as parents, these pronouns abruptly disappear to be replaced by “*I*” at the point his daughter is born and he is rapidly “*escorted out of the theatre*”. He is not reunited with his partner in a “*we*” again in the temporally progressing story until the family is physically reunited on the maternity ward. This indicates both that John considered himself part of a couple to be seen as a unit as he came into hospital, and that he became entirely cut off from that, and the care that comes with the position of patient, once things became critical. A similar phenomena was discussed by Longworth and Kingdon (2011), who described fathers as disconnecting from their partner’s birth and not considering themselves a family until the enforced separation of hospitalisation ceased.

John positions himself as in need of care with his references to “*back-up*” plans in which he enlists support from other, usually more parentally experienced, adults. This need is extensively justified by his being “*done in*” and “*shattered*”, linking those feelings to a lack of sleep, though no reference is made to any emotional need. When John does not pick up an answer phone message before leaving for the hospital one morning, he appraises his thinking as “*really odd*” and “*crazy*”, positioning his behaviour as out-of-character. Indeed by saying “*there was a part of me that kind of thought(.) I’ll deal with it when I get there*”, John further constructs a

separation of his enduring self from this split off self who behaves “*bizarrely*” and thinks “*stupidly*”. However aside from the conjecture that it was “*probably a bit of denial*”, a phrase possibly positioning himself as able to appraise his behaviour with a degree of expertise as a counsellor, John allows his construction of this uncharacteristic interlude to make implicit to anyone utilising the same interpretative repertoires around stress the emotional strain he was under without having to detail it. He uses a similar technique in referring to “*emotive stuff*” and “*fall-out*”, simply allowing his audience to fill in the detail based on the accompanying interpretative repertoire. Speculatively, this may help John negotiate the dilemmatic positioning as masculine within a discourse in which men don’t succumb to “*emotive stuff*” and his position as a counsellor who is comfortable and familiar with “*emotive stuff*”.

Major Interpretative Repertoires

Normal Birth

Repertoires of birth presented by the men in this study are notable by their use as a juxtaposition against which the men measure the experience they had. Whether prepared for an “*alternative*” birth like John, evoking an identity as holistically orientated, a “*normal*” birth like Dave, or “*clockwork*” caesareans like Rich and Chris, evoking a straightforward disinclination to unnecessary drama, the men present these repertoires of commonly anticipated births as the starting point from which their own experience deviated. With a paucity of repertoires encompassing their experience, the men instead demonstrate its departure from a repertoire they establish as expected early on.

Medicine

A repertoire of medicine as belonging to a different, separate world from the everyday real life world of the men is used with comparison to fictional and even science fictional scenarios by Dave, John and Rich. Recourse to a repertoire only accessed through fiction suggests a shortage of real-life widely available interpretative repertoires genuinely useful to those undergoing a medical crisis, but also illustrates our use of stories and television to make sense of our experiences. John and Chris also illustrate this idea of a medical world as separate from the

every-day world by describing the language used as different and excluding to non-medical professionals. This separation of worlds not only separates men's feelings, positions and behaviour within that context from their more enduring identities but also accounts for their powerlessness in an unfamiliar context.

The Brink Of Death

The participants in this study have been selected on the basis of having experienced a near-miss event in which their wife or partner was at risk of death during childbirth, though the women did ultimately survive with medical intervention. It is unsurprising then that repertoires of being on the brink of death are presented. While Dave presents a repertoire of life and death out of the hands of mortal medicine, including himself, with the notion that that *"all you can do is pray. There's nothing the hospital can do"*, Rich and Chris both describe how their perception of the presence of an interpretative repertoire around dying (talk of the hearing being the last thing to go, and the removal of rings) led to understandings of their situations which are used to account for their subsequent emotional distress.

Emotional Distress

Interpretative repertoires of emotional distress are used differently throughout the narratives. John uses phrases such as *"emotive stuff"* and *"fall out"* referencing an interpretative repertoire of emotional response whilst leaving its content as conjecture for the listener. This still affords the advantage of enabling him to attribute his behaviour during the crisis to emotional distress by using an interpretative repertoire in which emotional distress accounts for out of character responses. Rich counters his difficulty reconciling his emotional *"breakdown"* with his familial repertoire that men *"don't do emotions"* with a repertoire of mental illness drawn from a military scenario. However this repertoire of emotional distress as lying outside the permissible range of functioning as a "man" is used by other Dave and Chris also. Further, Rich, Chris and John each present physical descriptions of their distress, suggesting a physical domain is more concordant with their identity construction, or that emotional distress requires verification, physical evidence.

Masculinity

A number of interpretative repertoires regarding masculinity are used by the men, as will be discussed in more detail below. However, an interpretative repertoire of being a “*traditional*” man is widely referenced, creating a position as a stabilising, strong provider and protector within the family system. Rich describes the family’s confusion at having gender roles disrupted, though John considers this to have been a positive thing. Dave discusses his role as the supporter of others in the family, and Chris makes explicit the failure of maintaining this position as “a man” if he allows himself to cry. Though John does not make an explicit link between his “*practical mode*” in the light of emotional crisis and his masculinity, each of the other men demonstrate a dilemma between maintaining a “traditional” masculine position and acknowledging their emotional vulnerability, both demonstrating to any listener their position as “men” under normal circumstances, and the limitations of a “*traditional*” man interpretative repertoire.

Motherhood

An interpretative repertoire in which a nurturing, present motherhood is seen as a natural, necessary and desirable state is called upon by each man in describing the toll the events of the near-miss took on their families. Dave describes how he tried to plug the gap, temporarily, in enacting a maternal role for the baby, but Rich and John report the lengths that were gone to in order to facilitate their partner’s being able to begin to establish that role themselves. Rather than adopting a repertoire in which the men view themselves as “father”, the utilisation of this repertoire of motherhood creates a position of “not mother”, and the child-caring they perform is from within a repertoire in which child-caring remains in the female domain, with men demonstrating flexibility in being perform that role.

Separating the strands

Failing birth narratives

One of the first things that became apparent on listening to the interviews was that each of the men expressed a sense of what they expected to happen at a birth, a canonical narrative of childbirth in which labour begins, obstacles are overcome, a baby is born and joy wells, which was instrumental in the way they made sense of what DID happen.

Though less immediately available than the narrative I have described, narratives are available for births in which problems arise for the baby. However, maternal morbidity in the UK is currently mercifully rare, which means we don't have the scripts so easily to hand. John sums up the issue the men in this sample seem to grapple with:

"I can remember(.) thinking kind of what opposite kind of experiences were happening because you know there's kind of healthy parents with ill children and(.) I suppose that was kind of almost(2) that's your worst fear(.) going to have a(.) child you think(.) or I was thinking of all the things that can be wrong with the child(.) you know(.) it can be born with [inhales] you know(.) disabilities or things can go wrong and it can die or(.) and I never(.) thought that(.) the baby would be fine(.) the parent would be ill(.) you know(.) kind of(.) it was the thing that(.) it's not a scenario that you kind of(.) go in with"
(John:24/1.05.09)

Pollock (1999) suggests birth stories "embody in miniature long and wide histories of sometimes violent knowledge practices. They (re)produce maternal subjects" (p.1). She discusses the widespread availability of the linear, "progressive" narratives, describing how "with all the flourish of a Shakespearean comedy, they delivered order from disorder and pleasure from abandon, transgression and pain" (p.4), and argues that whilst taboos against talking about birth are eroding, about "bad" births they may be getting stronger, bodily failure or indeed death being "an embarrassment to discourses of scientific progress" (p.6). Indeed she argues that even before birth, conventional conversations about due dates and anticipated sex of the baby "locks new parents into a narrative script that simply lacks room for...

aberrations in the “normal” scheme of things (p.5).” Constructing a narrative which includes this disallowed discourse may then risk creating a subject position for the men or their wives as also aberrant. This renders these stories hard to tell and perpetuates the scarcity of utilisable interpretative repertoires of “bad” births for parents and healthcare practitioners alike.

All four men seem to continue to fit their experience into the dominant “normal birth” narrative, moving attribution of blame for events away from themselves or their wives, who were proceeding according to this narrative. There is evidence of different interpretative repertoires of “normal” birth. John positions himself as almost immediately deviating from his “*alternative*” approach to birth:

“there was the normal(.) bit and then there was this bit where we were(.) meant to be going(.) which was for kind of(.) water-births and kind of bits of alternative suite [interviewer: Hmm] er and(1) we didn’t go in there”
(John:2.26/1.05.09)

By contrasting “*the normal bit*” with the more exclusive sounding “*alternative suite*” he was “*meant*” to use, he positions himself within a repertoire in which birth is constructed as a natural, woman-centred experience, in opposition to that of birth as a medicalised procedure, but nevertheless an established and easily available repertoire. Rich however, describes a planned Caesarean as running “*just like clockwork*”, while Dave’s description of how his wife “*gets it over and done with as normal*” when having an induction and Chris’s use of the medical phrase “*so we all gowned up*” as part of preparing for surgical birth suggest wide acceptability of a medicalised birth repertoire as part of the accepted narrative of birth. This positions them as not objecting to or overly fearful of this type of birth, countering potential accusations of being unduly dramatic in their telling of a story of a normal medical birth rather than an abnormal birth. Indeed the normal birth story is expected by Chris to be so ubiquitous that after beginning it, he simply indicates that we should assume it is there:

Oh(.) in ten minutes we’ll have two little babies(.) Blah di blah
(Chris:5.40/34.20)

Difficulty relinquishing this normal birth narrative is suggested by each of the men’s stories. Indeed often it seems to be the dissonance between expected progress

based on the “normal birth narrative” and what is actually happening which alerts the men to an issue. John describes things not matching up:

“I just thought this isn’t how it [laughs] how I’ve seen it on TV you know(.) cause [daughter] was taken over to um I know that they weigh the child(.) but she was put over on a(1) table(.) but on(.) like a stand er and I dunno there was something about the looks tha- I I didn’t pick up any words or any clues that kind of(.) set off alarm bells but there was kind of(.) looks and um cause the baby came out and I was like(.) what is it? You know [laughs] I’d sort of(.) I’ve seen people, you know(.) they say(.) Oh congratulations it’s a whatever(.) you know.” (John:6.01/1.05.09)

Rich draws on his position as a man who has waited for two previous caesareans to finish to judge what was normal:

“bearing in mind how quickly they’d(.) the other two had gone(.) about ten eleven minutes or whatever start to finish(.) I think half an hour had gone by and no-one had come out and I didn’t even(.) I wasn’t even worried” (Rich:16.31/1.35)

He establishes an identity as someone not inclined to undue worry, which, when he tells that he “*started to get a bit twitchy(.) with an hour*”, because he still had no information, renders his concern more credible. In essence, the men in this sample told of how they understandably drew on established narratives (either from personal experience or cultural norms) of what to expect, and of how they were left feeling shocked, in need of a “*back up plan*” (Chris) when events diverged from available narratives, or to be provided in advance with other possible narratives:

“Difficult to cope with but you could get your head around(.) what’s coming(.) what could potentially come(.) so it’s not a shock like before(.) I had no idea(.) didn’t see that coming in a million years” (Rich:41.50/1.35.01)

Using in-depth interviews with men before and after the birth of their first baby, Dolan and Coe (2011) suggested it was the uncertainty surrounding childbirth which caused men most concern. The men in the current study set out efforts to create predictability in birth. John and his partner made a birth plan, while Rich and his wife planned a caesarean after experiencing an unplanned one, telling their doctor “we’re

not even going to chance that". Chris "decided we would never have any more children" and had a vasectomy following his experience, perhaps the ultimate control over the progress of a birth. As things veer off plan, Rich constructs medical staff as failing to provide alternative narratives that could re-instate some predictability, saying "it wasn't like they said(.) "look(.) this is heavy stuff(.) you know(.) this could *potentially happen*". Though medical staff may have scant information to communicate in an unpredictable emergency, its lack is something highlighted by each man, perhaps enabling them to attribute their lack of preparedness to medical staff rather than suggest their own culpability. This may have important ramifications for whether their distress can be seen as something they could have prevented, or something beyond their control, with each having its own social implications.

Rich and Chris both talk about the desire to "get your head round" what was happening, and their inability to do this due to lack of information, their difficulty making cohesive sense of the traumatic without the necessary sense-making discursive resources. Rich makes clear the importance of being prepared to use an alternative story:

"I would have liked to have known some idea(.) rather than going in on that morning all(1) everything's lovely(.) and we're going to have another baby [laughs] and then the whole world just caving in on me" (Rich:14.45/1.35.01)

Here the impact of the failure of events to match expectations is described as a complete collapse of Rich's constructed world.

But it is not just the absence of an alternative discourse that challenges the men as they try to make sense of their experience. The contrast of what happened against the contrast of what was expected to happen is also jarring. As Dave says:

"meant to be a happy time picking your baby up don't ya(.) You know (unintelligible) and everything(.) your brothers and(.) y'know the siblings come along(.) but it's not(.) all I get is visions of her being whizzed passed me(.) my wife(.) doctors ran and nurses ran and all of a sudden your baby is being whizzed straight past you(.) and she's going to(.) special care baby unit(.) you know(.) in an incubator(.) it's not nice" (Dave:24.43/40.45)

and Chris:

“I just(.) stood there(.) I(.) I just honest to God couldn’t understand how how we got from(2) a joyful(.) experience(.) having children(.) being induced(.) I don’t know if that’s enjoyable for Tia but for me, it’s sort of bringing new life into the world” (Chris:11.40/34.20)

Striking here is that Chris is able to tell what they have moved *from*, but fails to articulate what they have moved *to*.

The pursuit of resources to create coherence from fractured narratives continues after the immediate crisis. Rich suggests his wife would benefit from talking to someone with similar experience, “*you know(.) just someone to come round who’s had that particular thing done”, with Dave echoing this:*

“Because Tia hasn’t got anyone to talk to(1) you know. Which I feel sorry for her. [Interviewer: Hmm] I suppose if you had cancer(1) throat cancer or whatever cancer(.) you could find a few thousand people in this country who’s got that and you can talk. But she can’t” (Dave:20.12/40.24)

Dave and Rich construct this process of being able to co-construct an ongoing narrative to help make sense of difficult events, with social sharing key to that process as important, with Dave constructing his wife’s experience as being so far removed from birthing norms that this construction based on shared experience is unavailable to her. Whether such support is available or not, both Dave and Rich portray their understanding that it is not, and that it is needed, though it is interesting the men do not apply this need to themselves. In line with conclusions from Seymour-Smith et al. (2002), it is women who are seen as the consumers of healthcare and the dismissal of the need for help may be seen as part of a performance of masculinity (Courtenay, 2000), a point that will be explored further in a later section.

Being a Passenger

The experience of the men is constructed as separate from that of women. Chris makes this explicit:

“Childbirth in general can be(.) f-for the male can be(.) qu-(.) I can only talk from the male side(.) can be very stressful(.) because w-w-we’re there for the ride really(.) we’re not(.) you know(.) stroking your wife’s back(.) and saying what a wonderful job she’s doing and you know(2) y-y-you’re a passenger aren’t you(.) on the whole whole child birth thing” (Chris:29.19/34.20)

Here Chris attributes the stress he experiences to his inability to take an active role, to DO something, to steer the process. As discussed in the literature review, many men reported feeling disappointed by birth and confused about their role (e.g. Dellmann, 2004), and unsupported in their role or not included in care by medical staff (e.g. Chandler & Field, 1997). In their study of how masculine identities are constructed in “normal” childbirth, Dolan and Coe (2011) conducted interviews with five first-time fathers and five maternity health professionals. They suggest that during childbirth, men drew upon repertoires to construct a masculine identity portraying men’s role as “instrumental/active” (p.1024), a position John takes when he operates the TENS machine and encourages his wife, corroborating the interpretation here that a “passenger” role is undermining to many men. They also suggested healthcare professionals tended to position men within this repertoire by giving them a “task”.

Other research has suggested maternity caregivers utilise repertoires regarding partner involvement in which partners are constructed as spectators (White, 2007), and as wanting to absent themselves from feminine health environments (Dolan & Coe, 2011). Chris indicates his sense of being positioned thus when he recounts being told *“it will probably take(.) about eight hours to start working. So I should go and then come back”*, adding *“they thought I was just trying to run away(.) or get out of there”*. This suggests he feels positioned as an unwilling spectator. His inclusion of this speculative attribution of his intention to leave as being due to a desire to escape to some extent indemnifies Chris against this accusation, suggesting his preference for a position resistant to this discourse of men.

As concluded by the primary researchers (Hinton et al., 2014), the men tell of excluding experiences as soon as things began to go wrong. Chris describes his distress at being removed from the operating theatre:

“So I was literally(.) hushed out of the operating theatre and put back into the waiting room [Interviewer:Hmm]. And um(3) I’m sorry(.)um I’m trying not to cry here. [Interviewer: Sorry. Take your time. Sorry] Be a man, be a man [laughs]”
(Chris:6.06/34.20)

Encompassed within his description is, very apparently, distress at remembering this separation from the process, with his mumbled self-talk at the end of this extract a poignant reminder of the interaction of discourses of masculinity with all aspects of his sense-making and the ideological dilemmas arising for the men. Though seemingly directed towards himself, this entreaty to “*be a man*” is said aloud and followed by a small laugh, perhaps both acknowledging to an audience Chris’s deviation from a masculine repertoire of emotional containment he is trying to perform, and establishing a resistance to that. Wetherell and Edley’s (1999), following interviews with 61 men, suggested a construction of male identity in which men construct a position of resistance to “macho” stereotypes, whilst simultaneously using that resistance to buy into the masculine ideal of autonomy and personal strength.

Chris’s passive description of his removal to the waiting room indicates his sense of powerlessness in this moment, but also his attribution of his behaviour to the decisions of others, not to personal choices which may not be in keeping with his preferred identity. This is echoed by John’s description of “*being escorted out of the theatre*” and “*being taken to this room and being sat there*”. Dave allocates himself the only action available to him, which is waiting:

“They whizzed her off. I waited outside(.) to see what was going on. They wouldn’t let me in” (Dave:2.50/40.45)

Pollock (1999) argues that birth acts as a rehearsal for the private, nuclear family functioning. The fathers in this study constructed themselves as being separated from their families, and described their ability to perform a role as husband or father in the hospital in passive terms of being “*allowed*” to see or touch their loved ones, “*They said I could touch her*”, “*eventually they let us see her*”, “*and let Tia feed her*”. This passive positioning in their family often follows their descriptions of being disempowered or disenfranchised from the birth. Rich takes on the role of advocate for his wife but finds himself made impotent by the consultant describing how he “*left*

the room(1) and that was the end of our(1) consultation.” Chris describes being made to feel not a partner, but in the way:

“And(.) I poked my head out of the room(.) and some(.) young lady came up and said “Oh you’re in the way there. Can you go back in the room.”

(Chris:6.46/34.20)

His dismissive term “*some young lady*” positions this unnamed person as comparatively irrelevant to the process of which he should have been a central component, and he describes how he felt he needed to act to obtain recognition:

“...if somebody didn’t and see me(.) very soon(.) then I’ll start shouting and screaming(.) until somebody does come in and talk to me and tell me what’s going on with my(.) my family” (Chris:7.09/34.20)

This sense of needing to make a fuss to be heard is echoed by Rich:

“You know you go through all the different(.) li like a kid who wants some sweets(.) you’re try it nicely, an’ you’re trying the begging and then you have a temper-tantrum” (Rich:9.50/1.35.01)

Rich places himself in a childlike position, amplifying his lack of power. Despite this, there are many descriptions of attempts to include men in decisions and invite them into the process. Rich is asked permission for his wife to have a hysterectomy, John is asked how he wants to feed his daughter, Chris gives voice to a “*nice nurse*” who invited his voice:

“I think it would be nice to take some pictures of the babies. We’ll put them around her bed(.) so you know I’ll print them off and I’ll put them round the bed(.) with your permission(.) would you like to come and see your children and take some pictures?” (Chris:11.35/34.20)

In their analysis of masculine identities in childbirth settings, Dolan and Coe (2011) concluded that men were not always placed by others in a marginal position but placed themselves there within a challenging environment, with no evidence that they “*blamed*” others for that position, indeed praising staff for seeking to include them.

There seems, then, to be dilemmas, exacerbated by the unfolding and unpredictable crises, between repertoires of partnership and passenger at birth, between identities encompassing agency and those who cannot be culpable.

Medicine: Like something out of Dr Who

Each of the men describe medical input beyond that customarily seen at birth. Dave describes how *“they were taking her down to um Intensive Care(.) so I went in there(.) and it was like a(.) space ship(.) something out of Star Trek(.) it was just amazing”*, a science fiction repertoire regarding medicine also used by John, who describes *“this big machine that looked out of the seventies episodes of Dr Who(.) they’d wired her up(.) it was almost comical this big machine [laughs]”*. This recourse to images from popular, but fictional, culture is also used by Rich who describes how his wife

“had like(.) I dunno about(.) ten or fifteen(.) wires in her(.) I mean she had about(.) ten coming out of her neck an’ machines an’ everything. And you know what I mean it’s just(2) you know(.) it don’t look nothing like it does in Casualty [laugh] d’ya’know what I mean? [laughs]” (Rich:28.35/1.35.01).

The use of these images suggests the absence of a “real life” repertoire to draw on – that this is the realm of fictional story-telling, a realm in which you are audience, not actor, separate from day-to-day lived human stories, and part of an alien technological world. In telling of this mechanised medical arena, an ideological dilemma between medicine as a caring, human endeavour and medicine as a mechanised process is created.

In addition to images in which the human patient is subsumed by actual machines, there are also constructions of the larger system. Dave discusses the hospital as if it were an organism in its own right when he says *“I made(.) friends with basically the whole hospital”*. He uses the doctor’s voice to perform the same construction when the doctors tell him *“All you can do is pray. There’s nothing the hospital can do”*, implying that even within the system, the component operating parts position themselves (and possibly their personal accountability) as subsumed by the larger system.

This repertoire of medical professionals working procedurally crops up repeatedly. As well as conjuring his human, felt sense of a nurse as being “*very cold*” with an enacted shiver, Chris quotes doctors as saying “*Oh it was only a little problem(.) it was only this(.) it was only that*” in describing what went wrong, contrasting their trivialisation of something medically “*a little problem*” against his incomprehensible shock. Rich constructs the consultant as neglecting the human element when he says “*it was just another(2) another day in the office(.) appointment for him*”. Immediately after describing crying and having temper-tantrums to obtain the care he feels necessary, Rich adopts an angry tone demonstrating his own emotional reality when he says “*not once has this doctor(2) not even register(1) any emotion what-so-ever*”. Dave uses his first negative emotional descriptor of himself when talking about process orientation of medicine:

“But then(.) what I got annoyed about a little bit(.) he put a price on how much this(2) was worth(.) you know(.) it doesn’t really matter whether it’s like 10p or like £100 grand” (Dave:5.16/40.45)

This serves to position himself in antithesis of a dehumanised, procedural repertoire of medicine, as a real, feeling person. Mishler (1994) discusses the separation of a “voice of medicine”, concerned with medically pertinent features, and “voice of the lifeworld”, concerned with life features medical issues are embedded in. These voices compete for control in medical interviews, and these narratives demonstrate a similar separation of voices competing to construct the crisis being described.

In contrast to this construction of medicine as mechanical, but perhaps still sitting within a concept of medicine as beyond human, there are also constructions of medicine and medical staff as heroic. Dave talks about doctors being “*like a God in my eyes(.) and [doctor’s name](.) they’re like er sort of heroes of mine*” and Rich describes the efforts to save his wife’s life:

“because of the team in the(.) Intensive Care and the High Dependency and I think because of(1) because of everything that they did um and nothing(.) you know(.) they never stopped you know. Always investigating, different blood tests(.) I mean she had blood taken out of everywhere and like I say she had all these different wires and everything and they were pumping her full of different stuff taking bits out of her and putting more stuff in and(.) you know(.)

as I say at one point I think she had seven different types of medication going in. I mean they was trying everything(.) I mean(.) you know I mean(.) I mean you know(.) I just can't even begin to imagine how much it must have cost(1) you know(.) not that there's a price on human life" (Rich:46.21/1.35.01)

Here, though his wife is objectified and physically deconstructed as something doctors are "taking bits out of" and "pouring it in", their efforts are described as heroically unceasing and ultimately successful, while Rich retains the presence of his wife at the core of these efforts by pointing out "not that there's a price on human life". And yet this contrasts markedly with his earlier construction of not heroes, but villains:

"they woke her up(.) from this coma to tell her(.) that they were going to do some more(.) surgery on her(.) and then put her back to sleep again. Which I thought was one of the cruellest things in the world... My wife was absolutely bloody terrified. She didn't even know where she was and they just wake her up and said(.) we're gonna(.) you know. But I was so shocked, where we were(.) I didn't even question it(.) you know(.) I didn't even question it" (Rich:34.04/1.35.01)

At different times, the men do different attributional work with their constructions of the course of their partner's health. In the example above, Rich attributes his wife's terror to the "cruel" and process orientated actions of doctors whilst accounting for his own failure to intervene as due to his contextually understandable shock. In the previous extract however, he attributes his wife's survival to the heroic endeavours of the same medical staff.

For some there was a clear division between the heroes and villains of the medical team. Chris describes how he stood up to one staff member when he "felt the(.) the lady that was(.) the nurse or whatever they call them(.) was trying to shame me all the time. What I(.) she would shout things at me. "Where's your babies nappies?" culminating in illustrating the severity of her unpleasantness by telling how he "started worrying if she mistreated my children(.) you know(.) when I'm not there", and yet describes how "other people in general were amazing". Rich says

"in Intensive Care and HDU I can't fault the nurses. Doctors were just all morons. But the nurses you can't fault you know. It's almost like they're a

different(.) they're a different breed of nurse in them places"

(Rich:36.44/1.35.01).

Between the almost superhuman, heroic repertoire of medicine and the inhuman, mechanistic repertoire of medicine, there remains the “*shocked*”, “*annoyed*” human narrator. It is in the small personal acts of catering to individual need in which medical staff are constructed as caring, human. Chris’s “*nice nurse*” who helped him take pictures, the nurses Dave tells “*were ever so good to me*” in helping him find places to sleep or shower, John’ “*fairly unhelpful nurse(.) although she’d been nice to me(.) you know(.) she’d been sort of calming and been in the room with me*” and the nurses who Rich tells “*looked after me really well*”, describing them having time to make him a cup of tea. Through these attentions by others to their non-medical needs, the men are able to connect with and be recognised as present by a part of the medical system which seems otherwise characterised by its otherness, to assert their presence in the story, legitimising their distress and their needs, and giving them the right to tell it.

Negotiating the power

Over several listenings to the interviews, a strand which ran through the accounts with what felt like a high degree of influence on the experience and the telling of it, was that of power, including the interaction between power and performances of masculinity. Though I shall discuss the theme of masculinity as it relates to some other spheres in the following section, the threads of masculinity and power remain crucially intertwined as men construct their experience of the medical world in which they found themselves.

From the outset, there is a separation between “*they*” and “*we*” in the way the men discuss their interaction with health-care professionals. I had perhaps expected, as a professional who constructs my role as a team endeavour with my clients, to hear men constructing themselves, their partners and the professionals caring for them as a team united in a common endeavour. This was not the case. Either “*they*” made decisions or “*we*” (referring to the man and his partner only) or even “*I*” made decisions. This separation is reinforced by talk of doctors’ use of a language the men find difficult to make sense of. What doctors have said is often glossed over as, as John puts it “*vague medical speak*”. Rich covers the explanation for why surgery would need extra precautions with “*blah blah blah*”, though whether this is illustrative an assumed shared construction of how doctors talk, his understanding of what was said, or the importance he placed upon it is unclear. Chris differentiates between explaining things using “*laymen’s terms. Not in doctor’s terms*”, effectively creating two categories within which people in the story must sit:

“Or if they talk big long terms(.) you know sort of(.) the doctors’ terminology(.) tha’(.) I’m not(.) maybe I’m not the cleverest person(.) but I just didn’t understand what(.) they might as well have been talking Chinese to me”
(Chris:16.30/34.20)

By suggesting the doctors’ talk was like Chinese, Chris amplifies the sense of difference by allusion not only to a separate, unrelated language to his own, but also to a foreign culture, evoking the culture shock he may be experiencing. He also attributes ownership of that language to the doctors, implying both an exclusivity to the category of doctors, and an employment of language to maintain that exclusivity.

In utilising this repertoire of the impenetrability of doctors' language, Chris also negotiates the dilemma of maintaining positions both of personal competence and of a contextual innocence which may absolve him of responsibility in what occurred. There is the sense that information is a powerful tool in the negotiation of power within the context at hand, and perhaps the "reality" which will dominate.

Within the hospital setting, a repertoire of doctors as powerful dominates. However, the context provided by the medical emergency here overlaps with the context of family in which a repertoire of men holding power may operate. This may be particularly important in this reproductive context as men may assume some degree of responsibility for having impregnated their partners, precipitating the current problems. They might feel expected to be a support and advocate for their very ill family members. Yet, they have been largely impotent in that drama where others have acted to save their families. Thus in these interviews they have a complex task of managing their identity for any projected audience (including their partners), as men, as husbands and as disempowered bystanders. These issues are illustrated well by Chris:

We went back and saw the surgeon um who was dealing with it(.) she's quite an important lady because everybody stands to attention when she's walking around(.) um(.) and(2) immediately you knew(.) I'm sorry(.) immediately you felt that there was a cover up going on(2) I mean maj majorly so(.) it's only when I turned round and said(.) "Are you scared we're going to sue you? Or something(.) because that that's not our intention whatsoever." um "we just wa. I just want answers (Chris:16.58/34.20)

Davies and Harré (2001) suggest that when people position themselves within a discourse they choose images and metaphors which invoke the ways of being that they understand themselves to be involved in. By using an image from a military domain of everybody standing to attention, Chris imbues the surgeon with a power recognised by consensus within the hospital context, but also positions her within the traditionally masculine world of the military. Interestingly her gender in this construction seems to matter less than her professional position.

This militarising of the scenario is also used by Rich:

“he used some special packing stuff which they use on um on the battle front(.) some special stuff to stop the soldiers bleeding. I don’t know what it’s made from but that’s what they used on Sarah(.) because they said it was like(.) you know(.) like a gun(.) wound or whatever” (Rich:26.25/1.35.01)

Dolan and Coe (2011) suggest that childbirth, and in this instance that can be extended to medical emergency, requires men to engage with healthcare professionals within a domain discursively constructed as feminine. This can be seen in Seymour-Smith et al.'s (2002) research looking at the discursive practices used by GPs and nurses in constructing men as healthcare users, in which men’s accessing of healthcare was seen as mediated by women, who are the primary routine users of health services. Dolan and Coe (2011) argue that engaging in healthcare then, may therefore indicate weakness and “assign men to lower-status positions”. This military analogy may be useful to Chris and Rich as within such a domain, subordination to a chain of command is not seen as emasculating, but rather as appropriate participation in a very macho institution and this may work to maintain masculinity in the face of disempowerment. Yet that disempowerment also allows Chris to attribute “*what went wrong*” to the hospital and away from him, such that he considers he would have grounds to sue. However Chris’s image is also a little comic, a deliberate overstatement which creates a position resistant to the repertoire of doctors as powerful by opening that power, and perhaps those who stand to attention, to irreverence and slight ridicule. Talk of how he “*turned round*” and changed the dynamic by finding her Achilles heel, a risk to financial and reputational power, amplifies the potency of his action.

Rich also highlights the sense of separation between doctors and their positioning of themselves as holding power, and ordinary people like himself, introducing a repertoire of social class differentiation:

“I dunno(.) he was so hoity(.) do you know what I mean? He was proper posh(.) I’ve got nothing against posh people(.) I mean I know a guy who goes fox hunting and stuff like that(.) you know(.) I’ve got nothing against posh people(.) at all(.) I know plenty(.) but(1) he was so far up himself it was almost like(2) he didn’t even want(.) he couldn’t even look at us when he was talking you know(.) he was just(.) no(.) we were just beneath him(.) do you know what

I mean? We were just(.) I can't even begin to describe(.) I mean you know [laughs] he may be a lovely guy in real life(.) he may be a nice guy(.) but the persona he was giving out was(.) I'm a consultant surgeon whatever(.) and you know you're not anybody really(.) you're just a number(.) a patient."

(Rich:38.39/1.35.01)

Critiquing of the notion constructions of masculinity as complicit or resistant to hegemonic masculinity, Wetherell and Edley (1999) conclude from interviews with 61 men that the "heroic" model of masculinity is in fact used less than a model of "normality" or indeed of rebellion. These constructions are complicated by their utilisation of the ideas of personal strength and independence from social pressures which feature within a hegemonic ideal of personhood. Here Rich positions himself as counter to a stereotype of success and masculine power. Rich's story about knowing people who engage in "posh" activities, and his suggestion that the consultant may be a "nice guy" helps this not be seen as a story of his own bigotry but of the consultant's positioning within the contextually appropriate repertoires. It is interesting that he uses the term "real life", separating the micro-culture of the hospital and its power differentials in which he is personally disempowered, from life outside. This extract also highlights an interpretative repertoire about the use of such repertoires themselves, in which Rich describes the doctor as "giving out" a persona entitled "consultant surgeon". This suggests that even while constructing his story he is aware of the contextually flexible actions people perform constructing their identity. He seems to view the consultant's "persona" as an action in maintaining a power differential, a discourse he resists when he questions the value of doctors' knowledge and expertise:

"I don't know where they went to medical school because they was all stupid they really weren't thinking through that(.) you know(1) not(.) the bigger picture. You know. There's stuff they've got to do obviously you know(.) and they know what they're doing up to a point(.) but they're not thinking about(2) I dunno they're not logically thinking about the impact it's gonna have(.) you know(.) they're making a decision(.) to save someone's life(.) which is a good thing(.) go ahead and do that(.) um But waking her up(.) going back to that(.) waking her up to tell her she was going to have some more surgery(.) it makes no sense(.) it don't figure to me that" (Rich:37.24/1.35.01)

Here he counters a discourse of medical empowerment by constructing his own common-sense understanding of the situation as superior to their expertise or policies. Chris also queries the medical professionals' common sense:

*“They knew something(.) was going wrong(.) and they still gave her food.
[Interviewer: Mm](2) That is very difficult for me(.) [Interviewer: Mm] you know(.) if(.) in my profession if I had done that(.) people(.) people would sue me” (Chris:21.38/34.20)*

This extract also allows Chris to construct himself as a fellow professional holding power and responsibility, reducing his disempowerment.

Steen et al. (2012) in a synthesis of qualitative research regarding fathers' maternity care experiences, suggested fathers feel themselves to be “partner and parent” but experience maternity care as “not-patient and not-visitor”, leaving them in an emotionally and physically undefined situation. Though the men in this study do not inhabit the bodies subject to medical ministrations, there is some evidence in their use of “we” in the early stages of their narratives that they considered themselves part of a patient dyad when they arrived at hospital, and certainly they remain locked into an interaction with the medical domain. Courtenay (2000) also suggests that participating in healthcare is constructed as feminine, while the institutional practice of conducting, researching or providing healthcare is constructed as masculine and defined as a domain of masculine power. He argues that doctors maintain power and control over the bodies of women and men who are not doctors, forming an arena in which the negotiation of different masculinities is pertinent. Courtenay defines hegemonic masculinity as the idealised form of masculinity at a given place and time, the socially dominant gender construction in which power and authority are attributed to that ideal. He argues that within a health sphere men demonstrate hegemonic masculinity through denial of weakness or vulnerability and the dismissal of a need for help, and the appearance of strength, emotional and physical control and displays of aggressive behaviour or physical dominance. Dolan and Coe (2011) apply these ideas to the construction of masculine identities in childbirth settings in particular. They argue men's narratives within their study are removed from the demonstrations of hegemonic masculinity through technical competence, hands-on ability and being in command. Instead they see narratives suggesting men found

themselves in marginalised positions, lacked confidence in their ability to act, and were excluded from the decision making process.

Yet within the narratives of these men, there are demonstrations of masculinities contesting the power of doctors. Rich's construction of physical strength and aggression, and indeed aggression under personal control, re-asserts a masculine identity in the face of failed agency:

"And we asked the doctor about being induced or having um a Caesarean before(1) And(1) I've got to be careful because the camera's on(.) but how I didn't knock him out I don't know. Because he just looked at us and he said, "We don't induce, or have Caesareans for women early, just because they're feeling a bit tired." Was his exact words and then left the room(.) and that was the end of our(.) consultation" (Rich:8.32/1.35.01)

A curious feature of this extract is Rich's awareness of tailoring his discursive actions to an unspecified audience. Chris regains empowerment within a disempowered situation by taking physical action as opposed to continuing a verbal dispute:

"Then she kept on saying "When are you taking your daughter? When are you taking your daughter?" I said "Well we're not allowed to take the daughter(.) my daughter(.) cause(.) the wife's just(.) been released from maternity care and she needs time to recuperate(.) She kept saying "When are you taking your daughter?" I literally picked my daughter up and said "Okay, we're going to go now." She goes "Yu- well you can't go?" I said "You keep te- asking me when I'm taking my daughter(.) well I'm going to take her now"(.) And then she went "Oh no, no, no" (Chris:25.10/34.20)

In this extract Chris takes control not only of the immediate situation, but also of his daughter, reframing her from "*the*" daughter to "*my*" daughter, empowering himself as a relevant and potent actor in the scenario. This ownership/membership issue is also evident in how the men construct their relationship to their wives, with Chris, Rich and Dave all using "*my wife*" only in contexts where they have scant control over what is happening to them – "*Is my wife going to be okay?*", "*my wife was actually bloody terrified*", "*I get visions of her being whizzed past me, my wife*". Pollock (1999) describes a feminist perspective on the historical shift from birth as the domain of women in the community into a patriarchally controlled medicalised

process. She argues the increasing presence of men at birth is an extension of a discourse of ownership. While this may be indicated by the use of “my wife”, it could also indicate membership of a family unit which gives the men the right to be considered as invested parties to events. Interestingly John, who is not married to his partner, does not use the proprietorial “my partner” in these contexts at all.

Like Chris, Rich also constructs a masculine position by taking control of a situation:

“An’ I an’ I remember as clear as day I said to him “Well what you stood here for then(.) Just(.) just go and do it.” you know(.) he said “Well we have to ask your permission...” I said “Stop talking to me.” [laughs] d’yu know(.) none of this “We have to ask your permission.” you know(.) Yeah. I can understand why(.) you know. Don’t want me suing you afterwards for doing it when I didn’t say. But for goodness sake(.) you know(.) if you know, if you’ve got to stop her bleeding you just whip it out don’t you?” (Rich:18.52/1.35.01)

Here, despite his medical impotence, Rich builds an identity for himself as the man who makes the decisions, who acts decisively and takes charge, based on common sense. Chris also positions himself as taking charge, this time of the flow of information, also controlling the agenda of what is important, prioritising the “voice of the lifeworld” over the “voice of medicine” (Mishler, 1994):

“I went in and I turned round and said “Look(.) you know(.) stop(.) I don’t want to hear medical talk(.) you know(.) you’ve used big long words that I have no idea what they mean(1) is my wife going to be okay?” (Chris:13.47/34.20)

John too, takes this control:

“I can remember me saying(.) I remember it being sort of(.) kind of(.) you know(1) very vague(.) medical speak(.) and I actually had to say at the end “So there’s a chance she won’t make it?” I think you know(.) I just wanted the kind of(.) I wanted a kind of meat and potatoes kind of conversation(.) I didn’t want some fancy words of well(.) you know(.) I kind of said “What, so there’s a chance she won’t make it?” And(.) and they actually said “Yes.”” (John:8.49/1.05.09)

John uses a phrase “meat and potatoes” which taps into a repertoire of masculine unfussiness, aligning his communication style to such a position through his

preference for *“direct information(.) rather than sort of airy fairy stuff”*, or as Rich puts it *“this wishy-washy sugar-coated stuff”*.

The men in this sample then, seem to find a means of reasserting personal potency within a medical domain in which doctors are not only positioned as possessing a contextually situated power, but also perhaps represent a position of hegemonic masculinity, possibly regardless of their actual gender, through their social position as well educated professionally potent people. Dolan and Coe (2011) suggested their cohort’s constructions of masculine identities did not represent a straightforward adherence to dominant ideals, but nonetheless occurred within the shade of hegemonic masculinity, and perhaps the men here negotiate their construction of their experience under the same shade.

Being a Man

As well as positioning themselves relative to people outside the family, the men’s talk in the interviews also works to build identities within their family as husband and father. These multiple positionings as men and as people in the varied contexts of the dialogue, then create dilemmas for their experience of birth, caregiving and subsequent distress.

These accounts are given within the context of an interview, with a female interviewer, and an awareness they will be publically available not only for family and friends to view, listen to or read (participants were given the choice of medium), but also to anyone with an internet connection. Their narratives of the workings of their family life are neither private in the telling or the construction, with Rich referring to wider narratives in explaining his role within his family:

“because I’m brought up um you know(.) very macho or men are men(.) and women are women um in my family” (Rich:52.15/1.35.01)

Rich employs a repertoire of division of roles as *“traditional”*, fitting with a long standing social construction, and perhaps thus, as Billig (2001) suggests, seeming natural and inevitable. He seems to place a high value on his wife’s role and her innate emotional need to fulfil this role:

“our roles have reversed(.) through circumstances I’ve always worked(.) long hours and Sarah’s always been at home(.) because we’re quite traditional in that way(.) you know(.) not that(.) I’m a sexist or owt but you know(.) I like Sarah being at home do(.) doing the house and that(.) and Sarah likes that(.) you know(.) I don’t make her do it(.) and she you know we’re quite traditional on that front(.) so she missed her role as a mother(.) and as a wife. She missed that(.) um I think more then I’ll ever(.) I’ll ever know(.) because a mother’s love for her children is different from a bloke’s” (Rich:50.41/1.35.01)

Rich defends his position in light of ideological dilemmas regarding gender role by pre-empting and refuting a potential accusation of sexism on the part of his female interviewer and potential wide audience. Stating that he’s not sexist, that *“I don’t make her do it”*, and using his grandfather’s voice in comedic tone to say *“you do what my boy?”* and *“that’s women’s work”*, he removes himself from and lightly mocks the position he is nevertheless adopting regarding men doing childcare. However the notion that he could be perceived as able to *“make her do it”* acknowledges the “traditional” power imbalance.

Dave and Chris both position themselves as decision makers or the voice of superior reason in the household. Chris tells how he made the decision to have a vasectomy, recalling his explanation of his logic to his wife:

“I sat down with Mary and I said “You know(.) we’ve been graced with two children(1) I couldn’t take(.) the risk(1) y’know(.) that something bad would happen(.) and we should be grateful that we’ve got the two(.) so(.) quit while we’re ahead as it were.” (Chris:30.28/34.20)

Dave tells how he explains to his wife she should “think yourself(.) grateful and lucky”, adopting a patriarchal position in his care:

“You know(.) so I I do tell her off(2) but then obviously(.) she’s obviously gonna be down I can’t do this and I can’t do that. You know but I then put her in her place” (Dave:27/40.45)

Despite this patriarchal positioning, there is scant overt construction of fatherhood in these narratives, while motherhood is held in high esteem. The contrast between the positions *“mother”* and *“bloke”* in Rich’s extract above for example, does not provide

a position for Rich as “father”, but only as the type of man who fits the family construct of men who “*drink beer, play snooker*”. The sanctity of motherhood is constructed by each man, making use of a Madonna and Child repertoire in their positioning of their partners as mothers. Rich justifies the neonatal nurses’ flouting of procedure to attend to the “*important*” emotional imperative of mother and child bonding by bringing the baby to his wife against the rules:

“But(.) you know(.) the issue’s not about health and safety. It’s about mother and baby and you know(.) these things are important” (Rich:44.40/1.35.01)

Dave does not identify himself as “father” when his wife is unable to look after their daughter in hospital, but rather describes his attempts to fill the “obviously” important role of “*mum*”:

“Cause obviously she should have been with her Mum straight away. She should have been(.) you know(.) so I had to take that role” (Dave:12.30/40.45)

Though it is interesting that this repertoire is used less by the two first-time fathers, there is still a sense of its presence. John describes how his partner “*had to see the baby*” as a matter of fact, going on to describe the logistic challenges this presented, and Chris describes looking at his wife “*in awe*” thinking “*wow(.) what a great mother*” as opposed to a great person. Indeed, in nearly four hours of interview data, John is the only person to use a word denoting fatherhood about himself, voicing an overheard conversation in which one nurse tells another “*the father’s doing all the feeding*”, describing a woman patronising “*daddy*” for forgetting gloves, and describing his daughter’s shift from “*father’s the one who feeds me [interviewer laughs] to mother’s the one who feeds me*”. Each time, he is voicing others’ perception of him as “*father*”, rather than identifying himself thus.

The contrast in these narratives between repertoires of the sanctity and importance of motherhood and the absence of fatherhood suggests it may be difficult for fathers to construct for themselves a role of importance, let alone primary importance, in the life of a new-born. Indeed from the two first-time fathers, there are also stories of this being made more difficult by their perception of being positioned by unhelpful repertoires of fatherhood. Chris feels like a nurse is trying to “*shame*” him by constantly asking questions about his preparedness for childcare, and John discusses being made to feel patronised as a new father:

“And I remember like this woman in this lift [laughs] first(.) said er(.) erm(.) she said s-it was a kind of patronising remark like(.) “Oh Daddy’s forgotten the(.) the gloves” or(.)you know [begins laughing] that kind of thinking like fuck off you know [laughter still continuing]” (John:43.43/1.05.09)

However, he also positions himself as subscribing to this repertoire when he laughs at the image of himself and a male friend looking after a new baby which his friend’s wife, a mother and a woman, comments upon:

“Obviously my friend’s turned up(.) and I partly felt obliged to talk to him(.) I just wanted to go to bed I think. [Interviewer: Hmm] er and also(.) you know(.) when we’re together we’re usually quite joyial(.) so there was kind of the(.) you know(.) and he was also saying(.) you know(.) his er(.) his wife thought it quite amusing that there were these two men sort of looking after a new-born baby [laughs] [Interviewer: Hmm] you know(.) in the house together and er you know(.) we had a bit of a laugh and a joke while I was also shattered and(.) everything you know(.) and er and he sort of did the night shift you know looking after [daughter]” (John:39.59/1.05.09)

John’ *“laugh and a joke”* is part of a larger sequence in which he asks his friend with childcare experience to come to his house and do *“the night shift”*, a phrase positioning his activities in the masculine world of shift work as opposed to the feminine domain of childcare. It is interesting that when John talks about this experience he positions himself as *“obliged”* to follow a protocol for how his *“joyial”* relationships with other men are conducted even when it feels inappropriate to him.

It further marks the departure from the expected family narrative when a father adopting a caring role is constructed as something unusual, requiring significant reorganisation. Immediately after using his grandfather’s voice to describe childcare as *“women’s work”*, Rich describes how *“you take on(.) you adapt(.) you adjust to each situation(1) and it came naturally to me. I wasn’t worried about doing it”*. John says *“I suppose it-it-it(1) skew(.) skew not necessarily in a bad way kind of the family dynamics cause(.) em I was kind of the main carer”*, opening for debate the extent to which this change in dynamic can be seen as good or bad. Dave says of looking after a child *“It doesn’t bother me(.) it doesn’t make me no less than a man to change a baby.”* This notion of performing masculinity in new ways fits with Dolan

and Coe's (2011) proposition that men's ideals and performance of hegemonic masculinity change through the stages of their life, as their roles change. Wetherell and Edley (1999) suggest masculinities are constructed in resistance to stereotypical "heroic" masculinities by emphasising an independence from social convention, constructing a masculinity in which men are confident enough of their masculinity not to need to display it through stereotypes, though conversely this strength and independence are themselves features of a "heroic" construction.

However John feels his role as a father was taken for granted inappropriately, saying "there was no co-certainly no conversations as to(.) "Are you happy doing this? Do you want to do this?" I mean I-I just sort of did it" and later:

"think now(.) it might have been useful(2) knowing(.) the order of what happened(.) for me to actually go home one night(.) and(.) have a shower and have a night's sleep and come back(.) and no one kind of said(1) "If you went home we'd hold the fort we would you know we wouldn't let your daughter starve we would feed her and change her(.) er but in a way that was never given as an option(.) really" (John:56.43/1.05.09)

This extract also highlights another dilemma men in this sample seemed to struggle with; the tension between caring for others and being cared for themselves.

The men position themselves as caring for their partners, casting themselves as protectors, advocates and carers. Dave talks about "trying to protect" his wife from difficult information about their baby, John about helping his partner shower, while Rich takes a heroic position when he says he "helped Sarah with whatever she might need(.) bathing(.) or pain-killers or whatever(.) you know nothing was too much trouble for my baby honestly(.) I give Sarah whatever she needs. I'd walk over broken glass for her". Yet they also describe difficulties accessing support themselves.

Falling apart and getting better

The men in this sample were selected on the basis of reporting lasting distress following the events surrounding the birth of their children. Dave talks about

flashbacks and visions and Rich about a “*breakdown*”. Chris positions himself as someone not given to over-reaction, with the experience to judge a difficult time, saying “*I’ve been through some not so good things(.) and this is probably the worst*” and John describes feeling “*there’s still(.) stuff to be dealt with*”. Bury (1982) discusses chronic illness as triggering a disruption of the taken-for-granted assumptions and explanatory systems we use to understand our biographical identities, and these men seem to negotiate similar disruption to the stories they expected to tell. Rich describes his breakdown as stemming from a specific point in his narrative where the coherence of the expected narrative of childbirth fragments, when he finds out his wife is being transferred to intensive care:

“[deep breath] and that moment was the beginning of the end(1) because further down the line jump a bit(.) I did have a breakdown(.)er diagnosed with(.) post-traumatic stress(.) which prior to having it I didn’t actually believe was a real thing(.) you know(.) and I had depression as well and agora(.)phobia? A few little few little things you know” (Rich:25.25/1.35.01)

By indicating there was a distinct beginning to his emotional problem, Rich hints at a before and after story which Horton-Salway (2001) argues is used to construct an identity to counter any suggestion that the state of illness at hand is typical of the speaker. Rich adds credibility to this notion using a “stake inoculation” device (Potter, 1996) in which he describes his own scepticism about PTSD, before stumbling over the pronunciation of agoraphobia, undermining any suspicion of any prior interest in claiming a diagnosis. That Rich specifies that he has been diagnosed, rather than simply naming symptoms again adds the corroboration of medical professionals to the difficulties he goes on to describe. He then positions himself as still a bit dismissive of these “*little things*”.

That Rich’s talk performs these actions may help him to negotiate a masculine position in the face of mental illness. Courtenay (2000) discusses the confluence of men’s enactments of masculinity and men’s health behaviours, considering how denial of vulnerability and dismissal of a need for help are part of a performance of masculinity which makes men less likely to acknowledge or seek help for health issues. Rich appears to subscribe to a view of emotional difficulty not fitting with his positioning of himself as masculine:

“You know you, you you try and stay strong(.) um you know(.) for your wife and for your children and you try and (er) you know(.) because I’m brought up um you know(.) very macho or men are men, and women are women um in my family. So er when the cracks started to appear(.) I couldn’t couldn’t get me head round that cause you know(.) we don’t do emotion(.) we definitely don’t cry(.) definitely not(.) we go to work. We drink beer. Play snooker. You know” (Rich:52.06/1.35.01)

Davies & Harré (2001) suggest that when people position themselves they choose words which contain images and metaphors for the ways of being they consider themselves involved in. Rich, who doesn’t “do” emotions has previously used an image of restrained physical violence to construct himself in relation to the doctor, and when talking about emotional issues, he again uses physical metaphors which sit more comfortably in a masculine domain, describing himself as “*crumbling away*” and telling how he “*physically couldn’t leave the house*” when unwell and “*couldn’t step foot into the hospital*” for a follow up appointment. He also offers corroborated validating evidence of his suffering from the physical domain he positions himself within:

“then I collapsed in the lounge(.) just fell to the floor(.) um so er we rang a friend and he took me down to the hospital um and I was admitted that night(.) I stayed for two nights I think it was(.) admitted with nervous exhaustion(.) and then discharged(.) um and then(.) then I started to get the flash(.) then I started to get to the flashbacks(.) although I was keeping that to myself(.) I wasn’t telling anyone(.) um although I think Sarah kind of had an idea(.) because I wasn’t sleeping and I wasn’t eating. And I look back at pictures and I look horrendous(.) I mean my bags I’ve got bags(.) I was pale and really skinny(.) um er I ended up getting IBS which I now have really bad um now(.) which I suffered quite horrendously with that because of the nature of my diet or lack of it at that time” (Rich:1.01.32)

Chris also presents evidence of his experience as “*the most stress I’ve ever been under*” from within a physical domain, saying “*I just thought I was going to have a heart attack at any stage*”, and John presents being “*done in*” as a physical

exhaustion, evidenced in its extremity by saying *“I remember taking sort of paracetamol every four hours because I just had a headache just from lack of sleep”*.

These issues of balancing a masculine identity against emotional distress, pertinent in dealing with any fractured narrative, may be particularly marked in the context of childbirth, where Dolan and Coe (2011) concluded that the culturally idealised forms of masculinity which construct men as stoical and self-reliant were magnified, and questions may be raised regarding the legitimacy of their trauma where men are *“not patients”* and women experience *“real”* physical pain. This construction which excludes the emotional responses of men as irrelevant may also be practiced by healthcare professionals making it very difficult to resist as Rich found when he visited his GP:

“You know and hard for me to do I plucked up the courage to go(.) and I went to the GP like to ask for some help(.) and you know what he said to me right(.) I said(.) as I’m sat here now(.) he said to me(.) he looked me right in the eye(.) and he said to me, “Mr [name],” he says. er “Your wife is the one that went through all the trauma(.) and everything else. You just need to pull yourself together and be there for your wife.”(3) and that was it(.) That that that for me(.) I fell into a pit of despair from there. Because of course what am I going to come away thinking(.) I’m thinking(.) he’s right(.) he’s right. What is the matter with me? I’m having all these flashbacks and that(.) I can’t go to work(.) What sort of a man am I?” (Rich:1.07.52/1.35.01)

Courtenay (2000) suggests low rates of diagnosis rates and help-seeking amongst men with mental health problems work in tandem to perpetuate a discourse in which men are constructed as invulnerable. He suggests that when experiencing symptoms of depression, men are more likely than women to withdraw and rely on themselves, choosing not to discuss their symptoms. In this extract Rich challenges the way he was *“brought up”* in a masculine discourse by seeking help, but also questions his masculinity in light of the loss of some behaviours he associates with the category of “man”. He talks several times across his narrative of crumbling and falling apart, and in this context, his description of the *“despair”* of finding his help seeking rebuked evokes the feeling of an identity falling to pieces. The absence of a readily available alternative discourse for men struggling emotionally after childbirth

to draw from may be a significant factor in the way Rich has been able to make sense of his own responses.

Just as Rich talks of staying strong for his wife and children, Dave also references a repertoire of men being invincible, and his awareness of the dilemma its mismatch with his understanding poses:

“I like to keep things to myself(.) [Interviewer: Hmm] Why should I share something(.) if I can get rid of myself because I’m a man. [Interviewer: Hmm] No(.) it doesn’t work like that” (Dave:36.06/40.45)

And earlier::

“I’m the worst person er the impact was on me(.) [Interviewer: Hmm] because um I don’t show my feelings(.) I don’t see why I should(.) because I’m the man of this house and I don’t see why I should do it(.) I’m here to protect my children” (Dave:30.31/40.45)

Like Rich, when asked if he had been offered counselling, he articulates a repertoire in which men are self-reliant and do not need help:

“No I’ve had none(.) you know I would like some I must admit. I suppose being a man you don’t want none(.) you know(.) but at the end of day everyone needs help at the end of the day(.) if there’s a problem” (Dave:25.34/40.45)

Again, Dave acknowledges as inadequate the stereotypical “heroic” discourse of masculinity in repairing trauma, using “you” to imply the generality of this position, but follows this with an equally generalizable position that “everyone” needs help. This positions his own desire for help as falling inside a “normal” repertoire, perhaps of recovery, but also of masculinity (Wetherell & Edley, 1999). He frames this help-seeking behaviour with a decisive, practical phrase, “at the end of the day”, which negotiates the failure to enact the invincibility of heroic masculinity by prioritising its problem-solving practicality.

John, too, constructs his emotional responses in a practical manner:

“there was the emotive(.) stuff immediately but then(.) I suppose I did what I(1) I’ve only had to do several times because(.) erm(.) and partly I’ve noticed

it at work as well is that when(.) there really is a(1) a major kind of(.) um(.) event happen(.) I'm very good at kind of(.) thinking well I can deal with the emotions later I kind of(.) really get sort of into practical mode and that was starting to happen for me” (John:14.16/1.05.09)

John highlights the common use of a practical coping repertoire for dealing with any crisis. This extract, which occurs around a quarter of the way through John's narrative may also set up the remainder of the narrative in which practicalities and logistics are discussed in far greater detail than emotions. He glosses over what “*emotive(.) stuff*” means, perhaps assuming we all share the same repertoire of expected emotions, but, without having to detail them, he also identifies himself as someone who does have emotions. He then describes his practical, under control technique for dealing with emotions, one which he has professional experience of and takes active responsibility for. This is something he does, through the power of his thinking, and yet he also takes a passive position relative to this skill when “*that was starting to happen for me*”, as if this skill is so practiced or even innate that it no longer requires wilful control. This again fits with a discourse of masculinity in which men are emotionally under control (Courtenay, 2000). The desire to retain control clashes with a repertoire of mental illness as loss of control. Chris describes how he needed

*a lot of external support(.) from from friends(.) doctors and friends
[Interviewer: Hmm] to advise me [Interviewer: Hmm] otherwise I'd freak out(.)
I'd either be(.) well I wouldn't be here now(.) I'd be [Interviewer laughs]
running down the motorway going “Aaahhhhh” [interviewer laughs]”
(Chris:28.42/34.20)*

Rich says he cannot physically “*step foot*” back into the hospital as he “*felt that I would begin to cry and never be able to stop*” as he was “*starting to really(.) you know (snort?) lose my mind big time*”.

These extracts also illustrate a repertoire regarding what to do about emotional distress. Talking about emotional difficulties is co-constructed by the interviewer and interviewees as a logical and helpful activity. All the interviewees express the notion that there is something to “*deal with*”, and the interviewer pursues questioning regarding this in each interview. She asks John whether his emotions are “*still parked*”, Rich if he has been back to the hospital to ask for help, Chris if he has

“talked through what happened”, and if Dave talked to anyone. Dave and Rich, as we have seen, encounter an ideological dilemma between finding help-seeking simultaneously problematic to repertoires of masculinity they subscribe to and necessary for resolution within repertoires of emotional distress.

Dave however, constructs an alternative repertoire of emotional distress more concordant with his identity as self-reliant. He talks about dealing with his *“visions”* on his own, saying *“I seem to block them out straight away(.) because I don’t like it”*. This repertoire of personal control and agency in tackling emotional difficulties is utilised by each of the men where external help-seeking, while acknowledged as part of a repertoire of resolution of emotional distress, is not. John, despite, or perhaps because of, his job as a counsellor, makes no allusion to seeking external help but plans to sit down and talk about things with his wife, suggesting there is an *“either”* option to talking, but failing to construct what that is:

“No but all that fall out(.) I think(2) in-w-er-er in my own head there’s kind of(.) something in the future(.) in(.) th(.) there’s something where we deal with it either we(.) sit down I mean I actually wondered if this would be the catalyst for us(.) sitting down and talking about it(.) erm(5) yeah” (John:52.47/1.05.09)

Dave attributes his coping to his positioning as a *“normal”* person, responding when asked *“it’s a lot to manage, isn’t it?”*, *“Of course without a doubt(.) but you would manage with it as well(.) Just to be here”*, constructing coping and recovery as something everyone will do if they have to. He constructs his family as resilient, and thus by proxy himself when he says *“All I know is my kids come from good stock and so does the wife(.) and she’s tough”*.

Chris also talks about the ongoing process of sense-making as something he and his wife are constructing together, at the same time building an identity as an enduringly positive person:

“We’ll sit there and then we’ll(.) I’ll say something(.) and then Mary will say “Do you remember? Do you-?” You know an- and then it brings it all back um I’m not a a person that(.) dwells on bad things too much(.) I you know(.) if you

give me a glass me a glass that's half full it's half full(.) it's not half empty(.) it's half full(.) and um yeah(.) some you know(.) I'm I'm really trying to put it behind me(.) to to to move on(1) Look for the joys of things rather than the negatives of them” (Chris:32.50/34.20)

Rich too, who describes seeking but being let down by external help, positions himself and his family as resilient and self-reliant in their coping:

“I know how we made it(.) Sarah and I love each other so much that you know(.) what we've got is is worth hanging on to. And worth the fight and worth(.) you know(.) the pain now we've been through has been horrific(.) but we've come through together and we've worked it together and that's the key(.) you see(.) you know you know(.) we realised we weren't going to get any help from anyone else(.) so there was only us(.) so we had to(.) you know not(.) you know and it's made us stronger and stronger(.) I mean we've always been strong together as a(.) as man and wife” (Rich:1.11.43/1.35.01)

In keeping with Gergen's (2001) notion of progressive, regressive or stability narratives, each story potentially moving through phases of each, each of the men present, ultimately, a progressive narrative. Gergen suggested that the narrative we tell has implications for future relational possibilities, and each of the stories presented here creates an opening for a progressive future, one in which things are better.

Ultimately, these men offer progressive narratives of their birth experience (Gergen, 2001), in which though there are regressive segments of the story, the endpoint is largely one of an improving situation. Frank (1995 – cited in Whitehead, 2006) proposes three distinct types of narrative which apply in illness narratives– that of restitution (yesterday I was healthy, today I am sick, tomorrow I will be better), that of chaos (life will never get better, no one is in control) and that of quest (illness is a challenge and impetus for change). Though it would be contentious to apply a theory of illness to childbirth, these families have experienced illness and childbirth as intermingled. It seems the predicted course of the childbirth narrative is akin to a restitution narrative- “*she gets it over and done with as normal*”. The failure of the expected narrative forming the middle of each story is akin to a chaos narrative in the efforts to reinstate predictability, and the impotence and vulnerability of the teller.

Dave's narrative perhaps hovers more between restitution and chaos in its final tone, constructing "*basically we're just a normal family*" but also with Dave saying he still has emotional issues to be got rid of. However the combined effect of these, the strength of the predicted narrative and the chaos of its failure, seems to lead three of the men into a quest narrative in which some transformative and positive impact can be found. Rich tells of how "*we've worked through it and we've done it ourselves(.) you know(.) and I'm quite proud of that(.) because it's been bloody hard*", and Chris says that "*its brought Mary and I closer*" John discusses the change in family dynamics and says "*in a way(.) y'know that-that was kind of one positive(.) thing that it did*". Each man opens the potential for a future narrative in which they are changed by their experiences, but in which they have survived.

Conclusions

Summary of analysis

At the outset of the study I discussed evidence that men can become distressed by their birth experiences, and that this experience has the potential to impact negatively not only on men themselves, but on their families too. This study sought to add a further dimension to the exploration of the content of men's accounts undertaken by Hinton et al (2014). By also considering the factors influencing men's constructions of their accounts and the actions they perform, this research aims to enhance an understanding of how and why those particular accounts are constructed with the aim of using that understanding to better reduce and manage distress.

Some distress men discussed in this study pertains to those aspects of childbirth which may be considered routine if not optimal. However some pertains to life-threatening complications forming a medical emergency linked to childbirth. As I listened to and read through the interviews, narratives of childbirth did seem to be constructed as distinct from accounts of medical emergency, as the overall accounts began in a childbirth experience expected to be "going to plan" even where that plan required medical intervention. Indeed these canonical narratives seemed to form the basis for what men expected to happen, what their role would be, and the context for

their construction of something going wrong. Due perhaps to the comparative rarity of life-threatening complications or perhaps the cultural taboos Pollock (1999) suggests hide less “happily ever after” stories of birth, narratives which might lend a sense of coherence to men’s sense making do not seem readily available to the men in this study. In line with the previous analysis of the larger data set from which this data was drawn (Hinton et al., 2014), issues of exclusion, powerlessness, difficulty in dealing with the new baby, support, communication and recovery emerged as important features for men who found their partner’s childbirth distressing, both during birth and the following medical emergency. A discourse analytic approach suggests insights into how these features are constructed in men’s accounts of their experience.

The men positioned themselves in their experience of the medical emergency as bystanders in a rarefied, dehumanised, realm, in which language served a separating function between medicine and the men, and their agency was minimised, but with it, their responsibility. The men attend to issues of personal accountability, telling of failed attempts at advocacy or personal agency, and constructing context specific attributions for aspects of behaviour they may anticipate might be seen as personal failing, in line with the discursive actions discussed by Horton-Salway (2001). Despite this they also work to retain elements of potency within their identities in this disempowering context, constructing the potential to employ physical, professional or litigious power, a greater grasp of common sense in the face of procedural thinking, or simply aligning themselves with the power wielded by others.

Another feature that emerged from the accounts was men’s positioning of themselves in their family relationships, as husband and father. Despite taking up “traditional” positions of breadwinner and protector, men were able to reconcile these with a position of carer for children or partners under a discourse of doing whatever was needed and having a masculinity robust enough to be undiminished by a caring role. Nevertheless the position of “Mother” seemed to be drawn from a “Madonna and child” repertoire which had no equivalence for “Father”, and men described feeling undermined and temporary in their role as primary carer for their children.

As the subsample of men chosen for this study were those who expressed lasting distress, inevitably that distress formed another theme, and one in which masculine discourses of strength and self-reliance featured strongly. The men constructed their experience of emotional distress in such a way as to refute suspicions of being prone to dramatizing or struggling with such things, and separate their experience of that distress from their continuous identity. Personal distress, in line with McCreight's (2004) conclusions regarding men's narratives of pregnancy loss, was seen by the men as failing in the expectation to be strong for their partners. Though this discourse of stoicism and self-containment in supporting an unwell partner fits within repertoires of masculinity, it is also perhaps a discourse common to the position of partner or carer of an unwell loved one regardless of gender. The expectation of personal emotional containment expressed by the men in this study may therefore be across a far wider spectrum of scenarios in which a loved one is under threat.

There was also evidence of an accepted canonical narrative regarding emotional distress in which issues are spoken about as a route to resolution. Despite this men did not find discourses of masculinity conducive to seeking such a route to recovery from outside the family, and instead attributed any recovery to personal and familial self-reliance.

Through all aspects of their narrative, men negotiate the construction of their masculinity in the female domain of childbirth and the feminising domains of medicine and mental health (Courtenay, 2000), using images of agency and control in line with a "heroic" or hegemonic masculinity, but also positioning themselves within a "normality" model and indeed a "rebellion" model in which masculinity is seen as autonomy from hegemony (Wetherell & Edley, 1999).

Bury (1982) suggests that chronic physical illness can be seen as a biographical disruption, a disruption to a person's understanding of their identity, proposing three elements to this disruption which, though this is a study of childbirth, acute medical emergency and lasting emotional distress, can still be seen here. Firstly, a "disruption of taken-for-granted assumptions and behaviours" can be seen in the failure of birth narratives in enabling men to make sense of their experience. Secondly, "disruptions of explanatory systems" requiring a re-thinking of biography and self-concept, can be seen as the men negotiate the dilemmas of maintaining

their “traditional” masculine identities in light of circumstances in which they have experienced disempowerment, a lack of agency and a confrontation with their own emotional vulnerability. This perhaps is the thread running through the narratives, the work the men do throughout their interviews to make sense of what has happened and who they understand themselves to be in light of that, but also to construct a telling within the social context of an interview, which will be made publically available. Third of Bury’s elements of disruption is the response to that disruption – the “mobilisation of resources, in facing an altered situation” visible in their narratives of family resilience and self-reliance.

Clinical Relevance

Taking an epistemological position that our understandings of our experiences are socially constructed through talk, this research offers a useful contribution sitting alongside previous qualitative research into men’s experiences of birth by adding to the literature a consideration of how men go about constructing their accounts and the ways in which their context informs that construction. The aim is not to dismiss the content of their accounts in any way, but to consider those accounts as part of a constructive process influencing how men are able to make sense of their experience.

Previous research regarding men’s postpartum mental health has recommended improving communication and support specifically for men (Dellmann, 2004; Garten et al., 2013; Snowdon et al., 2012) including improved preparation for the reality of risk and uncertainty in childbirth (Steen et al., 2012), and providing guidance for the support of partners after complicated childbirth (Hinton et al., 2014), screening for mental health issues (Zubaran and White, 2008) and acknowledgement by healthcare professionals of men’s emotional responses (McCreight, 2004). Certainly the issues identified in this study support the utility of these recommendations in improving outcomes for men and their families. However, this study highlights the ways in which identity construction, particularly as men in the feminine world of childbirth and healthcare, makes it difficult to acknowledge a need for support or facilitated by health care professionals in accessing it. This identity of self-reliance and stoicism is co-constructed in these accounts by both the men and healthcare professionals like the GP who dismisses or fails to acknowledge men’s emotional

responses or need for support. Thus a part of facilitating better support for men must entail not only the assimilation of the experience of emotional distress and the viability of help-seeking into the preferred identity constructed by the men, but the promotion of self-care among men by healthcare professionals. It is worth noting that the separation between doctors and men constructed in these accounts suggest that doctors may not be best placed to identify emotional needs in men who may already feel disempowered or angered by the medical personnel they have been dealing with. By incorporating contact with a psychologist or counsellor into a standard care package following a birth in which significant problems arise, the opportunity to explore emotional needs could be seen as an expected and appropriate part of a narrative of problematic birth, which can be taken up or otherwise depending on the desires of men who have at least had the opportunity to discuss their needs. Help-seeking may also hold less stigma when perceived as part of a process as opposed to a personal choice.

Provision of support by psychologists and counsellors itself needs also to take account of the wider discourses influencing the way men talk about their experience, constructing formulations which encompass the social mediation of men's constructions of their experience. The men in this study do not describe emotional responses as a linear progression of cause and effect, but as situated within their expectations of who they understand themselves to be. Men are not merely passive enactors of dominant discourses of masculinity or wider personhood, but active authors of those discourses as they take positions relative to them. Support can assist men in reconstructing the nature of their emotional responses and altered roles or renegotiating their construction of their own identity such that dilemmatic positions may be resolved into a cohesive and more comfortable understanding of self.

Notable within the data is the emotional impact of separation from partners during a crisis and the construction of those familial relationships as being the primary resource for healing. Facilitating the shared meaning-making families co-construct by reducing separation where viable and working systemically as opposed to individually wherever appropriate may also foster repertoires of familial self-reliance as a positive resource for healing. This is in accordance with (NICE, 2006, 2007) regarding the inclusion of partners and attention to their needs but perhaps suggests

a provision warranting further investigation in light of the recommendation to avoid formal debriefing.

An increased awareness of the discursive restraints influencing men may also facilitate better understanding of their needs by healthcare professionals working with families during birth or medical crisis.

Previous recommendations regarding antenatal and postnatal support better tailored to men's gender specific requirements are relevant here. Garten et al. (2013) recommended father specific peer support for fathers of infants in neonatal intensive care, and Lupton (2000, cited in Dolan & Coe, 2011) suggested that where men are present only in small numbers they may be denied opportunities to use talk with other men to construct and confirm masculine identities, and this may be particularly marked in the female dominated domain of childbirth. As such, the facilitation of male specific support may be of benefit, including perhaps the facilitation within antenatal preparation of men's construction of being a father to a new-born in its own right as opposed to as an adjunct to the deified role of Mother.

Methodological considerations

This study is small, with just four interviews analysed. However the intention is not to produce conclusions generalizable to all men, but to produce considerations which may assist in our conceptualisations of men's sense making.

Both strength and weakness in this study is its use of secondary data. This has had the advantages of reducing the ethical dilemmas of interviewing people about their difficult experience, especially when the interviewer has no plan to offer therapeutic input. A second set of men have not gone through this process. While an interview may in its own right serve a therapeutic function, as perhaps for Dave who says it has been his first opportunity to talk about what happened, it may also be distressing, as potentially for Chris, who expressed the thought that having talked about what happened it will be on his mind more. I was aware, as a therapist, and in John' case perhaps a fellow mental health professional, that had I conducted the interviews I might have been seen differently by the men, and different stories may

have emerged. However, I was also unable to make use of interviewees to endorse or dispute my analysis as part of the process of ensuring rigour.

However, using secondary data has also created greater separation between analyst and data. Working from audio tapes, the nuances only observable through physical presence were lost to me. The narratives were also shaped by the intent of the original researcher, and while this forms evidence of the co-constructive nature of the men's talk in itself, it may be argued that interviews are insufficiently naturalistic for narrative or discursive analysis. However, they may be seen as sufficiently ubiquitous in western culture to be a naturalised discursive context familiar to most people. Mishler (1994) argues that interviews contain "implicit assumptions of how to talk and of what to talk about in this situation", and are a valid social exchange to study, however within the context of medical interviews, he argues that by the sequencing of interviews, the questioner retains control of the topic and defines the relevance, or irrelevance, of features in the account by the questions asked.

Interviews may also be criticised for any suggestion that they offer a democratic research tool which avoids silencing or disempowering the voice of the interviewee (Atkinson, 2005). These interviews were conducted in the men's homes, at times convenient to them, with an agenda of hearing the voices of those men. Nevertheless, they were conducted by a highly educated, employed female equipped with questions the men expected, by the convention of interviewing, to answer. Further, extracts from the interviews would be made public on the internet. The context of the interview is likely to have influenced the discursive acts the men performed, and that context needs to be held in mind when analysing their accounts. Epistemologically, this is a strength of this study, however the use of secondary data may have had both clarifying and clouding effects in considering the micro-context at hand as the men told their stories. As analyst but not interviewer I felt not only that I was sometimes more able to see the impact of that context on the account given, but also that it was harder to remember that context. I had the words spoken, but not the personal connection to that context which helped me to keep it in mind as I worked.

Future research

While even within these four interviews there is more to say, more participants would create new opportunities to see trends in discourses and areas of difference or dissent. Obtaining additional data through non-interview means such as online forums or focus groups or in all-male environments would also potentially lead other features to emerge.

As well as considering a greater number of cases, two areas for further research would be to continue secondary analysis of data from the men who did not report lasting distress within the same study, from the one lesbian partner, whose social context will differ from that of the male partners interviewed, and from the partners of these men, comparing not only the content, but also the construction of their stories.

Given the understanding of discourse as constructed within a historical and social context, it would also seem appropriate to conduct similar analyses regarding the constructions of men (and women) from more varied contexts, nationally and internationally, as this study discusses only the discourses of white British men between the ages of 29 and 48 at this moment in history.

It would also be useful to investigate the impact of the utility of facilitating shared meaning-making opportunities with families following traumatic births.

Personal Reflections

As described in the methodological section of this thesis, reflexive practice it is important in undertaking qualitative research. For me, research around birth was not of particular interest when I began my clinical psychology training. However, the progress of my training was perturbed when I gave birth to my first child and, almost overnight, my interests, my perspectives, my understandings, my identity, changed. I say overnight, but of course that change was far from contained in a moment, but was rather a product of my own culture and history. Conducting this research was born out of my childbirth experience, but my childbirth experience has been altered by conducting this research and as I sit down to write myself overtly into it, I realise that my identity is also changed retrospectively, by this work that I have done.

Emotionally, I have had an unexpected journey with the stories of these men. Without having met them, I feel like I have both connected with and disconnected from them. Initially, I found their stories moving. I have cried over them, I have physically reached out and laid my hand over the words one man spoke as I felt his desperation to hold onto the people he loved. I have felt honour bound to treat their stories with dignity and respect. And yet, over repetitions, I have also felt irritation, impatience and perhaps worst of all, nothing whatsoever. The data became data. Where I expected to add richness and complexity to my understanding of these men, I also felt a sense of having deconstructed their identities into data. I felt wary of seeming to accuse them of deliberate manipulations and nervous that I was offering conjectures about their discursive actions they could not endorse and retain their preferred identities at the same time.

I was also very aware throughout my analysis that I did not come from an impartial perspective. I approached the data from a position of feeling men are under-acknowledged in childbirth and early parenthood, of considering their mental health and their opportunities to be a father to be important enough for me to choose to focus on them in my research. The themes which emerged to me from the data may be different from the themes that may emerge to another. While this doesn't make my analysis wrong, I feel it is important to acknowledge that at no point could I contend that my analysis is right. I have not sought truth about how men manage a difficult birth experience, I have sought to open another window on this landscape.

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Appendix 1 – Ethical Approval

NHS National Research Ethics Service - Berkshire Research Committee -
09/H0505/66 - Letter of Favourable Ethical Opinion

NRES Committee South Central - Berkshire - 12/SC/0495- Letter Confirming
Favourable Ethical Opinion with Conditions

NRES Committee South Central - Berkshire - 12/SC/0495- Letter Confirming
Conditions Resolved



National Research Ethics Service

Berkshire Research Ethics Committee

Building L27
University of Reading
London Road
Reading
RG1 5AQ

Telephone: 0118 918 0560/1
Facsimile: 0118 918 0569

22 May 2009

Ms Sue Ziebland
Reader in Qualitative Health Research
University of Oxford
Rosemary Rue Building
Old Road Campus
Roosevelt Drive
Headington
Oxford
OX3 7LF

Dear Ms Ziebland,

Full title of study: Narratives of health and illness for
www.healthtalkonline.org (formerly DIPEX) and
www.youthhealthtalk.org

REC reference number: 09/H0505/66

The Research Ethics Committee reviewed the above application at the meeting held on 12 May 2009. Thank you for attending to discuss the study.

Ethical opinion

Ms Ziebland was invited to join the meeting to discuss the study and was thanked for attending. She was asked by the Chair to clarify the following issues:

1. The researcher was asked the reason the application had been submitted to an NHS REC and it was explained that the researchers want to include NHS staff and also recruit through the NHS, therefore approval was required. This was accepted.
2. The members felt the information in the application form was vague in parts and the researcher explained that they have MREC approval from 1999 and they had requested a number of extensions to the study. The study was originally given 'no local investigator' approval, which no longer exists and so it was decided it would be more appropriate to obtain new approval.
3. The researcher was informed that the application form did not contain a description of the structure of the interviews. The researcher explained that they are using narrative research methods and will conduct the interviews using questions such as 'tell us all about it from when you first noticed a problem'. Structured prompts will not be used. The researcher will handle each interview separately and it will be co-constructed with the patient and staff member.

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4. The researcher was asked whether Social Services or the Police would be alerted if it is suspected a young person has been abused. It was explained that this has never occurred. When the research was extended in 2003 to include 16-18 year olds the REC that gave approval required a procedure to be in place if abuse was identified and this same procedure remains.
5. The researcher was asked whether participants may have mental health problems and it was explained that they would like to complete studies on Dementia and Alzheimer's patients but they have not received funding for this yet. The Committee recommend that if the researcher wanted to include these patients they should make themselves familiar with the Mental Capacity Act (MCA) Regulations. The researcher was informed that under the MCA research cannot take place on a person who lacks capacity to consent if it can be carried out on a person with capacity. This was noted.
6. The Committee questioned whether the research would be used towards the academic qualification of the student involved. It was agreed the Information Sheets could be amended to explain the researcher is part of an educational qualification.
7. The researcher was asked to clarify what the wording 'optional depends on funding' referred to in the Information Sheet. It was explained that participants may be interviewed in their home and they will be asked to tell their story. If they are willing, then the interview will be recorded. They will write a transcript and send this to the participant to approve. The participant can then choose to give permission for video or audio recordings to be used on the website. If they prefer to be completely anonymous they can have a written version of the transcript on the website or have an actor speak their words. Some studies may have funding for the use of actors, but this will not be available for all studies.
8. The researcher was asked how the analysis will be validated. It was explained that the researchers will send a transcript of the interview to the participants to validate for accuracy. Each study has a researcher who is responsible for carrying this out. The researchers will use thematic and discourse analysis. For the website, the researchers will carry out thematic analysis of about twenty-five different topics. They will be different for each illness. The analysis will then be checked by a research buddy and then by an advisory panel, which is made up of members of the public and Clinicians.
9. The Committee questioned what would happen if the content of the interview contained factually incorrect information. The researcher confirmed that they select clips to put on the website. They select ten clips, which then go to the specialist on the advisory panel to check the information is factually correct. The researcher confirmed that this is to ensure that only factually correct information is available on the website.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

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The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

Other conditions specified by the REC

1. The following amendments should be made to the Information Sheet:
 - a. Please add the heading title 'Participant Information Sheet' to all the sheets.
 - b. In the section 'Do I have to take part?' please amend the final sentence 'If you do not take part...decreased' to 'Deciding whether or not to take part in the study will not affect the standard of medical care you receive'.
 - c. Please add a section near the end of the sheet 'Who has reviewed the study?' followed by 'This study was given a favourable ethical opinion for conduct by the Berkshire Research Ethics Committee'.
 - d. Where relevant, please add a statement to the beginning of the sheet stating: 'The research is being carried out as part of an educational qualification'.
2. Once the above changes have been made to the participant documentation, the version number should be amended, a new date added and the revised documentation submitted to the REC office (by post) for information. PLEASE NOTE: You are not permitted to make any other changes to the application or documentation than those requested by the Committee. If you wish to make any other changes, these should be submitted separately as an amendment.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		14 April 2009

This Research Ethics Committee is an advisory committee to South Central Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Application	1	23 April 2009
Sponsor's Signature page of application form		03 April 2009
Investigator CV		23 April 2009
Protocol	1	01 April 2009
Participant Information Sheet: Generic Adults	2	01 April 2009
Participant Information Sheet: Generic Young People 16- 18 yrs	8	01 April 2009
Participant Information Sheet: Generic Staff	2	01 April 2009
Participant Consent Form: Copyright form - future use of interview	1	19 January 2009
Participant Consent Form: Young People 16 - 18 yrs	9	01 April 2009
Participant Consent Form: Generic Adult	9	01 April 2009
Young People Advertisement	1	01 January 2009
Generic HTO Advertisement	1	01 January 2009
Generic Advert for Metro/ Evening Standard	2	01 April 2009
Letter from Sponsor		03 April 2009

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

A declaration of interest was made by Ms Tonks. The member remained in the meeting room and took part in the review of the application.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email

This Research Ethics Committee is an advisory committee to South Central Strategic Health Authority.

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

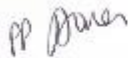
referencegroup@nres.npsa.nhs.uk

09/H0505/66

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



Professor Nigel Wellman
Chair

Email. scsha.berksrec@nhs.net

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments
'After ethical review – guidance for researchers'

Copy to: Sponsor - Miss Heather House, University of Oxford

This Research Ethics Committee is an advisory committee to South Central Strategic Health Authority
*The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England*

NRES Committee South Central - Berkshire

Bristol REC Centre
Whitefriars
Level 3, Block B
Lewins Mead
Bristol
BS1 2NT

Telephone: 0117 3421389
Facsimile: 0117 3420445

07 September 2012

Ms Sue Ziebland
Reader in Qualitative Health Research
University of Oxford
23-38 Hythe Bridge Street
Oxford, OX1 2ET

Dear Ms Ziebland,

Study title: Narratives of health and illness for
www.healthtalkonline.org (formerly DIPEX) and
www.youthhealthtalk.org
REC reference: 12/SC/0495

The Proportionate Review Sub-committee of the NRES Committee South Central - Berkshire reviewed the above application on 05 September 2012.

Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study:

1. Please complete the highlighted 'xxxx' and '[]' with the correct information on all patient information sheets.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

A Research Ethics Committee established by the Health Research Authority

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation.

Approved documents

The documents reviewed and approved were:

Document	Version	Date
Advertisement	Generic Recruitment for Metro Evening Standard: Version 1	21 August 2012
Advertisement	PPI Health Research Flyer: Version 1	21 August 2012
Advertisement	YHT Generic Flyer: Version 1	21 August 2012
Covering Letter		20 August 2012
Investigator CV	Sue Ziebland	
Letter from Sponsor		21 August 2012
Other: Copyright Form HTO	1	21 August 2012
Other: Copyright Form YHT 10-15	1	21 August 2012
Other: Copyright Form YHT 16-25	1	21 August 2012
Participant Consent Form: HTO	1	21 August 2012
Participant Consent Form: YHT 10-15	1	21 August 2012
Participant Consent Form: YHT 16-25	1	16 August 2012
Participant Information Sheet: Generic	1	21 August 2012
Participant Information Sheet: Service User Researcher	1	21 August 2012
Participant Information Sheet: Mental Health	1	21 August 2012
Participant Information Sheet: PPI	1	01 July 2012
Participant Information Sheet: Staff	1	21 August 2012
Participant Information Sheet: YHT 16-25	1	21 August 2012
Participant Information Sheet: YHT 10-15	1	21 August 2012
Participant Information Sheet: YHT Information for Parents	1	21 August 2012
Protocol	1	21 August 2012
REC application		21 August 2012

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

12/SC/0495	Please quote this number on all correspondence
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With the Committee's best wishes for the success of this project

Yours sincerely



pp Mr David Carpenter
Chair

Email: scsha.berksrec@nhs.net

Enclosures: List of names and professions of members who took part in the review

After ethical review – guidance for researchers

Copy to: Ms Heather House, University of Oxford
Ms Heather House, Oxford University Hospitals NHS Trust

NRES Committee South Central - Berkshire

Attendance at PRS Sub-Committee of the REC meeting on 05 September 2012

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Mr David Carpenter	Social Scientist	Yes	
Mr Richard Merewood	Director	Yes	
Ms Susan Tonks	Senior Research Support Associate	Yes	



Health Research Authority

NRES Committee South Central - Berkshire
Bristol REC Centre
Whitefriars
Level 3, Block B
Lewins Mead
Bristol
BS1 2NT

Telephone: 0117 3421389
Facsimile: 0117 3420445

11 September 2012

Ms Sue Ziebland
Reader in Qualitative Health Research
University of Oxford
23-38 Hythe Bridge Street
Oxford
OX1 2ET

Dear Ms Ziebland,

Full title of study: Narratives of health and illness for
www.healthtalkonline.org (formerly DIPEX) and
www.youthhealthtalk.org
REC reference number: 12/SC/0495

Thank you for your letter of 07 September 2012. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 05 September 2012.

The Committee apologises for adding the following condition to the study Favourable Opinion:

1. Please complete the highlighted 'xxxx' and '[]' with the correct information on all patient information sheets.

The documentation received below reveals that this condition was added erroneously; the generic nature of the documents is clear.

Documents received

The documents received were as follows:

Document	Version	Date
Covering Letter		07 September 2012
Other: Example Completed HTO PIS		

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

12/SC/0495

Please quote this number on all correspondence

Yours sincerely



Ms Rae Granville
Committee Co-ordinator

E-mail: scsha.berksrec@nhs.net

Copy to: *Ms Heather House, University of Oxford*
Ms Heather House, Oxford University Hospitals NHS Trust

Email from Prof. Richard Southern, LMS ECDA Chair to Nicholas Wood, cc. Wendy Solomons regarding ethical approval.

From: Southern, Richard
Sent: 01 May 2014 15:05
To: Wood, Nicholas
Cc: Solomons, Wendy
Subject: Re: Hannah Moore - DCLinPsy
Importance: High

Dear Nick

I have now checked this and am content that there are the correct ethical clearances in place.

Sorry for the delay in responding.

Regards

Richard

Appendix 2 - Participant Information Sheet & Patient Reply Slip

The following pages show the participant information leaflet and reply slip from the original study.

Contact for further information

I hope that this information sheet about has told you what you need to know before deciding whether or not to take part. If you have any queries at all about the project or wish to make a complaint please telephone Lisa Hinton on 01865 289328 or Sue Ziebland of the Health Experiences Research team on 01865 289302.

Notes:

- I am a professional researcher and am paid for my work.
- The study has been approved by **Berkshire Research Ethics Committee for health research**

Given the nature of this study, it is highly unlikely that you will suffer harm by taking part, however if you are harmed by participation in the study, you may have grounds for legal action for compensation against the University of Oxford.

Many thanks for reading this information sheet.

Lisa Hinton

The Healthtalkonline site is run by DIPEX, which is a registered charity, number 1087019 and a company limited by guarantee, company number 04178865, whose registered office is at PO Box 428 Witney Oxfordshire OX28 9EU.



Tel : 01865 289328
Fax : 01865 289287
www.healthtalkonline.org

Email :
francie.smee@dphpc.ox.ac.uk

Health Experiences Research Group

Dept of Primary Health Care,
University of Oxford, Old Road Campus
Oxford OX3 7LF

PARTICIPANT INFORMATION SHEET TAKING PART IN RESEARCH - A STUDY OF EXPERIENCES OF CONDITIONS WHICH THREATEN WOMEN'S LIVES IN PREGNANCY & CHILDBIRTH.

Hello

My name is Lisa Hinton. I am a researcher working with the Health Experiences Research Group at Oxford University. I am asking you to take part in research. Before you decide if you want to take part or not, I want to tell you why the research is being done, and what you can expect if you do take part. Please read what I have to say carefully. Talk about it with friends, relatives and your GP if you wish. Ask me if you have any other questions. Please take as much time as you like to decide. Thanks for reading this.

What is the purpose of the study?

The aim of our research programme is to improve understanding of people's experiences of health and illness, and provide resources to support people living with a wide variety of health conditions, their families, friends and the health professionals involved in their care. We collect video, audio and written interviews, which may be used in several ways:

- to find out what is important to people faced with conditions which threaten women's lives in pregnancy and childbirth

- to contribute to the www.healthtalkonline.org website which is run by the DIPEX charity
- to develop other support and information resources for people
- to train health and social care professionals
- to write research papers

www.healthtalkonline.org is a website that has:

- people's stories of health and illness
- information about tests and treatments,
- details about support groups & other resources (e.g. self-help books)
- a teaching and learning area for health and social care staff.

The idea is that Healthtalkonline will help people to:

- understand & cope with health problems and issues
- know what really matters to people when they are ill or are facing health issues; and
- answer common questions and provide information.

People who are faced with difficult choices (e.g. which tests or treatment to choose) will be able to go to the Healthtalkonline website to find out how others have made their decisions. Health professionals who want to understand what it is like for people to have an illness or face health choices can also visit the website.

Anyone who has access to the Internet would be able to use Healthtalkonline.

Can I choose how my interview will appear?

You will have a choice about whether a video, audio or written version of your interview is included. If you want to be anonymous, you will be invited to use an alias for yourself and others, and you can keep out of the interview anything which might identify you.

You may wish to discuss this with members of your family, since they might possibly be connected to your appearance on the screen.

If you are recognised on a website or a DVD, this would be a little like appearing on the TV. The material on the website is protected by copyright and people are not allowed to copy or record what they find there but it is possible that they could. If you have any doubts about how you want the interview to be included, talk to me, or I could find an independent adviser for you to talk to if you prefer.

Who has reviewed the study?

This study was given a favourable ethical opinion for conduct by the Berkshire Research Ethics Committee.

Who is organising and funding the research?

The Health Experiences Research Group is based at the Department of Primary Health Care, University of Oxford. The project for **CONDITIONS WHICH THREATEN WOMEN'S LIVES IN PREGNANCY AND CHILDBIRTH** is being funded by the NHS National Institute of Health Research (NIHR) and conducted as part of the UKNeS (UK Near-miss Maternity Surveillance Programme) being run by the National Perinatal Epidemiology Unit (NPEU) at the University of Oxford.

I will send you a copy of the interview transcript to help you decide whether you want your interview to be made available to use for our research, including on Healthtalkonline and other audio-visual resources. A copy of the interview tape can also be provided if requested. You would be asked to read or listen to the interview and consider if there was anything you would like to change or remove, to keep anything secret or hide your identity, or to delete or change some of your interview. We can remove any sections that you do not want us to use. You can take as long as you need to do this. You can also choose how your interview will appear in any resources we produce (see below).

How would the researcher use the interview tape and transcript?

You will be asked to sign a form 'Further use of my interview'. If you sign this form, you give copyright of the interview to the University of Oxford. It is very important that you take time to think about and discuss the copyright form before you sign it. You will be given a copy of this form to keep.

If you do decide to allow your interview to be used for the study, it would be used along with interviews from between 30 and 50 other people (women and their partners) who have experiences of conditions which threaten women's lives in pregnancy and childbirth. A summary of these interviews would be prepared for the healthtalkonline website. People who use the site would be able to see the summaries of the interviews as well as read extracts from the interviews and view the video clips of people who agree to this kind of use of their interviews. All data use is strictly within the terms of the Data Protection Act (DPA 1998). The study data may be looked at by individuals from the University of Oxford, for the purpose of audit and monitoring.

The interviews we collect contribute to the information presented on the site, and extracts from many of them will be used to show what it is like for people facing illness or health issues. The interviews will not be used for profit or commercial gain.

As well as the website, we may use interviews to help create other information and support resources, such as DVDs or short films. These may for example be shown to people by health professionals as part of their care or they may appear on other websites approved by the University of Oxford

Interviews may also be used to develop training materials for health and social care professionals, so they can learn from people's experiences and improve the care they provide. Again, these training materials may be presented on the teaching and learning area of the www.healthtalkonline.org website, on other approved websites, and on DVDs.

All the interviews we collect are included in our analysis for preparing research articles and papers.

Why have I been chosen?

You have been contacted because I want to interview people who have had experience of health issues and decisions such as yours. I will be interviewing a range of people who have had such experiences. Your name has not been given to us at the Health Experiences Research Group, so I will only be able to contact you if you fill in the 'reply slip' (in your information pack) and post it to us in the reply paid envelope.

While people sometimes find it helpful to talk about their story to researchers this research is not the same thing as counselling. However, I can give everyone a list of useful contacts which can

Do I have to take part?

No. It is entirely up to you to decide whether or not you want to take part. If you decide to take part, you will be given this information sheet to keep. You will also be asked to sign a 'consent form'. If you decide to take part, you are still free to stop at any time without giving a reason. No questions will be asked if you stop. Deciding whether or not to take part in the study will not affect the standard of medical care you receive.

What will happen if I take part?

If you complete and send back the enclosed 'reply slip', I will contact you to arrange an interview at a time and place that suits you. If this place is not your home, you will be paid for the cost of your travel. I will try to answer any questions you may have about the interview or the Healthtalkonline project. Before the interview I can show you the Healthtalkonline website on a portable computer. You can see how clips from other people's interviews look in video, audio and written formats.

What would the interview be like?

I will ask you if you are willing to have the interview video or audio tape recorded. You will be given the 'consent form'. You only sign this form if you agree to take part in the interview. You will be given a copy of the consent form to keep. The interview will be a little like a conversation, in which I will help you talk about yourself in your own words. I will ask you to talk about your experiences of conditions which threaten women's lives in pregnancy and childbirth. I will ask questions about what happened to you, what your thoughts and feelings have been at different stages, how you have got information, what you have done, and what have been the good and bad parts of the experience.

be used to get more help if you want.

How long would the interview take?

The time it takes for an interview varies, depending on how much you have to say, but most interviews last at least an hour. If you would prefer, I can interview you on two different occasions. Remember, if you want to stop the interview at any time, you can do so without giving any reason at all.

What if I decide to withdraw after the interview has taken place?

You are free to leave the study at any time. If you decide to leave after an interview has taken place, all video, tapes, transcripts and typing of your interview would be destroyed. If you decide to leave after the website or other audio-visual resources have been finished, we would remove your contribution from all later versions, but we would not be able to destroy existing material, which other people could already have seen or copied.

What would happen after the interview?

I will label the interview tape with a code number and give it to a typist who will type out everything you said in the interview. The typist has signed an agreement to keep everything you say in the interview secret. The tape and the typed up record (transcript), identified only by the code number, would be kept in a secure place at the Department of Primary Care at the University of Oxford.

Reply slip for Module:

Conditions which threaten women's lives in pregnancy and childbirth

Yes, I am happy for a researcher to contact me about this project.

Name:

(Block Capitals)

Address:.....

.....

..... Post Code:

Telephone number: Day: Evening:

Best time to contact me:

Age:

Date or year of diagnosis:

Occupation:

(if retired please state and give last occupation)

Ethnic Background.....

(It is important for us to include perspectives from a range of ethnic groups in our research).

ADD/DELETE AS APPLICABLE (IE SENSITIVE SUBJECT)

I would prefer to be interviewed by: Female researcher

Male researcher

Either

Please return to:

LISA HINTON
DIPEX Health Experiences Research Group
Department of Primary Health Care
University of Oxford
Old Road
Headington, Oxford OX3 7LF

Tel: 01865-289328/Mobile 07976 607015

Appendix 3 – Transcription Key

The following transcription notation has been used:

Quotes from the interviews are italicised.

(.) Short Pause

(*number*) Timed pause, e.g. (2) denotes a 2 second pause

[*text*] Clarificatory information, e.g. actions, laughter

Text emphasis placed on this word, or part of word

At the end of substantial quotes:

(Interviewee Pseudonym: time in interview quoted text begins/full length of interview)

Appendix 4 – Sample of transcript analysis

But, you know, because, and I was still working as well, although I did reduce my hours. And it, it all went by in a blur. I don't know what happened. But we just did, you know, I did my bit at work and Sarah's family would come round and babysit or whatever and then when I came home I'd look after the kids." And, you know, and, it helped Sarah with whatever she might need, bathing, or pain killers or whatever, you know, nothing was too much trouble for my baby honestly. I give Sarah whatever she needs. I'd walk over broken glass for her, you know, we did, we did it all. You know, and we worked together, you know. She did as much as she could which wasn't very much at the start, but she wanted to, you know, because she'd missed out on so much, she feels like, you know, [2 sec pause] especially now with [third daughter] being the last baby, she'd missed out on, you know, such an important part for this family. She want, she want there for it. So she was determined to be there, you know, but it was difficult. She couldn't hold [third daughter] for every long and you know, and with [second daughter] not being very well, you know, she's not very well at all. So there was a lot she couldn't do for her, and she found it pretty tough. And it was really hard not to be able to do, you know, because apart from at the moment where our roles have reversed through circumstances I've always worked long hours, and Sarah's always been at home, because we're quite traditional in that way, you know, not that I'm a sexist or owt, but you know, I like Sarah being at home do, doing the house and that, and Sarah likes that, you know, I don't make her do it, and she you know, we're quite traditional on that front. So she missed her role as a Mother,

and as a wife. She missed that. [um] I think more than I'll, I'll ever know, because a Mother's love for her children is different from a bloke's, and I can't even begin to imagine [um] the heartache that she's gone through to miss [third daughter]'s birth and miss those, those few first days and not being able to hold her properly and not being to hold [second daughter] who's not very well, and [first daughter] as well, you know, not missing her out, but you know, she was only tiny herself, because we had them really close together so .. I can't even begin to imagine the trauma she was going through herself. She was just heartbroken you know.

[07.48] But we tried. [um] You know, just the best we can. You know, you, you, you try and stay strong. [um] You know, for your wife and for your children and you try and [er] you know, because I'm brought up, you know, very macho or men are men, and women are women [um] in my family. So when the cracks started to appear, I couldn't, couldn't get me head round that, you know, we don't do emotion, we definitely don't cry. Definitely not. We go to work. We drink beer. Play snooker, you know, we do, you know, we do all that. We definitely don't do emotion and as for looking after children quite so much, that, you know, my grandfather nearly fell over that, you know, you do what the my boy? You know, that women's work. You know, but you take on, you adapt, you adjust to each situation and it came naturally to me. I wasn't worried about doing it, but at the same time I was doing it, I can't say I was doing it all, because that's a selfish thing, because Sarah did as much as she could. But I was doing so much of it, that I felt I was taking some away from Sarah as well as she felt like she was losing it, you know, but there weren't anything we could do.

So that was, so that was kind of putting a bit of, I suppose that was the start of some of the beginnings, of a pressure between ourselves as a couple. Rather than a family. You know, Sarah's losing her role and I'm trying to sort of, not take over, but I've got to fill that role and it's not actually my role. So don't quite know what I'm doing, and she wasn't... so you know, so things started to get quite difficult at home. Because we were both there, because I obviously had to give up work in the end. So we were both there and you know, no one knew, suddenly no one's got a role in the house. You know, so that was, so emotionally that was quite, that was quite a difficult, I mean I know in the grand scheme of things, it's 'what you talking about?' you know, it's neither here or there. But because we had such clearly defined roles to suddenly they're not being that within the house, that was quite a tough, that was quite a tough thing to adapt to. More so for Sarah, to lose this, and then to try and cope with what happened, you know, the operation that she'd had. You know, because she had no support at all. Not really. I think the health visitor came round for a couple of days to check the wound and pretty much nothing really. Bloody I could have done a better job. Do you know what I mean? And then that was it. Nothing. Sarah didn't have counselling, [er] she had no, you know, she didn't even get a, I don't know, a friend or whatever from the hospital. I don't know somebody who'd been through it to come round and have a cup of tea and a chat. She got nothing like that

Appendix 5 – Interview Schedule

INTERVIEW SCHEDULE (March 2011)

Interview Checklist:

Demo

Consent Form & Patient Info Sheet

Opening Question:

Tell me about your story from the beginning

Follow up areas:

1) Pathway

- Previous pregnancy experience
- Expectations
- Midwife led care?
- Was it a complex pregnancy throughout
- Other problems/past history
- Family history (e.g. eclampsia)

2) Hospital experience

- Crucial hours
- Woman's experience
- Partner/husband's experience
- Haemorrhage
- Hysterectomy/surgery
- Discharge
- ICU?
- Where does the baby go?

3) Follow up

- What were the first few weeks like?
- What follow up were you offered?
- 6 week GP check, health visitor, anything else?
- What questions did you have after in the weeks after the experience, were they answered?
- Notes?

4) Aftercare

- Ongoing health issues
- Impact on family, partner, marriage
- Children (relationships, child's development)
- Integration of care

5) Longer term effects

- Future pregnancies?

6) Mental health

- Psychological impact
- anxiety/PTSD
- counselling
- Bereavement parallels

7) Particular issues around hysterectomy

- Immediate recovery period
- Ongoing health issues
- Resulting fertility issues
- Information and support needs

8) Men's experience

9) Communication: what was communicated, to whom, how could it be done better?

10) Information and support needs: at the time and afterwards

- Where have you found support?
- Has that support been sufficient?

11) Areas of care that could be improved?