GOING THROUGH A 24-HOUR BOX: HOW WOMEN'S EXPERIENCES OF CHILDBIRTH SHAPE THEIR EMBODIED SENSE OF SELF

by

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ABSTRACT

Women's experiences of childbirth are presently understood primarily in terms of role change and physical or cognitive impacts. In order to bring a more holistic perspective to understanding childbirth, this study explored how women's childbirth experiences shape their embodied sense of self. Six women's childbirth experiences were analysed using Gilligan's (1982) Listening Guide (LG) method, adapted by integrating Längle's (1993) Existential Analysis (EA) framework of Four Fundamental Motivations (4 FMs). The analysis uncovered women's voices of fulfillment (e.g., trust, empowerment, connection, appreciation, meaning) and suffering (e.g., mistrust, disconnection, disregard, meaninglessness). Specifically, research findings indicated that positive birth experience led to positive embodied sense of self while negative birth experience (e.g., disrupted embodiment) led to negative sense of self. However, both of these experiences can appear simultaneously in women's experience. A positive embodied sense of self was experienced as being a mother and being strong. These findings suggest that childbirth and motherhood can empower women to grow and be strong even in spite of possible traumatic or negative birth experience. This study has important implications with respect to promoting a holistic understanding of women's subjective experiences of childbirth, and the role of women's lived experience in shaping their embodied sense of self.

Keywords: Childbirth, embodiment, embodied sense of self, Listening Guide.

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CHAPTER 1: INTRODUCTION

> "Everyone has a mother as the source of his life and body. So, the mother has to be strong in mind and body." Sathya Sai Baba (n.d.).

Childbirth is a pivotal experience in a woman's life in which she becomes a mother and contributes towards the continuation of the human species. Birth is an embodied experience which can range from one of fulfillment and happiness to one of sadness and trauma. Thus, it can have a lasting positive or negative impact on the woman's psyche, affecting her physical health, and the health of her child (Kitzinger, 2006; Kjaergaard, Foldgast, & Dykes, 2007; Walsh, 2010). The childbirth experience is imprinted as a flashbulb type memory and remembered by the woman for many years afterwards (Lundgren, Karlsdottir, & Bondas, 2009). Birth is not just remembered in her mind but in her body too (Walsh, 2010). According to Chrisler and Johnston-Robledo (2018), the dominant medical view of mind and body as separate entities is being increasingly challenged with a holistic view of mind and body as one whole person. The view of a mind-body whole is accepted both in the biopsychosocial model of health and illness, and through increasing research on embodiment, which has been identified as an important construct in understanding human subjective experience. In line with this approach, the concept of embodiment is used in this study to understand women's subjective experiences of giving birth.

Embodiment is "the experience of living in, perceiving, and experiencing the world from the very specific location of our bodies" (Tolman, Bowman, & Fahs, 2014, p. 760). Embodiment is also awareness as a body, and consciousness of the feelings and sensations within one's body as they relate to the outer world (Varela, 1996). Childbirth is an embodied experience of one's self giving birth, and a conscious awareness of the feelings and sensations of

giving birth. Connecting to the embodied self means having an awareness of this self-body unity (Ferrè, Lopez, & Haggard, 2014). A disruption in embodiment, or disembodiment, is a state of separation of self and body (Piran, Carter, Thompson, & Pajouhandeh, 2002), and it is a response to emotional distress (Morse & Mitcham, 1998), which can impact the woman's embodied experience negatively. Csordas (1999) argues that from a phenomenological perspective, embodiment is widely regarded as an existential condition, or lived experience of being-in-the-world, where the body is the subjective ground of experience: meaning is taken into or on the body through lived experience and culture. One's lived experience is a dialogical experience between the embodied self and the world. We shape our experience of the world, and our sense of self is shaped by our experience of the world through interactions with others, through culture, and through social discourses about the body.

A sense of self is one's identity, an intuitive knowing of who one is as an individual (Chrisler & Johnston-Robledo, 2018; Rochat, 1995). A sense of self is also an awareness of one's own identity (Chrisler & Johnston-Robledo, 2018), one's own strength in the body (Tolman et al., 2014), and of one's self as a person (Sáenz-Herrero & Díez-Alegría, 2015). Childbirth is a dialogical interaction with the world, where the woman shapes her experience of giving birth, and her sense of self is shaped by the experience. Given the profound impact of childbirth on women's body and mind, this experience shapes who she is as a person and how she experiences and interacts with the world, altering her perception of herself (Kitzinger, 2006), and affecting her relationships with her newborn baby, her previous children and her partner (Halldorsdottir & Karlsdottir, 1996). For instance, research by Simkin (1991, 1992) found that women who had given birth 15 to 20 years ago said they regarded childbirth to be a highly significant experience, and that they still had vivid and deep-felt memories of it. Those who felt

a sense of accomplishment from giving birth said it increased their self-confidence and self-esteem. Those who felt the opposite, said they felt angry and had become more assertive, whilst others said they had a more negative self-image. Therefore, childbirth is a significant life experience with long-term impacts on the woman and it points to a need for more research on the embodied sense of self shaped by childbirth. According to Gaskin (2011), women have a sacred right to experience fulfillment and meaning through a positive experience of giving birth, but this has been largely forgotten or ignored in current understandings of childbirth, and there is little regard for the significant long-term impact that this event has on the birthing woman.

Dominant conceptualisations of the woman's experience of childbirth are still largely focused on her physical and mental well-being (Van Teijlingen, 2005), on cognitive understandings of the identity shift that she experiences in becoming a mother, and on her adaptation to the maternal role (Dhayanandhan & Bohr, 2016). Childbirth is a phenomenon that is experienced differently by each woman. Childbirth researchers have called for more research to understand women's embodied experiences of childbirth, as well as research on how to prevent disruptions in women's embodied experience (Walsh, 2010). In order to help mothers to be strong (Sai Baba, n.d.), there is a need for more in-depth research to understand women's subjective experiences of childbirth, as well as how these experiences shape their embodied sense of self in continuous development.

Rationale for the Study

Women can have vastly different experiences of childbirth, ranging from fulfillment to suffering and trauma, which can profoundly shape a woman's embodied sense of self, with implications for her health, and that of her newborn (Kitzinger, 2006; Kjaergaard et al., 2007; Walsh, 2010). There is a need to take a more holistic perspective of childbirth and to integrate

theories of embodiment into mainstream conceptualisations of childbirth. There is increasing interest in embodiment as a construct in understanding women's subjective experiences of childbirth. Research has shown that disruptions in embodied experience which occur during childbirth (Kjaergaard et al., 2007; Walsh, 2010) can be traumatic and negatively impact the woman's embodied sense of self over time. Increasing our understanding of women's lived embodied experience of childbirth, and rejecting mind-body dualism in favour of an embodied view of mind and body as intertwined, could increase understandings of how to protect women from such disruptions. Therefore, research which increases knowledge of the embodied experience in childbirth, and how the embodied sense of self is shaped by the childbirth experience is much needed because it could bring valuable understanding and insights.

Purpose and Research Question

There is a need to understand women's subjective experiences of childbirth, and how they shape their sense of self. In particular there is a need for such research from a counselling psychology perspective, which is concerned with the whole person in continuous development. The purpose of this study was to understand in depth women's subjective experiences of childbirth with an embodiment lens, and to understand how their embodied sense of self was impacted by giving birth. The research question for this study was: How do women's experiences of childbirth shape their embodied sense of self?

CHAPTER 2: LITERATURE REVIEW

Not all pain is bad

like birth pains when having my children

that pain was good

Not all tears are sad

like the joy I felt when I first touched their tiny hands

and kissed their soft-scented cheeks …

No not all anger is bad

For every tear there is joy

a happy sunny place following the rain

Look up at the rainbow and smile

The bright colors are reminders of

the magnificent gift of life

and remember those precious moments

when you too will hold your newborn

child for the very first time

Smile and let the feeling of joy

surround you and swallow you up

for it is you who will teach this tender soul

the power of loving and living

in a positive creative world

you my friend who will have the chance to say

not all pain is bad.

(Written for a pregnant friend who was terrified to go through labor), Janice M. Pickett.

Women can have vastly different experiences of birth. The quote above by Janice Pickett highlights that childbirth can bring pain and suffering and/or fulfillment and meaning. The purpose of the study is to explore how women's experiences of childbirth shape their embodied sense of self. This section begins with conceptualisations of childbirth, the childbirth experience and how it is influenced by women's perceptions, compassionate care, model of care, psychological stressors, culture and omitting women's subjective experiences. Then, drawing on philosophical context of embodiment and underpinnings of Existential Analysis, an argument is made for the importance of understanding women's embodied experience of childbirth as a crucial existential event that shapes women's embodied sense of self as conceptualized by contemporary neuroscience. After a discussion on disembodiment, this chapter concludes with a discussion on the rationale, purpose, and research question of the present study.

Conceptualisations of Childbirth

A literature review by Parratt (2002) on the causes of positive sense of self in childbirth found that women's health and their ability to bond with their baby were supported when there was a positive impact on their sense of self through: having control over the environment, receiving positive affirmations, effective communication with care-givers, and experiencing mutually trusting relationships. However, this study omits the causes of negative impact of childbirth on sense of self. Considering that a woman's sense of self can be impacted positively and/or negatively in childbirth, and that giving birth is an embodied experience that can lead to fulfillment and/or suffering, an embodiment perspective is important for understanding the woman's whole experience. In the last few decades there has been a growing interest in the

construct of embodiment (Bartky, 1988; Blood, 2005; Bordo, 1989, 1993; Crossley, 1993; Diprose, 1994; Piran & Teall, 2012). Walsh (2010) argues that theories of embodiment applied to childbirth could be used to maximise agency, and they ought to be integrated into routine humane maternity health care practice. Walsh also argues that although childbirth is a life-altering moment in a woman's life the embodied experience has not been prioritized in research and there is a need for more research which looks at the woman's embodied experience of childbirth.

Research on women's childbirth experiences has mostly focused on the physical and medical views of giving birth such as: the impact of medicalization of childbirth (Cahill, 2001; Johanson, Newburn, & Macfarlane, 2002; Van Teijlingen, 2005; Walsh, 2010; Williams, 2006; Wilson & Sirois, 2010; Zaers, Waschke, & Ehlert, 2008); risk in childbirth (Chadwick & Foster, 2014); factors that help or hinder in childbirth (Darra, 2009; Facchinetti & Basevi, 2008; Hunter, 2000; Kirkham, 2010; Monari, Mario, Facchinetti & Basevi, 2008; O'Hare & Fallon, 2011; Posmontier & Horowitz, 2004; Redshaw & Van den Akker, 2008; Wilson & Sirois, 2010); good-enough childbirth (Darra, 2009), women's choices in childbirth (Beckett, 2005; Demanuele, 2013) and childbirth-related mental illness (Alder, Stadlmayr, Tschudin, & Bitzer, 2006; Boath, Bradley, & Henshaw, 2005; Brown, Mills, McCalmont, & Lees, 2009; Stein et al., 2012). In all these studies the focus has been on the physical and mental well-being of the mother and child, as opposed to the birth experience of the mother.

Moreover, research about the psychological aspects of women's childbirth experiences has looked primarily at cognitive constructs such as: maternal identity (Dhayanandhan & Bohr, 2016; Marcia, 1967); maternal role adaptation/development (Kiehl & White, 2003; Rubin, 1967a, 1967b); maternal role attainment (Emmanuel, Creedy, St. John, Gamble, & Brown, 2008;

Holditch-Davis, Miles, Burchinal, & Goldman, 2011; Lesser, Koniak-Griffin, & Anderson, 1999; Miles, Holditch-Davis, Burchinal, & Brunssen, 2011); maternal involvement (Siddiqui & Hägglöf, 2000); transition to motherhood (Camberis, McMahon, Gibson, & Boivin, 2014; Darvill, Skirton, & Farrand, 2010; Lesser, Anderson, & Koniak-Griffin, 1998); and becoming a mother (Mercer, 2004). These constructs omit the experience of the whole person. They are focused on women's adaptation to their maternal role, and on the identity shift that women experience when they become mothers, as opposed to how their subjective birth experience shaped them.

In contrast with the over-focus on cognitive aspects, recently there has been an interest in understanding women's subjective body-anchored experiences (Teall, 2012) in the areas of: eating disorders (Katzman & Lee, 1997), self-harm (Whitlock et al., 2006), body image (Lipsman, Woodside, & Lozano, 2014), alexithymia, self-objectification (Teall, 2015), and the influence of social discourses (Blood, 2005; Katzman & Lee, 1997; Tolman et al., 2014; Walsh, 2010). Research specifically focused on women's subjective childbirth experiences has looked at: satisfaction with care provided (Waldenström, Borg, Olsson, Scold, & Wall, 1996; see also Bramadat & Driedger, 1993); birthing expectations such as: wishing for a balance between self-control and support during birth (Walker et al., 1995); and multiparous women's wishes for a fast and quick birth (Mackey, 1993). There has also been much focus on understanding how women experience childbirth when there is a gap between their expectations and their experience. For instance, findings suggest that positive psychological outcomes are linked to giving women enough information and a feeling of being in control (Green, Coupland, & Kitzinger, 1990; Mackey, 2003). Traumatic outcomes are linked to the woman experiencing: a lack or loss of control, communication and practical/emotional support (Carter, 2010; Hollander

et al., 2017), or the psychological trauma of prolonged labour (Kjaergaard et al., 2007; Nystedt, Högberg, & Lundman, 2006). This research omits the woman's embodied experience, and therefore the following section focuses on the woman's subjective embodied experience.

In summary, dominant conceptualisations of the woman's experience of childbirth are still largely focused on her physical and mental well-being (Van Teijlingen, 2005), and on cognitive understandings of the maternal role (Dhayanandhan & Bohr, 2016). More in-depth research is needed to understand women's embodied experiences of childbirth and how to prevent disruptions in their embodied experience (Walsh, 2010).

Childbirth

> "There is a sacred power in the innately feminine capacity to give birth."
>
> Gaskin (2011, p. 2).

According to Gaskin (2011), no matter whether childbirth is natural or surgical, it offers a woman a way to discover her self. Although it is the woman's right to experience fulfillment and meaning through the birth experience, this experience is shaped by many factors such as her previous experience of childbirth, her health, her choices in maternity care, and how she is treated by her caregivers on the day. The birth experience can be empowering, joyous, euphoric, giving the woman a sense of increased inner strength, or it can be disempowering, causing depression, a loss of inner strength and capacity. The woman in childbirth may feel a sense of agency and strength in being able to move around, or empowered and confident in her ability to bear the contractions, or secure in knowing she has trusted people to care for her. Some women report that childbirth has given them a stronger sense of self, feeling stronger as mothers, or they may see childbirth as a right of passage to womanhood or motherhood. On the other hand, the birthing woman could be overwhelmed by the painful contractions, or fearful with thoughts

about her own mortality and that of her baby. She may receive inadequate support, or unnecessary, unwanted interventions (Ettorre, 1998), leaving her feeling helpless and weak in her body, disempowered or traumatized. Childbirth poses a threat to a woman's existential meaning of life, bringing her attention to questions about life, death, and survival for herself (Prinds, Hvidtjørn, Mogensen, Skytthe, & Hvidt, 2014) as well as her responsibility for her child (Stern & Bruschweiler-Stern, 1998). The childbirth experience highlights the importance of caring about the woman's subjective experience of giving birth, as well as her physical well-being.

A woman gives birth as a body and through her body (Longo & Haggard, 2012; Walsh, 2010). Through childbirth she experiences a rebirth of herself (Stern & Bruschweiler-Stern, 1998), and she has an awareness of: her identity as a mother (Chrisler & Johnston-Robledo, 2018), her strength in her body (Tolman et al., 2014), and consciousness of the feelings and sensations within her body (Varela, 1996). Gaskin (2011) describes how the woman experiences each stage of labour through involuntary bodily processes. During the first stage of labour her cervix fully dilates. The second stage begins when she feels the urge to push, and it ends when the baby is born, or in some cases, when an unplanned C-Section is needed. In the third stage she delivers the placenta. During a planned C-Section, although the woman does not experience labour, and she is given an epidural to numb sensations below her waist, she has an embodied experience of being awake during the surgery, and being aware of the surgical procedure that is being performed on her. Whether the birth is vaginal or C-Section, the experience of childbirth is an embodied awareness (self-body unity), which can easily be disrupted (see disembodiment section). The subjective embodied experience of childbirth is influenced by a number of factors such as the woman's perceptions, whether she feels

comfortable with her caregivers, the model of care that she receives, psychological stressors, culture, and social discourses about childbirth.

Influence of perceptions. According to Mackey (2003), women often wish to have as much control over the birthing process as possible, with minimal interventions. Research by Lally, Murtagh, Macphail, and Thomson (2008) found that women feel they have no control when there is a gap between their expectations of giving birth and their experience. The expectation-experience gap was linked to the degree of engagement women had in decision-making, their ability to choose the type of pain relief they received, the extent of control they felt they had over their own behaviour, and whether the intensity of pain experienced during labour was what they had expected. Similarly, Halldorsdottir and Karlsdottir (1996) found that women's perceptions or satisfaction with the birth experience were influenced by how well they anticipated and coped with labour pain. For instance, if they were in greater pain than expected they felt like a failure, or if the pain was less than expected they felt pleasantly surprised. Although a woman's perception of childbirth shapes her experience of giving birth, the experience shapes her perception and sense of herself. The experience is also greatly influenced by whether or not the woman receives compassionate care.

Influence of compassionate care. The embodied experience of childbirth is unique in that the woman experiences both external and internal bodily processes, as well as pain which does not represent pathology (Walsh, 2010). According to Kitzinger (2006), during childbirth the woman is forced to open herself up physically, emotionally, and mentally. She must keep an open mind about how the labour process will unfold, and which interventions she may receive. She may have made a birth plan, but birth plans are often ignored by caregivers. She may have chosen her preferred caregiver and method of birth, but the care she receives will depend upon

who is present on the day, such as doctors, nurses, trainees, midwives, family, and friends. How she is treated will depend on whether they are compassionate, competent, and willing or able to follow her wishes. When the birth begins, her body opens up through autonomic processes which may make her feel that she has no control. Her contractions ebb and flow, her waters (amniotic fluid) flow, blood flows, tears flow as do her raw emotions. According to Ettorre (1998), some birthing women fear embarrassment through losing control of their bodily functions and emotions. Some have concerns about preserving the dignity of their body, because the most intimate parts of their bodies are subjected to the gaze and touch of doctors, nurses, or students, without having any intimate or social relationship with them, and sometimes without giving their consent.

Kitzinger (2006) argues that women in childbirth can feel vulnerable for many reasons. One reason is that when the birthing woman is in this open and possibly fearful state, she is susceptible to emotional or physical trauma or death of herself or her baby. Another reason for feeling vulnerable is that the birthing woman is reliant on the experience and encouragement of her caregivers to be kind, and to guide her through the birthing process with as few interventions as possible. In this manuscript, references to women's vulnerable states are not references to a presumed weakness, but rather an acknowledgement of an important aspect of a childbearing woman's experience.

Women in childbirth need constant comfort and support during childbirth, and those who receive it need fewer interventions and pain medication (Kroeger & Smith, 2004). Women who have traumatic births respond well to hearing affirmations from their caregivers (Berg & Dahlberg, 1998), and those who feel acknowledged and included as an individual experience less birth trauma (Byrne, Egan, Mac Neela, & Sarma, 2017). Women need compassionate care

during childbirth in order to promote a sense of personal agency and happiness (Walsh, 2010), and to shape their sense of self in a positive way. A woman's sense of self is also greatly influenced by the model of care that she receives during childbirth.

Influence of model of care. Throughout history, the care that a woman receives during childbirth has traditionally been the domain of women, and in most cultures, it has been led by female midwives (Gaskin, 2011). Since the beginning of the last century, due to the medicalization of birth, maternity care practices conceptualise childbirth as an illness or disorder to be treated in terms of the presenting biological factors and they exclude psychological, social, and cultural factors (Walsh, 2010). Women's life events such as pregnancy, giving birth and nursing have become processes which require the help of a medical specialist (Epstein-Gilboa, 2009). These changes in maternity health care practices have been accompanied by an increase in medical interventions which have inevitably impacted the embodiment of childbirth as well as the health of the mother and child. For instance, when the natural processes of birth are replaced by technological interventions, this can lead to nursing problems (Epstein-Gilboa, 2009). These interventions are often not tested for their usefulness, and they are quickly embraced as the norm in routine care (Williams, 2006), even when there is no evidence that using such interventions in normal uncomplicated childbirth are effective (Johanson, Newburn, & Macfarlane, 2002). For example, in Australia and the U.S.A C-Section rates are as high as one in every three women, and fifty percent of women undergo synthetic induction of labour or speeding up of contractions (Demanuele, 2013). By creating fear, many women are persuaded to consent to unnecessary interventions which have no proven benefit and furthermore cause them to suffer from physical and emotional trauma. One in four women experience childbirth related trauma (Czarnecki & Slade, 2000; Tham, Christenson, & Riding, 2007). Consequently, there is a crisis of confidence

in childbirth health care models worldwide (Walsh, 2010). The many contrasting approaches to childbirth have detracted from the realisation of humane maternity care by omitting consideration of women's subjective embodied experiences (Walsh, 2010).

The model of care for childbirth in modern hospitals determines that the woman in childbirth is cared for by teams of anonymous professional staff rather than individuals whom the woman knows well. According to Kitzinger (2006), this leads to fragmented care where the woman's genitals are exposed, observed, and internally examined by strangers in a labour room which is more like a public arena. Such models of care can also cause the woman to feel humiliated and frightened and she may suffer from distress, uterine malfunction, and prolonged labour. Those women who are able to deliver without interference tend to have more satisfying experience of giving birth than those who cannot do so. Considering that women's birth experiences are in such contrast to one another they tend not to talk too much about them for fear of triggering a hostile or judgemental reaction from others. Women are profoundly impacted by their birth experiences which become a part of their lives and their identity. Hence the model of care significantly impacts a woman's sense of self.

Influence of psychological stressors. Kitzinger (2006) asserts that childbirth can be a traumatizing experience for women who report feelings of intense fear, helplessness, pain, and loss of control during labor and birth. Negative social and emotional experiences have also been correlated with medical complications in childbirth. The most frequent perinatal mental health concerns include trauma depression and anxiety. Trauma experienced in childbirth can lead to PTSD post-traumatic stress disorder (Redstone & Tarrier 2003). PTSD sufferers often present with seemingly contradictory symptoms such as the ability to recall and narrate details of the trauma as well as re-experiencing uncontrollable vivid flashback memories of trauma that cause

the sufferer to freeze with an inability to talk. Trauma which causes a person to freeze upon remembering it through a flashback highlights also that memories are stored in the brain and in the body as embodied memories (Brewin, 1986, 1996, & 2001; Diamond, Campbell, Park, Halonen, & Zoladz, 2007). The incidence of childbirth trauma is high: 6-7% of women experience full childbirth-related PTSD and a further 24-34% (one in four women) experience elevations on at least one of the DSM-5 PTSD symptom dimensions (hyperarousal, avoidance, intrusions; Czarnocka & Slade, 2000; Kwee, 2015; Tham et al., 2007). Some predictors of PTSD are: emergency C-Sections (Tham et al., 2007), and birth experiences where women experienced fractured relationships with caregivers, and felt disconnected, helpless, and isolated (Thomson & Downe, 2010; Zaers et al., 2008). Depression and anxiety can also result from psychosocial stressors during pregnancy and childbirth such as: a woman's relationship to her care providers, her personality, and the support she receives (Boath et al., 2005; Kwee & McBride, 2016). The negative impact of depression and anxiety on the wellbeing of the mother and her children is well researched (Nagata et al., 2000; Zaers et al., 2008). Symptoms are complex and can include fatigue, poor concentration, crying, and insomnia (Bueno, 2010; Zaers et al., 2008). Hence negative social and emotional experiences of childbirth as well as birth trauma can have a negative impact on the woman's sense of self and this is also influenced by the woman's family culture and the culture in which she gives birth.

The women's embodied sense of self in childbirth is shaped by social and cultural influences. In some cultures of the world, such as East Asia, South Asia and the Middle East, childbirth is celebrated as a significant event in a woman's life and it signals a time of adjustment of cultural responsibilities (Posmontier & Horowitz, 2004; Steinberg, 1996;). In these cultures mothers receive social recognition for their ability to give birth and this has a

significant impact in preventing mental health issues such as trauma, depression and anxiety (Gaskin, 2011; Posmontier & Horowitz, 2004).

Influence of culture. In these cultures, the focus is on ensuring that the mother thrives and is able to care for her infant (Dennis et al., 2007; Posmontier & Horowitz, 2004). In the West in contrast, emphasis is placed on the infant's thriving (Dennis et al., 2007) or on the mother-baby unit, as opposed to the mother herself (Balsam, 2013a). Considering that the attention and recognition a woman receives during childbirth will shape her experience (Gaskin, 2011), culture can influence the woman's embodied sense of self. Such subjective experiences have been omitted from mainstream conceptualisations of childbirth.

Influence of omitting women's subjective experience. During the first half of the 20th Century, Freudian psychoanalytic theory with its phallocentric bias was notably silent on the subjects of childbirth and the pregnant fertile female body (Chodorow, 2017). Balsam (2013a) argues that despite challenges by female psychoanalysts such as Karen Horney (1924; 1926/1998; 1933), and Margarete Hilferding (1911), Freud's theories described human development from the point of view of the male, with female development as a variant of the male norm. They omitted the view of female development from a female perspective, and they omitted to describe childbirth in terms of the woman's subjective experience.

Balsam (2013a) argues that in the last century, few researchers have distinguished between giving birth (the mother's subjective experience of giving birth) and becoming a mother (the mother-and-baby unit or mothering the newborn). In the past, although second wave feminists championed women's equality, and the right to choose the method and place of birth (Gaskin, 2011), many women also viewed motherhood as a trap which made women victims of patriarchal systems (Bartky, 1988; Gaskin, 2011). In the present time, many young women still

see motherhood as a source of oppression (Baumgardner & Richards, 2010), and there are still feminist perspectives which marginalize the experience of childbirth as the domain of those women who choose to have children, rather than a central concern for all women (Walsh, 2010).

Chrisler and Johnston-Robledo (2018) assert that all women have reproductive bodies that experience reproductive events such as menarche, pregnancy, childbirth, breastfeeding, and menopause. However there is ambivalence and contradiction in people's attitudes towards the reproductive body (Ussher, 2006). The birth experience is viewed as beautiful but dangerous, disgusting, and making one vulnerable (Chrisler & Johnston-Robledo, 2018). Balsam (2013b) points out that childbirth makes women confront the possibility of death of self or their baby. She suggests that a view of valuing of the importance of childbirth for women is not yet consistently embraced among feminists. Due to the evident lack of attention which has been paid to mothers' experiences in childbirth, there is a need for feminist research to prioritize and pay attention to the uniquely feminine experience of childbirth and how it affects women's ongoing experiences of themselves in their bodies. Considering that Feminist theory seeks to empower the oppressed and to change the social systems which oppress them (Mertens, 2015), it makes sense to use a feminist lens to empower women to experience their body as a place of freedom rather than seeing childbirth as a medical condition which has to be treated (Smolak & Levine, 2001).

Summary. Childbirth is a pivotal moment in a woman's life because it offers the woman a rite of passage into motherhood and womanhood. For some women, childbirth is the point when they become adults. The embodied experience of childbirth is complex and is influenced by many factors which can profoundly shape a woman's sense of self. The following section will explore the philosophical origins of embodiment which are relevant to our understanding of

childbirth as an embodied experience.

Philosophical Context of Embodiment

"We do not 'have' bodies, but we 'are' our bodies." (Wilde, 2003, p. 171)

The construct of embodiment has been well researched in the fields of phenomenology, sociology, and feminist theory (Bartky, 1988; Bordo, 1989, 1993; Cresswell, 1999; Crossley, 1995; Csordas, 1994; Diprose, 1994; Tolman et al., 2014; Teall, 2015), but less so in the field of psychology (Blood, 2005; Walsh, 2010). Embodiment perspectives relevant to childbirth can be understood through the philosophical roots of embodiment theories. This section highlights the philosophical context of embodiment as it relates to the embodied experience of childbirth. By drawing together salient themes of cartesian dualism, phenomenology, the lived body, and the docile body, an argument is made for the importance of studying the woman's embodied experience in childbirth.

Cartesian dualism. The French philosopher, Rene Descartes' (Descartes, 1637/2006) concept of cartesian dualism, epitomized by his famous words "cogito ergo sum" (I reflect therefore I am; p. 73), asserted that the mind and the body are separate entities, where the body can be divided up by removing parts, but the mind or soul cannot. Descartes argued that the mind was the immaterial self or soul, the source of consciousness, thought, and knowledge, and superior to the material physical body. The body was considered a mere object and inferior because it was devoid of wisdom and something that should be struggled against to gain control over it (Bordo, 1993). A dualistic perspective of the mind and body as separate disembodied parts is present in much of Western thought, where we tend to value a disciplined mind that can control the body even though we know that this is not healthy (Teall 2015). A dualistic perspective is also evident in the medicalization of childbirth today and it is rejected in this study

in favour of an embodiment perspective.

Phenomenology. The philosophical origins of embodiment are grounded in the works of phenomenological researchers such as Heidegger (1962/1996), Husserl (1998), Sartre (1943), and Merleau-Ponty (1945/1962), who rejected the dualistic view and emphasised a holistic embodied perspective through their theories of embodiment. The phenomenological view is that we are aware of what we experience through an implicit, pre-reflective awareness of our own experience as we live it, and that these conscious experiences inform our insights (Gallagher & Zahavi, 2007). Heidegger was a German philosopher, and in his magnum opus, *Being and Time* (Heidegger, 1962/1996), he asked "What is the meaning of Being?" Heidegger was interested in the conscious or lived experience of the world, which he called being-in-the-world or Dasein (Wheeler, 2016). He conceptualised embodiment as an innate part of Dasein. Heidegger acknowledged the role of the body (objective self) in shaping the mind (subjective self), and he recognized that there is a reciprocal relationship between the subjective self and its surroundings which is mediated through the body (Winkielman, Niedenthal, Wielgosz, Eelen, & Kavanagh, 2015). A view of the body and mind as shaping one another was further developed by Merleau-Ponty.

The lived body. Maurice Merleau-Ponty (1945/1962; 1942/1963) was a French philosopher who drew on Heidegger's work to more fully develop the phenomenological concept of embodiment with his notion of the "lived body". He argued that we experience the world through our body in lived embodied experiences and that the mind and body are equal and inseparable and that both are a source of knowledge (Teall, 2015). Merleau-Ponty also argued that one's embodied experience is impacted by previous experiences (Butler, 1997). Hence lived embodied experiences are retained and become a part of the embodied self, and this is highly

relevant to this retrospective study on the lived experience of childbirth.

For Merleau-Ponty (1945/1962; 1942/1963) the lived body is neither object ("sensible" perspective) nor subject ("sentient" perspective) because it is continually constructed through perception in each situation. The lived body is the self which is different from the observed body which is observed by others. Husserl (1913/1998) described a similar perspective of Körper (body as an object), and Leib (body as a lived reality). Similar to this again is Sartre's (1943) view of "body being for oneself" (lived body as subject) and "body being for another" (physical body as object). Lindemann (1996) further defines the embodied self as both experienced (object) and experiencing (subject), and together they make up the lived body which is different to the objectified or observed body. Science focuses on the objectified body by researching how it is constructed and this is also evident in the medicalization of childbirth, which focuses on the objectified body. Considering that the woman's subjective experience of giving birth is as a lived body, this conceptualisation of lived experience as embodiment is relevant for this study.

Merleau-Ponty (1945/1962) thought of perception and consciousness as linked to the body, and intentionality as a way of being-in-the-world (Walsh, 2010). Merleau-Ponty's (1945/1962) concept of intentionality is that one's body is synonymous with existence; we have access to the world through our lived bodies, and without them there would be no world. Merleau-Ponty argued that the lived body and the world form an intentional arc which connects our experiences, such as speech, movement, time, the senses, and intelligence, in the body in meaningful ways, forming a unified experience in the body. The intentional arc can be disrupted in illness or injury or through negative experiences. According to Merleau-Ponty our perceptual consciousness is embodied understanding, where one perceives and experiences one's body through a sensorimotor form of understanding. In the same way, a woman's perceptual

consciousness or lived experience in childbirth is embodied understanding.

Merleau-Ponty (1945/1962) argued that there is ambiguity in our perception of things, and ambiguity in the knowledge we have of ourselves, due to the temporal situation which is inherently ambiguous. He asserted that "I know myself only in so far as I am inherent in time and in the world, that is, I know myself only in my ambiguity" (p. 345). According to Espeland (1984), the unity of mind and body is vague. For example, when we daydream, the mind takes over the body, or when we experience severe pain our body takes over our mind and we lose consciousness. Sometimes the body may show our feelings without our intention, such as when we blush. Hence although our mind and body are one, our body appears sometimes as an object and sometimes as a subject depending upon the context. Espeland argues that the body can become an object through the gaze or invasion of private bodily space by a doctor if he or she performs a procedure without consent, or no longer sees the body as a person. To mitigate this problem, treatment is performed with the consent of the patient, in which case the body becomes a subject. Merleau-Ponty's view of embodiment as lived experience is central to this study because during childbirth, the way in which caregivers interact with the birthing woman can profoundly change her embodied experience of childbirth. This view is complemented by Foucault's (1975) views about the docile body controlled though dominant social discourses.

The docile body. Michel Foucault (1975) was a French philosopher who, like Merleau-Ponty, rejected the Cartesian notion of body controlled by mind, asserting instead the notion of body (as subject) as the focus of cultural control (power) through social discourses (knowledge) (Blood, 2005). Foucault argued that dominant social discourses, or influential ways of speaking, writing, and discussing, control power in society and manipulate bodily behavior, and bodies become "docile" and "normalized" through bodily discipline and self-surveillance (Foucault,

1980, as cited by Yarnal, Hutchinson, & Chow, 2006). In this case, embodiment is when these norms and discourses inform our bodily feelings and behaviors (Bartky, 1990; Bordo, 1993). Some theorists refer to this concept as "social inscription" (Tolman et al., 2014). Foucault's work has been particularly influential in understanding embodiment and one's relationship with their body (Teall, 2015). Foucault's concept of the docile body is relevant to understanding embodiment during childbirth because social discourses can influence a woman in labour in how freely she expresses herself or asks for what she wants during childbirth, as well as how she feels about how she is cared for. These discourses are discussed further below.

Foucault's (1975) work has been influential in shaping feminist philosophy, which seeks to transform dominant patriarchal ideology and androcentric practices that lead to social injustice, for example, based on gender, race, class, disability, and poverty. His work on embodiment provides a way to recognise individual lived experiences as embedded in the flesh and to understand social differences of bodies constructed through specific social discourses. Foucault drew attention to how hegemonic discourses enable and constrain one's lived experience through regulations specifically related to the management of bodies, including reproductive health (Foucault, 1975). Discourses which are relevant to childbirth are those which relate to the female body. For example, Walsh (2010) argues that traditionally the female body has been viewed as a deviation from the male body as norm, and it has been viewed with suspicion because of its unpredictability, as evidenced by language such as the prefix 'hystero', which means womb but it is also aligned with madness. More examples are provided by Kitzinger (2006) who argues that medical discourses about childbirth use language that makes the act of giving birth appear like a test at which the woman either succeeds or fails. If the baby's head does not engage properly during birth, the woman may be told she has an

'inadequate pelvis'. When her cervix does not dilate, it is called an 'incompetent cervix', and when labour is slow, it is described as 'failure to progress'. Women are often told to be thankful that they have a healthy baby and not to focus on their wishes or expectations for giving birth. Also, if they do not conform to the caregivers' preconceived ideas about how they should behave, then they are seen as difficult. Kitzinger argues that "If we look at birth as a trial of the uterus or a reproductive performance, no wonder many women believe they have failed" (p. 22). Discourses such as these, which can constrain women in childbirth or lead them to self-evaluate their performance, and this can profoundly impact women's embodied experience of childbirth as well as their sense of self.

Feminism has drawn on the works of Foucault (1975) to understand the complex relationships that women have with their bodies and to understand why they conform to social control without being consciously aware of it. When women engage in self-surveillance, they experience a separation by seeing the body as separate to the self. When the body's natural appearance, internal states and desires are ignored and denied to conform to strict social expectations and ideals, this creates an experience of disembodiment (Teall, 2015). Examples include ignoring hunger to be thin, having plastic surgery to avoid aging, and in childbirth, ignoring one's own wishes in order to conform to the caregiver's wishes, or feeling unable to speak up about what one wants for fear of conflict, or of being regarded as difficult, or due to feeling helpless, disempowered or traumatized (Kitzinger, 2006). These efforts can result in the woman feeling not good enough (Bordo, 1989). Foucault's (1975) view of embodiment is relevant for understanding how social discourses shape a woman's embodied experience of childbirth.

Summary. This section described the philosophical origins of embodiment in order to

understand embodiment perspectives relevant to childbirth, and to highlight the importance of studying the woman's subjective experience in childbirth. Central to this study is Merleau-Ponty's (1945/1962; 1942/1963) notion of the lived body with a view of embodiment as lived experience. An embodiment view challenges the mainstream dualistic approach to childbirth which focuses on the objectified body and omits the woman's subjective lived experience of giving birth. According to Merleau-Ponty, our perceptions or lived experiences constitute embodied understanding, and they are pre-reflective, pre-conscious experiences that require a phenomenological method to integrate them into our consciousness through language and perception (Wilde, 1999). Language is important because it helps to bring the silent inner world of a person's psyche into the open. Merleau-Ponty (1945/1962; 1942/1963) argued that the lived body and the world form an intentional arc which connects our experiences such as our perceptions and consciousness in meaningful ways, forming a unified experience in the body, which can be disrupted in illness or injury or through negative experiences. The embodied experience of childbirth can be disrupted in the same way. A conceptualisation of embodiment in terms of the lived body is relevant to this study because lived experiences, such as childbirth are retained and become a part of the woman's embodied understanding of herself, changing her perception of herself. In addition to this, Foucault's (1975) view of embodiment in terms of the docile body is relevant for understanding how social discourses shape a woman's experience of childbirth and become a part of her embodied understanding.

Underpinnings of Existential Analysis

In order to understand how women's embodied sense of self is shaped by childbirth, the many layers of her lived experience can be understood through an Existential Analysis (EA) lens (Längle, 1993). An EA view complements an embodiment view in understanding women's

lived experience of childbirth. The underpinnings of EA are discussed by drawing together concepts of existentialism, Being, Logotherapy and Existential Analysis. Then an argument is made for utilising Längle's EA framework of the four fundamental motivations (4 FMs) (Längle, 1993) for understanding childbirth in terms of fulfillment and meaning for the birthing mother. Then each of the four FMs are described.

Existential analysis and embodiment. Existential Analysis (EA), according to Längle (1993), is a phenomenological and person-oriented approach to psychotherapy which supports an embodiment perspective because it is concerned with the person's existence as a whole and it provides a lens for understanding multiple dimensions of a person's life. According to Launeanu and Kwee (2018), embodiment is understood in EA as an experience of self as body, mind, and spirit, and childbirth is viewed as an embodied lived experience which represents women's ultimate creative potential. Childbirth is an existential struggle to exist and give life, where fulfillment in childbirth is the achievement of that struggle and suffering in childbirth is a deep suffering of embodied human existence. Women who suffer in childbirth struggle with disturbances in all aspects of their embodied experience: physical, emotional, relational, personal, and spiritual. Hence an EA view complements an embodiment view in understanding women's lived experience of childbirth. EA is based on the philosophy of existentialism.

Existentialism. The underpinnings of Existential Analysis are grounded in existentialism, a philosophy developed in the late 19th and early 20th century. Existentialism began with the writings of European philosophers such as Soren Kierkegaard (1974), Friedrich Nietzsche (1974), Jean-Paul Sartre (1943), Gabriel Marcel (1949), Albert Camus (1961), Simone de Beauvoir (1949), Ludwig Binswanger (1955), Martin Heidegger (1889/1976), and Maurice Merleau-Ponty (1945/1962). Existential philosophy is focused on the analysis of human

existence in the world. There is a focus on the existence of the individual person, who has free will, choice, and personal responsibility. According to Crowell (2016), a core belief of existential philosophy is that, in order to understand what a human being is, one needs to look at the meaning that individuals find in life. Each human being is searching for meaning in life as a free and responsible agent, and this determines his or her development through his or her choices, beliefs and outlook. The meaning one experiences is a part of one's subjective experience.

Being. The philosophical origins of Existential Analysis, like embodiment, are grounded in the works of Heidegger (1889/1976) whose work focused on understanding the meaning of Being, or Dasein, and on how people subjectively experience living in the world. Heidegger asserted that human beings are not isolated subjects who are cut off from objects, instead we are beings embedded in the world, outside and alongside a world from which, for the most part, we do not distinguish ourselves (Critchley, 2009). Heidegger (1949) was interested in our lived experience of the world. He argued that each existence is decided or taken up by the individual through his or her own choices and that finding fulfillment and meaning in life is also a part of this lived experience.

These philosophical roots form the basis of psychotherapy in the form of Logotherapy (Frankl, 1959) and Existential Analysis (Längle, 1993). Logotherapy is a part of Existential Analysis. These psychotherapies each have their own therapeutic framework based on existentialism. Whereas Logotherapy is focused on spirituality and meaning, Existential Analysis is additionally focused on addressing the patient's existential needs (Von Kirchbach, 2003).

Logotherapy. Logotherapy was developed by Viktor Frankl (1905-1997), who was an

Austrian neurologist, psychiatrist, and Holocaust survivor. Frankl described his personal triumph over his experience in Nazi camps in his book, *Man's Search for Meaning* (Frankl, 1959). Frankl's psychotherapy, called Logotherapy, is focused on the future and is concerned with a person's search for purpose and meaning, which is believed to be the primary motivational force. Logotherapy is an approach to counselling which deals with meaning-related concerns and assists clients in finding meaning in life (Frankl, 1959). As described by Von Kirchbach (2003), Frankl's anthropology consisted of three dimensions. The first dimension was that of human needs, which are experienced on a physical level. The second dimension was that of the psyche, where pleasure is sought, which is experienced on a psychological level. The third dimension was spiritual, where meaning is sought, which is experienced on a spiritual level. Given that only the first two levels were used by Freud and Adler in their therapies, Frankl had added a new spiritual level. Logotherapy is focused on human qualities such as a person's need for freedom, responsibility, and their search for meaning. Logotherapy has also been seen as a practical application of Existential Analysis.

Existential Analysis. Existential Analysis was developed by Alfried Längle (1951-), an Austrian psychotherapist, physician, and clinical psychologist, who worked with Frankl. Längle (1998, 1999) elaborated Frankl's three-dimensional anthropology with an existential analysis perspective. According to Längle (1993), Existential Analysis (EA) is a phenomenological and person-oriented approach to psychotherapy. Längle, who asserted that an individual's fulfilment is based on an existential foundation made up of four conditions, developed a model of the four fundamental motivations (4 FMs) required for a successful and satisfying existence. Längle's 4 FMs framework is used for understanding the subjective experience of being a person, being in this world, and being a body. The first fundamental motivation (FM1) is about existence, the

second (FM2) is about life, the third (FM3) is about being oneself, and the fourth (FM4) is about existential meaning. Längle's 4 FM model has been used in this study to understand the personal meaning that women attach to childbirth and how they experience suffering or fulfillment.

According to Längle (1993), a basic tenet of Existential Analysis (EA) is that a fulfilled existence is a life in which the individual experiences fulfilment and meaning. EA asserts that human life or existence (a whole life) requires the individual's subjective experience and relationship or dialogue with the world, and that having inner consent is the key to a fulfilling existence. Inner consent involves an outward dialogue, where the individual asks him or herself: What appeals, attracts, challenges or speaks to me? and an inward dialogue, where the individual seeks inner agreement for decisions that he or she makes, and seeks harmony between the inner experience and outward action (Längle, 2003). The primary therapeutic method in EA is called Personal Existential Analysis (PEA). The aim of this therapy is to empower people to live their lives with inner consent (Längle 1993, 1995a, 1999) and take responsibility for their actions so that they are mentally and emotionally free to live a fulfilled life (Kwee & Längle, 2013). In EA, an emphasis is placed on the human capacity for decision making and on a sense of duty for people to live their lives authentically and to come to a responsible way of dealing with oneself and one's world (Längle, 1993). One must balance the tensions of health and disease (physical level), pleasure and aversion (psychological level), and fulfillment and void or faith and despair (existential meaning level) (Von Kirchbach, 2003).

The four fundamental motivations. According to Längle (1993), EA enables patients to discover their own meaning of their personal existence by using Längle's EA model called the four fundamental motivations of existence (4 FMs). The 4 FMs are used to analyse whether the conditions required for a fulfilled existence have been met for a client and they also provide a

useful way of conceptualising the complexity of embodiment (Stankovskaya, 2014). According to Längle (2003), the four fundamental realities are structures of human existence or themes which concern us throughout our lives. They are realities which we are confronted with. They are: the world (concerned with the facts of our world), life (concerned with relationships and feelings), being (concerned with being able to be oneself and exist as an individual), and the future (which we can shape). As we encounter each of these realities we enter into or dialogue with ourselves about how we want to relate to each reality and whether one can give inner consent (accepting the reality as it is). The dialogical aspect adds to the relationality of the EA method. These fundamental realities correspond to four fundamental motivations for existence which are: the motivation to be (in the world), to experience value (in life), to be oneself (being), and to find meaning (for our future) (Kwee & Längle, 2013).

According to Längle (1999, 2012), the four fundamental motivations (4 FMs) provide a structure to analyse the conditions an individual requires for fulfillment. Each FM corresponds to an existential question. FM1: "I am here. Can I be? Do I have the necessary space, protection and support?" FM2: "I am alive. Do I like to live? Do I feel my emotions and experience the value of my life? Do I have the necessary relationships, time, and closeness?" FM3: "I am me. May I be myself? Am I free to be me? Do I have the necessary attention, justice and appreciation?" and FM4: "What am I here for? What do I live for? What gives my life meaning? Do I find the necessary meaning, purpose and context?" The four existential fundamental motivations are the cornerstones of existence. Fulfillment is experienced when one can give inner consent and answer "Yes" to each of the four existential questions of the 4 FMs: "Yes" to the world, "Yes" to life, "Yes" to one's self/person and "Yes" to meaning. These FMs provide a structure to understand a person in therapy. Längle's EA 4 FMs provide a structure to

understand the individual's experience, to connect it to a theory of fulfillment, and they provide a basis for the existential PEA approach to psychotherapy. When one cannot give inner consent to the questions of the 4 FMs, and one answers "No," this can be seen as suffering.

According to Längle (2008b), suffering is an existential challenge. People can suffer silently or they express their suffering in many forms such as crying, rebelling, and sacrificing. The four-dimensional model structures our understanding of suffering into four dimensions of suffering. These are the physical (somatic: pain, injury, illness), psychological (loss of something valuable, leading to anxiety, emptiness or absence of emotion), personal (dynamic dialogical relationship of the person with the world which has an underlying pattern such as self-alienation), and existential meaning (loss of something that is essential for a person to experience a fulfilled existence, such as insecurity, breach of trust, despair, absence of relationship, injustice, remorse or guilt). Existential suffering evokes feelings of futility, meaninglessness.

Längle (2008b) argues there is a need to understand how a person suffers (openly, privately, or through sacrifice), and how one relates to others whilst suffering (turn to them, or spare them from strain or burden, or turn to God), as this reveals the person's attitudinal values which reflect his or her relationship with life. Apart from this, it is important to understand whether the person has faith in a higher power which can provide hope and the possibility of salvation as this can allow a person to grow in maturity and motivate them to greater achievement so that they realise they are capable of surpassing (transcending) themselves. Each of the four fundamental motivations are now described.

The first fundamental motivation (FM1). The first FM is concerned with a person's existence in terms of their spiritual and physical presence in the world. FM1 refers to one's spiritual coping, and one's physical survival. According to Längle (2016), the ground of being

refers to a sense of being completely supported by something which is greater than oneself; a feeling that there is something on which I can trust, even in the case of death. The ground of being can refer to the world, the universe, a cosmos, a God, something that one can rely on, like soil in which the roots of a tree are embedded. The ground of being is a prerequisite of basic trust. When it is in place, a fundamental trust to the world can emerge. In FM1 the existential question being asked is "I am - Can I be?" This means, can I accept the environment, space and conditions of my life? Do I experience protection and support in the world? FM1 refers to how one experiences conditions for survival, such as space, protection, and support. These conditions define one's reality, and one needs to decide either to accept this reality as it is or not. If they are lacking, the question "Can I be?" is answered with a "No". In this case one feels one's survival is in question, one feels unsafe, insecure, and restless. When these conditions are present, one the question "Can I be?" can be answered with a "Yes" and one feels trust in oneself, in the world and possibly even God. Then one is able to securely exist, to feel that one can survive, have room to breathe, and have a sense of ability. One can have trust and confidence in oneself and in others and this is called fundamental trust, which provides the person with foundational support in their life. One can accept the facts and conditions of one's life as one's reality, even if one does not agree with them, and bear what is difficult, and this acceptance leads to a sense of ability (Von Kirchbach, 2003). In terms of embodiment, FM1 is concerned with the whole person's survival which includes one's coping in terms of finding meaning as well as the body's physical abilities and limitations (Stankovskaya, 2014).

The second fundamental motivation. FM2 is concerned with life, the quality of one's presence in the world, one's search for value of life and one's attitude towards life. In FM2 the existential question being asked is "I am alive - Do I like to be?" The meaning of this is "do I

experience my life as good and worthwhile? and do I sense that my life has sufficient quality?" (Von Kirchbach, 2003; p.39). Being here means being my whole self with my moods and feelings, joy and suffering. FM2 refers to the conditions for liking life such as relationships, time, and closeness. According to Längle (2016), in order to experience the value of one's life, a person needs a feeling of closeness to people, animals or things which add quality and meaning to one's life and give a sense that life is good and worthwhile. In order to like being, the person needs to decide that they will devote time to something that feels precious such as building and nurturing relationships. If the conditions of relationship, time and closeness are lacking, one is deprived of interaction, and the question "Do I like to be?" can be answered with a "No". One questions whether one likes being in the world, and one retreats inward, experiences a void, coldness, longing for connection and depression. When the conditions of relationship, time and closeness are present, one devotes time, and the question "Do I like to be?" can be answered with a "Yes". This means that one likes being in the world, and one experiences affection and warmth in relationships, resonance with the world and oneself. Together these form the fundamental value of existence, which enables one to be touched by life, and influences what one feels is valuable, such as relationships, music and feelings. Although this can bring up many different feelings such as joy and sorrow, it creates an inner experience of life. It creates a turning towards life which allows one to be touched by life and it leads to a sense of liking and a consent to life. In terms of embodiment, FM2 is concerned with the experience of "being alive," the body's lived experience that life is good, and that being alive is joyful (Stankovskaya, 2014).

The third fundamental motivation. FM3 is concerned with Being Oneself and asks the question "I am myself - Am I allowed to be (me as distinctive and unique)?" FM3 is concerned with one's world, one's identity and authenticity, and it refers to conditions for being oneself

such as attention, justice and appreciation. In FM3 one asks whether one feels they have received attention, justice and appreciation and whether one can experience these emotions towards oneself. The third FM refers to one's personal world, whether one has received recognition for one's own way of thinking, feeling, being. In FM3 one asks whether one can truly be themselves, live according to their values and stand by their actions according to their conscience, which plays an important role. One asks whether one can stand behind one's identity based on what one does and what one has become. One asks whether one has permission to be oneself, to receive attention and respect. If the conditions of attention, justice and respect are lacking, one does not have consent to being one's own person and the question "Am I allowed to be?" is answered with a "No". Hence one experiences loneliness, and one hides behind shame. When these conditions are present, one can consent to one's own person, and the question "Am I allowed to be?" can be answered with a "Yes", and one is capable of reaching authenticity, comfort and self-respect. In order to feel allowed to be, a person needs to make the decision to respect oneself and this leads to a sense of one's own worth and consent to one's sense of self. Together these experiences constitute self-worth, and authorisation and consent to be one's own person. In terms of embodiment, FM3 is concerned with identity and authenticity, the sense of self in the body, and the sense of personal agency as well as creating a social identity that authentically relates to oneself in the body (Stankovskaya, 2014).

The fourth fundamental motivation. FM4 is concerned with continuous becoming and change, and asks the question "I am here, for what purpose? What do I live for? (purpose and meaning)." According to Längle (2016), it is not enough to simply be and to discover oneself; one also has to transcend one's immediate situation, and to discover what existence is about. In FM4 one is concerned with finding meaning, purpose and context. One is concerned with

having a sense of being able to transcend oneself, and to have purpose and meaning in life. In order to feel a sense of purpose and meaning, a person has to make the decision to be open to living their life in a meaningful way, to become active and engaged and committed to people, aims, or values in order to experience fulfillment. One can then consent to the challenges and opportunities encountered, which provides a sense of existential meaning in one's life. In terms of embodiment, FM4 is concerned with the human body as a means of production of meaningful cooperation with others and constructing a better future (Stankovskaya, 2014).

Summary. Embodiment is understood in EA as an experience of self as body, mind, and spirit, and childbirth is viewed as an embodied lived experience which represents women's ultimate creative potential and an existential struggle to exist and give life (Launeanu & Kwee, 2018). EA supports an embodiment perspective because it is concerned with the person's existence as a whole and it provides a lens for understanding multiple dimensions of this experience (Längle, 1993). Längle's (2003) EA 4 FMs model provides a structure to understand the individual's embodied experience and to understand the personal meaning that women have about their childbirth experience as well as how they are shaped by it. The following section describes the embodied sense of self.

Embodied Sense of Self

> "The journey through pregnancy and birth offers an irreplaceable way for women to explore their deepest selves." (Gaskin, 2011, p. 1)

This section discusses the concept of embodied sense of self in terms of how the self is experienced by the individual as a fundamental part of one's being. The philosophical view is first presented in terms of self and embodiment. Then the neuroscience view is presented in

terms of interoception, perception, and individuality and continuity. An argument is made to show that research in neuroscience supports the view of the mind and body as intertwined, and the view of the embodied sense of self as both a mental and somatic sense of who one is as an individual (Craig, 2003).

Philosophical view. The self exists within the physical body and cannot exist without it (Chrisler & Johnston-Robledo, 2018). Embodiment is defined in the Oxford Dictionary (n.d.) as "giving a visible form to ideas or feelings." A sense of self is an idea, created in the mind, of who one is as an individual (Chrisler & Johnston-Robledo, 2018; Rochat, 1995). An embodied sense of self is an awareness of oneself as a body (Longo & Haggard, 2012), awareness of one's own identity (Chrisler & Johnston-Robledo, 2018) and strength in the body (Tolman et al., 2014), and it is consciousness of the feelings and sensations within one's body as they relate to the outer world (Varela, 1996). From a phenomenological perspective, embodiment is an existential condition, a lived experience, which offers a way of understanding 'being-in-the-world' as a dialogical experience between self and the world, culture, and social discourses (Cordas, 1999). According to Rochat (1995), one's sense of self is constantly shaped by one's life experiences and one's intentions, expectations, choices and actions. One's core self is shaped by how we participate in the world and learn from it.

The self, according to Leary and Tangney (2012), has been researched through many avenues such as self-awareness, self-esteem, identity, emotions, self-consciousness, and so forth. They suggest that research on the self can be grouped into five broad themes: self as the total person, self as personality, self as experiencing subject, self as executive agent, and self as beliefs about oneself. For the purposes of this study, a sense of self encompasses all of these themes. Leary and Tangney (2012) argue that although there is still no agreement on the

meaning of the construct of self, there is agreement that the self includes the capacity for reflexive thinking. One's sense of self comes from the ability to think consciously about oneself, to experience self-conscious emotions such as embarrassment, shame, guilt and pride, and it includes a differentiated sense of self or individual identity or personality (Leary & Tangney, 2012; Winkielman et al., 2015).

An embodied sense of self is therefore both an idea of a mental self, and a somatic or embodied sense of one's self experienced within the body. These are brought together through a conscious process and they are expressed through the body as embodiment of one's 'true self' (Ladkin & Taylor, 2010). However, this process is not automatic. According to Merleau-Ponty (1945/1962, as cited in Wilde, 1999), our lived experiences are separate from our conscious understanding and thus require a phenomenological method to integrate them into our consciousness through language and perception. In feminist scholarship, embodied sense of self is represented as 'voice' (Gilligan, Spencer, Weinberg, & Bertsch, 2003). According to Csordas (1994), language is important because it helps to bring the silent inner world of a person's psyche into the open. Language is needed in order to express one's embodied sense of self. The following section outlines how research in neuroscience supports the philosophical view of embodied sense of self.

Neuroscience view.

"Existence is known through the body." (Wilde, 1999, p. 27).

Research in neuroscience suggests that a sense of self is an embodied subjective sense (the brain's awareness) of the existence of one's own continuous being (Damasio, 2003). This section describes the embodied sense of self by drawing together the following concepts in neuroscience: interoception, perception, individuality and continuity.

Interoception. Interoception is the view that the body is a biological entity, and that embodiment is the perceptual experience of the body (Csordas, 1994). According to Craig (2003), when seeking to understand how the physical body produces the experience of body-ownership or the body as mine, it was found that there are specific brain regions which integrate sensory signals from the body which lead to an awareness of the self, or a sense of being me. Hence the self and body are one and that the self has a subjective sense of the material self as a feeling (sentient) entity. Exteroceptive signals are sensory signals which convey information about the body as perceived from the outside, such as vision and touch, and they seem to convey how the self perceives the world. Interoceptive signals are sensory signals which convey information about the body as perceived from the inside, such as thirst, hunger, itch, pain, temperature, respiration, heart rate, digestion, and elimination. Information is detected through nerve endings lining the respiratory and digestive mucous membranes. Interoception is consciousness of the feelings and sensations within one's body. Interoceptive signals convey an awareness of what is happening in one's body, and they convey the perception of the embodied self which is relevant for this study.

Perception. Perceptions are mental events that are grounded in experience. They can be emotions, reflective thoughts, or judgements which bestow meaning upon the world. Advances in cognitive neurosciences show links between mental events (such as empathy and placebo effect) and activation in specific brain regions, and these links highlight the role of embodiment in neural activation (Emde, 2007; Fonagy, Gergely, Jurist, & Target, 2002). Connections between perceptions or mental functioning and its effects on the brain and the body are continuously being discovered in the field of neuroscience (Fonagy et al., 2002).

Individuality and continuity. Further research by Damasio (2003) indicates that there

are parts of the brain dedicated to continuously updating a neural map of the body, and it is hypothesized that this is the source of being able to recognise oneself as an individual mental self, and have a sense of continuous being as a living organism. Individuality and continuity can be considered from two perspectives: that of introspection and that of biology. Introspection informs us that the mental self is not a thing but a process, one that produces phenomena ranging from the very simple (the automatic sense that I exist separately from other entities) to the very complex (my identity, complete with a variety of biographical details). On the other hand, combining the results of introspection with a biological perspective suggests that the mental self represents the individuality and continuity of a living organism. Some brain regions can map nothing but the body and they are the body's captive audience. These regions may form the basis of the mind's representation of the self that anchors the mental self. According to experimental psychologists Ferrè et al. (2014), an embodied sense of self is a first-person perspective which exists in the spatial unity of the self and physical body. By bringing together different sensory inputs linked to body parts (such as being able to see and move one's hand), the brain creates a self-body unity or a unified self which perceives the world from the internal embodied perspective (Chrisler & Johnston-Robledo, 2018). Chrisler and Johnston-Robledo (2018) assert that self-body unity (embodiment) can easily be misunderstood or disrupted. For instance, when a person has an out-of-body experience, this reflects that the person has altered vestibular function and therefore no longer sees the world from the internal embodied perspective (Ferrè et al., 2014). A conscious awareness of self comes from multisensory inputs from different modalities but these can easily be manipulated to create confusion. For example, a rubber hand illusion can cause a perception that a rubber hand is one's own, or a phantom limb pain can cause a perception that the pain occurs in one's own missing limb. According to Young

(1990), a disruption of self occurs naturally during pregnancy. Whereas philosophers such as Merleau-Ponty have focused on subject as a unity or a unified experience in the body through his intentional arc, pregnancy seems to create a split subjectivity (Young, 1990). As the woman's body changes to accommodate the growing child inside, the difference between self and other, or self and world becomes blurred (Young, 1984). Such disruptions or misunderstandings of the self show that one's embodied sense of self can easily be disrupted.

Summary. In summary, the embodied sense of self is awareness of oneself as a person, as one's identity, as well as an internal sense of what one feels, perceives, and thinks, and it is constantly shaped by our life experiences and it shapes who we are in the world (Chrisler & Johnston-Robledo, 2018). In childbirth, the woman's embodied sense of self is shaped by the birthing experience, and it shapes how she interacts with her world for many years to come (Simkin, 1991, 1992). A woman's embodied sense of self influences how she adapts to motherhood and cares for her child, it impacts her health, the health of her child, and it shapes her relationships with others, and with the world (Gaskin, 2011). In neuroscience, interoception is consciousness of the feelings and sensations within one's body. Interoceptive signals convey an awareness of what is happening in one's body (Craig, 2003), and they convey the perception of one's existence as a separate, individual, embodied self. Connections between perceptions or mental functioning and its effects on the brain and the body are continuously being discovered in the field of neuroscience (Fonagy et al., 2002). The interdependence of embodiment, neural activation and brain / body function emphasises the relevance of studying embodiment in childbirth. As the embodied experience of childbirth can be disrupted there is also a need to

understand disembodiment.

Disembodiment

According to Piran and Teale (2012), positive embodiment is a connection to the subjective experience of being a body, a connection to one's strength, and capability, and the freedom to be one's self, to express one's feelings and needs. Disrupted embodiment or disembodiment is when one feels disconnected from the self, a disconnection from the experience of being a body, weakness in the body, helplessness, inability to advocate for one's self, disempowerment, difficulty to express one's feelings and needs, and it can be a feeling of being outside the body or floating above it. These descriptions are used in this study as a broad framework to understand embodiment in childbirth. Positive embodiment is when a woman feels connected to the experience of giving birth, and disrupted embodiment or disembodiment is when the woman feels separate from the birth experience and memories of it.

Disembodiment is a response to emotional distress which entails a physical distancing from one's own body (Morse & Mitcham, 1998, p. 668). According to Akrich and Pasveer (2004), disembodiment, or lack of connection to the embodied experience, is perceived as problematic because it negates any sense of agency and it takes time for the woman to ground herself and reconnect to the embodied experience and this can have a direct impact on the birth process by inhibiting labour. Achieving a sense of grounding requires interpersonal connection and/or support from a person who is actively supportive in the birth and who is kind (Berg, 2005; Nystedt et al., 2006). Walsh (2010) argues that caregivers can mitigate adverse effects of disembodiment or separation through compassionate, relationally focused maternity care, especially in the case when labour complications develop.

Disembodiment is also a way of protecting the self in life-threatening situations by

distancing one's self from one's own body. For instance, Morse and Mitcham (1998) found that burn patients experience disembodiment due to the pain they endure whilst receiving excruciating treatments. Disembodiment is recognized through their descriptions of this experience because they use depersonalized or disembodying language such as referring to parts of themselves as *it, the* and *this*. When these same individuals describe the rehabilitation period, they begin to use possessive pronouns for these same parts of their bodies. Similarly, the birthing woman can have an out-of-body or disembodiment experience as a way of coping with labour pain (Walsh, 2010). Pain is lived and experienced within the body simultaneously as sensation and emotion (Jackson, 1994). In childbirth pain is a part of the subject, a dimension of the self, and when the pain is unbearable, one becomes disembodied from the self (Wilde, 1999).

Disembodiment can have a positive or negative effect during childbirth. A positive effect occurs by distancing oneself from physical pain as a form of protection (Young, 1992), or control (Morse & Mitcham, 1998). A negative effect occurs when women in childbirth have the feeling that they are being treated by their caregivers as just an objectified body rather than as a person. Such a dualist approach can cause women to experience a sense of disembodiment or separation which can adversely affect their experience of childbirth and their recovery from it (Bullington, 2009; Wilde, 2003).

Disembodiment may also occur due to a prolonged traumatising labour (Kjaergaard et al., 2007), non-compassionate care (Nystedt et al., 2006), a woman's perception that she is unable to give birth due to beliefs she has about herself (Gaskin, 2011), or even in response to internalised societal discourses about idealised femininity (Piran, 2016). For instance, the discourse that women should not express anger outwardly may cause her to have difficulty in advocating for herself during birth. In such instances, women may experience a loss of voice or inability to

speak (Gilligan et al., 2003) or she may dissociate from the experience of giving birth (Walsh, 2010). Whilst some women have learned to think critically to resist such social discourses (Chrisler & Johnston-Robledo, 2018), others are unaware or unable to do so and this can lead to a state of disembodiment (McBride, 2014). Such disruptions can have consequences for the mother's health. According to Chrisler and Johnston-Robledo (2018), it is important that women have positive experiences of childbirth because they lead to social empowerment and negative experiences lead to disempowerment. If a woman feels physically and mentally free and empowered, she experiences positive embodiment in the form of agency, self-care, and joyfulness. If a woman feels physically and mentally corseted and disempowered, she experiences disrupted embodiment in the form of a negative body–self relation.

Summary. In summary, positive embodiment is when a woman feels connected to the experience of giving birth, and disrupted embodiment or disembodiment is when the woman feels separate from the birth experience and memories of it (Piran & Teale, 2012). Disembodiment can be a response to emotional distress, resulting in a physical distancing from one's own body (Morse & Mitcham, 1998) or dissociation from the experience of giving birth (Walsh, 2010); it can cause women to experience a loss of voice with consequences for the mother's health (Gilligan et al., 2003). It is important that women have positive experiences of childbirth because they lead to social empowerment, whereas negative ones lead to disempowerment (Chrisler & Johnston-Robledo, 2018). Hence there is a need for further research to promote women's positive experiences of giving birth and a positive embodied sense of self. The following section outlines the focus of this study.

Focus of the Present Study

Existential Analysis, embodiment and childbirth. Considering that past

understandings of women's experiences of giving birth have been subjected to much reductionism and dualism (Gaskin, 2011), it is important to gain a holistic understanding of the impact of childbirth on a woman. EA supports an embodiment perspective because it is concerned with the person's existence as a whole and it provides a lens for understanding many dimensions of a person's life (Längle, 1993). According to Längle (2008a), in EA the body is viewed as a fundamental dimension of the human being, hence the body is perceived as an existential being. The subjective experience of the individual is the focus, as opposed to just the body, and this view provides a connection with embodiment. According to Launeanu and Kwee (2018), embodiment is understood in EA as an experience of self as body, mind and spirit, and childbirth is viewed as an embodied lived experience. The woman in childbirth is perceived in terms of her wish to experience fulfillment and meaning through the birth experience and suffering in childbirth is viewed as a deep suffering of embodied human existence. In EA, women who suffer in childbirth are struggling with disturbances in all aspects of their embodied experience: physical, emotional, relational, personal, and spiritual. Hence an EA view complements an embodiment view in understanding women's lived experience of childbirth.

Existential Analysis and the Listening Guide. The inclusively dialogical essence of EA resonates well with the relational aspect of Gilligan's (1982) Listening Guide method used in this study, which is discussed in detail in Chapter 3. Gilligan's Listening Guide is a phenomenological relational method for listening to the different voices within a person's subjective experience. The Listening Guide has been adapted to use Längle's EA 4 FMs model. According to Längle (1993), the 4 FMs of EA describe human life and existence in dialogue with life, and they are concerned with the conditions a person requires to experience fulfillment. They provide a structure to understand a person's inner experience of self and their outer

dialogical experience with life as well as their subjective experience of fulfillment or suffering. The participant's embodied voices which emerge in this study through the Listening Guide method are in dialogue with one another. They are like different instruments in a symphony or an orchestra. They co-exist and there could be tensions, and there could be harmony. The adaptation of the Listening Guide to use Längle's EA 4 FM model provides a framework to connect the individual's subjective experiences of childbirth in terms of fulfillment and suffering.

Research topic. The literature review has shown that women can have vastly different experiences of childbirth, ranging from fulfillment to suffering and trauma, which can profoundly shape a woman's embodied sense of self, with implications for her health, and that of her newborn (Kitzinger, 2006; Kjaergaard et al., 2007; Walsh, 2010). Hence there is a need to take a more holistic perspective of childbirth and to integrate theories of embodiment into mainstream conceptualisations of childbirth. There is increasing interest in embodiment as a construct in understanding women's subjective experiences of childbirth. Research has shown that disruptions in embodied experience which occur during childbirth (Kjaergaard et al., 2007; Walsh, 2010) can be traumatic and negatively impact the woman's embodied sense of self over time. Increasing our understanding of women's lived embodied experience of childbirth and rejecting mind-body dualism in favour of an embodied view of mind and body as intertwined, could increase understandings of how to protect women from such disruptions. Therefore, research which expands knowledge of the embodied experience in childbirth, and how the embodied sense of self is shaped by the childbirth experience is much needed as it could bring

valuable understanding and insights.

There is a need to understand women's subjective experiences of childbirth, and how they shape their sense of self. In particular there is a need for such research from a counselling psychology perspective, which is concerned with the whole person in continuous development. The aim of this study was to understand in depth women's subjective experiences of childbirth with an embodiment lens, and to understand how their embodied sense of self was impacted by giving birth. The guiding research question for this study was: How do women's experiences of childbirth shape their embodied sense of self?

CHAPTER 3: METHODOLOGY

> "Voice, because it is embodied, connects rather than separates the psyche and body." Brown and Gilligan (1993, p. 14).

The purpose of this study is to explore how women's experiences of childbirth have shaped their embodied sense of self. Carol Gilligan's Listening Guide method (Gilligan et al., 2003) was selected to analyse women's stories about their childbirth experiences. This chapter begins with a description of the research paradigms of the Listening Guide (LG). Then the LG is discussed with regard to its origins, analytical procedure, rationale for choosing the LG, rationale for adapting the LG to use an EA lens, and the researcher position. Then the research design is outlined with regard to: inclusion/exclusion criteria, recruitment, sampling, and data collection. Then data analysis is described in terms of: transcription, research team, process of analysis, listening stance, and implementation of the steps of the adapted LG method. Then this is followed by methodological rigor and quality.

Research Paradigms

Aligning with the feminist paradigm, this study seeks to understand the subjective lived experiences of women through their narratives about giving birth, and to challenge current medicalised conceptualisations of childbirth to include an understanding of the woman's subjective embodied experience of childbirth. This research is situated at a point of tension where the female subjective experience of childbirth is explored within a traditionally dualist patriarchal medicalised culture. This section begins with an overview of qualitative research, then a description is given of the feminist paradigm in terms of its alignment and integration for this study and the Listening Guide.

Qualitative Research. According to Guba and Lincoln (1994), qualitative data is designed to gain in-depth knowledge of self and others by conducting and analysing narrative discourses. A qualitative research design was selected for this study in order to facilitate the exploration of women's lived experiences of childbirth in all of their complexity. The goal is to understand the lived experience within its socio-historical context (Elliott, Fischer, & Rennie, 1999). Qualitative research is designed to provide rich, contextual insight into the idiographic, emic view of a few studied individuals, such as the meanings which people attach to activities (Morrow, 2005).

Feminist constructivist lens. A feminist approach has been chosen for this study in the light of women's disembodied experiences in childbirth, and to honour the sacredness of childbirth (Gaskin, 2011; Walsh, 2010). According to Mertens (2015), feminist research seeks to understand each individual's unique subjective experience, and this aligns well with qualitative research methods. The feminist approach places importance on the way a researcher engages with a participant to understand their narrative, to allow the participant's voice to emerge and be heard, and to allow the research to be shaped by the participants' voices. A central focus of feminism is that the construction of womanhood and femininity have been driven by a dominant oppressive patriarchal culture (Piran & Cormier, 2005) and that gender inequalities are systemic, leading to social injustice. According to Gilligan (1982), gender scripts created by this culture are often internalized by women as their own. Motivated by an inherent desire not to hurt others, women often collude with men in not voicing their experiences and dissociate from what they know as they try to conform to societal expectations and become a version of themselves that is acceptable to the script. Internalised gender scripts lead women to feel silenced as they struggle to separate their own voices from those of others, and it can lead to self-doubt, feelings of

powerlessness, loss of identity, and loss of self or voice. Through engaging personally with participants' lived experiences, expressed in their own words, researchers' understandings of women's embodied lives can be shaped directly by the women who speak. Listening to women's voices facilitates a more nuanced understanding of how the experience of childbirth may shape a woman's embodied sense of self, and therefore Gilligan's (1982) Listening Guide was selected as the methodology of choice for this study.

As a feminist method, the Listening Guide (Gilligan, 1982) is also transformative because a central focus of feminism is to address the gender inequality that leads to social injustice for women. The Listening Guide is a feminist relational method which is responsive to different voices and "concerned particularly with the reality of men's power at this time in history and its effects on girls and women as speakers and listeners, as knowers and actors in the world" (Brown & Gilligan, 1993, p. 15). The Listening Guide method is designed to address the issues of those who have experienced any kind of discrimination and oppression (Mertens, 2015). In such cases, women can feel silenced by others, or silence their own voice because they do not want to hurt others, or they fear they will not be heard (Gilligan, 1982). In the Listening Guide, 'attention to voice' is considered a criterion for assessing quality in transformative qualitative research. By listening to the voices of women who might feel oppressed in a patriarchal society, this method is transformative. By placing importance on what women have to say and examining the power dynamics within the system of childbirth, the Listening Guide offers women a chance to understand their childbirth experience relationally, and this is consistent with the transformative research.

Within a feminist paradigm, a constructivist lens has been used in this study with the aim of understanding women's subjective lived experiences of childbirth as well as how these

experiences shape their embodied sense of self. According to Guba and Lincoln (1994), constructivist researchers assert that knowledge is socially constructed during the research process and that data and interpretations of data are rooted in contexts (Slife, 2004). Whilst being explicit about their own values, researchers seek to understand the multiple social constructions of meaning and knowledge from the participant's subjective lived experience. This is an interactive process between the subject and researcher, where each one influences the other. The constructivist paradigm aligns with a feminist perspective because constructivists emphasize the need to include a balanced representation of views, raise the participants' awareness, and address issues of social justice (Mertens, 2015, p. 21). Constructivist research offers a way to understand the subjective lived experiences of individuals through their narrative. The Listening Guide is consistent with the constructivist view because it is a relational method that is designed to listen to different voices, and to understand others through narrative and through the researcher's own subjective experiences and interpretation (Doucet & Mauthner, 2008). The Listening Guide is used in this research to increase participant awareness of their childbirth experience and how it shapes their sense of self.

The Listening Guide Method

> The Listening Guide is a method of psychological analysis that draws on voice, resonance, and relationship as ports of entry into the human psyche. It is designed to open a way to discovery when discovery hinges on coming to know the inner world of another person. Because every person has a voice or a way of speaking or communicating that renders the silent and invisible inner world audible or visible to another, the method is universal in application. (Gilligan, et al., 2003, p. 157).

Voice is an important medium for expression of self and making one's inner world known to others (Gilligan et al., 2003). However, women's experiences of oppression and silencing have made them particularly prone to doubting their own voices as an expression of self. Therefore, it is important to select a method which allows women to describe their childbirth experiences from their point of view and to express what mattered to them in order for them to gain an awareness of their experience and to create a deeper understanding of how it shaped their embodied sense of self. The method chosen for this study is Carol Gilligan's Listening Guide (Gilligan et al., 2003). In his book, phenomenology of perception, Merleau-Ponty argues that the world is not what one thinks, but what one lives through (1945/1962). Our lived experiences are separate from our conceptual cognitive understanding and thus require a phenomenological method to integrate them into our consciousness through language and perception (Wilde, 1999). The concept of the lived body requiring language to integrate experiences into consciousness is central to the definition of embodiment used in this study and also the reason for using the Listening Guide.

Origins. The Listening Guide method (Gilligan, 1982) originates from Carol Gilligan's work on identity and moral development. According to Mertens (2015), Gilligan is an American psychologist who is well known for her criticism that psychological theory has traditionally been created from a male perspective using male subjects. Gilligan (1982) challenged Freud's theory of personality (Breuer & Freud, 1986), and Kohlberg's theory of moral development (1958), as examples using male behaviour as the norm, claiming that their theories are not generalizable to females. She asserted that psychologists have tended to regard male behavior as the norm and that female behavior, which does not conform to this expectation, is seen as a deviation from the norm, or worse still, it is seen as though there is something wrong with women (Gilligan, as cited

in McClelland, 1975). She argued that there is a natural difference in the way men and women speak, and that the norm is that masculine and feminine voices form a contrapuntal theme in life which influences people's thoughts, fantasies and judgements. The Listening Guide was developed in order to create better ways to analyze qualitative data (Gilligan et al., 2003). Using the clinical method developed by Freud (Breuer & Freud, 1986), and Piaget (1979), the Listening Guide follows the lead of the person being interviewed in order to understand them (Breuer & Freud, 1986, p. 158). In this way the Listening Guide addresses feminist concerns that researchers can potentially override a person's voice with their own interpretations.

The Listening Guide method is a more structured form of narrative analysis which acknowledges that the layered nature of a person's psyche is expressed through many voices (Gilligan et al., 2003). Gilligan refers to these as a polyphony[1] of voices. Voice is central to a person's identity; it connects the psyche and body and it is embodied in culture and relationship with self and others (Brown & Gilligan, 1993). Voice is the channel or pathway that allows us to express our inner feelings and thoughts in a relationship where they can be heard; it exists in

[1]According to Jackson (2018), in musical terms, polyphony generally refers to music consisting of two or more simultaneous lines of independent melody, whilst counterpoint (which is a type of polyphony) refers to the compositional technique or art of combining different melodic lines in a musical composition. Although they are different, the word counterpoint is frequently used interchangeably with polyphony.

language and is inherently relational. Gilligan et al. (2003) assert that each person's voice, distinct in range, harmony, dissonance, tone, pitch and rhythm, is composed of different voices embodied in society, culture, language, history, and relationship with oneself and with others. The Listening Guide (Gilligan, 1982) is influenced by music theory and incorporates the idea of counterpoint music which consists of two melodic lines that occur at the same time in the music. These are independent of each other, like separate voices, but one does not preclude the other. The relationship of different co-occurring voices to one another creates harmony or dissonance (Gilligan, 2015). The Listening Guide (Gilligan, 1982) consists of sequential listenings which enable the researcher to tune into distinct aspects of a person's multi-layered voice (Gilligan et al., 2003). According to Gilligan (1982), people are relational and complex beings with different parts of self, and women in particular experience difficulty in listening to themselves. The need for many listenings also arises from the assumption that we know things that we do not consciously know, that some of our experiences are held outside of our awareness. Considering that women have separated themselves from their own experiences and their own knowledge it is important to bring their experiences to the fore (Gilligan, 1982; Brown & Gilligan, 1993).

Gilligan (1982) created the Listening Guide Method as a way to give voice to people who are oppressed and silenced. Although it was developed to listen and engage with women's voices, it is also used for men. The Listening Guide (Gilligan, 1982) has been used in analyzing women's experiences of motherhood and postnatal depression, analyzing and interpreting U.S. Supreme Court decisions, as well as a variety of literary and historical texts, including novels and diaries (Gilligan et al., 2003). The following section outlines the analytical procedure for the Listening Guide.

Analytical Procedure. The Listening Guide (Gilligan, 1982) is a method used to

analyse narratives of participants in a study. Data is collected through semi-structured, unstructured or open-ended interviews, which are recorded and then transcribed. Sample size is determined by how well the participants have been heard (in their commonalities and unique differences). Analysis is carried out by a team of researchers (two or more listeners) through a series of listenings. A listening is when the research team listens to a recording and/or reads a transcript one time through from beginning to end.

Analysis involves 4 steps: In Step 1, the listeners listen to the recording and/or read the transcript and listen for the client's story or plot. They try to identify what is happening (what, when, where, and with whom and why), listening for silences, pauses, lowering or trailing off of voices, repeated images, metaphors, dominant themes, salient themes, striking metaphors or symbols, emotional hot-spots, gaps or ruptures, contradictions, and that which was not expressed or was absent (Gilligan et al., 2003). They also record their own responses to the interview by attending to their own response to the narrative, explicitly bringing their own subjectivities to the process of interpretation, identifying their own social location, emotional responses, and thoughts that emerge (Woodcock, 2010).

In Step 2 the researcher follows the participant's response through a second listening, following the use of the first-person pronoun "I", as it speaks of being in the world and picking up on the associative stream of consciousness carried by the first-person voice (Gilligan et al., 2003). Then the researcher creates an I-Poem by bringing together all statements that use the word "I" into an I-Poem.

In Step 3 the research team reads through the participant's transcript multiple times. For each listening (reading the transcript from beginning to end), the research team uses the guiding questions of the research question and the existential questions for each FM in Längle's EA 4

FM model. These questions are described more in the data analysis section. The listeners listen for contrapuntal voices.

Contrapuntal voices are multiple voices identified in a person's narrative. They can occur simultaneously, and each one is equally as important and the other. They are identified by reading through the interview two or more times, and each time tuning into a distinct voice or way of speaking of the participant. Step 3 offers a way of hearing and developing an understanding of several different layers (voices) of a person's expressed experience as it bears on the research question (Gilligan et al., 2003). Each time a voice is identified, the text corresponding to that voice in the transcript is highlighted in a different colour. The multiple listenings are rendered visually through underlining text using different coloured pencils, through interpretive notes and by having multiple listeners. Saturation and redundancy are factors considered through the procedure. Listenings are compete when saturation has been reached and no more new voices are heard. In Step 4 the principle researcher composes an analysis to pull together and synthesize what has been learned through the entire process or analysis.

Rationale for choosing the Listening Guide. The Listening Guide is a relational feminist method that looks at what is said and not said (Brown & Gilligan, 1993). Each person's voice is unique in what it communicates (McBride, 2014). Each relationship is ever changing and voice is inherently relational in that it contributes to how the relationship evolves. Women especially often speak indirectly whether intentional or not. Gilligan (1982) claims that this is because they are aware of the dangers of being too outspoken as well as those of silent resistance. Voice changes in resonance depending upon whether it is heard or responded to by self and others. Relational resonances can be detected when a person speaks and their voice resonates with other voices and is resounded by them, or when there is no resonance (Gilligan,

1982). The Listening Guide enables the listener to hear these voices literally in terms of what is said and not said, and to hear resonance which gives voice to the inner experience of the person. When women tell their stories about childbirth and express their experience, they feel empowered through speaking about what they had already known in their inner experience, and the researcher gains more depth of understanding.

According to Gilligan (1982), the Listening Guide method takes advantage of the fact that research can be relational and uses that relationship to generate trust, so that people are able to speak about things that have not been talked about or well understood, or that haven't been studied. The Listening Guide provides a way of listening from the viewpoint of the person (Brown & Gilligan, 1993). Gilligan et al. (2003) argue that this method is flexible as interpretation is not based on a fixed framework, and it is reflexive as the researcher is involved in the process. As the participant develops her voice through this method, the researcher witnesses this change, and both of them are changed by this experience. The strengths of this method are that it allows the voices of participants to be heard with historical, familial, societal, and cultural influences. The Listening Guide method is intended to recognize the layered nature of psychological processes and it is compatible with many psychological theories and cultures, and it allows themes to emerge through an induction approach (Mertens, 2015). The limitations are that there is room for ambiguity about how to complete the steps and interpret the listenings, it is a lengthy process and it is not possible to generalize findings for other women.

In the context of this study, the Listening Guide methodology (Gilligan, 1982) was chosen because it looks at the relationship between voice and embodiment; the development and expression of self through voice. Language is needed to integrate experiences into consciousness and the Listening Guide is a relational method that involves deeply listening to the participants'

experiences, capturing what they say, and interpreting the meaning and context behind their words. The researcher listens to women's polyphonic (many) voices to understand how their experiences of childbirth are layered, and how they have shaped their embodied sense of self. While previous research has focused on the health of the mother and child together, this study looks at the inner (emic) world of the individual mother, and the Listening Guide method recognizes the layered nature of the lived experience of childbirth. The Listening Guide was chosen in order to help women find their voices in expressing their needs for childbirth. The aim was that the voices which were operating as agents and/or missing from the process of childbirth would be discovered through the Listening Guide's voice relational methodology.

Rationale for adapting the Listening Guide. In this study, Step 3 of the Listening Guide method (Gilligan, 1982) has been adapted to allow analysis of data using Längle's Existential Analysis model of the four fundamental motivations (EA 4 FMs). Steps 1, 2 and 4 were not changed. The implementation of this adapted Listening Guide method is discussed in the Data Analysis section. This section focuses on why the Listening Guide has been adapted to use an EA lens.

As previously discussed, Existential Analysis (EA) provides a holistic perspective that is compatible with embodiment. EA is concerned with understanding multiple dimensions of a person's life, including personal meaning (Längle, 1993), as well as a person's dialogical relationship with the world. EA provides a framework for understanding how women's subjective experiences of childbirth shape their sense of self. Längle's EA framework is the model of the four fundamental motivations of existence (4 FMs), which provides a way of conceptualising the complexity of embodiment (Stankovskaya, 2014), as well as conceptualising the themes or voices that are present within participant narratives. Längle's EA 4 FM model is

relevant for this study because it is used to analyse whether the conditions required for a fulfilled existence have been met for a participant in terms of her physical, emotional, and personal needs, and in terms of the personal meaning she finds in her experience of giving birth. Considering that childbirth is a profound experience which can lead to fulfillment or suffering or both together, this model provided a way to bring attention to these experiences whilst honouring the woman's personal experience as well as the sacredness of childbirth. In methodological terms, it is possible to adapt the Listening Guide method (Gilligan, 1982) because it is not a fixed framework for interpretation, but a way of connecting to a person's inner voices (Brown & Gilligan, 1993). According to Gilligan et al. (2003) the steps in the method are meant as a guide and the researcher can decide how each step is implemented. Researchers are permitted to find different ways to fit the needs of their study (Woodcock & Hakeem, 2015). Gilligan et al. (2003) point out that the Listening Guide method has been used with other qualitative methods of analysis such as narrative summaries (Way, 2001) and conceptually clustered matrices (Brown, 2001)" (p. 169). A detailed account of how the Listening Guide has been adapted in this study is given in the Data Analysis section.

Researcher Position

Considering that for qualitative research the main researcher plays a central role in gathering and analysing information, it is important that I, as the principal researcher, explicitly state my own values regarding this research topic. The purpose of doing this is to increase my awareness about the topic, and potential personal issues related to the topic which may surface during the research process. My interest in researching childbirth is based on my own experience of giving birth to four children, in Germany and the USA, each time far away from my own culture and family. My interest is also based on the many accounts of childbirth I have

heard from other women in these and other countries. Some close women friends have experienced fulfillment through the childbirth experience and others felt traumatised by their birthing experiences. I am struck by the vivid memories that women have of childbirth, and by the deep impact this experience has had on them for many years afterwards.

During my first birth experience, where I received a series of interventions, my experience was one of feeling an increasing sense of fear, as I felt I had no control over what was happening. I felt silenced, disempowered, and helpless. I felt as if I was floating above myself and looking down. Although I was aware of what was happening, everything was hazy. Afterwards I felt elated to hold my healthy baby, but I also felt that the birth experience was disempowering, and my sense of self as a strong and capable person was shaken for a long time. My subsequent positive birth experiences helped me to heal and feel strong again. For the next three deliveries I felt I had space and time to labour at my own pace; my initial fear was quickly calmed because I felt supported. I trusted my caregivers and felt I had control because they asked for my consent to perform interventions and they explained what they were doing. I felt I had permission and encouragement to express my wishes. These births were empowering and I experienced feelings of immense happiness and fulfillment which I still remember vividly today. I was able to get to know myself through the experience of giving birth and I felt this led to a lasting sense of myself as a strong person, and as a good mother.

In the past I have felt discouraged by the mainstream model of care for childbirth, and I long to see change which is more humane and which considers the woman's subjective experience and the impact on her sense of self. In this regard I resonate deeply with the aims of the feminist paradigm. Having the ability to contrast my own different experiences of giving birth in different countries has given me a broader view of childbirth. Since embarking on this

research, I have begun to process and integrate these embodied experiences and this has been healing. As a result, I have a strong desire to create a greater understanding of women's embodied experiences of childbirth. I would also like to help women to feel empowered and have a better birth experience so that their health and their baby's health is positively affected.

Research Design

Inclusion and exclusion criteria.

The first birth. Depth research was conducted using a smaller number of participants and listening to their narratives in great detail. The women selected for this study were six mothers aged between thirty-five and eighty-four years, who had experienced at least one live birth, and who were able and willing to speak in depth about their first childbirth experience, as well as how this experience had shaped their embodied sense of self. The primary interest for this study was the embodied experience of the first live birth because this is the time when a woman becomes a mother for the first time, and the focus was on how this first experience of childbirth shapes her sense of self. There was no restriction on the number of births that a woman had experienced and some women who were reflecting on their first birth, who may also have delivered another baby less than a year ago, would have still been included.

Time elapsed since first birth. Women need time to reflect on how their sense of self has been shaped. Therefore, only women who had given birth for the first time more than one year ago were included in the study, and those who had given birth to their first child less than 1 year ago were excluded from this study. There was no restriction on how many years ago the first birth took place because research has shown that women remember their first birth throughout their lifetime (Gaskin, 2011; Lundgren et al., 2009; Simkin, 1991). For the participants in this study, the time elapsed since their first experience of childbirth ranged from four years ago (this

was the thirty-five-year-old participant) to fifty-seven years ago (this was the eighty-four-year-old participant).

Ability to recall and talk about first birth. Participants were chosen based on their capacity, willingness, and desire to reflect on their experiences of their first birth. A screening process took place (see sampling section below) for women who could remember their first experience of giving birth, who were able to reflect on how this shaped their sense of self, and who wanted to talk more at length about their first birth as the focus of the interview. If women wanted to talk about any similarities, differences, and embodied experiences in subsequent births, they were permitted to do this, and this information was included in the study as additional information which might shed some light on how their embodied sense of self was shaped by subsequent births.

Other criteria. There were no restrictions on the method of birth (vaginal or caesarean section); this study covered all experiences of childbirth. There were no restrictions on women who were suffering from PTSD, postpartum depression, or other mental health concerns. However, participants were screened for suicidality during the pre-screen interview by asking them about current suicide ideation or past attempts. A referral for counselling was available from the researcher if it was needed (see Appendix H, Flyer for Counselling Referral). Three of the participants in the current study had experienced postpartum depression after their first birth, and all three of them confirmed that they were still taking medication for depression at the time of participation in this study.

Recruitment. Participants were recruited through an advertisement for this study (see Appendix A for the advertisement) which was sent out via paper and email to colleagues and friends asking them to pass it on to anyone who might be interested in participating in the study.

Although other methods of recruitment were planned, these were not needed as the response to the advertisement was immediate, indicating that many women want to share their childbirth stories. The other planned methods were to post the advertisement on social media and to place a printed copy of the advertisement at various local venues such as: libraries, preschools, schools, universities, community centres, and churches. The intention was to recruit six to eight women for this study, and twenty women showed interest in participating in the study. Due to the exclusion criteria, only fourteen of them were selected for the pre-screen interview.

Sampling. Participant sampling (selection) was accomplished by the principal researcher, who conducted a pre-screen interview for each of the fourteen women who were selected for this study. Eleven pre-screen interviews were conducted in person, and three were conducted via telephone because the participants lived far away. Ten were invited to take part in this study. The pre-screen interview began with a short script to introduce the principal researcher and the study, then semi-structured questions were asked to determine whether they would be suitable for inclusion in the study (see Appendix B for the pre-screen interview). The expectation was that women would have vivid memories of childbirth, but that not all of them would think about that experience deeply. In accordance with the constructivist research, purposeful sampling was used to identify information-rich cases (Mertens, 2015). These were participants who were able and willing to speak in depth about their first childbirth experience. These women exhibited interest in exploring how their experience of childbirth shaped their sense of self at that time, and whether it has continued to do so since then. In addition, intensity sampling (Mertens, 2015) was also used to identify women who had found their first birth experience to be meaningful to them. The intention was intended to identify individuals where the phenomenon of interest was strongly represented; to identify women who said that giving

birth had mattered to them, whether it was traumatic or empowering or both (perhaps working through any trauma could be empowering). Of interest were women who said they were able to test their limits during childbirth and they found that they could do more than they imagined, women who said they could not do more, women who felt they thrived, and those who felt they did not thrive. Of particular interest were women who felt that having a baby had impacted them in some way, and women who were able and willing to talk about their experience of giving birth and how it had shaped their sense of self. It was anticipated that these women would have some commonalities and also unique differences in their experiences.

Data collection. ***Post-interview selection.*** Ten women were interviewed and six were later selected to participate in this study. The six women who participated said that birth mattered to them, that they could remember their first childbirth experience and that it had changed them because they realised that they were stronger than they imagined. They were selected because their stories were information-rich. The principal investigator conducted all ten interviews.

Interview. Data was collected through semi-structured interviews lasting approximately 1 to 1 ½ hours. There was time set aside before the interview to build rapport with the participant. The researcher began with a short script to thank the participant for agreeing to participate in the study (see Appendix C for the pre-interview script), and then the researcher read the informed consent form to the participant and asked her if she had understood what informed consent meant. At this point participants could ask questions about the meaning of informed consent, and the researcher answered their questions. After this, the researcher asked the participant to sign a consent form for participating in the study which explained the limits of confidentiality and the details of the study (see Appendix D for the consent form). Semi-structured interview

questions were then asked to understand the participant's childbirth experience (see Appendix E for a list of interview questions). The same initial questions were asked to each participant in order to lead the participant into an open conversation. At the end of the interview a short script was read to thank the participant for participating in the study (see Appendix F for the post-interview debriefing script). The participants were also informed that as we had just discussed a personal experience in depth, that if they would experience upsetting feelings or thoughts after the interview, that a referral for counselling could be arranged by the principal researcher if it was needed (see Appendix H, Flyer for Counselling Referral).

Method of interview. Three participants who lived in different countries, were interviewed via Skype, and all others were interviewed in person at a location chosen by them. Skype is a program which allows a person to place a voice or video call via their computer by selecting the online video conferencing option in Skype. For each Skype interview, the main researcher set up a laptop in a private room, and at an agreed time, "video Skyped" the participant, who was also in a private room in her home. The main researcher and participant could see each other during the interview via Skype. For each in-person interview a private room was chosen for the interview. For all participants two simultaneous audio-only (not video) recordings were made using the researcher's laptop and cell phone.

Storage and privacy: Interview recordings were stored onto the researcher's password protected laptop computer as password-protected audio M4A files. Given that interviews on the cell phone were transferred directly to the laptop, there was no need to use a USB flash drive or memory stick. Once the files on the cell phone had been transferred to the laptop, they were deleted on the cell phone. Transcriptions of interviews were also stored electronically on the principal researcher's computer, which was kept with the principal researcher or at that

researcher's home. Printed documents such as transcripts and consent forms were stored in a locked filing cabinet in the principal researcher's home office to preserve confidentiality requirements. All electronic and physical data was kept until the completion of this study, and then it was deleted from the computer or shredded.

Data Analysis

Transcription. Data was collected through the six semi-structured interviews, which were recorded and then transcribed. The principal researcher wanted to interact personally with the data in as much depth as possible, therefore five interviews were transcribed by the principal researcher. For the sixth interview, where the transcription was initially done by a member of the research team, the principal researcher wanted to interact with the data in as much depth as had been done for the other interviews. In order to maintain consistency for all transcripts, the principal researcher listened to the interview and checked the transcription and added to it. The reason was to ensure that nuances such as laughter, gestures, hesitations, volume, tone, pace and silences could be noted in this transcription in the same way as had been done in the other five transcriptions. These were noted in square brackets in the transcripts. In this way the principal researcher was able to maintain a consistent level of personal engagement for all transcripts. It was important that the principal researcher was able to be immersed in the participant's stories, be touched by their experiences and gain more understanding of the participant's subjective experience.

Research team. The research team was composed of eleven people: the principal researcher, and ten research assistants who were master's level students in counselling psychology. The research team was split into smaller teams of no less than two members for the analysis of each transcript. The principal researcher was present for all listenings. A listening is

when the research team read through a transcript. Once a team was selected for a transcript, the team stayed together until all listenings were complete. In order to protect participants' confidentiality, all members of the research team were required to sign a confidentiality and non-disclosure agreement (see Appendix G: Confidentiality and Non-Disclosure Agreement for Research Assistants and Transcriptionists).

Process of analysis. The Listening Guide method (Gilligan, 1982) is designed to conduct analysis in 4 steps, through a series of listenings for each participant transcript. For each listening, the analysis was completed by a research team who read through the transcribed interviews. The focus of their interest was determined by the steps of the listening guide. In this study Step 3 of the Listening Guide method was adapted to use Längle's EA 4 FMs model. The implementation of this adapted Listening Guide method and how it deviates from the original Listening Guide is now described.

Listening stance. The Listening Guide (Gilligan, 1982) is a feminist relational method which requires that researchers adopt a stance where they listen to marginalized and oppressed people (Miller, 1976, as cited by Gilligan, 2015). Researchers need to be resisting listeners, who resist the constraints of dominant patriarchal logic (Brown et al., 1993). According to Gilligan and Eddy (2017) in order to create trust and to give respect to each participant, the researcher must have a genuine curiosity and be open to surprise, discovery or having one's view of the world shaken.

When researchers listen with openness, and they replace judgement with curiosity, they become focused on discovering what they don't know, and that is when they really approach others as experts on their own story. The research team adopted this stance as they analysed the participants' transcripts.

Step 1: Listening for the plot and listeners' response to the interview. In Step 1 the first listening was conducted. According to Gilligan et al. (2003), the first listening consists of: (a) listening for the plot and (b) the listener's response to the interview. First researchers sat together as a group and individually read through the text, while attending to each participant's story or plot. They tried to identify what was happening (what, when, where, with whom and why), the cultural context and the larger context in which the story is being told. Attention was given to silences, pauses, lowering or trailing off of voices, repeated images, metaphors, dominant themes, salient themes, contradictions, and that which was not expressed or was absent and so on. Researchers took notes throughout the analysis process, noting the multiple meanings seen in the data. Then the researchers wrote down their own responses to the interview. According to Gilligan et al. (2003) this can be when a researcher feels a connection with a person or not, and what thoughts the researcher has as he or she listens. The aim is for researchers to identify their own reactions so that they do not interfere with how they analyse the data. The research team discussed each others' responses to the plot and this process required the researchers to be aware of and explicit about their own emotional responses and subjective thoughts that emerge, because they shape the process of interpretation (Woodcock, 2010).

Step 2: I-Poems. In Step 2 the second listening was conducted. According to Gilligan et al. (2003), the aim of this step is for the researcher to listen to the participant's first-person voice to hear how he or she speaks about him- or herself. The purpose of this is so that the researcher comes into relationship with the participant and does not distance him or herself from that person in an objectifying way. As the research team read the transcript, they followed the use of the first-person pronoun "I". Each time the word "I" was used, the researchers underlined the "I" together with the verb or important accompanying words to create an "I" phrase. Each

phrase was placed on a separate line and the phrases were maintained in the order in which they had occurred in the narrative. Then the principal researcher took these phrases to create an I-Poem for each participant. The phrases were grouped into stanzas which reflected a shift in meaning or change in voice. According to Gilligan et al. (2003), sometimes the I-Poem reveals a meaning which is central to the narrative but not being said. The I-Poem is created so that while the participant speaks of being in the world, researchers can pick up on the associative stream of consciousness carried by the first-person voice, which runs through the narrative but is not expressed in full sentences. The I-Poem brings this subjectivity to the foreground so that the listener can attend to it in the narrative. Several I-Poems can be created for the same participant at different points in the interview, and it is possible to examine them in relation to one another to listen to how the first-person voice shifts throughout the narrative. The I-Poem helps the researcher to listen to the participant's first-person voice before listening for answers to the research question.

Step 3: Listening for Contrapuntal Voices. In Step 3 the third, fourth, fifth and sixth listenings were conducted. According to Gilligan et al. (2003) in this third step by listening for contrapuntal voices, the researchers identify those parts of the interview that may speak to the research question. This process involves reading through the interview two or more times, each time listening to one voice or part of the story. Step 3 of the Listening Guide was adapted to use the theoretical framework of the EA 4 FMs model (Längle, 1993), which shaped the researcher's guiding questions (discussed below). This adaptation involved conducting four listenings, once for each FM, to listen for different voices. Each time attention was paid to the voices that emerged within a specific FM theme. The first two listenings were conducted in Steps 1 and 2 of the Listening Guide. In Step 3, the researchers completed listenings three to six. The third

listening was for voices within the theme of FM1, the fourth listening was for voices within the theme of FM2, the fifth listening was for voices within the theme of FM3, and the sixth listening was for voices within the theme of FM4. Although there were four listenings, one for each of the four FMs, the process of identifying voices was iterative in that listenings were repeated or text was re-read in order to get agreement from the research team (see section on *listening for voices* below). By having multiple listeners, interpretations could be compared and discussed until agreement was found. Saturation and redundancy were factors considered through the procedure. Listenings were compete when saturation was reached and no more new voices were heard.

Guiding questions. According to Gilligan et al. (2003), Step 3 helps researchers to understand the different layers of a person's expressed experience. In step 3 all listenings were guided by the research question which is: "How do women's experiences of childbirth shape their embodied sense of self?" In addition to this the listenings were guided by the theoretical framework of the EA 4 FMs (Längle, 1993). In FM1 the question asked is: "I am here. Can I be?" In FM2 the question asked is: "I am alive. Do I like to live?" In FM3 the question asked is: "I am me. May I be myself?" and in FM4 the question asked is: "What am I here for? What do I live for? What gives my life meaning?" In summary, the listenings were guided by both the research question and by the question asked for each FM.

Coding. First the transcripts from each interview were explored to look for common themes for each FM. For each interview transcript, text relating to each FM was highlighted in a different colour (relational coding). Care was taken to use the same colours for the same FMs for all participants, for instance highlights for FM1 were in blue for all participants, FM2 in yellow and so on. When there was text that related to two FMs, it was highlighted in two

colours. Considering that Längle's EA 4 FM model is concerned with conditions for a fulfilled life, a fifth colour was used to differentiate voices which expressed fulfillment or suffering. Secondly, the voices which were heard within each FM were identified.

Listening for voices. Whilst listening for voices, attention was paid to the participant's first-person voice and contrapuntal voices that emerged within that FM. As the voices were identified, the relevant text was marked by underlining or writing descriptive comments into the margins of the transcript. Notes were taken throughout the data analysis process to reduce the data to a form which could be analysed, noting the researchers' point of view, as well as the multiple meanings seen in the data. These notes served as a decision-making trail for the course of this study, for the purposes of an audit. One physical master copy of each participant's highlighted transcript with notes was maintained, and later it was scanned in electronic form. They were stored in the main researcher's locked drawer and computer respectively.

According to Gilligan et al. (2003) it is possible that some voices are in harmony with one another and that some are in opposition or contradictory to one another. For instance, individual voices were opposing in that some expressed fulfillment and others expressed suffering. Gilligan et al. (2003) describe how the researcher listens for one voice, and decides whether it highlights a meaningful part of the interview. Then the researcher may listen for the same or different voices several times, each time fine-tuning the details that represent the voice. In this way the contrapuntal voices are identified. This process of iteratively tuning into voices allowed the researchers to identify voices which expressed the participant's multi-layered experience of childbirth.

Step 4: Composing an Analysis. In this fourth and final step the principal researcher pulled together and synthesized what had been learned through the participant voices in relation

to the research question. For each participant, voices were analysed to see what was learned about how women's experiences of childbirth shape their embodied sense of self. Then an analysis was composed.

First, the transcripts were re-read to extract statements which reflected each identified voice. Then these excerpts were organised in an Analysis Table by FM and voice category and they were colour-coded by participant (see Appendix I: Analysis Table). The Analysis Table provided the evidence on which interpretations could be based. After that, for each voice category, a description of the voice was given using statements from the Analysis Table. Then, for each FM an analysis was done in order to understand the relationship of the voices to one another within that FM. After that an analysis was created for each participant in order to bring together their I-Poems, and the many separated voices expressed by that participant, in order to understand the complexity of each participant's experience of childbirth, and how it relates to the research question for this study.

Methodological Rigor and Quality

According to Morrow (2005), the quality of qualitative research should be assessed according to the paradigms of the study. The feminist paradigm used in this study has constructivist and transformative elements, due to its emphasis on constructed realities, interaction with participants, and rich description, as well as social justice, and human rights. This section first discusses criteria for quality in qualitative research. These are Guba and Lincoln's (1994) criteria for credibility, transferability, dependability, and confirmability. Then criteria for constructivist research from Morrow (2005) are discussed. These are: for authenticity, depth of understanding for participant meanings, and mutual construction of meanings. Then criteria for quality in transformative research from Lincoln (2009) are discussed. These criteria

are: fairness, ontological authenticity, catalytic authenticity, community, attention to voice, critical reflexivity, and reciprocity. Then the criteria of subjectivity (gaining an understanding of the subjective experience of the participant), and the criteria of agreement and resonance are discussed.

Assessing quality in qualitative research. Mertens (2015) argues that in order to judge the quality of qualitative research in terms of rigor, Denzin, Lincoln, and Guba (2011) created as set of parallel criteria for rigor, which were intended to loosely achieve the same purposes as quantitative criteria for rigor. However, these criteria do not accomplish the same goal as rigor in quantitative research because qualitative research is based on different knowledge claims than quantitative research. These parallel criteria consist of: credibility (which corresponds to internal validity in quantitative research), transferability (external validity), dependability (reliability), and confirmability (objectivity).

For credibility, researchers are required to have "deep and close involvement in the community of interest combined with sufficient distance from the phenomenon under study to record accurate observed actions" (Mertens, 2015, p. 269). The sub-criteria for credibility are: prolonged and persistent engagement, peer debriefing, member checks, negative case analysis (which was not used for this study), progressive subjectivity, and triangulation (which did not apply to this study). *Prolonged and persistent engagement* was achieved through in-depth interviews (which were long enough for participants to tell their story), by gathering thick descriptions of the participant's experiences of childbirth, and understanding the culture and context in which the birth experience took place. *Peer debriefing* was achieved through working with other researchers to analyse the data. *Member checks* were achieved at the end of each interview by summarizing what was said by the participant and asking if the notes taken

accurately reflected the participant's story. They were also achieved by analysing data as a group of researchers through reflexive sharing of research which was collaborative, open-ended, reflective and critical. Acknowledging that each researcher has a different reality and to ensure that knowledge was constructed without bias, this analysis process was considered as a discussion to elaborate on the emerging themes which added to the source data.

Progressive subjectivity was achieved during steps 1 (Listening for the plot), 2 (composing I-Poems), and 4 (composing an analysis) of the Listening Guide method, which were carried out by the principal researcher by keeping a journal of my own developing constructions to document the process of change throughout the study. These constructions were shared with the research team in order to challenge individual biases and understandings. Step 3 of data analysis was carried out by a research team, which met regularly to discuss the interviews and the participants' subjective experiences as well as to reflect on the researchers' own experiences acquired through the listenings.

Transferability, according to Mertens (2015), is the qualitative parallel to external validity (Guba & Lincoln, 1994); it enables comparison between research. Although the results of this study are not generalizable, there was sufficient data for the transferability criterion to be met by maintaining and providing thick description for multiple cases so that the reader of the research had enough detail about the context and complexity of the research setting to be able to make a judgement about the similarities and differences of the research findings and how they might transfer.

Dependability, according to Morrow (2005), is the qualitative parallel to reliability and it requires that the way in which a study is conducted should be consistent across time, researchers, and techniques. Although consistency cannot be ensured in constructivist research because

change is expected, the process of research should be repeatable as far as possible by tracking the research design and keeping an audit trail of the processes, analysis, and emerging themes. The audit trail should be tracked and be available for inspection. A dependability audit was met through regular checks about the study (semi-structured interviews, conceptualisation, data collection, data, analysis and results) by a research team. Dependability was also met through maintaining consistency of roles, such as that of the primary researcher and research team as responsible for data analysis.

Confirmability, according to Morrow (2005), is the qualitative parallel to objectivity (Guba & Lincoln, 1994) and it requires that findings should represent the situation being researched (Morrow, 2005). A confirmability audit is used to show that data and the integrity of the findings can be tracked to the original source, and the logic used to interpret the data is made explicit so that the reader can confirm the adequacy of the data. The confirmability audit is conducted mostly in the same way as the dependability audit so that other researchers can evaluate whether conclusions are supported by the data. The confirmability audit and chain of evidence were met by providing enough qualitative data such that it could be tracked to its source, which is the participant, thus highlighting that the researcher's judgement was minimized. In addition, the logic used to interpret data was made explicit so that a chain of evidence was provided confirming how data was synthesized and how conclusions were reached.

Assessing quality in constructivist research. The aim of this study is to understand how women's subjective lived experiences of childbirth shape their embodied sense of self. Although a feminist lens has been used in this study, the Listening Guide method (Gilligan, 1982) is also constructivist because it is used in this research to increase participant awareness of their childbirth experience and how it shapes their sense of self. In order to assess quality in

terms of constructivist research, Morrow (2005) suggests using authenticity criteria for trustworthiness, which are based on the work of Guba and Lincoln (1994) as follows: fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity. *Fairness* requires that researchers solicit and honour different viewpoints or constructions throughout the research process, and this was achieved by sharing the data and analysis with team members, soliciting and honouring their viewpoints. *Ontological authenticity* is maturing, expanding, and elaborating participants' individual constructions. Based on member checks, this was determined to be achieved through participants gaining a better understanding of their childbirth experiences. C*atalytic authenticity* refers to the extent to which the participant has been moved towards action. This was achieved through the participants interviews when they talked at the end of their interview experience about how, after their interview, they saw their childbirth experience in a more positive light, and that this created a more positive sense of self. *Educative authenticity* means enhancing participants' understandings for the constructions of others (Morrow, 2005). Educative authenticity was achieved by talking to the participants about their experiences, and validating their constructions by placing importance on their subjective experience of childbirth. It was also achieved by telling them about the aims of this study to complement mainstream conceptualisations of childbirth with a view of women's subjective childbirth experiences. Morrow (2005) also proposed additional constructivist criteria: "(a) the extent to which participant meanings are understood deeply … and (b) the extent to which there is mutual construction of meaning (and that construction is explicated) between and among researcher and participants, or co-researchers" (p. 253). In order to validate and better understand the participant meanings the interview results were analysed by the researchers as a team, and each researcher expressed his or her construction which was then discussed as a team.

Mutual construction of meaning was achieved by researchers making their assumptions for interpretation of the data explicit; personal biases could be recognised and challenged by the research team if they interfered with the interpretation of the participants' unique experiences.

Assessing quality in transformative research. Although a feminist lens has been used in this study, this research is transformative on an individual level for participants because it aims to challenge oppressive structures and conceptualisations of childbirth which restrict opportunities for women and their families during childbirth. In order to assess quality in transformative research, Mertens (2015) suggests using authenticity criteria as a type of validity. The authenticity criteria, based on the work of Lincoln (2009), are as follows: fairness, ontological authenticity, catalytic authenticity, community, attention to voice, critical reflexivity, and reciprocity (Mertens, 2015). For this study, fairness, ontological authenticity, and catalytic authenticity were the same as described by Morrow (2005) and have already been discussed as part of the constructivist paradigm above. C*ommunity* means that as research takes place within a community; it affects that community, too. Hence the researcher is expected to link the results to positive action within the community as well as establishing a sense of trust and mutuality with the participants. In this study, a sense of trust and mutuality was achieved via the researcher spending time with each participant before the interview in order to understand the participant's context and culture. The positive outcome of the interview was through the acknowledgement of the woman's subjective experience of childbirth. The *attention to voice* criteria refers to seeking out those women who are silent and marginalised, and this was achieved by bringing attention to women's voices regarding their childbirth experiences. The *critical reflexivity* criteria acknowledge that all knowledge is contextual and it required the researcher to acknowledge the context of the research. The principal researcher keept a journal of her

interpretations of the research process and her awareness of the psychological state of the participant. The *reciprocity* criteria were concerned with giving back to the community and this was met by increasing awareness about childbirth which will hopefully result in findings from this study to be incorporated into mainstream conceptualisations of childbirth. The *praxis* or *social change criteria* is an extension of the catalytic authenticity criteria. For this, researchers need to reflect deeply to understand the implications of bringing change to a particular setting (Mertens, 2015), and understand that real change can occur if facilitated by a collaborative relationship between the researcher and participant. The criteria for praxis or social change was met by using the Listening Guide method, which gives attention to voice in understanding the participants' subjective experiences of childbirth and how they shape their embodied sense of self. The transformative aspect of this study was to challenge mainstream conceptualisations of childbirth to include a view of childbirth from the subjective lived experience of the woman.

Subjectivity. In feminist research the researchers' beliefs are valued as necessary for understanding a subject's lived experience. So rather than claiming researcher's objectivity, the researcher's values are made explicit before conducting research (Breuer & Freud, 1986). Research may involve the researcher being immersed in the participant's life and as a result, identifying with the participant's experience. Through this process both the participant and the researcher are changed in some way, and results can be presented in a way as to bring about social change. In this study I, as the principle researcher, was deeply immersed in the participants' childbirth narratives and I could identify with their experiences. I was changed through this process because I felt that my own experiences of childbirth were not uncommon. The participants were also changed because they felt that they were able to share their childbirth experiences in a safe setting and they all felt that they could understand their experience in a

more positive light.

Agreement and resonance. In transformative and constructivist research, qualitative methods are used to gather many perspectives via multiple sources to support the validity of findings. Different researchers can have different perspectives and rigor of the study is based on its thick description (Ponterotto, 2005). The Listening Guide Method (Gilligan, 1982) is designed to encourage agreement and resonance, where multiple listeners (interpretive community) analyse interview data via multiple listenings using relational coding (multiple codings of the same text). The goal is not necessarily agreement, but rather the exploration of the different connections and interpretations that each listener has (Gilligan et al., 2003). The researchers use the backdrop of their own multiple experiences to enter into relationship with participants' stories, to understand them in their complexities, and to allow themes to emerge. In this way, the researchers' values are included in the research. This study was consistent with both the feminist paradigm in addressing the forms of oppression of women as well as the ways of knowing, because the Listening Guide is concerned with voice, resonance and relationship to understand the human psyche (Gilligan et al., 2003). This method is universal in application because everyone has a voice or a way of speaking that makes the silent inner world visible to others (Gilligan et al., 2003).

CHAPTER 4: RESULTS

> Women often need to talk about the labor, ponder it, mull it over, and make sense of it. They have to put into words what they felt. For them, labor was not experienced at a verbal or cognitive level. They have to match what happened on the inside … with what others saw. This process of integrating and understanding these various parts takes time and effort. (Simkin, 1992, p. 77).

This study was designed to explore how women's experiences of childbirth shape their embodied sense of self, and this was done by listening to the stories of childbirth experiences of six participants called: Alice, Barnie, Janelle, Jess, Tara and Susan. The Listening Guide (Gilligan, 1982) was adapted for this study to use Längle's Existential Analysis Four Fundamental Motivations (4 FMs) model. As previously discussed, the intention of this study was to allow researchers to engage personally with the participants' birth stories, and to analyse their stories with an openness to hearing and honouring their unique experiences and to connect with the many voices in their narrative. Consistent with the Listening Guide (Gilligan, 1982) and feminist research, this study allows participants to shape the methodology and analysis as the research develops (Gilligan et al., 2003). As the research team immersed themselves in the data, they better understood the participants, themselves, and each other. According to the method (see Step 3 of Data Analysis, guiding questions), the researchers were guided by both the research question, and by the questions and conditions for fulfillment for each Fundamental Motivations (FM) as summarised in Table 1.

Table 1

Guiding Questions

RQ: How do Women's Experiences of Childbirth Shape Their Embodied Sense of Self?			
FM	Relates to	Existential question	Conditions
1	World	I am here. Can I be?	Space, Protection and Support
2	Life	I am alive. Do I like to live?	Relationships, Time, and Closeness
3	Self	I am me. May I be myself?	Attention, Justice and Appreciation
4	Meaning	What am I here for? What do I live for? What gives my life meaning?	Meaning, Purpose and Context

Note. RQ = Research Question, FM= Fundamental Motivations

These questions and conditions provided a way to identify the different voices in each participant's psyche. As the researchers read the participant narratives, they highlighted statements which reflected each identified voice within each FM. These statements were organised by voice and FM into an Analysis Table (see Appendix I: Analysis Table), and this represents all voices that emerged in this study and provides the evidence on which analysis could be based.

This chapter begins with an overview of the voices that emerged to show the voices within in each FM and the voices expressed by each participant. Then for each FM, an overview of the FM is given, then a description of each voice within that FM, and an analysis of the relationship of these voices to one another. Then for each participant, her I-Poems are presented with an analysis of the voices she expressed, and a summary analysis of the relationship of these voices to one another. In order to understand the complexity of the participant's experience, the summary discusses whether the voices expressed were mainly those of fulfillment or suffering, which voices were most predominant, which resonances and dissonances emerged between the

voices, and what this participant said about how her embodied sense of self was shaped by her childbirth experience. After that the findings are discussed. Tables are presented to show how fulfillment, suffering, embodiment and disembodiment were expressed in each FM, and a discussion and a table are presented on what participants said about how their embodied sense of self was shaped by childbirth.

Overview of Voices

The voices identified had two overarching themes: voices of fulfillment, and voices of suffering. Although the voices are shown in pairs, for instance, empowerment and disempowerment, participants may express either of these voices at different moments during childbirth. A total of twenty-five voices were identified as shown in Table 2.

Table 2

Voices

FM	Voices of fulfillment		Voices of suffering
1	Empowerment	⟷	Disempowerment
	Trust	⟷	Mistrust
	Acceptance/ Endurance	⟷	Struggle
2	Connection	⟷	Disconnection
	Accompaniment	⟷	Abandonment
	Taking Time	⟷	Time Pressure
3	Being Seen	⟷	Disregard
	Appreciation	⟷	Judgement
	Uniqueness	⟷	Conformity
4	Meaning	⟷	Meaninglessness
	Belonging	⟷	Not Belonging
	Choosing	⟷	Not Choosing

Note. FM = Fundamental Motivations, 1= Existence, 2 = Life, 3 = Being Oneself, 4= Existential Meaning.

Table 3 provides an overview of which participants expressed which of the twenty-five voices that emerged through this study.

Table 3

Voices per Participant

FM	F/S	Voices	Alice	Barnie	Janelle	Jess	Tara	Susan
1	F	Empowerment	✓	✓	✓	✓	✓	✓
		Trust		✓	✓	✓	✓	✓
		Acceptance					✓	✓
		Endurance		✓	✓	✓	✓	
	S	Disempowerment	✓	✓	✓	✓	✓	✓
		Mistrust	✓	✓	✓	✓	✓	
		Struggle	✓					
2	F	Connection	✓	✓			✓	✓
		Accompaniment					✓	✓
		Taking Time		✓			✓	✓
	S	Disconnection	✓	✓	✓		✓	✓
		Abandonment		✓	✓	✓	✓	
		Time Pressure						
3	F	Being Seen		✓			✓	✓
		Appreciation	✓	✓	✓		✓	
		Uniqueness	✓				✓	
	S	Disregard			✓		✓	
		Judgement	✓	✓	✓		✓	
		Conformity	✓					
4	F	Meaning	✓	✓	✓	✓	✓	✓
		Belonging	✓	✓	✓		✓	
		Choosing		✓	✓		✓	
	S	Meaninglessness						
		Not Belonging						
		Not Choosing	✓					

Note. FM = Fundamental Motivations, 1= Existence, 2 = Life, 3 = Being Oneself, 4= Existential Meaning, F = Fulfilment, S = Suffering, ✓= voice expressed

The childbirth experience has aspects which cause suffering and aspects which bring fulfillment, and that the experience of the participant is dynamic and shifting from moment to moment. The birthing woman can experience moments of suffering and moments of fulfillment.

Therefore, these voices can be seen as simultaneously reflecting different aspects of the experience, appearing sometimes momentarily and sometimes constantly and with some voices being more predominant than others. Although these results will show that some participants speak more with voices of fulfillment and suffering or vice versa, this should not be taken as the participant's overall feeling of fulfillment or suffering, as it is possible that the participant speaks with many voices of fulfillment, but that one small voice of suffering can leave an imprint which overshadows the other voices. Rather it is necessary to look at each participant's expression of how this experience shaped them.

FM1 Overview

The first fundamental motivation (FM1) is concerned with existence and one's physical presence in the world. In FM1 the existential question being asked is "I am - Can I be?" It refers to how one experiences conditions for survival, such as space, protection, and support. If these conditions are lacking, one cannot accept the conditions of one's life, and one feels unsafe, insecure, and restless. If these conditions are present, one feels trust in oneself and the world that one can survive, have room to breathe, and have a sense of ability. One can have a fundamental trust in oneself and in others, and this allows one to accept the facts and conditions of one's life as one's reality, and to bear what is difficult and this acceptance leads to a sense of ability (Von Kirchbach, 2003). In terms of embodiment, FM1 is concerned with the whole person's survival which includes one's spiritual grounding as well as the body's physical abilities and limitations (Stankovskaya, 2014). In this thesis project, the voices within FM1 are shown in Figure 1.

Fulfillment		Suffering
Empowerment	⟷	Disempowerment
Trust	⟷	Mistrust

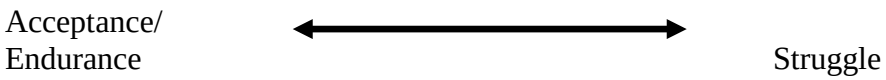

Figure 1 FM1 Voices

FM1 Voices of Fulfillment

Voice of empowerment. The voice of empowerment occurred as participants showed an ability to speak about their birth experience with certainty and confidence. The voice was identified when participants said that although they had not given birth before, they had a sense of knowing what to do, knowing that they had the ability to give birth and to endure the pain of childbirth, and this led to a sense of empowerment. For instance, Susan said calmly that "I could handle the contractions pretty well … I remember thinking … its manageable, the breathing process worked really well to keep in control." Alice said she felt unsure when she told her nurse "I think you need to check me, how dilated I am, I feel like I have to push." When the midwife agreed, Alice was surprised and laughed that her sense was correct, thinking "Oh! Maybe I do know something … I can do that!" Jess's eyes lit up as she said "I felt the need to push … it felt like my body knew what to do and I knew." Barnie was proud when she said "Yes, I felt that because I can do that, I am strong." Susan felt happy that her body could do this "It was that strength that, yes, I think that also surprised me." Janelle said with a sense of pride that "No matter how exhausting it was … I got through that … it was the hardest thing I ever had to do, so if I can survive that, then I must be strong, even if I don't feel it," she said "I'm … stronger than I thought I was."

Voice of trust. The voice of trust occurred when participants expressed that they had trust in their own capacity to give birth, or trust that they would be supported by others such as caregivers, family and friends. The voice of trust was identified before the voice of empowerment was identified, because it was identified when participants expressed *trust in their*

capacity to deliver a baby. For instance, Janelle said assuredly that: "I just mentally prepared myself and then I was able to physically follow through." Jess was very sure of her own intuition: "I think I trust myself a lot. I trust my instincts and what feels right." Susan also trusted her ability to control her own emotions such as fear: "I was also anxious of course, … I remember saying … 'OK, I think I can do this.'" Barnie took pride in her physical strength: "I was a very strong girl… I was quite strong enough to bear the pain … I did not feel scared … I felt I can do it." The voice of trust was also identified when participants *trusted their family*. For instance, Barnie was sure she would have died without her mother's help. She stuttered as she had a fever for a few weeks during her first pregnancy and she explained "My mother was the pillar. If she had not helped I don't know how I would have done it." For some women, *trusting others meant having skilled caregivers and a calm and relaxed atmosphere in which to birth.* Susan calmly related that she and her husband had decided that "'we feel safer going to a hospital … I accept that things can go wrong, and that if that happens I am in the best hands." Susan also recalled that "they gave us that, that, breathing space … it was our little bubble … I could take it in my own pace and space, so it felt good … that's why we called it our home birth in the hospital."

Voice of acceptance. The voice of acceptance occurred when participants spoke about accepting the circumstances of giving birth. The voice of acceptance was identified when participants expressed that they *accepted that they did not have the type of birth they had wished for*. For instance, Jess rationally and calmly said she accepted that she would not be able to deliver naturally due to her baby's large head. Barnie, who delivered at home in Uganda, accepted the decisions of her caregivers. She said that although she had a hemorrhage and needed stitches "they just wrapped me up for the night without stitches … the doctor cannot

come at one am, … you cannot wake the doctor, he does not come in the night." Susan was surprised because she thought she knew what to do, and she had to accept that she did not because her baby was born so fast. She said laughingly that "I don't like losing control … it forced me to accept that you can't control what's happening … and that's ok."

Voice of endurance. The voice of endurance is one where women spoke of deciding to bear with the situation and agree to it even if they did not like it. For instance, Janelle, who cried because she was not happy that there were so many intern doctors who came into the delivery room to watch her deliver a baby. She felt exposed and upset, but she was able to calm herself during the birth and she said determinedly: "In some ways, I felt empowered … Because, most of the people in the room from what I can recall, were male, and I'm thinking "I'm doing something that you will never do!", so I was kind of like 'Let them watch!'" In this situation there was no space for Janelle to deliver her baby in a quiet room, instead the room was crowded with strangers. There was also no protection from strangers or support from a doctor who could have asked her permission. Although none of the conditions for FM1 were met, Janelle decided to endure the situation because the baby was coming anyway. Barnie was not emotional when she said that her doctor stitched her up without any pain medication and she said "It was so painful …we don't know what the reasons are for what they do." Although she was in great pain, she decided to endure it, because she felt that her midwife and doctor were well qualified. For Barnie it was worth it because at least she and her baby would survive in their care.

FM1 Voices of Suffering

Voice of disempowerment. The voice of disempowerment occurred when women spoke hesitantly, with uncertainty, and lack of confidence, with phrases such as: "I'm kind of sure," "I think," and "I didn't know." Experienced by five of the participants, this voice was expressed as

not knowing, disembodiment, a lack of support from caregivers, a lack of having control, a lack of access to women with birthing experience, and blind trust to caregivers. The voice of disempowerment was identified when *women expressed not knowing*. For instance: Barnie was embarrassed to relate that she had no knowledge about childbirth, and she said "I did not know … what's supposed to happen. I did not even understand that my water had burst." Some women felt their *birth classes had not prepared them well*. Tara was frustrated when she said "it didn't really do much to prepare you … we didn't get a sense of the enormity of what it was." Some women expressed *disembodiment, a feeling of self and body as separate*. For instance, Jess who had a prolonged and painful labour, said she felt separate from her body. She seemed to be angry and hurt and she almost cried as she said "So um I pop out of my mind at this point." Janelle also had a long labour, and she cried a lot as she related that "I just was getting shouted at a lot, and I felt like I was watching this happen, like I was kind of out of my body, … It was kind of traumatic!" Janelle cried as she described a separation from her body as "It was not like I could see above, it was more like I was floating above myself and everything sounded like an echo, and the voices sounded like they were at a distance, and it was hard to focus." Similarly, Susan was calm as she said: "I sometimes felt, I think, dissociated from my body… it was something that was there [laughing], rather than it was me." Her voice shook as she referred to the deaths of her parents: "I haven't always been … strong in … health … but what happened to my parents during my pregnancy, it was … a roller coaster emotion … that, … contributed to … some dissociation from my body." Tara sounded desperate as she referred to the pain "by that time, my endorphins had already kicked in, and I was in a completely different planet altogether … I was completely in another zone and I could tell I was both here and I was not here." All participants *expressed feeling a lack of control*. Alice wept when she said her mother had died

when she was young: “I didn’t have my mother … and I wished my mom had been there… I had nobody I could ask [about how to give birth].” Finally, some women *felt unsupported by their caregivers*. For instance, Tara felt angry when she said “I didn’t want to have the drugs. But right from the time I got there, um, you know, my nurse … started talking about the epidural, … overall, it was not very empowering, no, not at all.” For instance, Jess expressed enormous hurt when she said she had laboured for thirty hours before she was given a C-Section, and although she spoke matter-of-factly, she was clearly still traumatized by her experience. She said “I kind of wish maybe they hadn’t maybe let me go on so long.” She felt that her caregivers did not protect her from suffering unnecessarily and she felt helpless and disempowered.

Voice of mistrust. The voice of mistrust occurred when participants spoke with hesitancy and an air of feeling forced or ignored or not listened to, and it was experienced by five participants. *Some expressed fear for their own survival.* For instance, Barnie’s voice stuttered as she recalled how afraid she was. She said “Our neighbour’s daughter …after pregnancy she died, she was only nineteen… [my mother] was scared of my... my… my… health … somehow, I barely managed.” *Some felt mistrust that their body could not do what it is supposed to do*. For instance, Jess expressed her frustration that her baby’s head was too large, and she could not deliver it. She said “your body is just … not doing its job properly.” *Some felt their body had been invaded.* For instance, Alice sounded disgusted when she said “I felt like my body is not necessarily my own … there’s something inside of me that has taken over.” *Some felt their body was overpowered by others.* Jess remembered feeling helpless: “it was kind of like other people took over and um it got to a point where I really couldn’t think for myself, and that was a very helpless feeling.” *Some women said they did not trust family members to take care of them.* Barnie was angry at her in-laws when she said “I started having a fever … my temperature was

not going down and I had the side effects from tablets and all that….and still I had to work, work, work."

Mistrust of caregivers was present in many forms. For instance, *some felt helpless because their caregivers did not protect them from strangers* walking into the room, checking them and invading their privacy. Janelle felt humiliated and angry when she said "they brought interns to watch … there was no consent on my behalf … they wanted to check my cervix … I totally lost all dignity …I felt very vulnerable, exposed … there's nothing I can do about it." *Some women felt upset that their primary caregivers left them to deliver with strangers.* Tara was angry when she quietly said she could not believe it when her doctor informed her that "Its Father's Day, so I'm gonna … spend some time with my kids." *Some participants did not feel they received skilled care.* Jess said "I didn't feel safe, mentally, physically." Janelle was crying as she said "the baby got stuck and they had to use a vacuum on me [Ventouse birth] … and it broke, inside of me, and they had to get another one … it was really painful." *Some were upset that their caregivers did not ask for consent before performing an intervention.* Alice was indignant and she cried when she said "She was examining me, and then she broke my membrane, without warning me." Similarly, Tara was tearful when she said "She didn't even ask me, but she … flicked a membrane off … she told me after." *Four participants felt they had received unnecessary interventions.* Jess's eyes welled up with tears as she said "I can see the way they say, well if you start with one intervention than it can tend to snowball. After an exhausting thirty-hour labour Jess had to have an emergency C-Section. She cried as she said: "They strapped my arms down and I didn't like not being able to move … being tied down on the table … it just didn't feel right. The way I was there on the table, in the surgery." Jess cried, saying "they took the baby out … I couldn't touch her or hold her or anything with my arms

strapped down." Similarly, Tara said she felt bullied by her nurse "right from the time I got there, they started talking about the epidural, and "it started to feel very forceful." Tara related that they decided to induce her contractions with Pitocin. She said "because I had been induced, it was a whole lot intense all of a sudden, it was not gradual, I didn't, it didn't prepare me for the sudden onslaught of all that pain." Later Tara cried a lot and asked for an epidural even though she had not wanted to take any medication. Here the voice of mistrust was expressed by the participant as feeling that her caregiver was forceful in suggesting medication which was clearly against her wishes, and that she did not explain that induced contractions are more painful, making it difficult to forego medications. Tara felt very disempowered later when she realised that being induced meant painful contractions which led to her asking for an epidural that she had not wanted. She said she felt cheated of the experience of a natural birth. *Some participants did not feel that they were given all the information they needed.* For instance, Jess wished that her caregivers had told her earlier that a natural birth was not possible, because she was exhausted from a prolonged labour. Jess said "The drugs were never mentioned … If I'd been able to think clearly, I probably would have said, give me the C-section, yeah. But that never came up." *Some participants were upset that they were not allowed to move around.* Tara wanted to move around during the birth in order to cope with the pain: "They did the ultra sound … his heart beats are not steady … they don't want me walking around too much … I, I, I can't imagine being strapped on my back to the bed" Tara said "I realised I'm, I'm completely immobile … I'm, I'm slowly starting to, you know, starting to feel a little sense of despair … I thought "Oh my God, I don't know if I can do this." In some of the more extreme examples such as those of Jess and Tara, the voice of mistrust was accompanied by fear, helplessness and a feeling of being trapped.

Voice of struggle. The voice of struggle is one where women spoke with an air of frustration, silence, feeling they were not in agreement, or having no choice or control. They spoke in sentences that had words like: "I can't," "I'm done," and "I didn't choose this." The voice of struggle is expressed in relation to exhaustion, complications, and body changes. *All participants expressed feeling exhausted.* For instance, Alice said "it was just very overwhelming, I was just completely exhausted." Janelle was angry as she said that there was a point where she thought: "I can't do this anymore, I'm not strong enough … I'd been up for like 2 days. When its so painful, and you're … being literally ripped open from the inside out, and … everybody's yelling and arghh!" Similarly, Jess was sad as she said: "you just are living moment to moment, contraction to contraction … just like, get this over with, I'm just, I'm just done and now." *Some endured complications.* Barnie's voice sounded exhausted as she said she had a hemorrhage: "There was so much blood, so much … the blood filled the towel beneath and began to fall on the floor, it flew out, and then quickly she gave me an injection and she made me a drink, Brandy."

Some participants struggled with how their body had changed through childbirth. For instance, Alice was sad as she recalled: "I felt like I didn't choose this, it was thrust upon me and um, and the way it effects your body, I have stretchmarks … I still don't like them, and I just felt like 'This isn't fair.'" Here the voice of struggle was expressed by the participant as feeling unhappy with the changes in her body.

Analysis of FM1 Voices

Birth is primarily about the survival of the mother and her child. Therefore, it is not surprising that the participant's stories are rich with experiences which relate to FM1. The voices of FM1 express rich detail about the conditions for space, protection and support. In FM1

the existential question being asked is “Can I be?” The voices that answered “yes” to this question were the voices of empowerment, trust, acceptance. The voices that answered “no” to this question were the voices of disempowerment, mistrust and endurance. These voices are in dialogue with one another such as the voices of empowerment and disempowerment, trust and mistrust, acceptance/endurance and struggle. FM1 refers to how one experiences conditions for survival, such as space, protection, and support. These conditions were heard in the voices that emerged. For example, protection and support were heard in the voices of trust/mistrust. Being able to trust oneself or others meant that the participant felt protected and supported. Feeling mistrust to self and others meant the participant felt unprotected or unsupported. Similarly, the voice of acceptance referred to accepting the conditions of giving birth, the voice of endurance meant bearing with the conditions of birth even if one did not like them, and the voice of struggle referred to being unable to bear with the conditions of giving birth. The difference lay in the amount of freedom one experienced. Freedom is an experience of space, it can be physical space, or space to breathe, move, think, not worry, and choose. The voices of acceptance and endurance expressed having freedom and space due to the fact that the participant made a choice to accept, whereas the voice of struggle expressed a lack of these conditions and no choice. In summary, a real sense of being and empowerment (voice of empowerment) was facilitated by having space, protection and support, whereas a sense of disempowerment (voice of disempowerment) was expressed when any of these were missing.

Embodiment is most clearly seen in FM1. For example, it is expressed in the voice of empowerment, as having a sense of knowing what to do during labour and having a sense of one’s ability and strength. Embodiment is expressed in the voices of acceptance and endurance as having space to tune into and care for the needs of the self as a body, to relax, to introspect,

and it is also expressed in the voice of trust as a sense of safety. Disembodiment also emerges clearly. For instance, in the voice of disempowerment, disembodiment is expressed as being passive and helpless in the body, not trusting the self in the body, a lack of strength in the body, a sense of fear, a sense of being overpowered or invaded, and of not knowing what to do. In the voice of mistrust, disembodiment is expressed as a lack of safety, a sense of being taken over, and in the voice of struggle it is expressed as not being able, restriction, and exhaustion.

FM2 Overview

The second fundamental motivation is concerned with Life, and it is concerned with the quality of one's presence in the world, one's search for value of life and one's attitude towards life. In FM2 the existential question being asked is "I am alive - Do I like to be?", which refers to the conditions for liking life such as relationships, time, and closeness. If these conditions of are lacking, one questions whether one likes being in the world, and one retreats inward, experiences a void, coldness, longing for connection and depression. If these conditions are present, one devotes time, and this means that one likes being in the world, and one experiences affection and warmth in relationships, resonance with the world and oneself.

In terms of embodiment, FM2 is concerned with the experience of "being alive", the body's lived experience that life is good, and that being alive is joyful (Stankovskaya, 2014). The voices within FM2 are shown in Figure 2.

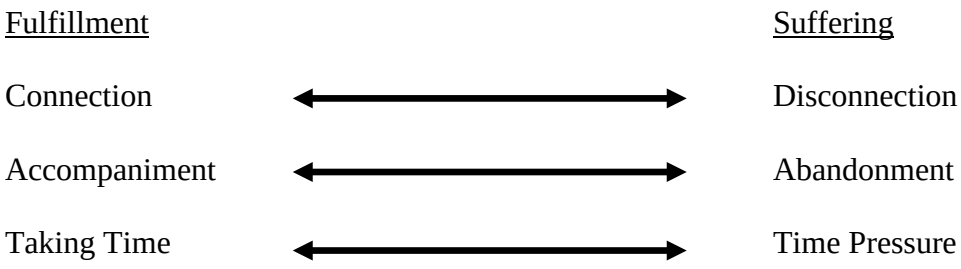

Figure 2 FM2 Voices

FM2 Voices of Fulfillment

Voice of connection. The voice of connection is one where women spoke with a sense of connection to life, a turning towards life, a lust for life. With this voice, women expressed their felt emotions, such as love, joy, and a bursting with life about giving life. The voice of connection was expressed by all participants in the study in relation to finding out that they were pregnant, feeling a connection to family, a connection to the baby, and a connection to self. *Some women expressed they felt more connection to family* from the moment when they found out they were pregnant and through to childbirth. The voice of connection was expressed by Tara, Susan, and Barnie. For instance, Tara felt more connected with her husband when she found out that she was pregnant. She said "we looked at each other and [were] beaming at each other, not quite believing that this is what it was." She also felt more connected to her mother when she told her on the telephone. She said happily that "That was a very, very, happy moment for me." Tara said she was bursting with happiness: "I was really excited." Susan described her happiness when she said "we were very happy to have a baby coming, very excited." Barnie smiled when she said "I had a lot of love from others in the family and community … my father took me for a walk in the evening every day." She said there was a lot of excitement in her maternal home as this was the first baby being born there after so many years. *All of the women talked about feeling a connection to their baby.* For instance, Jess smiled and said "They popped her head over the top of this little blue sheet … it was instant. I was just like, I'm in love. Like it was just instant connection." Janelle said: "it's nice to love and be loved unconditionally … when you see that kid and it's yours and you're connected and it's beautiful and its perfect and it grew inside of you, and you're like "Oh wow, I made that!" Barnie said "When I looked at her I felt so much love. I loved that baby." Tara said when she first held her baby, it was "awesome,

amazing, it was completely unreal! I couldn't believe that this was my baby! That I had made this baby! … He's my kid! I'm a mother! … it was a happy moment." *Susan expressed that she felt a connection to self.* She explained that before she had children, although she had liked her body, she had not felt connected to it. After the birth, she felt more connected to her body. Susan described this as follows: "I sometimes felt, I think, dissociated from my body, where I was always, I think a mind person living in my head, rather than in my entire body." Susan calmly said that after the birth: "it felt more like a unity here … I felt a bit more connected and strong." Here the voice of connection was expressed by the participant as connecting to her embodied sense of self.

Voice of accompaniment. The voice of accompaniment was one where women expressed a feeling that they had a relationship with people around them, whether family, friends, or professionals. In childbirth it was expressed as a feeling that one was not just seen as a patient, but seen and treated as a person, with respect and courtesy. The voice of accompaniment was a feeling of not being alone, and a feeling of accompaniment and it was expressed by Jess, Janelle, Tara, and Susan. For instance, Jess laughingly said she felt she had a connection with her caregivers some of whom were from her home country. She said: "it was kind of fun … they pulled her out… and I got to hold her … I think my husband was holding her … they put her on my chest … wow, it was just great." Janelle cried as she said, "There was one nurse present. She was, um, she held my hand for a lot of it actually." Janelle also felt happy about the caregivers for her second birth, she said: "they really knew what they were doing, and um, very warm and welcoming … and my mom was there again and my husband. Tara said "The nurses were really amazing. Whoever I had as my nurse, they were very supportive … I

felt like I was in good hands with them."

Voice of taking time. The voice of taking time was one where the women described a feeling of having enough time and it was expressed as feeling more relaxed or taking it easy. Some women said that they felt they had time to enjoy the pregnancy, to prepare for birth, or to allow the birth to go at its own pace. This was expressed by Barnie, Susan, Jess, and Tara. For instance, Barnie happily talked about taking time during her pregnancy to think about her baby. She said: "My father used to sit with me and told me to … think good things … send the baby good messages … I was reading good things, religious books. My father r-r-read…took me for a walk in the evening." Similarly, Susan's voice really slowed down when she said she felt that during the birth she had "breathing space … it was our little bubble … it felt, it felt good." Jess also talked about taking time during her second birth, which was a scheduled C-Section. Jess felt that for her second birth, because she was not so exhausted, she was "more relaxed and more content." Jess felt she could take time to bond with her baby: "I got to hold her." Overall, during childbirth, the voice of taking time was expressed by the participants as taking time for all aspects of giving birth. For instance, taking time to: enjoy the pregnancy, connect with the baby, create an atmosphere of intimacy, allow the contractions to progress at their own pace, not to feel rushed into having interventions, and plan for a C-Section if needed.

FM2 Voices of Suffering

Voice of disconnection. The voice of disconnection is one where women spoke with a sense of disconnection to life, a turning away from life, a distancing or separation from life. The voice of disconnection was expressed by all participants in the study as isolation, disconnection to self (self and body as separate) and a disconnection to others**.**

Isolation. Alice expressed a sense of isolation because her mother had died when she

was only eight years old. When her husband referred to the baby as an alien her sense of isolation increased. Alice said "I mean I was hurt, but, … that made me feel, probably made me feel more alone in uh this endeavour."

Disconnection to self. Some women expressed feeling numb, a disconnection to their own feelings. For instance, Janelle said that she felt traumatized that so many people were in the delivery room. "Numb is a good way to describe it," she said. She felt a numbing out of emotions due to having her private parts displayed to people who were strangers. Janelle also expressed that she felt silenced. Janelle said: "I felt very, like vulnerable, and um, exposed … I was in a lot of pain, I remember thinking that I did not want my mother to worry about me so, uh, I was quiet and I did not make much noise."

Disconnection to others. Some women felt a sense of disconnection to others due to social ignorance of caregivers or feeling distanced from loved ones. Jess said: "I didn't have that community … my parents … weren't over as much, or available as much as I, I guess I had hoped." Susan talked about the death of both of her parents. Tara said that she was glad that her mother was with her, but she was sad that her mother was frail and could not help her. *Social ignorance* on the part of caregivers was detected when they were disinterested or hurtful. For instance, Barnie described feeling disconnected when she said: "she [midwife] was screaming at me … she was very rough … it was not caring … I felt upset … she was rude." Here she felt disconnection because she felt hurt. Jess also talked about not being able to bond with her newborn daughter because the baby and her husband were taken away to another room and Jess did not get to hold her baby right away. Tears welled up in her eyes as she said: "It took me a while to actually bond with my daughter because of how tired and traumatized I was." Some participants expressed a sense of disconnection because they felt distanced from their loved

ones (especially parents or close family) due to physical distance, death, or relationship issues. For instance, Susan whose parents died when she was pregnant said, "I was really sad, … its, its, always hard to have to say goodbye to parents." Alice cried as she talked of her family's disapproval of her: "it was an unplanned pregnancy, and I was young and scared and we were newly married and um, we didn't have a lot of family support, I didn't have my mom." She said that was "the hospital that my mother had died in, and I don't think I had been back to that hospital until …. well until we did the tour… and I knew I was going to deliver my daughter there."

Voice of abandonment. The voice of abandonment is one where participants spoke with a sense of not being properly cared for by their caregivers. With this voice, women expressed their felt emotions such as rage, anger, frustration, neglect, a lack of continuity of care, a desire to protect oneself and the baby. *Some participants said they felt angry about their body not functioning the way it was supposed to and it was as if their body had abandoned them.* For instance, Jess said she felt angry when she could not deliver vaginally "and even though [I knew before that] it couldn't happen that way, it pissed me off. That they were saying that … maybe it affected my connection with my daughter." *Some expressed a sense of abandonment due to caregiver neglect*. For instance, Janelle said: "she [doctor] was teaching the resident how not to hurt herself when she was delivering the baby [with a vacuum]." She said angrily "I kind of, I actually felt a bit neglected, I kind of felt a bit ignored, and then they were just shouting at me, "Stop pushing! or Not yet! or Now's the time to push!" *Some women felt their caregiver did not advocate for them.* Jess said she felt angry that after her C-Section her midwife did not speak up and ask for her to be able to hold the baby as soon as she was born. Jess said: "I felt like maybe she could have asked … with midwives! … would you not advocate for that? … It ticks me off."

Some women expressed anger that they received superficial care from caregivers. Alice's doctor told her she was leaving at 4:30pm to go away for the Easter weekend. Alice said: "I thought she was staying until the baby was delivered." *Some expressed anger that they had a stranger as caregiver due to lack of continuity of care.* Janelle said: "I feel that if you are going to do that, give birth, then you should do it with people that you trust, and I didn't feel I trusted them, I didn't feel that."

Voice of time pressure. The voice of time pressure was expressed by Jess, Janelle, and Alice, and it occurred when participants spoke with a sense of being rushed. With this voice, women expressed that they had no time to bond with their baby, that their caregivers did not take time to take care of them, that they ran out of time to have the procedures they had requested, or that they felt a sense of being rushed to deliver the baby. *No time to bond with baby.* Some participants expressed that they missed valuable time with their baby because their caregivers took too long to give them their baby after it was born. For instance, Jess was upset as she felt the time lapse between delivering her baby and being able to hold her was too long and that this made it difficult to bond with her baby afterwards. She said "I think that, that might have affected things too, it felt like a long time. I, I don't know, probably like 45 minutes." *Pressure to deliver quickly*. Some women felt pressured to accept interventions to speed things up. Alice said that her doctor increased the oxytocin because she was going away for the weekend, then she left to deliver another baby and left Alice to deliver with strangers. Alice said angrily "then the doctor came in, um, yeah, right about then, like it was almost immediately after, and I said "Oh! you're too late!" She also said, "There was no time for an episiotomy so I tore…I asked

for an epidural and I didn't have it because I didn't have enough time."

Analysis of FM2 Voices.

FM2 refers to how one experiences value in life and one's attitude towards life. The FM2 conditions for liking life are such as relationships, time, and closeness. The voices of FM2 express rich detail about these conditions. In FM2 the existential question being asked is "Do I like to be?" The positive voices that answered "yes" to this question were the voices of connection, accompaniment, and taking time. The voices that answered "no" to this question were the voices of disconnection, abandonment, and time pressure. These voices parallel voices which are in dialogue with each other, such as the voices of connection and disconnection, accompaniment and abandonment, taking time and time pressure. The conditions of relationships, time, and closeness were heard in the voices that emerged. For example, relationship and closeness were heard in the voices of connection/disconnection and accompaniment/abandonment. Feeling accompaniment from one's partner, professionals and family meant that one felt cared for and one had relationship with others and this gave a sense of connection, continuity of care and one felt touched by life. Without accompaniment and relationship, the voice of abandonment emerged. Suggesting that one did not feel cared for, there was no continuity of care, and this led to a sense of rage, anger, and a feeling of neglect, and the participant felt a desire to protect the self and the baby. The voice of taking time referred to time to enjoy the pregnancy, prepare for birth and to create an intimate atmosphere in which to give birth as well as bonding with the baby. Having time meant time to enjoy life, and to feel close to people (closeness), to feel loved and cared for. Time pressure referred to others not taking time to care for me, having interventions to make the birth go faster and caregivers rushing to go back to their private lives. Feeling that there was no time to bond with my baby

led to a feeling that one was not cared for (lack of relationship) and there was no time to feel close to others (lack of closeness). When the voices of accompaniment and time were present, this allowed the voice of connection to emerge, which created a feeling of connection caring, and emotions such as love, a lust for life, kindness, a turning towards, and a bursting with joy. When the voices of abandonment and time pressure were present, this led to a feeling of disconnection, loneliness, alienation, turning away, distancing, and grief. Therefore, a real sense of liking life was facilitated by the voice of connection, which expressed having the conditions of connection such as relationships, time, and closeness, the voice of disconnection expressed a lack of these conditions.

Embodiment is expressed in FM2 mostly in the voice of connection, as feeling a sense of connection to the self, and to the baby, it is a sense of feeling whole and of tuning into one's intuition in the body. Embodiment is also the feeling that one can rely on oneself and it is expressed in the voices of accompaniment and time as feeling an embodied sense of being cared for, love and connection, not feeling rushed. Disembodiment is expressed mostly in the voice of disconnection, and time pressure as: isolation, alienation, not having connection to the self or the baby, a separation of mind and body, feeling overpowered by anger. Disembodiment is also expressed as rushing, not having time to connect with self or baby, and feeling alone.

FM3 Overview

The third fundamental motivation asks the question "I am myself - Am I allowed to be (me as distinctive and unique)?" and it is concerned with one's world, one's identity and authenticity. FM3 refers to conditions for being oneself such as Attention, Justice and Appreciation. If these conditions are lacking, one does not have consent to being one's own person and one experiences loneliness, one hides behind shame, and hysteria may develop. If

these conditions are present, one can consent to one's own person, and one is capable of reaching authenticity, comfort and self-respect. In order to feel allowed to be, a person needs to make the decision to respect oneself and this leads to a sense of one's own worth and consent to one's sense of self. Together these experiences constitute self-worth, authority and consent to be one's own person. In terms of embodiment, FM3 is concerned with identity and authenticity, the sense of self in the body, the sense of personal agency as well as creating a social identity that authentically relates to oneself in the body (Stankovskaya, 2014). The voices within FM3 are shown in Figure 3.

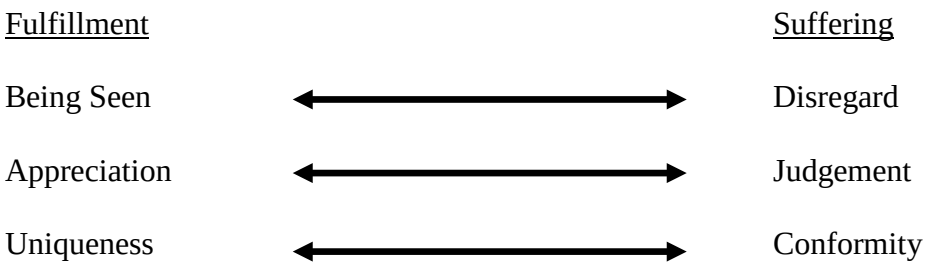

Figure 3 FM3 Voices

FM3 Voices of Fulfillment

Voice of being seen. The voice of being seen is one where women felt that they had been seen or acknowledged by others in their role or identity as a mother and that their wishes had been considered by others. All of the participants expressed this voice as receiving acknowledgement in the new role of mother from others and oneself. All of the women expressed that they *felt a shift in their identity or role; the way they saw themselves.* For instance, Alice said "For me, having a baby was huge and that gave me my sense of identity." Jess said: "My whole view of my self and my place in this world or in life had to shift … you go from being me … to mother and that, that's the biggest, the most important role I've ever had." Tara said "It was just this moment in the middle of the night when they brought him to me and I

thought 'I am his mother.'" When she was asked what it was like to be a mother, Janelle said: "nice … its nice to love and be loved unconditionally." Barnie said "I thought I am a mom, and I loved that baby." Susan said about being a mother: "its like, kind of opening a complete new part of yourself … to develop yourself so immensely in that role of being a mother."

Voice of appreciation. The voice of appreciation is one where women felt valued because their wishes had been considered by others. They could value themselves as mothers, feel valued by others in their role as a mother, and value other mothers. Here the voice of being appreciated was expressed by five participants: Alice, Barnie, Janelle, Tara, and Susan. *Some participants expressed that they valued their bodies through the childbirth experience.* For instance, Tara said that during her pregnancy "I was looking a lot prettier." Janelle said after the birth: "I had never had any body issues … stretchmarks should be seen as, warrior stripes … your belly's going to sag … you just have to accept that … and wear it as a badge of honour instead." Janelle also said "I can look at other women too now and appreciate that about them [bodies post childbirth], and know that they are trying, but that they shouldn't really have to." Here the voice of appreciation was expressed by the participants as valuing their body after childbirth without judgement.

Some participants expressed that they felt valued in their role as mother and they could value themselves in that role. Alice said happily that she felt valued by her nurses when she said "well, and the nurses listened to me and so … I do have something to contribute here." Alice said she valued herself as a mother "Yes, I remember feeling that "I am a good mother.'" Similarly, Susan was happy when she said "Yes, I think maybe I also learned to rely more on my intuition." Tara was happy when she said that she felt valued and nurtured by many people around her, she said they were: "Teaching me how to nurse him …and my mom was trying to

recall from her experience." Janelle said she was also able to value others in their role as mother. Janelle said mothers need help and that "no-body has it all together."

Voice of uniqueness. The voice of uniqueness occurred when participants felt that they could be their authentic selves, express their feelings, set boundaries, and decide for themselves what they wanted, and it was experienced by four participants Jess, Alice, Susan, and Tara. *Some participants expressed that the need and ability to create boundaries to protect the self so that the self is not lost in the process of giving birth and following or obeying instructions.* For instance, Alice said that during her second pregnancy: "I chose the timing, made a conscious decision that this time it is going to be different, and um, the pregnancy was different." Jess also set some boundaries after her first birth. She said: "I feel like … from that birth experience … that was the point of [deciding] I'm important." *Some participants expressed the need to advocate for themselves and make and stand by their own decisions.* For instance, Jess said: "I know that, what I choose for my, my kids or what my husband and I choose is what's best for us, and that it doesn't have to be what other people think is best." Tara said she and her husband had agreed that she would not take any pain medication during the birth. Later, although her husband was upset with her, she was in pain and decided to take the medication, and she felt happy about this decision.

FM3 Voices of Suffering

Voice of disregard. The voice of disregard occurred when participants had the feeling that they were not seen, they experienced a loss of self, and a feeling that their wishes were dismissed or not listened to by others, and it was experienced by five of the participants: Alice, Barnie, Tara, Janelle, and Jess. For instance, Alice said that after giving birth she thought "OK, I am just a mother, and there is no more me … the only thing that is important is my children."

Here the voice of disregard was expressed as a feeling of not being seen. Jess said that she trusted her caregivers but that they did not care for her properly. She felt her wishes were not considered when "a new one [midwife] came on and she seemed a bit more dismissive of some concerns … It just put that little kind of, you know, bad feeling into the situation." Jess also said that her midwife ignored her wishes of wanting to hold her baby right away when she was born. She said "I'm a very, touchy feely connection kind of person, and to not have that with my daughter … it was um unsettling."

Voice of judgement. The voice of judgement occurred when participants were concerned with one's interpretation of the world: judgement of me by self and others, labels that tell me the type of person I am, what others have told me about myself, how I see myself, how I think others perceive me. In this voice, women felt silenced because they did not want others to worry about them, or judge them for being too loud, or they wanted to be a good patient, or they wanted to show that they could birth well, and this voice was experienced by five participants: Jess, Tara, Alice, Barnie, and Janelle. Some women expressed that they felt shame for getting pregnant. Alice said she felt shame because she was unmarried when she became pregnant. Alice said "it was an unplanned pregnancy, and I was young and scared and … um, we didn't have a lot of family support." Tara, on the other hand, said she felt shamed by her doctor for having a birth plan. Tara said "I was still naive [because it was my first baby] … I felt like it [birth plan] was not liked [by the doctor]", Tara felt like he was saying: "Hey I've seen a lot of these … this is a new mom syndrome … and hey I'm the professional, I know better, it doesn't work like that" She said "I kind of felt like a fool at the time." Here the voice of judgement was expressed by the participants as not having their wishes considered by their caregivers.

Some women expressed a sense of feeling judged by others. They expressed that they felt

unable or not willing to make any sound when birthing, because they were afraid to be judged, or to cause worry to others or they were unsure of how others would respond. For instance, Barnie said: "I was in a lot of pain, and I made no noise, otherwise everyone in the house would hear. It was not done." She said "I remember my mother and grandmother had laughed about my aunt who had screamed so much during the birth. The whole neighbourhood knew." Janelle also talked about being quiet. She said: "I felt very, like vulnerable, and um, exposed … I was in a lot of pain, I remember thinking that I did not want my mother to worry about me so, uh, I was quiet and I did not make much noise."

Some women expressed judging themselves for their birthing performance. They based this on their ability to follow instructions and be a good patient or being able to deliver without taking any drugs and be a good mother. For instance, Barnie wanted to be a good patient and she said "I just followed instructions." Tara judged her own performance because she felt her husband was so disappointed that she was not able to deliver her first child without an epidural. She also spoke about her guilt towards her baby. She said that her baby did not fall asleep at night and "I used to think it was because I had the epidural, maybe because of the drugs that were in my system when he was born." Similarly, Alice also said: "I had a lot of preconceived notions and ideas about what it meant to be a mother and a wife … I had ideas in my head of when I become a mother, I'm going to do it this way and it's going to look this way."

Finally, some women felt upset that their body image had been ruined because their body had been altered through childbirth. Alice talked about being angry about ruining her body. She said: I felt like, after having children there is never any going back." She said "I always struggled with my self-esteem, and, so if I felt like I was attractive, then I was ok, um, so yeah, for me, pregnancy and childbirth all that really threatened that physical sense of attractiveness."

Here the voice of judgement was expressed by the participants as judgement of self for having an epidural, and judgement of the changes to their body.

Voice of conformity. The voice of conformity occurred when participants had the feeling that they did not have permission to be themselves and that they had to conform to the wishes of others, and this voice was experienced by Jess, Tara, and Barnie. For instance, Jess was upset when she said "I didn't feel like I had permission to be myself, permission to ask for things, and I, I, I didn't feel physically or mentally capable of asking for it either at that point." Tara was also upset when she also talked about feeling that she did not have permission to be herself. She said "I was just, I was talking to them, I was incredibly polite saying all of my pleases and thank you and all of that." Tara said she felt she felt pressured to obey her caregivers' suggestions and she said: "It began to feel forceful … They were kind of thrusting it [epidural] on me, every time she came to check me, she was like, "Why do you want to feel the pain?" Alice said that she felt the need to be attractive: "Am I attractive? and did men find you attractive, that was my concern."

Analysis of FM3 Voices.

FM3 refers to how one experiences conditions for being oneself, such as Attention, Justice and Appreciation. Childbirth shapes a woman's sense of self as she embraces her new role as a mother. The voices of FM3 express rich detail about the conditions for Attention, Justice and Appreciation. In FM3 the existential question being asked is "Am I allowed to be me?" The voices that answered "yes" to this question were the voice of being seen, appreciation and uniqueness. The voices that answered "no" to this question were the voices of disregard, judgement and conformity. These voices are parallel voices such as the voices of being seen and disregard, appreciation and judgement, uniqueness and conformity. The conditions of Attention,

Justice and Appreciation were heard in the voices that emerged. For example, in the voice of being seen, attention can be recognised as being seen and listened to by others, which led to feeling acknowledged and that one's wishes were listened to. Justice is seen in the voice of uniqueness, as being able to decide for oneself and to set boundaries. Appreciation is recognised in the voice of appreciation as feeling valued by others and as valuing others. Similarly, lack of attention means that the voice of disregard emerges and one feels not seen or that one's wishes are not considered. Also, when justice is not provided, the voice of conformity emerges and one feels unvalued and under pressure to obey the wishes of others. The voice of judgement emerges when one does not feel appreciated, and this leads to a feeling of embarrassment, and judgement. A real sense of being oneself (voice of uniqueness) was facilitated by having attention, justice and appreciation, whereas a voice of conformity was expressed when any of these were missing. In FM3 embodiment is expressed in the voice of being seen, as being acknowledged, in the voice of appreciation as feeling valued, and in the voice of uniqueness as feeling a sense of dignity. Disembodiment is expressed in the voice of disregard as not seen or loss of self, in the voice of judgement as judgement of self, and in the voice of conformity as conforming to the wishes of others.

FM4 Overview

The fourth fundamental motivation is concerned with continuous becoming and change, and asks the question "I am here, for what purpose? What do I live for? (purpose and meaning)". FM4 refers to the conditions for finding meaning, purpose and context and it refers to having a sense of being able to transcend oneself, and to have purpose and meaning in life. In order to feel a sense of purpose and meaning, a person has to make the decision to be open to living their life in a meaningful way, to become active and engaged and committed to people, aims, or

values in order to experience fulfillment. FM4 leads to a consent to the challenges and opportunities encountered, which provides a sense of existential meaning in one's life. In terms of embodiment, FM4 is concerned with the human body as a means of production of meaningful cooperation with others and constructing a better future (Stankovskaya, 2014). The voices within FM4 are shown in Figure 4.

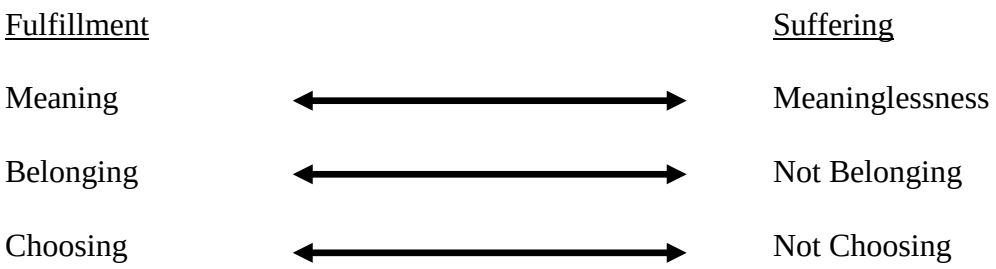

Figure 4 FM4 Voices

FM4 Voices of Fulfillment

Voice of meaning. The voice of meaning or sense of purpose occurred when participants spoke with purpose, meaning, a sense of contributing and happiness, joy or elation, and this was expressed by Alice and Tara. *Some participants expressed that they found a lot of meaning in giving birth*. For instance, Alice said about motherhood "it certainly gave me for many years my reason for living … that is the greatest accomplishment in my life." *Some expressed that they found meaning in contributing to others by sharing their birth story.* For instance, Tara was able to contribute her experience to others. When I shared this birth story online in my blog, there were so many moms who … could not have that natural birth experience, who had hungered for it, and who had had caesarians … they shared many tears of, regret … through hearing my experience, it kind of came full circle for them. They were so engrossed in, in, in reading my story that they could kind of live, live, live it, and then somehow, be fulfilled from it. *Some expressed pure happiness*. For instance, Tara described how happy she felt after her second birth

"this was such a happy birth, and it was such an empowering one, that I was, I was happy, I was literally happy!"

Voice of belonging. The voice of belonging occurred when participants felt a sense of belonging, felt connected to their womanhood through the rite of passage of giving birth, felt a sense of pride in being able to give birth and felt an ability to accept and love oneself. *Some participants expressed that they found a sense of belonging just from giving birth.* The women used words such as "beautiful", "amazing", "I know what my body is designed to do." For instance, Janelle smilingly said she felt proud of giving birth, and she said "Oh wow, I made that!" After the second birth Tara beamed as she said: "I was in completely in awe of my body, in awe of God's design, and the way that he has engineered the whole thing, you basically have to get out of the way, you just have to kind of get out of the way and let things kind of happen, and just breathe and flow with it. So, I had let that happen, and I had felt such a sense of achievement through that, and I felt so incredibly lucky … so, I completely had an amazing sense of myself, because of birthing the way I did the second time. Jess said happily, "it's everything. I wanted to have a kid, it's everything. I think it has to be." Janelle said, "I think that childbirth opens up the world for you, and it puts you into a world of other people that have experienced childbirth" "it changes how you relate to people … and it's a bit of a bonding experience I guess." Barnie smiled and said, "I thought I am a mom, and I loved that baby …. I felt it is my duty to be a good mom." Tara said, "my second birth … that was the experience that I cherish, that is the truest sense of being a mother." Susan said, "it [giving birth] was a beautiful experience actually." Susan said thoughtfully: I found it such an impactful experience, … it is such a really, a power of nature almost going through your body … it kind of opens up a new dimension … it's such an amazing experience to feel life growing inside you, to go through the

whole birth experience and to hold this little person in your hands, I don't think, that I can compare it to anything that I have experienced.

Some expressed that giving birth was experienced as a rite of passage and connection to one's womanhood. All of the participants felt this way. For instance, Janelle "it was just fascinating to me that my body could do this, like I grew a human you know." Janelle said that "just knowing that that's how a woman's body was created, it was to procreate … knowing that I was created to be able to give birth to a healthy baby, that makes me feel strong …its changed me forever." Tara said her second childbirth experience was empowering because she had no interventions. She said: "I felt so amazing, … I had done it … completely empowered. Everything I had missed out the first time, I got it," she said. "I knew that this is how a birth is supposed to be like, and I felt very grateful for that." Tara also smiled when she said, "This was such a happy birth, and it was such an empowering one, that I was, I was happy, I was literally happy!" Janelle also said, "Just knowing I'm giving birth and bringing a life into the world is empowering." Alice said, "I did feel kind of a sense of, I guess a power that I was able to give birth to the baby," Similarly, Susan said, "I, I, felt strong and I was, I was literally quite proud, of myself that ... OK, I think I can do this, its manageable." Here the voice of belonging was expressed through connecting to being a woman, having the ability to give birth and having gone through this rite of passage.

Some women expressed that they found a sense of belonging from motherhood. For instance, Barnie said, "Mother is a very responsible job, we are responsible for the future whole next generation of the world." Susan – when asked what does it mean to you to be a mother? She said, "to me it means that the most uh, I think it's the most essential part, or one of the most essential parts of being me. Uh, it's such a core element and such an all-encompassing uh thing

to do." She also said, "it seemed that the more a mother is in connection and uh, with herself, the easier it is to be a mother."

Some expressed that they had found a sense of belonging in the circle of life. For instance, Susan said: "it was the circle of life on a square meter … one person in your life dying and another person coming in, it was a little strange, it's strange, and it's, its, it's a complicated situation." Tara said she was so proud of giving birth. She said, "It was the first grandchild, it was very symbolic, and I was completely carried in the sentiment of that moment." Alice said about becoming a mother – it is "something very selfless … I wouldn't change it!"

Finally, some women expressed that their sense of belonging included a sense of self shaped by childbirth. For instance, Janelle describes her sense of self as shaped by childbirth: "I feel like I have a place in the world." Susan was asked to describe how the birth experience shaped her sense of self after, and she said: "it's like adding such a … new role. … it also, requires you to … develop yourself so immensely in that role of being a mother that it's such an important part of who I have become." Susan also said about giving birth: "it's a kind of a box, a 24-hour box that you go through and then there's the rest of your life as a mother … I have felt that strength, that really, it was a beautiful experience."

Voice of choosing. The voice of choosing or desire occurred when participants felt a sense of being able to choose and advocate for their own wishes, and they felt active in their own life and had self-determination. *The voice of choosing was expressed by all participants as a desire to have a child*. Barnie said, "I wanted a baby." Alice said, "I always wanted children … I just really wanted to be with my kids." Alice said, "I want to get pregnant, I want a second child, and this is the timing." It was expressed as a desire to choose the caregiver, Alice said, "When it's my time, I want to make sure I have you [doctor]." *Some expressed a desire to choose how*

to give birth: Janelle said, “I knew I wanted to give birth in the hospital, and that I was fine with having an epidural.” Jess said, “I just was like I want to try this way [without medication] and if it doesn’t work that’s ok [to have medication].” Tara said: “I want to do this on my own [deliver without drugs]” then later she said, “I want the epidural I was just that desperate. So, I pressed that call button and told them just give it to me.”

This section discussed the positive voices of FM4. The next section will discuss the negative voices of FM4.

FM4 Voices of Suffering

Voice of meaninglessness. The voice of meaninglessness occurred when participants felt a lack of meaning or an empty void. In this study, all of the participants were able to find meaning in having a child and becoming a mother. However, Susan, who is a breast cancer survivor, hinted at a feeling of meaninglessness when she said that she had attended a memorial service for the mother of one of her children’s friends, who died of cancer and had to leave her 3 boys behind, aged 7, 9 and 11 years old. Susan said, “that was such a, it was such a hurtful and horrible experience, which was so hard to see that.”

Voice of not belonging. The voice of not belonging occurred when *participants felt a lack of belonging*. For instance, Jess said she suffered from post-partum depression after the birth of both her children and that it took time for her to feel a connection to her babies. After the birth, Jess’s depression made it difficult to enjoy time with her baby and feel a sense of belonging as a mother. Jess said: “I feel like … from that birth experience ... I didn’t feel important, because I had to prioritize my child, I admit this is not working for me and I’m struggling … it’s hard to ask people for help.” Jess also said: “My whole view of myself and my place in this world or in life had to shift. And I think I resisted it for a long time and I think that

might have contributed to my post-partum depression." She said, "to have your whole world shift from such a high pace of thinking sort of environment to goo-goo ga-ga and rattles and bottles was, like, was so hard for me … you go from being me … to mother." Here the voice of not belonging was expressed by Jess as lack of connection to other people as well as other mothers, and it was also expressed as difficulty in embracing her new role as a mother.

Voice of not choosing. The voice of not choosing occurred when participants felt a *lack of ability to choose* because the circumstances were such that one could not change them. For instance, Alice said about motherhood, "It means "everything [but] … this was not the plan … I guess I have no choice, this is when I am having kids." Here the voice of not choosing was expressed by the participants as feeling unable to determine any course of action.

Analysis of FM4 Voices.

FM4 refers to how one experiences conditions for finding meaning, purpose, and context. The voices of FM4 express rich detail about these conditions. In FM4 the existential question being asked is "What do I live for?" The voices that answered "yes" to this question were the voices of meaning, belonging and choosing. The voices that answered "no" to this question were the voices of meaninglessness, not belonging, and not choosing. These voices are aspects of parallel voices such as the voices of meaning and meaninglessness, belonging and not belonging, and choosing and not choosing. The conditions of Meaning, Purpose and Context were heard in the voices that emerged. For example, meaning and purpose were heard in the voice of meaning and this was expressed as finding meaning in motherhood, a sense of purpose in raising the child as a good citizen and having the context of support from family and friends. They were also heard in the voices of belonging and choosing. Similarly, Meaning, Purpose and Context were missing in the voices of meaningless, not belonging and not choosing. In summary, the voice of

meaning is facilitated by having purpose and context, whereas a voice of meaninglessness was expressed when these were missing. Embodiment is not seen so clearly in FM4, because it is seen in the presence or absence of: purpose or meaning in what one does, a sense of belonging to motherhood or womanhood (or not) and having the ability to choose. The next section discusses participants' I-Poems and gives an analysis of their experiences.

Participants

In this section an analysis was created for each participant in order to bring together their I-Poems, and the voices expressed by that participant. The intention was to bring the voices together to understand the complexity of each participant's whole expressed experience of childbirth, and how it relates to the research question for this study.

I-Poems, according to Gilligan et al. (2003), can reveal a meaning which is central to the narrative but not being said. The I-Poem is created so that as the participant speaks of being in the world, researchers can pick up on the associative stream of consciousness carried by the first-person voice, which runs through the narrative but is not expressed in full sentences. The I-Poem brings this subjectivity to the foreground so that the listener can attend to it in the narrative. In the following sections two I-Poems are given for each participant, one about suffering and one about fulfillment. They show that the childbirth experience has aspects of suffering and aspects of fulfillment, and that the experience is dynamic and shifting from moment to moment.

Alice.

The following table shows Alice's Suffering I-Poem and Fulfillment I-Poem.

Table 4

Alice I-Poems

Suffering I-Poem	Fulfillment I-Poem
I'm in so much pain	I actually gave birth to a real human being
I was panicked	I'm now a mother
I started to kind of be like a little more out of it	I felt empowered
I didn't have my mom	I don't know
I lost my mother	I could do this
I was really scared	I did that
I didn't really have anybody	I did it!
I didn't know	I was actually in awe
I didn't feel calm	I actually ended up with a real live baby
I didn't know what to expect	I was
I didn't want to know	I was surprised
I was just too scared	I can do that
I thought what if I died?	I did feel
I thought am I dying?	I did
I just tried not to think about it.	I guess a power
I don't know	I was able to give birth
I was just completely exhausted	I was a mom
I felt abandonment	I think that is the greatest accomplishment in
I, I had nobody I could ask.	my life

Analysis for Alice. Alice is fifty-years-old, she is of Canadian origin, and lives in Canada. She is the mother of two children. She has a twenty-five-year-old son and a twenty-three-year-old daughter, who were born in Canada in 1992 and 1995. Alice was aged twenty-five years when she had her first child. Alice cried as she described her first experience of childbirth. She spoke primarily with voices of disempowerment, disconnection, and mistrust. Alice's voice was primarily that of disempowerment as shown in her I-Poem. *The voice of disempowerment* was identified as Alice explained that her mother died when Alice was eight years old and she missed her a lot during her birth experiences. She said she grew up with her

father with whom she did not talk a lot, and she said she had few women in her life as she grew up. She said she felt she did not know what to expect during childbirth and she did not have access to a close woman friend or relative who could tell her about what it was like to give birth. Alice said that during pregnancy she felt a sense of separation (disembodiment) between her mind and her body, and she felt she was being invaded by the baby. Alice explained that she and her husband found the birth prep class to be too detailed and gross and so they stopped attending. Alice said that at the time she did not know about giving birth and she did not want to know. She said she decided that she would let the experts take care of it. However, this meant that Alice was uninformed and unprepared for giving birth. *The voice of disconnection* emerged as she described her family. Alice said she felt isolated because her extended family, who disapproved of her becoming pregnant so young, did not support her and because her husband reacted to her pregnancy with aversion, referring jokingly to the baby as an alien. Alice said she felt she could not count on her husband to support her during labour as he tended to faint at the sight of blood. *The voice of connection* emerged when Alice said she asked a friend to be in the birth room on the day, when she expressed a desire to be taken care of by an expert, and said she found herself a well-known obstetrician. *The voice of mistrust* emerged when Alice said she feared delivering her baby at the same hospital where her mother had died because she or her baby might die, and also when her obstetrician performed a procedure without Alice's consent. Alice said that as she was two weeks overdue and she had been having Braxton Hicks contractions, and that at her last check-up her doctor examined her and performed a membrane

sweep[2] without her consent. Alice said she was angry about this procedure and that if she had been asked she would have refused to give her consent. Alice said she no longer trusted that the doctor would provide proper care for her in the future. Alice explained that the doctor advised her to go to the hospital, but when she arrived there, as Alice did not have any contractions, the nurse applied a prostaglandin gel to her cervix in order to speed up her contractions. The gel was re-applied every few hours, and later Alice said that she was given an Oxytocin drip. Alice explained that eventually her contractions started, but as they were induced, they were extremely painful and she was unable to bear them. Alice's voice of mistrust was present when her doctor told her that she would be leaving early for a weekend trip away and she increased Alice's Oxytocin so that she would deliver before she left. Alice felt upset that instead of delivering Alice's baby, she left to attend to another birth, and she left Alice to deliver with strangers. When the doctor returned the baby had already been born. Alice said that she had thought that the doctor would remain by her side for as long as it took to deliver the baby. She regretted trusting her doctor to take care of everything. *The voice of not choosing* was present when Alice said she felt she had no choice about when she would get pregnant, because it just happened. *The voice of struggle* appeared when Alice said she did not feel it was fair that her body changed so much through pregnancy. *The voice of judgement* emerged when Alice said she felt upset that

[2] A membrane sweep is when the caregiver sweeps a finger around the inside of the cervix to separate the amniotic membrane from the cervix. The purpose is to cause the cervix to efface and dilate and to induce labour, which means it is done to bring on contractions.

her body was ruined through childbirth, and *the voice of conformity* appeared when Alice she said she always felt she had to be attractive for men, and that childbirth had threatened her physical sense of attractiveness. *The voice of appreciation* emerged when Alice said she felt she was acknowledged by the nurses for knowing how and when to push, and *the voice of uniqueness* emerged because she felt encouraged to be herself when her nurses listened to her wishes. *The voice of empowerment* was identified during Alice's first birth, when she asked the midwife to check her cervix because she had the urge to push. Alice said she had been passive up until that point and relying on the experts around her. When the midwife said that she was fully dilated, Alice said "maybe I had an experience of a slight shift in thinking, uh, you know, I'm actively going to do something here to make this happen. Whereas I felt like before, um, they were all, they were just going to do stuff to me, and it was all just going to happen to me." This gave her a feeling of empowerment which helped Alice later. During her second birth, Alice said she was more active and empowered and she began to tell her caregivers about how she wanted the birth to be. *The voice of belonging* emerged when Alice said that motherhood was a selfless act, and *the voice of meaning* appeared when she said that being a mother meant everything for her.

Overall Alice expressed the voice of disempowerment throughout the first stage of labour and developed the voice of empowerment in the second stage of labour, and this was important for Alice as it gave her a sense of herself as strong. The reason for this change was that once Alice realised that she had a good sense of knowing what to do during the birth, and how to push, she felt empowered (voice of empowerment) and this changed her belief in her capacity to give birth (voice of trust), motivating her to connect to the experience. She began to feel stronger and surer of herself (voice of trust) and also became more aware of her embodied

experience, which changed from being disempowered to being empowered, and from not knowing to knowing.

Alice said her second experience of childbirth was much more empowering than the first. She chose her family doctor to deliver her baby. Alice said she was much more vocal with her caregivers about what she wanted this time. For instance, she told them she wanted an epidural, but this was not needed. Alice said she delivered her second baby naturally and she felt amazed that she could do this and that she felt empowered by this experience.

Summary for Alice. The most prominent voice in Alice's story was that of disempowerment which is in FM1, and this was due to her need for protection through more support from her family and caregivers. The voice of judgement was also strong. Suffering is expressed in Alice's story through the voice of disempowerment, due to missing her mother, not having another woman whom she could ask about her experience of childbirth, and not knowing what to expect in childbirth. The voice of disconnection emerged from a feeling of isolation and lack of support from her husband and family. The voice of mistrust emerged due to a fear of death, a feeling of her body being invaded by the baby and a feeling that her doctor may perform more procedures without her consent. Fulfillment is expressed through the voice of empowerment due to knowing when and how to push, the voice of connection with the baby, and through appreciation from the nurses who listened, and the voice of meaning due to becoming a mother.

There is some dissonance when Alice said she did not know how to give birth, and that she did not want to know, but she wished she had a woman whom she could have asked how it was for her to give birth. She may have preferred to be looked after by an experienced female during this time. There is also some dissonance when Alice blindly trusted her doctor to take

care of her, but she had good reasons to mistrust her doctor. Dissonance is also evidenced when Alice said that motherhood was a selfless act, and that being a mother meant everything for her. On the other hand, she said that she felt as if the timing of her first pregnancy was thrust upon her. Alice explained this contradiction. She said that she had always wanted to be a mother, but not so soon, and that she did not like the process of childbirth and its impact on her body. Resonance was present when Alice spoke with empowerment when she described her second birth, and when she selected a different doctor and advocated for herself regarding the timing and method of giving birth.

When Alice was asked to describe how her sense of self was shaped by childbirth, she said her sense of self is that she has low self-esteem. She said that before childbirth she felt attractive, and now she feels less attractive than before. She also said that she felt less confident of herself in the first two years after childbirth and that she needed other people to tell her what to do as a mother. Alice said that whilst raising her children, she felt less important as she focused on her family's needs more than her own, and that now they are grown up, she is prioritizing her own needs again. Despite this, Alice's second experience of childbirth, which was more empowering than the first, led her to believe more in herself. She said that through childbirth, she was happy to become a mother (identity) and that she discovered a sense of herself as being strong and more capable than she had imagined. She has a sense of herself as a good mother and this has given her a purpose for living. She feels respected for being a mother, and for going through the rite of passage of giving birth. She said she feels as if she has a place in the world as a mother even though she did not know what it was like to have a mother.

Barnie.

The following table shows Barnie's Suffering I-Poem and Fulfillment I-Poem.

Table 5

Barnie I-Poems

Suffering I-Poem	Fulfillment I-Poem
I had a hot enema!	I was exhausted
I did not like it, it was not caring [the rudeness of the nurse]	I was relaxing
	I did not even think
I knew I could die, my neighbor did	I was watching her bath the baby
I pushed so hard	I looked at her [baby]
I strained myself that much	I felt so much love
I was completely cold	Everyone said I would have a boy
I was exhausted!	I thought its good you came even though it was a girl
I was doing this for 2 days	
I did not know what to do	I had a lot of support
I pushed it very hard	I had a lot of love
I had hemorrhage, there was so much blood	I felt I will be a very good mom
I was shaking like that [from being stitched]	I thought I am a mom
I was torn very badly, 35 stitches no anesthetic	I loved that baby
I had too many stitches, it was so bad	I felt it is my duty to be a good mom
I don't know what she did!	I knew about birth now
I was so exhausted	I loved her so much
I had not slept for 3 nights, day and night	I was her mom
I could not get up	
I was very weak	
I did not cry	

Analysis for Barnie. Barnie is eighty-four-years-old. She is of East Indian origin, born in Uganda, and lives in the UK. She is a mother to five children. The first four were daughters, then she had a miscarriage, and then a son. Barnie was twenty-five-years-old when she had her first child, and her children are aged fifty-seven, fifty-five, fifty-four, forty-six, and forty-four. The first three children were born in Uganda, in East Africa, and the last two were born in England. She is also a grandmother to four granddaughters and five grandsons aged five to eighteen years old. Barnie's first three babies were delivered by the same midwife in her

maternal home in Uganda in 1960, 1962 and 1963. Her last two deliveries were hospital births which took place in England in 1971 and 1973. In Africa, although she lived with her husband's large family in Tanzania, she delivered her babies at her parent's home in Uganda for the sake of her health. Barnie said that she delivered her babies in Africa at a time when the combination of poor medical conditions and the tropical climate increased the risk of mortality and death. As Barnie described her first experience of childbirth, she stuttered and paused a lot. She spoke primarily with voices of trust, empowerment and disempowerment. Barnie's I-Poem primarily reflects the voice of trust. Barnie said that her main focus was on survival for herself and her child, and that she tried not to focus too much on her feelings. The voice of abandonment was identified when Barnie said that at the beginning of her first pregnancy she lived with her husband's family in Tanzania, where she was responsible for a lot of housework and was not supported by her husband or his family with this work. Barnie said that due to lack of rest she became unwell and developed a fever which came and went over several weeks, and that she may not have survived if her mother had not intervened. The voice of mistrust emerged as Barnie said that most families knew first hand of women who had died in childbirth or who had lost their babies due to complications in childbirth. At that time in Uganda women's survival in childbirth also depended on support from family to remain healthy and most people in the community wanted to help in some way, often by sending good food. The voice of trust emerged when Barnie said she trusted her own family, and her doctor who had known her since she was a child. He told her "You need your body to be strong … you have to eat well and do whatever I say and make your body very healthy." Barnie said once she moved back to her parents' home, she received medical attention and iron injections from her doctor. Although the midwife had a reputation for being rude and unkind, Barnie said she chose this midwife because

she was a medically trained nurse who worked with her family doctor. At her parent's home Barnie said that her mom cared for her health. Barnie said "My mother was the pillar. If she had not helped I don't know how I would have done it." *The voices of connection and appreciation* were heard when Barnie said that she also received a lot of love and support from her parents and grandmother. Barnie cried a little when she said that her father took her out for a walk every evening and that he read to her each night. *The voice of taking time* emerged when Barnie said that in her Indian culture it was believed that a pregnant mother's thoughts would imprint on the baby, and her family went to great lengths to ensure her health and happiness, advising her to eat well, rest a lot, reflect on her baby and to send the baby good thoughts. *The voice of empowerment* was present when Barnie said she had always been a strong girl because she played a lot of sports, and that she was confident in her strength and ability to give birth. Barnie said "I did not feel scared … I felt I can do this … when you don't know what is going to happen, then you don't worry." She said "We [women in those days] did not know what it was [giving birth], we could not compare." *The voice of judgement* was present in the form of shame as Barnie explained that although she had a friend who already had children, she felt that she could not talk to her about childbirth. *The voice of disconnection* was heard when Barnie said that her midwife was very rude and unkind during all three births. Barnie said "My mother was there, she wanted to come in but she [midwife] wouldn't let her … I thought they are not allowed … there was nobody, nobody was there to hold my hand." Barnie trusted her midwife's ability, but she felt she got no compassion or kindness from her and she did not allow Barnie's mother to fill that role. *The voice of endurance* was identified when Barnie explained that her midwife gave her several enemas with hot water and hot spices over 3 days to induce labour which made Barnie feel unwell. Barnie said that as the contractions did not progress, and as midwife slept in

the same room as Barnie during the birth, they both became very tired. Barnie said that as time went on, the midwife yelled instructions at Barnie, who did what she was told. Barnie said that in her culture it was important to respect elders, and that she had been raised to be a good girl. She said she felt she was strong enough to take the midwife's yelling, and that she should just do as she was told. Barnie said she decided that even though she felt upset with her midwife, she put her feelings aside and decided to focus on her trust into her midwife's skill. She said "I felt that my nurse was the best, even if she was rude… she knew what to do … she was working with the doctor in the operating room and she was very qualified." Barnie said she had a hemorrhage after the birth and the loss of blood made her feel extremely cold, so the midwife administered an injection to stop the bleeding and gave her Brandy to warm her up. *The voice of disempowerment* appeared when Barnie said she lacked support from her mother, grandmother or school in terms of education about sexual reproduction. She said she did not feel that she had any knowledge of childbirth or an embodied sense of what to do. She could not remember having felt the urge to push in her first three deliveries. She said perhaps she felt unsure because the midwife was rude and she had no knowledge. Barnie said that she focused on following her midwife's instructions more than on her own sense of what felt right. So, when the time came to deliver the baby, Barnie simply focused on her midwife's instructions to know what to do. *The voice of endurance* was present again as Barnie recalled how she had survived her first childbirth experience. Barnie said she tore badly before the midwife could make a clean cut, so Barnie also needed stitches. She said "The baby came at 1am in the night… she just wrapped me up … and put me to bed until they stitched me in the morning." She explained that "you cannot wake the doctor, he does not come in the night." Barnie said that on the following morning, the midwife and doctor stitched the tear, but they did this without anesthetic and Barnie was in a lot of pain.

She said “They both stitched me live, with no injection, no anesthetic, they put my feet on a stool and I was shaking like that … I don’t know, he forgot the injection or whatever.” She also said “I said “it is hurting too much” and they said it will be over soon, and I was badly torn … I had too many stitches, it was so bad. There was no anesthetic.” She said “We don’t know what the reasons are for what they do.” *The voice of being seen* was present when Barnie said that she had an important role in being a mother. *The voices of meaning, belonging, and choosing* emerged as Barnie said she felt proud to be a mother, and that “Mother is a very responsible job, we are responsible for the future whole next generation of the world”. She said “I thought I am a mom, and I loved that baby …. I had a wonderful time, motherhood, I really enjoyed it”, and “I wanted a baby”. Barnie said her last two pregnancies took place in England, and at the time she was aged 37 and 39. She said that in England she attended birth preparation classes with her husband. Barnie spoke with the *voice of empowerment* when she said that she and her husband both became knowledgeable about childbirth, that her husband attended the births of their fourth and fifth children, and that those births were much easier.

Overall Barnie said she remembered feeling disempowered because she did not know how a baby is born, and she had a fear of dying in childbirth and yet her embodied experience was one of empowerment. Barnie’s story highlights the importance of choice. She chose to trust her caregivers, she chose to believe she was strong enough to give birth, and she chose to be involved in the birth. Her embodied experience was one of empowerment and strength in her body, which shaped her sense of herself as a strong and good mother.

Summary for Barnie. The most prominent voices in Barnie’s story are those of trust and empowerment, which are related to FM1. The analysis of Barnie’s story reveals that the voices of fulfillment are stronger than voices of suffering. The voices of suffering in Barnie’s story are

mostly those of disempowerment, due to not knowing or being educated about how to give birth, and mistrust due to a fear of death, as well as disconnection due to the midwife's yelling. Fulfillment is expressed through the voice of empowerment due to feeling strong enough to deliver the baby, through the voice of trust regarding trust to her family, doctor and midwife, as well as through the voice of meaning due to the responsibility of becoming a mother, the voice of belonging due to experiencing motherhood, and the voice of choosing due to wanting and having a baby. There appears to be some dissonance when Barnie talked about her first childbirth experience as: "that was a giant trauma in my life." Barnie said that although she felt very hurt by the midwife's rough approach, she trusted her midwife, as evidenced by her going to the same midwife for her following two deliveries. Barnie explained that this was due to how rudimentary medical care was at that time. There is a lot of resonance between the voices in Barnie's story, as Barnie was consistently motivated by a desire to survive.

When Barnie was asked to describe how her sense of self was shaped by childbirth, she said that before childbirth she already had a sense of herself as physically strong, and that just after childbirth she felt her strength had been confirmed. Although she felt it was worth going through the pain and some trauma of childbirth, she said she had an initial sense of herself as disconnected from others. For instance, she felt disconnected from her midwife who was rude and unkind, from her in-laws who did not support her in her pregnancy, and from her baby due to exhaustion and trauma. She said she felt strong because she gave birth and that this made her feel she would be able to handle motherhood too. She believed that she was already a good mother because she had taken good care of herself and given birth to a healthy child. She said she had a sense of self as a learned mother who fulfilled her duty to her children by doing her best. For instance, she felt that even though she was not educated in how to look after a child,

she took the time to learn from her friends, from her own experience, and by studying for courses in health sciences (nutrition) and first aid. Barnie said she really enjoyed motherhood, that she feels satisfaction and pride in being a mother and that this experience was a right of passage to womanhood for Barnie, who did not know anything about giving birth beforehand. Being a mother also gave her a sense of belonging and a good status in her family and in society.

Janelle.

The following table shows Janelle's Suffering I-Poem and Fulfillment I-Poem.

Table 6

Janelle I-Poems

Suffering I-Poem	Fulfillment I-Poem
I kind of, I actually felt a bit neglected	I have stretchmarks
I kind of felt a bit ignored	I call them warrior stripes
I just was getting shouted at a lot	I did that
I almost felt like I was watching this happen	I grew people
I was kind of out of my body	I wear it as a badge of honour
I was kind of, "What is going on down there?"	I feel more confidence I think
I got a third-degree tear, and I had 37 stitches	Who am I? I'm a mom.
I remember screaming a lot, it was painful	I feel empowered
I don't know, I lost all dignity	I felt empowered and that is separate from
I felt very, like vulnerable and exposed	the post partum depression
I was in survival mode	I can survive that
I was floating above myself	I must be strong, even if I don't feel it
I didn't, I was just being shouted at	I think deep down, I think that I am strong
I don't know what she all did, because there	by the grace of God
were so many people in the room	I don't know, [being a mother feels] nice
I lost all dignity that day	I don't know, I like it, I think
I'm thinking "I'm doing something that you	I didn't think I had that [maternal instinct]
will never do!"	but it turns out that I do
I was kind of like "Let them watch"	I think its nice to love and be loved
I felt empowered, but also exposed	unconditionally
I hadn't met anyone [caregivers] before then	I think that childbirth opens up the world for
I didn't feel I trusted them, I didn't feel that	you, and it puts you into a world of other
I felt numb, I was kind of in survival mode.	people that have experienced childbirth
I didn't have any control	I feel like I have a place in the world
I didn't know how to have a baby	
I had not really thought about my body	

Analysis for Janelle. Janelle is thirty-six-years-old, she is of Canadian origin, and lives in Canada. She is the mother of two sons aged nine and seven, who were born in Canada in 2008 and 2010. Janelle was aged twenty-seven years when she had her first child. As Janelle described her first experience of childbirth, she spoke primarily with voices of mistrust and disempowerment. Her I-Poem shows that her experience seems traumatic, but she can access an empowering thought.

The voice of mistrust was present because Janelle said she felt upset by her caregivers, who overlooked her need for privacy and support in many ways. First, Janelle said she had already decided before the birth began that she would not be able to endure the pain of contractions and she had agreed with her doctor beforehand that she would like to have a walking epidural but the epidural she received was so strong that she could not walk and she had no sensation of giving birth. She said that this left her feeling cheated of having a natural birth experience and she said she felt traumatised by the care she received. Janelle explained that she felt upset that her doctor did not come for her birth and that she was never given an explanation as to why he did not come. As she was delivering at a teaching hospital, she said she was looked after by two strangers who were never properly introduced to her. They were male resident doctors whose skills she did not trust. Janelle said she felt humiliated and ignored when the two male doctors allowed eleven male interns to enter the birthing room without Janelle's consent, and allowed them to check her cervix. Janelle said she felt traumatized by this experience. She said that she wondered if any of them had any real experience of delivering a baby and she said "I felt very, like vulnerable, and um, exposed." In that moment, Janelle said she felt as if she could not rely on them and that it was up to her to deliver the baby. She said "I don't know, I was in survival mode, thinking 'I've got to get this baby out.'" *The voice of disregard* was heard

when Janelle said she felt that her needs were irrelevant because an attending doctor ignored her pain during a Ventouse birth of her baby and continued to teach the interns how not to hurt themselves whilst performing this procedure. Janelle said that there was no consideration for what she needed. *The voice of disempowerment* was heard when Janelle said she felt she had no choice but to comply, but she felt traumatized by this experience. During the time she said she felt that she was being shouted at by her caregivers and then she experienced a separation from her body, she said she was unable to focus and that she felt as if she floated above herself, and the other voices echoed far away. Janelle's experience was one of disembodiment caused by the birth trauma. *The voice of disconnection* was also present when Janelle said that she felt silenced and felt a numbing of her emotions in response to having her private parts on display to so many strangers. *The voice of judgement* emerged when Janelle said that "There were like ten interns standing around, watching, which also made me feel very conspicuous, you know, like I said, I lost all dignity that day." *The voice of abandonment* was identified when Janelle expressed her rage that there were fourteen people (two residents, ten interns, and two doctors who came later at the time of birth) in the room, most of whom were male, who were touching and looking at her private parts. *The voice of endurance* was present when Janelle said she endured a lot of pain and she told herself that "usually when something hurts, you stop, but when you're delivering a baby, if it hurts, you've got to keep doing it otherwise someone is going to die." Janelle said she also endured the presence of so many strangers in the delivery room and she thought to herself "let them watch!" This appears to have been a pivotal moment for Janelle in being able to access a more resilient, empowered part of herself. Janelle said that she felt empowered even though moments before she had felt traumatized that so many strangers [eleven students] were checking her cervix. She said she was able to say "I do feel empowered and I was traumatised." *The*

voice of trust was identified when Janelle expressed how she trusted her own ability to give birth and that she mentally prepared herself for this experience. *The voice of empowerment* was identified when Janelle said to herself, "Ok I'm much stronger than I thought I was." She said she felt empowered by the thought that she was the only one in a room full of people, apart from her mother, who was actually able to give birth. *The voice of appreciation* was heard when Janelle said that before childbirth, "I had never had any body issues" and that now after childbirth she sees her body with compassion. She said, "stretchmarks should be seen as, um, like warrior stripes instead of a scar … wear it as a badge of honour instead." She said she feels compassion for the women who try so hard to get their bodies back into shape, but that they should not have to do that. *The voice of choosing*, was expressed with a desire to give back to others and to make a difference in their lives and in the world when she said, "sometimes when I look at another mother, I can just tell, she's falling apart and I need to speak to her, and just you know, a little encouraging goes a long way right?" She also said "I don't know, because I had such a bad time of it for myself after, I think I can see it in other people. *The voice of meaning* was heard when she said that "I think that childbirth opens up the world for you, and it puts you into a world of other people that have experienced childbirth." She also said "knowing that I was created to be able to give birth to a healthy baby, that makes me feel strong." *The voice of belonging* was heard when she said "Its boosted my confidence I think, I feel like I have a place in the world."

Overall Janelle's voice of disempowerment was present throughout the first stage of labour until she had an empowering thought (of being the only one in the room who could deliver a baby), which helped her to feel empowered and this created in her a sense of herself as strong, and this highlights the importance of how one chooses to react to the environment.

Although this did not protect Janelle from suffering post-partum depression, Janelle chose to use that feeling of empowerment to connect to her strength in her body, which shaped her sense of self as being stronger than she had expected. She later said that because she had survived this traumatic experience, she was sure she would be able to survive anything else and be a good mother to her child.

Summary for Janelle. The most prominent voice in Janelle's story was that of mistrust which is in FM1. The analysis of Janelle's story reveals that the voices of fulfillment and voices of suffering are both strongly present. The voices of suffering in Janelle's story are mostly those of mistrust due to inconsiderate caregivers and having to endure the trauma of birthing with many people in the room who were strangers, the voice of disempowerment due to a sense of separation or disembodiment, and the voice of disconnection due to caregivers that ignored her needs. Fulfillment is expressed through the voices of empowerment due to feeling strong enough to deliver the baby and knowing when and how to push. Fulfillment is also expressed through the voice of connection due to connection with the baby, and appreciation from the nurses who listened, the voice of trust due to trust her own ability to deliver a baby and the voice of choosing due to wanting to have a baby and help others in similar situations, as well as through the voice of meaning due to experiencing the joy of motherhood and the voice of belonging due to feeling a sense of belonging as a mother.

There appears to be a lot of resonance in Janelle's story in that in response to not having her needs met she experienced mistrust towards her caregivers as well as disempowerment, disconnection, and disregard. Despite this she is able to endure and feel empowered and strong enough to embrace the challenge of motherhood and find meaning in her new role. However, what came through this analysis was the depth of Janelle's suffering due to her first experience

of childbirth, and how this experience has shaped her.

When Janelle was asked to describe how her sense of self was shaped by childbirth, she that she did not expect to automatically have any maternal instinct but she did. She said that "its nice to love and be loved unconditionally" and that she sees her stretch marks as warrior stripes for going through something difficult. She said that her childbirth experience has made her feel that she can face anything in life. She said she has a sense of self as a strong and good mother.

Jess.

The following table shows Jess's Suffering I-Poem and Fulfillment I-Poem.

Table 7

Jess I-Poems

Suffering I-Poem	Fulfillment I-Poem
I pop out of my mind at this point	I feel more connected by the experience
I was incapable of thinking	I'm much more aware of my body
I was in such pain	I'm more aware of, of more like cell things
I want to be out of this pain	I, I, I listen to it differently
I'm freaked out	I don't regret that at all [C-Section]
I'm gonna start having a contraction and move	I'm glad that that happened
and get paralyzed	I feel more connected by the experience
I didn't like not being able to move	I'm much more aware of my body
I do not remember much	I think now I'm more aware of, of more like
I was so tired and so out of it	cell things
I felt the need to push	I, I, I listen to it differently
I can see the way they say, well if you start	I felt I can do almost anything now
with one intervention than it can tend to	I mostly felt that way after I gave birth
snowball	
I, I, I kind of wish maybe they hadn't maybe	<u>Second birth:</u>
let me go on so long	I felt it was instant [connection with second
I think physically and emotionally…	baby]
I don't know that being tied down on the table	I was just like, I'm in love
was particularly	I hadn't even touched her, it was just instant
I was waiting for the C-section	I think that whole experience was just so, so
I, I just was kinda waiting for it to be over,	more empowering
which is unfortunate	I think it maybe helped
I'm just done and now I'm strapped down by	I have thought about how different the
the arms	experience was and how nice it was that I

I don't want to be like this	had that second experience. Um, so
I'm struggling	differently. Yeah.
I could die	I was able to process stuff a bit better
I didn't feel	I would have been more concerned about
I didn't feel safe	what people thought about things before
I didn't like being there	I'll be tactful almost up to a point and then
I, I, I didn't feel	you know what, I don't care
I really do think of it as being traumatic	I feel like
I didn't get to hold her [baby] for 45 mins after	I had to prioritize my child
she was born	I, I don't like give a crap anymore about
I thought the midwife would have advocated	stuff
for me	
I have this depression	
I'm sitting there feeling empty	
I'm like, just smile, just smile, just fake it, just	
smile at your kid	
I went back to work and I felt like things felt	
more manageable.	

Analysis for Jess. Jess is thirty-six-years-old. She is of South African origin and lives in Canada. She is the mother of two daughters aged seven and four, who were born in 2010 and 2013 in Canada. Jess was aged twenty-nine years when she had her first child. As Jess described her first experience of childbirth, she spoke primarily with voices of disempowerment, mistrust and abandonment and this is shown in her I-Poem.

As Jess prepared for her first birth she said that she told her midwives that the babies in her family are typically born with big heads, and that as a result, her mother had had to have a C-Section. She said "I know it's not going to be a small baby going into this." Jess said that she told her midwives that she wanted to try for a natural birth but that she would be ok if she had to have a C-Section. Jess said, "they didn't see me as a particularly high risk." As they did not mention the C-Section, Jess said that she believed she would be able to deliver naturally. *The voice of mistrust* was identified when Jess said that she had trusted her midwives' ability to know if a C-Section would be needed, but looking back, she remembered the midwives saying "this

baby has a very big head, and your pelvic bone feels very narrow" and she wondered why they had not then planned for a C-Section. Jess said that she had a prolonged labour which lasted 30 hours before the midwives decided that because her baby's head was too large to deliver vaginally she should have a C-Section. By that time, Jess said that she had become so exhausted, that the labour became a traumatising experience for her, and she said, "I didn't feel safe, mentally, physically." She said that she felt as if her body was not doing what it was supposed to do and she feared she would not survive the ordeal. Jess said that she and her husband both lost trust to her midwives because they had allowed Jess to labour so long without offering her the C-Section earlier. Jess said that she was too traumatized to say anything at that moment, and she said "because they're the experts, you defer to them." *The voice of disempowerment* was heard when Jess said that she was told that she would have to have a C-Section. Jess said that she had already reached the second stage of labour where she felt the urge to push her baby out. Exhausted with the effort she had put into enduring many hours of contractions, Jess said she thought she would deliver her baby soon, and she said she was not mentally prepared for a C-Section. She said that when she realised that she had laboured in vain, Jess felt passive and weak in her body and she said she experienced of a separation of self and body, and she felt herself floating outside her body. She said, "So I pop out of my mind at this point, everyone talks about this headspace you go into." Jess said she could not focus, and that as the nurses prepped her for the C-Section they strapped her arms down. Jess said that she was upset that her midwife did not advocate for her to have her arms untied. She said this made her feel so helpless, as if her body was being overpowered by others from the outside. Jess said she felt traumatized by this experience of being tied down and she said "it was just, it just didn't feel right. The way I was there on the [operating table], in the surgery." Jess cried a lot as she relayed these events. *The*

voice of endurance emerged as Jess said that whilst waiting for the C-Section she was told not to push but it was almost impossible not to push because it was painful to work against the intense contractions, which were now less than a minute or two apart. She said "I was incapable of thinking at that point" due to the pain. She said "you just are living moment to moment, contraction to contraction with this gas, and that's all." *The voice of abandonment* was heard when Jess said that she felt a sense of rage that she was being robbed of the experience of a natural birth. She said that she had been so close to delivering, and that she felt a rage that her body could not do what it was supposed to do. In response she said she mentally dissociated from the situation and during the C-Section, everything became blurred and she did not feel present or aware of what was happening to her. After the C-Section, Jess said she was not able to hold her newborn baby because her arms were strapped down and Jess again felt rage that her midwife did not even try to advocate for her to hold her baby. Too exhausted to speak, Jess later said she realised that she was not allowed to hold her baby for forty-five minutes after the birth. Jess said that knowing this increased her anger and that at the same time it made her feel helpless. Jess said that she believes that because of this she was slow to bond with her baby. Jess said that she felt there were too many incidents one after another that contributed to her trauma. She said, "there were a lot of things that happened there, one thing off of another that were, not great." After the birth Jess said she suffered from significant post-partum depression and she still takes anti-depressant medication on a daily basis. *The voice of empowerment* was heard as Jess talked about her first birth where she briefly felt the urge to push and she knew what to do. She said that in that moment she knew she could deliver the baby and she felt empowered in knowing this. Later she said she felt cheated of this experience. Jess said she felt more empowered in the second birth because she asked for a planned C-Section and she had

more control. *The voice of trust* was heard when Jess said that her instinct to plan the C-Section for the second birth was the right thing to do. She said, "I think I trust myself a lot. I trust my instincts and what feels right." Jess said she felt that the second birth was almost a corrective experience because she was able to plan it, and she was not as exhausted, her arms were not tied down, and she was able to hold her baby right away. *The voice of meaning* was identified when Jess talked about seeing her baby for the first time. Jess said that she saw her little face and she was instantly in love and she felt proud, but she also said that it took her some time to feel connected to the baby.

Overall, Jess felt disempowered throughout her first birth. She said she was traumatised by her prolonged labour and she was unable to think or speak clearly. Jess lost trust in her midwives for not giving her a C-Section sooner, for allowing her arms to be strapped down, and for not advocating for her to hold her baby straight after birth. Afterwards Jess said she suffered for many years from post-natal depression which she attributed to her own resistance to her role as a mother, as well as her disempowering and helpless experience of giving birth. After the first birth Jess said she loved her baby but she felt detached from her. She said she felt like a good mother in providing for her baby's physical needs, and she spent a lot of time with her baby alone, but that she did not feel a lot of joy inside herself. She said she knew that her baby needed interaction for her development and so she worked hard to smile and engage the baby as much as she could but she felt she had to play act as opposed to it coming naturally. She said that after the birth, "I didn't feel important, because I had to prioritize my child … it was a shift mentally … shift from such a high pace of thinking … was so hard for me. I need that stimulation." Jess said she felt she was missing the challenge of higher level thinking at work and she decided to return to work and put her baby in a day care centre where she would receive more stimulation

than Jess could give.

Summary for Jess. The most prominent voices in Jess's story are those of disempowerment and mistrust, which are related to FM1. The analysis of Jess's story reveals that the voices of suffering are stronger than the voices of fulfillment. The voices of suffering in Jess's story are mostly those of mistrust and disempowerment which emerged from the very real possibility of self or child not surviving in childbirth, as well as having to endure an unnecessarily prolonged labour. The voices of fulfillment are empowerment and trust.

There is resonance in Jess's story because her mistrust towards her midwives as well as her feelings of disempowerment and abandonment are consistent with not having her needs met. The birth experience made her mistrust her body, and left her feeling helpless, angry. The trauma that Jess suffered stands out as a life altering experience which Jess says she cannot forget and this memory still gives her much reason to feel sad. Despite this she was able to feel strong enough to embrace motherhood and find meaning in her new role.

When Jess was asked to describe how her sense of self was shaped by childbirth, she said that before the birth her sense of herself was that she was accomplished, bright and capable of thinking at a high pace. Although Jess still thinks of herself as accomplished, she said that the trauma of her first birth left her feeling disconnected from her self and so she did not feel connected to her child and she took a long time to bond with her baby. Jess's second birth was a more empowering experience, and she felt healed by this experience. She said she felt stronger physically and mentally, more connected to her children and that she sees herself as a good mother. She also said that since having gone through the birth experience, she is less concerned about other people's opinions and that she has more trust to herself. She said that she was not this way before, but that the childbirth experience has given her more clarity to know the things

which are important for her.

Tara.

The following table shows Tara's Suffering I-Poem and Fulfillment I-Poem.

Table 8

Tara I-Poems

Suffering I-Poem	Fulfillment I-Poem
I felt like it [birth plan] was not liked by my regular doctor	I couldn't believe that this was my baby
I kind of felt like a fool	I had made this baby
I didn't know…when she [doctor] was examining me she flicked a membrane off	I thought he was inside all this while, he's outside now
I didn't register, she didn't even ask me	I thought he's my kid
I wouldn't have wanted her to	I'm a mother, and it like hit me when I was holding him
I would have said "No"	I couldn't believe it
I realised later	I couldn't understand why everyone else wasn't as excited as me
I felt my water break	I couldn't wrap my head around the fact that they were not awake at that time
I thought he [regular doctor] would deliver my baby	I'm so excited
I heard the doctor say "Its Father's Day, I'm gonna, spend time with my kids …" and he left. It felt so cold.	I don't recall it in such detail
I didn't want to have drugs but she [nurse] kept offering them to me	I thought "I am his mother"
I'm like, it started to feel very forceful	I am his mom
I have no idea what that [Pitocin] entails	<u>Second birth:</u>
I am hoping that I will go natural	I so wanted to feel those endorphins so much!
I want to do this on my own	I realised that "Oh my god, this is it, this is it, this is what [the type of birth] I have wanted!"
I'm, I'm, I'm kind of sure	I was so touched
I can do this on my own	I was so teary
I was getting a little worried because this is the first time	I felt so amazing, you know
I didn't feel prepared for the sudden onslaught of all that pain	I had done it, you know
I have no idea what arrhythmia means	I felt completely empowered, completely empowered
I I don't know how to manage	Everything I had missed out the first time, I got it
I, I, I can't imagine being strapped down	I knew that this is how a birth is supposed to be like
I am not walking or moving or bending	I felt very grateful that, you know
I simply cannot get up	
I'm, I'm completely immobile	
I felt them inserting electrodes through the	

uterus	I thought everything had gone exactly the way had wanted
I'm, I'm slowly starting to feel a sense of despair	I was thanking [God] for it
I thought "Oh my God, I don't know if I can do this"	I was amazed … every little thing that I wanted, happened
I was only like, 3 cms	I felt this was such a happy birth, and it was such an empowering one
I've completely lost all grip on myself,	I was, I was happy
I completely feel that I am done	I was literally happy!
I want the epidural	I, I was in completely in awe of my body, in awe of God's design
I can't take this pain	I, I, I, I, I didn't even want my husband to stay in the hospital
I want it	I completely had an amazing sense of myself
I just felt desperate	
I felt like I wasn't being heard	
I'm really scared	

Analysis for Tara. Tara is thirty-nine-years-old. She is of East Indian origin, born in India and she lives in the USA. She is the mother of two sons aged fourteen and ten, who were born in the USA in 2003 and 2007. She was aged twenty-five years when she had her first child. Tara described her first childbirth experience as a joyous meaningful occasion which was also very disempowering. As she described her first experience of childbirth, she spoke primarily with voices of disempowerment, mistrust and abandonment. Tara's I-Poem voice was primarily that of disempowerment.

Tara described her pregnancy with voices of fulfillment. *The voice of empowerment* was evident when Tara related that she felt healthy and confident that she could give birth. *The voice of trust* was present as both her family and her husband's family were supporting her in all respects. *The voice of connection* was present as Tara talked about receiving lots of love from her husband family and in-laws. *The voice of accompaniment* was apparent as she talked of having a good doctor, and of how she and her husband read together about the development of the baby in utero. *The voice of being seen* was evident as she said she felt that everyone was fussing over her. *The voice of appreciation* was also expressed as she explained that she felt

valued for having a baby but she also felt valued by her father when they talked. *The voice of taking time* was present when Tara said that during pregnancy her mother-in-law was cooking for her, and her husband was giving her massages. Tara said she was very happy during her pregnancy, and she said, "I really thought that this was the life."

Tara described her first childbirth experience mostly with voices of suffering. *The voice of mistrust* was present when Tara said she felt her caregivers had given her too many interventions. For instance, Tara said when she was near to term, she jokingly told her doctor that she felt impatient wondering when the baby would come. Tara said her doctor examined her and performed a membrane sweep without her consent. Tara said she felt angry and she said that if she had been asked for her consent she would have refused. She said "If she had asked me, I wouldn't have wanted her to intervene at that time." Tara said she felt she could not trust her doctor any more to ask for her consent in the future. Tara said that this mistrust was compounded by her fear of not knowing how to deliver the baby: "There's the fear of the, you know, what, what the actual birth is going to be about." Tara said that the membrane sweep caused her waters to break that same evening, so Tara went to the hospital, where she was given a series of interventions to speed up her labour. Tara said that the nurse at the hospital neither asked for Tara's consent, nor did she give any information about the interventions she would be performing. Tara described how the nurse applied a prostaglandin gel every few hours to Tara's cervix to speed up her contractions. After a few hours, when there were still no contractions, Tara said the nurse gave Tara a Pitocin drip. Tara said: "My water breaks, and I did not have any pain … they tell me 'we have to get you started on Pitocin.' Ok, um, I have no idea what that entails but I am hoping I will go natural." As Tara said she did not know that Pitocin is Oxytocin which brings on synthetic contractions which are more painful than natural contractions, and

they have fewer pauses between contractions, so they typically lead to the need for pain control. In Tara's case, she said she eventually begged for an epidural even though she had not wanted any pain medication. Tara said she felt cheated out of having a natural birth. *The voice of disregard* was identified when Tara said that she felt as if her caregivers at the hospital had not even intended to honour her wishes for a natural birth. In this moment Tara remembered that early in her pregnancy she had given her doctor a birth plan for a natural birth. She remembered how he had dismissed it, saying he would do what he thought was appropriate at the time, and how foolish she had felt. She said she felt that he did not like the fact that she had come to him with a birth plan. For instance, Tara said "He barely looked at it, … and he said 'all this is fine, but we are going to do what, you know, what we can do at that time.'" Tara said "So, it was not even, uh, well received, you know, giving him the birth plan. I felt like it was not liked." *The voice of disempowerment* was heard when Tara said that neither her doctor nor her nurses gave her any information about the procedures, and nor did they ask for her consent. As a result, she said she felt as if she was having things done to her, without her knowing was happening. She also said she felt as if her caregivers were speeding things up to happen according to their pace as opposed to allowing the birth to progress at its own pace. As Tara became more and more aware of this, she said she felt more and more disempowered. For instance, Tara said she had told her caregivers that she did not want to take any pain medication. She said that she could only cope with the extreme pain by walking and breathing through it. Tara said that when her caregivers found an irregular heartbeat, they strapped a heart monitor to Tara's stomach to be able to monitor her baby's heart rate, and they did not permit her to move around anymore. Tara described her sense of panic that she could no longer walk around. She knew she would not be able to cope with the pain if she could not move. She said, "the whole thing is getting restrictive,

because I don't know how to manage it if I am not walking or moving or bending. You know, … I, I, I can't imagine being strapped on my back to the bed." She said she understood why this had to be done, but when she could not move she felt so helpless that she asked her husband to call the nurse to administer the epidural. Tara said that as she and her husband had agreed that Tara would not take any pain medication, so he tried to convince her not to have the epidural. When she insisted on having it, he became upset and stopped supporting her and this added to her feeling of disempowerment. *The voice of abandonment* (not being cared/advocated for, anger, neglect) was present when Tara said she felt angry that her doctor did not intend to fulfill her wishes in her birth plan, and she felt upset at how cold her husband had been towards her during the birth. She said she remembered how she had begged her husband to ask the nurse for an epidural to control the pain and how he had refused. Tara said that when she realised that he would not help her she decided that she would have to do it herself. She said that normally she would never go against her husband's wishes. She said she reasoned to herself that he could not know how much pain she was in, and she pressed the call button herself. She said he responded by becoming cold towards her and sitting in the corner. She said that he did not even care how she would cope without him. Tara said that she was upset that even as the epidural was given, and he could see how scared she was, he refused to come and hold her hand. She said she felt very neglected and hurt that he did not try to understand her. After the birth, Tara said she felt upset that she was not able to deliver naturally without drugs, and she wondered whether she would have been able to do so if her caregivers had allowed her and if they had not intervened so much. She said she felt cheated of a natural birth. Tara said that she was left with a feeling of neglect because she felt that her doctor, and her husband were not there for her when she really needed them and she did not feel properly taken care of by her nurse. She said that from the

moment she arrived at the hospital, although Tara did not have any contractions, the nurse kept suggesting that she take an epidural for the pain and this began to feel a little forceful. As Tara had hoped to deliver without taking any drugs she said she tried so hard to resist it, but she ended up having to succumb to it. *The voice of disconnection* was identified when Tara said that she felt her doctor did not intend to respect her wishes for a natural birth, and that he behaved like the expert who would tell her what to do. She said that she felt unsupported by her doctor when he left her to deliver her baby with strangers so that he could go home to see his children for Father's Day. Tara said she felt disconnected from her husband during the birth because he refused to call the nurse when she told him that she wanted the epidural. Tara said that although he thought he was helping her, she felt he did not understand the extreme pain she was suffering and she was angry that he decided to sulk instead of helping her. *The voice of endurance* was identified when Tara described how desperate she felt that she would not be able to continue with the pain. She said that as she struggled to breathe through the contractions, she was also moving around to cope with the pain. *The voice of judgement* was present when Tara said that she worried that if she asked for an epidural after resisting it for so long, that her nurse would look at her with "I told you so" eyes. Tara described herself as very naïve for having believed that her doctor would honour her birth plan. Tara said she felt judged by her husband for having an epidural and that she was longing for him to be more supportive and appreciative of her in that moment. She said she was worried that her husband would judge her badly for not being able to bear the pain, for wimping out, and worse still, that he would judge her for allowing drugs to flow through her body to her baby and cause some kind of damage to the baby. *The voice of uniqueness* was heard when she said she decided to set a boundary, she told her husband that he could not decide for her whether she had an epidural or not, and she reached for the bell

to call the nurse. *The voice of choosing* was present when she said she asked for the epidural herself. *The voice of accompaniment* was heard when Tara described her nurse's response. She said she felt that the nurse did not judge her, but that she took care of her, and from that point onwards, Tara felt completely looked after by her nurse, and she focused on that support. *The voice of acceptance* was identified when Tara said that although her mother was supportive, she took a very passive role throughout the whole procedure because she had come all the way from India to the USA to support her and she did not understand the system. *The voice of belonging* was heard when she said "I am his mother." *The voice of meaning* was heard when Tara said that although her first experience of childbirth, together with not being able to have a natural birth, caused her to feel very disempowered and sad, but that at the same time she experienced a lot of joy in seeing her baby. Tara also spoke of the pride she felt in having produced the first grandchild for her parents and her parents-in-law.

When Tara spoke of her second experience of childbirth, *the voice of empowerment* was identified. Tara said that although the first time she felt she had missed out on the experience of having a natural birth, she felt she had a corrective experience with her second birth which was the natural birth she had wanted. Tara said she prepared herself differently for her second birth. Instead of attending birthing classes she read books about the Bradley Method of Natural Childbirth and she also found a doula to help her during the birth. Tara said she felt empowered because she was better prepared and she knew this time what childbirth was. Tara said that once labour started she stayed at home as long as possible before going to the hospital. She said "I felt that if I could stay home as long as I possibly could then once I got to the hospital, there is very little thing they can do to me in the way of intervention!" At home Tara said she was able to move around, and she felt she could bear the pain of the contractions better this time, that she

could breathe correctly, and she told the nurse it was time to push. She said she knew what to do, and this felt empowering. *The voices of trust and appreciation* are expressed during her second birth as support from a kind nurse, her doula and husband. *The voice of taking time* was heard when Tara expressed having trust to her doula and husband meant that she had the space to relax and attune to her contractions. *The voice of belonging* was heard as Tara said she felt a connection with other mothers. *The voice of meaning* was present when Tara spoke of birth as a rite of passage and she said that women should be allowed to give birth without interventions. Tara said that after her second birth she remembers feeling very happy and elated that she was able to give birth naturally. She said she had heard of the joy that women can experience through a natural birth and she felt fortunate that she could experience this. She said she felt "completely empowered. Everything I had missed out the first time, I got it, but I knew that this is how a birth is supposed to be like, and I felt very grateful that, you know, everything had gone exactly the way had wanted." Tara seemed to be saying not only that her wish was granted but that as a result she felt fulfilled. She said she had craved this experience and she felt satisfied and thrilled by this experience. Tara also said that she had read that at the time of birth the woman's body naturally releases endorphins which reduce the pain. She said "so I wanted to feel those endorphins so much! and even then, as it was happening, I realised that 'Oh my god, this is it, this is it, this is what I have wanted!'" Tara said that she knew she would be able to birth naturally when she heard that her cervix was dilated to 8 cms. She said, "I knew that there was no way I'm going to get that epidural now and I knew I was finally going to have the birth of my choice, that I had wanted." Tara said that the nurse told Tara not to push as she had to put on her gloves, but Tara could not respond to her, she pushed her baby out anyway, and she said, "by that time, my endorphins had already kicked in, and I was in a completely different planet

altogether… I was completely in another zone and I could tell I was both here and I was not here." Tara said she felt immense happiness, elation and joy and she said later that as she was immediately given her baby to hold, she bonded with him quickly and that this is why the baby is a happy baby.

Overall Tara said she felt upset by the many medical interventions she was given, by the fact that she could not bear the synthetic chemically induced contractions, and how this led to her asking for an epidural when she had planned to have a drug-free birth (voices of disempowerment, mistrust and abandonment). She said she felt mistrust to her caregivers and her husband who was upset with her for having the epidural (voice of mistrust and abandonment). Although she was able to advocate for herself (voice of uniqueness), she said she did not feel empowered by the birth (voice of disempowerment). Tara said that her first birth experience did shape her sense of self as being strong. However, she felt disempowered by the number of interventions she had and by the care she received from her caregivers. Tara said that she felt this birth was traumatic for her. She was unable to access any empowering thoughts or to be actively involved. Despite feelings of happiness and euphoria at delivering a healthy baby, Tara said she felt that this birth was disempowering and that she had a sense of herself as helpless. Tara said that she later suffered from post partum depression.

Tara described her second birth as an empowering one (voice of empowerment) where she was able to be actively involved and was able to deliver without taking drugs. She said she was present and actively involved in this birth. Tara's embodied experience was one of feeling empowered and this shaped her sense of self as being stronger than she had expected.

Summary for Tara. The most prominent voices in Tara's first childbirth narrative are those of disempowerment and mistrust, which are related to FM1. Tara described her birth

experience in rich detail and as she was very articulate in her ability to describe the range of feelings that she experienced as many voices across all four fundamental motivations were identified in her story.

The analysis of Tara's story reveals that the voices of suffering are stronger than the voices of fulfillment. The voices which refer to her life with her family during pregnancy as well as those that refer to her second childbirth are mostly voices of fulfillment. These are voices of empowerment and trust. The voices that were heard during her first childbirth experience are voices of suffering. These are mostly voices of mistrust, and disempowerment which are related to FM1. These were identified when Tara said she felt that that her wishes were not heard or honoured, that she was given a series of unwanted interventions, and that she felt cheated of the experience and satisfaction of having a natural birth. Tara said she was able to find meaning and belonging despite the trauma of childbirth. Perhaps her resilience is due to the love she received from her family, which has been a protective factor for her.

There is resonance in Tara's story regarding her first birth experience because her mistrust towards her doctor as well as her feelings of disempowerment and abandonment are consistent with feeling helpless and upset and not having her needs met. The trauma of this experience stands out for Tara as a life altering experience which she is says she cannot forget and this memory still gives her much reason to feel sad. Despite this she was able to feel strong enough to embrace motherhood and find meaning in her new role.

When Tara was asked to describe how her sense of self was shaped by childbirth, she replied that her sense of self was that she was not confident and that she became very anxious. She said, "I'm usually a very positive and upbeat person in general." She said that after her first childbirth experience she experienced a lot of guilt for asking for an epidural and that after the birth, when

her baby would not sleep in the night she thought it was her fault. She said, "sometimes I used to think it was because I had the epidural, maybe because of the drugs that were in my system when he was born." Tara said that the trauma of the first birth left her feeling disempowered and unsure of herself. As her second birth was a more empowering experience, she felt healed by this experience, and she felt stronger as a mother, more connected to her children, and she sees herself as a good mother. Tara's second birth seemed to have satisfied her craving for a natural birth and this gave her immense joy and fulfillment.

Susan.

The following table shows Susan's Suffering I-Poem and Fulfillment I-Poem.

Table 9

Susan I-Poems

Suffering I-Poem	Fulfillment I-Poem
I lost my father during the first pregnancy	I look on the experience as a good one
I felt strange, not to show your baby to your father	I felt it was very intense but beautiful
I usually tend to live in my head	I felt very strong
I have a heart disorder	I was literally quite proud
I think that strength surprised me	I, I remember thinking I can do this
I didn't feel weak before	I was really, I was really happy to have him [husband] there
I sometimes felt, dissociated from my body	I found it such and impactful experience
I was always a mind person living in my head	I don't think I can compare it to anything
I haven't always been strong in terms of health	that I have experienced before
I was interested to see if I could handle it well	I felt it opened up a new dimension for me
I felt indeed stronger because it went so well	I was curious whether I would be able to
I found it harder when my mother fell ill	I was also anxious of course
I am going to lose both parents in one pregnancy	I was happy I could handle pregnancy well
I lost my mother in the fourth pregnancy	I think I felt indeed stronger
I say it was the circle of life on a square meter	I felt a bit more connected
I felt it was a roller coaster emotion	I think maybe
I felt dissociation from my body	I also learned to rely more on my intuition
I think after childbirth it felt more like a unity	I think it [being a mother] is the most
I felt more whole than before	essential part of being me
I think the past year… as a cancer patient	I, I also feel very grateful
I think it's also a life changing experience	I can't imagine what it was like before

I've lost a lot of faith in my body I remember I was shaking after that I think my sense of self was a little bit shaken I don't like losing control I had two miscarriages I lost confidence in my ability to have this baby, keep this baby	I'm the combination of being a, mother and a wife and a, a, a, entrepreneur I think, its opening a new part of yourself I see childbirth as a very concise experience I see a 24-hour box that you go through I feel proud that I am able to do that

Analysis for Susan. Susan is forty-eight-years-old. She is Dutch and she lives in the Netherlands. She is a mother of four children. She has a fifteen-year-old daughter called Emma, a thirteen-year-old son called Quinten, a nine-year-old son named Ruben, and a seven-year-old daughter called Paola. The children were born in the Netherlands in 2002, 2004, 2008, and 2010. Susan was thirty-three-years-old when she had her first child. As she described her first experience of childbirth, she spoke primarily with voices of empowerment, trust and accompaniment. Susan's voice was primarily that of empowerment and this is shown in her I-Poem.

Susan describes her first childbirth experience as a joyous meaningful occasion which was also very empowering. *The voice of connection* was heard when Susan said that she was fortunate in having a good, strong, relationship with her partner Theodore, and that this gave her a lot of comfort and support. *The voice of disconnection* was present when Susan said that her father died of a stroke when she was pregnant with her first child, and that her mother died of cancer when she was pregnant with her last child. She said: "it was the circle of life on a square meter. One, person in your life dying and another person coming in."

The voice of disempowerment was heard when Susan said that she seemed to rely on her cognitive abilities to rationalise and accept what was happening with her parents as they became ill and later passed away. Susan talked about both the joy and sadness that she felt after her first child was born: "after the birth, it was strange that you can't show your baby to your father,

because he is no-longer there." Susan said that with her father's illness and passing away she felt a sense of separation from her body. She described this as follows:

> It was a roller coaster emotion … that kind of contributed to the feeling of some dissociation from my body … I sometimes felt, I think, dissociated from my body where I was always, I think a mind person living in my head, rather than in my entire body … it [my body] was something that was there [laughing], rather than it was me.

Susan said that after the birth she felt more connected. *The voice of Acceptance* was identified when Susan said she had to accept the illnesses and deaths of loved ones. For instance, Susan who said that during her first pregnancy, "I also lost my father … there was, just no possibility for him to recover … so it was ok," when Susan said that she approached each birth with an open mind and knowing that she would not be able to control what happened and hoping it would be easy and not long and drawn out as she had heard from other women. Acceptance was also identified when Susan said that she was also diagnosed with breast cancer after she had given birth to her children, and a year and a half before this study. She said that "Being a cancer patient … has impacted my sense of self and my connection to my body because all of a sudden everything that feels for granted is taken away." What stood out for the research team was Susan's ability to keep accepting each new situation that she had to face, and her ability to remain thankful. T*he voice of taking time* was identified when Susan described the feeling of having space to deliver her baby at her own pace. For instance, when Susan arrived at the hospital with her waters broken, and weak contractions, she said, "they were quite relaxed about it … we also felt rather relaxed about it, so that was good." The nurses told her, "Well, why don't you just walk around here in the hospital for a little bit of time, and let's see how it progresses." This created more space for Susan to relax and wait for her contractions to become

stronger. Susan said that after walking for some time "the contractions started to really get stronger, and that felt good to kind of move … I was happy that it continued, that it was not going to be a long drawn out thing." Susan said that several hours later, when her contractions were strong enough and she returned to the birth room, there was no attempt by her nurses and doctors to rush things along. The voice of taking time is evidenced again here. They simply checked her at regular intervals and they allowed Susan and her husband relax between contractions and take their time. Susan said, "they just came in and they checked and they went away again." *The voice of accompaniment* was identified when Susan said the nurses and doctors at the hospital were relaxed. She said, "We had our own room, and every now and then somebody would look in and say "everything ok?" … it was, … actually very, very, relaxed." She said, "They also gave us that, that, breathing space almost … there was not all the time people coming in and things like that … it was our little bubble." She also said, "yeah, I, I could take it in my own pace and space, so it felt, it felt good, it was a good experience." *The voice of being seen* was identified when Susan said her nurses and doctors really respected her wishes and her privacy and her need to have a quiet space: "That was really, that's why, that's why we called it our home birth in the hospital. It was really like a home birth, in the setting of the hospital … it was quiet, it was peaceful." Susan also said it was the same with her subsequent deliveries: "Those birth experiences were again … like being in being in a little room in a hospital, and we could just take that easy, and it was our, it was really our birth, rather than having all kinds of people running in and out." *The voice of trust* was identified when Susan said that she had a hole in her heart since birth and when she told this to her midwife at the beginning of her pregnancy, the midwife did not think that this would be a problem for childbirth. However, later at a routine hospital check-up, Susan said she was informed by a doctor that as

she was born with a hole in her heart, her baby could potentially have the same problem, and that she should give birth in the hospital. Susan said she felt more trust towards the doctor than her midwife, who had not thought to get the baby's heart checked. Susan opted to give birth at the hospital instead. She said that she and her husband decided that "'We feel safer going to a hospital." *The voice of empowerment* was identified when Susan talked about her ability to give birth. She said, "I was curious whether I would be able to do it well, … it was that strength that also surprised me." She described the moment when she had the urge to push the baby out "my body knew what to do… I, felt strong and I was, I was literally quite proud, of myself." *The voice of meaning* was heard when Susan said that she felt fortunate to have been able to give birth:

> I found it such and impactful experience, that its different from anything that I had experienced before. It is such a power of nature almost going through your body, that's really, uh, it, it kind of opens up a new dimension …but there was the whole pregnancy, its such an amazing experience to feel life growing inside you, to go through the whole birth experience and to hold this little person in your hands, I don't think, that I can compare it to anything that I have experienced.

Susan said she feels grateful to have four healthy children who have brought so much happiness and meaning in her life.

Overall, Susan had an empowering first birth with lots of time and space to connect to her embodied experience. She also trusted her caregivers and husband to support her. She felt safe and had enough physical and mental space to be able to focus on the birth (voices of empowerment, trust, taking time, being seen, accompaniment). Susan's embodied experience was an empowering one. She had said that she had always tended to live in her head and that

during birth she felt dissociated from her body, but that now she is more aware of her self as whole (embodiment). She said that "I think it felt more like a unity here, more of the whole, more whole than it was before." Susan felt connected to her strength in her body, and this shaped her sense of self as being stronger than she had expected.

Summary for Susan. The analysis of Susan's story reveals voices which are related to all of the four fundamental motivations: FM1, FM2, FM3 and FM4. The voices of fulfillment are stronger than voices of suffering, indicating that Susan felt she had time, space and support from her caregivers. The voices of fulfillment are trust, acceptance, taking time, being seen, accompaniment, empowerment, and meaning. Fulfillment is expressed through trust to caregivers, acceptance of the circumstances of giving birth and loss of her parents, taking time and space to allow the birth to progress naturally, feeling seen and accompanied by her caregivers, feeling empowered through the birth experience and finding meaning in becoming a mother. The voices of suffering are disempowerment and mistrust which emerged only briefly from the feeling of surrendering control and feeling a sense of separation of mind and body.

There is a lot of resonance between the voices in Susan's story. She wanted to take time to allow her contractions to develop because she wanted a natural birth, and she hoped her labour not to be long and drawn out so that she would not suffer too much. Susan was primarily focused on allowing the birth to happen at its own pace, and she was allowed to birth in this way without any attempt from her caregivers to intervene or rush her. She felt grateful for this.

When Susan was asked to describe how her sense of self had been impacted by childbirth, she said that before having children she did not feel as if she had a strong body, and so she tended to live in her head more and she had a sense of herself as a separate mind and body. Susan said that she has a sense of herself as someone who tends to live in her head and

who feels in control most of the time. Susan felt that her first childbirth experience shaped her sense of self by connecting her to her strength in her body and trusting herself. Susan was happy that her body was strong and able to bear children, and she felt empowered that she would be able to handle motherhood too. After having children, Susan felt a unity, a whole which consisted of a mind-body connection and strength and intuition. She said she felt she had an embodied sense of self. When she said she felt more comfortable with her intuition, as this is part of the self, she was saying that she felt more comfortable with her embodied self and this is a connection and liking to her embodied sense of self. When Susan described her sense of self as a mother she said:

> I think its the most essential part, or one of the most essential parts of being me. Its such a core element and such an all-encompassing thing to do … its like, kind of opening a complete new part of yourself … a new role … it also requires you to develop yourself so immensely in that role of being a mother that its such an important part of who I have become, of course that's with the children. Its almost hard to remember how it was before … I also think regularly that raising children is such a daunting task, its such an immense task, it sometimes makes me feel that 'Oh, am I really doing this well? … everything has been working really, really, well at the moment … I think that the birth experience contributes to that and I also see it as a very, its, its, a concise experience, that its really, it's a kind of a box, a 24-hour box that you go through and then there's the rest of your life as a mother. I think that for me it helps in the sense that I have felt that strength, that really it was a beautiful experience, but it also makes me realise, it also makes me humble, to be allowed to be able to help these small persons on their path in life.

Susan said that she experienced childbirth as a concise experience which changed her core sense of herself as a mother so much so that she can hardly remember how it was before. When her second child was born so fast, Susan said that she was no longer sure of her sense of self, as someone who is always in control. She explained that "well I can't handle everything, but I can still feel empowered and strong to do it again." Susan said she felt that each childbirth experience shaped sense of self more, and that each experience has contributed to how she mothers her children.

The next section describes the findings for this study.

Findings

Voices. As previously mentioned, the childbirth experience has aspects which cause suffering and aspects which bring fulfillment, and the experience of the participant is dynamic and shifting from moment to moment. The birthing woman can experience moments of suffering and moments of fulfillment. Therefore, these voices can be seen as simultaneously reflecting different aspects of the experience, appearing sometimes momentarily and sometimes constantly and with some voices being more predominant than others. Although these results will show that some participants speak more with voices of fulfillment or suffering or both, this should not be taken as the participant's overall feeling of fulfillment or suffering, as it is possible that the participant speaks with many voices of fulfillment, but that one small voice of suffering can leave an imprint which overshadows the other voices. Rather it is necessary to look at each participant's expression of how this experience shaped them.

Participants often experienced opposite voices together at different points during the birth. For instance, some participants expressed both voices of empowerment and disempowerment, or both connection and disconnection, trust and mistrust, or appreciation and

disregard. However, within FM4 none of the participants expressed the opposite voices of both meaning and meaninglessness in their narrative or choosing with not choosing or belonging with not belonging. Also, all participants found meaning through the childbirth experience. Hence although these participants were concerned about their own survival and that of their child, the experience of giving birth was full of meaning for them.

Fulfillment and suffering. The voices that emerged in this study had two overarching themes: fulfillment and suffering. Table 10 gives a description of how fulfillment and suffering were expressed through these voices.

Table 10

Overarching Voices of Fulfillment and Suffering

FM	Fulfillment	Suffering
1	• confidence, • a sense of knowing what to do during birth • trusting one's ability to give birth • feeling strong, trust in caregivers and family • feeling safe • a calm and relaxed atmosphere in which to give birth • not feeling rushed • and ability to accept/endure circumstances of birth.	• Uncertainty • lack of confidence • not knowing • disembodiment • lack of support from caregivers • not having control • not feeling knowledgeable about birth • feeling helpless, forced, ignored, or not listened to • fear for own and baby's survival • mistrust to own body's ability to give birth • feeling overpowered or taken over by others • inability to think for ones self • lack of trust to family and caregivers • lack of protection from stranger caregivers coming into the delivery room • strangers giving and watching internal exams • invading one's privacy • feeling humiliated and angry • loss of dignity • feeling vulnerable, exposed • upset that primary caregiver left them to deliver with strangers

		• not feeling safe • not being asked for consent or given information before performing an intervention • lack of protection from unnecessary suffering • receiving or being coerced into having unnecessary or unwanted interventions • being strapped down for a C-Section • not being allowed to move around • fear, helplessness • not being in agreement or having control over care provided • feeling body is less attractive • exhaustion.
2	• love • joy • feeling seen and well-treated • a feeling of being accompanied • feeling supported by caregivers and family • trust and connection with caregivers, family and self • having enough time to let contractions progress at their own pace • not feeling rushed into having interventions • time to bond/connect with her baby.	• isolation/feeling alone • a feeling silenced, vulnerable, exposed • a lot of pain • disconnection to others, self, own feelings • social ignorance of caregivers • being distanced from loved ones • not being able to hold newborn right away • not being properly cared for by caregivers • feeling rage, anger, frustration, neglect • lack of continuity of care • a desire to protect oneself and the baby • angry about one's body not functioning the way it was supposed to • sense of abandonment due to caregiver neglect • being shouted at • feeling that caregiver did not advocate for me • receiving superficial care from caregivers who leave before baby arrives and leave a stranger in charge • lack of continuity of care • a sense of being rushed • no time to bond with baby • no time for an epidural • being rushed to deliver the baby • feeling pressured to accept interventions to speed things up.
3	• feeling acknowledged listened to and valued by others	• feeling not seen • loss of self

	• identity as a mother • valuing self without judgement • able to express own feelings • set boundaries, and make own decisions.	• one's wishes were dismissed or not listened to by others • feeling silenced or judged • less attractive • judging self for having an epidural • conforming to the wishes of others.
4	• meaning • belonging to womanhood and motherhood • having gone through the rite of passage of giving birth • a sense of pride in being able to give birth • ability to accept and love oneself • a sense of self shaped positively by childbirth • being able to choose and advocate for own wishes • choosing how to give birth.	• feeling a lack of meaning • lack of belonging • lack of ability to choose.

Note. FM = Fundamental Motivations, 1= Existence, 2 = Life, 3 = Being Oneself, 4= Existential Meaning.

Embodiment and disembodiment. Embodiment is an awareness of self where mind and body are one. Disrupted embodiment or disembodiment is when the woman feels a separation of mind and body. Disembodiment is a response to emotional distress which entails a physical distancing from one's own body (Morse & Mitcham, 1998, p. 668). Table 11 gives a description of how participants expressed embodiment and disembodiment in their narratives.

Table 11

Narratives on Embodiment and Disembodiment

FM	Embodiment	Disembodiment
1	• knowing what to do during labour • a sense of one's ability and strength • having space to tune into and care for the	• Fear • not knowing what to do during labour • feeling passive and helpless in the body

	needs of the self as a body • to be able to relax and connect with one's self • a sense of safety.	• a lack of strength in the body • not trusting the self in the body • a sense of self being overpowered, invaded or taken over • a lack of safety • a sense of not being able, restriction, and exhaustion
2	• feeling a sense of connection to the self, to the baby • a sense of feeling whole • tuning into one's intuition in the body • a feeling that one can rely on one's self • a sense of being cared for • love, connection with others • not feeling rushed.	• isolation • alienation • not having connection to the self or the baby, or to others • a separation of self/mind and body • feeling overpowered by anger • rushing, not having time • feeling alone.
3	• feeling valued • feeling a sense of dignity.	• feeling not seen or disregarded/ignored • a loss of self • judgement of self • the feeling of conforming to the wishes of others, which can be experienced in the body as emotional distress.
4	• purpose or meaning • a sense of belonging to motherhood or womanhood • having the ability to choose.	• meaninglessness • not belonging and not being able to choose, which can also be experienced in the body as emotional distress.

Note. FM = Fundamental Motivations, 1= Existence, 2 = Life, 3 = Being Oneself, 4= Existential Meaning.

Embodied sense of self shaped by childbirth. At the end of each interview the participant was asked about the research question for this study. She was asked to describe how she felt her embodied sense of self was shaped by her childbirth experience. Although the focus of this study was on the first experience of childbirth, participants automatically talked about

how each birth shaped her sense of self differently. Table 12 gives examples of quotes, organised by category, of what each participant said regarding how her embodied sense of self was shaped by childbirth. They are also organised in order of negative sense of self to positive sense of self.

Table 12

Descriptions of Sense of Self

Participant	Description of sense of self
Alice	Less confident (in self, in body) - "Before pregnancy, I remember feeling like my body was just mine" - "pregnancy and childbirth all that really threatened that physical sense of being attractive" - "I am just a mother, and there is no more me … the only thing that is important is my children" - "I'm still struggling with "Who am I?" and um, "what do I want?" - "I put all of that aside for so many years and lived for my children" - "it took … almost 2 years for me to feel like I could be a good mother" - "that first 2 years was a lot of feeling like "I don't know … somebody needs to tell me what to do" Disconnected (from self, from others) - "it made me feel like, ok, this is something that is happening to my body, kind of, that's disconnected from me, and er, there's nothing I can do about it, umm, and this is all kind of beyond my control, and so I just have to wait until the baby's born" Strong (physically and mentally) - "I feel kind of a sense of power that I was able to give birth to the baby" - "I felt empowered" - "I felt strong … I feel like, yeah, I feel I have energy and I'm strong" Mother (identity, status, ability, rite of passage) - "I remember feeling that 'I am a good mother'" - "I really felt like "I'm a really good mother, like I can really do this, and these kids are going to be fine" - "For me, having a baby was huge and that gave me my sense of identity [as a mother]"

- "I think that becoming a mother is something that is in my mind, something very selfless, its extremely demanding, it takes a large toll on you physically, mentally, emotionally, but, yet, I wouldn't change it!"
- "[giving birth] is the greatest accomplishment in my life"
-

Barnie

Disconnected (from self, from others)

- "When she [midwife] did not talk to me with respect, I felt upset. There was no love"
- "After the birth I felt helpless for 10 days. I was totally helpless. But I felt supported by my family"

Confident

- "I felt as if I knew what to do, even though I did not understand how"
- "I felt sure of myself. I felt very confident, I felt I can do it"

Strong (physically and mentally)

- "I felt that, because I can do that [give birth] I am strong"
- "I was a sports girl, my body was strong, I never used to get ill. I was very fit"
- "I have become very strong now"

Mother (identity, status, ability, rite of passage)

- "I thought I am a mom"
- "I felt I was a great mom"
- "I have always given my best for my children, to support them"
- "I had a wonderful time, motherhood, I really enjoyed it"
- "Even though I am old now, I feel responsible for my children and my grandchildren, to look after them"
- "Mother is a very responsible job, we are responsible for the future whole next generation of the world"
- "I didn't fail in childbirth"

Janelle

Disconnected (from self, from others)

- "No, I had no control, I was just being shouted at"
- "it was more like I was floating above myself and everything sounded like an echo, and the voices sounded like they were at a distance, and it was hard to focus a little bit"

Confident

		- "no-body has it all together … I don't have it together" - "Its boosted my confidence"
	Strong	
		- "knowing that I was created to be able to give birth to a healthy baby, that makes me feel strong" - "its changed me forever" - "Childbirth … just empowered me" - "I felt calm and strong" - "it was the hardest thing I ever had to do, so if I can survive that, then I must be strong, even if I don't feel it" - "I do feel empowered and I was traumatised"
	Mother (identity, status, ability, rite of passage)	
		- "I'm a mom" - "It is a big responsibility to be a mother" - "when you see that kid and its yours and your connected and its beautiful and its perfect and it grew inside of you, and you're like 'Oh wow, I made that!' [chuckling]" - "stretchmarks should be seen as warrior stripes … as a sign that I did that, as a badge of honour" - "I think I'm at a place of acceptance [of my body]" - "its nice to love and be loved unconditionally" - "I feel like I have a place in the world, if that makes sense" - "[I belong to] a world of other people that have experienced childbirth"
Jess	Disconnected (from self, from others)	
		- "it was kind of like other people took over and um it got to a point where I really couldn't think for myself, and that was very helpless feeling" - "I was glad to have her but I, I, I just didn't have that, that connection like I'd expected" - "I'm a very, touchy feely connection kind of person, and to not have that with my daughter … it was unsettling" - "I pop out of my mind at this point, everyone talks about this headspace you go into, which is kind of true, you can't really think properly"
	Confident	
		- "I trust myself a lot. I trust my instincts and what feels right" - "I, I don't like give a crap anymore about stuff, you know, it's definitely changed, you know I've always been pretty technical about stuff and um

	polite and you know, I, I, I've always been strong, but you know, I would have been more concerned about what people thought about things before and now it's just like, I'll be tactful almost up to a point and then you know what, I don't care. You know, so that's kinda changed. It feels good actually. My new self. (laughs) Yes. I feel like I definitely, from that birth experience and everything, that was the point of I'm, I'm important"
	Strong (physically and mentally) and more aware of body - "I'm much more aware of my body … I'm more aware of, of more like cell things, like I, I, I listen to it differently … I would say [I feel] physically strong … mentally stronger" - "It felt pretty powerful getting through that and coming out the other side being like yeah, I can, I can do almost anything now"
	Mother (identity, status, ability, rite of passage) - "I'm a mom" - "you [become a] mother and that, that's the biggest, the most important role I've ever had" - "its good [to be a] mother and that, that's the biggest, the most important role I've ever had. It's great. I feel very comfortable and I feel very competent now" - "I would not be a good stay at home mom. I'm grateful for a job! My career is important to me, and I am a good mom" - "responsibility wasn't difficult per say, [but] it's huge" - "I feel pretty accomplished in my life."
Tara	Not in control - "The birth was just a set of circumstances that I, I could not really control"
	Less confident (in self, in body) - "the actual childbirth process was not very empowering, whether it contributed later to me being a very anxious kind of mother" - "I'm usually a very positive and upbeat person in general" - "I was a very anxious mother, and I was always led by the opinions of others" - "wait, I don't know how to take care of this baby, I don't know anything about taking care of babies" - "I'm like, in my head, even as they were wheeling me out, I'm screaming in my head 'don't send me home, because I don't know what

		to do, don't send me home'. - My mental state impacted my kids. The first time I was anxious and I had a more anxious baby. There were drugs in his system when he was born. - "[my first child] had a very hyper-anxious mother, who was going through a lot of, you know, negative emotions" - "my sense of self was very, very poor" - "I was not a very empowered mother" Disconnection (from self, from others) - "I was very disillusioned, I got very bitter, and it distanced me from him [husband] a lot" - "it wasn't that supportive environment, I really was looking for that from, you know, my doctors and nurses, and the way they were acting" Strong - "I felt very capable!" - "it was such an empowering one [birth], that I was, I was happy, I was literally happy! - "[my second child] had a mother who was completely involved with her body, you know, so in tune with her body that it was almost like a meditative experience the entire time" Mother (identity, status, ability, rite of passage) - "It was just this moment in the middle of the night when they brought him to me and I thought 'I am his mother'" - "you feel a little more recognised at the end of it" - "I did everything for my baby" - "I had felt such a sense of achievement through that, and I felt so incredibly lucky" - "I completely had an amazing sense of myself" - "After the second birth, I, I was in completely in awe of my body, in awe of God's design, and the way that he has engineered the whole thing" - "I knew that this is how a birth is supposed to be like, and I felt very grateful that, you know, everything had gone exactly the way I had wanted"
Susan	Cancer patient	- "I've lost a lot of faith in my body" - "Being a cancer patient, its probably more like going through a drawn-out birth experience, you have to go through a lot - "[cancer] has impacted my sense of self and my connection to my body

because all of a sudden everything that feels for granted is taken away"
- "you're really sick, and there's a possibility that you may have to leave your family behind if the cancer comes back"

Less confident (in self, in body)

- "I think after [the second] birth … my sense of self was a little bit shaken [laughing]"
- "I don't like losing control, [laughing] and I lost control there! I felt like I lost control! [laughing]"
- "think it took me some time to … rely more on my intuition again"
- "I didn't trust my body … like my body had played a trick on me"
- "I think it forced me to accept that you can't control what's happening in a birth situation … you have to let go of some parts, and that's ok"
- "I felt, after two births, that I was able to let go of that idea of being in control a bit"
- "I had two miscarriages … I had so much comfort in my body being able to handle pregnancies pretty well and all of a sudden, two times it didn't work out"
- "I lost confidence in my ability to have this baby, keep this baby, and, grow this baby"

Connected (to self, to others)

- "I needed to get in connection with my body and I was this whole person again, rather than these separate pieces"
- "I sometimes felt dissociated from my body, I was always a mind person living in my head, rather than in my entire body"
- "it was something that was there [laughing], rather than it was me"
- "I haven't always been that strong in terms of health"
- "that was interesting to see if I could handle pregnancy well, and handle the birth well"
- "I felt indeed stronger because it went so well ... but there was also, of course, what happened to my parents during my pregnancy … it was a roller coaster emotion, and I think that … contributed to the feeling of, yes, some dissociation from my body"
- "I think I, um, it felt more like a unity here, uh, more of the whole, more whole than it was before, uh, because it is such a bodily experience of course, its such an intense experience, but I think that indeed I felt a bit more connected"

Strong (physically and mentally)

- "I think that for me it helps in the sense that I have felt that strength"
- "it was that strength that, yes, I think also surprised me"
- "I have felt that strength … it was a beautiful experience"
- "I think the later births … where I knew, I felt … more empowered"

- "well I can't handle everything, but I can still feel empowered and strong to do it again"
- "I think it's the realisation that there are so many different ways of feeling empowered"
- "its not just one thing, its not only strength, its also relying on your intuition"

Mother (identity, status, ability, rite of passage)

- "I think its like … opening a complete new part of yourself … adding such a new role. It also, requires you to develop yourself so immensely in that role of being a mother"
- "it [being a mother] is such an important part of who I have become, it is … one of the most essential parts of being me"
- "I'm the combination of being a, mother and a wife and entrepreneur"
- "it makes me humble, to be allowed to be able to help these small persons on their path in life"
- "[I feel] really grateful that he was alright [after miscarriages]"
- "I also feel very grateful, because, of course, we see also, we see a great many things that can actually go wrong [death of parents to cancer, self as cancer survivor]"
- "its, a concise experience, that its really, it's a kind of a box, a 24-hour box that you go through and then there's the rest of your life as a mother"
- "I feel proud that I am able to do that"

As Table 12 shows, Susan said that her sense of self was shaped not only by each birth, but by life events such as the deaths of both parents in her pregnancies and learning that she has breast cancer. As this study is focused on the birth experience, only Susan's statements about sense of self being shaped by birth are included in the results.

Participants described their embodied sense of self as: less confident (in self, in others), disconnected (from self, from others), connected (to self, to others), confident, strong (physically and mentally, feeling of being able to handle anything in life), a mother (identity, status in family and society, ability). Interestingly, all participants said they felt a sense of self as stronger and more empowered through having gone through the experience of childbirth.

As described earlier, positive embodiment is when a woman feels connected to the

experience of giving birth and this can be detected clearly when participants describe their sense of self as connected or they express a positive sense of self. Embodiment is an awareness of self where mind and body are one and this awareness was expressed most clearly by Susan in her description of having a sense of self as connected. Disrupted embodiment or disembodiment is when the woman feels separate from the birth experience and memories of it, and this can be understood when participants describe their sense of self as disconnected or they express a negative sense of self. From the categories above, it can be seen that all participants, except for Susan, felt disconnected from their birth experience due to fear or trauma. Some of them also felt they were not in control, as if others were doing things to them, and some felt less confident in themselves. Despite these negative impacts, these participants were still able to experience an overall positive sense of self in the areas of: feeling strong and being a mother and this highlights the power of the birth experience in giving all participants a sense of accomplishment, capacity and meaning.

In summary, this chapter described all of the voices identified across all FMs. First an overview of all of the voices was given. Then for each FM an overview was given with an analysis of the relationships between the voices. Then each participant's I-Poem was presented with an analysis of the voices which co-exist within her narrative. For each participant a summary was given of the most predominant voices within her narrative, whether there were more voices of fulfillment or suffering, any resonances and dissonances between the voices, and a description of how childbirth has shaped her embodied sense of self. After that, the findings were presented in terms of: voices, fulfillment and suffering, embodiment and disembodiment and embodied sense of self shaped by childbirth.

CHAPTER 5: DISCUSSION

Although birth does not fit into a neat 24-hour experience, in the title for this study I have used the metaphor of "Going through a 24-hour box" to represent that childbirth is a concise but life changing experience for the mother. It was originally used by Susan, a participant in this study when she said birth is "a 24-hour box that you go through and then there's the rest of your life as a mother."

This chapter begins with reminding the reader of the rationale for this study and the research problem, and then it will discuss findings that fit with the existing literature, new findings, childbirth and embodied sense of self, clinical implications, strengths and limitations, future research directions and conclusion. As the review of the literature has indicated, women can have vastly different experiences of childbirth which can profoundly shape their embodied sense of self. Research which expands knowledge of the embodied experience in childbirth, and how the embodied sense of self is shaped by the childbirth experience is much needed as it could bring valuable understanding and insights. Therefore, this study explored the research question: "How do women's experiences of childbirth shape their embodied sense of self?"

Summary of Findings

Six women were interviewed retrospectively to explore their first experience of childbirth to understand how it shaped their embodied sense of self. Subsequent birth experiences were also discussed in the interviews. The Listening Guide method (Gilligan, 1982) was adapted to use the EA 4 FM model (Längle, 1993), to listen for the twenty-five voices that emerged in their narratives. These voices fell into two overarching themes of fulfillment and suffering. Voices of fulfillment in FM1 were: empowerment, trust, mistrust, acceptance, endurance; in FM2: connection, accompaniment, taking time; in FM3: being seen, appreciation, uniqueness; in FM4:

meaning, belonging, choosing. Voices of suffering in FM1 were: disempowerment, mistrust, struggle; in FM2: disconnection, abandonment, time pressure; in FM3: disregard, judgement, conformity; in FM4: meaninglessness, not belonging, not choosing.

The voices were analysed in terms of fulfillment, suffering, embodiment, and disembodiment. In order to understand embodiment in childbirth, positive embodiment is defined in this study as when a woman feels connected to the experience of giving birth, and disrupted embodiment or disembodiment is when the woman feels separate from the birth experience and memories of it. Voices of fulfillment were heard when the woman felt a positive embodied birth experience and voices of suffering were heard when the woman felt disrupted embodiment or disembodiment. The connection between embodiment/fulfillment and disembodiment/suffering are discussed in more detail later.

Fulfillment was expressed in FM1 as: confidence, trust, feeling safe. In FM2, it was expressed as: love, joy, accompaniment, and enough time. In FM3, it was expressed as: feeling acknowledged, listened to, valued, self-acceptance and identity. In FM4, it was expressed as: meaning, belonging, status, choosing, and positive sense of self. Suffering was expressed in FM1 as: lack of confidence, mistrust, fear for one's survival/lack of protection. In FM2, it was expressed as: isolation, neglect, lack of support and time, insufficient care. In FM3, it was expressed as: feeling not seen, not listened to, dismissed, self-judgement and feeling silenced. In FM4, it was expressed as: lack of meaning, lack of belonging, lack of choice, and negative sense of self. Embodiment was seen most clearly in FM1, where it was expressed as: knowing what to do, ability, strength, space to connect with one's self and safety. In FM2, it was expressed as: connection to self, connection to one's intuition, a trust in self, having time. In FM3, it was expressed as: feeling valued and having dignity. In FM4, it was expressed as: meaning,

belonging, and choosing. Disrupted embodiment or disembodiment is an experience of self-body separation. For example, in FM1 it was expressed as: not knowing what to do, fear, feeling helpless, lack of ability and strength, restriction, and exhaustion. In FM2, it was expressed as: isolation, lack of support and time, no connection/ separation from self. In FM3, it was expressed as: feeling not seen, disregarded, and self-judgement. In FM4, it was expressed as: lack of meaning, lack of belonging, and lack of choice.

Participants described their embodied sense of self as: less confident (in self, in others), disconnected (from self, from others), connected (to self, to others), confident, strong (physically and mentally, feeling of being able to handle anything in life), a mother (identity, status in family and society, ability). Positive embodiment was shown when participants described their sense of self in a positive way, particularly when they said they felt connected to themselves. Disrupted embodiment or disembodiment was shown when participants described their sense of self in a negative way. Apart from Susan, all participants felt disconnected from their birth experience at some point due to fear or trauma. Some of them also felt they were not in control, as if others were doing things to them, and some felt less confident in themselves. Despite these negative impacts, these participants were still able to experience an overall positive sense of self in the areas of: feeling strong and being a mother, and this highlights the power of the birth experience in giving all participants a sense of accomplishment, capacity and meaning.

Discussion of the Findings

Findings that fit with the existing literature.

EA dialogical aspect. EA is consistent with Merleau-Ponty's (1945/1962) view of the dialogical relationship between the self (perceptions and intentionality) and the world. Längle's EA 4 FM model (Längle, 1993) describes human life and existence in dialogue with life, and it is

concerned with the conditions a person requires to experience fulfillment. EA provides a structure to understand a person's inner experience of self and their outer dialogical experience with life as well as their subjective experience of fulfillment or suffering. The inclusively dialogical essence of EA resonates well with Merleau-Ponty's dialogical self-world relationship.

Embodied self. Childbirth as an experience supports a conceptualisation of the body according to Merleau-Ponty's (1945/1962) conceptualisation of the lived body in terms of the impossibility of separation of the body. Merleau-Ponty argued that we experience the world through our body in lived embodied experiences and that one's embodied experience is impacted by previous experiences (Butler, 1997). Hence lived embodied experiences are retained and become a part of the embodied self, and this supports the view that the lived experience of childbirth profoundly impacts the woman's sense of self.

Interoception. Childbirth as an embodied experience is consistent with a conceptualisation of the body according to the neuroscience conceptualisation of the body in terms of interoception. Interoception is consciousness of the feelings and sensations within one's body. Interoceptive signals convey an awareness of what is happening in one's body, and they convey the perception of the embodied self which is relevant for this study. Through interoceptive signals participants had a good sense of knowing what to do during the birth, and they said they knew where and how to push. Some said they felt empowered because they knew what to do, and that this changed their beliefs in her own capacity to give birth, motivating them to stay connected to the embodied experience.

Trauma. The childbirth experience supports a conceptualisation of trauma as outlined by Czarnecki et al. (2000) and Tham et al. (2007), who assert that one in four women experience childbirth-related trauma. Five out of six participants said that they felt traumatized during their

first birth experience. They described their experience of trauma as follows: not being treated compassionately *(Barnie),* not feeling listened to *(Tara),* feeling helpless and disempowered and strapped down during the C-Section *(Jess),* receiving an intervention without consent *(Tara)* or feeling loss of control when the birth did not go according to birth plan (*Tara*). The childbirth experience also supports Kitzinger's (2006) view that 1): the woman in childbirth is cared for by teams of anonymous professional staff rather than individuals whom the woman knows well (*Alice, Tara, Janelle*), 2) this leads to fragmented care where the woman's genitals are exposed, observed, and internally examined by strangers (*Janelle*), 3) it also leads to the woman feeling humiliated and reporting feelings of intense fear, helplessness, pain, and loss of control during labor and birth (*Janelle*), uterine malfunction (*Barnie*) and prolonged labour (*Jess*), and 4) those women who are able to deliver without interference tend to have more satisfying experience of giving birth than those who cannot do so (*Susan*). Susan did not feel traumatized, because she said that her birth experiences more or less followed what she had wished for and that she felt well treated, listened to and respected. The five other participants who said they felt traumatized said they are left with lasting vivid and painful memories of these feelings. Their experiences support Walsh's (2010) view that the many contrasting approaches to childbirth have detracted from the realisation of humane maternity care by omitting consideration of women's subjective embodied experiences.

EA conceptualisation of childbirth.

EA is consistent with a conceptualisation of childbirth where FM1 is concerned with the corporeality of birth and its surroundings, FM2 is concerned with the woman's feelings about the birth, FM3 is concerned with the woman's ability to be herself, and FM4 is concerned with the meaning of the birth experience for her. The following sections discuss how childbirth as an

experience supports a conceptualisation of birth as an embodied experience which can be disrupted (disembodiment) and bring suffering as well as an embodied experience (embodiment) which can bring fulfillment.

Disembodiment and suffering.

A review of the literature revealed that self-body unity (embodiment) can easily be misunderstood or disrupted (Chrisler & Johnston-Robledo, 2018; Ferrè et al., 2014). The feeling of not knowing was disempowering. At the start of labour, all participants experienced some fear due to not knowing about their ability and/or capacity to give birth. In terms of embodiment, not knowing or not being agentic is ceasing to be and boundary crossing, such as when interventions are given without asking for consent, is a crossing or violation of self. A feeling of not knowing or a feeling of being violated can cause a separation from one's self, or disembodiment. In this study, drawing on research by Piran and Teale (2012), the term positive embodiment is used when a woman feels connected to the experience of giving birth (*Susan*), and disrupted embodiment or disembodiment is used when the woman feels separate from the birth experience and memories of it. For instance, an out-of-body or disembodiment experience can be a way of protecting the self in life-threatening situations by distancing one's self from one's own body (*Jess and Janelle*) (Bullington, 2009; Morse & Mitcham, 1998; Wilde, 1999, 2003; Young, 1992), and it can also be positive as a way to gain control of physical pain (Morse & Mitcham, 1998). Disembodiment may occur due to a prolonged traumatising labour (*Jess*) (Kjaergaard et al., 2007) or non-compassionate care (*Barnie, Janelle*) (Nystedt et al., 2006), or a woman's perception that she is unable to give birth due to beliefs she has about herself (*Alice*) (Gaskin, 2011) or even in response to internalised societal discourses about idealised femininity (*Alice*) (Piran, 2016).

Some of the participants (*Jess, Janelle and Barnie*) said they felt traumatized by their birth experience. A review of the literature revealed that birth trauma can result from emergency C-Sections (*Jess*) (Tham et al., 2007), feelings of helplessness, isolation and disconnection (*Tara, Janelle and Alice*) (Thomson & Downe, 2010; Zaers et al., 2008), or due to interventions such as Ventouse or forceps (*Janelle*). In addition to this, many birthing women fear embarrassment through losing control of their bodily functions and emotions or when the most intimate parts of their bodies are subjected to the gaze and touch of caregivers, without having any intimate or social relationship with them, and sometimes without giving their consent (*Janelle*) (Ettorre, 1998). Women who have traumatic births respond well to hearing affirmations from their caregivers (*Susan*) (Berg & Dahlberg, 1998), and treating the mother as an individual can protect against trauma (*Susan*) (Byrne et al., 2017). Women need to receive compassionate care during childbirth which gives them a sense of personal agency and happiness (*Susan*) (Walsh, 2010). Caregivers can mitigate adverse effects of disembodiment or separation through compassionate, relationally focused maternity care, especially in the case when labour complications develop *(Jess),* and this is critical in shaping women's experience of giving birth (Parratt, 2002; Walsh, 2010). Trust to caregivers can create feelings of safety and empowerment *(Susan)* which can positively shape a woman's sense of self in terms of strength and capacity.

A negative or disempowering experience of birth can lead to depression and anxiety (*Jess and Janelle*) (Boath et al., 2005; Kwee & McBride, 2016), which can have a negative impact on the wellbeing of the mother and her child (*Jess*) (Bueno, 2010; Nagata et al., 2000; Zaers et al., 2008). Traumatic memories are embodied, as evidenced by a person freezing when experiencing flashback memories (*Janelle*) (Brewin, 1986, 1996, & 2001; Diamond et al., 2007). In this study five out of the six participants *(all except Susan)* who experienced such interventions said they

experienced them as violations, and they felt unsafe at some point during the birth. In existential analysis terms they felt that they could not be and their basic need to exist and survive was threatened. For instance, when the doctor performed a membrane sweep of the cervix to induce labour (*Alice and Tara*), or when drugs such as oxytocin were administered to create synthetic contractions which were more painful and with fewer rest periods than natural contractions (*Tara and Alice*) (Gaskin, 2011). Some participants said that in such situations they felt tense, and their stories revealed that their labour did not progress as well because either their contractions slowed down or that their cervix stopped dilating (*Janelle, Barnie, Tara).* When the participants experienced fear, their contractions seemed to be less bearable (*Tara*) or sometimes they stopped altogether (*Barnie*). When they were able to work with the pain of the contractions, they felt more empowered and began to believe in their ability to bring the baby into the world (*Susan*). According to Gaskin (2011), when a woman in labour is afraid, embarrassed, or angered she may experience a reversal process whereby the dilation of the cervix is stalled or reversed. For instance, "when a shift change occurs when a woman is in strong labour, her dilation often lessens when the midwife she has become used to suddenly leaves and a complete stranger comes to her side" (p. 31) (*Tara, Alice, Janelle*). There is a need to protect the birthing woman from experiencing fear, embarrassment, or anger.

Disembodiment is a response to emotional distress which entails a physical distancing from one's own body (Morse & Mitcham, 1998, p. 668). Disembodiment can be caused by fear due to things such as: not knowing how to deliver the baby *(Alice),* receiving interventions (Jess), feeling violated due to internal examinations by strangers *(Janelle)* or unkind caregivers *(Barnie).* Achieving a sense of grounding requires interpersonal connection and/or support from a person who is actively supportive in the birth and who is kind (Berg, 2005; Nystedt et al.,

2006). According to Akrich and Pasveer (2004), disembodiment or lack of connection to the embodied experience can have a direct impact on the birth process by inhibiting labour *(Tara).* Disembodiment is perceived as problematic because it negates any sense of agency and it takes time for the woman to ground herself and reconnect to the embodied experience *(Tara, Barnie, Janelle, Jess, Alice).*

In summary, according to Launeanu and Kwee (2018), disembodiment is problematic because in EA terms it represents suffering in childbirth which is viewed as a deep suffering of embodied human existence. In EA women who suffer in childbirth are struggling with disturbances in all aspects of their embodied experience: physical, emotional, relational, personal and spiritual. Research has shown that suffering in childbirth can result in long-term negative impacts on the woman (Gaskin, 2011; Lundgren et al., 2009). Women have vivid and deep-felt memories of their birth experience throughout their lifetime (Simkin, 1991), and according to the findings of this study, suffering in childbirth can lead to a negative sense of self.

Embodiment and fulfillment. Embodiment is relationship with the self; a connection with one's own body and listening to the needs and desires of the body (Piran & Teale, 2012). In order to be in relationship a person must be able to listen to him or herself (Gilligan, 1982). During childbirth, this can be achieved by having a calm atmosphere and focusing on the body through caring for oneself, such as walking (*Susan*), taking a bath (*Tara*), moving into a comfortable position, massaging the back or hips to cope with the pain. These were identified as helpful in calming any fear, relaxing, being able to focus on the body and allowing the contractions to become stronger. Those participants who had a calm atmosphere (*Susan*) said they were able to tune in and connect to their strength which helped them to cope, and this removed a lot of fear. Gaskin (2011) argues that medical caregivers are "no longer taught that

many labouring women have a need for privacy and kindness that is similar to that of other mammals" (p. 31). A striking example of the benefits of privacy and kindness is given through Susan's four birth experiences which took place in the Netherlands. For each birth Susan experienced her caregivers as relaxed, calm and non-intrusive and this enabled her to relax and turn her attention inwards to her own body's needs, connect with her baby, and focus on relaxing to give birth. Susan described her embodied experience of childbirth as positive and empowering, and this highlights the importance of relationally focused maternity health care in creating a positive experience of childbirth, and a positive impact on women's physical and mental health. Participants who were able to connect in this way experienced safety and relationship to themselves without judgement of themselves. This allowed them to come into their bodies more fully, accepting themselves as they felt accepted by others.

Having a network of support for self promotes care for self and promotes embodiment. For women in childbirth, being supported by caregivers, having a sense that they can do this (give birth), and having affirmative statements spoken to them by others are relevant to how they experience childbirth and are relevant to each woman's sense of self. The woman's relationship with self and body has parallels her relationship to self and world. So how she treats and is treated by others has a relevance to her embodied experience of self because we all have a dialogical relationship between our inner world and the outside world.

In summary, childbirth can be unpredictable: a woman may experience fear and therefore it is important for her to feel supported. She may also have unmet expectations about how she wants to give birth, and she may feel challenged to either accept what is given to her, or to speak up and advocate for herself. The dialogical experience between what the woman feels internally and how she communicates externally is an embodied experience. Women need support to face

these challenges in a way that is empowering for them. There is a need to focus on the well-being of the mother as well as the child, and in empowering the woman to feel a sense of agency, confidence and support during childbirth, so that she may have a more positive embodied experience. It is important that women have positive experiences of childbirth so that they feel a sense of agency and positive self-body relation (*Susan*) (Chrisler & Johnston-Robledo, 2018). A positive childbirth experience can lead to feelings of fulfillment. According to the findings of this study, fulfillment can positively influence a woman's sense of self.

New findings.

Representation of women's voices on their embodied experience of childbirth.

Balsam (2013a), a feminist researcher, argues that in the last century, few researchers have distinguished between becoming a mother and the mother's subjective experience of giving birth. This study aimed to address this imbalance by understanding how women's subjective embodied experiences of childbirth shape their sense of self. The findings of this study bring to light the woman's subjective experience of childbirth in terms of suffering and/or fulfillment and they show that that the childbirth experience profoundly shapes the woman's sense of self over time.

The participants in this study described vivid, powerful, painful experiences of childbirth, bringing our attention to the struggle of bringing life into the world. All of the participants described the palpable tension between their vulnerability, struggle, and suffering, as well as their wish to find meaning, dignity and fulfillment through the experience. They spoke about moments in which they felt they did not know how to give birth, and they felt afraid, helpless, disconnected. They also described moments, such as when it was time to push, where they suddenly felt they knew what to do, and they felt empowered, strong, and connected. They

recounted moments of feeling incapable of giving birth, disbelief in their body's ability to give birth, and moments when they felt a quiet determination and sureness that they could do this. For the participants the birth experience was dramatic, intense, painful and full of meaning. Some felt a sense of triumph and euphoria through giving birth, others felt trauma, disconnection, and disempowerment which overshadowed their sense of achievement. When describing their experiences, participants spoke in voices which appear as opposites, such as empowerment or disempowerment were expressed within the same interview. The experience of the participant is dynamic and shifting from moment to moment and it is possible for the birthing woman to experience moments of suffering and moments of fulfillment. Therefore, these voices can be seen as simultaneously reflecting different aspects of the experience, appearing sometimes momentarily and sometimes constantly and with some voices being more predominant than others. Although these results will show that some participants speak more with voices of fulfillment than suffering or vice versa, this should not be taken as the participant's overall feeling of fulfillment or suffering, as it is possible that the participant speaks with many voices of fulfillment, but that one small voice of suffering can leave an imprint which overshadows the other voices or vice versa. Rather it is necessary to look at each participant's expression of how this experience shaped them overall.

Childbirth and embodied sense of self. The findings of this study support the view that the childbirth experience can shape a woman's sense of self positively and/or negatively and that the embodied experience of being a person, does bear echoes or imprints from the birth experience. Those participants who felt empowered during childbirth had a positive birthing experience and a positive sense of self as: a mother, strong, connected, and confident. They said that over time, this had given them a sense of accomplishment, it had increased their self-

confidence and that they found meaning through this experience. Those participants who felt disempowered during childbirth had a negative birthing experience and a negative sense of self as: less confident, and disconnected. They said that over time this had led to them having a more negative self-image, with feelings of sadness and/or anger which made them become either more disempowered or more assertive.

In addition to their feelings about the birth experience, all participants in this study said that regardless of whether the childbirth experience was empowering or disempowering, they felt stronger because they had survived the experience. All participants described their sense of self as *strong* (physically and mentally, feeling of being able to handle anything in life), and as *being a mother* (identity, status in family and society, ability, having gone through a rite of passage, belonging to womanhood and motherhood). For instance, two participants (*Jess and Janelle*) felt traumatised whilst giving birth, but they found great meaning and joy in being able to give birth.

At certain points during the birth, all participants but one felt disconnected from their birth experience due to fear or trauma. Despite these negative impacts, which caused the participants to feel a negative sense of self, the all participants also had an additional overall positive sense of self due to feeling strong and being a mother. Those who had a negative experience said they had intentionally chosen not to focus on this negative experience, but instead to focus on the meaning they derived from giving birth because this was the moment when they brought a new life into the world. Although they described their sense of self shaped by the childbirth experience as: disconnected, they also had an overall sense of self as: a mother and strong and this suggests that all participants in this study were able to find a sense of accomplishment, capacity and meaning through this experience.

Finally, all five participants also said that as their first birth was traumatic, they described

their sense of self as disconnected or less confident, and they said that they felt this way about themselves until they were healed by their second or subsequent births which were positive and not traumatising *(Tara, Jess, Janelle, Barnie, Alice).* Childbirth and motherhood push women to grow and be strong in spite of trauma or negative birth experience, but the degree of trauma determines how much. *The healing power of an empowering birth is enormous for women who have had previous negative birth experiences.*

Methodological contribution: Adaptation for EA with Listening Guide.

Step 3 of the Listening Guide (Gilligan, 1982) was adapted in this study to use Längle's EA 4 FMs model as a framework for listening for contrapuntal voices within each of the 4 FMs. The LG is designed as an open method which allows for such adaptations. EA and embodiment have a natural compatibility in their holistic focus on the lived experience of the individual. EA is concerned with a holistic perspective of human experience with focus on the subjective experience of the individual, as opposed to just the body (Längle, 2008a). Embodiment is understood in EA as an experience of self as body, mind and spirit, and childbirth is viewed as an embodied lived experience (Launeanu & Kwee, 2018). Längle's EA 4 FMs model provided a novel more nuanced understanding the childbirth experience because it provided a structure for focusing on a more thorough and deep understanding of how fulfillment and suffering are experienced in childbirth and how they shape the woman's sense of self. Längle's EA 4 FMs model provides a novel way of understanding how childbirth shapes a woman's sense of self, and this method can inform both theory and clinical practice.

This adapted LG method highlighted tensions which exist between the feelings that women have about the birth experience and the joy they feel in giving birth. Some participants (*Janelle, Jess, Tara, Barnie, Alice*) had negative birth experiences which left them feeling

traumatised and disempowered, but they still felt strong in being able to survive the ordeal, and they felt joy and a sense of achievement in being able to give birth to a healthy baby. These tensions co-existed for five out of six participants for many years after the birth. Those who said they experienced this disparity the most said they had been taking depression medication for many years. Hence trauma can occur simultaneously with the euphoric feelings of having given birth and this points to the strength of using the EA 4 FM method with the Listening Guide. Through this adaptation, it was possible to identify these tensions and to hold these tensions together and this also provided a realistic representation of giving birth, which can be painful and frightening, but it is also a right of passage, which can be beautiful and meaningful. The adaptation of LG with EA provides a unique contribution to research as it has not been done before.

Clinical Implications

Women can be empowered before they give birth to teach a trust in one's body for embodiment and empowerment. Genuine care is important to foster a sense of being valued and appreciated. Having a sense of meaning and belonging was important for many of the women, and it might be important for counsellors who are setting up a group for pregnant women, where they have the potential to help women to increase their resilience and to know how to ask for and give support. Some women may feel overwhelmed because they do not have a good support network, or they may specifically need to learn how to be a part of such a network, or how to provide support for others. Having connection and support was of critical importance for women. Building on the capacity for connection in women is an important priority, as well as having a network of people who are accountable for providing support, as this fosters a sense of belonging.

Clinicians who receive training in the Listening Guide (Gilligan, 1982) are trained to listen to the multiple layers of the participant's lived experience and this would be valuable for clinicians in understanding their clients and in understanding their own inner experiences. By understanding that many voices exist simultaneously within a person's experience, a clinician can relate better to the many contradictions that appear in their client's experiences and understand their internal struggles. Learning from the value that the participants found in reflecting on their own experiences, this value could be provided in a clinical setting. Opportunity for deep reflection can be offered individually and in group settings.

Empowerment can lead to a positive experience of childbirth, sense of agency, positive self-body relation (Chrisler & Johnston-Robledo, 2018), and a positive impact on women's health. Hence empowerment may be of critical importance in childbirth as a protective factor against trauma and dissociation. This suggests that having early intervention therapy prior to the birth experience may be helpful in order to help women to have an empowering experience of giving birth.

Strengths

Depth research. In accordance with qualitative research, this study is idiographic and emic, and it has focused on understanding the experiences of six participants. Although this small sample size prevents generalizability, listening to the complexity of the participant's experiences has provided a better understanding of their embodied experiences of childbirth, and a better understanding of the embodiment construct in terms of childbirth.

Rigor and Quality. Guba and Lincoln's (1994) criteria for quality or rigor in qualitative research were achieved for this study. These criteria are: credibility, transferability dependability, and confirmability. ***Credibility*** sub-criteria which were met were: prolonged and

persistent engagement, peer debriefing, member checks, and progressive subjectivity. *Prolonged and persistent engagement* was achieved through the principle researcher's deep immersion in the data via in-depth interviews to gather thick descriptions of the participant's experiences of childbirth. *Peer debriefing* was achieved through working with other researchers to analyse the data. *Member checks* were achieved at the end of each interview by summarizing what was said by the participant and asking if the notes taken accurately reflected the participant's story. They were also achieved by analysing data as a group of researchers through reflexive sharing of research which was collaborative, open-ended, reflective and critical. Acknowledging that each researcher has a different reality and to ensure that knowledge was constructed without bias, this analysis process was considered as a discussion to elaborate on the emerging themes which added to the source data. Interviews were analysed by the researchers as a team and mutual construction of meaning was achieved through peer debriefing and member checks, and by researchers making their assumptions for interpretation of the data explicit, personal biases could be recognised and challenged by the research team if they interfered with the interpretation of the participants' unique experiences. The research team analysed the participants data in teams of at least two people, which meant that there was a continuous dialogue about how the research team was reacting to the participants' stories, and this was helpful in avoiding bias. The relational way of performing data analysis was robust; the researchers had the opportunity to discuss differences in their reactions, or interpretations, and to deepen their understanding of each participant before arriving at an agreement on how the data was interpreted. *Progressive subjectivity* was achieved during steps 1 (Listening for the plot), 2 (composing I-Poems), and 4 (composing an analysis) of the Listening Guide method (Gilligan, 1982), which were carried out by the principal researcher. Progressive subjectivity was achieved by keeping a journal of own

developing constructions to document the process of change throughout the study. These constructions were shared with the research team in order to challenge individual biases and understandings. Step 3 of data analysis was carried out by a research team, which met regularly to discuss the interviews and the participants' subjective experiences as well as to reflect on the researchers' own experiences acquired through the listenings. ***Transferability*** was achieved because although the results of this study are not generalizable, there was sufficient data for the transferability criterion to be met by maintaining and providing thick description for multiple cases so that the reader of the research had enough detail about the context and complexity of the research setting to be able to make a judgement about the similarities and differences of the research findings and how they might transfer. ***Dependability*** was met with a dependability audit through regular checks about the study (semi-structured interviews, conceptualisation, data collection, data, analysis and results) by a research team. Dependability was also met through maintaining consistency of roles, such as that of the primary researcher and research team as responsible for data analysis. ***Confirmability*** was met with a confirmability audit and chain of evidence providing enough qualitative data such that it could be tracked to its source, which is the participant, thus highlighting that the researcher's judgement was minimized. In addition, the logic used to interpret data was made explicit so that a chain of evidence was provided confirming how data was synthesized and how conclusions were reached.

Critical Reflexivity, which is a part of Lincoln's (2009) authenticity criteria for transformative research, was achieved through the principal researcher keeping a journal of her interpretations of the research process. The relationship between the principal researcher and the participants was interactive and interviews were conducted with an awareness of the cultural complexities in that relationship. Participants were empowered to express their lived

experiences of childbirth. Importance was placed on what they had to say, on examining the power dynamics within the system of childbirth, and on offering women a chance to understand their childbirth experience relationally. The Listening Guide method (Gilligan, 1982) allowed the participants to share their stories in more detail than they had before, and they found this to be healing. The participants of this study reported that they felt more empowered through the process of talking about their experiences, because they felt they had been heard and understood. The participants felt that taking part in this study gave them the valuable experience of being able to re-examine and integrate their childbirth experiences in a more positive light, by identifying their own strengths such as their ability to give birth and accept the circumstances of their birth experience.

Subjectivity, as outlined by Breuer and Freud (1986) for feminist research, was achieved by explicitly stating the principal researcher's position regarding this research to participants and to the research team and using this as a lens through which research was conducted. The participants were changed because they felt that they were able to share their childbirth experiences in a safe setting and understand their experience in a more positive light.

Relational research. The Listening Guide method (Gilligan, 1982) provided a relational process to construct knowledge by understanding the lived experience of the participants. The method enabled the research team to engage and listen deeply and personally to participant stories, enabling them to gain a better understanding of women's subjective lived experiences of childbirth as well as how these experiences shaped their embodied sense of self. The research team were aware of the power structures and culture of the maternity care systems within which the participants delivered their babies. Five participants delivered their babies in hospitals in Western countries (Canada, USA, Netherlands) and one participant had a home birth in a third-

world country (Uganda) with a midwife at her side. The differences in these approaches to childbirth created widely different procedures of care and resulting embodied experience for the women.

Diversity. This study welcomed participants of different ages, with different cultural backgrounds, and with experiences of giving birth in different countries with different systems of care. The aim was to study a wide range of childbirth experiences. Four participants were Caucasian (Alice and Janelle from Canada, Jess from South Africa, and Susan from the Netherlands) and two were of East Indian origin (Barnie from Uganda, and Tara from India). The first births of the six participants took place in Canada (Alice, Janelle and Jess), USA (Tara), The Netherlands (Susan) and in Uganda (Barnie). Despite the small number of women in this study, and their diverse circumstances, several common themes emerged which applied to almost all of the participants, and highlighted that childbirth is primarily a human experience, which is common to all nationalities and cultures.

Transformative. Through the interviews, participants expressed their subjective experience of childbirth in a safe setting and this gave them a deeper understanding of their experience and enabled them to connect more to their own strength in being able to give birth and the sense of accomplishment and responsibility they felt in having a child and in becoming a mother. They were able to experience their vulnerability in a safe and supportive environment, and learn that relationships can provide healing, enabling participants to create more healthy relationships in their own lives. By talking about their birth experience, the participants were able to create a more empowering story of their experience, one that portrayed them as survivors of a difficult experience. They were able to focus on their ability to give birth and what that meant to them. According to their expressed experience, the participants said that through

childbirth they realised they were stronger than they had thought and that this made them feel that they would be able to face any challenge that motherhood could bring. They also said that through sharing their stories they were more aware of the feelings of fulfillment they experienced through childbirth.

Adapted Listening Guide. The Listening Guide (Gilligan, 1982) was adapted in this study to use Längle's EA 4 FMs model as a framework for listening for contrapuntal voices within each of Längle's 4 FMs. The adaptation was used with full awareness that this would impose the theory structure of Längle's EA 4 FM model on the original Listening Guide method, and that it would create a limitation in that researchers now listened for voices within the pre-defined structure of the EA 4 FMs model. However, it provided a more thorough and deep understanding of how fulfillment and suffering are experienced in childbirth and how they shape the woman's sense of self. The adaptation still allowed researchers to engage with the data with openness in a dialogical inquiry, but this was done with consideration for the EA conditions for fulfillment within the EA model. This adaptation provides a unique contribution to research as it has not been done before.

Limitations

This research offered an opportunity that was not used in that participants could have been interviewed once more, after they had had time to reflect, in order to see if the study had met feminist-transformative aims to help them understand their birth experience in a larger context.

The opportunity to centre the participants' voice and authority was not utilised, whether as a member reflection, a member check, or participation in analysis, and this could have been done more to fulfill one of the rigor steps in qualitative research. The interviews could have

been videotaped instead of doing audio recordings and this would have provided richer data.

As this was a retrospective study, it was not possible to know how the participants experienced their embodied sense of self before childbirth and therefore it was not possible to compare their sense of self before and after childbirth.

Future Research Directions

All human beings are born, and yet the phenomenon of childbirth is so understudied. Childbirth is an experience of unity in the physiological and personal, in being a body and being in the world. The Listening Guide method (Gilligan, 1982) is useful in that through learning from individual experiences, researchers find new questions to be studied (Gilligan et al., 2003). The experiences of the participants in this study (Susan in particular) show that there are significant differences in the context of birth for each participant which shaped their embodied experiences of childbirth. There is a need for further research on childcare practice that is more woman-centered, taking women seriously, and giving women more say during childbirth. The childbirth experience matters to a person's embodied sense of self and there is a need for more research on women's subjective experiences of childbirth.

This study aims to increase knowledge of the constructs of embodiment in childbirth and embodied sense of self shaped by childbirth, and it aims to encourage further research in these areas. There is a need to bring an embodiment perspective into mainstream conceptualisations and practices of childbirth.

Conceptualisations of childbirth which have been focused on the physical well-being of the mother and child, with emphasis on the child, needs to be focused on the whole embodied experience of the mother and child, with emphasis on the mother's well-being and on empowering the her to feel a sense of agency, confidence and support during childbirth.

Future studies are needed to understand how a woman's embodied sense of self before childbirth affects her childbirth experience, and how it is changed by childbirth. Future studies are needed to get a baseline understanding of how the participants experienced their embodied sense of self before childbirth and to compare their sense of self before and after childbirth.

Studies are needed to understand the influence of culture in childbirth, and to differentiate between the culture of the birthing establishment, the birthing culture of the country of birth, and the birthing culture of the woman's family of origin. These studies on culture could be combined with studies on sense of self to understand how a woman's embodied sense of self is shaped by childbirth and culture.

Conclusion

The results suggest that women's embodied sense of self is shaped by the childbirth experience. It can be shaped negatively when their experience of childbirth causes them suffering through disempowerment and/or a separation from self (disembodiment), and it can be shaped positively when their experience of childbirth gives them a feeling of fulfillment through empowerment and/or a connection to their self (embodiment). It is also possible for women to experience both positive and negative aspects in the same birth experience, and this can lead to a mixture of feelings of both suffering and fulfillment together.

The power of birth as an integrating, unifying and mind-body event was interrupted for some of these women through their disempowerment and trauma, but it wasn't fully taken away from them because once they delivered their baby, it also fulfilled them with a sense of self as strong, and a mother, which led to feelings of accomplishment and increased capacity. Hence the power of the birth experience is that it can give all participants a positive sense of self as strong and as a mother and it highlights the power of human resilience through the sacredness

and beauty of giving birth. Childbirth and motherhood push women to grow and be strong in spite of trauma or negative birth experience, but the degree of trauma determines how much. The healing power of an empowering birth is enormous for women who have had previous negative birth experiences.

In order to promote a culture where women have strength and capacity, we need to support them in childbirth and let them be whole in their bodies. There is an opportunity to shape and influence the embodied experience of childbirth so that it promotes strength, capacity and empowerment. We need ways to support women in childbirth, so that they do not need to suppress or numb their feelings and so that they can experience fulfillment and joy.

Using the metaphor of the 24-hour box, the birth experience stays with the woman over time, and it shapes her sense of self both in negative and positive ways. For these participants, there were empowering aspects during the birth in spite of disempowering and disconnecting aspects. Although it was a complex experience, each participant described the experience of giving birth as a lived experience that is remembered vividly. For each participant, this experience continues to shape her embodied sense of self, and it continues to matter in her life. Hence the woman's embodied sense of self is shaped by the birth experience in positive and negative ways.

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Appendix A: Advertisement for Participants

How Women's Experiences of Childbirth Shape their Embodied Sense of Self

What is your childbirth story? Would you be interested in sharing it? We are researchers looking for mothers who would be willing to share about how their first birth experiences have remained with them. Would you like to participate in a study to research childbirth? If:

- you are 19 years or older
- you are a mother with one or more children
- your first experience of giving birth was more than one year ago (or much longer)
- you can remember your childbirth experience
- you are able to reflect on your birth experience and are willing to talk about it
- you feel that giving birth has played an important role in shaping your sense of self and /or how you feel in your body

then we need your help to find out how the experience of childbirth shapes women's embodied sense of self. Your experience is extremely valuable and will help us to understand how mothers experience childbirth.

If you choose to participate in the study, you will be invited to take part in an audio-taped interview and several telephone conversations. Compensation will be offered for your participation.

For further information please contact Neeta Sai and leave your name, your phone number and a short message to let us know that you are interested in participating in the study.

Janelle Kwee, PsyD, Faculty of Graduate Studies, Counselling Psych, Trinity Western University. Contact [phone number] or [email].	Neeta Sai, B.Sc., MBA, M.A. Student in Counselling Psych, Trinity Western University. Contact [phone number] or [email].

Appendix B: Telephone Interview

Introduction:

- Introduce myself as the researcher
- Explain that the purpose of the call is to discuss their potential participation in the study, and to determine whether their experience fits with the purpose of the study
- Explain that if they do not meet the criteria for inclusion in the study, that all information they have provided will be destroyed
- The participants will be informed that their participation is voluntary and that they have the right to withdraw participation at various points during the research process, including screening, informed consent, and the pre-interview script
- Explain that once interview data has been collected and analysed it will not be withdrawn from the study
- Briefly explain the purpose of the study: How do women's experiences of childbirth shape their embodied sense of self?
- Ask how they found out about the study
- Ask whether they have time to participate in a 30-minute conversation
- Record date of call, participant name and contact information

Semi-structured questions:

- How old are you? (must be a female aged 19 and older)
- Do you have any children? (must have at least one or more children)
- How long ago did you have your first child? (must be at least more than one year ago)
- Do you remember your first live birth experience?
- Are you able to reflect on this experience and talk about it?
- Has childbirth been significant for you in your life? If so what made it significant?
- Do you feel that your experience of childbirth has played an important role in shaping your sense of self?

Appendix C: Pre-Interview Script

Thank you very much for your interest in this study. I am very grateful to for your willingness to make time to share your unique story with me.

Before we begin, I would like to go over the informed consent and confidentiality form with you [read together]. Do you have any questions or concerns about this?

As mentioned on the online survey and in our telephone conversation, I would like to ask you some personal questions about your first childbirth experience. Please feel free to let me know if, at any point, you prefer not to answer my questions or if you feel uncomfortable in any way. Your participation is entirely voluntary and you may choose to discontinue the interview at any point in time without penalty. However, once interview data has been collected and analysed it can no longer be withdrawn from the study.

In order to protect your identity, you may choose an alias name to be associated with your interview data for the purposes of publication.

Thank you once again for your willingness to participate in this study.

Appendix D: Consent Form

How Women's Experiences of Childbirth Shape Their Embodied Sense of Self

Principal Investigator: Neeta Sai, M.A. Student in Counselling Psychology, Trinity Western University. Contact number [phone number] or [email address].

Supervisor: Janelle Kwee, PsyD, Faculty of Graduate Studies, Counselling Psychology, Trinity Western University. Contact number [phone number] or [email address].

Dear Potential Participant

Thank you so much for your interest in this research project. In this study, I would like to explore women's' experiences of childbirth and how this impacted them in important ways. I am interested to know their stories.

Purpose: The purpose of this study is to understand how women's experiences of childbirth have shaped their embodied (lived) sense of self. This study is designed to inform the academic community, clinicians, and most importantly women, with the purpose of helping women develop awareness of their embodied sense of self through the experience of childbirth.

Procedures: In order to take part in this study, you must be a woman aged 19 years or older that has experienced at least one live birth regardless of how long ago this happened and regardless of whether the child was delivered vaginally or through a caesarean section. If you agree to participate in this study, you will first be invited to participate in a screening process.

During the screening process, you will be asked to participate in a semi-structured telephone interview, which will determine whether your experience meets the criteria of the study. If it does not, then your information will be retained until the study has been completed and then it will be destroyed.

If you are selected to participate in the study, you will be contacted by phone or email, and more details about the study will be provided at that time. During the interview process, you will be asked to take part in a 60 to 90-minute semi-structured interview at a location where you feel comfortable to talk with the researcher about your childbirth experience. The interview will be audiotaped and transcribed as part of this study. Information will be gathered according to a method which is designed to listen to the unique experience of childbirth from the viewpoint of the woman, with a focus on how this has affected her embodied sense of self. In this interview, the researcher will ask you questions about your first childbirth experience, how you experienced that in your body and how it has shaped your embodied sense of self.

Potential Risks and Discomforts: The risks involved in this study are minimal, however there is potential for you to experience discomfort in talking about your childbirth experience. In addition, discomfort could occur if you are not selected for the study. Non-selection could occur if you do not meet the specific criteria such as: having had time to reflect on the experience of giving birth, being able to remember the first experience of giving birth, having a feeling that giving birth has impacted your experience of yourself and/or your body, and having a willingness to talk at length about your first birth in terms of the focus of the interview. Should you not be invited to participate in the study but you wish to know why, you will be able to contact the researcher. If any part of this process creates emotional discomfort, a referral for counselling will be provided by the researcher.

Potential Benefits to Participants and/or to Society: Benefits from participation in this study include an opportunity to reflect on your experience of childbirth and how it has influenced who you are. Your participating in this study will assist the researchers to better understand how the childbirth experience shapes women's embodied sense of self. This will help to better inform other clinicians and researchers to better understand a healthy embodied sense of self as a method of preventing trauma.

Confidentiality: All information that can be identified with you, which has been collected through this study will remain confidential and will be disclosed only with your permission or as required by law. If you are not selected for participation in the study, your information will be kept securely as follows: physical documentation will be kept in a locked filing cabinet in the researcher`s office and electronic information will be kept in a password encrypted folder on the researcher's computer. Upon completion of the study, all information will be securely destroyed. If you participate in the study, your interviews will be recorded for transcription. Further details will be provided during the study.

Remuneration/Compensation: Participants who participate in the screening process will be asked if they would like to enter a draw for a Starbucks gift card by giving their email address to the researcher. For participants who take part in the study, further compensation will be given in the form of a $10 gift certificate to Starbucks or Chapters.

Contact for information about the study: For further information about this study, or if you are interested in the findings for this study please contact Neeta Sai [phone number] or [email address] or her researcher supervisor, Dr. Janelle Kwee, at [phone number] or Janelle.kwee@twu.ca.

Contact for concerns about the rights of research participants: If you have any concerns about your treatment or rights as a research participant, you may contact Ms. Sue Funk in the

Office of Research, Trinity Western University at 604-513-2142 or sue.funk@twu.ca.

Consent: Your participation in this study is entirely voluntary and you may withdraw from the study at any time without penalty by contacting the researcher (in person, via email or telephone). Please note that withdrawal from the screening process will prevent you from participating in the study and that withdrawal is not possible if you have participated in the interview and your story has been integrated into the dataset. In order to protect your identity, all data collected from your contribution to the study will be published under a pseudonym which will be chosen by yourself.

Signature
By signing this form, you are agreeing that any questions you may have about the study have been answered to your satisfaction and that you have received a copy of this consent form for your own records.

Your signature also indicates that you consent to participate in this study and that your responses may be put in anonymous form and kept for further use after the completion of this study.

_____ _____

Participant Signature Date

_____

Printed Name of the Participant signing above

Appendix E: Interview Questions

Questions about the childbirth experience:

1. I would like to begin by asking you to tell me about your first birth experience (If they wish to, participants can share whatever they want, and I will help them bring the experience to focus by asking where did they give birth, who was their attendant, who else was there, what kinds of preparation did they do, what were the surprises, how did you or others advocate for your needs, etc.).
2. You have already told me that your experience of childbirth has been significant in your life. Please tell me how so. What parts about your birth experience were most significant? (Here the intent is to ask about: who, what, where, when, why, and particularly ask about bodily experience)
3. How did you experience yourself through your body during your birth experience?
4. Was this any different than how you experienced yourself through your body before?
5. How have you experienced yourself through your body since your childbirth?
6. How has your childbirth experience contributed to you being you in your body? (Negatively or positively, strength, intuition, etc.)
7. What was it like to give birth?
8. In which ways do you know that now?
9. When did you become aware of it?
10. What does it mean to you to be a mother?
11. What have you observed about mothers?

Questions about embodied sense of self

1. How did you experience your body before, during and after the birth?
2. How did you experience the birth through your body?
3. How has childbirth contributed to your sense of self/ sense of who you are?
4. How has your sense of self (identity) been shaped in important ways by your experience – this is implicit not explicit.
5. How would you describe your sense of self now?

Appendix F: Post-Interview Debriefing Script

Thank you very much for your interest in this study. The purpose of the study is: How do women's experiences of childbirth shape their embodied sense of self?

I am very grateful to for your willingness to make time to share your unique story with me. In order to protect your identity, your chosen alias name to be associated with your interview data.

What was this experience like for you? Do you have any questions or comments about your participation in this study?

You are invited to participate in a follow up interview, by phone, if you choose, to review the findings from your interview and the overall findings of the study.

Thank you once again for your willingness to participate in this study.

Appendix G: Confidentiality and Non-Disclosure Agreement for Research Assistants and Transcriptionists

WHEREAS, the researcher (Neeta Sai) agrees to furnish _____ certain confidential information products for the purposes of research and/or transcription;

WHEREAS, _____ agrees to review, examine, inspect or obtain such confidential information only for the purposes described above, and to otherwise hold such information confidential pursuant to the terms of this Agreement.

BE IT KNOWN, that the researcher has or shall furnish to _____ certain confidential information and may further allow _____ the right to analyse or transcribe the interview data of the researcher on the following conditions:

1. _____ agrees to hold confidential or proprietary information or trade secrets ("confidential information") in trust and confidence and agrees that it shall be used only for the contemplated purposes, shall not be used for any other purpose, or disclosed to any third party.
2. No copies will be made or retained of any written information or prototypes supplied without the permission of the researcher.
3. At the conclusion of the research project, or upon demand by the researcher, all confidential information, including prototypes, written notes, photographs, sketches, models, memoranda or notes taken shall be returned to the researcher or destroyed upon the researcher's request.
4. Confidential information shall not be disclosed to any employee, consultant or third party unless they agree to execute and be bound by the terms of this Agreement and have been approved by the researcher.
5. This Agreement and its validity, construction and effect shall be governed by the laws of British Columbia.

AGREED AND ACCEPTED BY:

Date: _____

By_____ Witness: _____

Title: _____

By_____

Title: _____

Appendix H: Flyer for Counselling Referrals

Counselling and Psychological Services for Women for Childbirth Experiences

Counselling Services

Fraser River counselling,
Tel: 604-513-2113 (Langley)

New Life Christian Counselling,
Tel: 604-856-2578 (Langley)

Burnaby Counselling Group,
Tel: 604-430-1303 (Burnaby)

Appendix I: Analysis Table

Step 4 of the Listening Guide

Voices within each FM with excerpts from participant stories

FM1	
Voice of Empowerment Speaking with clarity, certainty, and sureness. "I felt well connected with my own body", "I think you need to check", "I feel I have to push", "I do know", "I am strong" • <u>Knowing what to do</u> o How to breathe (help from doula): Susan "I could handle the contractions" o When and how to push: Tara "I think you need to check me, how dilated I am, I feel like I have to push", Jess "it felt like my body knew what to do and I knew" o Feeling strength in body (I survived, achievement): Janelle "if I can survive that, then I must be strong, even if I don't feel it … I'm … stronger than I thought I was"	**Voice of Disempowerment** Speaking with uncertainty, lack of confidence, lack of clarity, and lack of direction. "I'm kind of sure," "I think," and "I didn't know" • <u>Not knowing what to do</u>: "I wondered", "I could not ask", "I did not even understand", "it didn't really do much to prepare you" o No education / knowledge about birth o Insufficient education birth prep class o Too much education/ overwhelmed or no desire to know o Feeling unsupported Tara "I felt disempowered … because it wasn't that supportive environment, I really was looking for that from, you know, my doctors and nurses, and the way they were acting" o Jess - Prolonged labour not necessary if C-Section needed o Epidural suggested when not wanted • Dissociation/ disembodiment: Jess "I pop out of my mind", "this headspace you go into", "you can't think properly", "I was kind of out of my body", "I was floating above myself", Susan "it [my body] was something that was there, rather than it was me", Tara "I could tell I was both here and I was not here" o Sense of watching, being outside body o Sense of hearing, echo, distant voices • Lack of control Janelle "I didn't have any control, I didn't know how to have a baby " • No access to others that know "I had nobody I could ask and say "What was it like for you?" • Following instructions blindly: "if I followed all the instructions correctly, then we'd be ok"
Voice of Trust • <u>Trust in Self:</u>	**Voice of Mistrust** Speaking with hesitancy and an air of feeling

• In capacity to deliver (with <u>no</u> prior experience) o mental preparation/confidence): Janelle "I just mentally prepared myself and then I was able to physically follow through" o trust own instincts/strength: Jess "I trust my instincts and what feels right", Barnie "I did not feel scared … I felt I can do it." • In ability to focus (and forget about needs of others): Susan "I took a moment", Tara "I was focusing", "I was concentrating", • In capacity to deliver (with prior experience) o Experience, planning, sense of agency: "I knew what to expect", Janelle "I knew that if it did go badly, that I could handle it." • <u>Trust in others:</u> o To care for my survival: "my mother was the pillar. If she had not helped I don't know how I would have done it." o To be caring and be nearby - family & nurses/doctors: "it was good to have her [mom] there", Tara "she [nurse] was right there" o To have skill to care for me: Susan "we feel safer going to the hospital", "I am in the best hands" o To provide a calm relaxed atmosphere to birth: Susan "they gave us that breathing space", "it was our bubble"	forced, or ignored or not listened to • Fear, worry about survival "what if I died?" • Body not doing what it is supposed to do: Jess: my body is "not doing its job properly" • Body invaded/ overpowered: "there's something inside of me that has taken over", Jess "other people took over … that was a very helpless feeling" • No trust that family will take care of me: "I started having a fever … still I had to work, work, work" • No trust to caregivers to: • 1) Protect me from strangers: Janelle "they brought interns to watch … there was no consent on my behalf" • 2) Stay for the delivery: "I thought she was staying until the baby was delivered." • 3) Provide skilled care for my safety: Jess "I didn't feel safe, mentally, physically." • 4) Ask for my consent before performing an intervention: "she broke my membrane, without warning me." • 5) Refrain from unnecessary interventions: Jess "They strapped my arms down" • 6) Provide all the information I need: Tara "I have no idea what that entails but I am hoping I will go natural" • 7) Respect my wishes: Tara "the birth plan … I felt like it was not liked" • 8) Allow me to move Tara "I realised I'm, I'm completely immobile … Oh my God, I don't know if I can do this"
Voice of Acceptance • accept circumstances of giving birth, with statements like "it was ok" o type of delivery not as I wanted o death/ illness of loved ones: Susan "I also lost my father … there was, just no possibility for him to recover … so it was ok" o I cannot control everything: Barnie "we don't know what the reasons are for what they do", Susan "you can't control what is happening"	**Voice of Struggle** Bearing with the situation when one is not in agreement. Feeling one has no choice, disempowered, speaking with frustration, silence, struggle, with an attitude of putting up with a situation, which can also be experienced as a violation or trauma: "I can't," "I'm done," and "I didn't choose this". • Exhaustion: Jess "you just are living moment to moment, contraction to contraction … it's just like, just like, get this over with, I'm just, I'm just done and now"

<table>
<tr><td>Voice of Endurance
Deciding to bear with the situation and agree to it even if they did not like it. Feeling that this it is worth it to endure the situation because of a higher gain
• Janelle, said “most of the people in the room from what I can recall, were male, and I’m thinking “I’m doing something that you will never do!”, so I was kind of like ‘Let them watch!’”</td><td>• Complications: Barnie hemorrhage - “There was so much blood, so much”
• Tear or cut: Janelle “I got a third-degree tear … 37 stitches … I had torn so badly … that kind of scared me”
• Body changes: “I have stretchmarks … I still don’t like them, and I just felt like this isn’t fair”</td></tr>
<tr><td>FM2</td><td></td></tr>
<tr><td>Voice of Connection
Speaking with a sense of connection to life, a turning towards life, a lust for life. With this voice, women expressed their felt emotions, such as love, joy, and a bursting with life about giving life.
• Connection to family: Tara “That [telling my mother I am pregnant] was a very, very, happy moment for me”
• Connection to baby: Jess “They popped her head over the top of this little blue sheet … I’m in love”, “He’s my kid! I’m a mother!
• Connection to self: Susan “I was always, I think a mind person living in my head, rather than in my entire body … it felt more like a unity here … I felt a bit more connected and strong”</td><td>Voice of Disconnection
Speaking with a sense of disconnection to life, a turning away from life, a distancing or dissociation from life.
• Isolation “made me feel more alo…alone in uh this endeavour”
• Disconnection to self: Janelle “Numb is a good way to describe it”, “I felt very, like vulnerable, and um, exposed … I was in a lot of pain … I did not want my mother to worry about me … I did not make much noise”
• Disconnection to others due to:
o Social ignorance: Barnie “she [midwife] was screaming at me … she was very rough … it was not caring … she sent my mother outside, ‘don’t come, you are not allowed’ … I felt upset.”
o Conflict: Barnie “The Aya [maid] came to massage me and she was rude”
o Distance: Jess “my parents … weren’t over as much, or available as much as I, I guess I had hoped”, “I was young and scared and … we didn’t have a lot of family support”</td></tr>
<tr><td>Voice of Accompaniment
Expressed by participants as a feeling that they had a relationship with people around them, whether family, friends, or professionals. That one was not just seen as a patient, but seen and treated as a person, with respect and courtesy. This gave them a feeling of accompaniment
• Not feeling alone: Janelle “they really knew what they were doing, and um, very warm and welcoming … and my mom was there again</td><td>Voice of Abandonment
Speaking with a sense of being not being properly cared for by their caregivers.
• Anger/rage: “it pissed me off” (not being able to deliver vaginally)
• Neglect: Janelle “I actually felt a bit neglected, I kind of felt a bit ignored”
• Caregiver did not advocate for me: Jess “would you not advocate for that? [being able to hold my baby after a C-Section] … It</td></tr>
</table>

and my husband"	ticks me off" • Superficial care: Tara "Its Father's Day, so … I'm gonna spend some time with my kids at home"
Voice of Taking Time Speaking with a sense of being allowed to take the time they needed to give birth. • Feeling relaxed or taking it easy: Barnie "My father used to sit with me and told me to … think good things … send the baby good messages … I was reading good things, religious books", Jess "more relaxed and more content"	**Voice of Time Pressure** Speaking with a sense of being rushed. • Taking too much time to give the baby to the mother: Jess "that might have affected things [ability to bond with baby] too, it felt like a long time. I, I don't know, probably like 45 minutes" • Not taking time to care for me: "then the doctor came in almost immediately after [the baby was born], and I said 'Oh! you're too late!'" • Running out of time: "There was no time for an episiotomy so I tore." • Rushing: "You know, I'm turning up this dial [for oxytocin drip], because I have to leave on vacation for the long weekend"
FM3	
Voice of Being Seen Participants felt that they had been seen or acknowledged by others and that their wishes had been considered by others. • Role/Identity: Jess "you go from being me … to mother and that, that's the biggest, the most important role I've ever had", Tara "I am his mother", "its nice to love and be loved unconditionally", Susan "its like, kind of opening a complete new part of yourself … to develop yourself so immensely in that role of being a mother"	**Voice of Disregard** Participants had the feeling that they were not seen and that their wishes were dismissed or not listened to by others. • Not being seen/ loss of self : "OK, I am just a mother, and there is no more me" • Wishes not considered/ ignored: Jess "she [midwife] seemed a bit more dismissive of some concerns … It just put that little kind of, you know, bad feeling into the situation" •
Voice of Appreciation Participants felt valued because their wishes had been considered by others. • Value my body: Tara "I was looking a lot prettier", Janelle "stretchmarks should be seen as, warrior stripes", "they [other women] are trying [to regain their shape] but that they	**Voice of Judgement** Participants felt silenced • Shame: "it was an unplanned pregnancy, and I was young and scared and … um, we didn't have a lot of family support" • Judged by others: Barnie "I was in a lot of pain, and I made no noise, otherwise

shouldn't really have to" • Valued in role as mother: "the nurses listened to me and so … I do have something to contribute here", Tara "Teaching me how to nurse him …and my mom was trying to recall from her experience"	everyone in the house would hear. It was not done" • Judging self: Tara "I used to think it [baby not sleeping well] was because I had the epidural, maybe because of the drugs that were in my system when he was born." • Body image: "pregnancy and childbirth all that really threatened that physical sense of attractiveness"
Voice of Uniqueness Participants felt that they could be their authentic selves. • Boundaries: "I chose the timing, made a conscious decision that this time it is going to be different", Jess "that was the point of [deciding] I'm important" • Advocate for self: Jess "I know that, what I choose for my, my kids or what my husband and I choose is what's best for us"	**Voice of Conformity** Participants had the feeling that they did not have permission to be themselves and that they had to conform to the wishes of others. • Not having permission to be myself: Jess "I didn't feel like I had permission to be myself, permission to ask for things, and I, I, I didn't feel physically or mentally capable of asking for it either at that point", Tara "I was just, I was talking to them, I was incredibly polite saying all of my pleases and thankyous and all of that" • Being pressured to obey caregivers: Tara "They were kind of thrusting it [epidural] on me, every time she came to check me" • Need to be attractive: "Am I attractive? and did men find you attractive, that was my concern"
FM4	
Voice of Meaning Participants spoke with purpose, meaning, a sense of contributing. • Meaning in giving birth: "It is the greatest accomplishment in my life" • Meaning in contributing to others: Tara "through hearing my experience [on blog] … they could kind of live, live, live it, and somehow, be fulfilled from it"	**Voice of Meaninglessness** Participants felt a lack of meaning or an empty void. • Lack of meaning: Susan went to a memorial service of a mother of three "it was such a hurtful and horrible experience, which was so hard to see"
Voice of Belonging Participants felt a sense of belonging as well as connecting to their womanhood through the rite of passage of giving birth. It is also a sense of pride in being able to give birth. • Sense of belonging: Janelle "I was in completely in awe of my body, in awe of	**Voice of Not Belonging** Participants felt a lack of belonging. • Not belonging: Jess "I didn't feel important, because I had to prioritize my child, I admit this is not working for me and I'm struggling … it's hard to ask people for help"

God's design" • Rite of passage Janelle "knowing that I was created to be able to give birth to a healthy baby, that makes me feel strong …its changed me forever." • Motherhood: Janelle "I think that childbirth opens up the world for you, and it puts you into a world of other people that have experienced childbirth". Janelle "it changes how you relate to people … and it's a bit of a bonding experience I guess", Susan "I think its the most essential part, or one of the most essential parts of being me" • Circle of Life: Susan "it was the circle of life on a square meter … one person in your life dying and another person coming in" • Sense of self shaped by childbirth: Janelle "I feel like I have a place in the world", Susan "its like adding such a … new role. … it also, requires you to … develop yourself so immensely in that role of being a mother that its such an important part of who I have become", "it's a kind of a box, a 24-hour box that you go through and then there's the rest of your life as a mother … I have felt that strength, that really, it was a beautiful experience"	
Voice of Choosing Participants felt a sense of being able to choose and advocate for their own wishes. • Being active in one's life, and wanting to self-determine • Desire to have and care for own child: Barnie "I wanted a baby", ", I wanted a boy, I did not want to wait too long to have a second baby", "I wanted [midwife] her to be there", Alice "I always wanted children, • Desire to choose caregiver: Alice "When its my time, I want to make sure I have you [doctor]" • Desire to choose: o Alice "I didn't want stretchmarks", "all I want is an epidural" o Janelle "I knew I wanted to give birth in the hospital"	**Voice of Not Choosing** Participants felt a lack of ability to choose because the circumstances were such that one could not change them. • Not choosing: "this was not the plan … I guess I have no choice, this is when I am having kids"