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'Mentalizing possibilities' - A Grounded theory of antenatal women's decision making of their birth choices in pregnancy following a previous Caesarean Section (CS)

Thesis submitted by

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Declaration

I declare that this thesis is my own work and has not been submitted for another degree either at University College Cork or any other University. The work of others has been used to argument this thesis and these are acknowledged/ referenced accordingly.

Student signature: ----------

Date: ----------

Glossary of terms

AAFP	American Academy of Family Physicians
ACOG	American College of Obstetricians and Gynaecologists
CGT	Classic grounded theory methodology
CS	Caesarean section, (other terms include caesarean birth or caesarean delivery)
DOH	Department of Health
El CS	Elective Caesarean Section
EM CS	Emergency Caesarean Section
ERCS	Elective Repeat Caesarean Section
Health professionals	Obstetricians, GPs and midwives
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
KPMG	Klynveld Peat Marwick Goerdeler
LAC	Labour after caesarean
LSCS	Lower Segment Caesarean Section
NHS	National Health Service
NICE	National institute of clinical excellence
RCOG	Royal College of Obstetricians and Gynaecologists
VBAC	Vaginal Birth after Caesarean Section
WHO	World Health Organisation

Abstract

Title: An exploration of women's decision making of their birth choices in pregnancy following a previous caesarean section (CS)

Aim: To develop a grounded theory of antenatal women's decision making of their birth choices in pregnancy following a previous CS.

Rationale for theory: Reports identify a lack of choice for pregnant women including women's choice of vaginal birth after a previous caesarean section (VBAC) (HIQA, 2016; DOH, 2016). VBAC is a safe choice for most women (RCOG, 2015; HSE, 2011). Women's experience of decision making about VBAC has been described as 'groping through the fog', where decision making and information during pregnancy and the birth is unclear and contrasting (Lundgren et al, 2012, p3). To date, no theory has explained how women make decisions with their birth choices in pregnancy following a previous CS.

Method: Classic grounded theory based on Glaser and Strauss (1967). Pregnant women who had expereinced a previous CS (elective or emergency) were recruited through antental clinics, 15 formal and 15 informal interviews and 2 non-participant observations were conducted. Ethical approval was obtained.

Findings: The theory of mentalizing possibilities is a substantive theory which explains pregnant women's decision making about their birth choices after a previous CS. Women's main concern is to achieve a positive experience. Mentalizing possibilities explains how women process their previous experience, adapt to uncertainty and deal with the decisional conflict. There are behavioural and cognitive strategies which women use to go through this process. Women use different behavioural strategies based on their self-determination; accordingly, they are classified into four different types-uncertainty acceptors, innocent modifiers, slippery slopers and comfort seekers. There are internal and external factors which influence their self-determination enabling women to develop awareness. Cognitive strategies go through three stages. They are possibility seeking in early pregnancy, probability distancing in mid pregnancy and reality re-seeking in late pregnancy.

Conclusion: Women want a positive birth experience in pregnancy after a previous CS. These women require support and continuity in decision making in order to help them decide the optimal birth choice for their current pregnancy. To provide a positive birth experience for individual women, healthcare professionals should engage with women in pregnancy and listen to their concerns.

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CHAPTER 1 INTRODUCTION AND BACKGROUND

1.1 Introduction

A recent WHO recommendation suggests that a "positive childbirth experience" is a significant endpoint for women when going through pregnancy and labour. It defines a positive childbirth experience as 'one that fulfils or exceeds a woman's prior personal and sociocultural beliefs and expectations, including giving birth to a healthy baby in a clinically and psychologically safe environment with continuity of practical and emotional support from a birth companion(s) and kind, technically competent clinical staff. It is based on the premise that most women want a physiological labour and birth, and to have a sense of personal achievement and control through involvement in decision-making, even when medical interventions are needed' (WHO, 2018, p1).

The National Maternity Strategy of Ireland (DOH, 2016) proposes one model of care, with three separate care pathways. It recommends that women should be offered choice in line with their clinical needs and best practice. All care pathways should support the normalisation of pregnancy and birth and women should be encouraged, and supported, to make their individual experience as positive as possible (DOH, 2016). One such area of decision making where women struggle in decision making is for a choice of birth after a previous CS (Lundgren *et al*., 2012). This study aims to explore what determines women's birth choices and how they make their decision for a birth choice in pregnancy following a previous CS, with a view to generate a theory.

This chapter provides a brief introduction to the problem area with the incidence and prevalence of caesarean section (CS) and Vaginal Birth after

Caesarean section (VBAC), the background to the study, the effect of information and knowledge on decision making and women's experiences with decision making.

1.2 Global concerns about caesarean sections: an aspect of maternity care

Caesarean section is one of the most commonly performed surgical operations in the world today (WHO, 2015). For nearly 30 years, the international healthcare community has considered the ideal rate for CS to be between 10% and 15%, but for a variety of reasons it has become increasingly a common procedure in both developed and developing countries (WHO, 2015). Rates higher than this are not associated with any reduction in maternal mortality or morbidity (Ye *et al*., 2016). There is disparity of CS between the richest and poorest countries in the world because of poor access and overuse of CS. CS use is five times more frequent in the richest countries compared to the low-income and middle income countries and 1.6 times more frequent in private facilities than public facilities (Boerma *et al*., 2018). The rapid increase in the rate of CS worldwide without clear evidence of improved maternal and neonatal outcomes, especially among low obstetric risk births, is now of great concern (Sandall *et al.*, 2018; Boerma *et al.*, 2018).

According to the latest statistics from 150 countries, currently 18.6% of all the births occur by CS ranging from 6% to 27.2% in the least developed and the most developed countries respectively (Pilar Betrán *et al.*, 2016). In Ireland, the rate of CS was 31% in 2015; 32.1% in 2017 and 33.8% in 2018 (Health Service Executive (HSE), 2017; IMIS, 2019). While primary caesarean section is the main contributor for the largest number of caesarean deliveries, the principal single indication for a caesarean delivery is a prior CS or prior uterine scar (Boerma *et al.*, 2018). This explains the rising rate of caesareans each year and a contributing factor

behind this increase is a decline in the number of Vaginal Births after Caesarean (VBAC) (Guise *et al*., 2010). The mode of delivery after previous caesarean can be either a repeat CS birth or VBAC. There is consensus from the National Institute for Clinical Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG), and the American College of Obstetricians and Gynaecologists (ACOG), that planned VBAC is a clinically safe choice for most women with a single previous lower segment caesarean delivery (ACOG, 2015;RCOG, 2015). These institutions recommend that women who have had one uncomplicated lower section caesarean section (LSCS) and have an otherwise uncomplicated pregnancy should be encouraged to attempt a VBAC. VBAC refers specifically to women who deliver vaginally after a previous caesarean (RCOG, 2015). The success rate of VBAC is between 72 to 76 % if the woman has never had a vaginal birth and 85 to 90% if she had a previous vaginal birth (RCOG, 2015; Guise *et al*., 2010). Induced labour, no previous vaginal delivery, BMI greater than 30, and previous caesarean for labour dystocia, gestation more than 41 weeks, interval of less than 2 years from previous CS and advanced maternal age are associated with an increased risk of unsuccessful VBAC (RCOG, 2015).

Despite the available guidelines (ACOG, 2015; NICE, 2016, RCOG, 2015) and their recommendations, in some European countries, many women who had a previous CS will have a routine CS subsequently (European Perinatal Health Report, 2010). Mode of delivery differs markedly throughout Europe, with lower levels of caesarean sections around 16% to 17% in most Nordic countries and the Netherlands, and higher caesarean rates in Cyprus, Romania, Bulgaria, Poland, and Hungary, around 40% or higher. Percentage of caesarean sections with an indication of previous caesarean section also varies between different European countries

ranging between 95.3% in Cyprus, to 44.6% in Finland (European Perinatal Health Report, 2018). Due to methodological issues in the calculation, reporting and interpretation of the data, as countries differ in the way they classify caesarean sections, hence VBAC rates range between30-51% to 50-85% (European Perinatal Health Report, 2018; Foureur et al., 2010).

The primary caesarean section rate continues to rise internationally and differences in obstetric interventions across Europe raises questions about the impact of CS on short-term, but also longer-term, maternal and child health (European Perinatal Health Report, 2018). It is important to highlight the impact such an invasive surgical procedure can have on the health outcomes for mothers and babies, including higher morbidity and mortality rates (WHO, 2015;Sandall *et al.*, 2018). In addition, delivery by caesarean section has cost implications for health services as it is significantly more expensive than spontaneous vaginal delivery (Brick and Layte, 2009, Petrou and Khan, 2013). It has also been shown that trial of labour for women who have had a previous CS is cost-effective even with the success rate of 64% (Fawsitt *et al*., 2013).

CS can be life-saving intervention when medically indicated however it leads to short-term and long-term health effects which can extend beyond the current delivery and affect the health of the woman, her child, and future pregnancies (WHO, 2015; Sandall *et al.*, 2018). Complications of VBAC include the possibility of uterine scar rupture 0.3%, whereas, the complications of Elective Repeat Caesarean Section (ERCS) are haemorrhage 0.3-29%, and the risk of maternal death is 13/100, 000 which compares with the risk of maternal death with planned VBAC at 4/100,000(Guise et al., 2010). ERCS prevents uterine scar rupture, reduces the risk

of pelvic organ prolapse and urinary incontinence in comparison with a vaginal birth. The advantage of ERCS is that the delivery date can be planned in selected women, but it leads to a longer hospital stay than women who experience a VBAC (Guise et al., 2010). Risks to the baby include a transient respiratory morbidity of 2-3% with VBAC compared to 4-5% in ERCS, hypoxic ischemic encephalopathy (HIE) with the VBAC is 8 per 10000 (0.08%) compared to <1 per 10000 (<0.01%) with ERCS; and risk of delivery related perinatal death or HIE is 4 per 10000 (0.04%) with VBAC. The overall favourable outcome of VBAC is that most women who have a trial of VBAC will have a successful outcome, and they and their infants will be healthy. For the mother it increases the likelihood of future vaginal births (RCOG, 2015; Guise et al., 2010). Apart from the complications already mentioned, studies have shown there may also be impaired fertility among women who have had a caesarean section (Nilsson et al., 2017;Nilsson et al., 2015). The RCOG (2015) recommend that it is important to make it clear to the women that a successful VBAC has fewer complications than a repeat CS.

In a growing number of cases worldwide, caesarean sections are being performed without any medical need (WHO, 2015). The media has often put forward the view that the rise in caesarean rates has been a result of the demands of the pregnant women 'too posh to push' but this is not the primary reason (Churchill and Francome, 2009). A pregnant woman is entitled to decline the offer of treatment such as a CS, even when the treatment would clearly benefit her or her baby's health. Refusal of treatment needs to be one of a woman's options (RCOG, 2015; NICE, 2016). Choice of CS should not be motivated by the unavailability of effective pain management (ACOG, 2013) and it is not recommended for women desiring several

children given that the risks of placenta praevia, placenta accreta, and gravid hysterectomy increase with each caesarean delivery (European Perinatal Health Report, 2018). When a woman requests a CS in the absence of an identifiable reason, the overall benefits and risks of CS compared with vaginal birth should be discussed and recorded (NICE, 2016). Appropriate referral services such as perinatal mental health services for women who request CS because of anxiety about childbirth must be available to women (Gholitabar *et al*., 2011).

The reasons for the rise in CS use fall into three broader, interconnected and sometimes overlapping categories. They are factors related to childbearing women, families, communities and the wider society, factors related to health professionals and factors related to health care systems, financial re-imbursements and organisational design and culture (Betrán *et al*., 2018). Hence multifaceted strategies are needed to reduce CS rates (Betrán *et al*., 2018). Adjunct clinical interventions such as system-level interventions, provider-level interventions such as guidelines or information for providers and provider characteristics and patient-level interventions can have effect on VBAC rates (Wingert *et al*., 2018). Non-clinical interventions recommended for increasing VBAC uptake or success are seen when institutions develop local guidelines, adopt a conservative approach to caesarean section, use opinion leaders, give individualised information to women, and give feedback to obstetricians about mode of birth rates (Catling-Paull *et al*., 2011).

The above discussion suggests that a planned VBAC is appropriate for and may be offered to the majority of women with a singleton pregnancy of cephalic presentation at 37+0 weeks or beyond who have had a single previous lower segment caesarean delivery, with or without a history of previous vaginal birth (RCOG, 2015). There are many interrelated factors involved in this process of decision

making for a choice. Women's decision for a choice depends upon whether a choice is offered to them or not and whether their choice is an informed one. The difference in mode of delivery is an example of differences in obstetric approaches (European Perinatal Health Report, 2018). How existing practices in a clinical setting inform women about their choices and enable them to make a decision for a choice of birth after a previous caesarean section and how women actually make a decision for a choice in the maternity care setting in which they receive care is explored in the next section.

1.3 Choice and decision making in contemporary maternity care

In the UK, NICE (2016) recommends that women with one previous delivery with a low transverse incision are candidates for and should be counselled about VBAC. Implementation of a VBAC versus ERCS checklist or clinical care pathway is recommended to facilitate best practice in antenatal counselling, shared decision making and documentation (RCOG, 2015). In the USA, the AAFP recommends labour after caesarean (LAC) is a reasonable and safe choice for most women with a history of one or two prior caesarean births (AAFP, 2014). It is recommended that health professionals discuss the possibility of VBAC, starting early in antenatal care, with all women who have had a prior caesarean delivery. Health professionals should specifically discuss the benefits and harms of VBAC considering the individual risk factors, values and preferences of each woman. This discussion should include information regarding local resources, access to facilities and clinicians who offer VBAC (AAFP, 2014). In Ireland, obstetricians, other doctors including the woman's GP and midwives may have conversations with women about their choices for the birth after a previous caesarean section. But it is the hospital

doctor or the woman's private obstetrician who is responsible for discussing this with her so that a plan can be made for the birth, in particular the decision for a repeat CS as this will have to be scheduled.

Reports on choice and decision making in Ireland

Various reports (Health Information and Quality Authority (HIQA), 2016; DOH, 2016) have identified that there is a lack of choice for expectant mothers in Ireland and the need to improve Irish maternity services has been recognised (HIQA, 2015, 2013). Investigations undertaken highlighted that women have faced serious failings in their maternity care and a series of significant service deficits were identified (HIQA, 2016). The review by Hanafin and Dwan O'Reilly (2016) to inform the maternity strategy took place in the context of several reports (KPMG & HSE, 2009; KPMG, 2008) and investigations into adverse events within the maternity services (Harding Clarke, 2006; HSE, 2008). Common areas of concern within these reports include variation in clinical and corporate governance, failure to adhere to clinical guidelines, poor safety standards, poor communication, lack of service user participation, workforce issues and poor data systems (Hanafin and Dwan O'Reilly, 2016). The review identified a number of challenges in antenatal care especially fragmented organisational structures, different perspectives on antenatal health and inadequate inter-professional communications and it emphasised the need for improved coordination between midwifery and obstetric professionals. Subsequently, the National Maternity Strategy of Ireland (DOH 2016) was launched. It identifies the need to view pregnancy and birth as a normal physiological process and, in so far as it is safe to do so, a woman's choice should be facilitated. The strategy recommends that all pregnant women should have appropriate and informed

choices, and access to the right level of care and support. A care pathway according to women's risk profile will be available, where she will be supported to make an informed choice and her care will be delivered by a particular team. The strategy stresses the need for continuity of care and individualised care that is appropriate to women's needs. Antenatal care should encompass a holistic approach to women's healthcare including physical, social, lifestyle and mental health needs. There are also recommendations on how to facilitate choice for pregnant women in various aspects (DOH, 2016); however, it lacks any details or any specific guidelines on the issue of choice of birth after previous caesarean section.

Decision making

Decision making is a cognitive process that produces a choice (Smith, 2011). How these decisions are made depends upon the maternity care system and health care setting (HSE, 2011; Lundgren *et al*., 2015). It is recommended that pregnant women should be offered evidence-based information and support to enable them to make informed decisions about childbirth. Addressing women's views and concerns should be recognised as being integral to the decision-making process (NICE, 2016).

The National Consent Policy (HSE, 2017) favours a functional and decision-specific approach to define decision-making capacity. The capacity of the person is to be judged in relation to a decision to be made and at the time it is to be made. It should be issue specific, time specific and dependent upon the ability of an individual to comprehend reason and express a choice regarding information about the specific decision (HSE, 2017). It is important to give time and support especially to those who may have difficulty making decisions to maximise their ability to do so (HSE, 2013). Hence information provision by the health care professional, the

woman's ability to understand that information and informed consent are underlying concepts in the decision-making process.

Informed consent for decision making

An important goal of decision making is to achieve informed consent (Cox, 2014). Consent is giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication about the proposed intervention (HSE, 2017). The process of communication begins at the initial contact and continues through to the end of the service user's involvement in the treatment process, provision of social care or research study (HSE, 2017). Seeking consent is not merely getting a consent form signed; the consent form is just one means of documenting that a process of communication has occurred (HSE, 2017). For consent to be valid the service user must have received enough information in a comprehensible manner about the nature, purpose, benefits, and risks of an intervention, not be acting under duress, and have the capacity to make a decision (HSE, 2017). The doctrine of informed consent states that patients have the right to make treatment decisions even if those decisions are medically inadvisable. A woman can refuse treatment, or a choice provided it is voluntary and she is appropriately informed (HSE, 2017).

Recently, a High Court judge in Ireland refused to grant the HSE an order forcing a pregnant woman to have a CS against her will to protect the life of her unborn child. The HSE sought the order after doctors advised that if the woman's fourth child was delivered vaginally after her three previous caesarean sections there was a risk that her uterus would rupture posing a risk to the life and health of herself and her baby. A natural birth in such circumstances was 'unheard of', which meant

that there was no evidence to approve or disapprove woman's choice. The woman believed that seeking a natural labour would expose her to a 3% risk of uterine rupture and if she had a CS the risk would be 1%. The obstetric evidence suggested that the risk with a normal delivery would be higher but there was no evidence to support this view. The woman did not have a history of mental illness and had the necessary capacity to decide on the medical treatment (Carolan, November 2, 2016).

Hence what is lacking in this process is the ability of the healthcare professional to understand women's concerns and the support needed to enable women to make their own decisions by providing evidence-based information.

Shared decision making

A National Institute for Health (NIH) panel urged clinicians to use evidence-based information in a way that will enable women to participate in a shared decision-making process (Shorten et al., 2014) and make informed decisions about childbirth (NHS, 2015). Previous research has shown that patient participation in health care decisions is positively correlated with improvement to patient physician relationships and trust in the physician. All these factors contribute to patient satisfaction, perception of experience, enhanced emotional well-being, increased sense of patient empowerment and self-esteem (Goldberg, 2009). Contrary to this, findings from a meta synthesis on studies from the UK, US and Australia (Lundgren *et al.*, 2012) showed that women felt uncertainty and anxiety in relation to their choice of VBAC and believed that health professionals were mostly non-supportive towards their choice. Hence, promotion of evidence-based information and women's participation in promoting choice is essential in maternity care and to its reform.

The relationship between those who provide care and the service user should be a partnership based on openness, trust and good communication. Good decision making requires a dialogue between parties that recognises and acknowledges the service users' goals, values and preferences, as well as the specialist knowledge, experience and clinical judgement of health professionals (HSE, 2017). Women's interests in making decisions about labour and delivery are not only informed by their medical needs, but also by their values, tolerance for risk and pain, and how they weigh health against other elements of wellbeing (Flanigan, 2016). HIQA (2016) recommends that women should be provided with information based on best available evidence, in a variety of formats, on the full range of options available to them throughout pregnancy, labour, birth and the postnatal period. This enables them to actively participate in their own care. In the context of maternity services, factors such as inadequate informed consent processes, women's lack of preparation for making informed decisions, the limitations of views in the media, and popular discourse have also been identified as barriers in the decision making process (Hanafin and Dwan O'Reilly, 2016).

In all facilities where caesarean sections are performed, health care providers should be trained to discuss the risks and benefits of CS with the women in their care (WHO, 2015). Finland and Sweden differ from the Netherlands regarding the structure of care for women with VBAC. In the Netherlands, VBAC is a responsibility for obstetricians in hospitals, while in Sweden and Finland, VBAC is a responsibility for midwives in hospitals if everything is progressing normally (Lundgren *et al.*, 2012). In the UK setting, VBAC is currently positively promoted in NHS Trusts by obstetricians and midwives as part a nationwide strategy for lowering

the caesarean rate (NHS, 2015). In Ireland, maternity services are available free of charge to all women who are ordinarily resident in Ireland under the 1954 Maternity and Infant Care Scheme (The Maternity and Child Health Services Regulations, 1954, 1964). Care is jointly supervised by general practitioners and maternity health care providers and it is obstetric led. Under the public scheme, a woman availing of the public maternity care service may be seen by different doctors and/or midwives throughout her pregnancy. For women who remain low risk, care in labour and birth is provided by midwives and non-operative vaginal births are largely conducted by midwives. A feature of the maternity services in Ireland is the co-existence of private care. For women who opt for this form of maternity service, care alternates between a general practitioner and a private consultant obstetrician, who will attend the delivery. There is evidence to suggest that women who opt for private care are more likely to have obstetric intervention, irrespective of the clinical risk factors (Lutomski *et al*., 2014).

The discussion above explains how the current guidelines and reports identify the need to consider pregnancy and childbirth as a normal process, avoiding overmedicalisation of pregnancy in particular procedures that have side effects (European Perinatal Health Report, 2018). The context of the care setting in which women receive their antenatal care and the effects of shared decision making between a health professional and the women receiving care influences their decisions. The following section discusses whether provision of adequate information has any effect on women's decision making on a choice and explores the role of information provision in enabling women to make a choice that suits them best.

1.4 Effect of information and knowledge on decision making:

Decision aids present balanced personalised information about options in sufficient detail for patients to arrive at informed judgements about the personal value of those judgements (O'Connor *et al*., 2007). The aim of any decision aid is to improve decision quality and to reduce related unwarranted practice variations. This is achieved by providing facts about the conditions, options, outcomes and probabilities, clarifying patients' evaluation of the outcomes that matter most to them, and guiding them in their deliberations and communications so that a choice can be made that matches their informed values (O'Connor *et al*., 2007). Several decision aids such as decision aid booklets, computer based decision aids, evidence based interactive decision aid, evidence based educational brochures have been developed and evaluated for use by women with a previous caesarean section (Shorten *et al*., 2005; Montgomery *et al*., 2007; Eden *et al*., 2009; Eden *et al*., 2014). Clinical trials have shown that decision aids, and specific patient information literature and VBAC checklists, facilitate the decision-making process for women by lowering decisional conflict, improving the level of knowledge and satisfaction and increasing women's perception of making an informed choice (Shorten *et al*., 2004, Shorten *et al*., 2015, RCOG, 2015).

A randomised controlled trial was conducted in Australia with 227 women who had a previous CS. A decision aid booklet describing risks and benefits of elective CS and trial of labour was given to the intervention group at 28 weeks gestation. The results showed that women who received the decision aid demonstrated a significantly greater increase in mean knowledge scores than the control group. The intervention group also demonstrated a reduction in decisional conflict. The decision aid increased knowledge about the choices and reduced

decisional conflict. However, it did not significantly increase the rate of uptake of trial of labour or elective caesarean delivery (Shorten *et al*., 2005).

A randomised controlled trial conducted in the UK, tested two computer-based decision aids, an information programme and decision analysis, to ascertain their effects on decisional conflict and mode of delivery among women with one previous caesarean section (Montgomery *et al*., 2007). It compared the effect of the interventions with the usual care provided by obstetricians and midwives. Both the interventions were computer based and conducted in the women's homes. After a brief introduction, the woman moved through the programme in her own time. The information programme guided women through descriptions and possibilities of clinical outcomes for mother and baby associated with planned vaginal birth, elective CS, and emergency CS. In the decision analysis group, the means of delivery was recommended based on utility assessments performed by women combined with probabilities of clinical outcomes within a concealed decision tree. Primary outcomes and secondary outcomes were measured. Primary outcomes were decisional conflict and actual mode of delivery and secondary outcomes were anxiety, knowledge, subscales of decisional conflict, and satisfaction with the decision. Women who experienced the interventions had reduced decisional conflict compared to women in the usual care group. The rate of vaginal birth was higher for women in the decision analysis group compared with the usual care group, but authors conclude that this result was a chance factor. However, the rates were similar in the information programme and usual care groups. Compared with the usual care group, satisfaction with the decision was higher in the decision analysis group, but not in the information programme group. Women in the intervention group reported reduced anxiety compared with the usual group (Montgomery *et al*., 2007). The

study suggests that computer-based decision aids can reduce decisional conflict and anxiety and increase knowledge; however, the best approach for decision making and the type of decision aid that can make a difference in this area is still not clear.

Eden *et al* (2009) developed an evidence-based decision aid to help women with a previous caesarean to prioritise their childbirth preferences in a future birth. Ninety-six postnatal women with a prior caesarean were randomized to use 1 of 2 preference scale formats in a computerised childbirth decision aid. The results showed that when the trade-offs involved risk, women were more consistent when using graphic-numeric rather than text-anchored formats. They prioritised safety for their babies as four times more important than any other decision factor including safety for themselves (Eden *et al*., 2009). Hence women consider many factors in their decision making especially how they value and judge safety.

In another randomised control trial women were allocated to receive either an evidence based interactive decision aid or two evidence-based educational brochures about CS and VBAC. The effect on the decision-making process was assessed before and after the interventions. The results showed that women in both groups were better informed, were clearer about their birth priorities, felt more supported and overall reported less decisional conflict after receiving either intervention compared to usual care. None of the decision aids have provided any information on likelihood of success of VBAC based on individual factors (Eden *et al*., 2014). Hence decision aids can provide information and reduce decisional conflict, but they have not been shown to assist women to make individualised decision making.

Vlemmix *et al*., (2013) carried out a systematic review to determine the effectiveness of decision aids to improve informed decision making in pregnancy care. They included studies of randomised control trials or cluster randomised design

trials evaluating decision aids. The quality of studies was assessed using GRADE criteria and IPDAS (International Patient Decision Standards instrument) and a collaboration quality criteria framework was used to assess the quality of the decision aid. They found that decision aids in pregnancy can significantly decrease decisional conflict, increase knowledge and decrease anxiety. Decision aids also reduce decisional regret, reduce the proportion of women who are undecided and increase the accuracy of risk perception. They investigated ten decisions in pregnancy including mode of delivery after previous caesarean section. However, the study suggests that the greatest benefits were found when the decision support technique was implemented in the form of counselling from a care provider involving information, discussion of options, and clarification of values. The greatest benefit to people was less uncertainty and anxiety. However, the findings from this systematic review cannot be exclusively applied to this area as it included only two studies involving mode of delivery after previous CS. The results imply that the women who had one previous CS may benefit from increased information and support in pregnancy based on their individual factors.

A systematic review was conducted to evaluate the effectiveness of women-centred interventions during pregnancy and birth to increase rates of vaginal birth after caesarean (Nilsson *et al*., 2015). The primary outcome measure was the incidence of VBAC. The secondary outcome measures were maternal satisfaction with mode of birth preference/decision and birth experience, knowledge about birth choices, maternal anxiety levels, compliance with the intervention, rate of decisional conflict, mode of birth (spontaneous vaginal birth, instrumental birth, and emergency CS), maternal mortality, perinatal mortality, length of labour, uterine rupture, birthweight of the baby, neonatal Apgar scores, and admission to a neonatal

intensive care unit. Three studies met the inclusion criteria. The review concluded that there are few studies evaluating the effects of interventions on women with the aim of increasing VBAC rates. Decision-aids and information programmes are of importance because they significantly decrease women's decisional conflict about the mode of birth, and significantly increase their knowledge about the risks and benefits of possible modes of birth. The findings also demonstrate that the use of decision aids and information programmes does not have a significant effect on VBAC rates (Nilsson *et al*., 2015). Hence, women's knowledge and their preference of a choice are indirectly related. Women formulate their own opinion from their previous experience, which leads them not to pursue information and support for the choice which they feel risky. This explains that there is a need to identify what determines women's choice which needs to be identified and assessed prior to information provision. The studies clearly indicate that decision aids help women to overcome decisional conflict and increase knowledge, however they have not been shown to assist women to make a choice. The current study aims to explore other factors that influence women in decision making and how and why women make a particular birth choice and factors that influence or impede this process.

The above studies have shown that women need to be offered choices and decision aids help women to make informed decisions. But these decisions aids are unable to predict the success of a choice based on women's individual factors (Eden et al., 2014). Women's information needs change as they progress in pregnancy, but which type of decision aid suits different stages of pregnancy is not explored in the above studies. The above literature also suggests that knowledge and information do not appear to influence women's final birth preference significantly, but it emphasises the important role played by health care services and providers in

decision making (Shorten *et al*., 2005). Studies on decision aids have been shown to improve decision making in pregnancy, however, they have not been shown to increase the uptake of VBAC. Hence it is important to separate these decision aids from some topics such as birth choices after a previous CS to evaluate their effectiveness. It does not imply that decision aids are not effective in this area, but a woman's previous birth experience may lead to decisional conflict and anxiety. Hence choice of birth depends upon many factors as women are not only concerned about themselves (mother) but also their babies (Eden *et al*., 2014). Women may have significant unresolved issues and experiences from their previous pregnancy. The following section explores some of those issues and women's experiences with the decision making and what really matters for women.

1.5 Women's experiences with the decision-making process

For women who have had a previous delivery by CS and are expecting a subsequent child, deciding whether to opt for a repeat caesarean or to undergo a 'trial of labour' is a complex process. It is contextual, interconnected and multifactorial (Goodall *et al*., 2009, Shorten and Shorten, 2014, Cox, 2014; Betrán *et al.*, 2018). Personal, social, emotional and philosophical factors affect preferences and choices for both health professionals and women (Shorten *et al*., 2014). It is contextual as women have different ways of viewing birth in the circumstances of their individual lives and this affects their decision-making in terms of viewing risk and the influence of health professionals (Tolmacheva, 2015). There is a profound cultural and symbolic significance to birth and social discourses influence women's knowledge about birth and the subsequent choices they make (Regan *et al*., 2013). Emotions, such as fear, anxiety, uncertainty, a desire to control, the influence of practitioners

and significant others, all compound this complexity (Shorten and Shorten, 2014). Ultimately, the decisions related to the care options made by women are informed by the individual midwife, doctor or members of the team and are influenced by numerous factors such as different levels of knowledge, past experience, individual differences of the women making a decision, and other people on whom the decision has an impact such as their partners and their families (Smith, 2011).

Fenwick *et al*., (2007) explored the expectations and knowledge of women who had experienced a caesarean and would prefer a vaginal birth in a subsequent pregnancy. Thirty-five women from Western Australian who experienced VBAC or stated that VBAC was the option they would choose in the subsequent pregnancy were interviewed by telephone. Thematic analysis was used to analyse the interview data. The study revealed that women's beliefs, desires and expectations of birth 'normally', 'naturally' and 'vaginally' were reinforced, or strengthened, by the experience of their first CS. The major influencing factor for their decision making was their own belief in the importance of experiencing natural childbirth. The positive attitude of family members and friends became a decisive reinforcement for a vaginal birth. A belief that vaginal birth promotes the health and well-being of both mother and baby, enhancing maternal infant interactions and the transition to motherhood, also determined their choice of VBAC.

McGrath *et al*., (2010) explored, from the mother's perspective, the process of decision making about mode of delivery for a subsequent birth after a previous CS. Data were collected from twenty women who had a previous caesarean section. A descriptive, phenomenological method was used for data analysis. The results showed that many women did not agree that CS is an 'easy option'. Women also felt that there was lack of choice for natural birth. Women's lack of ability to cope with

the birthing process was the main reason to choose CS. Women who wanted VBAC but failed to achieve were frustrated with the clinical reasons, expressed a sense of failure and some regretted not trying for natural birth. Women held a single-minded belief in the significance of a natural birth for the new-born and were strong minded and passionate about VBAC. Mothers who opted for a VBAC took personal responsibility for their birth choices. The perception women received from their doctors was that VBAC is the riskiest option (McGrath *et al*., 2010).

A study in Australia (n=169) revealed that women's satisfaction with the previous birth has a direct relationship with the choice of birth in the next pregnancy. The aims of this study were to examine women's postnatal perceptions of planned VBAC more closely and to explore outcomes for women who experienced successful VBAC (spontaneous vs instrumental vaginal birth) and women who experienced a caesarean birth with labour (emergency caesarean birth) or elective repeat caesarean delivery (ERCD) without labour. The multiple regression analysis confirmed that satisfaction with the decision making was significantly related to mode of birth. Specifically, those experiencing either instrumental vaginal birth or emergency caesarean birth reported significantly lower satisfaction levels (1-2 points lower) than women who experienced spontaneous vaginal birth or elective caesarean birth. Women who experienced spontaneous vaginal birth had a lower incidence of depression as measured by the Edinburgh Postnatal Depression Scale (EPDS) compared to all other women who experienced all other modes of birth. Women who experienced vaginal birth reported postnatal problems with soreness from episiotomy or stitches from a tear (n = 25, 58.1%). Pain from a caesarean wound was a common problem among the group who experienced caesarean birth (n = 59, 51.3%). Women who achieved spontaneous vaginal birth and elective repeat CS rated their functional

health status higher than those women who had instrumental vaginal births or emergency caesarean birth. Most women (76.8%) either agreed or strongly agreed they would make the same choice again. Further analysis on mode of birth data revealed that only forty percent of women who experienced instrumental vaginal birth stated that they would make the same choice again, compared to 87.9% who achieved spontaneous vaginal birth as planned. Eighty five percent of women who had an elective repeat CS stated that they would make the same choice again, compared to 70.1% for the entire planned VBAC group (Shorten and Shorten, 2012).

A study using interpretive phenomenological analysis (IPA) explored women's perceptions of the role of health professionals on decisions of mode of delivery following CS. Ten women aged over 18 years, who were expecting their second child and who had had one previous delivery by CS were recruited for the study. Semi-structured interviews were conducted in the interviewees' homes. The results were grouped under four headings - lack of knowledge, probabilistic information, latent communication and relinquishing control. Women did not fully understand the possible implications of a previous delivery by CS on subsequent VBAC or an elective repeat CS. Women also expressed that they were unable to gain the knowledge that they needed. Over the course of their antenatal consultations women found that the focus on the choice was not helpful as it was explained in a context of probabilistic statistics. Women felt that the information was not relevant to their personal decisions. Their decision was based on success and failure of VBAC rather than maternal and neonatal morbidity. Women felt that they received conflicting messages and latent persuasions. Some women experienced little control over their second pregnancy and some others liked to give control to others as it resolved difficult personal emotions for them (Goodall *et al*., 2009).

A study in Australia was conducted to identify possible factors influencing women's information gathering and decision-making on birth options for their subsequent pregnancies and to identify what information may be useful for women to make an informed choice in their subsequent pregnancy. A sample of women (n=33) who had a previous CS were surveyed. The study showed that for most of the women the source of birth option information was from the childbirth classes (54.4%) followed by book(s) (42.4%) and leaflets (33.34%). Most women (75.8%) were aware that they had a more than a 50% chance of giving birth vaginally if they wanted to attempt VBAC. Many women (69.7%) were not aware that babies may have problems with breastfeeding when their mothers have a CS. All women were aware that CS was major surgery and 75.8% were aware that having a CS would not protect them from pelvic floor weakness. Of the twenty-four women who responded to intended choice of birth, 2 chose normal birth and 22 chose a repeat CS. Even though CS was perceived as major surgery most women still chose this option for their subsequent births. This could have been because of lack of knowledge and misinformation indicating VBAC was dangerous for the baby and CS assures safety for the baby, despite opposing evidence (Chen and Hancock, 2012). Generalisability of the results of this study is limited because of the small study sample.

A cohort study was conducted using data from the hospital episode statistics (HES) database to investigate the demographic and obstetric factors associated with the uptake and success rate of VBAC (Knight *et al*., 2014). The researchers identified 143970 women as potential candidates for VBAC. The majority (52.2%) (75086) of women attempted a VBAC. Of the women who attempted VBAC, 63.4% achieved a successful vaginal delivery. Younger women and women of white ethnicity had higher success rates compared to women of black ethnicity. Women

who gave birth more than three years after the first baby was born were also less likely to have a successful VBAC. Clinical risk factors, including gestational diabetes and premature rupture of membranes, as well as higher birthweights, decreased the VBAC success rate. Those with a history of failed induction of labour were the least likely group both to attempt and to succeed with a VBAC (Knight *et al*., 2014).

A systematic review of factors influencing pregnant women's decisions with respect to planned repeat CS and planned VBAC revealed the complexity of women's decision-making (Flannagan and Reid, 2012). A total of 25 mixed method studies were included in the review. Effective decision-making was contingent on the health professionals judgement of and sensitivity towards individual cases and was the result of their collaborative negotiations. Women predominantly follow advice from healthcare professionals, especially obstetricians. Women's knowledge and perceptions of risk were individually based because of their previous experience and depends upon their ability to understand and comprehend the risk information. The information provided by health professionals was variable and more commonly related to procedural aspects of care rather than a discussion on the risks and benefits associated with VBAC and repeat CS. Counselling and education programmes should be initiated pre-conception or in very early pregnancy, as many women form opinions about birth options before or early in their pregnancy. The non-clinical aspects of care that reflect women's responsibilities as mothers, wives and members of society were found to be the primary factor influencing decision-making rather than the careful evaluation of health risks of VBAC or repeat CS for mother and baby (Flanagan and Reid, 2012).

A meta-ethnography was conducted by Black *et al*, (2016) to identify influences on women's preferred mode of birth after caesarean section. 20 papers reporting the views of 507 women from four countries were included in the study. The results were grouped under six themes: longstanding anticipation of vaginal birth, responses to previous birth experiences (positive and/or negative); encouragement or dissuasion from influential people for either birth mode; fear or reassurance from risk-related information on VBAC; perceived net benefit or harm of birth options and extent and nature of involvement in decision-making. Women were classified into three groups and distinctive clusters of influences were identified for each group of women. Women who confidently sought vaginal birth after a caesarean section were typically driven by a long-standing anticipation of vaginal birth. Women who sought a repeat caesarean section were strongly influenced by distressing previous birth experiences, and at times, by encouragement from social contacts. Women who were more open to information and professional guidance had fewer strong preconceptions and concerns, and viewed a range of considerations as potentially important.

A metasynthesis based on the interpretative meta-ethnography conducted by Lundgren *et al*., (2012) which included eight studies, four from Australia, three from UK and one from US. It studied women's experience in relation to different aspects of VBAC, decision-making whether to give birth vaginally, the influence of health professionals on decision-making, reason for trying a vaginal birth, experiences when choosing VBAC, experiences of giving birth vaginally and giving birth with CS when preferring VBAC. Experiences of vaginal birth after a previous CS for women were like groping through the fog, where decision making and information from the health care system and professionals, both during pregnancy and the birth,

is unclear and contrasting. Being in a fog is like groping for a way out by asking health care professionals during pregnancy, and even during the birth, but getting no clear answer, contrasting answers or answers not in agreement with their own choice. Women also owned a strong responsibility for giving birth vaginally in terms of information seeking and were open to try for VBAC. Women described they had to confront risk which was explained to them by healthcare professionals, and there was lack of information about benefits of VBAC, and lack of support for VBAC. VBAC was considered a meaningful experience which was important for women in terms of experience and recovery.

From the above literature it is difficult to predict that women who had elective repeat CS and previous emergency CS would make the same choice again as childbirth satisfaction has been found to relate to factors including personal control, level of labour pain, and whether their expectations were met (Shorten and Shorten, 2012). Success rates of VBAC varies according to the indication of the primary CS and maternal demographic variables (Knight et al., 2014). This emphasises that women need an opportunity to go through VBAC by informed decision making. It is important for women to have a choice and involvement in choice (Lundgren *et al*., 2012). Generalised statistical information does not seem to aid women in decision-making and that is the reason they expect health professionals to make relevant decisions (Goodall *et al*., 2009). Healthcare professionals judgement of risk is different than women's concerns of risk (McGrath *et al*., 2010). When there is disagreement between women's judgement of risk and success and those of healthcare professionals' women had to fight for their choice especially for VBAC (Lundgren et al., 2012). There is a need for childbirth education classes to provide up-to-date unbiased evidence-based risk and benefit information for both CS and

VBAC to women and their families (Chen and Hancock, 2012) and women need additional support in decision making.

1.6 Role of risk and safety in decision making

How a woman considers risk and safety depends upon how she perceives them and how they have been communicated to her. The KPMG (2008) report suggests that the concept of safety in maternity care is ambiguous and appears to be person, politically and socio-economically dependent. Some may regard 'birth asphyxia' as the most important indicator of safety. Others regard emotional wellbeing, mode of delivery, and control as the most important indicators of safety (Devane and Begley, 2004). The technocratic culture of childbirth maintains that decision making in any situation should be based on the assessment of 'safety and risk'. For women safety is undoubtedly a key issue but the interpretations and meanings associated with risk and safety may be at odds with those identified by health professionals (Pairman, 2006). Studies have shown that VBAC is neither presented as the first alternative nor presented positively (Lundgren *et al*., 2012; Goodall *et al*., 2009; McGrath *et al*., 2010). According to Goodall *et al*., (2009), women base their decisions on the success or failure of VBAC rather than safety and it is difficult for them to come to a decision when they are provided with general and probabilistic statistical information. VBAC is mostly referenced in relation to risk especially the risk of uterine rupture and is rarely presented in terms of benefits (Emmett *et al*., 2006a, Goodall *et al*., 2009, Lundgren *et al*., 2012). This is evident in studies where women struggled in comprehending risk and in receiving support in their decision-making (Lundgren *et al*., 2012; Goodall *et al*., 2009; McGrath *et al*., 2010). While obstetricians and midwives tend to focus on the physical aspects of safe birth, for women, there are also the psychosocial implications that go beyond

the physical process of birth (Baxter and Davies, 2010). When deciding the mode of delivery in pregnancy after a caesarean section, women seem to be influenced by personal beliefs about birth, past experiences, having a normal delivery, practical issues and experiential factors more than concerns about safety (Emmett *et al*., 2006) and therefore the previous birth experience has a strong influence on deciding for VBAC (Tolmacheva, 2015; Emmett *et al*., 2006a; Moffat *et al*., 2007, Fenwick *et al*., 2006, HIQA, 2016).

1.6 Conclusion

Giving birth is a unique and powerful event in a woman's life. There is strong evidence to suggest that VBAC is a safe choice for women who have had one previous CS (Guise *et al*., 2010). Women go through a complex process of decision making about birth choices in pregnancy following a previous CS, because of various interrelated factors (Shorten et al., 2014;Betrán *et al*., 2018).

As discussed, there are quantitative and randomised control trial studies (RCT) to suggest that decision aids are helpful in reducing decisional conflict (Shorten *et al*., 2005;Eden *et al*., 2014) but there is a gap in the use of these decision aids as women look towards health professionals to sort out information and help them to identify what suits them best as based on their values and preferences in spite of the availability of decision aids (Goodall *et al*., 2009; Flanagan and Reid, 2012; Lundgren *et al*., 2012). What is not known is the type of decision aid that will suit individual women and how women make decisions based on their individual experiences, values and preferences and explain what happens in the process. A systematic review identified that there was no research looking specifically at any method for increasing VBAC rates other than by supporting women's decision-making (Nilsson *et al*., 2015). There is also scant research to explain what type of

support could potentially increase the uptake of VBAC and satisfaction among pregnant women who have had one previous caesarean birth. There is a gap in the literature surrounding the psychosocial aspects of decision-making regarding birth choices in terms of decision-making process and support for decision making (Lundgren *et al*., 2012, McGrath *et al*., 2010, Fenwick *et al*., 2007, Tolmacheva, 2015). The National Maternity Strategy (DOH, 2016) has identified that there is a need for women to have access to safe, high quality, nationally consistent, woman-centred maternity care. However, the available literature suggests that women do not have much say in the decision-making process despite the rhetoric on care being women centred. Hence, the need to undertake a study to explore what matters most to pregnant women, what their childbirth preferences are and to what extent they are involved in making birth choices, and what is their main concern about delivery after a previous CS. Strategies to maximise the positive experience of pregnancy, labour and, where possible, achieve normal physiological birth as opposed to operative birth do not appear in recommendations and advices in many settings as there are variations in obstetric practices.

The above literature points to a focus which should be unified and must be based on the concept of woman-centred care and creating positive birth experiences for women. There should also be appropriate support for women who choose trial of labour in addition to promoting safety for mothers and neonates. There is a paucity of evidence on the values pregnant women place on birth choices and how the actual decision making for a choice after a previous CS is made. It has been suggested that there is a need for a wider research agenda that includes studies on other women-centred methods of decision making (Nilsson *et al*., 2015; Shorten et al., 2015). This will enable health professionals to understand women's values, views, preferences

and knowledge in order to provide the best care through shared decision-making and partnership (HIQA, 2016; NICE, 2016). Even though previous qualitative methods have described womens experiences, they have not been able to explain the actual process of decision making. What is also unknown is whether women judge the success of a choice (VBAC) in the same way as health professional's judgement. Therefore innovative and different approaches and methodologies are needed to understand why women make a particular decision in pregnancy and what happens in this journey. Developing a grounded theory will provide an explanation for this complex process.

This chapter provided a broad overview of birth choices after previous CS with a specific attention to mode of delivery. It outlined the current research available, the incidence and prevalence of CS and VBAC rates, their advantages and benefits for women with each choice, the effect of decision aids on women's decision making and women's experiences with the decision-making process. In the final section, the chapter explained the need to consider research which will enable understanding of the decision-making process from women's perspective, the inter-related nature of the choice women must face and the complexity of their decision making. This review helped in the development of a theory - which will be presented later - that can be used as a base to understand why women who have had one previous caesarean birth make choices for their next birth, the factors that contribute to their decision making, the challenges and conflicts they face and how they overcome these challenges to achieve a positive birth experience.

CHAPTER 2 METHODOLOGY

2.1 Introduction:

The previous chapter explains that women after a previous CS go through a complex process of decision-making. Developing a grounded theory of women's decision-making can explain the main concern of women and why they make certain decisions about their birth choice. To achieve this aim classic grounded theory methodology (CGT) (Glaser & Strauss 1967, Glaser 1978) was selected. This chapter explains the need to develop a grounded theory, the reasoning for selecting classic grounded theory and some of its unique characteristics and features.

2.2 Classic grounded theory methodology: Need for a theory

Women who have had one previous caesarean section and with an uncomplicated pregnancy have a choice of either repeat elective caesarean section (CS) or a vaginal birth after caesarean section (VBAC). As has been established in the previous chapter, the issue of birth choice after a previous CS is underexplored in relation to explaining how women make decisions. The complexity of their decision-making (Tolmacheva, 2015; Flannagan and Reid, 2012; Black *et al*., 2016) needs to be explored so that women will make a decision that will give them a positive experience. There is also a need to find out the factors that influence women to choose VBAC and a repeat CS to determine how these factors are interrelated so that effective support services can be put in place to make it an informed, individually based and satisfactory experience.

As noted in Chapter 1 this research aims to develop an understanding of how women, following a previous CS, make birth choices for their next pregnancy and why they make a choice of elective repeat CS or plan for a VBAC. In spite of the

available guidelines which suggest that VBAC is a safe choice for women, previous quantitative research in this area has not been able to explain the relationship between women's knowledge and its effect on their decision-making (Shorten et al., 2005; Montgomery *et al*., 2007; Eden *et al*., 2009). These studies suggest that although women's knowledge may have increased and decision conflicts may have decreased, an increase in the uptake of VBAC has not followed (Nilsson *et al*., 2015;Flannagan and Reid, 2012). A number of qualitative studies have tried to explain women's experiences with decision-making, but they have questioned the aspect of informed consent amid uncertain and unclear information provision (Black *et al*., 2016, Lundgren *et al*., 2012). Overall, there is a lack of a theoretical approach in understanding this process and in explaining the inter-relatedness of the informational, psychological, emotional, and attitudinal aspects in decision making. There is also a need to understand the primary issue women face when making choices as little is known about it. Generation of grounded concepts will enable health professionals to understand what women want, what their main concern is and what happens as they go through their pregnancies and will enable an understanding of the factors that influence their behaviour. Glaser and Strauss (1967) explained that the interrelated functions of a theory are to enable prediction and explanation of behaviour, to be valuable in the theoretical advance of midwifery, be useful in guiding practice and provide a perspective on the behaviour of women. Grounded theory can also generate hypotheses that account for a pattern of behaviour which is relevant and problematic for participants (Glaser, 1998). The aim of this study was to generate a grounded theory of women's decision-making relative to their birth choices.

2.3 Overview of classical grounded theory

Grounded theory is a general methodology linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area. The research product constitutes a theoretical formulation or integrated set of conceptual hypotheses about the substantive area under study (Glaser, 1998). The primary purpose of research is to improve our understanding of why things happen as they do (Glaser, 1998) and contribute to theory, knowledge and clarification of concepts or issues (Denscombe, 2010). Grounded theory methodology is the study of abstract problems and their processes (Glaser, 1992). A grounded theorist collects data on social phenomena and codes for indicators and properties of categories which are central to an understanding of the phenomena in question. There is always a social pattern hidden in human interaction and the role of the researcher is to unveil it (Glaser, 2001).

The outcome of grounded theory methodology is not the reporting of facts but the generation of probability statements about the relationships between concepts; a set of conceptual hypotheses is developed from the empirical data about the substantive area under study and not just probability statements about the relationship between concepts (Glaser, 1998). Grounded theory methodology describes the steps of the research process and provides a path to it. It can be adopted and adapted to solve varied problems and to conduct diverse studies, whether or not the aim is for theory development (Charmaz, 2014). Glaser disagrees with this viewpoint, asserting that grounded theory is the systematic generation of theory from data acquired by a research method (Glaser, 1998).

Choosing which method to use for a study includes various factors, for example, the goals of the researcher, the problem being investigated, cost, rigour,

interpretations and usefulness, the appeal of the method, as well as the preferences and skills of the researcher (Glaser, 1998). Hence, grounded theory extends beyond description to generate or discover a theory, an abstract analytical schema of a process or action or interaction (Strauss and Corbin, 1998). Since grounded theory is a general methodology it works well for analysing data within the perspective of any discipline (Glaser, 1992).

2.4 The philosophical debate

A research paradigm refers to a pattern or model for research. Clearly, this involves a philosophy of research. It also includes reference to the practice of research, preference for one set of beliefs and practices as better than others, and identification of particular research questions as more worthwhile than others (Denscombe, 2003, Denscombe, 2010). A research paradigm encompasses three elements: epistemology, ontology and methodology. Epistemology asks about the nature of knowledge. What is the relationship between the inquirer and the known? Ontology raises basic questions about nature of reality and methodology focuses on how knowledge about the world is gained. The major paradigms and perspectives that structure and organise qualitative research are positivism, post-positivism, constructivism, critical theory and related positions such as participation and pragmatism (Denzin and Lincoln, 1998).

Epistemology refers to the ways that humans create knowledge about the social world and involves philosophical debates about the bases on which one claims to have knowledge of social reality (Denscombe, 2003, Denscombe, 2010). When conducting a qualitative study, epistemology assumes that researchers get as close as possible to the participants being studied (Creswell, 2013). The two fundamental positions on this are ‘Positivism’ and ‘Interpretivism’. Positivism involves the idea

of using scientific methods to gain knowledge and regards the observation and measurement of the properties of objects as crucial to the way social reality is discovered (Denscombe, 2003, Denscombe, 2010). 'Interpretivism', by contrast, regards our knowledge of the social world as something that relies on the human capacity to 'make sense' of a reality which, of itself, has no inherent properties, no order and no structure. This epistemological position tallies with constructionist ontology (Denscombe, 2003, Denscombe, 2010). Interpretivism has been put forward as an alternative to positivism (Parahoo, 2014).

Ontology refers to the nature of social phenomena and the beliefs that researchers hold about the nature of social reality. The two basic positions here are realism and constructionism. Realism regards the social world as something that exists 'out there'; an objective reality that exists independently of whether any individual believes in it or approves of it. Constructionism regards the social world as a creation of the human mind; a reality that is constructed through people's perceptions and reinforced by their interactions with other people. Social reality is seen as something that is constantly being produced and re-produced; something that exists only if people persist in creating it through their everyday actions, words and beliefs. The constructionist vision of social reality acknowledges the possibility that the nature of the social world might vary between different cultures and different groups and unlike realists they see the world as comprised of multiple realities rather than a single objective reality (Denzin and Lincoln, 1998; Denscombe, 2010). Constructivism adopts relativist ontology. The inquiry aims to produce reconstructed understandings, wherein the traditional positivist criteria of internal and external validity are replaced by the terms trustworthiness and authenticity (Denzin and Lincoln, 1998).

The following section explains the relationship between different philosophical perspectives and whether GT fits within research paradigms.

2.5 Grounded theory and philosophical perspectives

For over a decade, the basic principles of grounded theory methodology have come under scrutiny both from within and outside the GT community. Some scholars have accused grounded theorists of naïve inductivism, and the method has been labelled as positivist (Bryant and Charmaz, 2007). However, it is important to reposition GT in the light of the current philosophical and epistemological landscape (Bryant and Charmaz, 2007). Repositioning will allow understanding of such issues as those shaping the research process, the roles, social locations, perspectives of the researcher, the production of data, and the dialectical relations between sensitising concepts and induction (Bryant and Charmaz, 2007). GT is a general methodology (Glaser, 2005) and does not have a stance, which may help to explain some of the criticism levelled against classic GT. Glaser (1978, 1992) insists that researchers let data emerge, and must not pre-conceive them either through applying extant concepts or asking extensive questions to research participants. Not having a philosophical stance, Glaser (1978) emphasises openness and constant comparison in order to minimise preconceptions and the philosophical stance of individual researchers. GT takes a middle ground between realist and postmodernist visions (Bryant and Charmaz, 2007). In the 1960s, Glaser and Strauss disputed the dominance of positivistic quantitative research. By the 1990s grounded theory became known for its rigour and usefulness and it has gained increased acceptance from quantitative researchers (Charmaz, 2014). GT only conceptualises the data to develop analytic categories and to derive relationships between those categories (Glaser, 1993).

Charmaz, (2014) considers CGT to be positivist in nature, but, GT adopts only conceptual rather than a realist or interpretivist perspective. Conceptualising requires higher level thinking and sensitivity especially for coding, memo writing, integrating and writing the developing theory than merely describing behaviour. But Glaser's (Glaser, 1993) classical GT brings the researcher close to the issues that people experience, provides a method for identifying and capturing the process and a possible explanation for it rather than static analysis of the phenomena.

This debate concludes by stating that the researcher agrees that grounded theory methodology does not fit within established research paradigms whether positivist, interpretivist, postmodern, or any other. The method is epistemologically and ontologically neutral. As a general and conceptual methodology and able to use any type of data, it transcends the specific boundaries of established paradigms to accommodate any type of data sourced and that data can be expressed through any epistemological lens (Bryant and Charmaz, 2007). Classic grounded theory methodology uses data of all types (Glaser, 1998) and it accommodates a range of epistemological and ontological perspectives without the need to adhere to any one perspective. As a general methodology GT can be applied to any type of data provided the researcher adheres to the scientific methodology of conducting the study. It directs and enables moving qualitative and quantitative data toward dense, durable, substantive and formal theories (Glaser, 1993).

2.6 The roots of Grounded Theory

Grounded theory was developed in the 1960s by Glaser and Strauss during their study of participants who were dying (1965) and was written up as a methodology by them (Glaser and Strauss, 1967). GT emerged at the time when theory was mainly a speculation whereby sociological researchers logically deduced a theory from interconnected groups of propositions. There was no grounding in the data, and the researcher came to the field with preconceptions. GT changed this by proposing the generation of theory from data (Cooney, 2010).

Grounded theory is considered to have its roots in the movement of symbolic interactionism, a theoretical perspective initially developed by George Herbert Mead in the 1920s and 1930s. Mead (1934) as cited in Gerrish and Lacey (2010), saw the use of symbols as a major feature of human life. In Mead's view, individuals develop their own action based on those of others; they take account of each other's behaviours, interpret and respond to them. The emphasis is on the process of interaction between people and the way they understand social roles (Gerrish and Lacey, 2010). Glaser has countered this assertion; he maintains that symbolic interactionism and grounded theory both have strong compatibilities (Glaser, 2005). Like symbolic interactionists, grounded theorists assume that people act as individuals and as groups. The symbolic interactionist emphasis on meaning and action complements the question grounded theorists pose in the empirical world: what is happening? The dual emphasis on an agentic actor and action in both grounded theory and symbolic interaction lead researchers to attend to process rather than assuming structures. But Glaser views symbolic interaction as just one of many possible theoretical codes and asserts that GT is not based on symbolic interaction (Glaser, 1978).

Grounded theorists attempt to discover fundamental processes. Symbolic interactionists view social life as somewhat indeterminate and open-ended because it consists of interactional processes. Both have pragmatist underpinnings. The grounded theory researcher enters the field with an open mind and allows concepts to emerge. Glaser (1978; 1992) and Glaser and Strauss (1967) advocate moving towards a general, abstract level, and addresses explanatory 'why' questions. Symbolic interactionists produce studies that answer 'how' questions. The fit between symbolic interactionism and grounded theory is extremely strong, but they are not same (Bryant and Charmaz, 2007).

GT is also described as a perspective-based methodology as peoples' perspectives vary (Glaser, 2003). Glaser contends that participants have multiple perspectives that vary pending on their actions. By raising these perspectives to the abstract level of conceptualisation researchers hope to identify the underlying or latent pattern of behaviour. GT uses constant comparative analysis (Glaser, 2003) for generating a theory. It is not the fact upon which it stands, but it is the conceptual category that is generated from it. GT is not fact based but based on conceptualising patterns of behaviour.

According to Charmaz (2014) a mid-century positivists' conception of the scientific method and knowledge stresses objectivity, generality, replication of research, and falsification of competing hypotheses and theories. Their belief in scientific logic as a unitary method, its objectivity, and its truth legitimised reducing qualities of human experience to quantifiable variables. Social researchers who adopted the positivist paradigm aim to discover causal explanations and to make predictions about an external, knowable world. Their beliefs in scientific logic, a unitary method, objectivity and truth legitimised reducing qualities of human

experience to quantifiable variables. As positivism gained strength in mid-century US sociology, the division between theory and research simultaneously grew (Charmaz, 2014).

Barney Glaser and Anselm Strauss, two sociologists from different but complementary backgrounds, developed grounded theory methodology. Glaser and Strauss (1967) countered dominant mid-century methodological assumptions. They challenged the belief that qualitative methods were impressionistic and unsystematic and the separation of the data collection and the analysis phases of research. They also challenged the supposition that qualitative research should be judged by the canons of quantitative research, an arbitrary division between theory and research; views that theory construction belonged to the dominant thinkers in sociology at the time and assumptions that qualitative research could not generate theory. They believed that it was critical to adhere to data, to be in the field, and to generate a theory that respects and reveals the views of the subjects in the substantive area under study. Their radical message proposed that systematic qualitative analysis has its own logic and could generate theory. Their aim to move qualitative inquiry beyond descriptive studies and into the realm of an explanatory theoretical framework provided abstract conceptual understandings of the studied phenomena (Charmaz, 2014). Since Glaser and Strauss's classic statements in 1967 (Glaser and Strauss, 1967) GT has developed in divergent directions (Glaser, 1978). Glaser's version of GT is often referred to as 'classic grounded theory', but Charmaz is of the view that reality is constructed, hence called her version constructivist GT (Charmaz, 2006; Charmaz, 2014).

2.7 The Glaser-Strauss Schism

Glaser (1992,1998,2003) maintains that his version of grounded theory is the version that emerged from the study on dying. By 1990, two distinct versions of grounded theory had emerged. Glaser's conceptual version and Strauss and Corbin's post positivist version. Glaser (1992) contends that Strauss and Corbin's new techniques forced data and analysis into preconceived categories, ignoring emergence, and resulted in 'full conceptual description', not conceptualisation (Charmaz, 2014). Walker and Myrick (2006) discuss the Glaser-Strauss debate by comparing the data analysis processes and procedures advocated by Glaser and by Strauss. Accordingly, in the process of generating theory both versions of grounded theory use coding, constant comparison, questions, theoretical sampling, and memos. Moreover, both versions adhere to the same basic research process: gather data, code, compare, categorise, theoretically sample, development of a core category, and theory generation. However, Strauss and Corbin (1990) see the generation of a core category as optional. The problem is that these similarities in language and process make any discussion of differences confusing.

There are two issues that relate to the data analysis process. The first is the issue of 'forcing' versus 'emerging' in relation to the coding procedures. Strauss and Corbin force descriptions, irrespective of emergence, on the theory to locate its conditions and to contextualise it, thereby losing its true abstraction and generalisability (Glaser, 2001; Glaser, 2003). Preconceived questions force participants' responses whereas a general question allows them to open up and express their real concern. Participants' unforced responses make constant comparison strong by generating new categories and properties. Glaser (1998) provides a tip to the researcher to record his own experience in a memo or in the data, in order to submit it systematically to ongoing constant comparisons in order to

avoid forcing. The second issue is that of verification which is the process of coding the data and coding methods according to Glaser (1978), appear simple, more focused and in keeping with the original way of coding grounded theory. He has divided the coding process into two procedures: substantive and theoretical coding. Substantive coding consists of two sub-phases, open and selective coding, and is concerned with producing categories and their properties. Theoretical coding occurs at the conceptual level, weaving the substantive codes together into a series of hypotheses and theory.

Strauss's coding divides the process into three phases and labels them open, axial and selective and he also discusses the conditional matrix. Although not directly related to selective coding (Strauss and Corbin, 1998), the conditional matrix seems most applicable to this phase and is also usable in axial coding. Glaser (1992) has claimed that this matrix imposes a too detailed and preconceived way of viewing the data. Strauss and Corbin (1990) assert that it is but one tool of many that could help the researcher look beyond the obvious, linking process to structure. Walker and Myrick (2006) argue that at the surface level, there are no recognisable differences, between Glaser and Strauss, as both look a lot alike. The differences lie not in the language or general processes but in how these processes are carried out. They reflect different methodological assumptions that must be illuminated and understood if informed choices are to be made. Cooney (2010) is of the view that Glaser's approach to data analysis is less structured than Strauss's whose more explicit method of data analysis makes it more difficult for some researchers to adapt for their study.

2.8 Constructivists Grounded theory

Constructivist grounded theory adopts some of the methodological strategies of classic GT but does not endorse its lack of an epistemology. The constructivist version adopts a relativist epistemology and seeks interpretive rather than conceptual understanding (Charmaz, 2014).

Constructivist grounded theory allows researchers to use grounded theory strategies without endorsing previous assumptions of an objective external reality, a passive neutral observer, or a detached narrow empiricism. It starts with the assumption that social reality is multiple, processual, and constructed. The researcher's positions, privileges, perspectives and interactions are considered as an inherent part of the research reality. Relativism characterises the research endeavour rather than objective, unproblematic prescriptions and procedures. Viewing the research as constructed rather than discovered fosters researchers' reflexivity about their actions and decisions. Constructivist's opposition of the notion of neutral observer and value-free expert mean that researchers must examine how their privileges and pre-conceptions shape the analysis and accept that their values also shape the very facts that they can identify (Charmaz, 2014). Constructivist grounded theorists aim to create interpretive understandings located in these particularities and to take into account how researcher and research participants' standpoints and positions affect researchers' interpretations.

Constructivists also reject Glaser's (1998, 2003) stance toward data, which does not take into account the research situation and how data are produced within it (Wertz, 2011). But it does take the research situation, such as context and conditions, into consideration, if these emerge as relevant in the process of data collection and analysis. Glaser and Strauss explain that discovering theory as emerging from data is

separate from the scientific observer whereas, Charmaz (2014) assumes that neither data nor theories are discovered either as given in the data or the analysis. Rather, she believes that the researcher is a part of the world in which collecting and analysing data are done. Constructivist grounded theory is created through the researcher's involvements and interactions with people, perspectives, and research practices and through past and present knowledge and experience. The development of a core category is optional in constructivist grounded theory, as opposed to classical GT, where it is a requirement (Charmaz, 2014).

Grounded theory methods shape and reshape data collection and therefore refine the collected data and let the imagination flow, by providing flexible guidelines rather than rigid prescriptions (Charmaz, 2006). A basic tenant of grounded theory is that "all is data" (Glaser and Strauss, 1967, Glaser, 1978; 2001). It means that whatever is happening in the research area is the data, whatever the source; it can be from interviews, observations, or documents (Glaser, 2001). It is what one observes and records in the course of doing research (Bryant & Charmaz, 2007, p 44). However, data may vary in quality, relevance for emerging interests, and usefulness for interpretation. Grounded theorists' background assumptions and disciplinary perspectives alert them to look for certain possibilities and processes in their data. These assumptions and perspectives differ among disciplines and shape research topics and conceptual emphasis (Charmaz, 2006 p16).

The above discussion explains constructivists grounded theory. The philosophical perspective of the researcher influences the data and the development of a theory based on the interpretivist paradigm.

2.9. Dealing with the background assumptions

Most researchers and research students already have some or extensive experience in their disciplines before starting a study. No one can claim to enter the field completely free of past experience. All these experiences become sensitising concepts and become useful to start the study but not to end it (Charmaz, 2014). To remain truly open to the emergence of the theory is among the most challenging issues confronting new researchers in grounded theory methodology. It requires the researcher to enter the research field with no preconceived problem statement, interview protocol, or extensive review of the literature (Bryant & Charmaz, 2007). The grounded theory researcher starts with an area of interest not a professionally predetermined problem and has no preconceived view of what problems may be encountered in the field or how participants resolve their problem or main concern (Glaser, 1998). Strauss (1987) said that the researcher is not a blank slate but that the data generated by the researcher in the specific project has pre-eminence. The background experiences of education and training may be used to sensitise the researcher to address certain kind of broad questions (Gerrish & Lacey, 2010). The sensitising nature of the methodological orientation forms guidelines and reference points which the researcher uses to deductively formulate questions which may then elicit data that leads to the formulation of inductive concepts (Glaser, 1978, p39). In other words, researchers may use their prior knowledge to make themselves more sensitive and alert to emergence, by remaining as open as possible in the early stages of research (Glaser, 1998, p123). Their previous experience and assumptions can contribute to the theoretical sensitivity and they become important reference points to formulate further research questions (Glaser, 1978). As researchers let the data speak for itself, their knowledge enables them to conceptualise it through constant comparisons and this is how the preconceptions are dealt with. Preconceived ideas

are not forced on the data, but the constant comparison tests and verifies the concepts and patterns (Glaser, 1998, p123). This makes the researcher theoretically sensitive, which refers to how the knowledge, understanding, and skills of the researcher are used in the generation of categories and properties.

2.10 Conceptualisation

Conceptualisation, the core process of GT, is the naming of a pattern of behaviour. In grounded theory a pattern is carefully discovered by the constant comparing of theoretically sampled data until saturation of interchangeable indices. It is done by comparing many incidents to each other and to concepts. The most important property of conceptualisation is that it is abstract of time, place and people. Constant comparison is used to generate concepts, categories and their properties to extend and saturate the theory. GT researchers think of a category as a variable, so negative and positive are just points on a continuum that varies the behaviour of the respondents (Glaser, 2003 p83).

GT is concerned with the conceptual levels. The core is the highest level, followed by the sub-core, and then the categories. The core category relates to all other categories and their properties, since through these relations it accounts for the predominance of behaviour in the substantive area being researched. The category that relates to much of the core is called a sub-core category (Glaser, 1998).

Another conceptual difference the researcher must deal with is that between substantive coding and theoretical coding. Substantive codes are the categories and their properties; theoretical codes provide a framework for theory integration (Glaser, 2005). Coding is the generation of categories and their properties by constant comparison of incidents and categories (Glaser, 1998). According to Glaser (1978) there are three levels of coding: open, selective and theoretical.

Open coding: Open coding is the first step of analysis that pertains to the initial discovery of categories and their properties. The researcher needs to analyse the data line by line, and sentence by sentence, constantly comparing, and in doing this many codes, their properties and dimensions are constructed (Glaser, 1978). Another important step in the analysis is to always interrupt coding to memo an idea and finally, the analyst should not assume the analytic relevance of any face sheet variable such as age, sex, social class, race, skin colour etc. (Glaser &Strauss, 1967). As more and more categories and their properties become saturated, this leads to theoretical completeness (Glaser, 1998).

Selective coding: Once the core variable has emerged, the analysis changes to selective coding (Parahoo, 2014) where coding is restricted to only those variables that relate to the core. The core variable becomes a guide to further data collection and theoretical sampling (Glaser, 1978).

Theoretical coding (TC): Theoretical codes model the integration of substantive concepts. They implicitly conceptualise how the substantive codes relate to each other as a modelled, interrelated, multivariate set of hypotheses to account for the processing or resolution of the main concern. They emerge during later coding, memoing and especially in sorting memo banks (Glaser, 2005). Without theoretical codes the substantive codes are empty abstractions. They help to maintain the conceptual level, and without them, conceptual description is more likely.

2.11 Constant comparison

Constant comparison is the fundamental operation in GT analysis. In this method the researcher codes incidents for categories and their properties and the theoretical codes that connect them (Glaser, 1992). In other types of qualitative research, the responses from and between participants are compared and contrasted.

In GT constant comparison happens throughout the study and the comparison is deliberate and systematic. It takes place as soon as data collection starts and ends after the substantive theory has been formulated (Parahoo, 2014). At first, similarities and differences are compared within the data. For example, interview statements and incidents within the same interview are compared to statements and incidents in different interviews. The researcher compares incident to incident, then as a category or its property, compares the incident to the next incident. This process verifies the concept denoting a pattern in the data, it verifies the fit of the category classification to the pattern, it generates further properties of the category and it saturates the category and its properties by interchangeability of indicators (Glaser, 1998).

2.12 Theoretical sampling

Theoretical sampling is a means of data collection for generating theory by which the grounded theorist jointly collects, codes, and analyses data and then decides what data to collect next and where to find them, in order to develop the theory as it emerges. This process of data collection is controlled by the emerging theory, whether substantive or formal (Glaser, 1978). Theoretical sampling continually guides data collection and ensures concept elaboration. Participants are chosen as they are needed, rather than before the research begins (Glaser, 1992).

The basic question in theoretical sampling is what groups or sub-groups are included next in data collection and for what theoretical purpose? The selection of groups and comparison of groups make the content of the data more theoretically relevant. This active sampling allows comparisons to be made with the existing theoretical concepts arising from the data and helps to delimit the scope of research (Holton, 2007). This informs the researcher as to how people vary what they do,

leading to a multivariate theory (Glaser &Strauss, 1967). Theoretical sampling pertains only to the conceptual and theoretical development of the analysis; it is not about representation in the qualitative research sense or increasing the generalisability of results in the statistical sense (Charmaz, 2014). Theoretical sampling on any category ceases when it is saturated, elaborated and integrated into the emerging theory (Glaser, 1992).

2.13 Theoretical memos

Memos are the theorising write up of ideas about codes and their relationships as they strike the researcher. Memoing is a constant process that begins when first coding data, and continues through reading memos or literature, sorting and writing papers or monographs to the end of the study (Glaser and Strauss, 1967, 1978, 2003). Memos produce the depth and meaning of patterns of behaviours emerging from constant comparison (Glaser, 2003). The researcher must write conceptually about the substantive codes at the stage of theoretical coding and not about people which helps to maintain the conceptual level of the analysis and enables the researcher prepare for the final writing (Glaser, 1978).

2.14 Theoretical saturation

The criterion for judging when to stop sampling the different groups pertinent to a category is the category's theoretical saturation. As similar instances are seen repeatedly, the researcher becomes empirically confident that a category is saturated when no new incidents or properties of a category emerge (Glaser, & Strauss, 1967; Glaser, 1978). Initially, the analyst compares incident to incident with the purpose of establishing the underlying uniformity and its varying conditions. Then she continues to code and compare the concept to more incidents generating new theoretical properties of the concept and more hypotheses and finally concept to

concept is compared with the purpose of establishing the best fit of the many choices of concepts to a set of indicators (Glaser 1978, p50). This 'intense property development' (Glaser, 2001) lifts the theory above description and enables its integration through theoretical prepositions (hypotheses) between the concepts, making it an abstract conceptual theory (Bryant and Charmaz, 2007).

2.15 Main concern

Grounded theory empowers the researcher with its high probability of a real contribution to the field under study by discovering its prevalent problem (Glaser 1998, p116). The continual processing or resolution of the main concern is the focus of the research. The main concern is not the voice of participants. It is a conceptualisation of it, based on a theoretical coding and conceptual saturation of interchangeable indices (Glaser, 2001).

2.16 Theoretical sensitivity

Theoretical sensitivity of the researcher lies with her ability to conceptualise, to generate concepts from data and relate them accordingly to generate a theory that resolves the main concern of the participants (Glaser, 1978). This is achieved through analytic temperament and competence (Holton, 2007, p274). Analytic temperament allows the researcher to maintain analytic distance from the data, tolerate regression and confusion and facilitate conceptual emergence. Analytic competence makes the researcher develop theoretical insights and ideas from various sources and type of data. Developing theoretical sensitivity enhances the researcher's ability to develop a core category and her ability to apply integrating codes from different disciplines (Holton, 2007, p283).

2.17 Theory

In GT, comparative analysis can be used to generate two basic kinds of theory, substantive and formal. The substantive theory is developed for a substantive or empirical area of inquiry, such as patient care, race relationships, professional education, delinquency and research organisations. Formal theory is developed for a formal or conceptual area of inquiry, such as stigma, deviant behaviour, formal organisation, socialisation, status congruency, authority and power, reward systems or social mobility. Both these theories are considered as "middle range" (Glaser & Strauss, 1967). Both substantive and formal theories must be grounded in data (Glaser & Strauss, 1967). Grounded theory is also multivariate using all kinds of data from various sources, as long as the researcher is clear on the exact nature of the data and adheres to the rigor of the method (Glaser, 1998, p42).

2.18 Comparative literature review

According to Creswell (1998), it is vital to do some groundwork for research and reading of relevant literature is needed to provide a justification for the study. Glaser (1978), cautions that the suspension of knowledge and experience is not feasible and may be disadvantageous, hence, the best way to remain open is not to conduct a prior literature review (Glaser, 1992). Research supervisors, and ethical review committees, need assurance that students know what they are doing, have a clear aim and will not be a source of risk for participants (McCallin, 2006). In response to this issue of ethical review committees, Glaser (2001) suggests keeping the designation of method short on details; concentrate on how it fits the area of interest and the general goal of generating a theory that explains the prime mover of action in the area. The substantive field the theory is situated may not be known until it has emerged sufficiently. The purpose is to integrate the generated theory with the other literature to show its contribution (Glaser, 1992). However, for this study a

brief literature review was done to develop a research protocol and the problem area was kept broad when applying for approval from the Cork Research Ethic Committee (CREC). A detailed account of the comparative literature review with the extant literature in the area of decision making is presented in detail in Chapter 5.

2.19 Judging the quality and credibility of grounded theory:

Conventional social sciences apply four criteria to disciplined inquiry, internal validity, external validity, reliability, and objectivity (Parahoo, 2014). Classic ground theory gives clear directions to test its rigour by judging its quality and credibility. A well-constructed grounded theory will meet four fundamental criteria: fit, work, relevance, and modifiability. If a grounded theory is carefully induced from the substantive area its categories and their properties will fit with the experiences of the participants, practitioners and researchers in the area (Glaser, 1992).

'Fit' means that the categories of the theory must fit the data. Data should not be forced or selected to fit pre-conceived or pre-existing categories or discarded in favour of keeping an extant theory intact. Because categories emerge quickly, it is important, as the research continues to constantly refit them to the data to be sure they fit all the data they claim to specify. 'Work' means that a theory should be able to explain what is happening, explain what happened, and predict what will happen in an area of substantive or formal study in a way that resonates with participants. A theory is modifiable if it can be changed when new and pertinent data is compared to extant theory. Though basic social processes remain universal, theory variation and relevance are continually changing as new data emerge (Glaser 1978).

2.20 Choosing Classical Grounded Theory Methodology

The type of methodology selected depends upon the purpose of the research. Descriptive research provides detailed accounts of events or situations in order to gain a clearer picture of what is going on. Exploratory research investigates new areas in order to generate new theories and concepts, and it aims to explain why things happen (Denscombe, 2010). The type of qualitative approach also depends upon the aim of the research. Ethnography is for understanding the social world of people being studied through immersion in their community to produce detailed descriptions of their cultures and beliefs. Phenomenology aims to understand the 'constructs', concepts or ideas people use in everyday life to make sense of their world and uncovers meaning contained within conversation or text. Interpretive phenomenological analysis (IPA) aims to explore the meaning and significance of relevant experience for a given participant, in order to gain insights into psychosocial processes. Symbolic interactionism aims to explore behaviour and social roles to understand how people interpret and react to their environment. Grounded theory aims at developing 'emergent' theories of social action through the identification of analytical categories from the data and the relationship between them (Ritchie et al.2014).

A preliminary literature review conducted for ethical approval indicated a need to develop a theory to guide clinical practice in this area. Recent reports on maternity services in Ireland (DOH, 2016, HIQA, 2016) have identified lack of choice for pregnant women. The National Maternity Strategy (DOH, 2016) envisages the need to develop a standard, consistent model of care to ensure that all pregnant women have appropriate and informed choices, and access to the right level

of care and support. Pregnancy after a previous CS is a unique situation and lacks a framework to inform health professionals and women. Developing a care pathway will be useful in the clinical area to ensure that women make informed choices in pregnancy. Even though there are descriptive studies to explain women's experiences there is no study explaining what empowers women to make a choice or how they go about making a choice. Developing a theory of what factors influence women in relation to birth choices and how it becomes their main concern was the centre of investigation for the researcher. As discussed in Chapter 1 it is known that women have difficulty in making a choice and feel there is lack of support. What is unknown is how they deal with these difficulties in making a choice which will give them a positive experience.

Theory can be developed in many ways; however, choosing Classic GT (CGT) results in a conceptual, grounded theory (Glaser 1992, p25). The product is always original, creative and conceptually general; meaning that a substantive theory in this area of pregnancy following a previous CS can be generalised to other areas depending upon the product and scope of the theory. The theory generated will explain to all the stakeholders in the decision-making process what women go through in pregnancy following a previous CS, how healthcare professional influence women, the nature and type of information provision and the provision of support services for women.

Cooney (2010) describes how choosing a grounded theory methodology can also involve making decisions about which type to adopt. GT is creative and relevant, since it explains "what is going on" in resolving the participant's lives, and not only the participants, but groups, and organisations (Glaser, 2003). In this research, it is how women make a decision about their birth choices and, in turn, has

the potential to contribute to the development of practice-based knowledge, something that is currently lacking. Classic GT was selected for three main reasons, emergence, procedural flexibility and cost. The first and foremost reason for selecting classical GT was its openness, and trust in emergence. Strauss's assumptions are, that in order to capture the intricacy of reality, one should make explanations during the study, the data must be conceptually complex and it is a requirement to do detailed, minute examination of the data. Strauss also recommends utilisation of experiential data, which consists not only of analysts' technical knowledge and experience derived from research, but also their personal experiences (Strauss, 1987, 2003).

It is important for the researcher not to preconceive the problem which will lead to forcing the data into the problem and that may not be the true concern of the participants. It is necessary to remain at a distance from the data, absorb the data as data, and then conceptualise it. Also, CGT suggests using prior knowledge to inform theoretical sensitivity. This allowed me not to discard my prior knowledge completely but to remain open for the emerging problem, an approach endorsed by CGT methodology. This increases the theoretical sensitivity (Glaser, 1978) of the researcher and allows drawing interrelationships and connections between the data. The second main reason for selecting CGT was its procedural flexibility. GT uses 'all is data' so data does not define the method, it simply uses data whatever it may be (Glaser, 2003) and no matter how is collected (Glaser, 2001, p 162). As a practicing midwife the researcher was in the middle of the data and had access to people and situations. Midwife-women interactions involve both formal interviewing and casual conversations throughout the time that they are in contact with the professional (Parahoo, 2014). CGT provides a set of procedures that guide the

researcher from the time of entering to leaving the field and that empirically establish the patterns of behaviours (Glaser, 2003). Proximity to the data enabled me to effortlessly explain 'what is going on?' and it made easy 'where to go next?' for the comparison of data.

The third reason for selecting Glaser over Strauss was its cost-effectiveness in terms of time and money. With course duration of two years, concentration focused on the practicality of conducting the study within a limited timeframe. CGT moves much faster than qualitative data analysis (QDA), it takes less time and is more cost effective, so CGT is more resource efficient. Data collection becomes efficient because analysing, coding and theoretical sampling proceed concurrently. Interchangeability of indices stops data overpowering the research process. Memos are a very efficient means for the capture of ideas and emergence happens faster than one would think (Glaser, 2003). Accordingly, data collection and analysis (constant comparative analysis) only took seven months. At the commencement of data collection, the first few interviews were digitally recorded. When constant comparative analysis began and the properties of a category were being identified, it became clear that recording and transcribing data was unnecessary and the taking of field notes was enough. This approach was helpful in preventing data overwhelm and it facilitated conceptualisation of the data and the development of concepts.

2.21 Conclusion

This chapter has described grounded theory methodology and its usefulness in eliciting theories to explain behaviour. It has explained the possible research paradigms and research approaches that could have been applied to this research and a rationale for the research approach chosen is provided. Having explored all the different philosophical and epistemological perspectives, GT with its general perspective has been identified as the most suitable research methodology for this research. An in-depth examination of classical GT along with an explanation of the historical developments and various steps in the research process involving data collection, analysis and write up, which are unique to GT, have been explained along with its criteria and credibility. Finally, a justification for choosing classical GT as opposed to other types of GT has also been outlined. The next chapter will discuss the research methods used in this research.

CHAPTER 3 OPERATIONALISING GROUNDED THEORY METHODOLOGY

3.1 Introduction

The previous chapter explained grounded theory methodology; this chapter provides an account of how the study was operationalised. At the outset, the aim of the study and the research setting are presented, followed by the details of access to participants, theoretical sampling, data collection and the analysis process.

The topic of birth choices after previous CS is an interesting one for health professionals. As detailed in Chapter 1, which gives an account of preliminary literature into this research on how women make decisions in relation to their birth choices, women's experience of making an informed choice, what were the enabling factors and what factors hindered them in making a choice was an appealing study option which led me to explore how women actually make a decision about a birth choice. As discussed in Chapter 2, grounded theory methodology was selected as the best research approach for this study.

In clinical practice, it has been noted that women are often confused, uninformed, and anxious about their birth choices in pregnancy. As outlined in Chapter 1, women who have had one previous CS have the choice of repeat CS or VBAC. There is a need to explore antenatal experiences of multigravida women in general, including the experiences of women with a previous CS. Grounded theory is an inductive research methodology where data is collected about an area of interest by a method of data collection that best suits the research question. The aim is to provide the participants with the opportunity to express their views rather than being limited to the issues that may be considered important by researchers or scholars in

the particular field. By this method, the participants can identify issues and aspects of their lives or their care that are important to them. Generating grounded theory can uncover the main concern of women by generating hypotheses between different concepts that are engendered in the research process(Glaser, 1998).

3.2 The aim of study

The research aim was to develop a grounded theory of women's decision-making about their birth choices in pregnancy after a previous caesarean section.

3.3 Ethical considerations

In the recent past, measures to assure ethical rectitude have become progressively more demanding because civil society was disturbed by the questionable actions of some health professionals engaged in research (Gerrish & Lacey, 2010). Pregnant women are considered a vulnerable group by the ethical committee, (CREC-Cork Research Ethics Committee) hence, the subject area was sensitive. These issues were given prime importance while undertaking this research to avoid undue problems arising during the research process.

Ethical principles have been defined and described by many philosophers and they can be summed up as beneficence, non-maleficence, fidelity, justice, veracity and confidentiality. These principles underpin the four rights of any person considering involvement in research, the right of self-determination, may choose to take part or to withdraw at any time, and the rights of privacy, anonymity and confidentiality (International Council of Nurses, 2003); and they were protected throughout the research process (Nursing and Midwifery Board of Ireland (NMBI), 2015; Parahoo, 2014). Anonymity is more important in qualitative research as there could be many indicators in the research process especially in data collection and analysis that could identify participants (Richards & Schwartz, 2002). In this study,

the participants' anonymity was maintained by assigning numbers to the interviews and memos were assigned with dates, referenced to the corresponding interview number. Field notes were only dated, names were not used. In addition, there were no identifying characteristics evident in the theory, as the unit of analysis was the behaviour rather than the individual. The theory is abstract from person, place or time so there are no identifying characteristics of the individual evident. Explicit disclosure of any personal information is completely masked and controlled by conceptual pattern generation; therefore, it avoids the harm of revealing any confidential material. In concurrence with GT values, illustrations were referenced by coded numbers, as per Glaser's advice on the use of illustrations especially in sensitive cases (Glaser, 2001). Even though direct quotes of participants are used to explain the theory in the write up these are assigned with numbers of the participants which are purely anonymous. The confidentiality of participants was maintained by not collecting any personal information about them, each recording and transcript was given a code number so the name of the participant did not appear on any material, all data was stored in a locked cabinet and the laptop is password protected.

Four potential risks to participants in qualitative research were identified by Richards & Schwartz (2002), anxiety and distress, exploitation, misrepresentation and identification of participants in published papers. The women were not exposed to physical injury as they were interviewed in the place that they considered was suitable for them. Potential psychological distress was anticipated and services were offered to them should they be required such as meeting with the obstetric team, or an explanation about their previous experience through the review of their medical records. The obstetric teams were informed and available if any woman needed further reassurance or discussion. Women were treated fairly and equally before,

during and after the interviews and interviews did not have any effect on their care and there was no value judgement on their birth choices

3.3.1 Consent

Important considerations of informed consent such as disclosure of information, comprehension, competency and voluntariness were given due respect (NMBI, 2015). People who can consider what participation will involve should be able to decide whether or not to take part in a study. However, obtaining consent should involve clear, unambiguous information to potential participants so that they can make an autonomous decision (Gerrish & Lacey, 2010). Informed consent should be considered as a process rather than a one-off event, and researchers should be mindful that, for participants, interviews may be viewed as a means of enhancing their health (Richards & Schwartz, 2002). As soon as the potential participant was identified by the staff midwives they were given a pack which involved information about the study, their freedom to withdraw from the study anytime and a consent form. Prior to conducting the interview consent was again discussed with the woman. Information on my background, my interest in undertaking this study, my role as researcher in the interview, as opposed to acting as a health professional, and the woman's right to freely consent to participate was provided. The aim and objectives of the research study were discussed, including storage of data, confidentiality and anonymity. Participants were encouraged to ask questions about the study, the interview process, data and confidentiality before, during, or after the study. Recording of the conversation and taking notes during the interview was also discussed and it was emphasised that the woman had the freedom to stop the recording or to withdraw from the study at any time. Only following the above discussion were consent forms given to potential participants. All the participants,

who took part in formal interviews signed the consent form at the time of the interview. For the informal interviews verbal consent was taken from participants. A written consent form was offered, which none of them wished to sign, as the conversation was very short; however, verbal consent was obtained from these women to include their information in the study. These interviews were kept as open as possible and unstructured. Every woman was appreciative of the study, was pleased to be included in it and was even ready to be contacted again if more information was required. This supports the idea that participants are not apprehensive about interviews once they know the researcher is interested in their concerns.

3.4 Access and recruitment

Insurance cover is a mandatory requirement of the Cork Research Ethics Committee (CREC) and it was obtained from University College Cork (UCC). With the insurance cover in place (Appendix I) an application was made to the CREC for ethical approval. Once ethical approval was granted (Appendix II), the Clinical Directorate for Women and Children at Cork University Maternity Hospital (CUMH) was approached for permission, which was granted, to conduct the study and for access to both private and public patients (Appendix III).

3.4.1 Access to sample

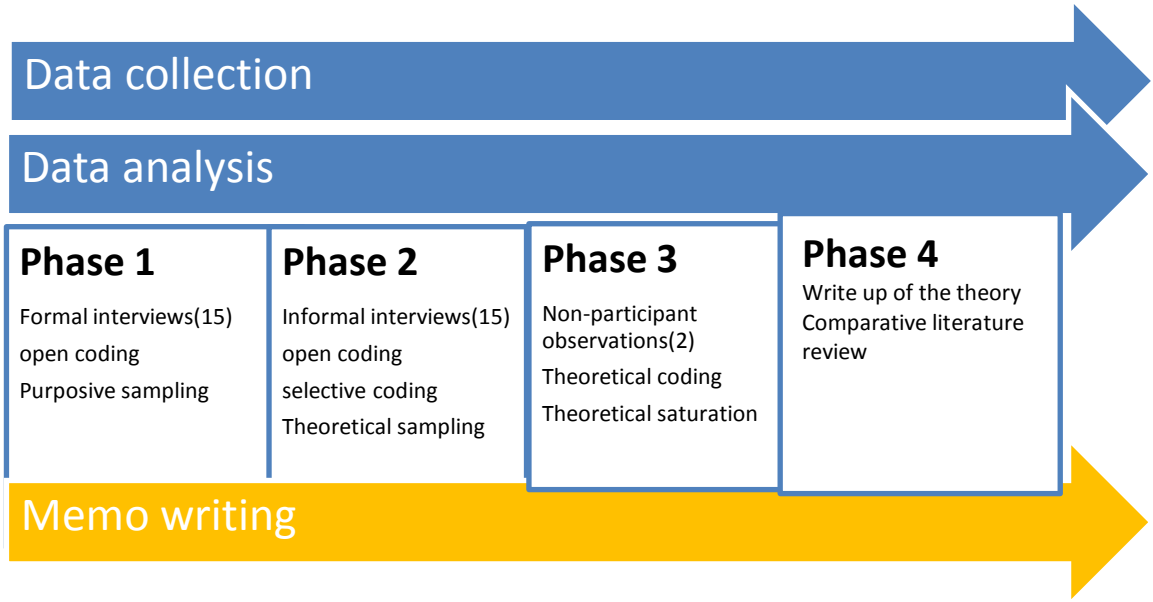
With ethical approval and consent to conduct the study in place, the project was explained to all the consultants and their teams and any related doubts were clarified. The obstetricians were interested and supportive and they agreed to the study being conducted and gave their permission to interview women from private clinics.

In accordance with the principles of GT, the sample size was not established at the outset but emerged as the study progressed through theoretical sampling. Participants (antenatal women) were recruited with the support of the midwives in the public and private clinics and antenatal and postnatal wards of the hospital. The Clinical Midwife Managers (CMM's) of the relevant areas were contacted, and the study was explained to them. A folder containing details of the study, booklets and inclusion and exclusion criteria was left in each department (Appendix IV). If a woman was interested in the study and met the criteria, the staff midwives were to offer her a study booklet. The names and mobile telephone numbers of women interested in participating in the study were put in a folder. The women were contacted by telephone; they were given a short introduction to the study, with an explanation on how the data would be collected and they were invited to participate. As participants volunteered to be interviewed, arrangements were made regarding a suitable time and venue to meet. Women attending for both private and public care were recruited.

3.5 Overview of the research process

Glaser explains that classical GT methodology requires constant data collection, coding and analysing to restrict data collection, in order to respond in a timely way to theory driven saturation of categories by sequential questioning of participants (Glaser, 2001, p166). This chapter describes how the actual research process was undertaken to complete the study.

Table 1 showing the research process



3.5.1 Sampling

In accordance with the principles of GT, the sample size was not established at the outset but emerged as the study progressed through theoretical sampling. Two types of sampling techniques are used in this study. They are purposive sampling (Gerrish and Lacey, 2010) and theoretical sampling (Glaser, 1978, 1992). Without an emerging theory at the outset, this study started out with purposive sampling of women who met the inclusion criteria (outlined below). Once the initial codes were assigned to the interviews and the constant comparative analysis commenced the sampling was directed theoretically according to the emerging theory. The codes from the previous interviews were used to direct further data collection. The process of data collection is controlled by theoretical sampling according to the emerging theory (Glaser, 1992). For this study, theoretical sampling suggested the freedom to change the interview technique from formal interviews to informal interviews and non-participant observations. As the constant comparative method continued, three sub-core categories were finalised. In order to develop the theory and integrate sub

core categories into the theory several questions had to be answered such as how these three sub-core categories are interrelated, are they cyclical or do they overlap? Obtaining data to help illuminate the categories is the reason for theoretical sampling. Theoretical sampling is not about characterising people or enhancing the statistical generalisability of the outcomes, but it is for theory generation. The focus was on events or incidents that provided answers to theoretical questions as they added properties to the categories and helped to classify the behavioural strategies used by women, in dealing with the decisional conflict.

3.5.2 Inclusion and exclusion criteria

Women were selected if they met the inclusion criteria:

- pregnant with their second baby and whose first baby was delivered by CS for a non-recurrent cause
- between 36-42 weeks of pregnancy
- have a low risk pregnancy
- over 18 years of age
- could communicate well in English

Exclusion criteria:

- Women who had conceived using assisted reproductive technologies

In the beginning of the data collection process women were selected between 36-42 weeks of gestation. As the study progressed and research progressed with constant comparative analysis of the data, data collection was extended to women who were at the beginning of pregnancy, in the mid trimester and at term. One woman, participant 4 was followed throughout her pregnancy. She was first interviewed at 12 weeks, the interview lasting only fifteen minutes. She was happy to be contacted during her pregnancy and was seen at each of her antenatal visits, at 20 weeks, 37 weeks, and for three days after the birth of her baby. These meetings

led to the recognition of the core category of mentalizing possibilities, where women use a behavioural strategy to go through the cognitive process. This explains how women process their previous experience, adapt to uncertainty and deal with decisional conflict when deciding about a birth choice. As a cognitive process it goes on throughout the pregnancy; and for some women it began with the previous pregnancy itself. This process evolves during pregnancy and there are factors which influence its evolution. Theoretical saturation directed theoretical sampling to cease when the core and sub-core categories were elaborated sufficiently to explain the theory.

3.6 Data collection

The method of data collection used for this study was interviewing, but how much of the data will be used and how much of it will be collected could not be stated in advance (Glaser, 1998, p 159). As the research process continued, this was guided by theoretical sampling and theoretical saturation. Fifteen formal interviews and fifteen informal interviews were conducted. Two non-participant observations were also included in the data. The formal interviews were conducted in the participants chosen area, most of them in clinic consultation rooms; informal interviews were done in the antenatal and postnatal wards. These are explained further in the following sections.

3.6.1 Semi-structured interviews

In the beginning open-ended, semi structured interviews were conducted which were audio recorded even though in classical grounded theory (CGT) the use of technology is discouraged (Glaser, 2011; Glaser and Holton, 2005). Glaser advises that recording an interview restricts the flow of data from participants and

distracts them. This happens because participants are aware that they are being recorded and, as a result, are not relaxed. There is an unnecessary focus on the technology instead of concentrating attention on the discussion. Recording is necessary but according to Glaser, (2001), transcribing verbatim is time consuming and does not allow the attainment of the required conceptual depth. It may bring a halt to theoretical sampling (Glaser, 2001). As a novice and not confident of my own interviewing skills, I decided to record the first 15 interviews. The interviews were recorded using a mobile phone placed on the table so that it would not be a distraction.

In the beginning of data collection, three general questions were asked to get the women talking. These were- 'Can you explain how this pregnancy is for you?', 'Can you tell me about your experience with birth choices in this pregnancy?', 'What were your expectations and what did you experience?'

True to Glaser (2001), it took time to transcribe and code the initial interviews, but it gave me a good starting point to think and analyse how women are trying to resolve their main concern. As a researcher my aim at this stage was to be open for the emerging issue facing the women. As I started with the constant comparative analysis of the data, I coded these transcribed interviews and they became sensitive points for me to progress for further data collection. As I continued interviewing women, I changed my style of asking the interview questions based upon these codes. This approach elicited more information and prompted women to talk freely bringing about interrelations between the codes and helped me to extract their properties.

3.6.2 Informal interviews

The second type of data collection method was informal interviews with women who were admitted to the maternity hospital for various reasons. Working in the maternity service made it easy to meet women who had a previous CS. Qualitative interviews are time consuming because of the in-depth nature of the information needed and because of the diminished control over the interview process (Parahoo, 2014). Being in contact with the participants in every day practice saved time and resources.

Because grounded theorists, who are not used to coding, analysing and theoretically sampling, tend to collect too much data at the start of the study (Glaser, 1998), informal interviews became an appropriate and useful method of additional data collection. These were directed by theoretical sampling. Field notes were made after these interviews which did not include any direct quotes or any direct identity. The informal interviews were unstructured and made constant comparative data analysis easier. The aim of the study was not description, rather it was to generate a conceptual relationship between the generated codes and concepts. At this point I began writing field notes. These informal interviews ranged anywhere between 5-15 minutes.

The initial ethical application was granted to conduct 40 interviews. As the data collection progressed, I decided to halt formal interviews due to similar concepts being raised and opt for informal interviews. Due to the flexible nature of GT and a lack of need to generate volumes of data, the informal interviews became a real useful tool. The informal interviews did not interfere with women's choice as the discussion was based on the generated concepts in order to develop their properties. Ethical consideration was an issue, but it was dealt with the utmost

sensitivity as the women were given the complete background about the study, discussions were not recorded, verbatim comments were short and were recorded in the field notes. These were written in the form of an explanation for a concept or a property and this was a transformed version of the discussion and not a verbatim record.

An interview guide is required as a research plan for research ethics committees and review boards (Glaser, 2003). The interview guide used for this study was basic and included the three general questions mentioned earlier. Progressing with constant comparative data analysis, concepts were identified which were patterned out or common to many women. A rough interview guide was prepared based on the initial codes so that questions could be directed to: on what, when, where, how, what made you do, why not etc.? These questions enabled identification of the properties of the concept in the beginning of the data analysis, and when the analysis progressed it related a concept to a category. As constant comparative analysis progressed the interview guide was changed twice (Appendix V &VI). The approach was informal and flexible which encouraged women to speak. Field notes were more useful than digital recordings as it reduced the volume of the data and the descriptions. In both types of interviews, the use of medical terminology was avoided and the conversation was kept casual.

Initially, even though the interviews were meant to be semi-structured and open ended, questions were focused on the women's birth choices rather than allowing the women to talk freely about their pregnancy. Interest was focused on how they were making choices rather than why they are making them. Because the early interviews were recorded it was possible to analyse the interview technique. Listening to the participants was not done well and they were asked the next question

before they had time to formulate an answer to the first one. I allowed my professional background as a midwife and my preconception that women were not making informed choices to influence my approach. The interviews were transcribed to assist with coding, developing categories and the relationship between categories. Once a category was saturated there was no requirement to collect further data about that category.

3.6.3 Non-participant observation

The third type of data collection method used for this study was non-participant observation (Salmon, 2015, Parahoo, 2014). VBAC classes are antenatal education classes for women who are opting for VBAC and are conducted by a midwife who has a qualification in managing antenatal classes. The researcher became a non-participant observer for two classes each lasting for two hours. The aim was to understand how women perceive and seek support to resolve their main concern. This happened nearly at the end of the data collection at the stage of theoretical sampling. It also gave me an understanding of how the context of information provision and support can enhance women's understanding of their choice. I was given an insight in how enabling women to express their concern made them feel empowered to achieve a positive experience. These non-participant observations also gave me an opportunity to observe women who were in different stages of pregnancy. The ethical principle of confidentiality, anonymity and informed consent were adhered to in this method of data collection as no descriptive or direct quotes have been used from this observation. As a researcher, no conversation was made with women who attended the class. Only field notes were taken on what was going on in the class, how the midwife leading the class encouraged women to talk and ask their concern. After listening and responding to

the women's concerns, the midwife offered education and guidance to prepare them for birth. Field notes were used to capture my impressions and feelings about the session. This method of data collection led me to conclude that 'mentalizing possibilities' is a cognitive process and it differs between women based on their self-determination.

As Glaser (2003) advises, field notes should be written as soon as possible, while they are fresh in one's mind, and it is preferable not to wait until a computer is available. As the constant comparative process continues, concepts emerge from the data (Glaser, 2003). The data collection and analysis were being done simultaneously and this informed the nature of the next interview question, especially when coding for similar patterns. This made the data collection process much quicker and easier. Formal interviews were recorded and transcribed; field notes were written for fifteen informal interviews and the strength of the codes emerging from field notes was greater than with the transcriptions (Glaser, 2001). An opportunity arose to follow one woman throughout her pregnancy which made the theoretical sampling process easier, enabling categories to be saturated and elaborated, and then integrating the concepts into the emerging theory of mentalizing possibilities. The non-participant observation provided additional information about women's behaviour and how education and information empower women to overcome fear about childbirth and enhance their self-confidence. This also enabled me to develop a hypothesis that education, information and support and listening to their individual concerns was important to women in mentalizing the possibilities for their birth. These non-participant observations also lead to the realisation that women were essentially envisaging a positive experience at the end of this pregnancy and delivery and this was their main concern.

Interviewing was an important method of data collection for this study. Formal interviews varied between 20 minutes to one hour and informal interviews lasted only for 5-10 minutes. Retrospective comparison of the two types of interviews, demonstrated that women spoke more openly in the informal interviews than in the formal ones as there was no barrier to communication such as recording and the formality of the interviewing process. For both type of interviews women's consent was taken to participate in the study and how data will be used for the study. The more the conversation was casual and open, the more they were at ease. Women were keen to talk as they recognised the interest in their affairs and the non-judgemental approach regarding their choice of birth method. Field notes and memos led to the realisation that conceptualisation of the data was more important than the data itself. As constant comparative analysis progressed through collecting, coding and analysis of the data, the focus was less on birth choices and more on the conceptual categories emerging. Already collected codes directed the questioning and the collection of data continued until the categories were saturated with the properties and similar instances were being heard repeatedly. Data collection continued until each category was saturated where no new incidents were found in the data.

3.7 Data analysis

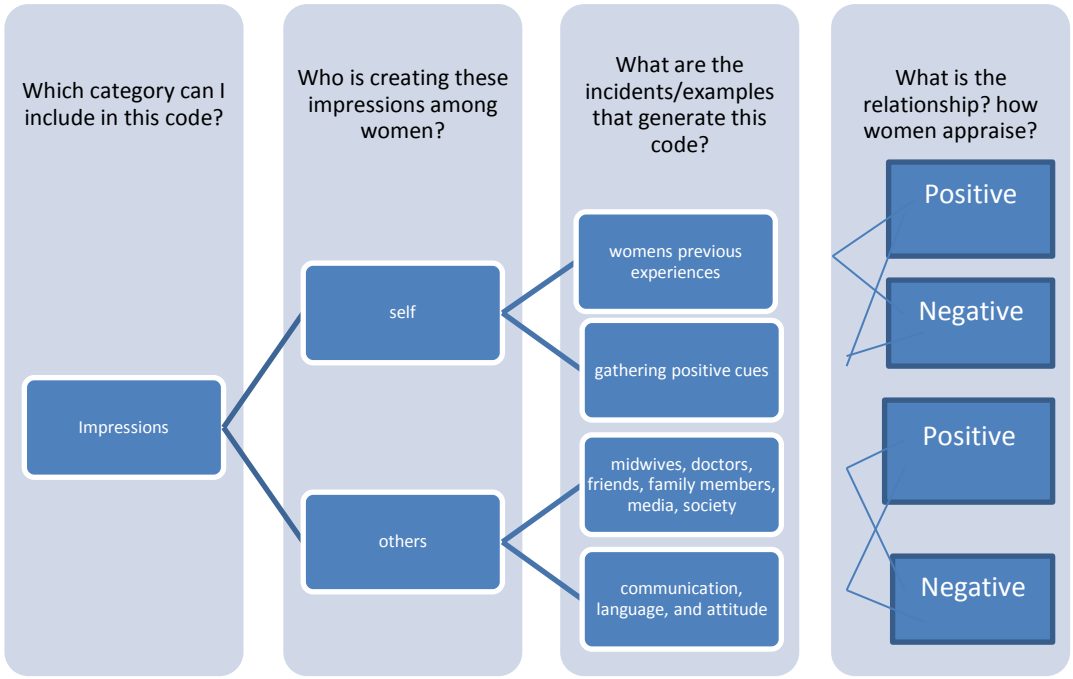
3.7.1 Open Coding:

The first interviews were recorded and transcribed, then coded, initially open coding followed by substantive coding, to see the emerging patterns. The data was analysed manually, in open coding the data was examined line by line, with the concentration focused on emerging incidents. Each incident was compared to the next as required by GT. This approach encourages concentration on behaviour rather

than just describing an event; the focus was on the action words of the participants, such as looking for, researching, asking, proving, redefining to focus on what participants were doing or engaging to resolve what they thought was their problem. Open coding involved comparing incidents applicable to each category. A coding and categories table was created and after every interview all the new codes were entered into it. A map of all these codes was created on a table format which directed the conceptual coding of a set of practical indicators for each category (Appendix VII Sample of line by line coding)

Repeated patterns were then coded and highlighted for use in subsequent interviews and for analysis purposes. This aided the comparison of incidents to incidents, code to code and later, category to category. At the beginning of the study, it was noted that all women had a specific goal in their current pregnancy. They wanted to achieve something in this pregnancy that they had not been able to achieve in the previous one. All of them were correlating and connecting every aspect of this pregnancy with the previous pregnancy and birth. Hence, past experience became an important trigger that initiates the process. This continued throughout the initial data collection. Initially, it seemed as if 'commitment proving' was their main concern. It seemed that they had a perceived obligation such as breast feeding, initial bonding with the baby but, in fact, as the constant comparative method of data analysis continued, their main concern was 'to achieve a positive experience' which incorporated 'commitment proving'. This facilitated the decision of 'where to go next?' An altered interview style focused on asking questions related to the category and to their main concern and noted the relevance of each woman's story.

Table 2. How the incidents were used to generate a category in constant comparative analysis.

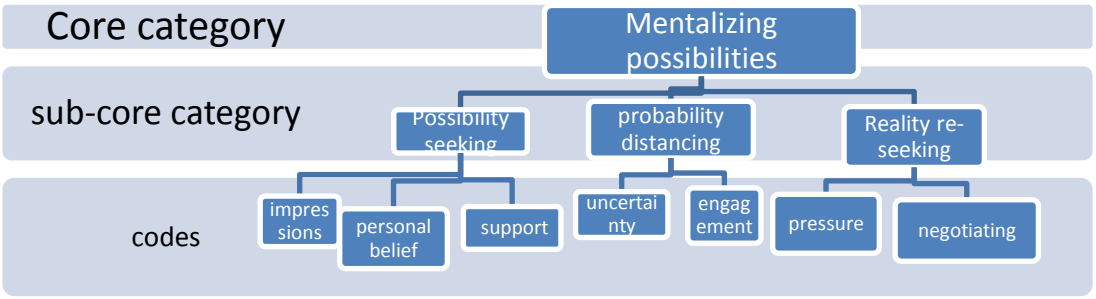


3.7.2 Selective coding

The selective coding process started when the emergence of the substantive theory began to appear for the first time, as the core category and sub-core categories were identified. The abstraction of codes from data happens throughout the coding process. This stage mainly involves integrating categories and their properties. The core category emerged at the end of the formal interviews, but saturation was reached at the twenty sixth interview. At this stage, though many categories were identified, they were restricted to three main categories and all the others became sub-core categories or properties. The core category was related to many categories as it accounted for the preponderance of behaviour (Glaser 1992). This core category 'mentalizing possibilities' explains the process of how women go through the

decision-making process to achieve a positive experience. Once the core category emerged, the sub-core categories were selectively coded into this core category until it had the capacity to incorporate the whole theory.

Table 3: Showing the relationship between the core category, sub-core category and codes.



The table explains the hierarchy of codes based on the level of conceptualisation. Core being the highest level it is related to sub core by its corresponding codes. The relation between the codes and the sub-core category explains the behaviour of the women. This will be explored in detail in the chapter 4 by referencing to the data.

3.7.3 Theoretical coding:

Theoretical coding explains how substantive codes relate to each other in a theory. Data is taken apart in substantive coding and reshaped into a whole by theoretical coding. Theoretical coding is a necessity for theoretical completeness (Glaser 2001, Glaser 1978, 2005).

At this stage, sorting the memos helped define the theory (Glaser1978, p116). Sorting and theoretical coding were done concurrently and required revisiting and

sorting of the codes on several occasions until "theoretical completeness" was achieved (Glaser 1978) (Appendix VIII shows sorting of memos). The concepts and categories that identified how women resolve their main concern were identified in the open and selective coding stage, but lacunae remained to hold all these categories and sub-core categories. Theoretical sampling which led to non-participant observations also led to the realisation that there was more to theoretical coding than just one code. Mentalizing possibilities led women to process information and support throughout their pregnancy however that varied between women. For example, as will be described later, to connect these properties, a typology of women's behavioural strategy was identified that demonstrate how they mentalize possibilities differently. At this point, a theory had been developed that sufficiently explained the way in which the participants process their main concerns.

The mental mapping about the theory changed frequently and everyday a map of interconnectedness of all the codes was put down in memos (Appendix IX a memo on mental mapping). The independent variable for the whole process is the previous event, which in this research is the previous CS. The dependent variable is the outcome of the process which is mentalizing possibilities. A process according to Glaser (1978, p74) is something that occurs and changes over time. Processing refers to getting something done, and this takes time; or something happening over time (p. 97). The core category was a process and the three sub-core categories are the strategies used in processing the core category and they are linked to each other by the awareness context. The phases are cyclical and inter-dependent. Each phase was determined by causes and conditions resulting in consequences. Accordingly, awareness has three contexts - personal, informational and support - which lead to the development of self-determination among women.

3.8 Memoing

Memoing is an important research strategy for any qualitative study but is particularly so in GT (Glaser, 2013). Memo writing was started from the beginning of the research, and a memo is usually a brief note. Field notes were also written but field notes portray the incident whereas memos described the codes and their properties and relate them to the incident. Memos included all the ideas that occur while interviewing and coding and were written, in a notebook with detachable pages, whenever or wherever an idea was indicated. In the beginning, memos were more descriptive and overlapped the field notes and the data itself. There were 107 memos written, which as the constant comparative analysis progressed, became more conceptual and helped to elevate the data to conceptualisation. Memos varied from a few words to few pages. They included examples, thoughts, mental mapping of the relationship between the codes and the categories, asking questions and possible suggestions by supervisors and experts (Example of a memo after attending VBAC classes is presented in Appendix X)

3.9 Writing the theory

At this stage in the process of qualitative analysis, the analyst possesses coded data, a series of memos, and a theory. The discussion in the memos provides the content behind the categories which become the major explanation of the theory (Glaser, 1994). Accordingly, to help in writing the theory, all the memos were organised. In the beginning the concept was described, meaning that every incident recounted by the participants was conceptualised and described with no theoretical meaning attached to it.

As the theory developed, several restricting attributes of the constant comparative method began to control it. As the theory strengthened, major changes decreased as I compared the next incident of a category to its properties. The theory was refined in the form of writing advanced memos, clarifying the logic, taking out non-relevant properties, and integrating elaborating details of properties into the major outline of the theory. Initially, six categories were created, subjective perceptions, seeking, facilitating, distancing, committing, and adhering. As data collection and comparison of incidents continued, the incidents and codes for these categories were recorded in field notes. Memos were written for each new idea and incident. Lastly, these six categories were amalgamated into three sub-core categories - possibility seeking, probability distancing and reality re-seeking - by regrouping the relevant codes under them.

The writing of many drafts and refining the memos improved conceptual ability, enabling an explanation to be made of the relationship between the codes and categories of the theory by incorporating theoretical codes. The theory explains answers to some theoretical questions that were problematic to women and how they resolved them.

Once clear on the theoretical codes, the challenge then was to write the multivariate theory. At the beginning the account was based on the incidents but this method was too descriptive. It was important to concentrate on conceptualisation and, in explaining behaviour, to relate category to category, omitting as far as possible the references to place, time, and events. Explanation for the theory is presented in the next chapter using quotes from women or from field notes (The theory and its explanation is presented in detail in Chapter 4).

3.10 Summary and conclusion

In this chapter the use of methodology to generate a substantive theory of women's experiences with the birth choices was discussed. It has presented the actual research process from ethical approval, sampling, data collection and data analysis. The methodological issues encountered during this study, such as theoretical coding and informed consent, are also discussed and have been debated in relation to the principles and practices of GT. Writing this chapter to explain the research process sequentially was difficult and challenging because of concurrent steps involved constant comparative analysis. The next chapter presents the theory of 'mentalizing possibilities' as a core category and its sub-core categories.

CHAPTER 4 THEORY OF MENTALIZING POSSIBILITIES

4.1 Introduction:

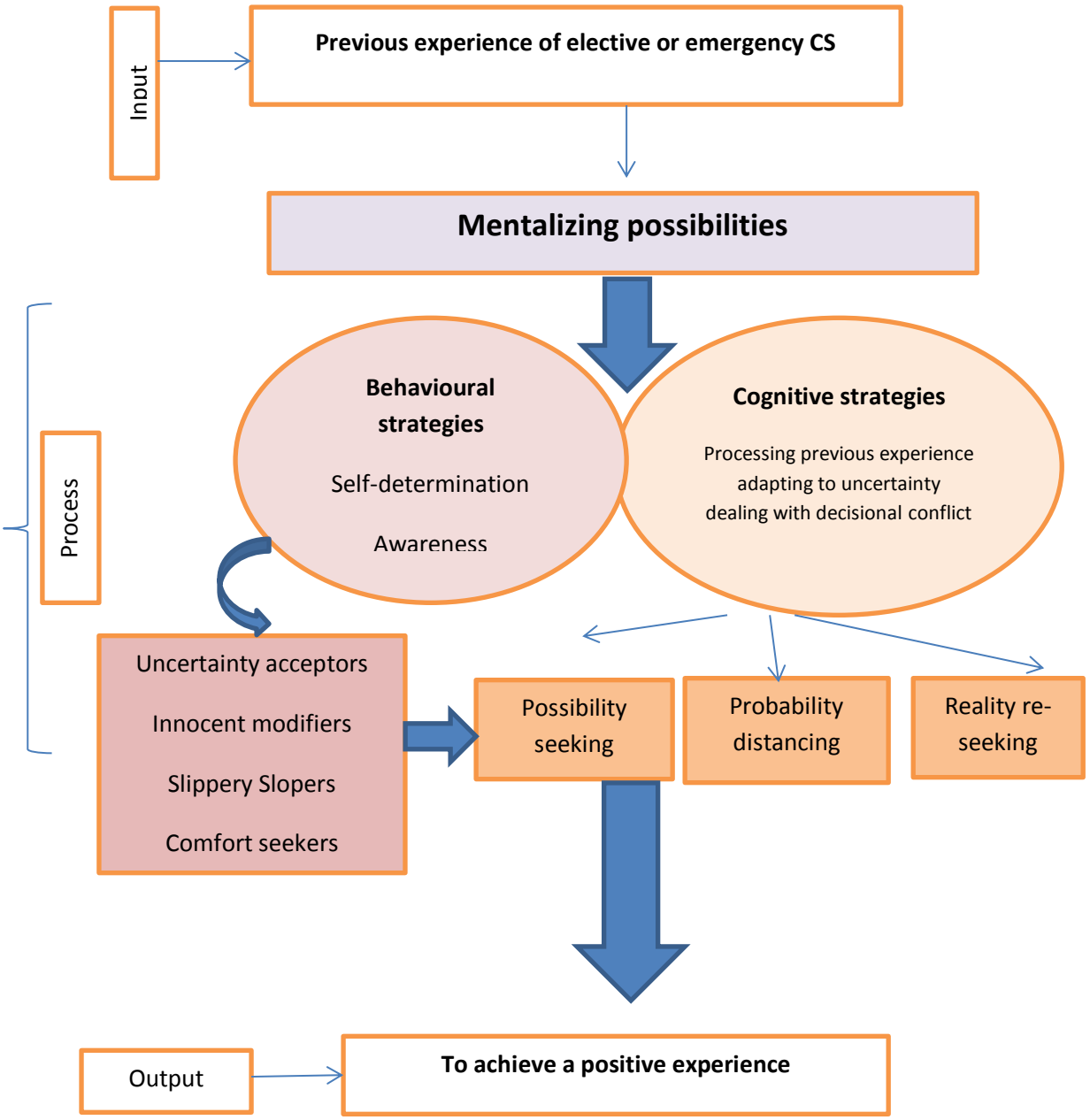
This chapter discusses how women who have had a previous caesarean section (CS) make decisions during pregnancy in relation to their birth choices. It explains the core category of mentalizing possibilities in relation to its sub-core categories and its properties. The reasons for choosing grounded theory methodology (GT) and how it was applied to discover the theory is explained in the previous chapters of methodology and operationalizing GT

4.2 Background of the theory

As discussed in the introductory chapter, the issue of birth choices for women especially after a previous CS is a complex one. The study involves interviews with women who had one previous emergency or elective CS. Those who experienced a previous emergency CS had been through labour and for a variety of reasons their labour led to an emergency CS. The resultant experience was either satisfactory or unsatisfactory depending upon women's perception of the event. In the current pregnancy, the main concern of women is to achieve a positive experience at the end of this pregnancy and delivery. If they perceived that their previous birth experience was satisfactory or positive and they value normal physiological birth, i.e. vaginal birth after caesarean section (VBAC), they hope to accomplish it. If they perceived that their previous birth was unsatisfactory or was a negative experience, then they want to have a planned elective CS in the current pregnancy if they do not value normal birth. If they value normal birth they still want to try for a VBAC.

Overall, the theory explains how women make their decisions in pregnancy in order to achieve a positive experience. This is explained by the core category of 'mentalizing possibilities', which has two interrelated strategies, behavioural and cognitive. Women's previous experience becomes an input for the process and their self-determination to achieve a positive experience is a pre-condition. Every woman goes through this process, but they use different behavioural strategies. Accordingly, women's behavioural strategy is classified into four different types based on their self-determination which is the sum of internal and external factors. They are 'uncertainty acceptors', 'innocent modifiers', 'slippery slopers' and 'comfort seekers'. Their self-determination leads to the development of awareness which enables them to mentalize possibilities. Cognitive strategies enable women to process their previous experience, adapt to uncertainty and deal with decisional conflict when deciding about a birth choice. Cognitive strategies go through three stages which are possibility seeking, probability distancing and reality re-seeking. Women mentalize possibilities by engaging actively or passively during these three stages of decision making. The outcome of the process is to achieve a positive experience (Figure 1). This theory will be explained below in detail in terms of its core and sub-core categories by providing examples from the data gathered from women.

Figure 1: Overview of theory of mentalizing possibilities



4.3 Baseline characteristics of women

Fifteen women participated in the study and most of them were within the age group of 30-39. Four of the women had previous elective CS and the remainder had an emergency CS. According to women themselves, the breech position was the reason for three of the elective sections, with a high head at term the cause for the fourth. All but one of the emergency sections was done for a failure to progress in labour; six following labour induction and the remaining followed a spontaneous onset of labour. The last emergency section was undertaken for an abnormal lie of the baby. The length of time since the previous birth ranged for one to five years. Ten women attended for public care with the remaining five opting for private obstetric care for their current pregnancy. In this pregnancy, six women wanted to have a repeat CS, five wished to have a VBAC and four were undecided. Four women had experienced miscarriage prior to this pregnancy.

4.4 Main concern

Every woman in the study wanted to positively experience childbirth in this pregnancy which included antenatal care, childbirth and postnatal care in the current pregnancy including the physical and emotional experiences associated with it. Women had a desire to achieve something that they valued and missed out on, a desire to accomplish something which was not accomplished in their last pregnancy and they engage in re-evaluating and reconsidering their choice. This includes a desire to replace a previous negative birth experience with a better birth experience in the current pregnancy or adhere to a choice which will provide a positive experience.

Some women wanted to reformulate their ability to go through a normal birth in order to fulfil the previous missed opportunity.

"Jesus yes. I would much have preferred a natural birth and immediate skin-to-skin and all that. I mean it was a massive loss of not seeing her and all that. That's a reason why I want to have a natural birth now. I had no milk. Nothing, I pumped for 2 weeks and my milk never came in. So, I think the odds were very much stacked against me- I had a section at 30 weeks, no skin-to-skin, so ……. And it was a lot of stress around the situation as well" (Participant 7)

"I think I will go for a natural birth if I can, because I missed out on so much last time, you know. There is nothing wrong with bonding. I feel I bonded with her and everything, but I feel I have missed out. Especially because I was under anaesthetic and I don't really agree with that. It takes me a while to wake up and I would prefer to see everything, and it is a magical experience really. So, I think I'm going to go for a natural birth if I can. If the pain is very severe I will go for the epidural. That will be the last-minute decision because I don't want to have another section if possible." (Participant 4)

Some women wanted to re-evaluate their choice in order to replace the previous negative experiences.

A woman who had her previous emergency CS under GA doesn't think she 'missed out' on any experience as she requested GA because of needle phobia (Field note 10).

Another woman who went through a difficult labour, who describes her previous labour as 'nightmare' and who requested CS in her previous childbirth thinks that she can't go through the same labour or experience again as the emotional impact was more overwhelming than the physical impact. So, she prefers to choose an elective caesarean section (Field note 12).

A woman had planned for home birth in her previous pregnancy. She was brought to the hospital in labour as she was not progressing. She received pethidine injection which made her totally 'disconnected'. She then received epidural, the baby went into foetal distress and she ended up with emergency CS. She felt that the whole experience was traumatic and she suffered from back pain after her delivery. Breastfeeding was a 'disaster', she said 'it took every element out of it. I was in a four bedded ward. I could not move; the baby was crying all the time. She breastfed for one and a half days. This time, her main aim was a quicker recovery as she had a toddler at home. She wanted to give her body a chance as she said, 'this is going to be my last chance, so I will give myself a best chance' (Field note 4)

"For me the recovery after my first section, it was a long process, I think. And obviously the breast milk is another thing. The more natural the labour the more chance I have. And because I feel like, well I didn't have it the last time; I think you are almost robbed of your body, it is the most natural thing to do you know? And I would feel very strongly about things like that about doing things naturally" (Participant 7).

Some women wanted to re-think a choice to achieve a positive experience

"No, you know I'm not one of those people who have a thing against the section. You know some people have a thing against sections…. No, it's mostly down to just experiencing it and a shorter recovery mainly I suppose. When you get pregnant and you think of having a baby, the picture in your head is that you are going to give birth that way. A section doesn't enter your head until later "(participant 6)

Women who appraise their previous birth experience negatively do so not only because they value normal birth but the whole experience associated with it. Some women appraised their antenatal care negatively due to lack of continuity in their care, which leads to a delay in decision making for the required caesarean section. Hence, it is the totality of the experience that led to a negative appraisal than the type of birth alone, but they attributed all these negative and missed out experiences (seeing the baby, holding the baby, skin-to-skin contact, and breastfeeding, self-care and independence) to previous CS. Women expected empowerment, trust, engagement and participation in the process which enhanced mentalizing possibilities.

The following section explains how women resolve their main concern of redefining a positive experience by mentalizing possibilities which is the core category of the theory.

4.5 Core Category

This theory provides overview of how women make decisions about their birth choices in pregnancy following a previous CS. Women go through decisional conflicts due to their past experience (positive and negative) and their expectation to achieve a positive experience in their current pregnancy. This process is intertwined with behavioural and cognitive strategies as explained above. The following section explains these in detail.

4.5.1 Behavioural strategy of mentalizing possibilities

Women's self-determination

Women's self-determination triggers mentalizing possibilities hence it is a pre-condition. Self-determination is the woman's determination to achieve something which she values and believes is important for her. This self-determination leads to a

sense of hope about a choice. There are internal (personal factors) and external (contextual) factors that lead to self-determination. These factors determine women's perception of controllability. Internal factors such as women's beliefs about birth, her values and her attitude about pregnancy and childbirth. External factors such as the support system and the information women encounter in pregnancy, the language and attitudes of health professionals, the consistency of the information provision and continuity of care and attitude of their family and friends.

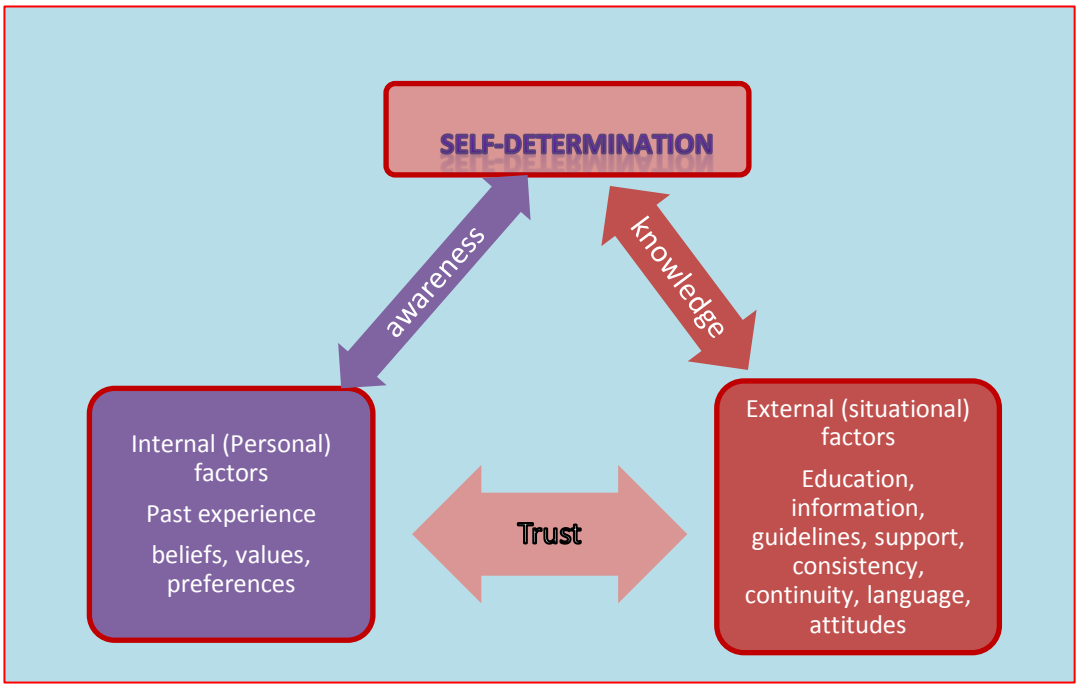


Figure 2: The factors determining women's self-determination

These factors are perceived by women as influences or barriers in processing their previous experience, adapting to uncertainty and dealing with the decisional conflict.

Classification of women's behaviour based on self-determination:

Women adopt different behavioural strategies based on their self-determination and they can be classified into four different strategies, which are 'uncertainty-acceptors', 'innocent-modifiers', 'slippery-slopers', and 'comfort-seekers'. The perception of self-determination is strong in 'uncertainty acceptors' and 'comfort-seekers' and weak in 'innocent-modifiers', 'slippery slopers'. 'Uncertainty acceptors' and 'comfort seekers' are highly determined hence it is difficult to change their attitude and they need less information and support (empowerment) from health professionals as they know what they want to achieve in this pregnancy and birth. 'Comfort seekers', are pre-determined to have a repeat elective CS. 'Uncertainty acceptors', are pre-determined for VBAC and regardless of whether they achieve a normal birth or not, they are seeking for an opportunity to labour and give birth. For these women, their decisional conflict is low and their personal and informational awareness is high.

In contrast, 'innocent modifiers' and 'slippery slopers' have low self-determination hence they are open to encouragement and require more information and support. Low self-determination among 'innocent- modifiers' is due to unawareness of their choices. They are highly susceptible to being influenced by health professionals and other support systems such as family and friends. They will adapt to the recommendations early and easily if proper information and support is provided. 'Slippery slopers' are aware but do not want to go through uncertainty as they do not value normal birth, they also need informational and support awareness. These women need constant engagement by health professionals.

Table 4: Characteristics of four different types of behavioural strategies women use based on their personal beliefs, influencing factors, and the aim of decision making

Types	Criteria Personal belief	Influencing factors	The aim of decision making
Uncertainty acceptors Can live with uncertainty to achieve their goal Have strong self-determination	Birth is a natural event. Happy to live with uncertainties surrounding VBAC. Understand the risk involved in both choices. The belief that 'I can do this'.	Past birth experience-positive or negative Are less dependent on information from health professionals. Feel VBAC is more controlled than CS, value normal birth. Take advice but are determined to adhere to their choice.	Strong desire to achieve a normal birth. Find a way to achieve a normal birth. Try to overcome a previous negative experience
Innocent-modifiers Can live with uncertainty if they are given support and information Can develop self-determination with strong support.	Believe that birth is a natural event but unaware that they can go through normal labour after a CS (low informational awareness). 'See what happens' attitude. Open minded when supported.	Past birth experience-positive or negative Feel strongly in control, once informed about their options. Negative influence may change their mind. Open to persuasion. Strongly influenced by the support system.	Plan for VBAC if choice is offered to them and are fully informed and well supported. Otherwise will opt for a CS
Slippery slopers Do not like uncertainty Are not strongly self-determined	Believe that birth is both a medical and natural event. Childbirth involves risks. Take the advice of doctors but want assurance that they will succeed with VBAC. They are familiar with CS. 'Anxiety', 'fear' of normal birth/labour-is a reason to avoid VBAC.	Open to persuasion. Value others' opinion and suggestions. Would prefer CS but agree to VBAC because it is not right to say 'yes' to CS without any reason. Prefer if a doctor recommends CS. Influenced by the support system.	Accept advice to have a CS but do not want to take any risks. They may opt for VBAC if proper information and support are available
Comfort-seekers Require certainty Have strong self-determination	Want a CS and for the doctor to advise it. They do not want any 'say' in the decision-making process. Excuses like 'fear of the unexpected'; 'fear of the unknown'; 'nervous about labour', 'anxious' are used to influence the doctor.	Feel CS is more controlled than VBAC. Request CS as considers this the best option, to organise their life around that choice. Difficult to change the attitude about VBAC.	Want the baby to be born by CS.

Uncertainty acceptor:

Women who have a strong belief in themselves are determined to experience normal labour. They engage in positive self-talk, feel that they can embrace uncertainties easily, and believe in the natural aspect of pregnancy and childbirth rather than interventions. They adopt 'wait & see' and 'I can do' attitudes when facing a problem. They can question health professionals and are always determined to achieve their choice. They define or consider risk as 'risk either way' meaning there is risk involved in both choices, but this is a unique opportunity for them to achieve VBAC. They have a strong mentalizing ability based on their self-determination which enables them to deal with the uncertainty.

"*I have no idea, for me I would like to experience a natural birth, a proper birth, as it is a rite of passage for women to get to do. I am conscious that if I have to have a section this time, that will never happen to me, my next baby will be section. So, this is the last chance as far as I am concerned as to have that experience. And then obviously the recovery is slow and long. It was OK, the last time I have one little baby to look after and myself and that was it. This time I have a toddler who I will want to pick up and cuddle and that will be very upsetting if…she won't….she isn't not old enough to understand you know, so it will be bad enough bringing home another baby to share in the house and on top of that cutting off all the hugs and cuddles she has been getting until now. So, it is really important to me that I have a natural birth. But as I said I am not in control of it" (Participant 15in patient in the hospital for unstable lie).*

Innocent modifier:

'Innocent-modifiers' believe that they have weak self-determination as they are unaware of the choices at the beginning of the pregnancy, but with information and support their mentalization can be enhanced from weak to strong. They can build up or change their awareness and can become increasingly determined to achieve their outcome.

"I just like to keep an open mind about things. I didn't want to just say "I want a section" and that's the story…. I suppose I want to see if nature will take its course before my due-date and I want to go with that if it does. But if it doesn't, I suppose it goes out of my hands if you know what I mean…. I do try to keep an open mind. But I suppose even though it is my second baby it would be my first time having a natural birth. Its normal I suppose to be a bit nervous and a bit apprehensive, so I am not trying to dwell on it or anything, I don't think I have a fear of childbirth….I am ……when I think of it I am just like "oh God!" you know….I think your body knows what to do you know. And you would have support, so I try to look at it that way. So, I will see what happens "(Participant 5).

"No, I'll go through the natural labour. I'll go through the vaginal birth and see if I can make it work and I will try. Because the doctors said it was better. So, they said that I should try the vaginal birth and …. also because of the risks in the C-section. Yes, I am going to take doctor's advice "(Participant 12)

I just want to see my baby when it is being born. I am afraid in case……. If I go into a section, I know you will be awake in a planned section, normally you wouldn't be under anaesthetic, but I think the days recovering afterwards are longer. You are in the hospital longer. I have another one at home as well and I want to…. I just want it to be a family bond at home, more than in the hospital because there is just so much going on here. I would just like to do it myself. It is a thing I always wanted to do from the first baby anyway. So, if I can do it the second time I will (Participant 4previous CS under GA).

Slippery sloper:

'Slippery-slopers' also have a perception of weak self-determination because of value uncertainty, but with information and support can be helped to boost their self-determination. When 'slippery slopers' are compared with 'innocent-modifiers' the 'slippery slopers' give up easily when uncertainties increase or overtake the situation because they essentially do not place a high value on normal birth.

"I wasn't comfortable with the decision being in my hands, not that ….I wasn't comfortable with the decision being in my hands….I just felt that….I don't know…I will be cheating myself if I go to another section. It's the whole…'too posh to push' kind of thing. I feel I should try and go myself, if I can…I do feel that I am kind of cheating….not cheating….but because I could possibly go myself…so I booked a section for the day before my due date so if I don't go myself before that I would have given a chance" If somebody could guarantee me that a natural birth I can sneeze and it would just pop out, then I would. That's why I like the idea of a section, but. I would love if the decision is made for me that I would have to have a section basically (participant 3)

Comfort seeker*:*

'Comfort- seekers' also have a consciousness of strong self-determination but they are focused on a particular outcome, which is birth by CS, as they are comfortable with their previous experience (CS) and are aware of the choices but value convenience and certainty than a normal birth. It is difficult to change their self-determination even with counselling, education or with support.

"I want to stick with what I know. I had decided that I would opt for CS from the beginning of the pregnancy. I would like to have a plan in place and if I don't have a plan, I will end up with panic stations which I want to avoid as I suffer from anxiety. There are hardly any problems with CS" (field note 9, previous CS for breech, planning for repeat CS)

'I think regardless, I am the type of person that I would do what I want to do, I don't think any person would have persuaded my decision (CS) or … I think I have just done what is best for the baby '(Participant 14).

Awareness

Self-determination and awareness are interrelated. Awareness of choices explains how well-informed women are about their choices and about their situation. For some women (uncertainty acceptors, comfort seekers), their self-determination enables then to develop awareness of a choice or they already have heightened awareness. For other women (innocent-modifiers and slippery slopers), their awareness of the choices enables them to develop self-determination and these women need to develop awareness through the contextual support that they receive in pregnancy. Awareness of support is the positive context through which women mentalize possibilities. When women's self-determination is weak, empowering them with the information, counselling and education enables development of awareness.

When their self-determination is strong, they have heightened awareness and need support for their choice. If not, they will end up with conflict and a negative experience. A health professional's interaction with women facilitates the development of awareness among them. They need to be careful in assessing the awareness needs of women (personal, informational, support) as they differ. Their engagement with women helps them to develop awareness and change appraisal of the previous experience and develop self-determination.

Awareness has three contextual factors, personal, informational and support contexts. Personal awareness is developed by debriefing the previous childbirth experience and provision of options for this birth, elective CS or VBAC. Empowering women to develop awareness leads to processing the previous experience and make them aware of the future choices. It helps them understand and realise why the events occurred and this could change their appraisal about the

previous birth experience. This process of empowering women starts right after the previous delivery and should be a continuous process. It can increase or decrease their perception of a choice depending on how effectively the previous birth experience was debriefed and counselled. If the previous experience was debriefed well, women try to comprehend the information and previous experience positively. This also depends upon the content and time of debriefing and the language and attitude of the person debriefing the event. It also involves the health professional listening to women and understanding their personal beliefs and values and their main concerns. This personal awareness commences immediately after the previous event which enables women to process the information and develop informational awareness. But most of the women did not experience this. Some women felt they were not debriefed at all and some were not debriefed effectively.

"Yes. I didn't know I had an option. They hadn't said it to me after I had had my first child either. The only other thing they told me was to try not to have another baby until 12 months. That was it really, that's all they said. I had nothing wrong with a section but I would prefer to go for a natural birth if I can" (Participant 4-Innocent modifier).

If women do not receive appropiate and timely counselling at the time of their first caesarean section, the previous impact of that CS remains unresolved and it leads to the avoidance of vaginal birth as a choice (vaginal birth) and their appraisal of their previous birth experience remains negative (slippery slopers and comfort seekers).

"The only thing I was unsure of… and I did look it up on the internet and I did ask my ante-natal nurse at home, was that if the shoulders got caught, would it take me 12 months to recover or was I being silly not going with a section that I was offered straight away or not. But maybe I suppose as a woman, I just wanted a vaginal birth this time, because I know that if I do get pregnant again, it is an automatic section" (participant 11)

Informational awareness is developed after the previous pregnancy and is a continuous process until the end of the current pregnacy. However, women's ability to process the information is much higher in the beginning of the pregnancy than at

the end due to the fact that there is no time pressure and situational pressure. Hence the earlier the engagement and empowerment starts, the easier it is for women to develop personal, informational and support awareness.

"So, then this time around…. From the get-go at my first antenatal appointment at the hospital, I had said that I wanted to have a VBAC birth. I was given plenty of information in the antenatal meeting with the midwife about VBAC and it was at the front of my chart and everything. I was given the information and I did a bit of reading up myself on how the options were and how I could achieve it myself, all of that. I tried to be as informed as I could, but circumstances change and maybe things are out of your control" (Participant 8)

The information needs of uncertainty acceptors and comfort seekers are low as these women are determined with their choice (VBAC or CS) and they do their own research. In contrast, the information needs of 'innocent-modifiers' are high. These women are unaware of their choice about the mode of birth until they discuss it with a health professional during this pregnancy. Hence, their health professional's preferences of a choice, affects their decision directly. If the health professional recommends a CS or VBAC positively, these women will accept their recommendation. 'Slippery-slopers' are aware of their informational needs, but they need support to deal with any uncertainty. Innocent-modifiers and slippery-slopers feel strongly in control, once they are informed about their options. However, in times of uncertainty, innocent-modifiers and slippery-slopers who do not receive adequate support, are likely to opt for CS as that is the choice they know and are comfortable with.

Support awareness is the development of the perception of support among women. Support is the interaction and relationship between the woman and the health professionals she encounters. This makes women feel supported, they develop trust in their health care provider, it helps them to adapt to uncertainty, cope with the decisional conflicts and provides a network of supportive personnel (doctors and midwives) whom she can trust. This can help reduce uncertainty, women are able to

share their problems, and they have someone to rely upon who shows empathy and accurate information. This enables them to recover from their previous traumatic birth experience and in turn, empowers women to make a choice that they believe in and value.

Support awareness also starts after the previous pregnancy and continues throughout the current pregnancy. Awareness of support is developed through the interaction with a health professional who provides care and who also follows guiedlines, provides continuity and whose language and attitude is consistent. Health professionals are the gatekeepers of choices that are offered to women. Women's awareness of professional support leads to the development of trust among them which makes them process the previous event, and adapt to the informational and choice unceratinty. Ultimately how women appraise their previous event as positive or negative depends upon how they are treated by the health professionals they encounter. The attitude and language used in counselling and debriefing have an impact on women which reinforces their attitude and behaviour in analysing consequences of a choice. Hence, the few women who were not debriefed at all had no awareness of the choice and they perceived that the only option was repeat CS.

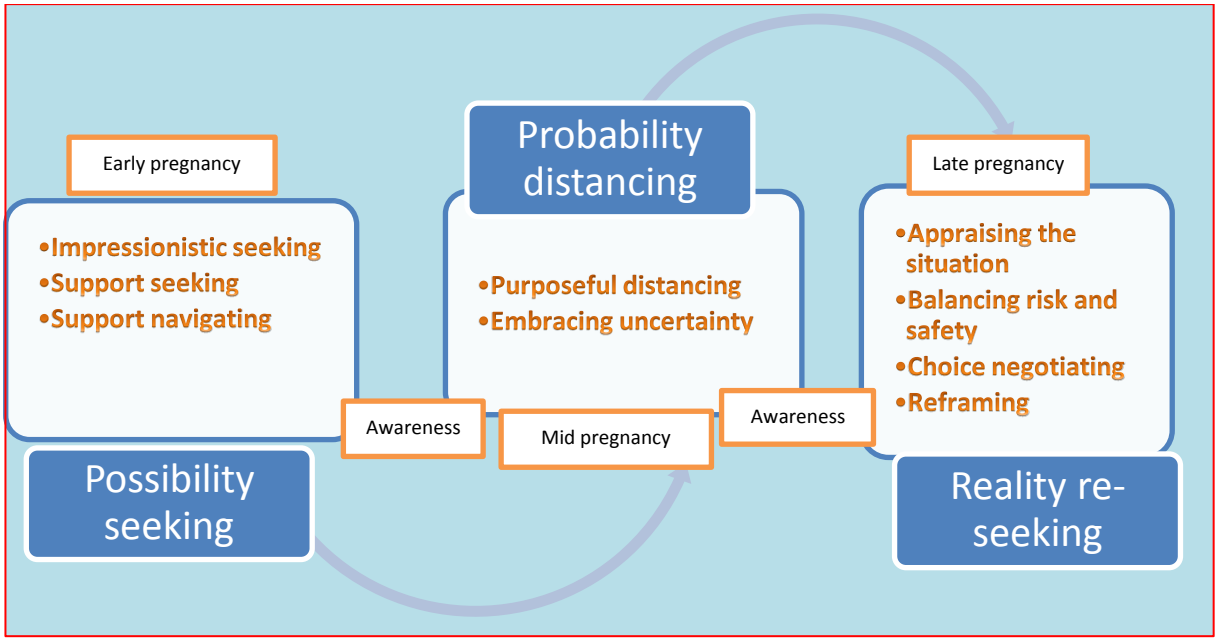
When there is lack of support from health professionals, then the previous birth experience is likely to continue to be viewed negatively. 'Uncertainty acceptors' and 'comfort seekers' have a strong belief in themselves and they expect less support, whereas 'innocent modifiers' and 'slippery slopers' who are not sure of their choice need more information and support. They are open to persuasion and their increasing awareness can build up their self-determination towards CS or VBAC.

I haven't even looked at the information, whatever happens, happens, you know I may as well go with it. I trust that I have been in good care, I have been looked after well, and that that's the job of people in the hospital, and I trust the people in the hospital, you are going to do that for me, and you are going to make these decisions for me, and I trust that. I haven't given lots of information. I asked questions and they were answered, so this is how it might be (participant 15)

4.5.2 Cognitive Strategies of mentalizing possibilities

Cognitive strategies involve processing the previous experience and the information, adapting to uncertainty and dealing with the decisional conflict. Cognitive strategies go through three stages of 'possibility seeking', 'probability distancing' and 'reality re-seeking' which are three sub-core categories of mentalizing possibilities (Figure 3). These three stages are cyclical, they may be interrelated, or they may overlap depending upon how aware women are. How women engage in processing and adapting at every stage is directly related to the reciprocal engagement by the health professional. This means that women need empowerment, participation and support in their antenatal care which enables the development of trust. This engagement leads to women's self-sufficiency and makes them informed in the decision-making process. Hence, as discussed previously, women's self-determination and development of awareness is a pre-determinant to this process.

Figure 3: Cognitive strategies in different stages of pregnancy



'Possibility seeking' is the stage of active awareness of mentalizing possibilities where women actively develop personal and informational awareness which will enable them to process the information and the previous experience. In this stage women explore all the possibilities of their birth choices that are available to them in order to achieve a positive childbirth experience. Women look for answers or the means to resolve their main concern. Once women understand and realise that there are different possibilities for this pregnancy and birth, they are enabled to resolve their main concern of achieving a positive experience, then they enter the stage of probability distancing. 'Probability distancing' is a passive stage of awareness where there is passive participation in the decision-making process however, development of support awareness is crucial at this stage. Women are trying to stay away from the uncertainty of considering their birth choices. This is temporary and voluntary, in order for them to enjoy this stage of pregnancy. Uncertainty results because of the

ambiguity, confusion and inconsistency of information and support women receive and because of their lack of self-determination to achieve a normal birth. For most women, 'reality re-seeking' is re-opening the decision-making process by negotiating expectations at the end of the pregnancy. This is also a stage of active awareness; where a woman tries to actively participate in the decision-making process. However, because of time pressure and situational pressure their information processing ability interferes with their ability to mentalize possibilities.

This theory will now be elaborated in terms of the sub-core categories and their concepts.

Possibility seeking

This occurs at the start of pregnancy, where women engage in seeking and exploring all the possibilities that will enable them to achieve their main concern of achieving a positive experience. It varies depending upon women's belief about birth, and women's awareness of the information and support that is available to them. Women had various beliefs and determinations in the previous pregnancy, but some women were unable to achieve those experiences. These personal beliefs enhance their self-determination in their current pregnancy making it more likely that they will overcome decisional conflict and uncertainty. When the perception of self-determination is strong, women overcome barriers easily. When their perception of self-determination is weak, they are more likely to end up in decisional-conflict and these women need a lot of support in the form of counselling, education and participation in their decision-making. A woman who knows about VBAC and really wants to achieve it formulates her own possibilities by doing own research or asking others. In this stage, a woman faces positive and negative influences and barriers. If

a she is really determined to achieve VBAC she tries to get over the barriers to her achieving this and stay open to only positive influences supporting her choice. Women engage in 'impressionistic seeking', 'support seeking' and 'support navigating' to meet their information and support needs.

Impressionistic seeking

Impressionistic seeking explains how women gather cues and information about different aspects of childbirth and create an opinion about birth choices. These can be in the form of past experience and its appraisal and from the information received from others. Women engage in information seeking if not counselled effectively. If women are aware of the options before they become pregnant, they are more comfortable with the options in possibility seeking than women who did not know about them.

The way choice is promoted positively or negatively influences women's impressionistic seeking. Positive language and positive attitudes towards choice lead women to choose VBAC and increased self-determination. On the contrary, when the doctor gives 'failure to progress' as a reason for the emergency CS and explains that there is a possibility that the same thing may happen again women are given the impression that they are unable to go through normal labour again or try for one.

When women are made fully aware of birth choices, their appraisal of the choice changes and this can be readily modified by new information and verbal talk. How each choice is promoted by doctors, friends, peers, and family members in the form of talking, media and leaflets, creates an impression in their minds. If the promotion of a choice is negative, slippery slopers may adhere to the choice which gives them more certainty. Women believe that positive and negative stories have a

major influence on their mentalizing. They consider that stories on the media about a baby's death in the hospital is because of poor management and hearing stories from family and friends about 'tears', 'episiotomies', and 'forceps' all negatively influence them in opting for a natural birth.

I have discussed with few friends that you know one girl who had a section with the first and had natural with the second, she had 'episiotomy' and when I hear things like that I really don't like that and she said the recovery was worse after that than after the section(Participant 3)

My doctor told me 'if it was me, I would have chosen an elective CS' (Informal interviews)

A vignette from Field note 33woman who was in a patient with PROM (premature rupture of membranes)

'My sister had told me that she had three sections and she had no problems, so I have to go for the section. Her friend had three sections because she was 'simply too posh to push'. But I am determined to try (VBAC)'

Debriefing provides an opportunity for 'possibility seeking' and reinforces self-determination. When women are debriefed well, they are clear about what to expect and better able to deal with the uncertainty around birth choices as they try to develop new impressions about their previous experience and appraise it differently. They think positively about challenging encounters and feel that the outcome will be a positive experience. Debriefing also increases their awareness of the uncertainties around the choices and they try to adhere to the choice with support. Having accepted the challenge of uncertainty, women begin to search for alternative courses of action and to seek advice and information from other people about ways of coping with uncertainty. They start to seek advice from experienced women or knowledgeable people like doctors. They learn how to avert the negative experiences that occurred in the previous event and become more attentive to the relevant information that is available to them. They also become more attentive to recommendations for coping with the challenge of making a choice, even though the recommendations may not be consistent with their present concern. 'Uncertainty acceptors' and 'innocent modifiers' adhere to VBAC if they form a good impression

of this at the beginning of the pregnancy. If they are exposed later to more powerful or challenging information, they seek more information about other alternatives such as a repeat elective CS. Women analyse the positive and negative aspects of each choice and tend to avoid the choice that has more negative consequences. Analysis and processing of the information and support are also based on their personal beliefs about birth.

"I have a daughter at home; I suppose if everything was ok, and I wanted to experience it (labour) myself. Every woman is different when I used to talk to people they would say, just go have a section it is so much easier, it is planned and organised, and another person will say do it naturally I think everybody is different, and everybody has their own personal choice"(Participant 14)

Support in the form of counselling and debriefing also make women feel more confident, less emotionally overwhemed and are more capable of utilising the resources that are available to them like VBAC classes or any other information sessions/discussions. Women who perceived their previous delivery as a negative and trumatic experience, view the choice of VBAC as a threat and believe that they are incapable of facing the same choice (Slippery Slopers, Comfort Seekers). They adapt poorly to demanding situations or try to avoid them altogether. These women consider VBAC as a threat and give reasons such as fear of labour and anxiety to go through the labour as reasons to avoid the threat. The emotional and physical impact of the previous event determines their appraisal. Emotional impact also interferes with information seeking. Women who have perceived that their previous delivery was a traumatic experience are not open to any information about VBAC as it reminds them of the previous labour/delivery experience. Some of these women were not debriefed at all, or some of them do not remember whether they were debriefed, or some were not informed about the services that they can attend.

Example: A woman who had a pre-term delivery the last time explained that her labour progressed quickly. During her labour the CTG (Cardio-Topography) was suspicious. Midwives were not able to determine whether the heart rate shown on the graph belonged to the mother or the baby. There was

also an argument between the senior midwife who was in-charge of the ward and the junior midwife who was looking after her. She ended up with an emergency CS and the baby went to the NNU. The baby stayed in the NNU for 3 weeks and she ended up with mastitis. So, this time her worse fear was 'what if the same thing happens again? What if they are not able to determine and differentiate between my heart rate and the baby's heart rate?' She said she could not even enjoy this pregnancy as every time she thinks of the delivery, she felt she was brushing up the traumatic experience again (informal interview, Field note)

Women's perceptions of social norms and social acceptance of a type of birth also contributes to the choice they make. For example, a woman said she opted for VBAC because a few of her friends had tried for VBAC and were successful. Her mother also told her that CS is only for emergencies and there were no elective CS in her time. She felt she just could not say 'yes' to CS. Some women only pretend to have chosen VBAC as they do not believe in going through normal labour but believe they must try because they perceive themselves to be under pressure. Some also believed that if they have a normal delivery, they are accepted more in society than if they did not. For others, they simply did not want to be left out of the group such as VBAC support groups or breast-feeding support groups. They want to be seen as the 'good mother'.

"At least I can say I have tried this" (informal interview16)

"It is my mother-she says in my days there are no elective sections, they were always emergency. She doesn't sit on the fence, she is a nurse and she influenced me, I guess, I should make some bit of an effort…At least I can say have tried', I don't want to be included in the 'too posh to push group" (participant 3).

", what I found was that when I attended the breastfeeding groups and stuff, I found that there was a lot of discrimination. I found it really tough actually, people were really anti-section" (Participant 1)

Support seeking

Impressionistic seeking leads women to engage in support seeking, where they seek help, information and support in favour of the pre-determined choice or assistance to make a choice which will lead to positive experience. It could be a natural birth or a repeat CS. Support seeking follows on from impressionistic seeking and is directly related to prior option awareness and debriefing of the event. If women are told that they cannot go through normal labour again, but they have a

strong belief themselves that they can (uncertainty acceptors) they will continue to seek support for their choice. Because they have strong self-determination, they will still adhere to their choice even if they experience informational inconsistency and lack of support. They do their own research and rely less on professional and other's support. 'Innocent modifiers' and 'slippery slopers' need more support if they opt for VBAC as they have a weaker self-determination and less belief in normal birth.

This is the reason why offering a choice at the beginning of the pregnancy becomes important. It leads to the development of personal and informational awareness. If women are unclear about the information they have at this stage, there is more time for clarification by information seeking and support seeking. Whenever a woman is confronted with challenging signs that she might sustain losses if she carries out the course to which she is almost ready to commit herself to or has fully committed herself to, she will become motivated to learn more about the choice, provided that she retains the hope of being able to cope with it adequately. This hope is influenced by the healthcare professional, family and friends.

Field note 24

This woman had previous CS for failure to progress in labour. S*he wanted to experience a natural birth and she was prepared for it. She is prepaed thinking that CS is always going to be there. She was well informed by her consultant. She said offering a choice is really important. Good to put a seed at the beginning of the pregnancy. Support from friends and other family members really matters. She prepared herself differently this time having no birth plan about labour and delivery and only included- wanting to breastfeed, delayed cord clamping; skin to skin contact in her birth plan.*

Informational support is sought from the internet and health professionals. Psychological support is sought from health professionals, family and friends, societal groups and the internet, such as breastfeeding support groups and social media. They also join groups such as a VBAC support group, Facebook groups and mother's audiobook. When family members or friends advise them to opt for a choice attractive to them, they feel supported. If their support groups suggest a

different choice woman feel unsupported and this undermines their self-confidence in the choice. 'Uncertainty acceptors' and 'comfort seekers' are determined in their choice and only concentrate on the advice that favours their choice. Sometimes when there is enough time and support, they become more open minded in accepting both the supportive and opposing information and it leads them to deal with the decisional conflict and adherence to one choice over another. 'Innocent modifiers' and 'slippery slopers' are confused with their choice so they accept support from both positive and negative influences and this leads them to conflict with the choices for which they need strong professional support.

"It is good because I have a lot of friends that have gone through natural labours and ended up having emergency sections after a previous section, so I have definitely heard that. You know I could try to do it, but then the baby would not be moving. So even if you go natural you are going to be in an emergency section anyway. At least this way, I think you are better prepared "(participant 10)

"Well my husband is very supportive. He is happy to go along with what I am happy with as long as myself and the baby are going to be safe and OK…. Same with my mother. My mother is great, she had us naturally. I told her I was worried. She said look, your body knows what to do, it is a natural thing, it is not easy, but you have to trust in your body. And plus, she felt the midwives were great when she was having us 30 odd years ago. So as well, the support here has been very good, so I couldn't fault anybody really" (Participant 5).

Being informed and having readily available information supports women in adhering to their choice. The degree of mentalization is directly related to the ease of availability of the information, time of information provision and women's ability to process and comprehend the information.

"The information would have come from 'me' primarily. They have given pros and cons of what can go wrong by having a natural birth after section, but they also said there are no reasons why I can't have a natural birth, they also gave me facts and figures." (Participant 1)

"Yes, but I mean if the choice is taken out of my hands and I have to have a section then so be it. But preferably I would have a natural birth. I would read up on these things as well. So, I looked into my options more than being told about them. I got my own information and I was very set on what I want, so basically, they were talking through my options with me and I said I want a VBAC. Even before they had a chance to say it to me, I had my own mind-set. I had my own goal" (Participant 7)

Knowing the choice early helps them to mentalize strongly and effectively and not knowing leads them to struggle with the mentalizing. Information provision

enhances women's possibility seeking, by equipping them with the necessary information in order to mentalize the possibility of their choice.

"I suppose I was informed…… I work in the medical area anyway; I am a medical scientist and I would have had some knowledge of it anyway. I have a sister-in-law who is very active in pursuing a VBAC herself. She had given me a book on VBAC in Ireland. I can't remember the author of it, but it is a very technical book! (laughs)… So, I was reading on that. So, the information the midwife gave to me added to it. But it was good to know that they were prepared in the antenatal clinic that it was going to be offered as an option, that it wasn't at a point that you have to have a caesarean. They were quite open and any doctor that I met would ask me do you want to have a caesarean/VBAC? It was always mentioned, it was never a case of you have to have another caesarean. People were actually quite open to the possibility of VBAC" (Participant 8)

Women expressed the view that an information booklet is useful but providing it without any explanation or discussion is not useful. For women with weak self-determination (innocent modifiers and slippery slopers), lack of discussion or talk hindered how they comprehend the information. Women who are aware that they can reverse their decision are open to both supportive and non-supportive information. This awareness is developed by providing continuous support and engagement. Women who had been through labour and ended up with an emergency caesarean section feel more uncertainty approaching labour again than women who did not previously experience labour. Women who had information about their options for the birth and the management of labour, such as the onset of labour, availability of pain relief and foetal heart rate monitoring, felt more prepared to experience labour. Women who had a planned CS evaluated the previous experience better than those who did not know about CS and who underwent an emergency CS. The more familiarity women have with the delivery method, the more they feel in control. Perception of control led some women to pre-determine their choice.

Support navigating

Lack of awareness of support leads to 'support navigating'. For some women their experience in the previous pregnancy of an untoward event, poor or

unsatisfactory care, and lack of continuity and support, lead to ‘support navigating’ and for some other women unavailability of support in the current pregnancy leads to ‘support navigating’.

A woman blames the midwife for her previous section because she was not diagnosed as breech until the last minute. She was attending a midwifery clinic and there were no scans, so they missed the diagnosis of breech presentation and the result was a CS. So even before she was pregnant this time, she had decided to attend an obstetrician.

Participant 3 was unhappy with her management of miscarriages by the doctors in the public system. She was seen by a different doctor every time, so she had to tell the same story to a different doctor every day. So, she changed herself to private care this time in search of continuity (Field notes)

We went to a 20 week appointment and I was trying to ask the doctor the question you know, so many unknowns, as I was speaking to him, he was walking out the door, so rude, so uncomfortable, everything I asked, I was told to ask my GP, and GP was saying talk to the consultant, and feel its’s more of a consultant’s role to answer these questions than the GP” (Participant 15)

‘Support navigating’ can be undertaken voluntarily by women who decide to book private obstetric care, they also involve in ‘doctor shopping’. This is common when women are possibility seeking at the beginning of their pregnancy. Women who had previous negative experiences engage in ‘support navigating’ for better care in the current pregnancy by choosing the private system.

“It was the consultant that day. I just felt that nobody was taking responsibility for this, and that you were falling in between two stools and if something happens, nobody is ever going to take responsibility. I don’t ever agree on joint responsibility in things like this. But somebody is responsible. I was very annoyed…very uncomfortable. I was talking to lots of people. And a friend who was a midwife said to me “if anything goes wrong, you will know about it. And if you are private you will get better care” basically. And my experience this time has definitely been that way. It was only because of weekly scans that I discovered that my baby was moving around so much…I would never have known otherwise about that.” (Participant15)

Private care is more accommodating and flexible because women have the freedom to select their obstetrician and they receive continuity and consistency of care. This leads to the development of trust with the obstetrician and influences women’s mentalizing and increases satisfaction with their care. When accessing private care, women are ready to undergo any procedure, such as external cephalic version (ECV), or wait until term plus ten days for spontaneous onset of labour because of the trust built up between them and the obstetrician. Overall, women in

private care are more likely to trust doctors and the decisions they make, than women in public care.

" I think…..if they were all singing off the one hymn sheet, a little bit more….than saying to me, "well, in my experience I worked in Limerick and I worked in Dublin for a different consultant, and I believe in the way, and this is how I have been trained and this is my way." And then you meet the next person and well…. that is easy for them to say because they are men and they don't have to heal. If I were you as a woman…. you know... it's confusing" (participant11 public care)

Yes, that's why I went back to the same doctor, the trust was there, and the relationship was there. I don't know if I went public, I would have a different experience, I can't say…. I am very happy with the service that I got. Sometimes it is up to yourself to get the information, if you haven't gotten in one place, to do your own research, my particular doctor he had an answer, or an opinion every time when I asked something….(Participant 14).

"Yes, definitely… It helps me build up trust and it's a lovely experience, and we did go public on the last baby for a while, but we switched to private because of the experiences we had there, and I am very, very happy that we did..... (Participant 15)

"I think I did. I mean I would have had questions but there was nothing too pressing like that which I wasn't able to ask my friend who is a midwife. No, I feel I got enough support. The midwives here were fantastic. My friend was great as well, I could ask for her help anytime. Yes, they were all very good. You hear about some midwives that are a little pushy towards the VBAC, but no, they were all very supportive "(participant 6).

"I don't think the social model of health and the medical model of health have to be separate. I think they need to be integrated" (Participant 1)

This woman explains her antenatal experience as follows (Vignette from field note 28)

"Antenatal clinics are a shame, waiting so long to be seen by a doctor. Everytime you are seeing a different doctor. Information was just given, without any discussion around it. I did not know about VBAC classes. You have to go looking for services. My previous experience was in England and it was totally different. I am a natural person. I believe in the naturality of things. I tried home birth the last time. But ended up with emergency CS. Breast feeding was difficult, recovery was difficult. Everytime I moved I felt my insides were coming out. This time I have tried natural things so that I will succeed in normal birth. I went to the chiropractor, accupuncturist, and also tried for natural induction"

Probability Distancing

Probability distancing is the second stage in the process of mentalizing possibilities in which women want to move away from their uncertainties about pregnancy and birth choices in the middle of pregnancy. At this stage, women show passive participation in decision making and information processing. 'Probability distancing' enables women to cope with the negative experiences of the previous pregnancy. They do this by concentrating on the current pregnancy and trying to

enjoy it. 'Probability distancing' follows possibility seeking but not every time. Women who are successfully debriefed and are determined with their choice put their trust and confidence on the health professionals. These women enter the stage of 'probability distancing' early in pregnancy without spending much time in 'possibility seeking' as they have the awareness of support.

Women engage in probability distancing for emotional stability and with a desire to enjoy this pregnancy while at the same time contemplating birth choices. 'Probability distancing' enables women to maintain self-determination in times of uncertainty. Women are seeking continuity in the form of engaging and supporting at this stage. The greater the continuity of care experience, the more likely it is that women feel in control. As a result, women in private care feel more in control than those in public care because of awareness of support. 'Probability distancing' has two properties, 'purposeful distancing', and 'embracing uncertainty'.

Purposeful distancing

Purposeful distancing is where women are consciously trying to stay away from making a choice due to inability to overcome the informational inconsistency they encounter and the previous pregnancy conditions. In pursuit of a positive experience in their current pregnancy, some women embrace uncertainty and remain open to accept all probabilities (uncertainty acceptors).

Women engage in purposeful distancing in order to adapt to the informational uncertainty and the unpleasant previous pregnancy experiences. Women consider these as 'known fears' and 'unknown fears'. Avoidance is one form of purposeful distancing. If they have a favoured choice for VBAC, they try to

keep away from any information that is distracting them from their choice and if they have chosen CS, they avoid any information that will distract them from CS.

A woman who had chosen VBAC and who had not experienced labour previously, said she didn't even think about scar rupture as she was trying to distance herself from 'fear of the unexpected'. Comfort seekers are satisfied and comfortable with the choice of CS, so they try to stay away from information regarding VBAC. Prior knowledge of the previous experience enables women to feel comfortable or uncomfortable with the choice. The woman who wants a repeat elective CS believes that she knows everything about CS and terms it as 'the devil I know'. This is the reason 'slippery slopers' find CS preferable.

No I didn't start things .so I had some pain, but I think that was more to do with the induction drug ….so I am a bit anxious about labour itself….I think just fear of the unexpected or your fear of the unknown.(Participant 5)

"The only fear was at the 12 week scan, when they said about low-lying placenta and I thought it was uncommon. I was a little fearful, that I would carry the baby full term. As I went on, I actually put it to the back of my mind and I didn't think about it. It was just the 1st few weeks…waiting to see…I had an extra scan and things like that. Other than that, this pregnancy was definitely easier than the last pregnancy" (participant11)

Perception of control or a lack of control, determines purposeful distancing and how women accept uncertainty. Uncontrollability results from ambiguity in the information about a choice and unpredictability due to the previous experiences in pregnancy which led to an emergency CS. However, if a woman is self-determined to adhere to the choice, her perception and meaning of this uncontrollability differs (Uncertainty acceptors, Comfort seekers). When a woman thinks that situation is predictable (due to her previous experinece) she perceives it as more controlled, her self-determination enables her to overcome that uncertain, unpredictable situation. Hence some women consider the situation as predictable but uncontrollable. If a woman values a choice she minimizes that unpredictability (Uncertainty acceptors, Innocent Modifiers) by convincing herslef that her choice of VBAC is worth the risk.

If a woman does not value a choice she tries to exaggerate the predictability and tries to convince herself and others that CS is worth the risk.

As pregnancy or delivery is uncontrolled, at this stage of pregnancy, women try not to dwell on the decision, as they know that anything could change about any plans they may make for the birth. They observe a 'wait and see' policy as a means to tolerate the uncertainty where they can maintain some control. Women wait cautiously until they reach a stage where they have passed the point where they had experienced a previous untoward incident. Because of the possibility of the reoccurrence of the event, women try to develop their self-determination in uncertain times. They temporarily avoid any decision making where they know that these situations are unpredictable. For instance, a woman who had a preterm delivery waited until she passed that stage in the current pregnancy before deciding on a choice.

Appraisal of the previous experience as unsatisfactory engages some women in purposeful distancing with a desire for a positive birth experience.

A vignette from Field note20 "I had previous CS for breech after failed ECV. I felt my experience was full of needles, a big cut, and no labour pain. It was surreal that anaesthetics were talking about their holidays when I was at the theatre table. I felt all the natural part was taken out of it. Breastfeeding did not work; there was no colostrum, used a pump that did not work out either. Everything was like a vicious cycle. In this I wanted it to be natural from the beginning. At 34/35 weeks they said my baby was transverse, in the next visit they said it was cephalic. I met a consultant in the outreach clinic who explained about certain options are closed such as induction of labour. I attended VBAC classes and felt they were really good. One doctor was really good gave structured information. Positives still do not outweigh the negatives"

"Basically, at the beginning of- course the fear is that you might miscarry, around the time and about spotting and things like that and also miscarrying which scared the life out of me because I miscarried with my first baby in the beginning. That's it really and then towards the middle…. kind of ok, you read so many stories and things like that and there is a fear that you could still miscarry around 20 weeks. And that worry is with you, so that's always there. I'm worried now……. a still birth. That's really worrying. Especially when I know someone had a stillborn in the last few months. You just hear of it happening and you just feel a bit worried I suppose "(participant 6).

Experiences with the uncertainties of the previous pregnancy lead women for purposeful distancing. Purposeful distancing is voluntarily disconnecting self from

reality as a mechanism of overcoming anxiety and stress. Conditions relating to the previous experience, pregnancy induced hypertension (PIH), antepartum haemorrhage (APH), preterm labour or pregnancy loss makes it more likely that they will engage in situational distancing. Purposeful distancing mainly manifests in the middle of the pregnancy or around the period of those previous experiences/events. Hospital admissions also lead to purposeful distancing as women perceive this as an emotional threat. If they have experience of unpleasant situations, they gain knowledge about these and the uncertainty surrounding them. Women evaluate these conditions with time, expectation, probability and predictability.

"Yes, counting and taking it day by day. I am willing to go with the professional opinion at the moment. I had always said from the beginning of the pregnancy that I am very eager to try a VBAC. I had been encouraged by the consultant that it should be possible. It really only became an issue at the scan at the 32 week appointment. It has revealed that the growth is not great. I have been told that I might possibly be placed in another section. We will see, I'm still not ruling out a VBAC…. (Laughs) And it is best for the baby as well at the end of the day. As of today, I have asked if I would possibly be allowed home. I have been told depending on the next scan or two it is a possibility. If they stay normal and the light and volume stay normal, I should possibly be allowed home and monitored on a regular basis. But I am aware that the baby is quite small- the last measurement was 4 lbs 3 ounces at the scan last week. They are going to do a growth scan again Thursday week, so they will see what the progress has been and then we can start making decisions as to what can be done. They are aiming to get me to 37 weeks. Hopefully a bit further and make a decision and see what happens (laughs)" (participant 8 antenatal who was admitted to the hospital for monitoring a small for dates baby)

Women get involved in purposeful distancing in order to avoid the anxiety associated with the choice they are not familiar with.

The only thing is that I don't know what to expect. I have a child already, but I've never laboured. So, I don't know what to expect. That's the only thing I'm worried (Participant 7).

Yes, at the minute I'm just praying and praying and praying that I'm going into labour myself you know! (Participant 6 in- patient for an unstable lie, still hoping for VBAC)

Embracing uncertainty

An increased sense of control is likely to result in mentalizing by 'wait and see', blocking, ignoring, embracing and 'blurring' the previous experience. When women feel in control, they are open for options and they follow a 'wait and see'

policy. When women are deferring the decision about a choice, the information that provokes them to think about that choice is neither sought nor welcomed.

"yes I suppose less can go wrong with the controlled operation I feel, than with the natural delivery, so I don't know if I knew that I was going to go myself it would be fine…I would give it a go, but I feel nobody can obviously give me the assurance, and I know you can't with the section" (participant 3)

Embracing uncertainty involves changing lifestyles as women thought that the previous caesarean section was the result of life-stresses. Uncertainty acceptors and comfort seekers involve more in this as they are hoping for a normal birth. Staying positive and working on their mental status becomes their main focus. They changed their jobs, changed houses, changed their diets, and started taking herbs or food supplements with the objective of reducing any complications in pregnancy. Women also try to avoid stress by concentrating on health promotional activities like yoga and walking and attending relaxation classes, acupuncture sessions, hypnobirthing classes and trying to be as calm as possible. If VBAC is their preferred option, they also attend classes in order to receive more information and support for their choice and to prepare for it.

"So up until this week, I was working Monday to Friday. I was getting up, getting my baby up, sending her off, going to work, coming back, picking her up, putting her to bed, sitting down flopping for an hour, then going to bed. Next, from this week on, I will be at home, walking the dog, trying to get the house ready, trying to get ready for the baby…all of that sort of thing. Trying to take it easy…" (Laughs) (Participant 15)

I was working for myself at the time and I was much stressed. And we moved house. I think stresses are massive. I think I was doing too much. That's what happened. Yes, we are living in our house now obviously. We won't be moving. I am not working for myself anymore. I'm being paid every week. And my life is now much more stable. Much less stressful (Participant 7).

Embracing uncertainty involves enduring inconsistency. Women at the beginning of the pregnancy embrace uncertainty more readily than women at the end of pregnancy. This is because of the heightened awareness which makes them engage in possibility seeking and leads them to 'being open' as they seek and search for supportive information. The condition of 'being open' enables them to accept the

difference in opinion from the medical staff and makes them prepared for the consequences. Uncertainty acceptors do not think much about the choices as they 'get on with it'. Innocent modifiers also engage in 'being open' however, 'slippery slopers' are less open as they wait for a chance to opt for CS. Comparing the two pregnancies, most women feel more accepting in the current pregnancy than in the previous one (innocent modifiers and slippery slopers). They were more determined with their birth plans on the previous pregnancy whereas in this pregnancy they do not have determined birth plans. Being open also means that they did not regret their decision if they failed to achieve a VBAC and required another CS. At the beginning of pregnancy, they follow 'see how I go' approach, so they are open to change the decision if situations change (uncertainty acceptors and innocent modifiers). And in the later pregnancy they follow a 'wait and see' approach, as they approach every day with 'caution' (uncertainty acceptors).

I didn't want to just say "I want a section" and that's the story….I suppose I want to see if nature will take its course before my due-date and I want to go with that if it does. But if it doesn't, I suppose it goes out of my hands if you know what I mean…. I do try to keep an open mind. But I suppose even though it is my second baby it would be my first time having a natural birth. Its normal I suppose to be a bit nervous and a bit apprehensive, so I am not trying to dwell on it or anything, I don't think I have a fear of childbirth….I am ……when I think of it I am just like "oh God!" you know….I think your body knows what to do you know. And you would have support, so I try to look at it that way. So, I will see what happens (Participant 5).

"I don't like when things bother me, they go over my head. But. ….. I can't endure pregnancy quite normally… whereas normally, on a normal day I would be in control I would be very independent. I suppose with pregnancy, you would be crying and all of that, I would be sort of talking to myself and saying 'Stop Crying'. There is no need. I like to be in control and I like to be independent" (participant 11)

"When you have another child at home anyway, you cannot just dwell on things, you just get on with it" (participant 5)

First the midwife at my appointment gave me the information. So, I was able to read it, but I had read up on it anyway…. but I didn't dwell on it too much too early in the pregnancy. And then I met up with the consultant around April and then she had a chat with me about it and she said that a natural birth would be better for me and the baby. So, I just decided to have an open mind and see what happens and see do I deliver myself but I am actually nervous about labour (Participant 3).

Reality Re-seeking

The imminence of the forthcoming birth triggers reality re-seeking where the decision making for a choice becomes reality. Reality re-seeking is the last stage in the process of mentalizing where women expect information and support to finalise the decision about the plan for their birth. This is a stage of heightened awareness where women's information needs are high, but their comprehension and processing of information is compromised due to the pressure of time. Reality re-seeking involves adhering to the original choice that was made in possibility seeking or it considers a different choice in order to finalise it. If women have not made their own choice by this stage, they become anxious due to time pressure and threat or potential risk to their health or the health of their baby. Another objective of reality re-seeking is to finally end their uncertainty.

Reality re-seeking is also a consequence of a lack of respect by the health professional for individual woman's preferences and concerns. At this stage women want full participation in the decision making about the plan for their birth; however, women expect support and assistance for their decision.

Those women, who are determined to try for a VBAC for this birth, believe they must engage in reality re-seeking more than women who have not chosen VBAC. They sense that it is easy to surrender to situational pressure if a VBAC is not supported by the professional whom they encounter at this stage. Some women perceived that they were completely aware of their choices, but this perception proves wrong when they realise that they were not well informed.

"I would have asked my sister. Just the odd questions, you know that kind of thing. Mostly I would go and Google things, looking things up online, I'm part of a Facebook group and a mother's audio book is due in July so people would write their experiences on that. My best friend is a midwife; I would ask her as well. I probably do much more research than a lot of women would. I get it all into my head (laughs) I just feel, not that I am in denial, but when reality hits you at the end of pregnancy

you think Oh My God! I really need to read up on this! I wouldn't have done too much till then" (Participant 6)

Reality re-seeking appears at the end of the pregnancy when women are not able to decide or deal with the decisional conflict. Sometimes, having made a decision may have to change it, because of the circumstances surrounding the pregnancy or any complications. When pregnancy is normal and uneventful, 'uncertainty acceptors' and 'innocent-modifiers' adhere to the choice they have made. Disturbing information can also trigger reality re-seeking. The outcome of this stage results in adherence or non-adherence to the decision/choice in order to achieve a positive experience. Reality re-seeking is done in three ways where women appraise the situation, balance risk and safety and negotiate the choice.

At this point the health professional's engagement with the woman becomes important. If a woman perceives that her health professional's interaction and engagement with her is unsatisfactory, she is forced into support navigation again. This is only seen in the public system where the women are sent from one doctor to another, usually from a junior to senior, to re-seek a second opinion or to agree to a choice which the doctors think is best. Involuntary support navigating is also done by women when the doctor informs them that the guidelines prevent or constrain them in making a decision.

"*I suppose when you are under a different consultant, maybe that his whole team, that they have all got that same opinion as such. I know I said everyone is going to have a different opinion, if every few weeks you are in the outpatients, you meet different people. I never met the same person twice. I think 5/6 different doctors I met. They all had a different opinion but they all worked for the one consultant*" *(participant11)*

Appraise the situation

The first step in reality re-reseeking is to appraise the situation in terms of evaluating the available time, information, and support. When health professional perceive something as risk, but women do not think it is, they then do not question

the health professional they agree to it as they are worried about the consequences. Sometimes when they consider it is not realistic to finalise a choice, they question the health professional. If there is enough time to seek another choice, they appraise the pros and cons associated with that alternative. Women do not think about their commitments and concerns but choose a decision that seems safest to them.

For example: a 36 year old pregnant woman had previous CS at 9cm, with the undiagnosed footling breech. She wanted to try for VBAC in this pregnancy. She knew about VBAC and she had the necessary information about VBAC. Pregnancy was uneventful until she reached 36 weeks. At 36 weeks the doctors said no induction because that has to be finalized by a consultant. At 39 weeks they said no induction as there is excessive fluid around the baby and the baby's head is high. So she was booked for CS. She came to the hospital at 40+1 for her CS. when I asked her the question 'how does she feel about undergoing CS?' she started crying, she felt that she was cheating herself. When did I ask her 'does she want to think about her decision? Or would like to talk to someone?' she said, 'no'. She said she was actually relieved when a decision was made for her CS the previous week. She said it was better in a way, as the doctors made a decision for her CS than she saying 'I want a section'. She always thought in this pregnancy that 'she could do it'. She said she was self-motivated, she went for more walking, eating curries, raspberry tea, using the gym ball etc. in order to get into labour before all this happened. She said "I did not see section coming until the last week". This lady then started complaining of some contractions. She was examined by a doctor and was suitable for ARM (artificial rupture of membranes), she was brought down to labour ward and had a vaginal delivery (field note 7)

Women become confident in adhering to a choice when they consider there is no perceived risk or no other problems or issues in pregnancy. In a context where there is a lack of support, some women (innocent modifiers and slippery slopers) try to find a better alternative (CS). 'Uncertainty acceptors' do not do this as they do not change their minds about VBAC even if there is lack of support.

Reality re-seeking can also be done in a way so as to shift responsibility to the 'experts. This happens when there is less time to decide, and where there is an opportunity to transfer the decision to someone else like a doctor or a consultant. This is done especially by 'innocent-modifiers' and 'slippery slopers' when they are not able to overcome the decisional conflict they would like to end the uncertainty. Hence, lack of support acts as antecedence to uncertainty than the decisional conflict.

Reality re-seeking also involves selective interest in information-searching for supportive information and avoidance of unsupportive information. Sometimes under conditions of time pressure, women's reality re-seeking is evident by a general failure to differentiate between information that is relevant or irrelevant, reliable or unreliable, supportive or non-supportive. This leads to informational overload and women feel there is not enough time to analyse and evaluate the information.

Where there is no time pressure, women's ability to differentiate between supportive and non-supportive information depends partly on support from the health professional. Uncertainty acceptors understand and evaluate situations quickly and try to maintain self-determination. They become aware of previous experiences, the gains and losses experienced. These women need less informational support from the health professional unless there is a condition of risk to themselves or their babies.

"Not really, speaking to other mothers who had had same things, I suppose I knew anyway, that once you have a section that you were more likely to have another section, so another friend of mine, who had her second baby, who also had an emergency section told me that you can no longer be induced, I didn't realise that. I also didn't realise that you can only have a certain number of sections in your life, so If I am going to have it will be dictating how many children I am going to have, I didn't realise all that stuff, until later on in this pregnancy"(Participant 15).

The health professional's preference influences reality re-seeking and the decisions that will be made. Women in private care spent less time in reality re-seeking as the decision about the choice is finalised earlier in the pregnancy during the period of possibility-seeking unless there has been a subsequent pregnancy issue or health problem. This enables these women to spend more time in probability distancing, in other words they spend most of their time enjoying the pregnancy.

"A woman in private care said the choice wasn't offered to her. As she had come for her booking visit she was told that she will be having another section she did not question the doctor as she thought that was the norm". (Field note-39)

"Another woman had tried for ECV in her previous pregnancy with the aim of achieving a VBAC but was unsuccessful. She had a different doctor in this pregnancy woman admits that she has chosen elective CS because her doctor felt that she would not be successful in VBAC "(Field note-40)

Reality re-seeking is also the determinant stage in adherence or non-adherence to the choice women desired. Flexibility by the health professional in adhering to guidelines and allowing the pregnancy to continue helped some women in reality re-seeking. Uncertainty acceptors want the expert to be flexible with the guidelines, if there are no conditions of a threat to their health or that of their babies; they want their doctor's approval for the pregnancy to continue for a longer duration than is advised in the guidelines.

For example, a woman who had her previous 4.8 kilo baby by CS because of failure to progress wanted to try VBAC. She negotiated with the doctor and the doctor facilitated her choice with the condition that she came to the hospital every day after term (40 weeks) for monitoring and for scans to ensure that the baby was well. She was allowed to wait until 40+9 when she went into spontaneous labour (Field note 12)

Some women deal with uncertainty more easily in their second pregnancy than their previous one (uncertainty acceptors and innocent modifiers). They are more experienced as a result of their previous experience and consider they are better able to handle the uncertainties associated with the choice and the pregnancy. For some women, late information and leaving the decision making solely to them without any support did not facilitate their mentalizing because they thought that they were generally bad in decision making and some degree of support would have facilitated their reality re-seeking (slippery slopers).

Balancing risk and safety

As the pregnancy advances, balancing risk and safety becomes paramount and women calculate the odds of a VBAC success. Professional advice may be directed towards a particular decision, because of potential risks involved, but as outlined earlier women's perception of risk may be different. Women start to re-

frame their choice and decision for the type of birth so that safety takes priority over other beliefs (innocent modifiers and slippery slopers).

No, nothing to think about my main concern is the safety of the mother and the child. That is just what I am really concerned about. Natural birth is going to be OK. If it is a C-section, it is going to be OK as well. So that is it. Just concerned about the safety towards birth (Participant 12).

"They have pointed out about the wound, how it could tear as it is not so long ago that I had a section, so they would have given me the fact of 'tearing'..... It actually didn't put me off; there is a risk in everything you do so it is the level of risk you actually calculate. I think once you have the percentage of facts you make the decision and that's what I did" (participant 1).

I think if the place had been cut before, and because of infection and things like that. I said I would just try the vaginal birth (Participant 12).

"I would be worried about say…oxygen, cord wrapped around the baby, all these sorts of things. I don't like hearing about words like 'forceps', 'rip' that is associated with a natural delivery. Yes, I would be nervous …but people are having babies all the time, but you know… I am nervous about the news again….two babies's died up the country, that again makes me worry about 'risk' and makes me nervous. I guess it's a fact that it is an elective section; it is planned as supposed to 'emergency'. So I am not worried about the safety with the section. I don't have any concern with the elective section (Participant 3)

Calculating the odds of succeeding with the choice of VBAC or CS is based on women's ability to comprehend the information they obtain at this stage of their pregnancy and the support they receive. Inability to balance risk triggers uncertainty about a choice at this stage. For women who are 'uncertainty acceptors', choice uncertainty is more likely related to the previous experience of failure than the success of VBAC. Issues such as not starting labour due to induction of labour, or where they had failed to progress in labour, foetal distress in labour or preterm labour were relevant. This means that odds are in favour of planned elective CS as the balance is in favour of the perceived safer choice.

Odds analysis is also more likely to be related to the health professional preference for the choice. If the health professional advocates for CS, women consider that they will have success with that choice. If women access private obstetric care, they have a better chance of having a CS as their choice will be respected. In some instances, this is also because the health professionals require

more certainty with the odds than the women. If the health professionals really do not believe in the women's choice, they show less interest in their choice and concerns.

"They have informed me that there is a 50% chance of success that I will end up with a section so I opted for CS" (Field note 30)

The consultant had given her percentage of success of 60-65% so she thought still there is a chance that she could end up with another emergency CS so she decided why not go for elective CS? (Field note 26)

"In my first pregnancy I was reading a paper and there was a statistic that 36% of births in private sector and 25% in the public sector were sections and I always feel and think that there should be no difference in that percentage, it shouldn't matter what system you are under. I thought it is quite substantial. Why is it that private sector the percentage is higher, it is this element of whole too posh to push…., but then there was another this year where 36% of all births are sections, I can't remember exactly, but there were a lot of factors like people are older and all that. People are impatient …in that I have heard people saying that 'I have a wedding that day….I suppose my mother does have a point, in her day's sections were emergencies, not elective (participant 2)"

Safety of the baby is another factor when engaging in calculating odds of success. Uncertainty acceptors who are determined to go through labour perceive that it is worth trying as they feel it is good for the baby. If they are not successful, they will end up with another section and they do not regret that but they want to use this pregnancy as an opportunity to achieve VBAC.

"*Yes, I mean …if I book for the section that is me giving up for it altogether….I have had to talk with the doctor that the fact the baby is unstable. You do run into more and more risks every day. So my baby is now less unstable so I am hoping that it has turned the odds back now in favour of natural labour, only this week I kind of realised that oh! Jesus I am going to the hospital now because the baby is so unstable" (participant15)*

"Well, up to today, knowing that the baby was head down for about a week and a half, I didn't know. I thought I will go for a VBAC or but I knew that if I went past a particular date, or around the week the baby was due, I would have nobody to mind my daughter. I really want a VBAC. I want to go into labour naturally it gives you the chance . . . You know, that's been a big worry" (Participant 6)

Findings from the ultrasound scan reports, information about the risks, recommendations from the guidelines, especially not being able to wait for longer than term for spontaneouus labour to start are risks involved for women. These induce fear among some women, and they find it is easier to surrender to the experts than to face any risk. These fears trigger choice uncertainty, making it more likely

that women will follow expert advice. Some women consider CS as safer option and some others think VBAC as a safer option based on their impressions gathered.

"Fear….(laughs). I think the fear of the unknown, and probably fear of being told all of the bad things that can happen. All of the "your scar can rupture" and all of that can happen, "you have the risk of placental abruption." I mean you hear all the negative things. But there are quite a lot of positive things that can come out of trying to achieve a vaginal birth yourself. I think it would mainly be fear. Some people might say "it's easier to have a section again, I have the scar and I'll do it again" (participant 8)

I didn't want any risk to the baby, a still born child or complications or anything like that; I just wanted to do what is best for the baby (Participant 14)

For these women, there is less concentration on numbers and figures and more on support and participation. This facilitates reality re-seeking because how women understand and interpret risk is different to how medical personnel interpret risk. Uncertainty acceptors can comprehend and process information, however if there is inconsistency and lack of support their ability to comprehend the risk information may be compromised due to time pressure or situational pressure.

"No because to be honest that figure/statistic is so low. I mean you can still have so many complications from a normal vaginal delivery as well. That kind of thing wouldn't bother me really. And in a normal delivery you would still be facing risks/complications. You will have the figures thrown at you saying-'Oh caesarean is safer' and whatever. Maybe it is but there are complications for whatever way you go about it, there is always a possibility that something can go wrong either way. So I wouldn't be fearful of it at all" (participant 8).

Facilitating informed choice, but also some degree of assistance in making a choice helps them to metalize more effectively (innocent modifiers, slippery slopers).

"Well, I would have preferred if they had all said look "we will bring you in and see if you are able for a vaginal and if you are not, we will talk you through it and then we will see what is happening. If they all said the same, but we are all….at the back of your mind you know that the outcome could be a section. But you don't need someone to say to you that "you should go for a section." (Participant 11)

"Now …doctors differ. Every time I came down, whichever doctor I met say had a different opinion; My 20 week scan, my doctor advised me that I should just go for an automatic section. That big baby… you know…….. I should stay safe. He didn't. What he said was because of the previous baby, more than likely I should look for a section at 38 weeks. And I didn't feel comfortable with that because, I know my dates were right. When I went to my 12 week scan, they said the baby looked a bit big and they made me 13 weeks. I suppose in the back of my head the whole time if I came in at 38 weeks, the baby will only be 37 weeks, and to give the lungs and things a chance. But then the next doctor, I met a doctor at 36 weeks and he was lovely. He agreed that it was my choice and he said to look for a provisional section to be booked for 40+7, and explained that everyone deserves a chance to try….And even the doctor I met at the ….last week… she was the same. It was just that in between

there were,… the doctor I met at 32 weeks, he told me that I should just go for a section"(participant 11)

Women's age is an important determinant of how they balance risk and safety. Older women have a stronger need to opt for CS as they perceive that it minimises risks and this view is supported by many doctors. Inability to weigh the risks and safety, also affects how women engage in reality re-seeking and choice negotiating. Failure to prioritise, especially the self or the baby, confuses some women and leads them to choose CS as they believe that is the safe option; this is especially so with comforts seekers. Women can accept potential problems such as wound healing or injury to themselves but delivering a healthy baby takes priority. Women's trust in the health professional facilitates engagement in reality re-seeking. Some women (innocent modifiers, slippery slopers) prefer assistance with the decision making rather than leave the decision-making to themselves

"I suppose there was not overwhelming information. I discussed what I want, so there……I haven't even looked at the information about the rupture of the scar and all that stuff, whatever happens, happens, you know I may as well go with it. I trust that I have been in good care, I have been looked after well, and that that's the job of people in the hospital, and I trust the people in the hospital, you are going to do that for me, and you are going to make these decisions for me, and I trust that. I haven't given lots of information. I asked questions and they were answered, so this is how it might be…" (Participant 15)

A woman who was forty years of age explaining that if she has some injury to herself, it is ok as she is able to manage with that, but if there is injury to the baby she will not be able to cope with that as she can't have any more baby's because of her age (field note)

'I was surprised that they would let me pick a section' (field note14)

"I am usually bad in decision making I would have preferred some help from the doctor (Field note16)

Choice Negotiating

When all the odds are against their preferred choice, women are forced into choice negotiation**.** This takes place between the women and the doctors. It is how both parties reach common ground to resolve the women's main concern of

redefining their birth-experience. For women who have opted for VBAC, choice negotiating may last for the entire pregnancy or may take centre stage only during the last few weeks of pregnancy. It depends on the women's experience and expectations. For instance, if women had a previous bad experience of labour and are trying to avoid going through the same experience again, but the doctor advises them to opt for VBAC, they must negotiate every time they meet the doctor. If the woman is not committed to trying for a VBAC, then negotiating becomes easy. This is because the health professionals have their own bias towards choosing a CS. Choice negotiating is easier when health professionals listen to women's concerns and if there is mutual trust help them to make a decision. If the practitioners are positive and show a confident attitude toward what they are doing and recommending, they have the power of persuasion and can change some women's decisions (innocent modifiers, slippery slopers). These women consider the doctors as 'experts' and they want the expert to decide for them (innocent-modifiers, slippery-slopers and comfort seekers). When there are no threats or time pressure women who want a VBAC plan to wait until term plus ten days to see if spontaneous labour will start, giving them an opportunity of achieving a successful VBAC. This is particularly so for uncertainty acceptors.

Negotiating unsuccessfully leads to support navigating. If women who are fully committed to a VBAC and are not happy with the alternative that is offered to them, they wait cautiously, provided there is no risk to them or their babies. They may go against the advice of a health professional to persevere with their choice. Women who are innocent-modifiers or slippery-slopers need more support from health professionals in choice negotiating as they perceive they have weak self-determination and they feel it is easy to surrender to experts. If women's choice is

for VBAC and if they receive enough support for this they adhere to this choice. If these women do not receive enough support, they will choose CS.

Re-framing

When all the possibilities to achieve a positive experience are exhausted, women change how they want to redefine their birth. Overall, they want a positive experience in this pregnancy and birth but to achieve this they may have to compromise on their beliefs for the safety of themselves or their babies. When all possibilities have failed in reality re-seeking, women come to terms with the actuality of the situation. Hence, reframing is one outcome of reality re-seeking. Reframing is evident with women who wanted VBAC but are required to have a CS for perceived reasons of safety.

There are three possibilities in re-framing. The first is adhering to one choice over another. As women are not able to select their preferred choice, the rejected choice receives negative re-enforcement with the prediction of failure, and concerns about complications. This is the consequence of poor information seeking and information processing especially evident in slippery slopers and innocent-modifiers. The rejected choice is also blamed for being less attractive. For instance, women who reject VBAC explain that VBAC has less of a success rate, as a reason for why they choose CS.

For example: *A woman who came to the hospital for planned CS and whose consultant had told her that if she starts to labour on her own she could try for a normal delivery. She starts to get some contractions and decides to change her decision at the last minute as she does not want a normal delivery she would like to have a CS, because she may not succeed (field note).*

"I wanted to experience it and also I have an 18 month old baby at home and I just wanted to go home to him. But also at the back of my mind I am happy about having a section today in the event that this is another big baby, and it might take me a longer time to recover. That is there as well. I am happy in one sense that my choice has been taken from me (participant 11)"

The second outcome of re-framing is adherence to the choice even in the face of negative information concerning the choice. This is done where safety is not an issue. Women who want to adhere to their commitments do not succumb to situational uncertainty; rather the attractiveness of the choice makes them adhere to it. Uncertainty acceptors are ready to wait for term plus ten days even if the guidelines suggest that it is risky. Women wanted to try a VBAC even if they were not successful in having a vaginal birth the last time and despite baby's admission to the NNU. A woman who was admitted for monitoring for a small for dates baby, wanted to wait for few more days under supervision for the spontaneous onset of labour. This woman felt that there was adequate support to do so.

The third outcome of re-framing is that women may have to compromise on their commitments and reframe their definition of the birth-experience for the safety and well-being of themselves and their babies. Compromising is done mainly because of medical advice and because they want to avoid post decisional regret. Sometimes, these women 'give up' on their choice because of unsuccessful reality re-seeking. They fail to convince the doctor why a particular choice is important for them and as they are fearful of the consequences they go with doctors' advice (innocent modifiers, slippery slopers). Comfort seekers who want a repeat CS and who are given a choice of either repeat CS and VBAC, decide to choose CS at the beginning of the pregnancy, and they do not want to change their choice.

'A woman came to the hospital for her waters to be broken in order for the labour to start. She was examined by the doctor and was told she can't have her waters broken; she has to go for CS (Field note 23).

A woman who came for CS started getting pains, starts with the spontaneous onset of labour and has VBAC. For this woman it was like 'dream come true' (Field note 12).

A woman who has a baby who is unstable who had originally decided for VBAC was monitored for a few days and doctor advised for CS has to make a gradual compromise with her dream. She had to give in her decision of VBAC.'

'When everyone encourages, it helps. Rather than fighting your corner, it makes it easy' (Field note 11)

A woman explaining why she opted for CS (Vignette from field note 21)

"I had previous CS for breech. I knew about the options. I had an uneventful pregnancy. I was well prepared for VBAC. Until yesterday at 38 weeks when I came to the clinic, they found out that the baby was in an unstable lie. I was given two options. One, I will be admitted and observed and if the baby turns cephalic, I can try for VBAC, two, if the baby does not turn I have the option of CS. I chose option two because I felt I had given myself a full chance, I do not want to continue in uncertainty anymore, and this is the safer option for me and my baby"

4.6 Conclusion

The theory of 'mentalizing possibilities' is a substantive theory of women's experiences of decision making with their birth choices after a previous caesarean section. Women engage in mentalizing possibilities with the resolution to achieve a positive experience. It is their resolution to achieve a positive experience in antenatal, intra-natal and postnatal period which triggers this process. This theory explains how women's self-determination and awareness, embedded in the personal, informational and support context, enable them to deal with decisional conflict and uncertainty. As a process it goes through interrelated phases of possibility seeking in early pregnancy, probability distancing in mid- pregnancy and reality re-seeking in late pregnancy. Possibility seeking explains how women seek information and support for their choice, probability distancing where women try to concentrate on the current pregnancy by distancing the uncertainty with the choices and reality re-seeking is where women balance risk and safety and negotiate for their choice.

The theory portrays four types of behavioural strategies among women (uncertainty acceptors, innocent modifiers, slippery slopers and comfort- seekers) which influences how they make their choices. Health professionals give their advice based on risk and safety and whereas all women wanted to feel safe for birth, the risk is viewed differently by women and health professionals. Women based their

opinion on holistic aspects which included their personal beliefs and circumstances and the health and safety of themselves and that of their babies. This theory postulates that the reciprocal support from health professionals and the effects of giving them accurate, quality and consistent information, understanding their beliefs and values and the continuity of support enables them to achieve a positive experience.

CHAPTER 5 COMPARATIVE LITERATURE REVIEW AND DISCUSSION

5.1 Introduction:

This chapter presents a discussion on the theory of mentalizing possibilities by comparing it with other theories available in the wider literature and specifically to midwifery literature and explains similarities and variations found in the current theory. The comparative literature review shows that the theory of mentalizing possibilities contributes to the theoretical understanding of internal and external factors responsible for self-determination of women which explains why and how women make a particular choice in pregnancy following a previous CS.

This literature review was conducted after developing a grounded theory of mentalizing possibilities in pregnancy after a previous CS and the literature is only weaved into the theory according to the grounded theory model so that it synthesises the theory generated and integrates it into a larger more general picture (Glaser, 1998). This chapter is a sincere effort attempting to answer two questions: how is the theory of 'mentalizing possibilities' refined by the available extant literature and what additional understanding does the theory of 'mentalizing possibilities' offer to the literature?

5.2 Sampling strategy and structure of comparison:

As explained in Chapters 2 and 3, GT discourages the researcher from reading literature in the same field prior to data collection and analysis (Glaser, 1978, p138). In this study, a brief literature review was done before the commencement of the study to support the research proposal to the ethics committee. This chapter is a presentation of similarities and differences of previous research and not an integrative literature review within the theory. It is a discussion of the theory's place

in the literature along with other's work on the same topic or ideas (Please refer to Appendix X for search strategy).

5.2 Role of Uncertainty in decision-making:

Decision making requires recognition of a need to decide (the stimulus for action) in order to attain or accomplish a desired outcome (Noone, 2002). Women's perception of the effect of birth choices on their lives with a view to attain a positive experience is their main concern in the decision-making process. This process revolves around the concept of uncertainty and how women resolve decisional uncertainty ultimately leads them to make a choice. In the current theory, there are two factors that lead to uncertainty among women; these are informational inconsistency and lack of support. Informational inconsistency interferes with women's perception of risk and safety. They balance and overcome that inconsistency based on their personal awareness of the informational and support context. Lazarus and Folkman, (1984) explained uncertainty as temporal uncertainty and event uncertainty. Temporal uncertainty refers to not knowing when the event is going to happen. Event uncertainty is related to the notion of probability (Lazarus and Folkman, 1984). Uncertainty associated with disease related conditions is entirely different in terms of its manifestation and coping as pregnancy is considered a normal physiological condition with a specified duration.

According to Janis and Mann (1977), "decisional conflicts" refer to simultaneous opposing tendencies within the individual to accept and reject a given course of action. Decisional conflicts are a source of stress. The most prominent symptoms of such conflicts are hesitation, vacillation, feelings of uncertainty, and signs of acute emotional stress whenever the decision becomes the focus of attention (Janis and Mann, 1977). People use five coping patterns in order to manage the

conflicts (Janis and Mann, 1977).They are unconflicted adherence, unconflicted change, defensive avoidance, hypervigilance, and vigilance. Defensive avoidance can take many forms (Janis and Mann, 1977). An evasive form of defensive avoidance, where a person shows a lack of interest in the problems posed by the situation, becomes selectively inattentive to cues and avoids thinking about the situation by distracting herself with other activities. It can also be buck-passing where a person depends on someone else to make the decision. Another form could be ignoring the available information or arguing against evidence of its potentially unsafe features (Janis and Mann, 1977, p 58).

All the above coping patterns can be compared to the four behavioural strategies women use to overcome decisional conflict. Women who believe in normal birth and their ability to go through it adhered to the choice of VBAC despite inconsistency and uncertainty. This can be compared to unconflicted adherence (Janis and Mann, 1977). Women who had the previous negative birth experience and feel unsupported try to avoid the choice of VBAC using anxiety and fear as defensive avoidance which can take many forms based on women's self-determination. 'Slippery slopers' are very susceptible to uncertainty with the choice as their self-determination to achieve a VBAC is low; hence, it explains the reason for their behaviour. On the contrary, comfort seekers and uncertainty acceptors avoid all the information about VBAC and CS respectively.

According to Janis and Mann, (1977), vigilance as a coping mechanism induces vigilant effort by the decision maker to scrutinise the alternative courses of action to identify a solution when there is a challenging threat. This is compared to possibility seeking where women look for all the possibilities to achieve a positive experience in the current pregnancy and they engage in gathering cues in

impressionistic seeking, information seeking, support seeking and support navigating to achieve a positive experience. When the time to escape the threat is short, hypervigilance is a state of panic seeking to find a way out of the conflict (Janis and Mann, 1977). This compares to re-seeking reality where women show an inability to process information and support due to perceived time pressure and situational pressure. Mishel, (1981) postulated that a high degree of uncertainty decreases the use of direct action and information seeking and encourages intrapsychic modes of vigilance and avoidance which also compares with the defensive avoidance by Janis and Mann, (1977). These two studies (Janis and Mann, 1977; Mishel, 1981) further explain why women give reasons of anxiety and fear of labour to cope with the decisional conflict or to avoid VBAC. Women failed to comprehend the information at the end of the pregnancy especially when there is no support for them to opt for a choice. However, the difference in the current theory is that some women who wanted to achieve a positive experience still tried for VBAC, went seeking information and support for their choice.

A concept analysis of uncertainty explains that “uncertainty is a dynamic state in which there is a perception of being unable to assign probabilities for outcomes that prompts a discomforting, uneasy sensation that may be affected (reduced or escalated) through cognitive, emotive or behavioral reactions, or by the passage of time and changes in the perception of circumstances" (Penrod, 2001). Uncertainty is also associated with the experience of illness, emotional experiences of threat and danger, lack of information and not being in control all of which are negatively viewed. Coping strategies such as self-advocating orientation, reframed support, withdrawing from non-productive social situations, selecting supportive persons, redefining or bracketing the threat and maintaining routines and normality

are some of the means patients deal with uncertainty in illness (Hansen et al., 2012). Janis and Mann (1977), state that adaptive behaviour leads to vigilant decision making and maladaptive behaviour into hypervigilanc. Lazarus and Folkman, (1984) explain coping as emotion and problem focused. Emotion focused coping is directed at lessening emotional distress and includes strategies such as avoidance, minimisation, distancing, selective attention, positive comparisons and wresting positive value from negative events. Problem focused coping is directed at managing or altering the problem causing distress and the strategies used are generating alternative solutions and weighing the alternatives in terms of costs and benefits (Lazarus and Folkman, 1984). Women have used some form of problem and emotion focused coping to achieve a positive experience such as selective information search, accepting and processing only positive information for some and accepting and processing both positive and negative clues in the stage of impressionistic seeking.

Janis and Mann, (1977) explain how people restore emotional stability by tampering with the probabilities when choosing a new course of action (p 94). Cognitive coping processes such as isolation, intellectualisation or distancing enable a person to cope with the emotional implications of an event. Women in this study used probability distancing in the middle of the pregnancy to distance themselves from the uncertainty and conflict of the choices in order to enjoy the current pregnancy. They also used a behavioural strategy that encompasses both cognitive and emotional tactics in order to cope with decisional uncertainty throughout pregnancy and this section of the research is a contribution to the field of uncertainty literature. The theory of mentalizing possibilities compares with the studies of Penrod (2001), Hansen et al. (2012) and Lazarus and Folkman (1984) in explaining the reasoning for women's behavior in decision making where they use different

behavioural and cognitive strategies at different stages of pregnancy. Women use cognitive processing in the form of active awareness in the stage of possibility seeking by information seeking and support seeking. They use distancing as passive awareness in the middle of pregnancy as an emotional strategy where they try to withdraw from the non-productive social situations which they perceive give rise to uncertainty. Some women who perceive their inability to assign a probability to the choice of VBAC use behavioural strategy in mid-pregnancy to distance that uncertainty by maintaining routines, enjoying their current pregnancy and engaging in health promotional classes and activities. The theory does not classify women's behaviour as adaptive and maladaptive but supports the previous findings that decisional conflict is a direct function of goal striving (Janis and Mann, 1977). It describes how women deal with uncertainties by selecting supportive persons and reframed support (Hansen et al., 2012) and how they change their perception of circumstances (Penrod, 2001) with adequate support. It adds to the literature that women's awareness of support can affect their perception of the situation and the processing of their previous experience.

The mentalizing possibilities theory also explains the findings of Lazarus and Folkman (1984) that there is a relationship between imminence and appraisal. Imminence refers to the availability of time before an event. The more imminent an event is, the more intense the appraisal becomes (Lazarus and Folkman, 1984); the quality of decision making also depends on the answer to the question "Is there sufficient time to make a careful search for evaluation of information and advice?"(Janis and Mann, 1977). This theory adds the concept of context to this relationship of imminence and appraisal. As pregnancy has a duration of 40 weeks, some women considered that there is no point in deciding at the beginning of

pregnancy as situations could change. However, the need for personal and informational awareness is important at this stage making women think about the choices, appraise and re-appraise their previous experience and adapt differently to pregnancy. But if they are not aware of the information until late pregnancy, they feel pressure. This changes their appraisal of the situation, they think there is not enough time to comprehend the new information and consequently, they shift the responsibility of making the decision for the birth to the 'expert' at the final stage of reality re-seeking. Therefore, this theory adds contextual factors for the appraisal of uncertainty in addition to the imminence identified by Janis and Mann (1977).

Lazarus and Folkman (1984) explain that when the information necessary for appraisal is unclear or insufficient a person can experience uncertainty. Even though information is unambiguous a person can still experience uncertainty. Such uncertainty may arise from conflicting values, commitments, and goals and simply from not knowing what to do (Lazarus and Folkman, 1984). This is further explored by Mishel (1990) where uncertainty is the inability to determine the meaning of illness-related events and occurs in situations where the decision maker is unable to assign definite values to objects and events. If uncertainty is appraised as a danger, there is an expectation of a harmful outcome resulting in the activation of coping strategies to reduce the uncertainty. If uncertainty is considered as opportunity, a positive outcome is implied and coping strategies to maintain the uncertainty are implemented (Mishel, 1990). In the current theory, women's personal beliefs about birth choices and their previous experiences increase the uncertainty of their decision making. In addition, women who valued predictability, control, and certainty with the decision choose a repeat CS. According to Mishel (1981), an event is considered uncertain if it has vagueness, lack of clarity, ambiguity, unpredictability,

inconsistency, probability, multiple meanings and lack of information. Uncertainty hampers the formation of a cognitive structure, which in turn limits the person's ability to adequately appraise a situation. Appraisal begins by evaluating an event as a threat, as benign or as a challenge. When an event is uncertain, it is evaluated as a threat because the individual is not able to obtain a clear-cut conception of what is to occur.

McCormick (2002) proposed an alternative model of uncertainty to that of Mishel, in which probability, temporality, and perception are the three attributes in addition to the above-mentioned characteristics put forward by Mishel (1990). Probability is the likelihood of something happening. Probabilities of a situation are an integral part of uncertainty where people/patients weigh the odds of a potential situation (McCormick, 2002). This theory links with some of their concepts such as assigning meaning to the situation, use of uncertainty as a challenge and how women try to overcome that uncertainty based on their self-determination. Those who experience lack of continuity and inconsistency for their choice consider that choice as lacking control and predictability and fear that the odds are high for a re-occurrence of the same experience again. What is exclusive to this theory is that some women manipulated this probability by reassuring themselves and considered this pregnancy as an opportunity for a positive outcome and experience. Uncertainty acceptors and innocent modifiers still adhere to the choice that has uncertainty associated with it. Some women considered that opting for a CS was itself a positive experience for them. They wanted to avoid the uncertainty and wanted support for their choice. This theory adds to the literature that perception of uncertainty is related to the resolution of a positive experience and awareness of support.

Lazarus and Folkman (1984) explain that how people perceive things in the environment will shape their understanding of its meaning. Beliefs about personal control have to do with feelings of mastery and confidence. The mentalizing possibilities theory extends the findings of Lazarus and Folkman, (1984) that everyone does not need mastery but confidence in the availability of support and that this determines how they feel personal control. Support (counselling) acts as a positive reinforcement and women can change their appraisal of the previous event/experience. This theory extends the findings of Lazarus and Folkman (1984) describing how, with self-determination and adequate support, uncertainty can be transformed into opportunity.

Thus, this study is a contribution to the field of uncertainty literature. Most of the uncertainty literature, available to date, explains uncertainty in illness-related situations and negative psycho-social outcomes. Studies on how women make decisions in pregnancy are lacking in the literature something this theory begins to address. Pregnancy is a normal physiological occurrence in the women's life cycle and how women assign meaning and value to uncertain situations or choices is explained in this theory. Perception of uncertainty is an important concept in mentalizing possibilities and it further explains the concepts by Lazarus and Folkman (1984), Janis and Mann (1977) and McCormick (2002) by adding the concept of self-determination in the process of decision making. This theory also adds that uncertainty with the birth choices carried from previous pregnancy/childbirth experiences is a major trigger to the process of mentalizing possibilities. It hypothesises that dual appraisal of uncertainty as a stressor and as an opportunity enabled some women to adapt to the uncertainty associated with the choices which compares with Lazarus and Folkman's, (1984) concept of dual

appraisal of uncertainty. For most women this pregnancy is not completely new; they have previously been through labour and childbirth and for most of them the experience was negative, they may have expected that pregnancy and birth would have been straightforward, but they encountered either problems in pregnancy or during labour which resulted in them having a caesarean section. Therefore, they predict that the use of support available to them in their current pregnancy will lead to an avoidance of same experience. Women's personal belief in a choice also contributes to the process of mentalizing possibilities which explains how they adapt differently to different challenging situations. Women who value choice consider the same situation as an opportunity compared to those who do not value the choice.

5.4 Role of birth belief in decision making about birth choices

Women in the current study had a personal belief about a type of birth which they believed would enable them to have a positive birth experience. Birth beliefs held by women either as a medical or natural process determine how they mentalize possibilities. Women's basic belief about the birth process is the fundamental building block that makes up perceptions of birth and influence birth choices (Preis *et al*., 2018). The cultural and social contexts and maternal expectations within which birth takes place also give it meaning (Possamai-Inesedy, 2006; Chalmers, 2013). A previous history of medical and obstetric problems has been related to stronger beliefs about birth as a medical process and more related to medical birth choices such as CS (Preis and Benyamini, 2017; Handelzalts *et al.*, 2012; Gamble *et al.*, 2007). A strong belief that birth is a natural process is related to optimism and a strong belief that birth is medical process is related to pessimism, greater health-related anxiety and fear of birth. Women who believe birth to be natural, make

natural birth related choices (Preis *et al*., 2018, Preis and Benyamini, 2017). Psychological dispositions such as optimism, health anxiety and maternal expectations relate to women's belief that birth is a natural or medical process and can determine their choice (Preis *et al.*, 2018). This theory has added to this concept of birth beliefs and gives some new explanation about how birth choices are viewed differently by women. Their previous history of a surgical birth which leads to a negative experience is an important factor in their self-determination. It also gives health professionals an understanding as to why women make the decisions that they do. They need to be understood and managed appropriately so that women make an informed choice free of bias and with psychological assurance that they will be supported in their choice.

Birth beliefs are closely linked with the medical/technocratic birth model or the natural/holistic/social/midwifery model of care (Loke *et al*., 2015, Davis-Floyd, 2001, MacKenzie Bryers and van Teijlingen, 2010). How women perceive risk differently if they are in different models of care setting is well documented (MacKenzie Bryers and van Teijlingen, 2010). These writers argue that concentration on population statistics can lead to increased intervention and medicalisation of childbirth. This study adds to the debate that the subjective perception of risk can be totally different from the objective perception of risk. This new theory addresses the role of women's perceptions in decision making. It makes a hypothesis that while the birth of a healthy infant is paramount, women's experiences with their pregnancies, childbirth and transition to the postnatal period are equally important. It is important for health professionals involved in women's care to consider this process as a holistic approach rather than considering it as a quick fix process to suit the conveniences of the busy hospital or the health

professional. Childbearing women need support to attain health and well-being for themselves and their babies rather than relying on interventions. It is very important to listen to women's perceptions of their previous experiences and reassure them rather than impose decisions on them without offering choice. Failure to do so will not address the issues which led to the perception of the previous experience as negative. This new theory also emphasises that women can adapt to uncertainty over their birth choices if they are aware that there is support available for them. This explains the relationship between birth beliefs and different models of care, and how best support can be provided to women.

In the study by Loke *et al*., (2015), based on the health belief model (HBM) of Rosenstock (1966), perceived susceptibility is the person's belief in her vulnerability to a disease condition. Perceived benefit is a person's belief that outcomes can be positively affected by engaging in a particular health behaviour. Perceived barriers are an individual's perception of the difficulties stopping them from following a particular health-related behavior. Cues to action are the factors that help the individual make health-related decisions. In that study women who preferred a vaginal birth identified benefits of vaginal birth and women who preferred CS identified benefits of CS. Women who preferred a vaginal birth considered health professionals, friends and relatives equally as cues for action, whereas women who preferred CS considered health professionals as cues for action. Along with that study, this theory also explains women's health behaviour. However, this study adds that women's behaviour is different based on their beliefs about birth and the perceived benefits and cues to action (self-determination). Women considered lack of appropriate support as a barrier in the process of mentalizing possibilities. This theory also believes that health professional play an

important role in women's decision-making process. Women's perception of benefits and harms of a choice and cues for action need to be identified and assessed by health professionals and educational interventions, counseling and adequate support to be directed and modified according to their individual preferences. Mentalizing possibilities further gives an explanation of how women form a preference for delivery based on the internal and external factors which make them aware of these choices. It also hypothesises that women's awareness and perception about a choice can be changed with appropriate counseling and support. In spite of the dynamic nature of the decision-making process, their final decisions are based on the advice and support of health professionals and is a shared responsibility between the them. How women perceive benefits or risk depends upon the information and communication between them and the health professionals who act as an additional element in altering their perception. However, this theory adds an additional component of self-determination to this model. Women's self-determination, based on their previous experience, establishes their behaviour, in addition to all the above factors discussed in the health belief model (HBM).

5.5 Role of previous experience and the reasons why women want to achieve a positive experience

Power et al (2011) have proposed a model integrating emotional, cognitive and motivational elements of decision making within a behavioural context of patient health decision making. The framework accounts for the cognitive representation of a health threat (i.e., identity, timeline, consequences, cause and controllability) whereby the problem is viewed as a weighing of positive and negative outcomes and probabilities. Important to medical decisions, the

consideration of potential outcomes of the decision includes physical, psychological and emotional outcomes. The emotion arising out of the health threat continues to be included as an influence on the resulting choice of behaviour (Power et al., 2011). They also studied the role of emotions in decision-making theory and have found that emotions affect value estimates and risk estimates. Patients tend to place a higher value on options that may provide emotional certainty, control, avoid regret, or avoid disappointment. The framework allows for incorporation of the view that medical decisions are coping behaviours aimed at avoiding potential negative emotions (Power et al., 2011). This theory agrees with the above study. When women value a choice as an opportunity then certainty, control, regret, or disappointment does not interfere with their decision making and their adaptation to uncertainty. In pursuit of a positive experience, some women will tolerate uncertainty and some women will try to avoid it.

A study by Thomson and Downe, (2010) explored women's experiences of a trumatic and subsequent positive childbirth event using a phenomenological approach, showed that an experience of joy following a truma led women to reframe and re-integrate their perceptions and beliefs surrounding their previous traumatic birth. The information, advice and support they received were important to face the subsequent birth experience. Women became focussed and determined to improve their well-being and the connection with their health professional allowed them to achieve an optimum birth experience. A positive birth experience for them was redemptive and transformative. Women who had experienced a previous negative birth had experienced trauma symptoms, many women had sought support from their personal network rather than from health professionals. Women sought support immediately after the previous traumatic birth and ongoing support thereafter

continuing in the current pregnancy. Women wanted to be made aware of support and provided with opportunities to discuss the birth with the health professional, (Thomson and Downe, 2016). Some wome internalise their previous traumatic birth experinece as a means of achieving a positive birth experience (Thomson and Downe, 2013). Being able to understand what had happened in their previous childbirth, remembering its positive aspects and 'being heard' - where someone interested is willing to put time and effort to engage with women - made women feel valued and improved their sense of emotional well being. Women were distressed when issues were unresolved due to lack of follow up after their previous experiences (Fenwick *et al.*, 2013). Women who have experienced a previous traumatic birth can experience fear and anxiety (Thomson and Downe, 2010). Such women have an increased likelihood of requesting a CS (Ryding *et al.*, 2015), because maternal request for CS is strongly associated with fear of childbirth and previous negative birth experience (Karlstrom *et al.*, 2011). This theory reveals that when women expressed uncertainty with the choice of or fear about normal birth, they did not receive any support to communicate their uncertainty or to alleviate the fear. Some women sought private care to get that support, and women in public care were left without any support.

Birth experiences are critical events in women's lives. For women, satisfaction as new mothers is directly related to how much control and involvement they had at every stage of pregnancy, labour and new motherhood. The experience of birth has an impact on how well they make the transition to motherhood, on their self- esteem, on their physical and mental health, on their relationships with the child, on the well-being of the child and on the family. When the memory is traumatic, disempowering and negative, it leads to long-term adverse effects

(Downe, 2008). The current theory suggests that when the birth experience was perceived as negative, women were much more likely to deal with this by trying to exert some control by ruling out VBAC. This is also consistent with the view of control as outlined by Power et al (2011). Mercer has also done an extensive study of maternal variables, one of which is the perceptions of the birth experience and the attainment of the maternal role (Mercer, 2006). The mother's experience during birth is related to her knowledge, her self-concept, and her perceived control over the process (Meighan, 2014). Women have considered seeking and gaining control over their previous birth experience as an important aspect of decision making. They preferred to communicate their birth preferences to their partner, doula or midwifery professional as they considered them as supportive towards their decisions (Munro *et al*., 2017)

Mentalizing possibilities advocates that there is a variation in women's expectations in the second pregnancy compared to the first. They need significant psychosocial support to go through their second pregnancies. This theory agrees with the above explanations of Mercer (2006) and Downe (2008), that women with a previous CS have significant previous negative birth experiences, which make them self-determined to achieve a positive experience for this birth. Most women believe that they were not debriefed appropriately and would have expected more support to resolve their lack of satisfaction with the previous birth experience. This type of support service is not usually available at antenatal clinics. Health professionals could play an important role in debriefing women and helping them overcome their uncertainty and decisional conflict. However, as midwives were predominantly not involved in these women's antenatal care, there was no one to support their psychological or holistic need. The current theory suggests that women, who have

given birth before, have significant birth experiences (positive and negative) but still need counseling, information and support similar to the needs of first time mothers. The theory contradicts the common assumption that women in second pregnancies need less support as they have been through pregnancy and childbirth before especially when they had an emergency CS. These women in fact need more support depending on the level of decisional conflict and uncertainty they experience for their unresolved psychological trauma. For most women, this pregnancy is different and unique and most are unaware of the services that can be utilised in order to deal with their uncertainty around their birth choice.

5.5 Women's knowledge and perception of risk and its relationship with decision making

Women's self-determination to achieve a positive experience is an important concept in deciding about a birth choice. A cross-sectional study was conducted on primiparous women to determine the difference and identify the predictors for the way women plan their childbirth based on the health belief model (Darsareh et al., 2016). A structured self-administered questionnaire was used to collect information from first time mothers on their preference for mode of birth and the factors that influenced this preference. Darsareh et al., (2016) found that women in the caesarean group had more knowledge about childbirth than women in the vaginal birth group. Women planning caesarean birth had significant lower self-efficacy than women planning a vaginal birth. Women planning caesarean birth are significantly less likely to perceive themselves at risk of the complications of CS compared to women planning for vaginal birth. When maternal self-efficacy is low the likelihood of planning for caesarean birth is high. Their high awareness of the benefits of vaginal

birth and the risks of caesarean did not incentivise women to select vaginal birth (Darsareh et al., 2016). Chen and Hancock, (2012) found that women who were aware that CS is major surgery, still chose to undergo repeat CS, many women were not aware that babies may have problems with breastfeeding when their mothers have a CS. Most women were aware that having a CS would not protect their pelvic floor from being weakened and some were not aware of the possibility of rupture of the uterine scar in labour. Systematic reviews by Vlemmix et al., (2013) and Nilsson et al., (2015) show women who received decision aids had significantly higher knowledge scores and lower decisional conflict scores but there was no meaningful difference between the uptakes of the trial of labour or elective caesarean section among them. Because the degree of decisional self-efficacy is not associated with any one choice of mode of birth (Scaffidi et al., 2014), the current theory proposes that how women assess their self-efficacy depends upon their belief on birth choices, how they view birth, their determination to achieve a positive experience and the support they receive to make this possible.

A study which examined the influences on women's decisions to try for VBAC or elective repeat CS found that women who wished for a VBAC used online resources for information, were more likely to be influenced by a supportive group and relied less on health professionals than women who desired an elective repeat CS (Konheim-Kalkstein *et al*., 2014). Sometimes women do not receive clear answers; they may get contradictory answers or answers not in agreement with their own choice. Women must struggle for a choice as they do not get a clear view as to what was best for them (Lundgren *et al*., 2012). In a study by Cox (2007), women who were determined about their choice at the beginning of the pregnancy adhered

to their choice of VBAC or CS and women who were not sure of their choice at the beginning of pregnancy chose elective repeat CS at the end of the pregnancy.

The above findings are reflected in the current theory. Women appreciate the opportunity for self-determination and valued being involved in the decision-making process. Accordingly, women planning CS did not perceive that they were at risk if they chose CS whereas women who opted for VBAC perceived risk in both options and VBAC as a less risky and more natural way to deliver their babies. This theory hypothesises that information about birth choices may increase women's self-efficacy, but it cannot increase their self-determination to achieve a positive experience. However, if they receive appropriate support it may change their perception towards a choice. The current theory addresses how women need different types of support from health professionals in order to make a decision. It suggests that how women make a decision about a birth choice depends upon appropriate information provision, timing of the information provision, constant and timely support in acknowledging women's concerns and appropriate referral services if they have an un-resolved psychological issue such as a previous traumatic or negative experience. All these supportive structures raise awareness among women enabling them to make an informed choice that best suits their personal context. The current theory also supports Darsareh et al's., (2016) findings that women's self-efficacy can be altered through active involvement and timely feedback for their previous experience. When women feel strongly about their perception of support the more active are their efforts in dealing with the uncertainty and fear.

Risk presentation is an issue for all maternity care providers. Risk calculation, communication, and its management are influenced by disciplinary perspectives (MacKenzie Bryers and van Teijlingen, 2010). As there are many health

professionals involved in a women's care in pregnancy and childbirth, their philosophy of care influences women's risk perception. Obstetricians tend to follow a biomedical model and midwives consider pregnancy and childbirth as normal physiological processes (Pairman, 2006, Lennon, 2016). Doctors concentrate on the bio-medical aspects of management, and midwives concentrate on its psychological dimensions (Linnet Olesen *et al*., 2015). How an individual woman decides about a birth choice depends upon her subjective perception of risk. Risk considerations have acquired considerable resonance within healthcare over the past decade (Symon, 2006; Downe, 2008). The risk in maternity care is an often-contentious subject, with risk being used as a label that denotes suitability for particular models of care (Symon, 2006). The technocratic culture of childbirth (Davis-Floyd, 2001) maintains that decision making in any situation should be based on the assessment of 'safety' and 'risk'. This is especially relevant given changing patterns of service delivery in Ireland by the National Maternity Strategy (DOH, 2016), where women have been grouped into 'high risk', medium risk' and 'low risk'. Pregnant women's understanding of risk is more contextual, being embedded in their own particular lives, with a correspondingly lower perception of the likelihood of an adverse outcome (Symon, 2006). Making sense of the realities of women's individual experiences and decisions compared with the claims of obstetric science is deeply challenging. The obstetric focus on risk can be experienced as both pervasive and disempowering, undermining the woman's confidence in her ability to birth her baby. Women consider that optimism based on watchfulness, rather than surveillance generated by pessimism, inspires confidence rather than fear (Symon, 2006).

Focussing on risk alone undermines the positive potential of pregnancy and birth. It is essential to ensure that women are given adequate and clear information

on which to make an informed choice about their childbirth experience. But this is not enough, how women receive support, counseling and education in dealing with the decisional conflict is an important determinant in their decision-making. Most women choose CS because of the perceived better outcome for the baby not realising that CS carries increased morbidity for both mother and baby (Symon, 2006; Chen and Hancock, 2012). Women sometimes opt for CS as they consider VBAC as risky and those who opt for VBAC consider CS as risky (Konheim-Kalkstein *et al*., 2014). A systematic review by Flannagan and Reid, (2012) showed that women's personal responsibilities for herself and her family were primary factors influencing pregnant women's decisions with respect to planned repeat CS and planned VBAC. A meta-ethnography (Black et al., 2016) has showed that serious concerns about maternal and infant health were not influencing factors on women's decisions. This theory emphasises the complexity of decision making by explaining the basis for women's perception of a choice as risky. This is not based on risk information alone, but factors such as women's personal beliefs and values, previous positive and negative experiences along with their personal and family life circumstances and how this risk is communicated to them.

There is little qualitative research available in the area of risk perception and how it affects decision making. A meta-synthesis comprised of six studies showed that one of the main factors that influenced women's risk perception is their interaction with health professionals (Lee *et al*., 2014) and their attitude toward the choices, guidelines and protocols available for them to make a decision (Healy, Humphreys and Kennedy, 2016). The risk in pregnancy is related to the possibility of harm to the mother or the baby. Personal beliefs about risk severity are an attribute of the concept of risk perception. Women's cognitive ability to perceive risk

has consequences for decision-making (Lennon, 2016). How the choice is presented to women and how the interaction is formulated in a supportive context taking into consideration the time of information provision, consistency and continuity takes precedence over the risk information statistic alone.

The mentalizing possibilities theory suggests that health professionals do not fully understand how women make decisions. Women do not necessarily focus on risk when deciding on a choice. It suggests that women and practitioners understand risk differently and to support women more effectively this needs to be accepted by practitioners. Women who decided before pregnancy what they wanted to do not seem to be actively engaged in seeking any further information on risk and benefits of the available choice. This theory supports the argument that women's self-determination engages them in exerting their autonomy which can reduce risk (Symon, 2006; Munro *et al*., 2017). Some women were so passionate about their choice, they could not remember much of the information about risk and safety, but they were aware that their particular choice best suited them. This compares with Fuzzy Trace Theory (FTT), which explains that judgments and decisions and consequently behaviour is affected by the gist (qualitative information) that people understand, rather than the verbatim (quantitative) facts with which they are presented (Reyna, 2008).

This theory also suggests that the biomedical model alone is not enough in women's antenatal care and challenges the notion of risk based on the bio-medical model, because women base their decision on social rather than clinical outcome (Black *et al.*, 2016; Munro *et al*., 2017). Professional perception of risk impacts on women's decision making. Women, who believed in normality and are determined to achieve a normal birth, attributed a different meaning to risk when compared to

women who did not believe or value normality in childbirth. Health professionals are important external influences for women's decision making. Mutual understanding and acceptance rather than imposing personal opinions and values in decision making are essential to avoid increased intervention and over-medicalisation of childbirth. Women need to make informed decisions and need an opportunity to go through a choice which they desire. Further adding to the complexity and to the relative simplicity of the bio-medical model with its focus on risk is that women prioritised achieving a positive birth experience over risk, irrespective of the choice of CS or VBAC.

5.6 Preference-sensitive care and decision making

Wennberg *et al*., (2004) proposed dividing medical care into 'effective' and 'preference-sensitive' care. Effective care is founded on strong evidence of efficacy which patients should always receive. Preference-sensitive care, on the other hand, describes a situation where the evidence for the superiority of one treatment over another is not available; there are therefore two or more valid approaches to care and the best choice depends on how a patient values the risks and benefits of the treatments available. These treatment choices should depend on informed patients' making decisions based on the best clinical evidence (Wennberg *et al*., 2004).

Elwyn *et al*., (2000) discuss situations with and without dual equipoise. Dual equipoise means the existence of options that are in balance in terms of their attractiveness, or that the outcomes are to a degree at least, equally desirable or undesirable. They also propose decision support interventions for situations of dual equipoise. Situations without dual equipoise are situations where strong evidence exists in favor of specific treatments or tests, or where there is a clear consensus that

one approach is superior to another (Elwyn *et al*., 2000). For pregnant women who had a previous caesarean section there are two options for mode of delivery in their next pregnancies, repeat elective CS or VBAC. Dual equipoise in this context means that options are in balance in terms of their attractiveness, or they are equally desirable. This is true as both the options allow the woman to deliver her baby safely. However, it is the informed choice of women to decide on an option that best suits their preference. This depends upon their awareness from the support context, the information they receive from their health professional and the personal context. The recent systematic reviews (Panda, et al, 2018; Lundgren *et al.*, 2015; Lundgren *et al.*, 2016) indicate that most clinicians advise CS as a safe option and this is one of the reasons for women's decisional conflict as their belief in achieving VBAC was not positively encouraged.

Women considered hospital doctors as the main source of information and the information booklet mainly gave information about CS (Cox, 2007). Even if evidence is not available to say CS is safer than VBAC, how the choice is presented to women creates pressure on them to choose CS over VBAC. When women are experiencing decisional uncertainty, even if they believe in their ability to labour normally, they adhere to professional advice. Once they are made aware that CS is a safer option, they change their attitude (slippery slopers and comfort seekers) in an attempt to avoid regret and disappointment. Along with the previous studies, the theory of mentalizing possibilities supports the view that attempts to reduce women's decisional conflict by adequate supportive interventions could lead to their making informed decisions. This also adds to the currently available theories in medical decision making by adding the concept of self-determination based upon which their decisional support needs vary.

A shared model of decision making (SDM) has been recommended and applied in many healthcare settings. The most commonly cited definition of SDM was developed by Charles *et al* (1997, 1999). It involves at least two participants, the health care professional and the patient. Parties participate in the process of decision making and information sharing which is a prerequisite to shared decision-making. A treatment decision is jointly made and both parties agree to the decision (Charles *et al*., 1997). They have also recommended that this approach may need to change as the interaction evolves. They also emphasised the importance of flexibility in the way that health care professionals structure the decision-making process so that individual differences in patient preferences can be respected (Charles *et al*., 1999). This flexibility in identifying women's needs was lacking in the current study which made decision conflict more probable.

A Cochrane review on interventions for supporting pregnant women's decision making about mode of birth after a caesarean (Horey *et al*., 2013) found that there were no studies that focussed on shared decision-making supports and interventions designed to facilitate shared decision-making with health professionals during clinical encounters. This suggests that shared decision making is not the norm when it comes to birth choice. However, women who used decisional support interventions had less uncertainty about their decision than those who did not (Horey *et al*., 2013) and involving women in shared decision making enhances their control. A shared decision-making process can also encourage evidence-based practice and incorporate women's values and preferences (Cox, 2014). However, this theory strongly suggests that women need a shared decision-making model to support them. It advocates for reciprocal engagement by health professional at every stage of decision making which is requisite for shared decision making. It suggests that if

women receive support immediately after the previous delivery in the form of debriefing as a pre-requisite of shared decision-making, they are better able to adapt to uncertainty and decisional conflict. It also advocates constant and continuous support in the form of information provision and education and counselling tailored to women's individual circumstances by a supportive health professional whom they will meet at every antenatal visit. This continuous support leads to satisfaction with their decision-making process irrespective of the choice they make. The theory also suggests that decision support interventions based only on meeting the informational needs of women are not enough in managing decisional uncertainty and, along with the other literature, proposes that women can be effectively supported in the decision-making process.

Witt *et al*., (2012) have integrated decision making theory and coping theory, describing a more holistic vision of human decision making in preference-sensitive health contexts. The Coping in Deliberation (CODE) is a multidimensional coping process and the framework applies to preference-sensitive decisions in healthcare contexts. This framework postulates that each phase in deliberation gives rise to an appraisal and coping process the result of which can influence a patient's attitude and behaviour in other stages of deliberation (Witt et *al*., 2012). The theory of mentalizing possibilities can be compared with the Coping in Deliberation (CODE) framework (Witt *et al*., 2012). Similar to the CODE framework, women in the current theory use deliberation in every stage of pregnancy and this varies in early, middle and late pregnancy. How women receive support immediately after their previous delivery determines how they process that event. Accordingly, they will deal with uncertainty and decisional conflict surrounding the choices depending upon the coping resources available to them which are support, counseling and

educational services. Many women were unaware of these services as they are not automatically offered to them. One of the salient contributions of this theory to the field of decision making is that in spite of the uncertainty that surrounds birth choices women are able to effectively manage uncertainty through possibility seeking, probability-distancing and reality re- seeking by going through awareness in various degrees and contexts as they progress through pregnancy.

Politi and Street, (2011) explain the importance of communication in collaborative decision making. They suggest that individuals actually need some level of anxiety or conflict in order to deliberate about options and recognise the significance of the choice. As a result, it might be more beneficial to help patients to tolerate and cope with uncertainty and decisional conflict, rather than to reduce it. Clinicians primarily focus on targeted outcomes such as improved patient knowledge. Clinician support for patient-centered behaviours that encourage choices that are consistent with patients' values and preferences are important in-patient choices. They recommend communicating uncertainty as the first step in reducing uncertainty. Providing clear explanations, checking for understanding, eliciting the patient's values, concerns, needs, finding common ground, reaching consensus on a treatment plan and establishing a mutually acceptable follow-up plan are the strategies recommended to achieve shared decision making and foster uncertainty tolerance (Politi and Street, 2011). Their study informs the current theory of communicating uncertainty which enables women to accept and value uncertainty and initiate their ability in mentalizing possibilities and develop awareness of support.

Their view is further supported (Elwyn *et al*., 2012, Stiggelbout *et al*., 2015) where the decision making process involves various steps such as 'choice talk',

which ensures that patients know that reasonable options are available, 'option talk', which provides more detailed information about options and 'decision talk', the step of considering preferences and deciding which is best. As a first step, the health professional informs the patient that a decision is to be made and that the patient's opinion is important. The options and the pros and cons of each relevant option are explained. The health professional and patient discuss the patient's preferences and the patient is supported in her deliberation. The health professional and patient discuss the patient's decisional role preference, make or defer the decision, and discuss possible follow-up (Stiggelbout *et al*., 2015). The current theory suggests that possibility seeking compares with choice talk and option talk where women are seeking informational and emotional support to make an informed choice and re-seeking reality compares with the decision talk where women want support in finalising their decision. The above study findings are like the current theory and it also emphasises the collaborative nature of decision making and emphasises the role of flexibility and empathy in facilitating women in decision making. However, women stated that the support to make that deliberation was lacking and this issue needs to be addressed in clinical practice.

5.7 The context of decision making and its impact on decisions

The current theory revealed that women are willing to cope with uncertainties and decisional conflicts in pursuit of a positive experience. They are influenced by the context in which they receive antenatal care, one that that takes account of issues such as women's risk status, the model of care provision, the manner of information provision (time, place, content, continuity, and consistency) and the availability of support. In the current theory, women's choice is restricted because they are

considered a high-risk group because of the previous CS and hence, they are cared for by an obstetrician whose background is based on a medical philosophy of care.

The theory proposes that provider preferences influence women's choice. The organisation of maternity care and the influence of health professionals are critical factors. Women are more likely to have a repeat CS in a maternity unit where CS is traditionally favoured and the characteristics and attitudes of health professionals are predisposed to elective repeat CS (Flannagan and Reid, 2012; Panda, *et al*, 2018). Hence the type of information, the sources of information and the timing of information provision influences women's decisions (Tolmacheva, 2015; Emmett *et al*., 2006a; Moffat *et al*., 2007, Fenwick *et al*., 2006, HIQA, 2016). The number of women seeking private care has accelerated since 1970 (Kennedy, 2010) and women in private care are twice as likely to have a caesarean delivery, emergency caesarean delivery, operative vaginal delivery and more likely to have an episiotomy if they have vaginal delivery. The increasing caesarean rate in multiparous women with private healthcare insurance is predominately driven by the increase in primary elective caesarean deliveries and a concurrent decrease in an attempted trial of labour for the subsequent birth (Lutomski *et al*., 2014) as maternity services have become more medicalised recently (Kennedy, 2010).

A systematic review reported that midwifery care (from antenatal to postnatal period) compared with traditional obstetric led care has shown higher rates of attempted VBAC (Wingert *et al.*, 2018). The individual characteristics of an obstetrician are also reported to be influencing factors for the uptake of VBAC. If women are cared for by an obstetrician who has overall CS rate of 15% or below, she has an increased chance of VBAC compared to an obstetrician whose CS rate is above 15%. Similarly, women in private care were less likely to attempt VBAC

compared to women using the public system (Catling-Paull *et al.*, 2011). As women's knowledge is based on support from health professionals such as obstetricians and midwives, it is futile to blame women for choosing CS, when they are not appropriately informed. This opinion is supported in another systematic review where women's requests for CS have not been identified as a factor for the increase in the rate of CS (Panda, *et al*, 2018).

The other context that women consider paramount is the where and how of information provision. Women were given information in a busy hospital clinic and some of them stated that information was only provided as one or two sentences during the last few days of pregnancy. This was a time when their information processing was weak as they were overtaken by the situational pressure of either the busy hospital outpatient's clinic or the busy hospital theatre list. Women consider this situational pressure as leading them to cope poorly with uncertainty. Wittman-Price (2006) has proposed a theory of emancipated decision making to decrease the decisional hazard. She explored the relationship between emancipated decision-making and satisfaction with the decision in relation to infant feeding practices. The results of this study showed that emancipated decision-making by women is enhanced when empowerment, flexible environment, personal knowledge, reflection, and awareness of social norms are in place in the healthcare environment. The flexible environment is emancipating because it includes respect for different types of knowledge, such as personal knowledge and knowledge gained from reflective practices (Wittmann-Price, 2006). This was also evident in the study by Linnet Olesen et al., (2015) where women were given information in a busy hospital clinic which led to difficulty in processing the information. Studies that explore women's experiences of VBAC have revealed that the ambiguity of information from health

professionals lead to uncertainty regarding the choice of VBAC (Emmett *et al*., 2006a, Goodall *et al*., 2009, Fenwick *et al*., 2006).

In the current theory, some women are not happy with the way the choice is offered to them. They believe that health professionals were under time pressure when they spoke to women in the clinics and that left them with inadequate knowledge, and they had to seek support and information for themselves. Seeking clarification with aspects of the information does not seem to be welcomed by health professionals, hence, the flexible environment in decision making is lacking. There is little information on the literature about how health professional should formulate their interaction with women because how women think and evaluate the information depends upon their understanding of the information. Health professional have difficulty in formulating their information because their judgements of probability interfere or overlap women's judgement or how women interpret the information qualitatively. This theory along with other theories sheds some light into this area and suggests that women rely on health professionals to make their final decision on a choice and suggests that flexibility in understanding women's knowledge, experience and values are parampount in supporting women.

5.8Decision-making Theory and midwifery

This theory reveals that women expected informational and relational continuity in their decision-making process. This is also seen in other studies where having a supportive carer (Fenwick *et al*., 2006) and connecting with a health professional are based on trust, mutuality and respect (Thomson and Downe, 2010). These are essential conditions for good decision making and women's satisfaction.

When there is lack of communication, participation and flexibility in decision-making it impacts negatively on women's perception of choice (O'Brien *et al*., 2017; Wittmann-Price, 2006). A positive birth experience is also considered as a transcendental experience, regardless of how the baby is born (Thomson and Downe, 2010). Therefore, it is important to focus on the positive outcomes that can result by providing timely and appropriate support for women, rather than concentrating on one adverse event. Counseling to alleviate their perception of previous traumatic and unpleasant experiences is essential to achieve a positive experience for women.

Choice, control, and continuity of care are allied to the contemporary notion of 'informed choice'. The concept of 'informed choice' is complex and recognition of its complexity is important for midwives. The use of the concept of risk to impose a choice on women is one of the pitfalls of the 'informed choice' (Pairman, 2006). These concepts are relevant at every stage of decision making. The current theory suggests that the supportive care model comprising of listening, communication and continuity are three elements which are essential in building awareness among women and in providing a positive experience. The current theory emphasises the importance of continuity of care and its relationship to satisfaction with the care by providing a positive experience for women. If continuity of care is achieved, then effective communication and consistency of care are more likely. According to Fahy *et al*., (2008) and McCourt *et al*., (2006), there are three types of continuity: the use of information on past events and personal circumstances to make current care appropriate for each individual (informational continuity), a consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs (management continuity), and an ongoing therapeutic relationship between a patient and one or more health professionals (relational continuity). The

informational level is an organised collection of the medical and social information about each woman that is readily available to any health professional caring for her. In the longitudinal level, in addition to informational continuity, each woman has a 'place' where she receives most care and which allows the care to occur in an accessible and familiar environment from an organised team of providers. The interpersonal level is the ongoing relationship between each woman and a midwife. Some informational continuity is required for longitudinal continuity to be present and longitudinal continuity is required for interpersonal continuity to exist in a midwife-woman relationship (Fahy *et al*., 2008, McCourt *et al*., 2006).

The current theory adds a new insight into this area of continuity where the theory hypothesises that women's perception of control is more likely to occur as a direct result of continuity of care. This in turn enhances informational and interpersonal continuity and the development of trust. Women trust health professionals to be consistent in their approach and to share a common philosophy. This trust enables them to develop awareness of the choice that they are going to make. The study also revealed that it is the continuity of the carer (interpersonal continuity) and her attitude, encouragement and empathetic listening which gives the women the support that they need for decision making rather than the provision of information alone. It is the combination of the informational and interpersonal continuity that led them to feel supported in their choice. This theory like other research has identified issues and some possible solutions in bringing about continuity in decision making and ensuring a positive experience. It can be used as a basis for supporting women in decision-making for a choice after a previous CS; material that is currently lacking in the midwifery and decision-making literature in this substantive area.

Concepts basic to midwifery care are women, health, environment, midwifery and midwife's self-knowledge. There is a lack of a conceptual model for midwifery care which makes it difficult to demarcate what constitutes midwifery care (Bryar, 1995). Pregnancy, as a normal physiological process, requires that midwifery models should concentrate on supporting women in the antenatal, intra-natal and postnatal period. However, pregnancy and childbirth are frequently medicalised and one reason for this is the lack of midwifery models of care. This theory can be used by midwives to develop trust and reduce inconsistency in their care, and it provides an important step in developing a collaborative midwifery model of care which involves obstetricians and midwives. In the assisted care pathway (DOH, 2016) women's care will be assigned to a named obstetrician, and care will be delivered by obstetricians as a part of the multidisciplinary team. However, as this study highlights women did not receive continuity of care as they were not able to see the same health professional in every visit. Along with the strategy (DOH, 2016, p85), this study suggests that a better system where midwives and doctors are assigned to a particular group of women (with one previous CS) to care for them during their pregnancy, would be beneficial to women as it leads to the development of trust and ensures continuity of care.

Mentalizing possibilities emphasises the importance of listening to women's concerns, their previous birth stories/ reflections and acknowledging their experience. Such an approach is also an opportunity for women to indicate what they want from health professionals in this pregnancy. The professionals need to recognise and understand the relationship between the previous experience and women's perception of it. For some women it is difficult to change their perception of their previous experience; however, discussions should be made about the birth

choices they have in this pregnancy. Accordingly, information provision should be directed to the needs of the individual women, who not only need information but also continuous support to process their previous experience. Women will not be able to develop awareness of their current choice unless their understanding of their previous experiences are acknowledged and accepted. This is the first theory to recognise this critical fact. To date, no decision support interventions have been found to have effect on women's birth choice (Horey *et al.*, 2013) but this theory favours women centred interventions by presenting a supportive model of decision making based on counselling (listening), communication and support (continuity and consistency). This approach includes perinatal mental health support after previous traumatic birth experiences, VBAC clinics where women can discuss their previous experiences, concerns and fears, and antenatal education classes with more input from midwives. This can enhance women's experience and satisfaction with the care and increase awareness and facilitate informed choice among women.

The philosophy of midwifery care needs to be evaluated locally to identify how women's decision-making process can be made into a positive experience. This is envisaged in a study where continuity of care by the midwife leads to the development of trust among women (Foureur et al., 2017). Case load midwifery can provide more choice and control for women (McCourt, 2006; Kirkham, 2004), midwife led antenatal care is found to increase the rates of VBAC (White et al., 2016, McLachlan et al., 2012) and a higher rate of maternal satisfaction occurs with midwifery models of care (Sandall et al., 2016). Women who have had a previous CS need to have a plan of care so that they receive information and support early in pregnancy and receive support throughout pregnancy according to their needs. However, recent reports (DOH, 2016; HIQA, 2016) highlight that the current system

of care does not allow woman to experience continuity and exercise choice or control. The lack of continuity in women's care was due to fragmented antenatal care. Not seeing the same professional at every antenatal visit lead women to feel that there was lack of support due to the inconsistent information and advice which they received. The current theory along with the other studies in the literature (Fenwick *et al.,* 2013; Thomson and Downe, 2016) proposes that individual women's satisfaction with their experience depends on their perception of the previous experiences, availability of support and awareness of support to go through the decision making process. For women who describe their previous experience as traumatic additional follow up and support in the form of counselling and perinatal mental health services can make a real difference to their experience. The ultimate choice that women make should be in collaboration with the health professional and must be based on women's values and in their resolution to achieve a positive experience which encompasses involvement in antenatal, intra-natal and postnatal experiences.

5.9 Conclusion

The literature presented in the chapter compares and contrasts the findings of this new theory with the sampled literature. This new theory emphasises the importance of supportive care for women who have had a previous caesarean birth to ensure that women have a positive experience of birth including their antenatal, intra-natal and postnatal experience. While there are several useful theories, they tend to focus on other health or illness related contexts and a theory explaining how women make decision about birth choices is lacking. There are many studies in the literature including systematic reviews and meta synthesis which have all identified that

women's decision making is a complex process not based on the provision of information alone. However, these studies do not propose supportive measures to deal with the women's experience. Significant negative perceptions, emotions and experiences can affect the current pregnancy for which appropriate counselling, education, and referral services are crucial. The current theory outlines the multifactorial means by which women make decisions in practice. This study extends other theories by suggesting how birth experience could be made much more positive for women by not concentrating on the choice alone, but on the process of how and why women make those choices and in supporting their choices. It also recommends the importance of understanding not only informational needs but also the psychological needs of women and reveals that women suffer from lack of choice, control and continuity, hence, a women-centred holistic approach to decision making process is lacking in pregnancy after a previous CS. This theory calls for health professionals to understand women's concerns and to support and assist them to achieve a positive experience in order that they can successfully redefine their birth experience.

CHAPTER 6 CONCLUSION AND RECOMMENDATION

6.1 Introduction

This chapter discusses the quality of this research in terms of evaluation of the theory. It also discusses the strengths and limitations of the study along with its implications for practice, research and education.

6.2 Contribution to knowledge

The theory of 'mentalizing possibilities' provides insights into the process of decision making by women as to how and why they make decisions. In addition to explaining the complexity of decision making by women, this theory also provides a theoretical understanding that builds upon the extant knowledge in the substantive area. A growing concern for the lack of choice for pregnant women has been identified in recent reports from (HIQA, 2016; DOH, 2016) and in the litertaure (Lundgren et al, 2012) which recommends the development and evaluation of women centred decision support interventions as well as appropriate care pathways based on their needs and risk status (Flannagan and Reid, 2012; Nilsson *et al.*, 2015; DOH, 2016). Facilitating informed decision making does not only comprise the provision of information, it is how effectively and efficiently women are empowered to develop awareness of the available choices. Obstetricians, midwives and other health-professionals need to ensure a holistic approach to understanding women's decision-making process.

The central contribution to the field of decision making is how women use a behavioural strategy to accomplish the psychological outcome of achieving a positive experience. The theory also reveals that there is lack of sufficient, evidence-based information for women to make a decision that upheld their self-

determination. It encourages a supportive model of care where health professionals work to understand that women's needs are informational and value based and that they need to be facilitated in a supportive context.

6.3 Critical evaluation of the theory:

The classic grounded theory methodology propounded by Glaser (1978, 1992, and 1998) has been outlined in Chapter 2 and its operationalisation, by using the constant comparative method of data analysis, is outlined in Chapter 3. Both these chapters emphasise the need for the researcher to move beyond description. The aim is to achieve the abstraction of participants, setting/place and time and to develop a theory that would move beyond the substantive area.

In keeping with classic grounded theory procedures, every effort was made to avoid application of preconceived ideas to the emergent theory. As noted in Chapter 5 the literature in the substantive area was reviewed after the theoretical framework was well developed, which provided context and general understanding of the theory's place in the wider literature. Constant comparison and memoing ensured that any pre-existing knowledge earned its place in the research along with the other data.

As discussed in Chapter 2, classic grounded theory methodology does not use the standards of quality and rigour utilised in qualitative research, it uses its own criteria for judging rigour and does not aim to produce an accurate description and verifiable results. Grounded theory is generated systematically from research data; it is not designed to be verified as right or wrong but demonstrates relevance, applicability and modifiability within the substantive area. Therefore, a generated grounded theory can be evaluated in terms of fit, work, relevance and modifiability (Glaser, 1978).

6.3.1 Fit

The criteria of 'fit' relates to the validity of the grounded theory. This is the degree to which the theory and its categories assess the behaviour under investigation (Glaser, 1978). It must correspond closely to the data if it needs to be applied to the substantive area (Glaser and Strauss, 1967). In this thesis, Chapter 3 and 4 demonstrate the constant comparison of data which allows identification of the main concern of the participants and development of the categories to explain how participants resolve their main concern. The extant category of 'mentalizing possibilities' was generated in this study. Chapter 5 describes how the theoretical sensitivity of the researcher is used to compare the broader literature and refines these categories to fit to the wider theoretical and empirical literature. The theory of 'mentalizing possibilities' fits the data as a means of resolving the women's main concern of achieving a positive experience. This has been achieved by allowing the concepts to emerge from the data, rather than forcing them with preconceived hypothesis or concepts. Consequently, this theory fits very well to the social reality of how women make decisions about birth choices in pregnancy after a previous CS.

6.3.2 Work

Work, in the context of grounded theory, is the ability of the theory to explain overtime what is happening in the area under investigation (Glaser, 1978). The emergence of the main concern of participants and how they resolve it was extracted from the data by rigorous application of the constant comparison method of data analysis. The theory of 'mentalizing possibilities' works in explaining the women's behaviour as it corresponds closely to the realities of what women experience in pregnancy and is easily understandable to women in the substantive area. As explained in Chapter 5, it also works when the concepts are applied to the extant literature related to decision making in healthcare and in pregnancy. This theory also

works in explaining how partnership in decision-making by health professionals contributes to their understanding of support. This enables the development of trust between women and health professionals which is lacking in the antenatal care context. It resonates with participant's experience as constant comparison of the incidents is used to develop concepts and categories from the data. When this theory is presented at national conferences, to women attending VBAC classes and to health professionals, it explains how, with support, women can overcome decisional conflict and uncertainty. It also explains and predicts what is happening in the substantive area of birth choices after previous CS.

6.3.3 Relevance

Relevance of the grounded theory explains how the theory allows core problems and processes to emerge (Glaser, 1978). The core category of 'mentalizing possibilities' explains how women's self-determination is used to develop personal, informational and contextual awareness with a view to achieve a positive experience in pregnancy. Relevance for this theory is achieved by applying the constant comparative method of data analysis, theoretical sampling and theoretical coding processes. Completing the literature review, to compare the theory to the extant literature, after the development of the theory, ensured that the core category emerged from the data. Relevance was also maintained by constantly working to avoid forcing the data along with memo writing to capture perspective and sensitivity towards the development of the theory. Once the core and sub-core categories were developed, they seemed very significant to the area of birth choices as they developed from the data (grounded) rather than attempting to apply a preconceived theory on the study participants. As concepts are grounded, they are not proven, they are only suggested, and they are a set of hypotheses not findings

(Glaser, 1978). The theory of 'mentalizing possibilities' has generated numerous hypotheses which are at a conceptual level, making it relevant to the area of birth choices. It explains how women adapt to the uncertainty and conflict that surrounds the decision-making process based on their self-determination and is a unique contribution to the area of decision making on birth choices currently lacking in the literature.

6.3.4 Modifiability

The theory has ample scope for modifiability. In a changing world a theory must be adaptable and modifiable if new data emerges while continuing to credit previously generated work within the same field (Glaser 1967, 1978, 1992). This is apparent in Chapter 5 where the theory was compared to the extant literature. The literature expanded the understanding and relationship between the concepts and explained the women's behaviour. This understanding and the relationship between the categories can vary depending on the data and if any new data emerges, the theory can be modified. It is also the conceptual nature of GT and the fact that concepts are not defined that makes it modifiable. While saturation was reached in data collection and analysis in the development of this theory, any new data has the potential to modify the theory. The theory of 'mentalizing possibilities' presented in this thesis is robust in assessing the quality of the theory as it shows fit, work and relevance to the substantive area, while being open for further modification.

6.4 Strength of the study

This is the first study to investigate how women make decisions about birth choices and it elucidates their behaviour in the substantive area of pregnancy after a previous CS. It explains how women's awareness of the personal, informational and support contexts lead to self-determination enabling them to process and adapt to

decisional conflict and deal with the uncertainty surrounding the birth choices. This theory contributes to the field of birth choices with its account of women's behaviour and the factors influencing those behaviours. It establishes that early intervention enables women to process the previous experience and information more effectively and constant support in the form of information provision, counselling, education and referral services enables them to achieve a positive experience. This theory is generated with a systematic approach using the constant comparative method of data analysis and it has used different data sets from the formal interviews, informal interviews and non-participant observations which are unique to this methodology, which enabled the development of the conceptual properties of this theory. This has also advanced the understanding of women's decision making to a more abstract level in an area where there is little or limited information.

6.5 Challenges

The most challenging aspect of using GT was to understand its methodology and it is best understood only by using it as a research methodology. Even though Glaser (2003) advises researchers to let participants define the research problem it was difficult to collect data without knowing what to look for and what is going to emerge. As a student, tolerating confusion in the beginning of the research process is difficult and working with a preconceived hypothesis seemed easier. However, when data collection commenced it was important but difficult not to focus on the title. Being a practising midwife and staying open was interesting but also testing because I had to forget I was a midwife and talk to women as a researcher. This did not happen until I started capturing my feelings and preconceptions in the memos. This made me more open and aware of the concepts than I would have been before. The basic difference between classical GT and other types of GT is the constant

comparative method of data analysis. There are many books on classical GT describing the constant comparative method but, for the novice researcher, the focus on 'what GT is not' was confusing. The advice to 'just do it' was unhelpful, but the realisation that constant comparison is done to tease out similarities and differences and to refine categories helped to make sense of the process. Constant comparative analysis was difficult to understand with the knowledge and experience of the step by step process of analysis (linear method) used in other methodologies, such as defining the problem, doing a literature review, collecting data, analysing it and reaching findings. However, the cyclical nature of constant comparison and the freedom to structure the data collection technique is unique and answered many questions. To begin with, it was difficult to recognise the patterns and incidents because the focus was on recording the interviews and describing the findings. The understanding that conceptualising needs constant comparison in order to create another property of the category, the process became real.

The language used in some GT books is complex and difficult to understand for a researcher new to the methodology and there is no single book that explained it in a clear, concise manner for a beginner. There are many books on GT, each explaining a different aspect of it, and the researcher preferred books which gave examples of conducting a study using GT. The advantage of using GT provided a chance to concentrate on the emergent problem rather than the professional problem by not conducting a literature review before discovering the main concern. In order to get ethical approval, formulation of a problem or title for the study was necessary. As explained earlier, a problem statement and a brief literature review were done for ethical approval.

Writing up the study findings involved the use of abstract language and it is difficult to explain a concept without quoting the participants 'voice'. Hence, the concepts in the theory have been explained with women's quotes wherever necessary. The use of memos was not fully appreciated until the writing up stage was reached. The field notes and memos were helpful to develop the theory as they enabled a rise above data and description.

As a novice in this methodology I was in the process of learning CGT, therefore I have not used it to its full potential. Even though attempts were made to be conceptual, I acknowledge that the theory is descriptive in places. The initial interviews were purposively and conveniently sampled, and women were interviewed at particular weeks of gestation. Due to limited time for the study, I followed only one woman during different times of her pregnancy and following birth of her baby.

6.6 Recommendations

6.6 .1 Implications for practice

- Women can use this theory in decision making for a choice and to overcome the uncertainty and the conflict that surrounds their choice. It encourages women to seek out all the possibilities to achieve a positive experience. If, after the previous event, debriefing was inadequate, they have the right to ask for clarification and support and seek for more information about it. Women should raise their concerns or wishes during the first antenatal visits.
- The theory highlights the importance to health professionals of making women aware of their birth choices and fostering their self-determination. It is important to ask women their main concern in pregnancy, their

informational awareness of birth choices, their birth beliefs and their perception of support for their choices.

- Women use behavioural strategies to achieve a positive experience but how they seek information and support varies. It is important for health professional to understand this and a care plan based on shared decision-making model to help women reduce decisional conflict must be implemented.

- As women experienced lack of continuity and support in their antenatal care, this theory recommends that an assisted care pathway be developed according to the maternity strategy (DOH, 2016) where women are cared for by a team involving obstetricians and midwives. It advocates for a collaborative/supportive decision-making model that puts women and their concerns at the centre of the process.

- This theory makes health professionals aware how women's previous negative experiences of pregnancy and childbirth can affect their decision making in this pregnancy. Therefore, encouraging and facilitating a choice should commence immediately after the previous delivery in the form of debriefing and information about future pregnancy choices i.e. the need for CS or VBAC. This should be done before women become pregnant again. This needs to be continued throughout the second pregnancy, as they require support. Support in the form of offering them the available resources to overcome their decisional conflicts involving counselling, education and referral services are needed to provide a long-term positive effect for women. The theory has the potential to be used as an intervention-based framework.

- There is no standard way to communicate risk information about both choices, apart from providing evidence-based information. Health professionals can make women aware of their choices keeping in mind they can influence them. It is important to use appropriate language and avoid bias as they give different impressions to women.

- Identifying a woman's concern in pregnancy is achieved by listening to her, taking into consideration her previous experiences and by developing a

meaningful dialogue with her. Provision of an informational leaflet cannot replace this meaningful dialogue with a health professional. This can also be enhanced by meeting with a support group involving women who have had a previous CS and had been through their second pregnancy.

6.6.2 Implications for policy

- This theory suggests that a national policy outlining support services for women needs to be implemented. Decision aids must be used in conjunction with the support services and must not be replaced for support services.
- A local policy to be developed by the health professionals working in the perinatal care with an emphasis on women centred care.
- A system of care that puts women at the centre of their decision making with appropriate support services in the form of counselling, education and referral services included in the antenatal care pathway.
- A policy or audit to provide an accurate picture of the recommended versus the actual practices used by each health professional and the level of women's input in the decision-making process needs to be implemented.
- A national policy is imminent where women opting for VBAC are supported and encouraged in specialised clinics such as VBAC clinics within the hospital setting, so that women receive services such as management of labour, pain relief during labour and emphasis on monitoring in labour in order that they are prepared for the labour. This will also alleviate their anxiety and fear of labour and normal birth.

6.6.3 Implications for education

- Midwifery and obstetric education should focus on educating and training midwives and doctors in effective counselling for women who have previous negative experiences. This needs to be incorporated into the perinatal mental health curriculum.
- This theory potentially acts as a framework for educators to develop shared decision-making models to enable and facilitate women to make decisions for themselves based on their previous experience, personal beliefs and resolution to achieve a positive experience. It also allows health professionals to take a holistic, flexible and consistent approach.

6.6.4 Implications for future research

- Further research needs to focus on whether changing the model of antenatal care, continuity of the carer and group vs individualised antenatal education will make a difference to women's experience. Establishing a collaborative model of care involving obstetricians and midwives, or a midwifery model of care must be evaluated in light of providing and promoting a positive experience for women. For some, this will involve opting for VBAC; others will choose a repeat CS.

- Future research should focus on reducing the overall rates of CS by provision of evidence-based information ensuring that women make an informed decision without bias and undue pressure from health professionals.
- Research, so far, has not considered the effects of early intervention on the uptake of birth choices. Future research should focus on the effect of debriefing after the primary CS on birth choices and effect on women's experiences and on the uptake of a particular birth choice.
- This theory recommends the DIESEL (Debriefing, Informing, Educating, supporting/continuity, and evaluation and learning) method of supporting women in their decision-making.

6.7 Conclusion

This study has used GT methodology to generate a theory to explain how women make decisions in relation to birth choices. This theory offers a possible explanation of an experienced phenomenon of decision making by women.

The chapter concludes the thesis by explaining how this theory can be evaluated and how its credibility lies in its integrity, relevance and workability. It explains the strength of the study which is the process of how women make birth choices. Thus, women's self-determination and behavioural strategies allows them to overcome uncertainty and conflict, and this is a unique contribution to the substantive field of women's birth choice decision making after CS. It discusses how the main findings

of the theory can be implemented for practice, education and research. This theory along with the other studies available (Nilsson *et al.*, 2015) concludes that information is important to increase women's knowledge, however it will not necessarily make them opt for a particular choice. As there are no shared decision making supports and interventions to facilitate shared decision-making in pregnancy following a previous CS (Horey *et al*., 2013), this theory concludes with the recommendation that health professionals and women need to work together, to ensure that women's experiences are positive irrespective of the choice they make and women need counselling, education and support to make this happen.

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APPENDIX 1 Insurance cover for the study

- **O'Driscoll, Kathryn** <kathryn.odriscoll@ucc.ie>

- 16/03/2016
- Today at 2:54 PM

To

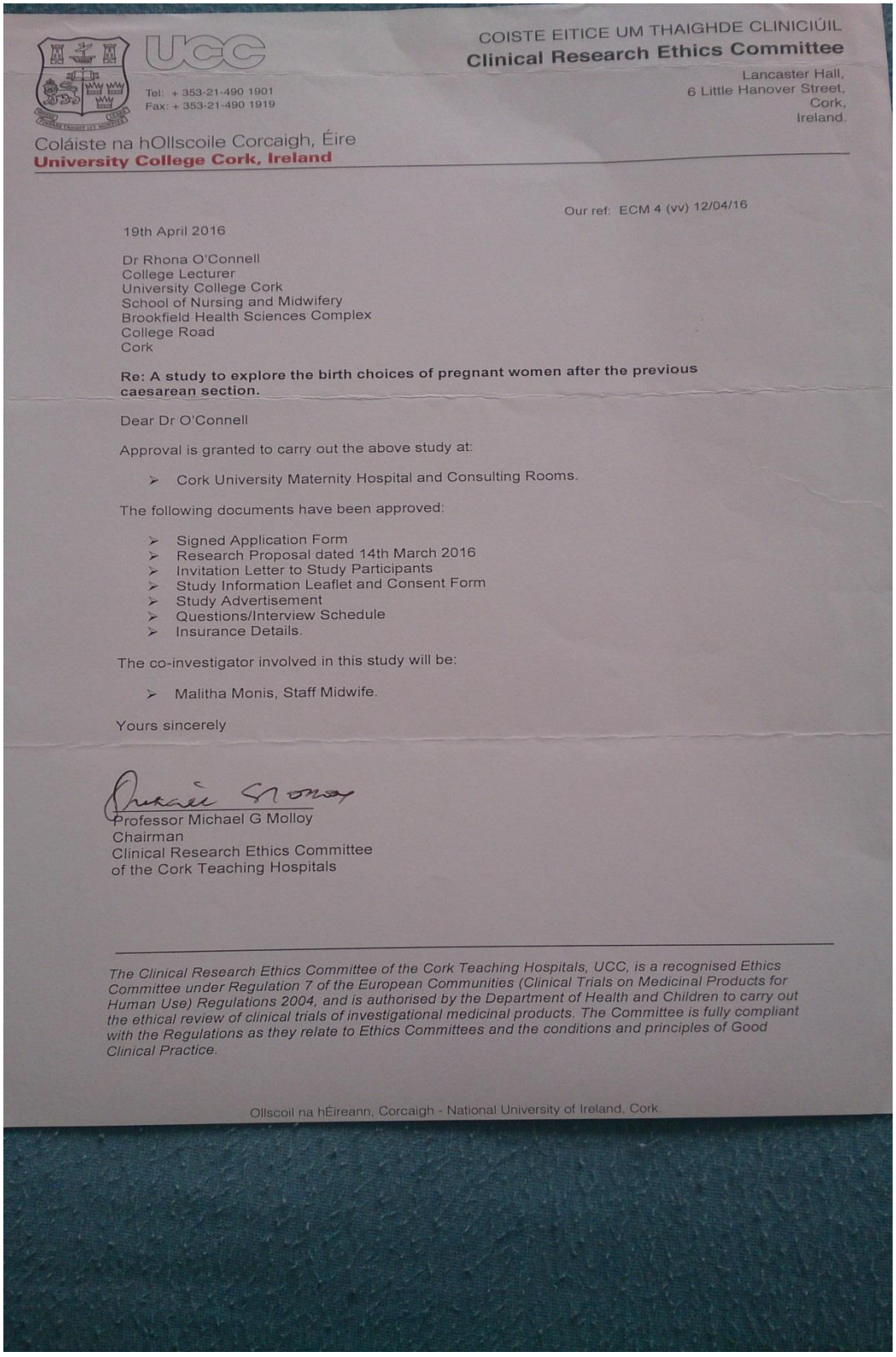
- malitha monis

Malitha, thank you. Dr Dowling has reviewed with your tutor and this office has also reviewed. I confirm that the research is covered under the University insurance programme. This e-mail is satisfactory for the Clinical Research Ethics Committee.

Regards,

Kathryn
Kathryn O'Driscoll
Acting Insurance & Claims Administrator
Office of Corporate & Legal Affairs - University College Cork
4902481

APPENDIX II CREC approval



UCC

COISTE EITICE UM THAIGHDE CLINICIÚIL
Clinical Research Ethics Committee

Lancaster Hall,
6 Little Hanover Street,
Cork,
Ireland.

Tel: + 353-21-490 1901
Fax: + 353-21-490 1919

Coláiste na hOllscoile Corcaigh, Éire
University College Cork, Ireland

Our ref: ECM 4 (vv) 12/04/16

19th April 2016

Dr Rhona O'Connell
College Lecturer
University College Cork
School of Nursing and Midwifery
Brookfield Health Sciences Complex
College Road
Cork

Re: A study to explore the birth choices of pregnant women after the previous caesarean section.

Dear Dr O'Connell

Approval is granted to carry out the above study at:

- Cork University Maternity Hospital and Consulting Rooms.

The following documents have been approved:

- Signed Application Form
- Research Proposal dated 14th March 2016
- Invitation Letter to Study Participants
- Study Information Leaflet and Consent Form
- Study Advertisement
- Questions/Interview Schedule
- Insurance Details.

The co-investigator involved in this study will be:

- Malitha Monis, Staff Midwife.

Yours sincerely

Professor Michael G Molloy
Chairman
Clinical Research Ethics Committee
of the Cork Teaching Hospitals

The Clinical Research Ethics Committee of the Cork Teaching Hospitals, UCC, is a recognised Ethics Committee under Regulation 7 of the European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004, and is authorised by the Department of Health and Children to carry out the ethical review of clinical trials of investigational medicinal products. The Committee is fully compliant with the Regulations as they relate to Ethics Committees and the conditions and principles of Good Clinical Practice.

Ollscoil na hÉireann, Corcaigh - National University of Ireland, Cork

APPENDIX III Permission from the clinical directorate to conduct the study

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Cork University Maternity Hospital
Health Service Executive
Wilton
Cork
Tel: 021 4920 500

6th May 2016

malitha74@yahoo.co.in
malitha.machado@hse.ie

Dear Malitha,

Your study "**A study to explore the birth choices of pregnant women after a previous caesarean section**" has been approved by the Clinical Directorate.

We would like to wish you every success in the completion of your study and look forward to receiving your final results.

Kind regards,

Yours sincerely,

_____
Maria O'Shea
Secretary

Cc: Jane O'Connor CMM3, OPD
Cc: Maria O'Donovan CMM3, Inservices

Women, babies and their families are the centre of our service as we strive for excellence and innovation.

APPENDIX 1V Patient information package

PART I

Baseline characteristics of the women

1. Age of the woman
2. Previous delivery
   2.1 Elective Caesarean section
   2.2 Emergency Caesarean section
3. Years since previous delivery
   3.1 1-5 years
   3.2 5 years and above
4. Ethnicity
   4.1 White
   4.2 Afro-Caribbean
   4.3 Asian
   4.4 other
5. Highest Educational level attained
   5.1 No formal education
   5.2 Primary Education
   5.3 Secondary Education
   5.4 Degree/ Postgraduate
6. Type of care received
   6.1 Public
   6.2 Private
7. The reason/type for the previous Caesarean section
   7.1 Elective CS
   7.2 Emergency CS
8. Intended method of delivery for this baby
   8.1 repeat Elective CS
   8.2 VBAC

PART II

INTERVIEW SCHEDULE

Q1. Please tell me about your experience of decision making about a birth choice in this pregnancy.

Q2. What were your expectations and what did you experience?

Q3. What major factors influenced your choice?

STUDY ADVERTISEMENT

ARE YOU PREGNANT WITH YOUR SECOND BABY AND YOUR FIRST BABY WAS BORN BY CAESAREAN SECTION? ARE YOU INTERESTED TO PARTICIPATE IN THE RESEARCH STUDY?

TALK TO YOUR MIDWIFE IN THE ANTENATAL CLINIC

Letter of Invitation to study participants

Dear Participant

I am currently undertaking Doctorate in Nursing Studies at UCC. As a part of this programme, I am conducting a research study that is being supervised by Dr. Rhona O'Connell Lecturer and Dr. Tom Andrews Lecturer, Department of Nursing & Midwifery, UCC.

The purpose of this study is to understand pregnant women's decision-making in relation to planned delivery method following a previous caesarean section. The reason for this study is to look at the way the birth choices are presented to the women by their healthcare provider (doctor, midwife), so that we can improve the experience of decision making for the future antenatal women. I recognise that you have views on this issue based on your current situation, and I would appreciate the opportunity to obtain your views, through an interview.

Please find enclosed a full information leaflet about the study. It is a part of the procedure that women who decide to participate in this study will be asked to complete. A consent form also needs to be signed. This will not link you in any way to the study and your information will be anonymous.

Thanking you

Your Sincerely,

Malitha Monis

STUDY INFORMATION LEAFLET FOR WOMEN

What is this study about?

This study is about the decision-making process of women about birth choice. This involves women who are pregnant with their second baby and who had their previous delivery by caesarean section

What is involved in this study for you?

This study has two parts. In the first part of the study you will be asked to provide some baseline information about yourself. During the second part of the study you will be interviewed by the researcher and you will be asked to describe your experience of decision making regarding the birth choices in this pregnancy. The whole interview may last for 30-45 minutes

Why are you being asked to take part in the study?

You have experienced a previous caesarean section and you have gone through the process of decision making in order to choose a mode of delivery with your current baby. You are chosen because you fulfil the criteria the researcher is investigating

Who else will be taking part in the study?

Other women who are pregnant with their 2nd baby and who had experienced previous caesarean section with their first baby will also be taking part in the study

Will the information you give be kept confidential?

Yes, all the information you give will be kept strict confidence, anonymous and no name or personal details will be revealed anywhere in the research process.

Why am I asked to fill out and sign a consent form?

The Researcher wants you to have a choice to participate or not to participate in the study.

Do you have to participate?

No, participation is completely voluntary. You are under no obligation to participate in this. If you decide to participate and change your mind, you are free to withdraw at any time without explanation.

What are the risks and benefits of this research?

There are no risks involved for you if you participate in the study. It will not benefit you anyway in this pregnancy. By understanding the complexity of the decision making regarding the choice of birth after previous Caesarean Section this research will add to the limited published data in this area of antenatal care. This will also help to encourage evidence based, individualised, woman-centred approach to the decision-making process.

There are no foreseen circumstances where any participant may come to harm, however if any emotional or psychological discomfort arises, a counsellor will be available to you. Should such an event arise the research will be stopped immediately. If you have any complaint pertaining to the research or the interview, you can contact me personally or my supervisor in complete confidence.

Does the researcher have permission to carry out this study?

Yes, permission from Clinical Research Ethics committee has been granted for this study. There is also consent from Cork University Hospital Quality and Risk Management Board. Written consent from consultants and midwifery mangers has also been granted

What if I don't understand what is being asked of me?

Stop the interview and ask the researcher to explain what is being asked of you.

THANK YOU

CONSENT BY SUBJECT FOR PARTICIPATION IN RESEARCH STUDY

Patient Name:_____

Study Title

A study to explore the birth-choices of pregnant women after the previous Caesarean section

Name of Chief Investigator: Dr. Rhona O'Connell

Name of the Co-Investigator: Malitha Monis

Contact Number for Chief Investigator:

You are being asked to participate in a research study. The aim of my study is to explore the birth choices of pregnant women who have experienced a previous caesarean section. In order to decide whether or not you want to be a part of this research study, you should understand enough about its risks and benefits to make an informed judgment. This process is known as informed consent. This consent form gives detailed information about the research study. When you are sure you understand the study and what will be expected of you, you will be asked to sign this form if you wish to participate.

AGREEMENT TO CONSENT

The research project has been fully explained to me. I have had the opportunity to ask questions concerning all aspects of the study. I am aware that participation is voluntary and that I may withdraw my consent at any time. I am aware that my decision not to participate or to withdraw will not restrict my access to health care services normally available to me. Confidentiality of records concerning my involvement in this project will be maintained in an appropriate manner. When required by law, the records of this research may be reviewed by government agencies and sponsors of the research.

I, the undersigned, hereby consent to participate as a subject in the above described project conducted at Cork University Maternity Hospital. I have received a copy of this consent form for my records. I understand that if I have any questions concerning this research, I can contact the Chief Investigator listed above. I understand that the study has been approved by the Cork Research Ethics Committee of the Cork Teaching Hospitals (CREC) and if I have further queries

concerning my rights in connection with the research, I can contact CREC at Lancaster Hall, 6 Little Hanover Street, Cork, 021 4901901.

Answer yes or no

I have read and understand the study: yes/no

I agree to participate in this research: yes/no

I agree to allow my interview to be audio-recorded: yes/no

I grant permission for the data collected to be used in this research only: yes/no

Chief Investigator Signature: _____

Signature of Study Participant: _____

Date: _____

APPENDIX V Updated interview guide (2)

Interview guide updated (2) on 25/06/2016

1. Can you talk about this pregnancy, how is this pregnancy for you? (thoughts, feelings, actions?)
2. Has your previous pregnancy affected you in any way? When and how has your previous experience/ pregnancy affected you?
3. Was your previous experience positive or negative?
4. Are you worried or concerned about anything in this pregnancy?
5. Are you aware of your birth choices?
6. Did you have any expectations in this pregnancy?
7. Who has been most helpful for you during this pregnancy? How has she been helpful? Influenced or supported?
8. Have you thought of any factors that were uncontrollable or uncertain in this pregnancy?? Can you explain or describe? How do you handle these?
9. What do you think are the ways your present experience can be improved?
10. What is the most important lesson you have learnt in this pregnancy? Negative or positive? Can you explain this to me...?
11. Is there something else about your experience that I should know or understand better?
12. Is there anything you would like to ask me?

APPENDIX VI Updated interview guide (3)

Interview guide updated (3)

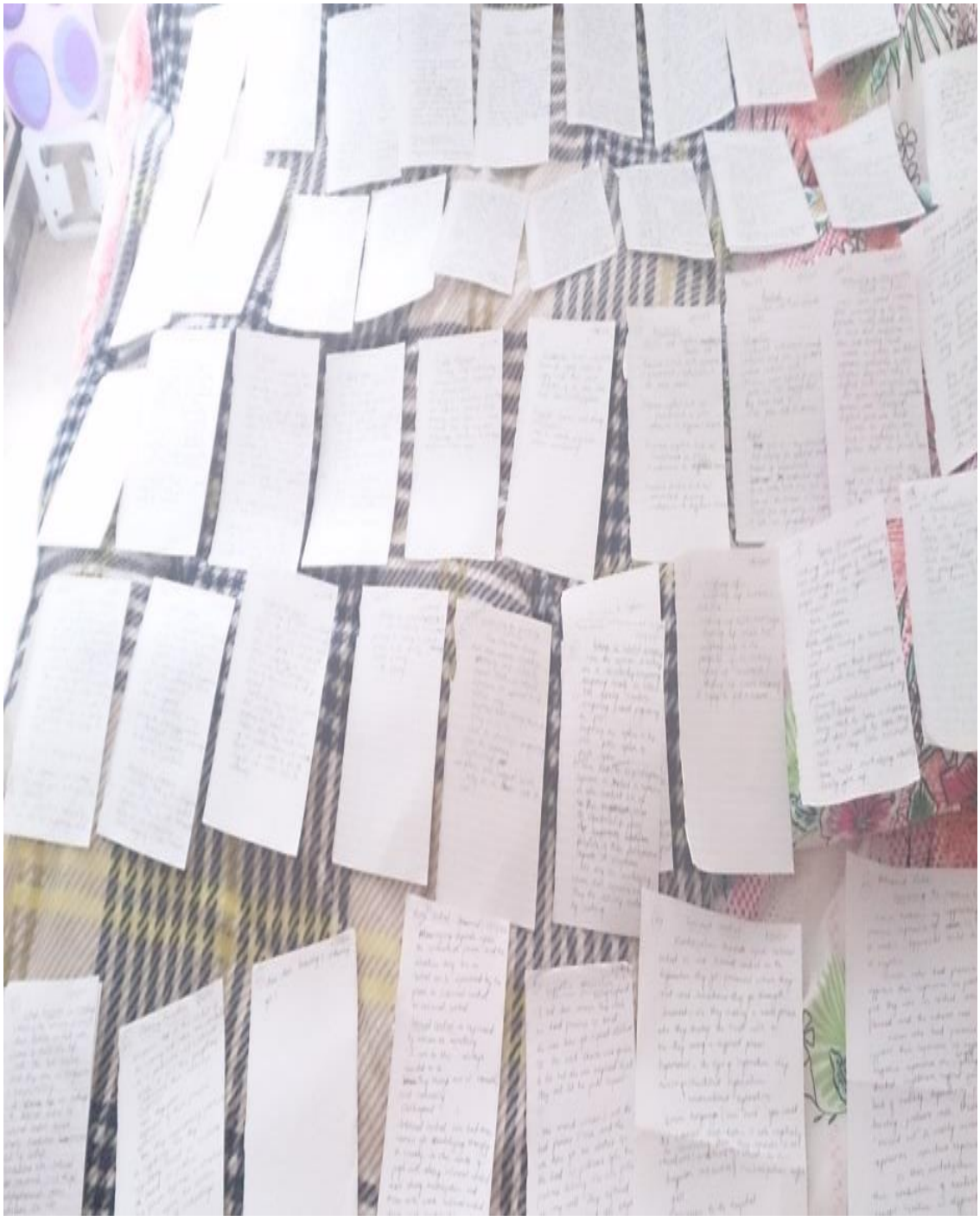
1. What is the method of delivery you have selected and can you explain why you chose this method?
2. What were you thinking in the beginning of the pregnancy with regards to information, support and help?
3. Did you get good support from your doctor/ midwife or others? According to you who or what you think is most helpful?
4. What are you trying to achieve or fulfil in this pregnancy with regards to you, or your baby, or to your family?
5. What are/ were your concerns as you progressed in pregnancy early, middle, and end (relevant)? Were you trying to stay away from something which was disturbing or confusing? Or are you OK with everything?
6. As you progressed in the pregnancy do you think you changed or re-considered, re-think, changed your mind or modified your original plan, if so why?
7. Do you think you are happy with the decision you have made?
8. How do you think your experience of this pregnancy could be improved?

APPENDIX VII Line by line coding

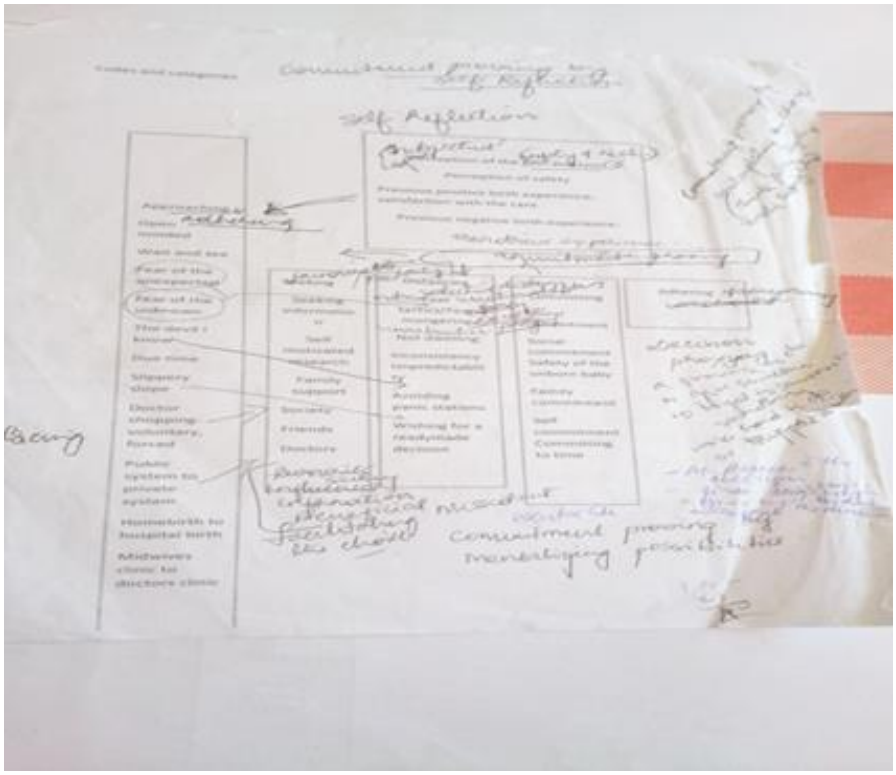
Table showing open coding

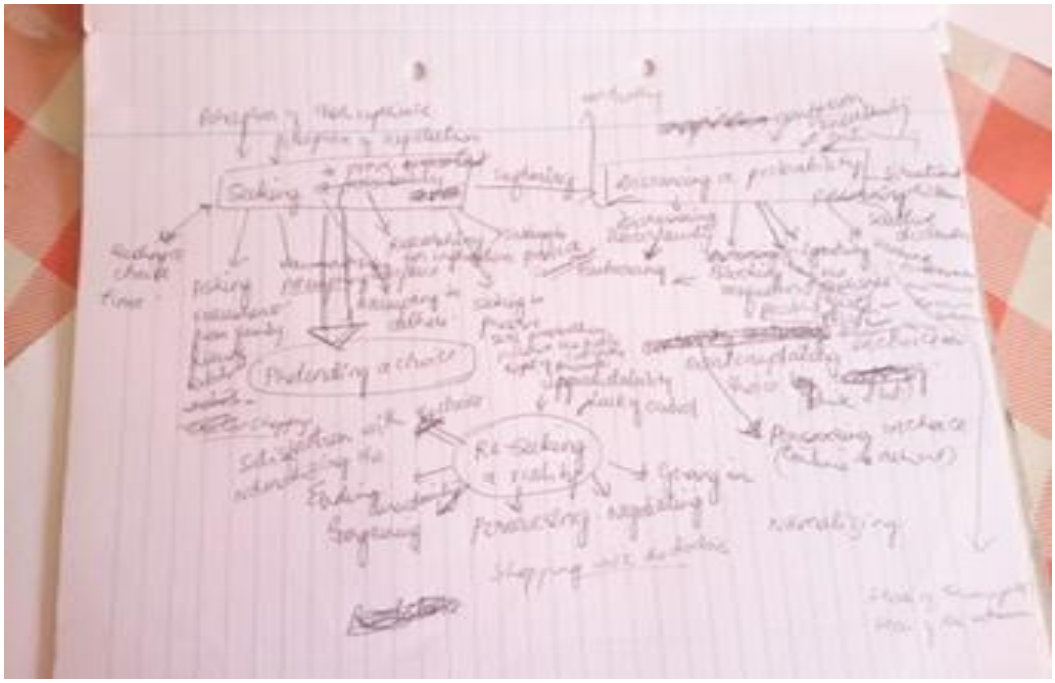
Codes from excerpts of the interview	Initial Coding or line by line coding
'*The information would have come from <u>'me' primarily</u>'. (1)* *'I didn't until after I went into my dating scan. The <u>nurse</u> explained it to me that I did have an option. But I didn't know before that I had an option for a section. Before it was said very briefly, I was asking the <u>midwife</u> more than anyone else that is it when I found out'.* *'First the midwife at my appointment so I was able to read it, but I had read up on it anyway…. but I didn't dwell on it too much too early in the pregnancy. And then I met up with the <u>consultant</u> around April and then she had a chat with me about it and she said <u>that a natural birth would be better for myself and the baby</u>. So, I just decided to <u>have an open mind</u> and see what happens and see do I deliver myself, but I am actually <u>nervous about</u> labour'. (5)* *'Yes, I was given information on it. A few sheets on it – which I never read! (Laughs…). But I would have been looking stuff up online. I am terrible at it. Last time as well my friend said you read anything up on anything! (6)*	Timing of information Source of information-self-informed, nurse, midwife, consultant. Reading leaflet, online. Open mind Not dwelling in the choice Being nervous Alluding to

APPENDIX VIII Memo sorting at the stage of theoretical write up



APPENDIX IX Memos about mental mapping





Appendix X Example of a memo

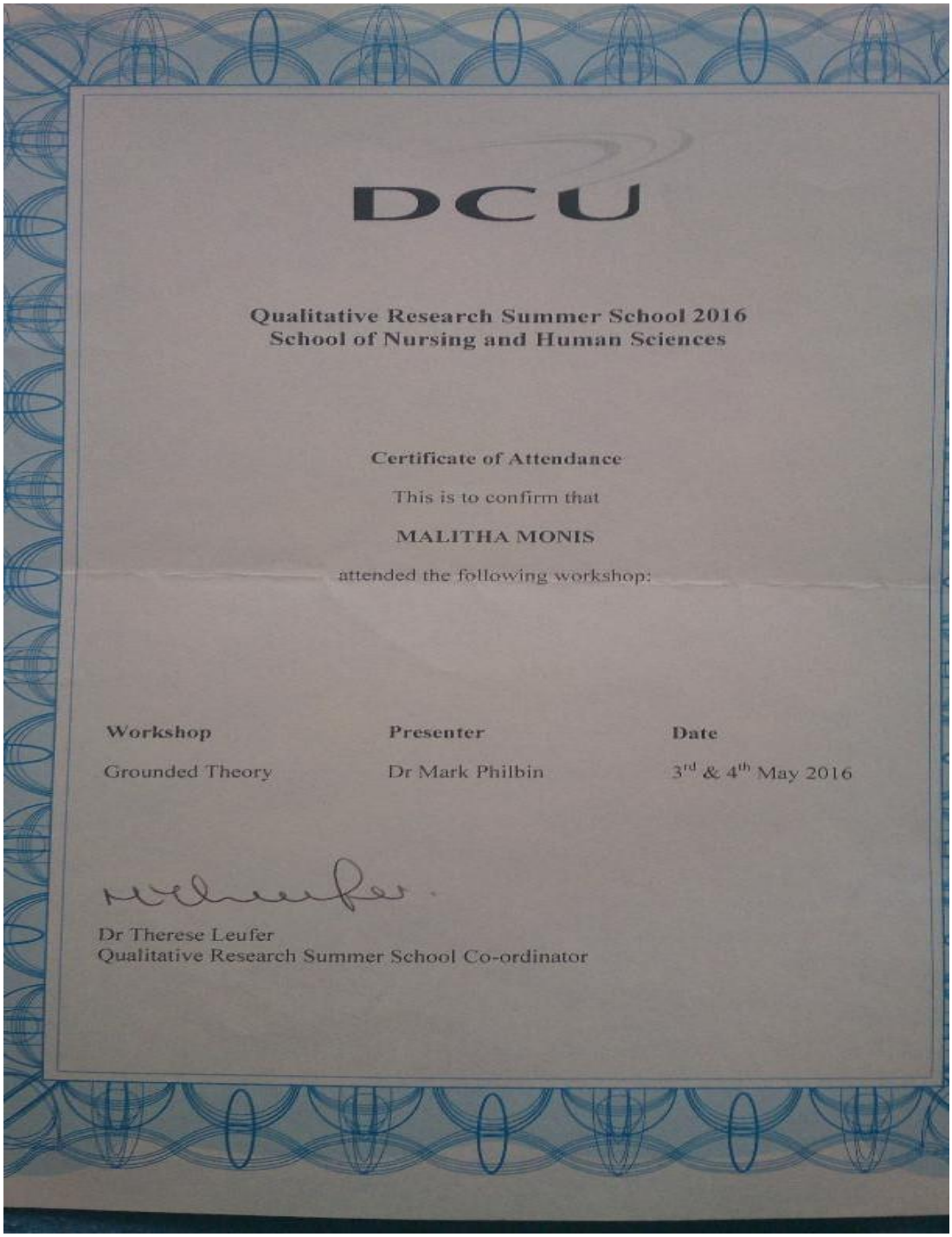
After attending VBAC classes

I think I have to include debriefing into engaging. Engaging included debriefing, clarification, explanation, listening, and supporting. Does this concept go under possibility seeking? Probability distancing? Or reality re-seeking? I think it spreads across all the three. In the beginning women are looking for engagement or involvement in the process. This involvement for some commenced at the stage of debriefing after the previous delivery. They were satisfied when the event was explained to them. Difficulties were clarified and future possibilities explained and offered. Some felt they were not debriefed at all; some were not able to remember as they feel everything was a blur. When they entered this pregnancy, they had their own story. They wanted someone to engage with them by listening to their concerns and this meant a lot for them. Their previous experience of not listening led some for doctor shopping and support navigating. Hence engagement is linked to continuity. Is engaging a theoretical code? Yes, engaging leads to awareness. I think awareness is better theoretical code as it encompasses all the above. Hence awareness needs reciprocal engagement by the professional. This reciprocity is related to the participation by women also. At the end of the pregnancy they needed (seeking) assistance in making a decision by sharing this process with the professional.

Appendix XI Search strategy

Terminology	CINAHL	PubMed	journals@ovid
decision making theory AND healthcare	122	3582	12
decision making theory AND healthcare choices	4	681	2
decision making theory AND women's healthcare choices	3	10	2
previous caesarean section AND decision making AND women's experiences	11	19	1
Decision making and previous Caesarean section.	31	170	13
Birth choices AND women's values	7	26	0
Birth choices AND women's preferences	26	88	0

Appendix XII Attendance at a workshop



DCU

Qualitative Research Summer School 2016
School of Nursing and Human Sciences

Certificate of Attendance

This is to confirm that

MALITHA MONIS

attended the following workshop:

Workshop	Presenter	Date
Grounded Theory	Dr Mark Philbin	3rd & 4th May 2016

Dr Therese Leufer
Qualitative Research Summer School Co-ordinator

Appendix XIII Poster presentation at the national conference

Irish Nurses and Midwives Organisation
Cumann Altraí agus Ban Cabhrach na hÉireann
Working Together

The Whitworth
North Brunswick Street, Dublin 7, D07 NP8H
Tel: 01 864 0600 Fax: 01 861 0460
Email: inmo@inmo.ie

General Secretary
Phil Ní Shaighdha

To whom it may concern:

Please be advised that Ms Malitha Machado entered the All Ireland Midwifery Conference which took place in the Crowne Plaza Hotel in Santry, Dublin 9. Her poster was entitled:

An exploration of women's experiences of their birth choices in pregnancy following a previous caesarean section (CS): a grounded theory study.

If you have any queries, please do not hesitate in contacting me.

With kind regards

Jean Carroll
Section Development Officer

Appendix IV Oral presentation at the local conference

Dear Malitha,

RE: “Delivering excellent healthcare in a globalised world: Challenges and opportunities”

We are pleased to inform you that your abstract has been accepted for an **ORAL 5x5x5 student** presentation at the 18th Annual Nursing & Midwifery Research Conference in the Catherine McAuley School of Nursing & Midwifery, UCC on Thursday the 29th of November 2018.

- **Confirm your availability to present by Monday September 24th the latest**
- **All presenters and attendees must register for FREE at the following link as places are limited:** https://www.eventbrite.ie/e/18th-annual-nursing-midwifery-research-conference-tickets-49885916118
- **The duration of your presentation is 5 minutes**. It is important that you do not exceed the allowed time as this will impact negatively on other presenters
- **Your PowerPoint presentation MUST contain 5 slides only (excluding title slide and references)**
- **Please email me your PowerPoint presentation at least a week before the conference date**
- **Presentation of the prize for best oral presentation will take place at the end of the conference (16:00 hrs)**
-

When the conference programme has been finalised, it will be circulated. We will contact you again with your timeslot.

Looking forward to hearing from you and welcoming you to the conference.

Kind regards,

Dr Mohamad M. Saab
PhD, MSc, PGDipTLHE, BSc, RGN

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MSc Advanced Practice Nursing Coordinator – Year 1
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Appendix V Oral presentation at the inter-national conference

NJF CONGRESS
REYKJAVÍK 2019

Date : 21-12-18
Conference : The 21st Congress of the Nordic Federation of Midwives 2-4 May 2019
Abstract : 122
Title : An exploration of women's experiences of their birth choices in pregnancy following a previous caesarean section (CS): a grounded theory study.

Dear Mrs. Malitha Monis,

On behalf of the Organizing committee:

Thank you for submitting an abstract with the title:
An exploration of women's experiences of their birth choices in pregnancy following a previous caesarean section (CS): a grounded theory study.
for the 21st Congress of the Nordic Federation of Midwives , held in Reykjavik, Iceland, 2-4 May 2019

I have the pleasure of informing you that the scientific committee of the congress has accepted your abstract for **ORAL** presentation.

Oral presentations:

- The length of oral presentations is max. 15 min with questions,
- Please bring your presentation (preferably on a USB flash drive or USB hard drive) and upload it at least 15 min before the beginning of the session. If your graphics or video clips are not embedded in your presentation, please be sure that you bring them as well.
- All session rooms are equipped with a PC.

If you have any questions on this, please contact Imma at
imma@corevkiavik.is

Please note that submission of abstract does not constitute registration to the congress.
We, therefore kindly ask you to register now through the following link, if you have not already done so.

Here you find the registration link, please copy it and paste it to your browser

https://www.njfcongress.is/registration/

Please note that authors of abstracts have the ability to register with the early fee until January 15th through the above link.
If none of the authors of your abstract has registered before Februarty 1st your abstract will not appear in the final program.

For updatates please check the conference web site
https://www.njfcongress.is/

Should you have any questions, please do not hesitate to contact us.

With best regards on behalf of NJF committee,