

**A Phenomenological Study Investigating Women's Experience of Written Birth
Plans in Childbirth.**

**Thesis submitted in partial fulfilment for the requirements of the
Doctorate in Clinical Psychology**

Submitted 26th April 2013

By

Gemma Cox, Trainee Clinical Psychologist

School of Psychology – Clinical Section

University of Leicester

Declaration of Originality

I confirm that this is an original piece of work. The literature review and research report contained within this thesis have not been submitted for any other degree, or to any other institution.

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Thesis Abstract

Title: A Phenomenological Study Investigating Women's Experience of Written Birth Plans in Childbirth.

Author: Gemma Cox, Trainee Clinical Psychologist

Part One: Literature Review

Background: The birth plan was introduced as a means of addressing the medicalisation of childbirth. However there is evidence of conflict existing between patient and caregiver regarding its use. Additionally research has begun to reveal the potential adverse effects of the use of a birth plan and its possible implications. This article aimed to review that evidence.

Method: Five databases were systematically searched and quality was assessed based upon standardised data extraction tools (Peersman, Oliver & Oakley, 1997) and Gough's (2007) Weight of Evidence scale.

Results: Eleven articles met inclusion criteria. A systematic approach was adopted to review the limited robust evidence base and conflicting results were discovered regarding the positive impact of the birth plan upon birth experience.

Conclusions: The review highlighted a dearth of rigorously conducted research in this area. The articles were variable in their quality and in their support of the birth plan facilitating positive birth experiences. Indeed two studies reported that plans may create negative birth experiences. Routine creation of a birth plan may thus be questionable.

Part Two: Research Report

Background: The birth plan is widely utilised and yet the research base is limited in its methodology and equivocal in its findings. Given the potential importance of experiences of childbirth upon the mental and physical well-being of both the mother and child, this research aimed to explore these experiences of birth with specific reference to the use of the birth plan.

Method: Interviews constructed and conducted in accordance with Interpretative Phenomenological Analysis were undertaken with six primiparous women postnatally. Data from verbatim transcripts were then analysed informed by the same phenomenological perspective.

Results: Analysis revealed a number of common and idiographic themes. The super-ordinate themes identified across transcripts were: - narratives that undermine the role of the birth plan, alternative approaches to the written birth plan and knowledge.

Discussion: Some of the phenomenology reported by participants resonated with previous published literature. However the current data presented richer accounts of disadvantages as well as benefits. Clinical implications of these findings are discussed.

Part Three: Critical Appraisal

Reflections on the overall research process, areas of learning and development, methodology issues and limitations of the study are provided.

Acknowledgements

Firstly I wish to thank those women who took precious time out of early motherhood to participate in this research. Secondly I would like to thank my supervisor Dr Noelle Robertson for her vast knowledge, patience and support. Finally I extend thanks to my family, my ever present furry companion Honey who have kept me sane through a diversely challenging period and above all to Garrick, my husband, my rock.

Word Counts

Part One: Literature Review (excluding tables)	7423
References	1120
Part Two: Research Report (excluding tables)	11614
References	1176
Part Three: Critical Appraisal	2639
References	77
Appendices	7180
Mandatory Appendices (E/F/I/J/K)	3620
TOTAL (excluding references/mandatory appendices)	25236

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Part One: Literature Review

How are women's experiences of childbirth affected by birth plans?

A systematic review

1. Abstract

Thesis title: A Phenomenological Study Investigating Women's Experience of Written Birth Plans in Childbirth.

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Introduction – One consequence of the increasing ‘medicalisation’ of birth over the last thirty years has been the evolution of the written birth plan as a means of communicating a woman’s preferences for childbirth. Whilst its use has burgeoned as an intervention considered to promote positive birth experience, to date no systematic reviews have explored its efficacy.

Methods – A review of published literature regarding the use of the pre-generated written birth plan and its impact upon birth experience was carried out in October 2012 and further updated in April 2013 using electronic databases (PsychINFO, Web of Science, Scopus, Google Scholar and Cochrane Library). Based upon specific inclusion and exclusion criteria eleven articles were identified, reviewed, assessed for methodological rigour and the results synthesised.

Results – The review revealed equivocal evidence for the impact of birth plans. It was reported that they can both have a positive affect upon childbirth experience and they are also associated with poorer outcomes when compared with a no birth plan control group. Although meeting inclusion criteria, methodological rigour of the articles was variable with evidence of unexplored confounds frequently manifested.

Conclusions – The written birth plan is well embedded in obstetric care and yet the evidence base to demonstrate its efficacy is limited. More meticulous research is needed with clear operationalisation of the intervention, use of standardised outcome measures and control groups. Controlling for confounding variables also appears essential to truly assess the impact birth plans have on birth experience, why they do not meet expectations, cause resistance and more widely whether indeed this is a key method to facilitate positive birth experiences and remain a foundation of obstetric care.

Keywords: birth plan, childbirth, birth experience

Target Journal: Journal of Reproductive and Infant Psychology

2. Introduction

History

Women have always planned their births (Kitzinger, 2000) and most typically until the mid-twentieth century the baby was delivered at home and involved family and friends. However, with developments in obstetrics, medicalised, hospital-based childbirth became dominant with the doctor as expert in a widely accepted model of optimal birth (Lothian, 2006). As this approach to obstetric care emerged women's experience of childbirth appears to have changed dramatically, arguably becoming a more alien, isolated experience determined by the hospital environment (Lothian, 2006).

The written birth plan, introduced in the late 1970's (Whitford & Hillan, 1998; Yam *et al.*, 2007) appears to have evolved to temper dominance of a medical perspective in which maternity services are constructed, unfamiliar and stress-inducing with potential for negative birth experiences (Kuo *et al.*, 2010). There does not appear to be one universal definition of the birth plan rather it is generally accepted that it was intended to be a written tool (Kuo *et al.*, 2010) which provided women with a means to express their preferences about birth (Moore & Hopper, 1995; Whitford & Hillan, 1998), assert their rights, impart control (Kitzinger, 1992) and communicate this with their caregivers (physician, midwife) to reduce the likelihood of escalating interventions and provide a positive experience of birth (Simkin, 1991, 1992).

However, the 'medicalisation' (Johanson *et al.*, 2002) of childbirth continued to hold sway, with hospitals increasingly the gatekeepers of antenatal education and often as the primary drivers of intervention (Carpenter, 2012). The drive to improve quality and consciousness of managing risk appears to have reified ideas of what constitutes childbirth thus controlling what women would come to understand about how a birth

may proceed. (Ondek, 2000). This appears to have fostered notions of the birth plan as a list of medical procedures rather than a tool for empowering and women.

Purpose of the Birth Plan

Childbirth is an intense event eliciting strong emotions, both positive and negative (Simkin, 1991). Many women experience joy, relief and elation as a result of childbirth, yet conversely around 1.5% (at six months postpartum) according to the studies of Ayers and Pickering (2001) and Wijma et al. (1997), women report symptoms compatible with a diagnosis of Post-Traumatic Stress Disorder (PTSD) in birth's aftermath (Olde *et al.*, 2006). Susceptibility to PTSD may be increased by professionals' non-adherence to an agreed plan (Ayres, 2007) and, in contravening maternal expectations, may adversely affect a couple's relationship and the parent-baby bond (Nicholls & Ayres, 2007). Hodnett (2002) identified specific factors that have an impact upon satisfying birth experiences which are arguably facilitated by a birth plan and are summarised below.

- *Determining personal expectation:* Brown and Lumley (1998) and Simkin (1991, 1992) highlighted the importance of the birth plan in providing women with the opportunity to think about, plan and discuss choices about their birth experience.
- *The amount of support from caregivers & the quality of the caregiver-patient relationship:* The birth plan is intended to be a tool for improving communication between the woman and her caregiver enabling dialogue at every stage of pregnancy and birth rather than merely a record of wishes.
- *Involvement in decision making:* Birth plans can promote informed decision-making and discussion between caregiver and patient. In contemporary society,

especially via the medium of such resources as the internet, from evidence based practice available through the Cochrane Library to 'Netmums' and the NCT (National Childbirth Trust) websites that are readily available for prospective mothers to examine and consider choices.

The Conflict

Despite the apparently empowering objective of the birth plan, tensions appear to have emerged between women and their caregivers about its use (Brown & Lumley, 1998). Key to these tensions are divergent beliefs between women and caregivers about extent of choice, control and the power over birth (Lumley & Astbury, 1980).

Resistance to the use of the birth plan or a sense of distrust between patient and caregiver/s is increasingly documented (Brown & Lumley, 1998) and may be due in part to the ambiguous nature of choice that the birth plan proposes (Moore & Hopper, 1995). Kitzinger (1987) suggests that patients are misled into believing that there is choice when it really is imperceptible.

It may also be associated with an impaired relationship or communication with the caregiver (Berg *et al.*, 2003). Conflict may arise from staff ignoring or disrespecting a plan (Brown & Lumley, 1998) or when rigidity in presented plans and expectations emerge which are sometimes unrealistic given the unpredictable nature of childbirth (Ekeocha & Jackson, 1985; Ford & Ayres, 2009). This may be escalated when coupled with the perception that a presented plan is no better than a list of inflexible demands on staff or a means of governing the 'rules' by the patient (Downe, 2007; Ekeocha & Jackson, 1985; Ford & Ayres, 2009; Moore & Hopper, 1995).

In addition, the discrepancy between the medical model of childbirth as hazardous and 'high-risk...requiring intervention' (Lothian, 2006) and alternative ideas

highlighting the natural birth process, may contribute to distress or magnify ‘incompatible assumptions’ (Moore & Hopper, 1995). The medical view raises women’s awareness that birth is risky which in turn leads to anxiety and confirms the caregiver (specifically obstetrician role), as the all knowing expert (DeVries, 1992; Cartwright & Thomas, 2001) in addition to compounding the notion that hospital is ‘safe’ and ‘[they] will do better there’ (Downe & Gyte, 2007). With this approach, medical interventions are more likely to increase.

Those subscribing to a natural view of birth, highlight the risks of interfering unnecessarily, citing the main goal of obstetric care as achieving a healthy mother and baby with the least intervention (World Health Organisation [WHO], 1996). Arguments for natural delivery are also bolstered by the recommendation to cease attempting to reduce risk by fetal-monitoring, as it can increase the chance of requiring a caesarean section (Cochrane Library, 2005). Within this natural narrative, ‘rigid rules’ regarding labour care are seen as problematic, such that even where strong evidence prevails for a medical intervention, it is based on population evidence that may not capture individual need. In addition, Downe (2007) suggests that the theme of rigidity pertaining to ‘promises’ made regarding the interventions during birth can be problematic.

This clash of belief systems and overriding belief in the expert position can alter the balance of power often disabling a woman’s ability even to question basic medical intervention (Perry 2002). In addition, within our increasingly risk averse society, coupled with the medical or hazardous view of birth, women tend to seek certainty and the physician is in the commanding position to provide this ‘risk management’.

Clinical Implications

The growing popularity of the birth plan in our contemporary consumerist approach to healthcare is widely acknowledged and accepted (Grant *et al.*, 2010). However, there appear to be tensions between health professionals and patients about birth plans which reflect wider debates within perinatal care, most particularly conflicting beliefs about birth (Lothian, 2006). To ensure safe, effective, satisfactory care and address the broader ethical issue of informed consent in an increasingly litigious culture, all parties need to begin to work together with greater cohesion. A collaborative 'working' relationship is necessary to avoid great risk to physical and mental health of both the mother and child (Ayres, 2007). One means of enhancing collaboration is to better understand the effects of birth plans given expressed conflict arising around their implementation.

Aim

The aim of this systematic review is to identify and evaluate the published research literature on the impact for childbearing women of pre-generated birth plans upon birth experiences.

3. Method

A systematic review of the literature examining the impact of explicit use of the pre-generated 'birth plan' upon birth experience was carried out in August 2012 and updated in April 2013 using the main electronic databases (PsychINFO, Web of Science, Scopus, Cochrane library and Google Scholar). The key words used for this search were 'birth plan*' (a summary of searches undertaken can be seen in Appendix A & B). The current review required articles related specifically to 'birth plans' and this appears to be a widely recognised single adjective, as a written tool providing women with a means to express their preferences about birth, widely endorsed by health providers in statutory and non-statutory agencies. Other synonyms for 'birth plan', specifically 'birth support' yielded irrelevant material which did not explore 'birth plans' specifically and were thus discarded. Expanding the search with further keywords ('birth experience/birth satisfaction') generated no additional new and relevant articles. No restrictions on date were set due to the relatively recent emergence of the 'birth plan' in addition to an apparently circumscribed volume of relevant literature available. The titles and abstracts were initially scanned for relevancy, duplicates removed and then scrutinised in relation to the following specific inclusion and exclusion criteria (which initially generated six papers). A PRISMA flowchart outlines this process (Moher *et al.*, 2009 [Appendix A]).

Inclusion Criteria: Studies could be incorporated in the review if they examined (i) participants who were adult women of reproductive age, (ii) who had prepared a birth plan in advance of delivery, (iii) the effect of the written birth plan on the overall birth experience satisfaction, were published in the English language.

Exclusion Criteria: Searches were limited to peer-reviewed journal articles written in English, relating to human adults. Books, theoretical and opinion papers, theoretical and purely discursive pieces were excluded. Papers examining the solely biomedical outcomes of birth plans were also excluded, as were articles which sounded applicable but on detailed reading were inexplicit in their use of a written birth plan. Although techniques for including and synthesising qualitative data remain undeveloped given the complexity of integrating conflicting epistemological positions (Dixon-Woods *et al.*, 2001), qualitative studies were also included as they provided breadth to the literature base available for review and were synthesised guided by Dixon-Woods *et al.* (2001), Harden (2010) and Sutcliffe *et al.* (2011).

The reference sections of the initial six relevant articles were then hand-searched revealing five further studies which met inclusion criteria and was thus incorporated (Brown & Lumley, 1998; Ekeocha, 1985; Moore & Hopper 1995; Sham *et al.*, 2007; Whitford & Hillan, 1998).

Systematic scrutiny of each of the final eleven eligible articles was undertaken based upon standardised data extraction and quality assessment criteria (Peersman *et al.*, 1997; Gough, 2007; Yardley, 2000), in which each quantitative article was appraised on the aims, methodology, sampling methods, participants and sample sizes; control groups used (where appropriate); and reliability/validity of the results, transparency of write up and limitations (Appendix B, C & D). Gough's (2007) transparent 'Weight of Evidence' scale involved assessing four quality elements: -

1. *Weight of Evidence A* – the coherence and integrity of the evidence
2. *Weight of Evidence B* – the appropriate nature of the design used
3. *Weight of Evidence C* – the appropriate nature of the research focus for answering the review question

4. *Weight of Evidence D* – the overall assessment of the study based on judgements in weight of evidence (subscales 1-3).

Based upon the weight of evidence judgements, each study was then assigned a quality rating of ‘strong’, ‘promising’, ‘weak’ (see table 1; Appendix D) which highlighted both overall quality and relevance of the study to answering the research question. In addition Yardley’s (2000) framework guided the quality assessment of the qualitative studies. This emphasises assessing four elements: -

1. *Sensitivity to context* - theoretical; relevant literature inclusion; data; socio-cultural backdrop; participant perspective; ethical concerns.
2. *Commitment and rigour* - in-depth engagement with subject; methodological competency; systematic data collection; depth & breadth of analysis.
3. *Transparency and coherence* - lucidity and power of description and/or argument; transparency with methods/data presentation; ‘fit’ between theory and method: reflexivity.
4. *Impact and importance* - theory (enriching knowledge); socio-cultural; practice (for policy makers, community, health workers).

4. Results

1. Overview of selected articles

Eleven articles were found to meet the selection criteria and were included in the critical review (summaries of reviewed articles limitations can be found in Table 1, Appendix D). Each examined the effects of a pre-generated written birth plan upon birth experience. The ‘birth plan’ was operationalised in the *introduction*. A number of descriptive factors effecting the nature of childbirth experience (overall enhanced birth experience; choice, control and knowledge; communication; relationship with caregiver; overall poorer birth experience; expectations and false hope) were frequently reported across the articles selected, which in addition to the critique of the studies methodologies, will form the structure of this review.

Key characteristics of the studies focused upon in this results section are summarised in Table 2. Each study was provided with an ID code from one to eleven (for references and ID codes see Appendix D/Table 1). The eleven studies were conducted in seven countries; two in the UK, three in Australia, two in Sweden and one each in Taiwan, USA, Hong Kong and Mexico.

Article/Year	Country	Sample	Outcome Measures	Design
1. Kuo <i>et al.</i> , 2010	Taiwan	330 (n=296) women	Childbirth expectations questionnaire, childbirth expectations fulfilment questionnaire, childbirth control scale, childbirth experience questionnaire.	RCT
2. Whitford <i>et al.</i> , 1998	UK	143(n=101) responders	Unnamed questionnaire adapted/added to from a previously validated tool used in other studies.	Case-controlled survey
3. Berg <i>et al.</i> , 2003	Sweden	n=542 women	Pre and post questionnaires constructed for the study.	Case-controlled survey. Quasi-experimental
4. Ekeocha <i>et al.</i> , 1985	UK	'First 100 English speaking patients who gave birth after completing a birth plan'	Post questionnaire constructed for the study.	Case-controlled survey
5. Brown <i>et al.</i> , 1998	Australia	n=1366 (62.5%) responders	Post questionnaire constructed for the study.	Case-controlled survey
6. Lundgren <i>et al.</i> , 2003	Sweden	n=542 women	Pre and post questionnaires constructed for the study.	Case-controlled survey. Quasi-experimental.
7. Grant <i>et al.</i> , 2010	USA	n=113 health care providers & n=103 women/patients	Unclear whether survey used was constructed for the study. Content explained incompletely.	Cross-sectional Survey
8. Moore <i>et al.</i> , 1995	Australia	100 women	Unclear whether survey used was constructed for the study. Content explained incompletely.	Case-controlled survey

Article/Year	Country	Sample	Data Collection Method	Design
9. Peart, 2004	Australia	42 women	Questionnaire & interview	Qualitative - Interview
10. Sham <i>et al.</i> , 2007	Hong Kong	68 women	Focus group interview	Qualitative – Focus group interview
11. Yam <i>et al.</i> , 2007	Mexico	13 women, 5 professionals	Interview	Qualitative - Interview

Table 2. Key characteristics of papers reviewed (See Appendix D for further methodological limitations)

Article	Control Group	Response Rate	Postnatal/Inpatient Hospital Based or Postal Survey	Demographic Data: - 1. Age; 2. Parity; 3. SES or occupation
1	Yes	93.7% expt. group; 85.5% controls. Total 296.	In situ: – 1 day postnatally.	1. Mean age: - Expt. group 29.01; control group 28.69. 2. 100% primiparous (controlled for). 3. 68.4 & 76.6% have ‘an occupation’.
2	No (compared responders to non-responders)	71%/101.	Postal: – 6-13 weeks postnatally.	1. Responders 25-29 36% (majority); non-responders 20-24 39% (majority). 2. 100% primiparous (controlled for). 3. Not reported.

3	Yes	98% expt. group; 91.4% controls.	In situ: - within 1 week postnatally.	1. Mean age: - Expt. group NPNC 29.67, CPNC 9.96, NPCC 31.33, CPCC 34.42; Control group NPNC 29.92, CPNC 30.88, NPCC 36.23, CPCC 33.74. 2. Expt. group NPNC 58, CPNC 26, NPCC 40, CPCC 7; Control group NPNC 61, CPNC 30, NPCC 33, CPCC 7. 3. Not reported.
4	No	'First 100 English speaking patients who gave birth after completing a birth plan', 100%.	In situ: - < 48 hours postnatally.	1. Mean age: - primiparous 25.1 (18-36); multiparous 28.5 (19-42). 2. 56% primiparous, 44% multiparous. 3. Not reported.
5	No (compared responders to non responders)	62.5%, 1336/2138.	Postal: - 6-7 months postnatally.	1. Expt. group 25-29yrs 39.2% (majority); Control group 30-34yrs 40.1% (majority). 2. Expt. group: - primiparous 132, multiparous 134; Control group: - primiparous 378, multiparous 681. 3. Not reported.
6	Yes	98% expt. group; 91.4% controls.	In situ: - <1 week postnatally.	1. Mean age: - expt. group 30.4, control group 31.9. 2. Expt. group: - primiparous 48.3%, multiparous 51.7%; control group: - primiparous 48.3%, multiparous 51.3%. 3. 'Salaried employee, higher & middle level': - expt. group 39.9%, control group 41.7% (majorities).
7	No (compared patient and medical staff)	82.4%, 103/125 health care providers & 90.4%, 113/125 patients (power reported).	In situ: - postnatal timeframe not specified.	1. Not reported. 2. Primiparous 42.9%, multiparous 57.1%. 3. 21/113 medically employed (no further breakdown).

8	No	98%, 100/102.	In situ: -2-3 days postnatally.	1. 20-29 82% (majority). 2. 66% primiparous. 3. Not reported.
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Article	Comparative Group	Response Rate	Postnatal/Inpatient Hospital Based or Postal Survey	Demographic Data: - 1. Age; 2. Parity; 3. SES or occupation
9	Yes (written, verbal & no BP choices investigated)	35% 42/120 questionnaires distributed completed & interviewed.	Questionnaires – distributed by recruited professionals postnatally. Interviews - at home between 6 weeks-6 months postnatally.	1. Collated but not reported. 2. Primiparous. 3. Collated but not reported.
10	No	68 volunteers.	Focus group interviews – conducted at care facility, 6 weeks postnatally.	1. 89.7% 19-34, 10.3% ≥35. 2. Primiparous. 3. Household income reported – 41.2% 10 0001-20 000 HK\$ (majority).
11	Yes	9 volunteers with BP; 4 without BP. 5 caregivers.	Interviews conducted at care facility, 1 week-1 year postnatally.	1. 18-40 years. 2. Multiparous 3. Not reported.

Table 2 continued. Control groups, survey method, response rate & demographic data of papers reviewed

NPNC – normal pregnancy, normal childbirth

CPNC – complicated pregnancy, normal childbirth

NPCC – normal pregnancy, complicated childbirth

CPCC – complicated pregnancy, complicated childbirth

SES – socio-economic status

2. Sample

The sample size varied greatly from 100 participants in three studies (Ekeocha & Jackson, 1985; Moore & Hopper, 1995; Whitford & Hillan, 1998) to 1376 (Brown & Lumley, 1998). *A priori* power calculations were only reported in the RCT (Kuo *et al.*, 2010) and in one of the surveys (Grant *et al.*, 2010). The sample size in the three qualitative studies (Peart, 2004; Sham *et al.*, 2007; Yam *et al.*, 2007) ranged from 18-68. Caution should therefore be exercised when evaluating the results and subsequent conclusions, as generalisability to the population may have been compromised. Indeed broadly speaking qualitative studies do not assume generalisability.

Although extent varied, all articles provided some data on demographic characteristics of their participants. Table 2 summarises reported age, parity and socioeconomic status (SES). Parity was consistently reported in each study although as a possible confounding variable, was only controlled for in two studies (Kuo *et al.*, 2010; Whitford & Hillan, 1998). However parity variation was noted in all studies and in five no differences between primiparous and multiparous patients were observed (Berg *et al.*, 2003; Brown & Lumley, 1998; Grant *et al.*, 2010; Lundgren *et al.*, 2003; Moore & Hopper, 1995). All but two (Grant *et al.*, 2010; Peart 2004) reported age via an overall mean score or age-category percentage. In the three studies (Kuo *et al.*, 2010; Grant *et al.*, 2010; Lundgren *et al.*, 2003) which reported SES or occupation, those with higher SES appeared overrepresented in relation to the general population. The RCT (Kuo *et al.*, 2010) appeared to be the most systematic in terms of reporting the following variables age, education, occupation, income, planned pregnancy and no significant differences were observed between the experimental and control groups. The use of control groups in other studies was variable; there were two who employed a control group to provide a comparative framework (Berg *et al.*, 2003; Lundgren *et al.*,

2003) and there were five that did not (Brown & Lumley, 1998; Ekeocha & Jackson, 1985; Grant *et al.*, 2010; Moore & Hopper, 1995; Whitford & Hillan, 1998). Therefore again prudence should be exercised where the sample is not adequately discussed since representative samples may not been investigated.

Response rate to birth experience questionnaires was variable (see Table 2), the lowest quantitative study 62.5% (1336/2138; Brown & Lumley, 1998) to the largest 100% (Ekeocha & Jackson, 1985); although the latter should be viewed with some caution due to the nature of the data collection ('the first 100 women, 48 hours postnatally approached in hospital') which is discussed further in the *procedure* subsection below. Whitford & Hillan (1998) compared responders and non-responders and found the former were significantly younger ($X^2=15.12$, $df=3$, $p=0.0017$) and lived in less deprived areas ($X^2=17.40$, $df=6$, $p=0.0078$). Furthermore some studies may have been affected by the method of questionnaire dissemination; postal distribution eliciting fewer responses and susceptible to self-selection bias (Brown & Lumley, 1998; Peart, 2004; Whitford & Hillan, 1998; see table 2). Many studies had a response rate in excess 80% although as alluded to, power calculations confirming sample size requirement were not conducted in the majority of studies suggesting a less robust approach to recruitment.

3. *Procedure*

All quantitative studies utilised either a case-controlled/cross-sectional survey or RCT design in which to assess the impact of the pre-generated 'birth plan' upon birth experience (see Table 2). Typically the studies all used questionnaires to collect their data which have been discussed in further detail below in the *measures* section. The qualitative studies employed interview or focus group design to collate the majority of

their data yet although all three studies transcribed and coded the data, it was not made explicit as to the method these studies drew upon to analyse their results. In addition transparency regarding reflexivity was also limited in all three studies. A minority of the studies used control groups to compare their data (Berg *et al.*, 2003; Kuo *et al.*, 2010; Lundgren *et al.*, 2003). Other studies examined professional versus patient evaluations (Grant *et al.*, 2010), respondents with and without birth plans (Brown & Lumley, 1998; Whitford & Hillan, 1998), both of these factors (Yam *et al.* 2007), written/verbal or no birth plan (Peart, 2004) or had no point of comparison (Ekeocha & Jackson, 1985; Moore & Hopper, 1995; Sham *et al.* 2007; Table 2).

Procedural limitations were identified in all studies. Ekeocha and Jackson's (1985) data collection from the first 100 women who had completed a birth plan, 48 hours postnatally in hospital risked prominence of the 'halo effect' (the instant relief experienced by mothers after childbirth coupled with the fascination they have for their child which extends for a couple of weeks, typically overriding any negative issues in the short term; Simkin, 2006). This may create a barrier to accurate recall of experience so close to birth. This 'halo effect' was also evident in other studies in which questionnaires (Berg *et al.*, 2003, Ekeocha & Jackson, 1985; Kuo *et al.*, 2010; Lundgren *et al.*, 2003; Moore & Hopper, 1995) or interviews (Yam *et al.*, 2007) were administered temporally close to childbirth. Furthermore answers given to questionnaires filled out similarly so close to birth may have been affected by acquiescence given participants remained on wards and/or were amongst their caregivers potentially creating a confounding effect (Berg *et al.*, 2003; Ekeocha & Jackson, 1985; Grant *et al.*, 2010; Lundgren *et al.*, 2003; Moore & Hopper, 1995; Sham *et al.*, 2007; Yam *et al.*, 2007). Later administration of questionnaires six months postnatally (Brown & Lumley, 1998) may also confer recall bias and interference either

from external influences or maturation effects occurring internally as a result of the passage of time. One of the studies was opaque regarding time of post-natal survey administration (Grant *et al.*, 2010).

Even within the most robust design of the RCT (Kuo *et al.*, 2010) three obstetricians who were approached to participate in the study refused to take part stating that the process was ‘too tedious and complex’ and that they ‘did not have the time to communicate with the pregnant women’. It therefore seems likely that a positively disposed sample was employed which may have affected the care received, the birth experience of the women involved and thus bias the results.

4. Measures

The majority of studies utilised questionnaires or interview schedules constructed specifically for each piece of research. Although useful to create a means by which to obtain the specificity of data required for any given study, validity and reliability arguably may be compromised.

The following domains which have been most commonly identified and discussed in relation to the outcome of birth experience, in the eight studies are: *overall enhanced birth experience* (with specific reference to *control, choice & knowledge; communication, relationship with caregiver*) and *overall poorer birth experience* (with specific reference to *expectations & false hope*) and will be considered further below.

Studies varied in the robustness and rigour of the analysis they conducted. Typically the RCT (Kuo *et al.* 2010) produced inferential statistical analysis to compare the data generated for the experimental and control groups regarding the standardised instruments they used. There is some doubt about the cultural sensitivity of these

questionnaires and thus reliability and validity. Six further studies (Berg *et al.*, 2003; Brown & Lumley, 1998; Grant *et al.*, 2010; Lundgren *et al.*, 2003; Moore & Hopper, 1995; Whitford & Hillan, 1998) employed primarily descriptive statistics which are arguably less robust and some inferential statistics to report results, the remaining quantitative studies used descriptive statistics only. All qualitative studies similarly lacked a transparency with regard to the analysis undertaken although it can be surmised that a basic thematic approach was adopted. The following section will reflect these factors.

5. Overall Enhanced Birth Experience

The pre-generated birth plan has been identified as ‘helpful’ with regard to overall birth experience by eight of the studies (Brown & Lumley, 1998; Ekeocha & Jackson, 1985; Kuo *et al.*, 2010; Moore & Hopper, 1995; Peart, 2004; Sham *et al.*, 2007; Whitford & Hillan, 1998; Yam *et al.* 2007).

Kuo *et al.* (2010) found a significant difference between women in the intervention group and those in the control group in terms of childbirth experiences ($t=2.48$, $p=0.01$) and in post-natal level of fulfilment of childbirth expectations ($t=2.63$, $p=0.01$) suggesting that those with a birth plan had a higher degree of positive childbirth experiences. However as noted above, this Taiwanese study acknowledged this ‘new’ approach to childbirth is markedly different from a more passive role of the pregnant woman that may have once been the norm.

Six studies (Brown & Lumley, 1998; Ekeocha & Jackson, 1985; Moore & Hopper, 1995; Peart, 2004; Sham *et al.*, 2007; Yam *et al.*, 2007) found that writing a birth plan had been a ‘helpful’ process for women. In Ekeocha and Jackson’s (1985) study, when asked to describe their feelings regarding the plan, 79% participants circled

that it was helpful. 'Helpful' was however one of six forced choice answers, of only six questions in totality. Little further explanation and range or depth of response was possible, limiting access to a full account of participant experience. Similarly Sham *et al.* (2007) found that a number of women believed that the birth plan was helpful as it proved to be a guideline or reminder of their plan for care during labour in addition to providing them with a means of preparing themselves. Although Sham *et al.* (2007) reported only positive narratives from their data, the birth plan appeared culturally less commonplace and the authors suggest that generally perception of 'empowerment and autonomy' was historically limited.

Similarly Moore and Hopper (1995) reported that being 'helpful/good' was one of the reasons why 95% women would recommend the birth plan to others potentially encouraging them to ask questions and for help. However, they recognised that choices were restricted in set format questionnaires and that women may have acquiesced as they were still in hospital.

Yam *et al.* (2007) suggested all participants positively constructed a birth plan and were subsequently satisfied with its use. None of the women anticipated any major disadvantages. Yet, as with Sham's (2007) study interpretative caution is warranted due to the 'novel' introduction of the plan and the authors' acknowledgment of a more passive patient role in the developing world.

However both Brown and Lumley (1998) and Peart (2004) found a smaller percentage (50% of the 270 women who had completed a birth plan & 40% respectively), found it 'helpful'. Of the 40% in Pearts (2004) study, only 19% would make a written plan next time although both a host of different plans (hospital and 'own plans') were employed making comparison challenging. In Browns (1998) study although not an overwhelmingly positive response, of the other 50% of the sample only

a further 5.1% said it was unhelpful, 40% said neither helpful nor unhelpful, and 4.9% were unsure. Indeed two thirds of those women with a birth plan believed that there were advantages of writing their thoughts and wishes down. In addition it cannot be surmised that data is representative as of the 62.5% responders overall only 20% of those individuals had a birth plan.

Two further studies reported the birth plan had been ‘helpful’ (Moore & Hopper, 1995; Whitford & Hillan, 1998) and found that 76% and 95% of their participants respectively would make another plan in the future. However Whitford and Hillan’s (1998) results should be regarded with caution as they acknowledged that clarity had not been sought from participants regarding their understanding of what constituted a birth plan.

5.1 Control, Choice and Knowledge

Ten studies (excluding Grant *et al.*, 2010) identified that control, choice and/or knowledge contributed to positive childbirth experiences.

Kuo *et al.* (2010) reported that there was a significant difference between the experimental group and controls with regard to childbirth control suggesting that women with a birth plan had higher perceived levels of control ($t=9.60$, $p<0.001$). However the *childbirth control scale* utilised had been translated possibly affecting the reliability of the observed results. This supposition is supported by Peart (2004) although she highlights that having control was a confusing concept as they were simultaneously expected to remain ‘open minded’. Indeed Brown and Lumley (1998) found that 21% of women with a birth plan, said that of the ‘advantages’ alluded to in the previous section, considering their options before labour began, was a benefit as explanations had already taken place. Similarly Moore and Hopper (1995) found that

93% of women reported that having the birth plan improved their knowledge and the choices available which both prepared them and avoided the need to make any decisions when in pain or under stress. Furthermore Sham *et al.* (2007) reported that a number of women believed that the birth plan enriches knowledge of the process and provided choice although there may be some doubt regarding the consistency of reliable data translation.

Interestingly Yam *et al.* (2007) reported that it was the practitioners interviewed who highlighted the benefit of the birth plan in providing women with choices. Although they were onto emphasise that both the mothers and practitioners alluded to the notion that completing the plan was an informative process. However with such small numbers interviewed conclusive conclusions cannot be assumed.

Conversely Whitford and Hillan (1998) found that although women with a birth plan felt that they had an improved understanding of the choices involved in childbirth, 50% said it made no difference to the amount of control they perceived themselves as having during labour, a finding supported by both Berg *et al.* (2003) and Lundgren *et al.* (2003). This was likely to be compounded by the fact that women felt that their caregiver paid little attention to the plan during labour thus creating apathy as the plan rendered itself futile.

5.2 Communication

Eight studies (Brown & Lumley, 1998; Ekeocha & Jackson, 1985; Lundgren *et al.*, 2003; Moore & Hopper, 1995; Peart, 2004; Sham *et al.* 2007; Whitford & Hillan, 1998; Yam *et al.*, 2007) disclosed that improved communication with caregivers as a result of the birth plan contributed to positive childbirth experience.

From comments made in the open questions Whitford and Hillan (1998) reported that ‘a number of women’ said that communication was enhanced due to the use of the birth plan suggesting that the plan opens channels of communication particularly with midwives although comparisons could not be made with a control sample. Indeed, communication may be first-rate at the hospital sampled, regardless of any birth plan. In addition it is difficult to assess quality of the data as the reader is not made aware of the questions asked, depth of full responses, volume of answers attained.

Similarly Sham *et al.* (2007) found that a number of women reported that the birth plan enhances the communication between women and midwives Furthermore Ekeocha and Jackson (1985) noted that one benefit of the birth plan was that it enabled a ‘proper discussion’ of procedures to be undertaken ahead of the birth facilitating communication in the labour if not going ‘to plan’. This sentiment is echoed in Brown and Lumley’s (1998) study who found 21% participants reported that the plan presented the options to the individual before labour and 27% reported that this typically facilitated communication during labour.

Moore and Hopper (1995) reported that although 33% of women were not encouraged to ask questions of their caregivers, 92% were able to ‘express their needs and preferences’ and 89% felt that having a plan ‘made it easier for them to express their needs and preferences during labour’ and that staff listened to their needs and desires conceivably forging a positive birth experience. Similarly the 95% of women in Pearts study (2004) that had either a written or verbal birth plan suggested that it was useful to articulate a plan of care for their childbirth experience.

Yam *et al.* (2007) reported that women without a birth plan anticipated that they may positively influence practitioner interaction with their patients, in terms of a more connected and informative relationship.

Conversely Lundgren *et al.* (2003) reported that there were significant differences between experimental and control groups, with regard to listening and paying attention to needs/desires in which women with a birth plan scored significantly lower ($p=0.016$) suggesting that less attention was paid to the experimental group potentially creating a poorer experience and thus negative emotional affect.

5.3 Relationship with Caregiver

Cited by Kitzinger (1983) as a primary objective of the birth plan to focus the relationship between mother and caregiver, two studies (Berg *et al.*, 2003; Lundgren *et al.*, 2003) found that the quality of relationship an individual had with the caregiver affected childbirth experience.

Berg *et al.* (2003) reported that although there were some differences between ‘normal’ and ‘complicated’ childbirth subgroups (see Table 2 for subcategories), overall groups with *and* without a birth plan generally had high ratings ($>68.4\%$) regarding trust and being listened to by their caregivers, however no statistical analysis for overall experimental and control groups were reported in order to appraise significance. By contrast Lundgren *et al.* (2003) discovered differences between women with a birth plan who reported lower perceived support and guidance provided by their caregivers compared to controls (to the $p=.016$, $p=.007$ respectively) in spite of reportedly overall high scores to questions pertaining to the relationship with their caregiver. This former point may be associated with higher expectations as a result of writing the birth plan and the latter is possibly due to the caregiver’s skill in engaging with women regardless of the presence of a birth plan.

6. Poorer or Equivalent Birth Experience

Two studies revealed that the impact of the pre-generated birth plan upon overall positive birth experience was poor (Berg *et al.*, 2003; Grant *et al.*, 2010) and two studies found no statistically significant differences between groups regarding overall experience or rating of care (Lundgren *et al.*, 2003; Brown & Lumley, 1998). It is important to note that three compared women with and without a birth plan (Berg *et al.*, 2003; Brown & Lumley, 1998; Lundgren *et al.*, 2003) and the other (Grant *et al.*, 2010) contrasted patients with caregivers' attitudes to childbirth. One further study (Peart, 2004) found that the birth plan had little influence over participants pregnancy and birthing experience, that fault of abandoned wishes was typically personalised by women and the nearly 50% of the opportunity sample had chosen to pursue verbal birth plans, preferring a more flexible means to plan an unpredictable event, that the plans were perceived to often be disregarded by professionals.

Of the three studies that compared women with and without a birth plan, one found that in two of the four subgroups (NPCC/CPNC; see Table 2 for subcategories) women with a birth plan scored significantly lower with regard to overall positive experience (to the $p=.004$, $p=.016$ levels respectively; Berg *et al.*, 2003). The second reported no significant differences between the standard and intervention group with regard to total experience (Lundgren *et al.* 2003), echoed by the results of the third study when rating overall care (Brown & Lumley, 1998). Comparing similar groups regarding one variable is likely to be a more rigorous method than comparing two divergent groups (Grant *et al.*, 2010) in which a host of confounding variables may be operating.

Grant *et al.* (2010) examined the differences between caregiver and patient attitudes to childbirth, reporting significant differences between these attitudes about

birth plans; 65% vs. 2.5% respectively stated that having a birth plan created overall worse outcomes (inclusive of obstetric results; $p < .001$). However these results must be viewed with caution as no control group was utilised to compare either patients or caregivers biasing the reported results.

6.1 Expectations and False Hope (Uncertainty of Childbirth)

Seven studies (Berg *et al.*, 2003; Brown & Lumley, 1998; Lundgren *et al.*, 2003; Moore & Hopper, 1995; Peart 2004; Whitford & Hillan, 1998; Yam *et al.*, 2007) identified two more specific contributors to negative childbirth experience as expectation and false hope, compounded by the unpredictable nature of childbirth.

Kuo *et al.* (2010) found that although there were no significant differences between the experimental and control groups regarding pre-natal expectations there were on the overall post-natal level of fulfilment of childbirth expectations ($t=2.63$, $p=.01$) which may be due to the act of writing the birth plan, stimulating ideas and expectations.

Indeed, Whitford and Hillan (1998) reported that many women were realistic about the limitations of writing a birth plan in advance and were critical of a process giving ‘false hope’ to an unpredictable situation. This is further supported by the fact that for 60% of women their birth plans were at best only partly followed and at worse that labour did not follow the plan although reportedly 67% said that they were either ‘quite happy’ or ‘not bothered’ about this. Similarly, Brown and Lumley (1998) supported the notion that birth is unpredictable and 10% of women said the birth plan was limited as it could not reflect the range of birth outcomes.

Furthermore Moore and Hopper (1995) found that the reasons that 5% of women who would not recommend a birth plan to others, were that birth was

unpredictable, was unlikely to go as expected and in creating a birth plan one is setting oneself up to fail.

Unpredictability was the reason why 5% of Pearts (2004) participants chose not complete a birth plan. Indeed they found that 50% of those women who had planned their birth suggested that the birth plan was unhelpful, limiting the ability to make useful choices and potentially disregarded by professionals in any case. Indeed ‘some’ of the 43% women who had chosen to use a verbal birth plan did not want to be ‘locked into a defined range of options’ which may leave them feeling like a failure if unpredictable events had transpired. Similarly Yam *et al.* (2007) found that two participants without a birth plan suggested that although the written plan was beneficial it should be personal choice and that ‘things may not always go as planned’.

5. Discussion

Since its inception, the birth plan's efficacy has generated interest and subsequent investigation. Therefore the aim of this review was to appraise the eight studies identified which fitted inclusion criteria, addressing the lack of systematic reviews in the literature, with reference to the impact of pre-generated birth plans upon birth experience.

Methodological quality of the studies was variable, limited and utilising Gough's (2007) framework typically 'poor' or 'promising' categories of study were revealed. Despite the increasing volume of literature only one RCT exists. Studies typically employed questionnaires or interviews to collect information regarding the impact of the birth plan but only one of the eleven used standardised measures (Kuo *et al.* 2010). All other studies created/adapted their own measures with attendant flaws noted earlier.

Other limitations commonly identified were a lack of control or comparative groups (Brown & Lumley, 1998; Ekeocha & Jackson, 1985; Grant *et al.*, 2010; Moore & Hopper, 1995; Whitford & Hillan, 1998; Sham *et al.*, 2007) and failure to consider the 'halo effect' which may have had impact upon accurate recall of experiences so close to birth (Berg *et al.* 2003; Ekeocha & Jackson, 1985; Kuo *et al.* 2010; Lundgren *et al.* 2003; Moore & Hopper, 1995; Yam *et al.*, 2007). Other methodological weaknesses included surveys or interview limits, specifically acquiescence which was particularly problematic when mothers were approached to complete questionnaires whilst still at the care facility (Berg *et al.*, 2003; Ekeocha & Jackson, 1985; Grant *et al.*, 2010; Kuo *et al.* 2010; Lundgren *et al.*, 2003; Moore & Hopper, 1995; Sham *et al.*, 2007, Yam *et al.*, 2007) and the 'Hawthorne effect' (Berg *et al.*, 2003; Brown & Lumley, 1998; Ekeocha & Jackson, 1985; Kuo *et al.* 2010; Lundgren *et al.* 2003; Moore & Hopper, 1995). This

‘Hawthorne effect’ (Barker *et al.*, 2002), a form of reactivity whereby the caregivers possibly changed or enhanced their behaviour in response to the fact that they were involved in the study, initially identified in the RCT and similarly in Yam *et al.*’s (2007) study, is likely to be due to the supplementary training which participating nurses received, and in addition to the use of the birth plan, the experimental group also received superior, extended and continued care similar to. Other studies may have been similarly affected by increased staff awareness due to the introduction of a new procedure (birth plan; Moore & Hopper, 1995; Sham *et al.*, 2007), where the staff involved were either simply aware of the research even though no change was made to standard care provision (Berg *et al.*, 2003; Ekeocha & Jackson, 1985) or were actively involved in data collection (Brown & Lumley, 1998; Lundgren *et al.* 2003; Yam *et al.*, 2007).

Finally, confounders regarding representative sample groups may have been operating; parity only being controlled for in two studies (Kuo *et al.*, 2010; Whitford & Hillan, 1998).

The limited rigour echoes the studies’ variable and arguably ambiguous results. Ekeocha and Jackson (1985), Kuo *et al.* (2010), Moore and Hopper (1995) and Whitford and Hillan (1998), Sham *et al.* (2007) and Yam *et al.*, (2007) demonstrated overall that the birth plan was a ‘helpful’ document and facilitated positive childbirth experience. Furthermore, studies identified that it could promote a sense of control, choice and/or knowledge (with the exception of Grant *et al.*, 2010), communication (Brown & Lumley, 1998; Ekeocha & Jackson, 1985; Lundgren *et al.*, 2003; Moore & Hopper, 1995; Peart, 2004; Sham *et al.*, 2007; Whitford & Hillan, 1998; Yam *et al.*, 2007) and the relationship with the caregiver/s (Berg *et al.*, 2003; Lundgren *et al.*, 2003). However, there was some contradiction; the majority of reports stating that

although overall birth plans were seen to be beneficial, 67% whose birth plan was not followed were 'happy' or 'not bothered' (Whitford & Hillan, 1998) or indeed stated that participants had 'no strong views' (Ekeocha & Jackson, 1985) in relation to birth interventions, which undermines the rationale of the plan.

Conversely Berg *et al.* (2003) and Grant *et al.* (2010) found that birth plans did not improve overall birth experience, indeed they appeared to engender a less satisfying experience compared to individuals without a plan. Grant *et al.* (2010) compared the views of professionals and patients and demonstrated marked disparity between them, the former markedly less in favour of the plan compared to the latter and the belief that patients with birth plans had overall worse obstetric outcomes.

Brown and Lumley (1998) and Lundgren *et al.* (2003) reported that there were no significant differences between those with and without a plan. Brown and Lumley (1998) found that although women who made use of a birth plan were more likely to be satisfied with pain relief, that overall they did not differ from those without a plan in terms of their total rating of intrapartum care, or involvement in making decisions about their care. In addition only 50% who had completed a plan found them helpful. Similarly Peart (2004) found that the birth plan made little difference to the overall experience of both pregnancy and birth.

These differences may be due to a range of factors and limitations discussed in the *results* including a cultural component which may have been instrumental in the observed results as the birth plan was a new concept introduced in a reportedly oppressive pre-natal care regime (Kuo *et al.*, 2010; Sham *et al.*, 2007; Yam *et al.*, 2007).

Due to the limitations and mixed results outlined and in order to achieve more reliable and robust data, such problems could begin to be overcome by developing

larger scale RCT studies utilising standardised measures; with several hospitals in numerous geographical locations.

Clinical Implications

The tensions between caregiver and patient regarding the functional role of the birth plan (Grant *et al.*, 2010; Lothian, 2006) in addition to the apparent discontent ‘to date [that they have] not offered a significant contribution’ (Peart 2004) needs to be addressed in order to provide more satisfying birth experience supported by a robust evidence-based approach. Satisfying birth experiences are critical as they can have considerable physical and psychological implications for the mother and the development of her child (Austin *et al.*, 2005; Lundgren *et al.* 2003). Indeed, anxiety in pregnancy is a good predictor of post-natal emotional state (Heron *et al.*, 2004) and beyond the risk of post-natal PTSD and post-natal depression (PND) it would be arguably more cost-effective to mitigate potential psychological morbidity.

Conclusions

The purpose of this review was to evaluate the impact of pre-generated birth plans upon birth experience. Findings suggest that there is no consensus about whether the birth plan is an effective tool for promoting positive birth experience. Coupled with the methodological limitations outlined, the current review has begun to highlight whether the birth plan in its current guise should be utilised and perhaps rather than quantifying how and why it is effective, research could explore *if* the birth plan is efficacious. Future studies may wish to conduct more in-depth exploration of women and caregiver’s opinions about birth plans to better understand possible ‘tensions’ between patients and caregivers or undertake robust randomised control trials similar to

Kuo *et al.* (2010) to explore the impact of birth plans on women's experience of childbirth, particularly in European health care systems. In addition studies could pursue efficacy of viable alternatives to written birth plans i.e. a more flexible verbal plan (discussions about birth choices between the patient and caregivers), considered more effective (Peart, 2004). Furthermore, as Grant *et al.* (2010) point out, although the pre-generated birth plan cannot conclusively produce positive outcomes, its popularity is unlikely to diminish in the foreseeable future therefore any further progress understanding and enrichment of its application may be valuable.

Limitations of the review

Although the current review made systematic attempts to exhaust the process of obtaining all potentially relevant papers, articles were excluded if not printed in English. In addition, the quality of papers included is somewhat limited but reflects the published material available.

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Part Two: Research Report

A Phenomenological Study Investigating Women's Experience of Written Birth Plans in Childbirth.

1. Abstract

Title: A Phenomenological Study Investigating Women's Experience of Written Birth Plans in Childbirth.

Author: Gemma Cox, Trainee Clinical Psychologist

Background: Pre-generated written birth plans were introduced in the 1970's with an ostensible aim to improve women's communication of labour preferences. Research has demonstrated that birth plans can facilitate childbirth satisfaction although some studies have found that they are associated with poorer experiences. Much of the relevant research has attempted to quantify how the written birth plan affects birth experience rather than explore if it delivers what it intended to. In addition, this literature base appears to lack rigour. Therefore this study aimed to rigorously and qualitatively explore the childbirth experiences of mothers who utilised a written birth plan.

Method: To investigate the impact of a pre-generated birth plan upon childbirth experience, data was collected through six one-to-one interviews with mothers post-natally. Data was transcribed, verbatim transcripts produced and analysed using Interpretative Phenomenological Analysis (IPA; Smith *et al.*, 2009) looking for convergence and divergence in emerging themes.

Results: Emerging themes included; narratives that undermine the role of the birth plan (flexible perspective, rigid perspective, positive experience birth is an uncontrollable event, damaging vs. containing, setting yourself up to fail, control - a dynamic not an absolute); alternative approaches to the written birth plan (verbal birth plan, mindful birth plan, informal birth plan) and knowledge (is it empowering?).

Conclusions: The themes arising herein appear to reflect the equivocal evidence for benefits of the written birth plan. Data arguably highlights the importance of perceived experience, personality traits and how the birth plan may be improved or tailored to suit the individual. Women expressed liking choice and information but were clear that this may not be appropriate if it sets one up to fail, compromising their physical and psychological well-being. This exploratory study has made tentative recommendations for both practice and future research.

Keywords: childbirth, birth plan, birth experience,

Target journal: Birth: Issues in Perinatal Care

2. Introduction

The Written Birth Plan

The birth plan is a relatively recent tool, introduced in the UK during the late 1970's as a reaction to the increased medicalisation of childbirth (Peart, 2004; Whitford & Hillan, 1998). Its use remains controversial (Kitzinger 1999), it is viewed by some midwives with resentment and trepidation (Weir, 2008) and its reported benefits are arguably undermined by methodological frailties in evaluative literature.

Although there does not appear to be one universally accepted definition of the birth plan its initial conception was as a written means of providing women with a method in which to convey preferences about how their birth experience may proceed (Kuo *et al.*, 2010; Moore & Hopper, 1995; Whitford & Hillan, 1998); for defending their rights; bestowing control (Kitzinger, 1992) and communicating this with caregivers in order to lessen probability of escalating interventions and ultimately to provide positive birth experiences (Simkin, 1991, 1992).

The birth plan has also been described as an advanced directive which releases the individual from the obligation to make high pressured decisions whilst in the vulnerable 'labouring' position, in addition to reducing the risk of litigation as wishes have been stipulated before this 'incapacity' has prevailed (Wier, 2008). However one problem identified by Scott (1996) is the contradiction of making rational and calm decisions about birth beforehand which may not fully translate to the reality of the labour experience.

Specific factors that are associated with birth satisfaction are argued to be facilitated by the birth plan (Hollins-Martin, 2008) are summarised below.

- *Choice & control:* Women who feel in control during their birth experience will report higher levels of satisfaction at both six weeks post-natally and

longer term (Green *et al.*, 2003; Simkin, 1991). Optimal satisfaction is derived from midwives through the exploration of wishes and desires and promotion of realistic expectations (Gibbens & Thompson, 2001).

- *Participation in decision making*: This was considered essential in creating birth satisfaction and has been correlated to the sense of being in control of one's emotions (Berg *et al.*, 1996; Gibbens & Thompson, 2001).
- *Preparation*: This had an impact upon confidence, length of labour (Niven, 1994) and post-natal adjustment established by pre-natal confidence and control (Beebe *et al.*, 2007, Sieber *et al.*, 2007; Soet *et al.*, 2003).
- *Respect*: Listening, considering and provision of a woman's needs are reportedly imperative in creating positive expectations (Gibbens & Thompson, 2001).
- *Good antenatal education*: Knowledge has a positive impact upon confidence and coping perceptions (Sinclair, 1999) which in turn affects perceptions of the birth experience (Gibbens & Thompson, 2001).
- *Self-efficacy*: One's own belief to succeed in a task or goal can be enhanced through *good antenatal education*. High self-efficacy beliefs regarding coping have been shown to lead to a reduction in pain (Larsen *et al.*, 2001; Stockman & Altmaier, 2001). Tailored support could be adopted to address this issue (Hollins-Martin, 2008).

The Literature Base

Contemporary literature investigating the impact of the pre-generated written birth plan upon birth experience suggests a circumscribed evidence base, with studies of poor quality and equivocal findings (Cox & Robertson, 2013 unpublished).

Studies have demonstrated that overall the birth plan was ‘helpful’ in facilitating positive childbirth experiences (Ekeocha & Jackson, 1985; Kuo *et al.* 2010; Moore & Hopper, 1995; Whitford & Hillan, 1998), could foster a sense of control (Brown & Lumley, 1998; Berg *et al.*, 2003; Ekeocha & Jackson, 1985, Kuo *et al.*, 2010; Lundgren *et al.*, 2003; Moore & Hopper, 1995; Whitford & Hillan, 1998), communication (Brown & Lumley, 1998; Ekeocha & Jackson, 1985; Lundgren *et al.*, 2003; Moore & Hopper, 1995; Whitford & Hillan, 1998) and the relationship an individual has with the caregiver (Berg *et al.*, 2003; Lundgren *et al.*, 2003). However Berg *et al.* (2003) and Grant *et al.* (2010) found that birth plans did not improve overall birth experience; indeed they appeared to produce less satisfying experiences compared to individuals without a plan. Furthermore, Brown & Lumley (1998) and Lundgren *et al.* (2003) reported that there were no significant differences between those with and without a plan.

The discrepancy observed may be due to a range of methodological limitations for example; cultural differences (Kuo *et al.*’s., 2010); the birth plan is a new concept in a reportedly oppressive pre-natal care regime; utilising non-standardised questionnaires, control groups were not employed (Brown & Lumley, 1998; Ekeocha & Jackson, 1985; Grant *et al.*, 2010; Moore & Hopper, 1995; Whitford & Hillan, 1998); the ‘halo effect’ may have had impact upon accurate recall of experiences so close to birth (Berg *et al.* 2003; Ekeocha & Jackson, 1985; Kuo *et al.*, 2010; Lundgren *et al.*, 2003; Moore & Hopper, 1995) and acquiescence which was especially problematic as participants were asked to complete questionnaires when still inpatients at their prospective care facilities (Berg *et al.*, 2003; Ekeocha & Jackson, 1985; Grant *et al.*, 2010; Kuo *et al.* 2010; Lundgren *et al.*, 2003; Moore & Hopper, 1995). In addition salient qualitative research demonstrates a lack of methodological rigour particularly in respect of interviewer and

response biases, interview location, lack of consideration to reflexivity, social desirability and similar cultural confounders, the overwhelmingly favourable response to birth plans as a recent, arguably ‘progressive’ approach in Hong Kong and Mexico (Sham, 2007; Yam, 2007).

Gaps in the Literature

The evidence base regarding the impact of the pre-generated birth plan upon childbirth experience is growing but largely lacking in methodological rigour, typically focussing upon the assumption that the birth plan is an efficacious method of facilitating positive child birth experiences rather than verifying *if* it is delivering what it set out to (Cox & Robertson, 2013 unpublished). Little exploratory groundwork appears to have been undertaken to investigate this more fundamental question and it is important to note that a number of studies would suggest that not only can a birth plan *not* improve birth experiences but can indeed create worse outcomes for women, when compared to those individuals without a plan (Berg *et al.*, 2003; Brown, & Lumley, 1998; Lundgren *et al.*, 2003). It has been identified that more ‘compelling and insightful’ data appears in the personal accounts of women (Rich, 1977) and consequently for the reasons outlined a qualitative approach will serve the aims of this study in providing rich data relating to women’s experiences of childbirth with specific reference to the use and impact of the written birth plan.

Clinical Considerations

The importance of positive birth experiences and the avoidance of negative birth experiences particularly in relation to the onset of post-traumatic stress disorder (PTSD) has been widely documented (Olde *et al.*, 2006). Susceptibility to PTSD may be

increased by professionals' often unavoidable non-adherence to an agreed plan (Ayles, 2007) and, in contravening maternal expectations, may adversely affect a couple's relationship and the parent-baby bond (Nicholls & Ayles, 2007).

Furthermore the growing popularity of the birth plan in our contemporary consumerist approach to healthcare is clear (Grant *et al.*, 2010). However, tensions between caregivers and patients about birth plans are both evident and reflective of wider issues within current perinatal care. To ensure safe, effective, satisfactory care and address the broader ethical issue of informed consent especially in our modern litigious culture, all parties need to begin to work together with greater cohesion. Without a collaborative 'working' relationship there is great risk to physical and mental health of both the mother and child.

Aims and Objectives

The overall objective is to establish an account of women's experience and beliefs about the written birth plan and how its use affects the childbirth experience. Examining how women think about the birth plan, exploring potential 'tensions', may give insight into whether or not it is successful in its assumed objective. Using qualitative methods will facilitate the in-depth exploration of participant experience and endeavour to examine women's perspectives of the efficacy of the written birth plan considering their accounts in context and developing understanding beyond the descriptives which have dominated in previous studies to explore how women make sense of their experiences (Green *et al.*, 2009).

The main aims were to explore:

- Women's experiences of the use of a written birth plan.
- Women's experiences regarding the efficacy of written birth plans.

- Women's perceptions of what facilitates or obstructs a positive childbirth experience.
- Women's experiences and beliefs about this existing approach to planning childbirth; whether it can be or needs to be improved and/or a more collaborative approach achieved.

3. Method

Interpretative Phenomenological Analysis

Although other qualitative approaches such as grounded theory, discourse analysis and template analysis were considered during the preparatory phase of this study, IPA (Smith *et al.*, 2009) was chosen for a number of reasons and is discussed in the critical appraisal.

Recruitment

Primiparous (a woman who is pregnant for the first time) post-natal mothers with a written birth plan were recruited from the same geographical region/local maternity services in a Midlands NHS teaching hospital. Purposive sampling was adopted targeting one trust to optimise homogeneity of the sample, controlling for any geographical variation of the written birth plan.

In order to diminish impact of the instant relief experienced by mothers after childbirth coupled with the fascination they have for their child which can extend for a couple of weeks, typically overriding any negative issues in the short term (Halo Effect; Simkin, 2006) and to avoid long-term memory bias, recruiting mothers in excess of two weeks following birth but less than two months post-delivery were sought (Seamark and Longs, 2004).

Suitable participants were identified by midwifery staff who had been briefed by the Consultant Midwife as to the nature of the study and the inclusion criteria. Mothers were excluded if they or their babies were ill or had died. Potential participants were then asked by the midwifery staff whether they were interested in the project and if they wanted to participate. If so, they were then sent a Participant Information Sheet (PIS) containing further details of the study (Appendix F) and after being given adequate time

to read and consider the PIS (minimum 24 hours) they were contacted again to determine whether they still wished to participate and whether they had any questions or concerns about the research which were addressed at that time. If the participant was happy to proceed then the Researcher contacted the participant to arrange a one-to-one interview date, time and location and request that they bring along their birth plan if it was still in their possession.

Procedure

Interviews – For the first six participants who volunteered from the list of 11 generated by the midwives, an interview date, time and location were set up at a venue of their choosing (their own home). Some of the participant information, including pseudonyms can be seen in Table 3. The first two interviews were initially treated as ‘pilots’ to ensure the interview schedule was acquiring appropriate material. A semi-structured, flexible interview format (see interview schedule; Appendix H) designed in consultation with supervisory support and in line with Smith *et al.*’s (2009) guidelines around the investigatory themes was employed. It aimed to ‘funnel’ questions in order to engender rapport, put the participant at ease and in order to begin in depth exploration of their experiences (Smith *et al.*, 2009).

A total of 100 minutes was allocated for the interview. Sixty minutes allocated for the one-to-one interviews; ten minutes before the interview was designated to check that participants are clear about the procedure, to gain consent (see ‘Consent Form’; Appendix G) and to address practical issues. After the interview was completed, up to and where necessary, 30 minutes were dedicated to reflect on the process, to monitor well-being, and to make arrangements for any individual support if the need arose.

The interviews were recorded using digital audio recording equipment. Each recording was transcribed by the researcher using pseudonyms for participant names (see ethical considerations) and as outlined the transcribed data was then analysed using IPA.

Participant (Pseudonyms; real names excluded for confidentiality)	Age Group	SE status	Post-natal timeframe	BP fully actioned	Pregnancy & birth type (with risk factors/complications)
Harriet	30-40	Middle	6 weeks	No	CPNC
Bethany	20-30	Middle	8 weeks	No	NPCC
Annabelle	30-40	Middle	5 weeks	No	NPCC
Miriam	30-40	Middle	6 weeks	Yes	NPNC
Lillian	30-40	Middle	8 weeks	No	NPCC
Patricia	30-40	Middle	8 weeks	No	NPNC

Table 3. Summary of participant information

NPNC – normal pregnancy, normal childbirth

CPNC – complicated pregnancy, normal childbirth

NPCC – normal pregnancy, complicated childbirth

CPCC – complicated pregnancy, complicated childbirth

Ethics

Ethical approval was obtained from both the University of Leicester and the relevant local research ethics committee due to the need for NHS patient recruitment (Appendix E).

Informed consent - The PIS (Appendix F) was initially given to participants to outline the purpose of the study, what participation involved, confidentiality, anonymity, right to withdraw up until the identifiable data linking the transcripts to the participant was destroyed and the possible risks and benefits that may ensue due to participation. The researcher led the participants through the PIS again before each interview, encouraging them to ask questions and if they agreed to consent they were asked to initial/sign the form which was countersigned by the researcher (Appendix G).

Confidentiality - An explanation of confidentiality was undertaken with all participants, identifying information would be excluded to maintain anonymity, audio-recordings would be stored on encrypted memory sticks until transcription was complete then destroyed and transcripts destroyed one year following completion of the research. Participants were informed that confidentiality would only be breached in the event of any information emerging that, for ethical reasons such as risk to self or others, must be passed to a appropriate professional i.e. General Practitioner.

Potential distress - Although the topics in the interview schedule focused on form and content of participants' experience, practice and opinion and discussion of experiences may have been a sensitive area leading to distress (Hadjistavropoulos & Smythe, 2001), it was deemed highly unlikely. However, consideration was given regarding what to do if someone became distressed, disclosed malpractice or chose to withdraw; the researcher would introduce a break, attend to the individual, and make sure their needs were met. Indeed a 'debrief' was offered to all participants following the interview regardless of clear distress. Participants were also told that they should only answer questions they wished to, take a break and/or withdraw from the interview at any time.

Analysis

Transcription - Interviews were transcribed verbatim (Smith *et al.*, 2009). Although the nuances of conversation analysis were not necessary for IPA transcription, the Researcher did note any important non-verbal utterances, pauses and hesitations in addition to wide margins for easing coding. For confidentiality purposes, participants were assigned pseudonyms and any identifying information was eliminated.

Data were analysed using the inductive and iterative process implicit in IPA and outlined by Smith *et al.* (2009), Larkin and Thompson (2012). Each transcript was analysed separately prior to final comparison and contrast to reveal emergent themes. It is usual in IPA to begin analysis through the transcribing procedure allowing the researcher to become familiar with the material. Interview transcripts were read and re-read, enabling data immersion, and to generate initial understanding of how generic explanations and specific events were framed in the respondent's narrative. Descriptive, linguistic and more interpretative conceptual points of interest were noted on the right hand side of the text (Smith *et al.*, 2009). Each participant was considered in their own right, so analysis was on a 'line-by-line' (Larkin *et al.*, 2006) and case-by-case basis. In addition noting of any salient observations and initial thoughts about the interview were made to aid reflexivity. Following initial 'noting', emerging themes were identified chronologically and highlighted in the left-hand margin.

In relation to each individual and across all transcripts the researcher then attempted to draw together themes. Although this can be done in a number of ways the researcher examined a chronological list of all themes recorded and then started to pull together clusters which were similar. The use of abstraction (collating similar themes) and subsumption (giving an emerging theme a super-ordinate distinction) were used to forge super-ordinate themes (Smith *et al.*, 2009). These themes were then recorded in conjunction with key quotes from the script.

Convergence and divergence across transcripts - The process outlined was repeated for each interview in turn and as the analysis progressed both recurring patterns and new themes were noted. In addition the superordinate themes and 'clusters' for all interviews were collated, examined and an overarching list was created. Themes

were then discussed both in relation to both the research questions and specific verbatim examples in supervision and the following *results*.

Transparency and reflexivity - In order to maintain quality the researcher utilised reflexivity (the explicit evaluation of the self) and transparency to guide the research process. Initial coding of each transcript was conducted separately by the researcher and resulting codes were compared and discussed in both supervision and with peers also conducting IPA research, in which justification of thematic decisions were duly deliberated. Some amendments to the themes were completed as a result of such discussions. In addition a research diary was maintained throughout the research process, in order to remain reflective regarding the process.

Furthermore quality evaluation guides were employed to guide the research and enhance rigour (Elliot *et al.*, 1999; Smith, 2011; Appendix L). This outlined what is ‘good’, ‘acceptable’ and ‘unacceptable’ in IPA research and guided the researcher’s analysis.

Researcher’s position (see Appendix I)

4. Results

The interviews conducted generated rich data regarding the nature of childbirth experience in relation to the use of birth plans. As outlined in the *method* each transcript was read anew and repeatedly to promote data familiarity in order to begin to understand the participant's point of view (Smith *et al.*, 2009). Emergent preliminary themes and any commonality or deviations were noted, listed for each transcript reflecting points of convergence and divergence (Appendix N; example of analysis) which ultimately led to the production of the following overarching themes (Table 4). The themes retained comprised those with sufficient evidence or high frequency across the data set, those which appeared to have the most significance to participants and salient clinical implications arising from the researchers' interpretative stance in line with IPA principals (Appendix M; frequency of themes). In order to facilitate understanding, verbatim extracts from the six transcripts were utilised to address the research aims. Extracts may also contain small modifications from the transcripts particularly when either the written format of the conversation is unclear/out of context or if a word has been omitted the researcher has utilised an ellipsis (...) or squared bracketed replacement words/explanations. In addition asterisks (***) are used to replace any names or identifiable material.

Super-ordinate Themes	Sub-ordinate Themes
<p>1. Narratives That Undermine The Role Of The Birth Plan – This theme captures the notion that when an individual creates certain narratives around their birth experience that the role of the written birth plan becomes redundant or problematic.</p>	<p>1.1 <i>Flexible Perspective</i> – It was considered imperative that narratives most participants generated regarding childbirth expectations remained flexible as this better prepared the individual to manage any deviations from the birth plan once in the throes of labour; arguably rendering the plan redundant.</p> <p>1.2 <i>Rigid Perspective</i> – Individuals hypothesised that where certain more concretised narratives regarding childbirth expectations exist that this <i>could</i> become problematic if the birth plan was abandoned.</p> <p>1.3 <i>Perceived Positive Experience</i>- This illustrates that when individuals frame their childbirth experience as favourable that the role of the birth plan becomes redundant.</p> <p>1.4 <i>Birth Is An Uncontrollable Event</i> – This captures a contradiction that the written birth plan appears to embody; searching to gain perceived control over an event which is in essence unpredictable and where ‘luck’ is identified to play a role.</p> <p>1.5 <i>Control - A Dynamic Rather Than An Absolute</i> – Control is a key function that the written birth plan purportedly offers childbearing women however participants alluded to the need for it to be a more dynamic concept than the more static quality embodied by the birth plan.</p> <p>1.6 <i>Damaging vs. Containing</i> – This illustrates a dichotomy that participants alluded to regarding the role of the birth plan providing emotional containment whilst at the same time accepting that it can be damaging.</p> <p>1.7 <i>Setting Yourself Up To Fail</i> – This depicts the supposition that although making wishes explicit can be empowering that this process could lead to negative emotional repercussions/persecution of the self.</p>

<p>2. Alternative Approaches To The Written Birth Plan – This theme depicts alternative approaches to the written birth plan alluded to in the participants accounts that may offer a more efficacious way to prepare and implement a birth plan in the perinatal period.</p>	<p>2.1 <i>Verbal Birth Planning</i> – This is a means alluded to in which the birth plan could be thought through and discussed with caregivers and /or partners without writing anything down.</p> <p>2.2 <i>Mindful Birth Planning</i> – Similarly this is a means alluded to in which the birth plan could be purely thought through with caregivers and/or partners without writing anything down or concretising wishes.</p> <p>2.3 <i>Informal Birth Planning</i> – This is a means alluded to in which the birth plan could be discussed with the birthing partner rather than caregiver/midwife, as the latter is typically more transitory during labour.</p>
<p>3. Knowledge Gained Regarding Pregnancy & Childbirth – This refers to the role of knowledge sought ahead of childbirth in order to prepare for the experience.</p>	<p>3.1 <i>Is It Empowering?</i> – This subordinate theme captures the question that is raised regarding the facilitative nature of preparatory knowledge.</p>

Table 4. Summary of themes

1. Narratives That Undermine The Role Of The Birth Plan

This theme encapsulates the notion that when an individual creates certain narratives around their birthing experience that the function of the birth plan becomes either redundant or problematic. The seven subordinate themes which underpinned this constitutive theme were *flexible perspective*, *rigid perspective*, *perceived positive experience*, *birth is an uncontrollable event*, *damaging vs. containing*, *setting yourself up to fail* and *control – a dynamic not an absolute* which appeared to be imperative in how women managed and/or constructed their experiences.

1.1 Flexible Perspective

A flexible perspective was identified within the transcripts and conceptualised as maintaining an open minded approach when writing and executing

the birthing plan which was considered imperative due to perceived unpredictability of the event. This concept then appeared to render the plan redundant.

All participants alluded to a level of perceived flexibility in cognitions or appraisals about birth when reporting their own childbirth experiences. This could imply the unconscious desire to dispose of the constricting nature of their pre-generated plans, recognising the uncertainty of childbirth and is an arguably protective position to embrace. This may also demonstrate a more resilient position which underpins the overall experience and indeed life in general. Indeed Miriam suggested that she initially thought the birth plan was ‘pointless’ (361) as ‘they’ might not be able to ‘follow it through’ but having talked through its remit with her allocated student midwife, countered this position with:

‘...¹ [I learnt] oh ok it’s not a bible to go by so to speak’ (Miriam, 331).

This suggests that although initially she believed that a birth plan was fruitless as it unlikely that it would be executed, that after consultation she started to believe that in reality it is a proposed plan rather than a fixed statement. However later her thoughts regarding being set up to fail, perceived lack of control and its impact upon low mood contradict this idea.

Perceived necessary flexibility with regard to making changes to the birth plan were reflected upon both prenatally and during labour.

‘I think because with that plan [for a home birth] I always knew might not be possible it was always more a vague plan I suppose so I knew from quite early on I knew I would have to be flexible’ (Harriet, 165)

‘...you can have these plans but you very much have to be flexible about it because you never know actually how its going to be...’ (Harriet, 210).

¹ ‘...’ Ellipsis denotes words omitted by the researcher

The flexible perspective also appeared to be influenced by sought preparatory experience in advance of birth, for example via NCT (National Childbirth Trust) classes successfully instilling an understanding of the need for flexibility when coupled with individuals' own beliefs.

‘[I perceived my birth plan to be] a wish list...the emphasis [of the classes] is very much that births don't go to plan necessarily so don't get too focussed on this ... I knew that for most people's experience that birth plans have never worked out' (Lillian, 195).

Constructions of flexibility or acceptance of uncertainty appeared to facilitate Bethany's tolerance when a divergence from the plan occurred during the birth. Indeed she went onto suggest that if she didn't embrace this idea that the result is likely to be self blame.

‘...they didn't give me a choice ... we're gonna have to do this, we're gonna have to do that and ok fine whatever ... at the end of the day I'd not gone into it with the idea that this is what I want and nothing else, it's just how it's got to be flexible' (Bethany, 155)

‘I think you've got to be flexible I guess if you really really set on it ... then you are setting yourself up (Bethany, 426).

Additionally, flexible perspective during the birth appeared evident in reconstructing personal need and subordinating the self to the needs of the baby.

‘I'm impatient, I'm organised, everything was written down from the minute I found out I was pregnant ... I'm anal she [mum] called me... my birth plan was written as soon as ... but it never went to plan (laughs)' (Annabelle, 66)

‘...but when it came to it I did what was best for the little man' (Annabelle, 62).

1.2 Rigid Perspective

Where narratives regarding childbirth expectations are more concretised through a written birthing plan, it was intimated that (rather than in relation to their own experiences) that there may be difficulties if the event that the plan had to be abandoned. It appeared influential in participant's constructions of labour and may affect childbirth experience.

Bethany suggested that whilst having a range of options in labour is favourable, being fixed upon certain ideas is unhelpful and creates barriers for the professionals attempting to impart life-saving advice.

‘To me it’s having that idea of what you want coz you can rock up in labour and there’s just so many options that’s its nice to be well I would like that and I would like that and I’d like to try that and I don’t want that but I don’t think people should be too rigid on it...I was watching an American one <programme> where one couple they were so rigid to their birth plan and they had to be like you can’t have this, the baby is distressed, no no no we want this and it was so ridiculous..’ (Bethany, 165).

Similarly a very narrow birth plan creating an obstacle to the physical safety of mother and baby was also highlighted by Lillian.

‘...the worst thing you can do is have a really prescriptive birth plan ... like I will never have an episiotomy, then she said at the point that you need one the midwife has a real problem because they have to try to persuade you about it because they have to try and follow what you have put in your birth plan when if they could just do it, it could end up being a much better thing’ (Lillian, 260).

Whilst there was some acknowledgment that the birth plan must be a fluid document due to the nature of childbirth, self-blame was still acknowledged to be a consequence of any divergence from it.

‘I suppose there’s the issue of how you feel when you’re thinking about the birth plan, how you feel at the time and it’s all very well to have this plan but you might feel incredibly different about it ... that’s a con you might really feel very differently at the time and didn’t follow the plan and you didn’t do this and why didn’t I? And get caught up with all of that.’ (Harriet, 250).

Similarly it appears that birth plans are proposed be problematic if choices are made in an emotional vacuum, independent of the experience where context and hindsight is often essential for making realistic decisions especially in relation to pain.

‘... you could be totally wanting these things that are on your list like I want a water birth for instance ... but you get there and you think y’know I don’t want that ... y’know you might change your mind or you might have in your birth plan I only want gas and air and you get there and you think oh god I really can’t manage this pain I need some pethidine or something’ (Patricia, 216).

Likewise;

‘... it’s alright me saying y’know I don’t want pain relief but what happens when I’m sat on the floor begging for pain relief’ (Miriam, 336).

1.3 Perceived Positive Experience

This subordinate theme captured the notion that although childbirth experience can initially progress contrary to planning, that overall if the individual believes that all has gone well that as a result the birth plan becomes redundant or forgotten.

‘I thought I would have been really sad not to have had a home birth but actually it was fine going on the midwife unit; they were great and it was a really nice experience ... I’d happily go there again.’ (Harriet, 110)

‘We had to stop in hospital because he was really poorly and I was ill and stuff like that but it was actually a pretty positive experience all round. It was quick, they were nice, yeah it was brilliant not that I would choose for it to be like <that>’ (Bethany, 319).

Overall perceived positive experience appeared to be influenced by a sense of trust created by health professionals. This was true for Bethany in which any difficulties encountered were eclipsed by the positive experience.

‘...a lot of my memories of being in labour was of being really ill ... I was worried but they were like monitoring you, ‘we’ll get him out’, I was on a drip but I thought at least I’m in the right place ... there’s people who are going to sort it.’ (Bethany, 87).

Similarly Miriam appeared to identify that her wholly positive experience was a consequence of the professionals creating such an affirming environment.

‘...***’s² heart rate was perfect it had never dropped once and I genuinely believe because it was so relaxed in the room ... and the midwives were so calm. ... I was panicking because he wasn’t crying and they were like “Miriam, it’s just because he’s so chilled” ... the whole experience was just amazing’ (Miriam, 206).

Perceived positive experiences were also reported when professionals offered continuity of care which also appeared to eclipse the role of the birth plan.

² ‘***’ denotes use of identifiable material omitted by researcher

‘... they said to me look Annabelle we’re really sorry but the pool is already in use, I said I don’t mind, I don’t care erm but they did everything they could to make me comfortable ... I had a student midwife all the way through my pregnancy ... [and] I had a midwife with me all the way through it while I was in hospital’ (Annabelle, 116).

1.4 Birth Is An Uncontrollable Event

This theme encapsulates narratives around an observed contradiction that the remit of the birth plan embodies; although the plan attempts to impart perceived control over the labour experience, it remains an event which although inevitable is in essence unpredictable. It also illustrates how the perceived ideas about chance and luck play out in this uncontrollable event. To some degree all participants alluded to these ideas and considered that they had been ‘lucky’ with their positive experiences.

‘I think for me I’ve been very lucky and I think I’d found it really hard if I had this plan that involved minimal intervention and it was apparent very quickly that that wasn’t going to happen.’ (Harriet, 243).

Good fortune appeared to be a key factor assisting participants in this study to construct their birth experiences in an adaptive manner.

There appeared to be some contradiction regarding the reported benefits of the birth plan. On one hand it apparently offered a means by which women could prepare themselves whilst at the same time acknowledging that childbirth is unpredictable.

‘Overall I would definitely say it’s helpful even though I believe strongly that you never know how it’s going to be’ (Harriet, 265).

Miriam believed that labour is uncontrollable and equated this position about the efficacy of the birth plan and indeed its redundancy with this belief.

‘... the thing is nobody actually knows what’s going to happen when you’re in labour ... so I suppose in a way I ... thought that a birthing plan was pointless’ (Miriam, 359).

She also reflected that her experience had been unexpectedly positive which she felt was almost accidental, believing that the birth plan often does not play out as expected.

‘...literally every little detail went to plan which was amazing. I think you’ll find that you’ll probably be surprised to find many people that its happened to...Some of it I think is luck ... if anything was seriously going to have gone wrong it have gone wrong regardless, y’know nobody could prevent that’ (Miriam, 444).

Patricia considered unpredictability in childbirth in a pragmatic manner, qualifying her reasons for keeping her birth plan brief. She also implies and is almost dismissive of other people who can be excessive or over inclusive with unnecessary detail contained in their plans. This also appears to highlight the redundancy of a plan.

‘... you can have all these bits of information like I’d like candles, I’d like music, I’d like mum to be there, my auntie there y’know whatever else you want there and erm you go there and then you’ve got to have an emergency caesarean’ (Patricia, 92).

Indeed, unpredictability is further highlighted by Patricia suggesting the written birth plan struggles to take this into consideration;

‘...but coz it’s a natural thing you can’t always pre-plan, it’s Mother Nature at the end of the day and you can’t pre-plan how you think its gona go. So it’s just a preparation for what you think *might* happen’ (Patricia, 421).

1.5 Control - A Dynamic Rather Than An Absolute

Perceived control is also considered in relation to a more evolving reality. Although control is a key facet that the written birth plan purportedly offers childbearing women it appears that it is and needs to be a more dynamic concept rather than the static quality that the birth plan embodies. This theme emerged in five of the interviews. It reflected experiences in which at the climax of birth, women choose to rescind both their perceived control and procedures contained in the plan.

Bethany suggests that when she was in labour although she felt vulnerable (which seems evident through the use of the colloquial comment ‘looking at my bits’) when safety became compromised and the plan sidetracked, this was tolerable as she believed that the professionals were managing her difficulties effectively.

‘...a lot of my memories of being in labour was of being really ill I was worried but they were like monitoring you, “we’ll get him out”, I was on a drip and I thought at least I’m in the right place for it there’s people who are going to sort it, like two doctors and two midwives, I had quite a lot of people looking at my bits ... they were very very nice actually they made me feel that they had got it under control.’ (Bethany, 91).

Interestingly she went on to comment about the alternate fantasy of the birth having gone as planned or remaining under her control.

‘... if I had had my birth plan and it had gone as I wanted what if I didn’t enjoy it ... it was almost nice that it was took out of my hands.’ (Bethany, 480).

The plan may not have lived up to expectation and the individual attributes possible adverse consequences to their own staging of the event.

Annabelle had a detailed birth plan and when events started to depart from it, she was initially unhappy. However it appeared that when labour became more complicated she was able to relinquish her perceived control for the greater good.

‘... I didn’t want to be on my back on the bed but because his heart rate was dropping ... they just wanted to be able to hear...they had to have me on the bed in stirrups ... it was another thing I didn’t want but obviously when it came to it I did what was best for the little man really’ (Annabelle, 58).

In addition she believed that control in childbirth over your body is unachievable.

‘I kept saying ... how will I know when he’s going to come ... she’s like “Annabelle” your body does it for you and you have no control ... you’ve got no control of your body and it’s not a nice feeling but you’ve gotta do it...’ (Annabelle, 151).

Miriam appeared emphatic about her beliefs about control. Although she indicated that feeling out of control tends to have a major influence over her ‘depression’ she also alludes to the fact that when in labour an individual should be prepared to surrender all control. This suggests that for her, under such circumstances writing down wishes could be problematic. However on this occasion she was ‘lucky’ and it all went to plan.

‘...when I suffer with depression a lot of my anxiety comes from not being in control and if there’s one thing you are not when you are in labour you have no control over what’s going to happen and I think that was why a birthing plan made me feel slightly uneasy, putting it down in black and white ... is it going to set my anxiety off?’ (Miriam, 370).

Patricia is very dismissive of the birth plan, suggesting that it is a futile exercise and objectively accepts that perceived control is often taken out of the individual's hands as childbirth is unpredictable.

‘I didn’t sort of take very much notice of it, I just thought to me that just seemed secondary because you’ve just got to deal with it ... yourself and if it’s out of your hands, it’s in the surgeons hands to deal with it for you’ (Patricia, 97).

1.6 *Damaging vs. Containing*

This theme encapsulates further implied contradictions regarding the role of the written birth plan. It illustrates the specific dichotomy that the birth plan provides emotional containment whilst at the same time postulating that it can be damaging.

Although all participants indicated that they would write another birth plan in future, there appeared to be some ambivalence about its contribution as simultaneously both a help and a hindrance. Harriet suggested that although the birth plan could promote a sense of control (or ‘staying on top of it’) in reality there could be adverse psychological consequences when it goes awry, possibly leaving the individual feeling out of control.

‘...but the flipside is if you follow a plan and it doesn’t (work out) then maybe that’s an added stress.’ (Harriet, 240)

‘I think I’d found it really hard if I had this plan that involved minimal intervention and it was apparent very quickly that that wasn’t going to happen. I’d find it really hard immediately because I’d just feel bad that it hadn’t gone well and I think in terms of staying on top of it that would go very quickly.’ (Harriet, 244).

Bethany appeared to hold contradictory beliefs that the birth plan was worth doing as it presented a 'safety net' irrespective of whether it could be executed, although it concretised and made immediate the birth as fear inducing.

'... it's a bit scary if anything that the baby's going to have to come out ... and I'm going to have to do this but at the same time it was like a safety net ... I wouldn't have wanted to go in without any preparation at all ... Your body's going to do whatever but it felt nice to have a bit of preparation about birth and stuff even if it all goes out the window.' (Bethany, 351).

Miriam, who arguably recounted one of the more positive experiences, due to her birth plan remarkably being executed in full, suggested that the birth plan was a protection of her interests if the experience was not going as planned.

'... it made me feel better thinking that if I did get to the point of not losing control, but going in on yourself, at least my wishes was written down' (Miriam, 333).

However, the overall tenor of her interview appeared to be much more cautious about the efficacy of the birth plan demonstrating some ambivalence. She equates that to historically struggling with out of control feelings and that the plan possibly represented this.

'... luckily it didn't but if something had gone wrong in my labour and my birthing plan had been thrown out of the window I'd have been quite annoyed, not annoyed but upset that it was a pointless exercise ... I still have very mixed views ... because ... when I suffer with depression a lot of my anxiety comes from not being in control ... that's why a birthing plan made me feel uneasy' (Miriam, 366).

1.7 Setting Yourself Up To Fail

This illustrates the supposition that although making your wishes explicit can be empowering this process could lead to negative emotional repercussions/persecution of the self. For some respondents the birth plan was constructed in a manner that engendered the possibility that they would experience a sense of failure. Lillian suggested that had the experience been different and the choices in a vaginal delivery were hers to make, she may have made pain relief decisions resulting in her feeling inadequate and her emotions spiralling negatively.

‘I don’t know if whether I had a vaginal delivery but requesting an epidural or something like that ... whether I would have felt like I’d failed, I’m quite harsh on myself’ (Lillian, 652).

Patricia similarly implied that birth plans could set women up to fail especially if they were interpreted as dictatorial and the birth did not proceed as anticipated.

‘... if you’d have been a very detailed mum and you’d have had a fast birth like me how you would have felt about it because you would have felt a bit cheated’ (Patricia, 333).

Furthermore Miriam suggests that a written record of wishes which cannot be actioned may lead to self-deprecation.

‘Because I do think y’know if you’ve got something written down ‘I don’t want to do this, I want to do that’ and it doesn’t happen I think you almost feel like a failure’ (Miriam, 486).

Bethany suggests that holding a rigid perspective could result in difficulties, setting the self up for a fall.

...your body changes you have no choice in it so its nice to have the choice in something. But at the same time I think you've got to be flexible I guess if you really really set on it ... then you are setting yourself up to fail' (Bethany, 424).

2. Alternative Approaches To The Written Birth Plan

This theme encompasses different alternatives to a written birth plan drawn from individuals accounts that may offer a more efficacious way to prepare and implement the birth plan in the perinatal period. Divergent ideas were expressed regarding alternative means of birth planning (mindful, discursive, informal) alluded to in the majority of interviews that suggested that a written birth plan as currently invoked is not optimal. Specifically comments regarding open discussion during labour, pre-emptive planning conversations prenatally and having dialogue with the birthing partner emerged throughout the interviews.

2.1 Verbal Birth Plan

This is a means alluded to in which a birth plan could be thought through and discussed with caregivers and /or partners without formally writing anything down. When Harriet is discussing her experience she suggests that verbally checking out with her during labour what she wanted or needed rather than referring to the preconceived plan worked out well for her.

‘...I suppose thinking about it the midwife ... was very much led by me in terms of asking about “I can examine you or I can leave you for a bit; do you want music on or not.” So informally in terms of a birth plan she was very much checking out what I wanted ... which was brilliant, she was great but no explicit

discussion about what's your plan ... It worked really well ... I felt really relaxed' (Harriet, 85).

Similarly Patricia highlights that she appreciated and possibly preferred that the professionals kept her informed, discussing options with her during the birth experience rather than explicitly using the plan.

'I'd just rather them communicate with me at the time which they do anyway and them say right we're at this stage now would you like this. We can do this for you or that for you, how do you feel about it and if you've got time then you can deal with those things.' (Patricia, 326).

2.2 Mindful Birth Plan

This is a means alluded to in which the birth plan could be purely thought through with caregivers and/or partners without writing anything down or making firm decisions. This concept of a 'mindful' birth plan appeared to embody the notion of having an image in mind about how an individual wishes the birth to proceed.

Annabelle whose narratives around planning were admittedly more rigid, suggested that she would have ideas for the birth in mind regardless of whether she had a written birth plan which might be a more fluid and thus potentially psychologically protective approach.

'...I think even if you didn't get asked you would have something in your head about how you wanted it to go...if there was no such thing as birth plan I would always have in head well I would like a birthing pool and no I wouldn't like an epidural' (Annabelle, 381).

Similarly Bethany expressed that the birth plan should be a concept of what you would like rather than a fixed list which is arguably more restrictive and potentially dangerous.

‘To me it’s having that idea of what you want coz you can rock up in labour and there’s just so many options that’s its nice to be well I would like that and I would like that and I’d like to try that and I don’t want that but I don’t think people should be too rigid on it. Again obviously a lot of my experience is based upon watching one born every minute. I was watching an American one where one couple they were so rigid to their birth plan and they had to be like you can’t have this, the baby is distressed, no no no we want this and it was so ridiculous. It’s nice to have an idea, but that’s all it should be.’ (Bethany, 165).

2.3 Informal Birth Plan

This is a means alluded to in which the birth plan could be used more informally between mother and birthing partner to discuss ideas and preferences because they are most likely to be present at the birth rather than the midwife attending to prenatal care.

‘...I just don’t know how they can be followed through in general, I genuinely don’t ... they’re good for your husband and possibly sitting down with your partner ... going through with them what you would like. Maybe that, as oppose to it being done on a professional level, it needs to be something that needs to be done between...mother and birthing partner and try to be put in place that way erm as oppose to just sortof a midwife sortof reading it. I think, doing a birth plan but going through it with somebody that’s going to be at the birth might make it better as oppose to doing it and expecting a midwife to even pay any attention to it whatsoever. Coz...you can go through it with your community midwife but who’s to say that’s she’s going to be there when you are delivering your baby.’ (Miriam, 528).

3. Knowledge Gained Regarding Pregnancy & Childbirth

This theme captures the drive to seek knowledge ahead of labour in order to prepare for the experience.

3.1 Is It Empowering?

This illustrates the question that is raised regarding the facilitative nature of seeking preparatory knowledge. Participants articulated different levels of understanding regarding the implications of childbirth and had undertaken variable levels of research shaping expectations prior to the event. Bethany demonstrated a lack of knowledge when asked to clarify details regarding onset, length and overall what constituted labour. Her blasé and amused attitude coupled with an apparent insouciance in describing both birth experience and birth plan appeared psychologically protective particularly as her plan was not executed.

‘I don’t know really to be honest, I’m not really sure when it actually did start because I know I started feeling ill on the Sunday...and I felt really grotty...I thought maybe I’d overdone it ... I felt fine on the day, like I said I’d been to the gym (laughs)’ (Bethany, 68).

However having pre-emptive dialogue with the midwife about the birth enabled this participant to feel better informed and thus arguably self-assured.

‘...having looked and talked through options I felt a bit more confident during stuff because obviously I had a bit more of an idea of what I was asking for’ (Bethany, 435).

Arguably Miriam suggested that compiling knowledge about labour seemed valuable for both physical and mental health of the mother.

‘...the main thing that stands out ... doing the birth plan with the case study midwife was the understanding I had of the whole process ... it was important for me to know that, why I may not be able to do, naturally deliver my placenta not just a case of I’ve failed ... the fact that actually it could be a medical reason why’ (Miriam, 647).

Although in part Lillian felt similarly prepared, having researched and written her plan, her assurance appeared somewhat eclipsed by feeling over informed particularly about vaginal tears, which appeared to be a ‘terrifying’(360) prospect.

‘[Having researched the topic extensively I felt] More confident that I was including everything and doing everything ... I like to plan things ... I don’t like not being in control ... there were certain things that I kind of chose I just don’t want to read anymore ... episiotomies and tearing and stitches, concepts that I just didn’t want to go near’ (Lillian, 351).

As discussed Patricia commented that she was not the sort of person to ‘really analyse things very much’ (87) and coupled with the fact that she points out that childbirth cannot really be ‘pre-planned’ (421) she suggested that seeking out information was pointless. Indeed she goes onto say that one should just get on with it or ‘deal with it’ (520) rather than getting caught up with unnecessary minutiae.

5. Discussion

This study aimed to explore the impact of a pre-generated written birth plan upon childbirth experiences utilising an IPA framework in order to glean rich accounts of the six participants identified meeting inclusion criteria, through one-to-one interviews. The following summary of results will be considered in relation to the research questions, existing literature base and the themes generated. The three super-ordinate themes housing the eleven sub-ordinate themes identified can be observed in Table 4.

Themes from dataset

The data will be discussed in relation to the thematic breakdown adopted in the *results*. The researcher arrived at the thematic divisions generated based upon the data presented and kept certain subordinate themes such as a *flexible perspective* and *rigid perspective* separate to preserve the integrity, richness and context of the narrative (in line with IPA underpinnings) in addition to emphasising subtle differences; *flexibility* was a way participants portrayed themselves whereas *rigidity* appeared to be an external factor that they described and acknowledged could be unhelpful.

Narratives That Undermine The Role Of The Written Birth Plan

The ideas identified in participants birth narratives outlined below were highlighted to some degree by all of the participants and arguably undermine the role of the birth plan rendering it superfluous or problematic.

Flexible Perspective

When developing the theme, it became clear that all participants alluded to the need to employ a flexible perspective, before or during labour which is arguably

protective in the likely shift in circumstances that typically emerged. However respondents' reports may be insulated by the benefit of hindsight and had more negatively perceived experiences transpired, this functional position may not have emerged. In addition all of the participants presented with the belief that they must be flexible, therefore it is not clear how more rigid perspectives would affect responses to any changes to their plans.

It was also interesting to note that *flexibility* appeared to be influenced by preparatory experience (NCT classes) which successfully instilled an understanding that flexibility was a necessity when coupled with individuals' own beliefs, similarly facilitating a functional attitude.

Rigid Perspective

Five participants alluded to the putative issue of holding rigid expectations in childbirth. Typically this concept was framed by participants in relation to appraisals of others or hypothetical scenarios rather than in relation to their own experiences. It may be subject to retrospective bias and positive birth appraisals may have been a mediating factor in this domain, nonetheless participants alluded to the problem of being too fixed when devising and ultimately following a birth plan, suggesting that it may lead to distress and more importantly risk to the safety of mother and child. This awareness seems to accord with findings demonstrating that rigidity of protocol prevalent in healthcare settings is associated with increased intervention rates during childbirth (Kennell & Klaus, 1991).

Harriet, Miriam and Patricia identified the changeable nature of pre-emptive choice in addition to an inability to predict personal pain tolerance which may contribute to the arguably restrictive nature of a somewhat prescriptive written plan.

This contextual acknowledgment resonates with debates (Scott, 1996) arguing the futility of defined planning and that one cannot be ‘truly informed’ until in the throes of the labour experience, suggesting that the plan is both flawed and lacks context. In addition Lillian alluded to the notion that the birth plan may even be a hindrance for both the professionals and the physical safety of mother and baby in the event that they have to gain consent to change the plan due to the frequent occurrence of unforeseen circumstances. These sentiments echo previous studies suggesting that conflict can ensue when birth plans and expectations are *rigid* and sometimes impractical given the unpredictability of childbirth (Ekeocha & Jackson, 1985; Ford & Ayres, 2009). Indeed a collaborative ‘working’ relationship is essential to avoid risk to both the physical and mental health of mother and child (Ayres, 2007).

Perceived Positive Experience

This appears to be a pertinent narrative when appraising the value or benefits of the birth plan. Typically all participants described being content or at least not patently traumatised with the way their birth experience had progressed and regardless of whether the content of the written birth plan could be executed. As a result the plan became irrelevant and disregarded and the experience independent rather than consequential of it. Perhaps coupled with a *flexible perspective* discussed above, this appears to be a protective factor. Indeed self-esteem, mastery and particularly optimism have been identified as key concepts affecting pregnancy and birth, having implications for both maternal and fetal health (Lobel *et al.*, 2000; Rini *et al.*, 1999).

Abandonment of the birth plan does not seem problematic if the birth has been perceived to have progressed favourably, but hypothetically if labour is seen to proceed inadequately then it could arguably become an object of blame, setting women up ‘to

fail' as alluded to by Miriam, Lillian and Patricia. However this supposition is speculative as none of the participants described a traumatic birth.

Furthermore it is possible that in this study participants' perceived adherence to the plan may have been looser which arguably permits its diminution, increasing likelihood of a positively framed experience and arguably indicative of an enduring positive framing/resilient approach.

The data from this research echoes the findings in a number of studies in which individuals with birth plans have been associated with an overall positive experience (Brown & Lumley, 1998; Ekeocha & Jackson, 1985; Kuo *et al.*, 2010; Moore & Hopper, 1995; Whitford & Hillan, 1998). However specific factors facilitating positive experience independent of birth plan have also been highlighted by this study.

Participants noted that a positive experience with the staff involved in their care, particularly allocation of the student midwife who could provide continuity that other midwives potentially could not, also contributed to a positive experience. This is supported by studies that suggest that the relationship with health care professionals is imperative (Kitzinger, 1983) and found that the quality of relationship an individual had with the caregiver was associated with the childbirth experience (Berg *et al.*, 2003; Lundgren *et al.*, 2003). Similarly these findings support a number of studies (Brown & Lumley, 1998; Ekeocha & Jackson, 1985; Lundgren *et al.*, 2003; Moore & Hopper, 1995; Whitford & Hillan, 1998) which identified effective communication with caregivers is associated with positive childbirth experience. Furthermore cognition or understanding of the childbirth process with regard to effective information exchange led by the caregiver/s is essential in creating positive childbirth experiences. Without it individuals may ascribe personal culpability when provided with inadequate information as to the reasons for non-vaginal delivery (Capero *et al.*, 1998). It has been

argued that this interpersonal process of caregiver-patient information exchange is essential to the success of the technical care implemented (Donabedian, 1966).

Birth Is An Uncontrollable Event

Participants suggested that they had been ‘lucky’ in experiencing birth as largely positive. Miriam and Patricia clearly suggest that the birth plan is ‘meaningless’ as birth is unpredictable. However there were some contradictions highlighted by other participants between the birth plan acting as a preparatory tool and yet acknowledgement that birth is an unpredictable event, in addition to acceptance of probable unpredictability whilst alluding to disappointment when the plan is abandoned. These contradictions highlight that the birth plan is attempting to control an event which is in essence uncontrollable and as a result could potentially create an array of problems for the mother, child and her caregiver. This sentiment is supported by Kitzinger (1987) who suggests that patients are misled into believing that there is choice when really there is none. Indeed we tend to assume that life is predictable, certain to continue ad infinitum and that we have control over the outcome of entirely chance events (Langer, 1982) which provides us with a sense of security (Braun & Berg, 1994). However these views are typically incompatible with reality and when confronted with certain life experiences can fail to afford us any reassurance and security, destroying our fantasies of predictability, control and continuity (Vickio, 2000).

Birth Plans: Contradiction Of Its Role – Damaging vs. Containing; Setting Yourself Up To Fail

This further contradiction emerged and participants’ beliefs within this theme appeared inconsistent and fluid. Participants felt they would write another birth plan

given its potential to contain an unpredictable event and experience yet the very nature of reifying the process was simultaneously noted as a difficulty. This intrinsic contradictory position is perhaps indicative of the written birth plan concept as a whole outlined when discussing the last theme.

Particularly poignant was the sense of ‘failure’ highlighted explicitly by Miriam and Lillian as a possible difficulty. Again their perceived positive experiences override any possible issues but this was identified as a prospective problem had things ‘gone wrong’ or circumstances been different.

Alternative Approaches – Verbal/Mindful/Informal Birth Plan

The majority of participants raised possibilities for changing or enhancing the birth plan as it exists presently and echoes others (Peart, 2004) who suggest that the birth plan is not effective in facilitating consistent positive experiences in its present guise. Participants offered ideas for the evolution of the planning process verbally discussing wishes in the moment (Harriet and Patricia), a discussion rather than a formal birth planning session with the midwife (Annabelle), and being mindful about what you may want in advance (Bethany) were identified. Indeed having a discussion helped to facilitate communication between the mothers and caregivers (Annabelle) filling gaps in knowledge. Furthermore one participant appeared resolute that the birth plan had flaws and that using one informally to discuss options with birthing partner/s might be more useful especially in the light of the typically transitory midwife (Miriam).

Knowledge Gained Regarding Pregnancy & Childbirth - Is It Empowering?

Some participants seemed to value knowledge acquisition through personal research or discussions with the midwife, a finding supported by Sinclair (1999) who suggests it acts as means of bolstering confidence and beliefs about coping. Indeed research supports the notion that pre-emptive education can have a positive effect upon post-operative outcomes with particular reference to anxiety, pain and compliance (Shuldham, 1999). It appears to act as a means of preparing the individual even though it may be futile if the birth advances contrarily to what was anticipated. Moreover, one participant suggested that it was good for both psychological and physical health having knowledge of why certain consequences may transpire in case the plan was abandoned and she was left feeling a failure. Indeed this coincides with Berg *et al.* (2003) findings that 10% of women with a birth plan expressed feelings of failure.

However, as suggested this informative and preparatory element can be excessive and that it could be attained through informal conversations with the midwife about what is realistic rather than formalising a written record of birth options which is open to the potential difficulties already discussed such as setting yourself up to fail.

Control In Childbirth - A Dynamic Not An Absolute

Reportedly control during childbirth does not increase with the use of a birth plan as choice is largely illusory and cursory echoing certain elements of this theme (Lothian, 2006; Too, 1996). In somewhat different guises this theme typically emerged in five of the transcripts once labour had begun. For some a sense of vulnerability in the labour suite or disappointment due to abandonment of their plan was evident. However ultimately when necessary they were able to relinquish control over the situation in favour of expert opinion. This is arguably a further protective factor which may have

facilitated a positive experience particularly when employing a written birth plan for an unpredictable event but is likely to be attributable to individual personalities rather than a direct result of using the plan. Therefore this highlights that where people are unable to relinquish control or when negative experiences transpire a birth plan may become an obstacle or figure of blame.

However these results do not support research (Kuo *et al.*, 2010) that women with a birth plan have higher perceived levels of control compared with controls. Indeed it appears that in this study the development of a plan emphasised how little control is evident in the moment. Explicitly contradicting the argument that the act of writing the plan encourages individuals to think about how they may maintain control during labour and contribute to decision making. Indeed one participant even suggested that having the plan down in writing can evoke anxiety about one's lack of control.

Clinical Implications

This study raises a number of questions about the birth plan as it is currently employed and its value. The written birth plan appears to superficially offer women a means of being in control and making choices about birth, but it is questionable whether it can consistently empower and deliver a realistic and satisfying image of how birth will transpire. Indeed it appears that as a written document it may in fact set women up to fail in its attempts to control an unpredictable event. However as a lack of perceived control can be a stressor which has direct, negative effect upon health, perhaps it can be bolstered without the rigidity of the prescriptive written plan, for example by having discussions with the midwife and birthing partner (Wallston, 1989).

It is apparent that the participants have been able to articulate both positive and negative aspects of the birth plan in addition to highlighting the contradictory elements

it embodies. Participants have also alluded to possible improvements/adaptations that could be considered to improve the experience of both birth planning and childbirth. Furthermore the participants reported positive overall experiences and yet still alluded to some of the birth plans shortcomings, therefore highlighting the issue that for those individuals who have more perceived negative experiences or who present more rigid attitudes that the risk to psychological and physical health may be greater for both themselves and their child.

The formulaic application of the birth plan may not be an optimal method and greater tailoring may be warranted; peri-natal pre-screening for *flexibility*, *rigidity* or risk of post-natal PTSD/PND may be a means to overcome this issue and/or employing a more informal or discursive approach to birth planning may temper some of the difficulties. Indeed this supports Hollins-Martin's (2008) sentiment that tailored support maybe necessary where poor self-performance is predicted in addition to the recent government driven NHS strategy highlighting 'personalised care'.

Consideration must also be given to the current economic/political climate and its impact upon the limited provision of support in general, irrespective of utilisation any form of birth planning aid. Indeed NHS midwifery cuts are anticipated, despite the 3,000 additional midwives of pre-election pledges and in spite of the 4,700 needed to provide a safe and high quality service for women. Midwives report 'getting used' to working conditions that are actually risky (Warwick, RCM, Jan 2011), the ramifications for labouring women may be dwindling standards of safety creating an increase in inadequate birth experiences.

It is important to clarify that the present investigation does not aim to address the limitations of the staffing levels and resources however this reality inevitably affects whether the birth plan can play any role in contemporary perinatal care. Nevertheless, it

does intend to begin to redress the issues and gaps outlined by way of affecting an exploratory study, fundamentally investigating women's experience of childbirth and use of written birth plans in the UK.

Methodological Limitations

This report attempted to respond to methodologically weak and equivocal findings regarding the value of the written birth plan as currently implemented (Berg *et al.*, 2003, Ekeocha & Jackson, 1985; Kuo *et al.*, 2010; Lundgren *et al.*, 2003; Moore & Hopper, 1995; defined in the literature review *results*) by adopting an exploratory phenomenological approach and conducting interviews independent of the caregivers or care facility. This study intended to produce detailed and rich accounts appropriated from a position of 'not knowing' within an IPA framework, whilst attempting to remain systematic throughout the process of conducting and writing the report, however certain limitations have still transpired.

The idiographic IPA approach does not attempt to produce positivist results and generalise them to the wider population. This study attempted to be more exploratory when investigating the experiences of post-natal women in relation to the use of the birth plan rather than assuming from the outset that the birth plan was an efficacious resource and quantifying its effect. This lack of generalisability (Barker *et al.*, 2002) is arguably true for this study; the views of post-natal women in general cannot be assumed from a small sample. Similarly due to the nature of the purposive sample necessary to extract information pertinent to the research question (Smith *et al.*, 2009), IPA is aware of the limitations in its capacity to form generalisations from its conclusions. However, this study achieved the goals predicted/alluded to, begun to address the limitations within the

literature, offered important observations into the area of birth plan usage and has laid foundations for future research.

In studies of this kind the possibility of self-selection bias is acknowledged as well as the potential different experiences of participants despite a homogeneous sample being sought. It is also feasible that those individuals choosing to take part may have been more invested in the impact of the birth plan upon birth experience and therefore willing to explore this topic.

Furthermore attempts have been made to ensure transparency and as alluded to adherence to IPA guidelines, texts have been consulted and peer/academic supervision sought in order to produce rigorous standards (Smith *et al.*, 2009; Smith 2011), however the themes that were developed are those that were prominent to the researcher at the time of data analysis; a different researcher may have found the emergence of other significant ideas.

Future Research

This study has begun to lay exploratory foundations regarding women and caregiver's opinions about birth plans in order to better understand the impact of the birth plan and consider its role in effective perinatal and postnatal care. It has been highlighted both in this report and by other researchers, that a more flexible approach to birth planning (i.e. a verbal plan or revised antenatal education approach including teaching, evidence based birth models, cognitive flexibility to or accepting uncertainty during labour) may be considered more effective (Peart, 2004). Future studies may wish to explore in greater depth the efficacy of other viable approaches. In addition conducting similar studies with women who have had more traumatic experiences in order to explore whether blame is attributed to the birth plan (not delivering what it was

supposed to) or that women feel that they may have been set up to fail, could provide some valuable insight highlighting any negative psychological outcome. Furthermore it is not clear whether plans are being filled in because women are prompted to and therefore feel some unconscious or conscious obligation to and/or in a bid to produce a (n arguably false) sense of security or control. Therefore a comparative study may be interesting to pursue.

Conclusions

This study has added to the literature base regarding the impact of the pre-generated birth plan upon childbirth experiences. The use of IPA has enabled the researcher to extract in depth experiential narratives in order to explore the research questions. This study has highlighted that the birth plan clearly has merits but individuals react differently in this highly emotive, unpredictable scenario and without certain qualities such as flexibility, ability to cope or perceived outcome could be hampered. A further essential finding of the study was that although knowledge can be empowering in the planning process, rigidity of choices made could prove to be problematic in light of the situation being subject to chance. Arguably these findings emphasise the importance of individualised care and its application to the birth plan process. The need for flexibility when birth planning rather than a one-size-fits-all approach may lead to tensions between the patient and her caregiver, disappointment if the birth does not go as planned and at worse result in post-natal PTSD/PND.

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Part 3: Critical Appraisal of the Research

1. Critical Appraisal of the Research

This chapter will outline some reflections regarding my research journey in terms of design, methodology and writing up the report. It is by no means exhaustive but will outline some pertinent areas informed by my research journal.

1.1 'Conception' of the research

Early in the planning stage I was keen to pursue a project in the area of perinatal psychology and birth. It was an interest which was sparked during my time as an Assistant Health Psychologist and consolidated after reading a paper by Slade and Cree (2010) who offered a psychological plan and practical recommendations for perinatal care. It highlighted to me that childbirth was a fascinating area due to its contradiction; as a certain event with a wholly unpredictable reality. This led to me having discussions with my academic supervisor who had a wealth of knowledge and experience in the health psychology field. Initially I was keen to write and evaluate a psychology informed component to antenatal education based upon Slade and Cree's (2010) ideas. However after discussions it was clear that the scale of this would be too great for a doctoral thesis. Eventually we developed an idea which was 'born' out of a previous trainee's thesis regarding the knowledge, beliefs and attitudes of health visitors regarding post-natal post-traumatic stress disorder (PTSD). The birth plan had been alluded to during the interview stage in relation to a query regarding its efficacy and we believed that there was scope to develop and investigate this further.

Ultimately this led to the completion of the preliminary literature review conducted in the first year of training. It became clear that although there was an emerging research base in this area, there were two obvious gaps or limitations; 1. methodology; which was often fairly weak and 2. the position of the researchers; who

typically assumed that the birth plan was an effective tool and measured its effectiveness rather than stepping back and exploring whether this method was executing what it set out to. Through further discussions this enabled me to develop the study and my research questions.

The developing 'foetus'

It felt natural that the research was going to be qualitative in nature due to the factors outlined above and after I had discussions with one University tutor who had a wealth of qualitative knowledge and experience it seemed in little doubt that Interpretative Phenomenological Analysis (IPA) was glaringly appropriate. This excited me as it fits with my own academic and clinical position about treating participants as different and individual people rather than reducing them to numbers and losing the meaning of the human experience. But it also made me nervous as I knew that I was both inexperienced in completing this type of analysis and that it could take a long time to really engage with the data in this way.

However, IPA appeared to be a 'good fit' and I began to read core texts and articles regarding how to complete IPA and reports in which the authors had used this approach. Unfortunately I was unable to attend an introductory course but have liaised with my colleagues who went and felt equally knowledgeable having completed my own research. So why did I choose IPA?

1. IPA methodology suited the epistemological position of the research questions posed and would provide an exploratory approach to develop understanding and rigorously explore the lived experience of childbirth and use of the written birth plan from the perspective of the mother. In addition IPA examines the individuals analysis of their world in an attempt to establish an

‘insider’s perspective’ (Conrad, 1987) regarding their lived experience, by exploring in depth how people make sense of and impart meaning to these experiences (Smith *et al.*, 2009).

2. IPA has phenomenological and hermeneutic philosophical underpinnings which claim that people will attempt to give meaning to ‘their activities and to things happening to them’ (Smith *et al.*, 2009) and that IPA researchers will be interpretative in their attempt to understand these constructions. IPA does not advocate that there is one truth to be discovered (Smith *et al.*, 2009), instead it is the researcher’s role to make sense of the individual making sense of their experiences (Smith, 2011).

3. IPA is idiographic and inductive highlighting a ‘bottom-up’ approach, moving from specific observations to generating broad generalisations. This bottom-up approach is not based upon any preconceived theory or assumptions and celebrates a position of curious uncertainty which therefore this suits the research aims of in depth investigation of a small number of individuals regarding an ambiguous topic (Smith *et al.*, 2009).

4. IPA has been established and widely utilised within the health psychology field (Smith *et al.*, 2009; Smith, 2011) yet there have been no such IPA studies conducted which examine the experience of childbirth with particular reference to the written birth plan.

5. Although there is ‘no clear right or wrong way of conducting this sort of analysis’ (Smith *et al.*, 2009) and indeed flexibility is the key (Reid *et al.*, 2005), guidance does exist regarding conducting IPA research and evaluating quality (Smith, 2011) which is invaluable for an IPA novice.

6. IPA also echo's the researcher's own epistemological position celebrating detailed individual experience rather than limiting human experience to a numerical form and its exploratory nature for investigating the 'unknown' which seems suited to the research questions. In addition IPA's iterative nature enables ongoing review of the schedule and amend if and where necessary in response to each interview.

In discovering and choosing IPA I needed to clarify why I was not using another qualitative approach. My understanding is as follows: -

IPA – (as above) is idiographic; celebrates the experience of the individual in addition to looking at areas of convergence and divergence between interviews. It allows the individual to come from a position of 'not knowing', which is arguably liberating for the participant, researcher and the unbiased development of the research assuming one remains reflective and reflexive. It is interpretative and hermeneutical; making sense of people making sense of their experiences felt like a natural position for a research-clinician. It requires a relatively small number of individuals who have had a similar experience and was established and is used widely in the health psychology field.

Discourse analysis – typically explores the role of language to describe experiences rather than attributing meaning or being interpretative. Language is important and attended to but is not the overriding analytical focus in IPA.

Grounded theory – as the grandfather of qualitative approaches probably is the most akin but has some distinguishing features which were not in keeping with my project. It sets out to create theory, requiring large numbers of disparate individuals and an exhaustive approach to theme recognition/development. The focus does not have to be psychological but it typically about looking for convergence.

Narrative approaches – content and/or structure of people's stories regarding their experiences are typically the focus; looking to identify how these ideas affect experience. It does not use thematic deconstruction.

However, IPA was not without its limits and this is discussed in the body of the report.

Following this stage of development the authorised signatory in the perinatal area for R&D activity at UHL was contacted in order to explain the research and to verify that access to participants would be feasible; the researcher then liaised with the trust's Consultant Midwife to ensure access to participants was possible.

'A challenging pregnancy' – ethics and beyond

Having produced my research proposal which had been sanctioned by the University the next task was ethical approval. This was a steep learning curve which will stand me good stead for future studies. It was long, repetitive, arduous and at times made me 'nauseous' but ultimately I managed to submit my forms before Christmas and following minor amendments received approval early in 2012. This deceptively short description does not do the lengthy nature of this process justice. Although I am keen to start any tasks early I have learnt that beginning this process as soon as possible is your best chance of remaining 'on track' due to the volume of back and forth emails that transpire as the process proceeds.

Recruitment was then undertaken and was a relatively straightforward process as I had already met with my consultant midwifery contact and discussed how this was likely to proceed. She was able to recruit her colleagues, some who were more proactive than others, to approach and seek consent from appropriate participants and forwarded details onto me. This felt like a quick process; I was able to arrange six interviews in the following two months. The first two I treated as pilots, although they appeared to be so

rich in data that they contributed to the final report. In these first two I had some issues with my recording equipment; I learnt that technology is extremely variable in quality and when I used a newer device for the following four interviews, transcription was infinitely quicker.

Unsurprisingly I found that interviewing became easier the more I completed. All the participants engaged well with the process and I felt that was a good indicator both that they felt at ease with me and that the questions I was asking were relevant and engaging. Indeed beginning with ‘warm up’ questions generally settled participants into talking about their experiences. I attempted to hold the phase ‘a conversation with a purpose’ (Smith *et al.*, 2009) in mind facilitating the individual to tell their story without a rigid adherence to the interview schedule. Prompting people to expand upon how they felt about the experiences they were reporting felt like a natural process akin to that in the consulting room. However I was by no means a perfect interviewer and found myself asking some leading or closed questions which I tried to be mindful of in future interviews. A further challenge whilst interviewing was focus; unsurprisingly these new mothers had their babies with them and my experience was split between a very calm/quiet to a busy/noisy environment which may have hampered my concentration on occasion. I was aware that this would likely be the case and that I would have to adapt.

In the intervening weeks between interviews I transcribed the data. This was possibly the longest process during the research timeframe which I had initially hoped to recruit help with. With the benefit of hindsight, I can reflect that I was lucky that the ethics committee stipulated that I would have to transcribe the interviews myself and this served me well. I was able to become ever more immersed in the data, consolidate what I had already gleaned from the participants and began to see items of interest in

the text, which coupled with my written reflections was helpful to begin to develop ideas and coding. Although I treated each transcript as piece in its own right and before I had created the overarching themes, it was challenging not to automatically spot similar themes emerging in each text. I was aware that this was happening and in order to console myself that I was not forcing similar themes onto each transcript I ensured that I had adequate quotes/evidence to back up my ideas. Furthermore IPA peer supervision was helpful in corroborating what I thought I had found. Indeed peer supervision was invaluable for reflecting upon the whole analysis process in addition to remaining reflexive and I would recommend this to any future novices.

My experience of employing IPA to analyse the data was both fulfilling and frustrating. For analysis there were no prescriptive rules or 'right' answers but a number of ways to tackle it; some which really didn't suit my style of learning/making sense of the data. On a practical level I could not have taken the approach in which transcripts are cut up and 'piles' are collated for each theme, the lack of compartmentalisation would have bewildered me. Instead keeping the transcripts whole and writing all over them, with wide margins to keep the themes to the left and the comments to the right, underlining interesting quotes suited me and also felt more in tune with the epistemological position of IPA – which maintains the links and connections in which the whole is greater than the sum of the parts. This also reifies my passion for qualitative approaches which celebrate the detail and do not over simplify the human experience.

I initially thought that due to my lack of personal experience in childbirth and parenting, my own beliefs would be a benefit when it came to the more deeper, conceptual or interpretative level of analysis. However it was soon clear that I had partially shaped views having completed the literature review which I was aware could

colour the coding and themes and is a criticism of IPA. I had encountered the possibility that there may be some problems with the birth plan as it is currently executed and that I found evidence to suggest that this may be the case but equally I was mindful to demonstrate that any benefits alluded to must also be credited; a balance I believe I managed to achieve. Through reflection and supervision I remained reflexive, aware of this possibility which focussed my approach. This was a process of continual self-checking.

'Birth' – production of the report

After having attempted to form my super and sub-ordinate themes and tabulated the frequency of examples pertinent to each I began the writing up process in the first three weeks of September 2012. This in itself was a learning curve having discovered that sitting at a laptop for three weeks of research leave does not suit my learning style and in the final week I got bogged down, unable to 'see the wood for the tree's' whereby I began writing my literature review as a change of tack. However in those first two weeks I concentrated on the results section and themes that most frequently appeared which were retained in order to best illustrate them within the body of the results section. As a novice I was surprised to see so much overlap potentially because of my inexperience. Writing the results section was challenging and I made great efforts to present quotes that illustrated and justified the themes identified, whilst also achieving an interpretative stance. It was tricky trying to balance a thorough analysis with a relatively small amount word count and I found it difficult to exclude data that was compelling and precious. I had gone on a mini journey with each of the women and felt the need to reflect each of their valuable narratives.

Post-natal reflections

Completing this report has given me a good grounding in the execution of a piece of independent and clinically-relevant research. I am now more aware of my preferred working style with particular reference to the importance of using and sticking to a timetable, completing a solid proposal and networking early in the process and the complexity of gaining ethical approval. I initially felt relieved to begin both the third year and my thesis, surmising that the benefit of the third year was only having one deadline. However, I learnt that one large deadline is more challenging than a few smaller ones particularly as it is difficult to remain focussed and objective. Finally I feel that this experience has consolidated why I was compelled in the first instance to pursue the multifaceted and dynamic role of Clinical Psychologist.

Future Research

I have outlined in the main body of the report how future studies could proceed. Personally I am particularly interested in pursuing the efficacy of alternative methods of planning birth, comparing a written plan with a more flexible, discursive approach. I believe that there are many benefits of a written birth plan but I am now intrigued whether alternative approaches may be both more efficacious and clinically safer.

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Appendices

Appendix A

PRISMA 2009 Flow Diagram

(deleted for copyright purpose – see references for origin)

Appendix B

Search summary

Database	Date Searched	Number Articles Retrieved	Relevant Unique Articles	Key Words	Limiters
PsychInfo	July 2013	7	2	<i>"birth plan"</i>	English; Peer Reviewed Journals; Human; Key word in 'title'
Web of Science	July 2013	15	(4) 2	<i>"birth plan"</i>	English, Article; Keyword in title
Scopus	July 2013	31	(5) 1	<i>"birth plan"</i>	Keyword in article title; English; Article
Cochrane	July 2013	2	(1) 0	<i>"birth plan"</i>	Search all text
Google Scholar	July 2013	100 (2,710 Pages 1-10 reviewed)	(5) 1	<i>"birth plan"</i>	Article
Total Number Relevant Articles Retrieved = 6					
Total Number Relevant Articles Retrieved (through reference search) = 4					

() : – Total with repeats

BOLD – Total without repeats

Appendix C

Adapted Data Extraction Pro-forma

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Appendix D

Table 1 – Preliminary Summary of Articles Limitations & Gough’s Quality Appraisal

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Appendix E

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Appendix F

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Appendix G

Participant Information Sheet

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Appendix H

Version 1

Interview Schedule

As you are now already aware, I will be asking you about your experiences and thoughts about childbirth and the use of written birth plans. Please take your time, skip or come back to any questions you feel you would like to. The few questions are very open and intended to allow you space and time to talk. Please feel to talk in detail about your experiences; I am very keen to hear about all aspects.

1) **Childbirth Experience**

Could you tell me about the birth of your child (from onset of labour/induction/caesarean)?

Prompts: (how you made sense of it; when, where, support, positive and negative aspects and why; staff involvement)?

How did you feel?

What were you thinking?

Tell me about the lead up (the antenatal period) to your birth experience?

How did you feel?

What were you thinking?

What were you doing?

2) **Written Birth Plan Experience**

Check: -

What is your understanding of the term '(written) birth plan' (any synonyms i.e. birth flow diagrams)?

Did you have a birth plan? Can you tell me about it?

How did you go about creating it?

Who was involved?

What information sources did you use (i.e. internet, professionals, books)?

Did having the birth plan affect your experience?

If so how? Why? What did you think, feel etc? OR If no, what do you make of that?

What did having a birth plan mean or suggest to you?

How did you feel about this?

How do you now feel about this?

3) **Thoughts and Views about Written Birth Plans**

Before the experience of having your baby, what did you know about birth plans?

What was your understanding of the purpose of a birth plan?

And now, after this experience of having your baby, what do you think about birth plans?

What are the pros and cons of a birth plan?

Did it effect communication with others (doctors, midwives etc) during the birth? And how?

Is there anything that could be changed regarding the nature of birth plans?

4) **Closing**

Is there anything else you would like to mention or reflect upon regarding your birth experience or the use of a written birth plan?

END

Appendix I

Epistemological Position of the Researcher

As a Trainee Clinical Psychologist I am required by the course to undertake a doctoral thesis. I have nurtured an interest in perinatal and health psychology over the years beginning as an Assistant Psychologist working in a physical health service, when I read a paper regarding the arguable inadequacies in psychological preparedness of mothers within perinatal care (Slade & Cree, 2010). I felt that childbirth was a fascinating area due to the conflicting predictable yet totally unpredictable scenario that it embodies. This ‘snowballed’ my interest and ultimately led me toward developing thesis idea’s in collaboration with my academic supervisor regarding this domain. Although I do not suggest that I have an extended repertoire of experience in this area, I do have a keen interest in both the topic and developing my qualitative research skills particularly in the emergent and developing realm of IPA, which both suits my research questions and my epistemological position. More specifically has IPA enabled me to start from a position of ‘not knowing’ and explore the experiences of the women in terms of their thoughts, feelings and how they make sense of the their childbirth experience. In addition I wanted to adopt an exploratory approach as the existing literature appears to take the assumptive position that the birth plan is delivering what it set out to (evaluating the success) rather than explore whether this is indeed the case which is poignant when we consider the costs of poor birth experiences are both high for the mother and child (i.e. PTSD; PND; affected bonding/attachment) and therefore to the NHS who have to pick up the psychological pieces.

Based upon my literature review my position regarding childbirth is somewhat more informed and yet diverse. I believe that the concept of the written birth plan is positive but can also be a source of discontent which may lead to difficulties for mother and baby. I believe that its typically formulaic approach is both lacking a sound

evidence base and erroneously assumes that it is useful for *all* mothers to complete. We are all individuals and I strongly believe a more tailored healthcare approach is necessary in all domains. In a typically unpredictable environment the written birth plan may provide a (n arguably false) sense of control. This supposition for me is one potential contradiction of the written birth plan – attempting to control what appears to be accepted as an unpredictable event. From a feminist perspective I am wholly behind the essence of the birth plan to promote choice and power for childbearing women. I believe that women should have a voice in what I understand to be an intense and often daunting event. Professionals involved have great expertise in the medical branch obstetrics but typically they are not experts with regard to the self or the individual which is where I believe that having some say in the childbearing process is valuable. I think that discussion about birth options is not only self affirming but likely to facilitate both communication between midwives and their patient and developing trust is imperative to create a sound working relationship. However I also believe that to write one's thoughts and feelings down in black and white does have a concretising effect for people (based upon my therapeutic knowledge and experience) which can be cathartic and also very powerful especially if this is with regard to goal setting or decision making whether therapeutically or perinatally.

Therefore I wonder whether if the plan could be used more flexibly than in the written format and whether it would be quite so debilitating for those women who perceive that they have set themselves up to fail or personalise any difficulties and any deviation from the plan. In addition I wonder whether if the culture around the plan was more flexible or there was a move away from formalising it into a document whether women would feel that they were expected to do it and in fear of the repercussions if they didn't fill it in. I'm keen to learn about women's childbirth experiences when using

a birth plan and whether they allude to the notion that it may not be working as well as it might be.

My position in relation to the medicalisation of childbirth debate is fairly neutral and again informed by the literature that I have been immersed in rather than personal experience. The litigious narrative is a zeitgeist that appears to be well embedded in our society. It appears that a further narrative around (perceived) risk minimisation is pervasive in western society, that women expect to give birth in hospital rather than the family home and anecdotally talking with primiparous mothers that it is a comfort to know that the ‘professionals’ will keep them and their baby safe. Typically the more traditional or ‘natural approach’ to childbirth which arguably promotes home birth appears to be a rare event, only championed in ‘low risk’ cases.

My position with regard to how we develop understanding or knowledge about ourselves, other people and the world is influenced by social constructionist and idiographic concepts, that it is constructed through individual subjective experience. I believe that there is no one truth to be uncovered but that as individuals we create our own realities, coloured by our experiences and relationships. The impact of experiences and relationships can create similarities, overlap or clusters of affect between people but to state that they are statically or definitely of a type or diagnosis seems too simplistic.

Themes in the analysis were derived hermeneutically through my own meaning making of the participants meaning making of their experiences. I used the material in the transcripts to guide my coding and thematic decisions and looked for both clusters and diverging ideas that could be discussed.

These ideas and beliefs will have an impact upon how I analysed my data but I attempted to remain reflexive and reflected upon this when undertaking peer and one-

to-one supervision. I do feel that the more I have read, the more my opinion upon the ideas/debates outlined has become increasingly open and curious to explore further.

Appendix J

Chronology of research process

What	When
Draft proposal submitted for Peer Review	May 2011
Make contacts/network	May 2011 – Jan 2012
Proposal submitted to Ethics Committee	Dec 2011
Participant recruitment	Jan – April 2012
Data collection	May – June 2012
Analysis	May – Nov 2012
Write Up	Oct – April 2013
Hand in	End April 2013
Viva Voce	July 2013
Minor / Major amendments	Plus one-six months
Submission for publication	Within 12 months

Appendix K

Guidelines to authors for journal targeted for literature review

Reference: - <http://www.tandf.co.uk/journals/printview/?issn=0264-6838%20&linktype=44>

Journal of Infant and Reproductive Psychology

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Appendix L

Smith (2011) IPA quality evaluation guide

(deleted for copyright purpose – see references for origin)

Appendix M

Preliminary Thematic frequency

Theme	P1	P2	P3	P4	P5	P6
1. 1. Narratives That Override The Role Of The Birth Plan						
1.1 Flexible Perspective	2	3	2	2	2	1
1.2 Rigid Perspective	1	1	0	1	1	1
1.3 Perceived Positive Experience	3	3	1	2	1	1
2. Alternative Approaches To The Written Birth Plan	2	1	2	1	0	1
3. Birth Is An Uncontrollable Event	2	1	2	3	2	3
4.1 Birth Plans – Contradiction Of Its Role	3	4	3	5	5	4
5. Knowledge Gained Regarding Pregnancy & Childbirth	0	2	2	2	1	1
6. Control	0	2	2	1	3	1

Appendix N

Example of analysis (lifted from original transcript 2)

Emerging themes	Line No.	Transcript	Comments
	143	I: Right, so it was different to how ...	
Flexibility	144	P2: I'd say it was the exact opposite to all the things I'd said but obviously I'd never said no to anything on my birth plan and I was like if he needs this or he needs that I rather them do it, I don't want to be ... we'll see what happens but there are things that when they explain it to you you think I don't want that, I don't want them breaking my waters. I was like I don't want cutting or that kindof thing	Total opposite experience of what was planned. But plan was flexible. Never said 'no'
	150	I: So just get him out as safely as you can	Leading?!
	151	P2: Yea, quickly because they had said y'know we want to get him out quick and ?try and makes sure he hasn't got an infection and stuff? So ...	
	153	I: So how did you feel about that at the time?	Good – clarified feelings
Flexibility	154	P2: At the time I wasn't too bothered I was just very much like we're gona have to; they didn't give me a choice not in a nasty way, we're gona have to do this, we're gona have to do that and OK fine whatever. After they got *** out I was like I didn't want that and I felt a bit sad about ... because I'd not had them but then at the end of the day I'd not gone into it with the idea that this is what I want and nothing else, its just how its got to be ?flexible?	At the time change was ok. No choice in the moment. Resigned? Acceptance?