

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

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Keywords: discourse analysis, birth trauma, narrative, fathers

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Abstract

Objectives

To explore the discursive construction and social actions achieved by accounts given by men following a birth in which the mother developed life-threatening complications.

Background

Existing qualitative research employing interpretative thematic analysis of the content of men's accounts of births in which the mother developed life-threatening complications highlights the distress and marginalisation expressed by men. This paper extends this by adopting a different epistemological and analytic approach to those accounts.

Methods

Secondary data in the form of audio recordings and transcripts of semi-structured interviews collected by Hinton et al. was re-analysed using an approach informed by narrative analysis (Riessman, 1993), discursive psychology (Edley, 2001) and the discursive action model (Edwards and Potter, 1993). **Participants were four white British men who attended hospital for the birth of their babies and whose partners went on to experience a maternal "near miss" event.**

Results

This analysis illustrates how men in this study draw on cultural narratives of 'normal' birth to construct their experiences. The content of stories highlights the marginalisation of fathers, with narrative constructions highlighting separation of health professionals from laymen.

These men use a discourse of self-reliance within their families to construct their path to recovery.

Conclusion

The strength of available narratives of birth and the limited accessibility of alternative ones may impact how men are able to tell of their experience. Men in this study discursively attend to issues of power, agency and male identity, re-establishing entitlement to speak about their experience, but construct emotional support as unavailable to them.

Keywords: Discourse, Discursive, narrative, childbirth, men, fathers

Introduction

Around 98% of fathers in the UK now attend the birth of their child (TNS System Three, 2005). Research to date suggests these fathers feel they occupy an undefined emotional and physical space between patient and visitor, often feeling excluded and fearful (Steen, Downe, Bamford, & Edozien, 2012), experiencing birth not only as wonderful, but also (sometimes) as distressing (Dellmann, 2004). For many men, feelings of fear dissipate after delivery (Chandler & Field, 1997), however around 5% to 12% of men (Ayers, Wright, & Wells, 2007; Bradley, Slade, & Leviston, 2008; Parfitt & Ayers, 2009) show symptoms meeting the diagnostic criteria for PTSD following any birth.

What health professionals may consider a traumatic in a birth does not always correlate with what parents consider a traumatic birth in terms of their felt experience. Beck (2004) used descriptive phenomenology to analyse the stories of 40 women in New Zealand, America, Australia, concluding that births could be perceived as traumatic even when viewed as routine by healthcare professionals. It is this perceived, self-defined trauma, influenced by the individual history, contexts and expectations of each person, which is likely to be the best

predictor of ongoing distress following birth. Johnson's (2002) study suggests that fathers' stress and fear during their reproductive experience peaks during the birth process, and can become very high where labour is prolonged or excessively painful, where complications arise, or where men do not feel they fulfilled their role expectations or felt pressure to be at the birth. Around 3% of men responding to a questionnaire in Berry's (1988) study indicated worry that their partners may die, but reported spending more time trying to hide their feelings and worrying than they did actually coaching their partners, suggesting the importance of discourses of what is expected of men and their perceived role in determining how they are able to interact with the birth experience. Harvey and Pattison (2012) used semi-structured interviews with 20 men to explore fathers' experiences of the resuscitation of their baby at delivery, an experience likely to be distressing to most people. They reported that predominantly negative feelings remained vivid after delivery, with several fathers describing feeling they had not yet recovered, some showing symptoms of PTSD. Fathers in this study also reported feeling a lack of opportunity to discuss what had happened with health care professionals afterwards. They also told of wanting to go to their baby but feeling they should stay with their partner and not impede resuscitation, feeling they were not "allowed" to go to their babies. Reports that behaviour was constrained by the perception of their roles suggests that such perceptions may shape behaviour throughout the reproductive process but also the ability to process and communicate experience.

Though rare (1.2% of births in England; Waterstone, Bewley, & Wolfe, 2001), "near misses", that is, severe, life-threatening obstetric complications such as haemorrhage, amniotic fluid embolism and sepsis requiring emergency medical intervention to preserve life (Waterstone et al, 2001) do arise, potentially, though not inevitably, giving rise to the experience of trauma.

Hinton et al. (2014) undertook semi-structured interviews with 35 mothers and 11 partners following near-miss events in the UK from 2010-2012. An interpretative thematic analysis suggested that life-threatening complications in childbirth can impact on partners as well as mothers. Partners described feeling powerless, side-lined and inadequately communicated with. However, small elements of thoughtful, personal care from healthcare professionals were said by parents to make a big difference to how couples coped (Hinton et al., 2014).

Previous research has sought to understand men's experience of birth and emotional distress following birth through attention to their voiced stories (eg Hinton et al, 2014, Dellman, 2004, Von Sydow and Happ, 2012). The present study seeks to explore stories, but through a different epistemological lens. Rather than treating stories as representations of 'experience', this study draws on social constructionist approaches which hold that the accounts men offer of their experiences can usefully be understood as discursive actions influenced by and contributing to the discourses that surround them. This form of analysis highlights the *context* of talk: exploring how personal accounts draw on and resist broader discourses (eg, of acceptable roles for fathers in obstetric settings); and hence seek to link personal stories to wider social understandings. It is important to stress that this focus on processes of construction does not imply a lack of concern for, or a questioning of, men's voices. Rather, it seeks to deepen understanding of the worlds in which these voices speak – and ultimately lead to better understanding of, and support for, men in similar circumstances.

Methodology

This study employs a qualitative analysis of previously audio-recorded interviews with four fathers whose partners had suffered a 'near miss' during childbirth. In line with its aim to explore the construction of men's accounts, the study synthesises several approaches to the analysis of language.

First, it draws on a critical discursive psychology approach (Edley, 2001) to explore how accounts are embedded within historical contexts, drawing on ‘interpretative repertoires’ - or culturally established units of understanding - to build culturally-understandable constructions of events or experiences. Relatedly, it considers the ‘subject positions’ available to speakers, to give an account of the identities of themselves and others - what sort of person (identity) they are.

Secondly, it draws on the discursive action model (Edwards and Potter, 1993; Horton-Salway, 2001) to consider how accounts attend to issues of agency, accountability and perceived factuality in their accounting. Such issues are argued to be particularly salient in telling of events or experiences that may be contentious (ie, where other versions may be put forward, or the actions of those involved may be questioned).

Lastly, it draws on context-focused forms of narrative analysis to explore how longitudinal aspects of the account reflect ‘canonical narratives’: that is ‘narratives of how a person might expect to live within the culture.

Thus, while remaining attentive to the content of the men’s accounts, the method is sensitive to how their construction - and their performance - reflects potentially-powerful cultural constraints on how it is possible to tell a story of being a man whose partner had a near-miss during childbirth.

Data

This study undertook secondary analysis of interview data collected by Lisa Hinton of the Health Experiences Research Group at Oxford University. This data was collected as part of the UKNeS Study funded by the National Institute for Health Research Programme Grant and

led by Professor Marian Knight. Previous analysis has been published on the Healthtalk website (www.healthtalk.org) and in peer-reviewed articles (Hinton, Locock and Knight, 2014a; Hinton Locock and Knight, 2014b). Of the 35 women interviewed who experienced a life-threatening complication during childbirth, 11 of their partners (10 men, 1 woman) were also interviewed about their experiences and the long-term impact of those experiences. Interview data from the 4 fathers selected (see below) lasted between 35 and 95 minutes. Data was provided as both audio recordings and initial transcriptions.

Ethical Issues

Ethical approval was granted for the project by Berkshire Ethics Committee (protocol number 09/H0505/66) from 05/09-09/12 and NRES Committee South Central (Berkshire) (REC reference number 12/SC/0495) from 09/12 to the current time. These approvals were inspected by Prof. Richard Southern and accepted as compatible with University of Hertfordshire standards. Informed consent for both the primary research and the use of data for secondary research was obtained by the primary researchers.

Participants

Recruitment of the original sample of ten male and one female partner of mothers who had suffered a condition which threatened their lives during pregnancy or childbirth is described by Hinton et al. (2014).

From the ten interviews from the original study conducted with male partners, whose child had survived, a subsample of six were originally chosen. This was a purposive sample,

selected for having described lasting distress within the interview. (Excerpts from these interviews are publicly available on the patient resource Healthtalk.org-online - <http://www.healthtalk.org/peoples-experiences/pregnancy-children/conditions-threaten-womens-lives-childbirth-pregnancy/topics>). However, on obtaining the full interviews on audiotape and written transcripts, it became evident that two of these interviews were conducted jointly with the men's partners. This relational context was considered likely to alter how these men constructed their accounts. Although worthy of study in their own right, for the purpose of relative homogeneity in a small sample, these two interviews were excluded, leaving a sample of four interviews. These interviews had been conducted between one and five years following the birth in question. Demographic data provided on Healthtalk.org http://www.healthtalkonline.org/Pregnancy_children/Conditions_that_threaten_womens_lives_in_childbirth_pregnancy/Topic/4304/) for the interviews which were used is presented here.

Insert Table Here

Analysis

An iterative process of repeated listening, identification of discursive features and refinement of analysis was conducted. Recurring elements of stories were treated as themes or distinctive strands for the purpose of structuring the analysis. Examples fitting and deviating from these strands were then sought as thematically orientated segments of analysis were developed. The functions and effects of the features identified in the interviews were then discussed.

Analysis and Discussion

Each story presented a tapestry of interwoven strands, lending depth and context to an intricate and complex larger tableau. Thus it has been difficult and somewhat artificial to tease out strands as if they stand alone, and while subheadings divide this analysis, the relationship between those parts of the discourses discussed must be held in mind.

In line with the constructionist ethos of this research, it is argued that the current analysis must be understood within the academic discursive context of surrounding literature, and hence these are presented together.

Failing Birth Narratives

Each man expresses a sense of having departed from a canonical narrative of ‘normal’ childbirth. With maternal fatality in the UK currently mercifully rare, these men seem to grapple with a lack of accessible scripts to help them make sense of their experiences:

I can remember(.) thinking kind of what opposite kind of experiences were happening because you know there's kind of healthy parents with ill children and... I never(.) thought that(.) the baby would be fine(.) the parent would be ill(.) you know(.) kind of(.) it was the thing that(.) it's not a scenario that you kind of(.) go in with

(John:24/1.05.09 – Interviewee pseudonym: time in interview utterance occurred/full length of interview)

Using in-depth interviews with men before and after the birth of their first baby, Dolan and Coe (2011) suggested it was the uncertainty surrounding childbirth which caused men most

concern. The men in the current study repeatedly narrate their efforts to create predictability in advance of, during and even after the birth. John talks of having made a birth plan, while Rob speaks of having planned a caesarean after experiencing an unplanned one previously, telling their doctor ‘we’re not even going to chance that’. The restoration of such a narrative can even be seen after the incident, as Craig tells that he later ‘decided we would never have any more children’ and had a vasectomy - perhaps the ultimate control over the progress of a birth - and highlighting the importance of this positioning.

In contrast to narratives of the men’s planning, the birth stories highlight the failure of predictability; and medical staff are positioned as failing to prepare them for this, or to provide alternative narratives that might re-instate some predictability. Rob tells that ‘it wasn’t like they said(.) “look(.) this is heavy stuff(.) you know(.) this could potentially happen”’. Rob and Craig both talk about the desire to ‘get your head round’ what was happening, and their inability to do this due to lack of information, their difficulty making cohesive sense of the traumatic without the necessary sense-making discursive resources.

Rob makes clear the importance of being prepared to use an alternative story:

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

(Rob:14.45/1.35.01)

Negotiating power

[.]they talk big long terms(.) you know sort of(.) the doctors’ terminology(.) tha’(.) I’m not(.) maybe I’m not the cleverest person(.) but I just didn’t understand what(.) they might as well have been talking Chinese to me

(Craig:16.30/34.20)

From the outset, there is a separation between ‘they’ and ‘me’ in the way these men discuss their interaction with health-care professionals. This is reinforced in talk of doctors’ use of a language the men find culturally alienating.

In utilising this repertoire of the impenetrability of doctors’ language, Craig negotiates the dilemma of maintaining positions both of personal competence and of a contextual innocence that may absolve him of responsibility in what occurred. The cultural repertoire of ‘talking Chinese’, demonstrating a sense of foreignness and communicative confusion, possibly together with the phrase ‘you know’, also positions Craig as similar to the listener, attracting empathy and understanding from her.

Rob also invites the listener to share his position using the phrase ‘you know’, choosing to illustrate an uneven distribution of power using a repertoire of social class:

I dunno(.) he was so hoity(.) do you know what I mean? He was proper posh(.) I’ve got nothing against posh people(.) I mean I know a guy who goes fox hunting and stuff like that... it was almost like(2) he didn’t even want(.) he couldn’t even look at us when he was talking you know(.) he was just(.) no(.) we were just beneath him(.) do you know what I mean? We were just(.) I can’t even begin to describe(.) I mean you know [laughs] he may be a lovely guy in real life(.) he may be a nice guy(.) but the persona he was giving out was(.) I’m a consultant surgeon whatever(.) and you know you’re not anybody really(.) you’re just a number(.) a patient.

(Rob:38.39/1.35.01)

Discourses of masculinity in interaction with discourses of personhood and personal agency, can be discerned in how these men tell their stories. Critiquing the notion of constructions of masculinity as generally being either complicit or resistant to a hegemonic masculinity,

Wetherell and Edley (1999) conclude that rather than a 'heroic' model of masculinity, men more commonly construct themselves as masculine by positioning themselves within a model of 'normality' (or indeed of rebellion). Rob perhaps uses this model of "normality" here as counter to a hegemonic ideal of success and power. Rob's story about knowing people who engage in 'posh' activities, and his suggestion that the consultant may be a 'nice guy' helps to inoculate him against accusations of social class prejudice whilst positioning the doctor's world as disconnected from the world of ordinary people. The term 'real life', separates the micro-culture of the hospital and its power differentials in which he is personally disempowered, from life outside.

These constructions are complicated by their utilisation of the ideas of personal strength and independence from social pressures, including the pressure to conform to a stereotype of ideal personhood or masculinity, which feature within a hegemonic ideal of personhood. This enables these men to simultaneously describe a position of situational powerlessness undermining to hegemonic ideals of personhood and masculinity, and to retain a position concordant with such ideals by constructing an acceptable position of independence and resistance to such ideals.

Courtenay (2000) argues that within a health sphere men demonstrate hegemonic masculinity through denial of weakness or vulnerability and the dismissal of a need for help, and the appearance of strength, emotional and physical control and displays of aggressive behaviour or physical dominance.

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

how I didn't knock him out I don't know. Because he just looked at us and he said, "We don't induce, or have Caesareans for women early, just because they're feeling a bit tired." Was his exact words and then left the room(.) and that was the end of our(.) consultation

(Rob:8.32/1.35.01)

Craig regains agency within his narrative in a disempowered situation by describing taking physical action as opposed to continuing a verbal dispute:

She kept saying "when are you taking your daughter?" I literally picked my daughter up and said "Okay, we're going to go now." She goes "Yu- well you can't go"

(Craig:25.10/34.20)

Like Craig, Rob also constructs an empowered, perhaps masculine, position by taking control of a situation:

An' I an' I remember as clear as day I said to him "Well what you stood here for then(.) Just(.) just go and do it." you know(.) he said "Well we have to ask your permission..." I said "Stop talking to me." [laughs] d'yu know(.) none of this "We have to ask your permission."

(Rob:18.52/1.35.01)

Here, despite his powerlessness in the practice of medical intervention, Rob builds an identity for himself as the man who makes the decisions, who acts decisively and takes charge. Craig also positions himself as taking charge, this time of the flow of information, also controlling the agenda of what is important, prioritising the 'voice of the lifeworld' over the 'voice of medicine' (Mishler, 1994). In his narrative, he tells of his own re-routing of the dialogue as a precursor to gaining some understanding of what was going on:

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

(Craig:13.47/34.20)

Getting better

The men in this study do considerable work in managing their identities in the light of emotional distress during their interviews, however the interviewer also prompts reflection on the ongoing impact, and the focus here will be on how they construct their recovery.

Rob tells of how ‘when the cracks started to appear(.) I couldn’t couldn’t get me head round that cause you know(.) we don’t do emotion’ having been brought up in a family where ‘men are men and women are women’, and subsequently tells of the difficulties he encountered in seeking help for emotional difficulties:

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

(Rob:1.07.52/1.35.01)

Dolan and Coe (2011) concluded that the culturally idealised forms of masculinity which construct men as stoical and self-reliant were magnified in the context of childbirth, and questions may be raised regarding the legitimacy of their trauma where men are ‘not patients’ and women experience ‘real’ physical pain. This construction which excludes the emotional responses of men as irrelevant may also be practiced by healthcare professionals making it very difficult to resist. Dave also voices the dilemma of balancing an acceptable masculine position with his altered identity as a man with emotional distress when asked if he had been offered counselling:

No I've had none(.) you know I would like some I must admit. I suppose being a man you don't want none(.) you know(.) but at the end of day everyone needs help at the end of the day(.) if there's a problem

(Dave:25.34/40.45)

Dave acknowledges as inadequate the stereotypical ‘heroic’ discourse of masculinity in repairing trauma. Use of the impersonal pronoun ‘you’ takes focus off the individual and lends itself to the implication that this position is not his alone, a position reinforced by his next comment that ‘*everyone*’ needs help. This positions his own desire for help as falling inside a ‘normal’ repertoire, perhaps of recovery, but also of masculinity (Wetherell & Edley, 1999). He frames this help-seeking behaviour with a decisive, practical phrase, ‘at the end of the day’, which negotiates the failure to enact the invincibility of heroic masculinity by prioritising its problem-solving practicality

Dave attributes his coping to his positioning as a ‘normal’ person, responding when asked ‘it’s a lot to manage, isn’t it?’, ‘Of course without a doubt(.) but you would manage with it as well(.) Just to be here’, constructing coping and recovery as something everyone will do if

they have to. He constructs his family as resilient, and thus by proxy himself when he says ‘All I know is my kids come from good stock and so does the wife(.) and she’s tough’.

Craig also talks about the ongoing process of sense-making as something he and his wife are constructing together, at the same time building an identity as an positive person, utilising a culturally widely used ‘glass half full’ repertoire to evoke an attitude of looking at the positives in a situation:

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

(Craig:32.50/34.20)

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

we’ve come through together and we’ve worked it together and that’s the key(.) you see(.) you know you know(.) we realised we weren’t going to get any help from anyone else(.) so there was only us’

(Rob:1.11.43/1.35.01)

These men offer progressive narratives of their experience (Gergen, 2001), in which though there are regressive segments of the story, the endpoint is largely one of an improving situation. Frank (1995) proposes three distinct types of narrative which apply in illness narratives— that of restitution (yesterday I was healthy, today I am sick, tomorrow I will be better), that of chaos (life will never get better, no one is in control) and that of quest (illness is a challenge and impetus for change). Though it would be contentious (perhaps due to the

limiting canonical narratives of childbirth) to apply a theory of illness to childbirth, these families have experienced illness and childbirth as intermingled. It seems the predicted course of the childbirth narrative is akin to a restitution narrative- ‘she gets it over and done with as normal’. The failure of the expected narrative forming the middle of each story is akin to a chaos narrative in the efforts to reinstate predictability, and the impotence and vulnerability of the teller. Dave’s narrative perhaps hovers more between restitution and chaos in its final tone, constructing ‘basically we’re just a normal family’ but also with Dave saying he still has emotional issues to be got rid of. However the combined effect of these, the strength of the predicted narrative and the chaos of its failure, seems to lead three of the men into a quest narrative in which some transformative and positive impact can be found. Rob tells of how ‘we’ve worked through it and we’ve done it ourselves(.) you know(.) and I’m quite proud of that(.) because it’s been bloody hard’, and Craig says that ‘its brought Mary and I closer’ John discusses the change in family dynamics and says ‘in a way(.) y’know that-that was kind of one positive(.) thing that it did’. Each man opens the potential for a future narrative in which they are changed by their experiences, but in which they have survived.

Conclusions

The stories told by these men suggest there has been a failure of existing birth narratives in enabling them to make sense of their own less expected experience. The necessity to re-think biography and self-concept can be seen as the men negotiate the dilemmas of maintaining their ‘traditional’ masculine identities in light of circumstances in which they have experienced disempowerment, a lack of agency and a confrontation with their own emotional vulnerability. This perhaps is the thread running through the narratives, the work these men

do throughout their interviews to make sense of what has happened and who they understand themselves to be in light of that, but also to construct a telling within the social context of an interview, which will be made publically available. The response to this disruption to their understanding of their own stories, the ‘mobilisation of resources, in facing an altered situation’ (Bury, 1982) is visible in their narratives of family resilience and self-reliance.

The narratives of these men imply a need for a reconstruction of who they are and how they imagine their future. The men here talk of developing a new biography within their families, with familial relationships as the primary resource for healing. This suggests there is potential benefit in facilitating this shared meaning-making within families by reducing separation where viable and working systemically with families to support the development of repertoires of familial self-reliance as a positive resource for healing.

However, there is also talk of the difficulty of accessing professional support in a context in which the dominant repertoire of masculinity excludes the necessity of help. One discursive action of the men’s talk in this analysis is to establish the relevance of their story to the wellbeing of the family unit, and thus perhaps also the possibility that they might require or be entitled to emotional support. The separation between doctors and men constructed in these accounts suggest that doctors may not be best placed to identify emotional need.

Normalising psychosocial support following a birth in which significant problems arise may help render such support more acceptable or even expected both by users and providers, as part of a narrative of problematic birth. However, provision of support by psychologists and counsellors itself needs also to take account of the wider discourses influencing the way men talk about their experience. Professionals may also consider how their responses to the stories they are told are shaped by those stories, and the responses they invite. Support can assist men in reconstructing the nature of their emotional responses and altered roles or

renegotiating their construction of their own identity such that dilemmatic positions may be resolved into a cohesive and more comfortable understanding of self.

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Table:

Pseudonym	Age/age at birth of child	Ethnicity	Previous births (prior to near miss event)
Rob	34/29	White British	2
Craig	48/48	White British	0
Dave	43/40	White British	4
John	43/40	White British	0