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Men and women s experiences of instrumental delivery: A qualitative study

and

Research Portfolio

Part 1

(Part 2 bound separately)

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August 2006

**Submitted in partial fulfilment of the requirements for the degree of Doctorate in
Clinical Psychology**

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CHAPTER ONE Single Case Research Study

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Most importantly, I would like to thank my family for their encouragement and reassurance over the last three years

CHAPTER ONE

SMALL SCALE RESEARCH RELATED PROJECT

An Analysis of One Year s Referrals to a Clinical Psychology Department

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ABSTRACT

Recent changes in Primary Mental Health Care Services (such as the addition of Primary Care Teams), have the potential to alter the frequency and the type of referrals received by Clinical Psychology Departments. This study aimed to establish and analyse base-line data regarding the types of referrals received by a Clinical Psychology Department. The study analyses one years (n=1052) referral s, according to the referring locality and the referring agent (General Practitioner or Community Mental Heath Care Team). A significant relationship was found between the frequency of referral problem (depression, anxiety, specific phobias and PTSD) and the referring locality, but not with the referral source (GP or CMHT). The importance of the socio-economic status of referring localities and recent changes in the health care system are discussed with reference to the differing demands they place on psychology services.

INTRODUCTION

Recent health care policies place a strong emphasis on the importance of joint working across professional groups and agencies (Greater Glasgow Primary Care Strategy, July 2001). As a result there is an increasing focus on delivering integrated care for people with mental health problems (Woods et al, 2002). Primary Care Teams (PCT s) are an example these changes in the mental health care system. PCT s have been established to offer short-term treatment for people with mild to moderate mental health care needs, and as such have the potential to alter the type of referrals received by clinical psychology departments.

These changes have led to mixed views about the role of psychologists working in primary care settings and the type of referrals they currently receive (Clinical Psychology Workforce Planning Group, 2002). As a consequence there is a need for clinical psychology services to assess the demands that are placed on them and map these in the future (Cape, 1995).

The fair shares for all document (Arbruthnott, 1999) states that the age structure of the population, the relative number of males and females and the level of deprivation, all impact on the level of service provision required within the area. Therefore services should have a method of identifying geographical differences in referrals to highlight specific areas of need in terms of service provision.

Although certain psychiatric and psychological problems are more commonly referred (e.g. depression and anxiety disorders), the geographical locality can have an

important effect on the prevalence of psychological problems. For example, Harrison et al (1998) found a link between social disadvantage and mental health, with much higher rates of psychological morbidity among markedly disadvantaged populations. This has been supported by others who have found that if the geographical locality is a severely deprived area, then it often has high levels of psychological distress that are consistent with such a sample (Kellet et al, 1999).

In order for psychology services to meet the variable needs of the patient population they need to have a system in place to allow the service to a) track trends in patient referrals and b) adapt to these trends through the provision of services. This involves the investigation of the patient population, which can be accessed via the referral lists kept within a department (Hill et al, 1999) and has the potential to perform a number of functions of audit such as identifying gaps in the service and equity of access to these services (Hill et al, 1999).

Current models of service improvement suggest that the network of specialist skills that exist within Primary Mental Healthcare Teams require an information system supporting audit (Framework for Mental Health Services in Scotland, 1997). The present study conducted a retrospective audit within a clinical psychology department in the North of Glasgow. The audit was designed to provide information for service planning (Paxton, 1995). The provision of baseline data on the frequencies and types of referrals that the department received would allow:

- a) The collection and analysis of base line data which is a crucial first step in the audit process (Crombie et al., 1993)

- b) The identification of any trends in referral data that indicate a need for the expansion of services and/or specialist services.

METHODOLOGY

Aims:

The overall purpose of this audit is to set up a baseline database that can be used for current and future audit purposes. The more specific aims are listed below:

1. To provide descriptive data on the number of referrals made to the department in 2003, and the demographic characteristics of the patients referred.
2. To provide descriptive data on the type of problems referred.
3. To examine any differences between referrals from different geographical localities covered by the department.
4. To examine the relationship between the problem on the referral letter and the referring agent (e.g. GP or CMHT)

Setting:

The audit was carried out at the Clinical Psychology Department at Stobhill Hospital in North Glasgow. The department covers three main localities known as Maryhill (population approximately 56, 410), Springburn (population approximately 65, 981) and Strathkelvin (population approximately 78,004) (Glasgow Census, 2001). These three areas vary in socio-economic banding according to Arbuthnott Indexes (Arbuthnott, 1999). Springburn has the most severe levels of relative socio-economic deprivation (average 8.82), it is followed by Maryhill (average 4.53), and Strathkelvin is relatively less deprived (average -1.78).

Design:

The current audit was retrospective in design. Data were gathered from the departmental referral records. The study analysed one year s referrals (1st January 2003 to 31st December 2003).

Data Preparation:

Anonymised data from departmental referral records were entered into a SPSS database. To enable analysis through SPSS, data for all the variables had to be entered in numerical format (e.g. male [1], female [2]). Variables recorded were:

- **The age of the patient:** entered as a number. Clients with their ages missing were left blank.
- **The gender of the patient:** recorded as male, female or not stated.
- **The referring locality:** referrals were either from Maryhill, Springburn or Strathkelvin.
- **Referral source and level of urgency:** referrals were classified as from a GP or Community Mental Healthcare Team (CMHT) and were additionally categorised as urgent or routine. For example, GP routine and GP urgent.
- **The route of referral:** several referral routes had been identified by the department and these were entered into the database in numerical format.
- **The problem on referral letter:** the diagnoses recorded on the departmental referral records were coded according to ICD-10 Guidelines. If a single client had multiple presenting problems all problems were recorded as separate variables (e.g. primary problem, secondary problem, tertiary problem). If there was doubt about

the order in which to record several diagnoses they were recorded in the numerical order in which they occurred in the ICD-10 classification.

- **Asylum seeker status:** the asylum status of the client was recorded unless not stated.
- **Appropriateness of referral:** Referrals were categories numerically according to whether they were kept on the waiting list to be seen or re-directed to a more appropriate service.

Data Analysis:

Data analysis followed three stages.

Step 1- descriptive summary of all referrals made to the department in 2003.

Step 2- descriptive summary of the characteristics of referrals from the three geographical localities served by the department

Step 3- a descriptive summary of the type and range of referrals made by GP s and CMHT s.

Categorical descriptive statistics, including numbers and percentages, and continuous statistics, including mean and standard deviations where appropriate were calculated for each variable. Relationships between specific variables were examined using Chi Squared statistics.

RESULTS

1. Referrals to the department in 2003:

A total of 1052 patients were referred, of these 112 (10.6%) were re-referred to a more appropriate service. The average age of clients was 35.5 years old, ages ranged from 14 years to 72 years. Of these clients 434 (41.3%) were male, 610 (58%) were female and for 8 (0.8%) clients the gender was left un-stated in the referral records. Of the total number of referrals 64 (6.1%) were recorded as asylum seekers.

Figure 1 shows the frequencies of different problems on the referral letter that would be classed as the primary problem according to the ICD-10. Figure 1 shows that depression was the most common reason for referral, accounting for 325 (33.2%) of the primary problems. Figure 1 does not include referrals classed as ambiguous (n=24, 2.3%) or those that did not state a reason for referral (n=48, 4.6%). This left a sample of 980 referrals that could be used in the current analysis.

Of the original 1052 referrals made in 2003, 394 (37.5%) had one additional diagnosis and 39 (3.7%) had two additional problems.

Figure 1 shows a number of anxiety disorders and a separate column for anxiety (possibly referring to Generalised Anxiety Disorder (GAD)). This is because some referrers simply stated anxiety on the referral letter while others qualified this by indicating a specific anxiety disorder. By combining the anxiety disorders to make a general category for anxiety the number of anxiety referrals increases to 466 (47.6%) compared to 292 (29.8%). This is higher than the number of referrals for depression.

INSERT FIGURE 1

The small referral numbers for several of the primary problems prevented full analysis of the differences in these figures. The use of small sample sizes would reduce the clinical significance of any findings and increase the probability of making type 1 errors.

Therefore comparisons were only made between referral problems that accounted for 5% or more, of the total number of referrals. Depression, anxiety, specific phobias and PTSD/trauma were the only primary problems that met this criterion. Therefore subsequent data analysis only included these problems.

2. Comparison of referrals across localities

Of the usable referrals ($n=980$), 412 (42.0%) referrals were from Strathkelvin, 272 referrals (27.8%) were from Maryhill and 296 referrals (30.2%) were from Springburn.

Figure 2 shows the frequencies of referrals for depression, anxiety, specific phobias and PTSD for each location. Referral frequencies were similar between localities for each of the four primary problems, with the exception of anxiety, which was referred more frequently from the Strathkelvin locality. Chi squared analysis showed that there was a significant relationship between the referring locality and the frequencies of referrals for each of the four problems ($X^2=20.64$, $df = 6$, $p= 0.002$). This result reflected a significant discrepancy between the observed and expected referral

percentages for these problems, based on the overall percentage of referrals for each locality. For example Maryhill accounted for 27.8% of all referrals yet a larger percentage (43.1%) of referrals for specific phobias came from this locality.

INSERT FIGURE 2

3. Comparison of referrals made by GP s and CMHT s

Of the total number of usable referrals (n=980), 862 (88.0%) were from GP s and 118 (12.0%) were from CMHT s. Figure 3 shows the frequencies of referrals for depression, anxiety, specific phobias and PTSD according to the referral source (GP or CMHT). Depression and anxiety were the most commonly referred problems regardless of the referring source.

Chi Square analysis showed that no significant relationship existed between the referral source (GP or CMHT) and the frequency of referrals for each of the four primary problems ($X^2 = 5.69$, $df = 3$, $p=0.127$). This indicated that the actual referral percentages for these diagnoses matched the expected referral percentages from each source. For example Maryhill accounted for 27.8% of all referrals yet a larger percentage (43.1%) of referrals for specific phobias came from this locality.

INSERT FIGURE 3

DISCUSSION

Referrals made to the department in 2003

The department received over one thousand referrals in 2003. This baseline frequency shows the current level of demand for the service and can be compared with future audit data to measure changes in frequency of referrals over time. It was noted that 112 (10.6%) of referrals had to be re-referred to a more appropriate service. This figure will provide a benchmark for future audits. It might be that referring sources need more information about the remit of the service and its related specialist clinics. The ongoing collection of similar data should provide an idea of how changes in the structure of primary care services (such as the addition of Primary Care Teams) impacts upon the number of appropriate referrals made to the department.

The types of problems referred

Anxiety and depression account for an estimated 73% of all GP consultations for mental health problems in Greater Glasgow (Health in Scotland, 2000). It is therefore unsurprising that they were the most common reasons for referral and perhaps reflect the appropriate nature of the majority of referrals.

Depression and anxiety are broad diagnostic categories, which encompass a variety of more specific problem areas. The frequencies of specific problems might be underrepresented in the results due to the vagueness of many referral letters and the referral records. In particular the term anxiety disorder occurred on a large percentage of referrals in the records, without any suggestion as to what type of anxiety this referred to. It is recognised that it is not always relevant or helpful to

label a condition. However for the purposes of audit, more specific referral criteria could help identify particular trends in referral patterns and service needs. The first step in addressing this issue would be to identify where the problem is occurring. Whether this is due to a lack of information on the referral letter or a need for more detail / more concise details in the referral records. Once this has been identified the department could develop guidelines for referring agents and departmental staff.

The numbers of referrals with more than one presenting problem allow a crude measure of co-morbidity. If these figures are tracked it will be possible to identify whether the case complexity of referrals alters over time with the introduction of Primary Care Teams (PCT s). One might expect that Clinical Psychology will receive more complex referrals in the future, since the remit of PCT s is to help people with more specific short term mental health care needs.

Comparison of referrals from the three localities

For most mental health problems in Greater Glasgow there is a strong link with social and economic deprivation (Arbuthnott, 1999). In contrast to this opinion, the current study found that the two areas with the lowest socio-economic status (Maryhill and Springburn) made fewer referrals to the department than Strathkelvin, which had the highest socio-economic banding. However, it should be acknowledged that Strathkelvin has the highest population, which may contribute to the higher number of referrals. A comparison of the point prevalence of referrals for each locality shows that the number of referrals per head of the population is actually relatively similar (Strathkelvin 55/10000, Maryhill 54/10000 and Springburn 49/10000).

The under-identification of psychological problems (e.g. clients not seeking help for their problems, or health care practitioners not recognising their problems), or a more efficient use of the referral system might explain why lower numbers of referrals were received from Maryhill and Springburn than were expected (according to the Arbuthnott indexes).

A significant ($X^2=20.64$, $df=6$, $p=0.002$) relationship was found between the referring locality and the type of problem referred. This indicates that certain localities are referring greater numbers of clients with specific mental health problems than would be expected based on the overall percentage of referrals for these localities. One example was the unexpectedly high percentage of referrals for specific phobias from the Maryhill locality. These discrepancies indicate a) that there may be certain geographical factors contributing to higher levels of certain disorders and b) the need for clinical psychology to provide a service that is tailored to geographical differences in the prevalence of certain problems. Future analysis may want to explore the specific problems that contribute to this relationship and the reasons behind this.

The strategy for Primary Care in Glasgow aims to improve the health of the people of Glasgow and reduce health inequalities between different groups of society through improved access to integrated primary care services (Greater Glasgow Primary Care Strategy, 2001). The geographical differences in referral rates and types of referrals identified in this study will allow future service audit to map potential geographical trends in referrals, which may reflect fewer discrepancies between mental health problems and socio-economic status.

The relationship between the problem on the referral letter and the referring agent (e.g. GP or CMHT)

In total GP s made a greater number of referrals to the department compared to CMHT s. These differences are expected, as patients will normally present at their GP as a first port of call .

As would be expected anxiety and depression accounted for the majority of referrals from both CMHT s and GP s. No significant relationship was found between the referring agent and the frequency of the problem referred. This suggests that GP s and CMHT s referred relatively similar numbers of clients with depression, anxiety, specific phobias and PTSD (based on their overall referral percentages).

The analysis of the referral pathways for clients with these disorders would be a useful addition to this audit. The route of referral was recorded, where possible, during data collection but could not be included in the analysis due to missing or incomplete data sets. This problem highlights the importance of recording complete data sets in departmental records, and indicates an area that the department may wish to address in future.

Recommendations for future research

This study has several acknowledged weaknesses that could be improved upon in future research studies.

Recommendation 1: This audit used a limited information source to categorise each patient s reason for referral. Future audits could use the original referral letters, rather

than the referral records as the primary information source, and use a standardised method of coding information (such as ICD-10 guidelines).

Recommendation 2: The remit of this audit was restricted to referral data alone. Future audit may wish to expand its remit and examine the type of problems treated in the department as defined by the psychological formulation developed during assessment.

Recommendation 3: Problems with referral data have limited the scope of the statistical analysis in this audit. As discussed this was especially noticeable with anxiety disorders, which were poorly discriminated in the referral records. A review of the department's methods for categorising the reasons for referral and the route of referral would facilitate future audit. This could also allow future audits to examine the relationship between the primary problem, the referring locality and the referral source for a greater number of problems.

Conclusions

In conclusion this study achieved its main aim, which was to create baseline data that could be compared and contrasted with future data. This is relevant in light of new strategy documents such as *shaping the future of primary care in Glasgow* (Greater Glasgow Primary Care Trust Report, 2002), which identifies that anticipating future Primary Care Trends is a key area for improvement. This audit will help to address this issue, as it has established a baseline, which will allow the mapping of changes in referral patterns in relation to the development of Primary Care Teams.

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FIGURE 1

Figure 1: The Frequency of Diagnoses on Referral Letter



FIGURE 2

Figure 2 - Primary problem according to locality

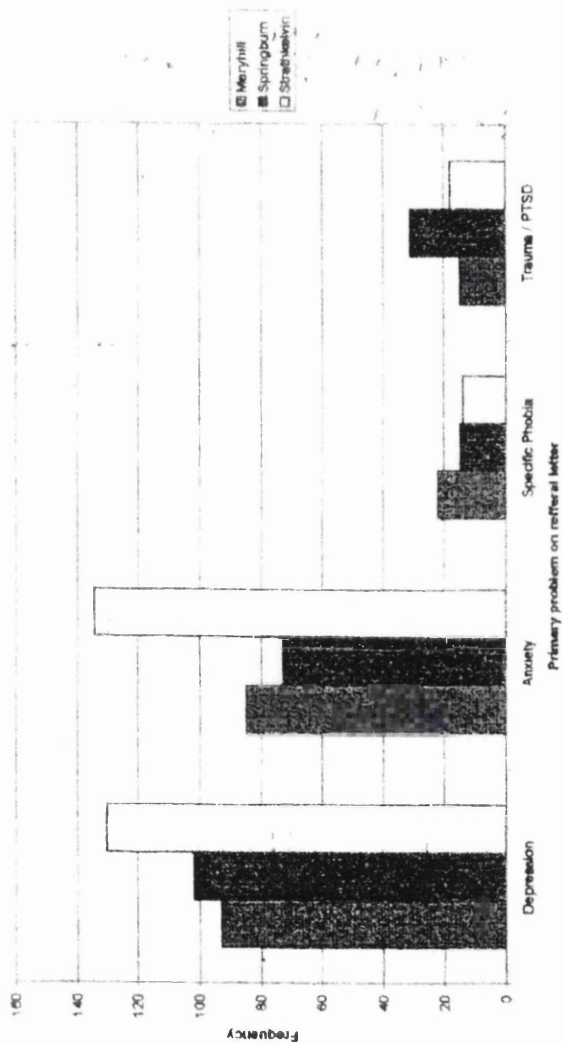
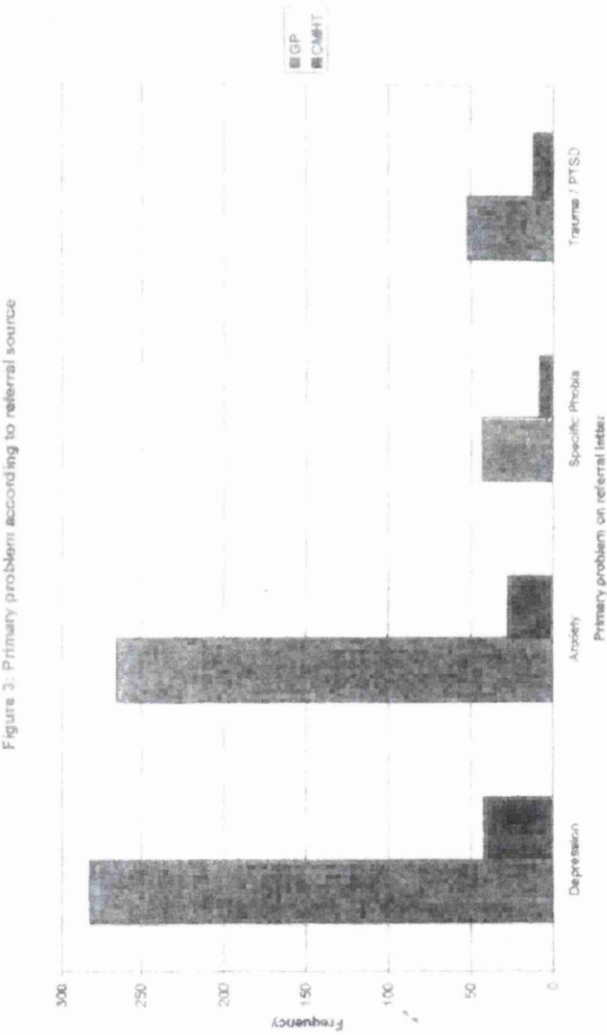


FIGURE 3



CHAPTER TWO

SYSTEMATIC LITERATURE REVIEW

**How well are we investigating father s experiences during the labour and delivery
process?**

A systematic review of qualitative methodology

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Prepared in accordance for submission to the Journal of Reproductive and Infant

Psychology (see Appendix 2.1)

ABSTRACT

Qualitative research methods have become increasingly popular in the exploration and understanding of subjective experiences, and can therefore offer an important contribution to health care knowledge and evaluation. Qualitative methodologies have been utilised within the field of Obstetrics and Gynaecology as a means to explore men's experiences of childbirth. Research into this area is considered important as paternal experiences of childbirth have been linked to various psychosocial outcomes for men and can impact on their relationships with their partner and their child.

Despite the growing literature base there have been few attempts to systematically appraise the methodological quality of qualitative research in this area. This article presents a systematic review of the qualitative methodology used in nine studies exploring paternal experiences of the labour and delivery process and draws together the main findings from the papers through discussion of the topics raised.

A combination of methods were used to maximise the identification of relevant articles, including database searches, and, a hand search of the literature from key journals and reference lists. All studies were appraised for quality using the Critical Appraisal Skills Programme (CASP) guidelines. The clinical implications arising from the literature are discussed and summarised.

Key Words: Systematic Review, Qualitative Methodology, Fathers, Childbirth.

INTRODUCTION

The father's presence at the birth of his child might now be viewed as a social norm (Draper, 1997). Depending on the source, estimates suggest that between 96% and 98% of men in western society intend to be present during the labour and delivery process (Royal College of Midwives, 1994; Singh and Newburn, 2000).

Although it is recognised that a proportion of the literature has investigated fathers' experiences of childbirth, the majority of research in this area has been conducted with women (Reynolds, 1997; Allen, 1998; and Soet et al, 2003).

Those studies which have explored fathers' experiences of childbirth suggest that male perceptions of birth as well as their coping strategies can differ from females, and that men may have unique needs during this period which sometimes go undetected (Chandler and Field, 1997; Koppel and Kaiser, 2001).

Evidence from the psychological literature investigating female experiences of childbirth suggests that certain events during the delivery process can increase the likelihood of negative feelings and appraisals relating to the birth experience. For example, increased rates of anxiety and depression have been linked to obstetric interventions, premature birth, and a lack of practical and emotional support for the labouring woman (Chan and Paterson-Brown, 2002).

Internal factors, such as an individual's appraisal of events surrounding the birth, may be as important as the environmental factors related to the event. For example, research into Post-Traumatic Stress Disorder following childbirth has been linked to maternal feelings of being out of control, and fears for their own health or that of their baby (Allen, 1998; Bailham and Joseph, 2003).

Therefore, the literature suggests that both the type of delivery experienced and individual beliefs and attributions relating to this life-event are important in our understanding of the related psychosocial context.

Initial research into mothers' perspectives of childbirth utilised qualitative methodologies, as is often the case in new and emerging areas of research where little is known about the existing phenomenon (Oakley, 1980, 1981). This might be because most qualitative approaches place an emphasis on 'providing rich descriptive accounts of a phenomenon under investigation' (Smith, 2003, p.1.). Initial research into fathers' perspectives of birth followed suit, and the popularity of qualitative methodologies within this area has grown over the years.

Qualitative research has, however, been open to criticism as it is not seen to be governed by the same principles as quantitative studies and as such it has been perceived to lack scientific rigour (Mays and Pope, 1995).

In a review article, Pope and Campbell (2001) commented that the best examples of

qualitative research adhere to the same principles of validity and relevance that are important in quantitative studies. They also added that the quality of qualitative research in Obstetrics and Gynaecology can vary greatly in its standard.

The commonly used phrase 'qualitative research' is perhaps best described as an 'umbrella term', encompassing a range of qualitative methodologies, drawn from a variety of disciplines and perspectives. Attempts to develop effective ways of appraising qualitative studies are reflected in a range of research articles such as, Dixon-Woods et al (2004); Parker (2004); Popay et al.,(1998); Barbour and Barbour (2002); Elliott et al (1999) and Yardley (2000). These articles highlight that the diverse range of qualitative research perspectives, origins, and approaches are not easily reduced to inflexible checklists and criteria often used in the appraisal of quantitative literature.

Yardley (2000, p.217) argues that the quality of qualitative research is best addressed using 'open-ended, flexible principles'. Indeed, Yardley advocates certain characteristics that good qualitative research should adhere to, including sensitivity to context, commitment to rigour, transparency and coherence, and impact and importance.

To address and facilitate the appraisal of qualitative research, The Critical Appraisal Skills Programme (CASP, 2002) have developed an assessment tool, consisting of a number of broad question areas, which attempt to address the 'principles or assumptions that characterise qualitative research'. The CASP guidelines consist of ten questions, which address the concepts of 'rigour', 'credibility' and 'relevance'.

Therefore, whilst there has been a move to improve quality in the development of guidelines for qualitative research, to the authors knowledge there has yet to be a systematic evaluation of the qualitative methodologies used to investigate fathers experiences of childbirth.

This systematic review will adopt an inclusive approach and will therefore aim to evaluate a range of qualitative methodologies used in studies that have investigated paternal experiences of the labour and delivery process.

Studies that investigate health care professionals will not be considered in this review as the focus is on paternal experiences of the labour and delivery process. In addition, studies of still-birth, miscarriage, parental death, or premature birth (below 32 weeks gestation) will also be excluded from the review as participants in these studies may present with grief and stress reactions that are unique to that population and separate to the broader research question posed here. Studies that review experiences of parenting or concentrate on post-partum events will also be excluded as they are restricted mainly to outcomes rather than the birth experience and process, which can be equally important in our understanding of psychosocial factors involved.

The main aims of this review are:

- 1) to systematically appraise the qualitative methodology of studies investigating parental

experiences of the labour and delivery process, using the CASP guidelines (2002), and

2) to provide a narrative synthesis of the main findings across studies, and the clinical relevance of these findings.

METHODS

Search strategy and procedure

Qualitative research can be difficult to identify using electronic data-bases (Shaw et al., 2004). Normally when articles are recorded on an electronic data-base they are categorised under an index system. These indexing systems are relatively well established for quantitative research papers but less so for qualitative papers. The approach described by Shaw et al (2004) for identifying qualitative papers was adapted for the current literature search and is outlined below.

Articles for inclusion in this review were identified from five electronic data-bases, chosen to represent the disciplines of medicine, nursing, psychology and social sciences (see Table 1)

INSERT TABLE 1 HERE

.....

Step 1: Thesaurus terms (or subject headings) relating to qualitative research, childbirth and fathers were used to search the data-bases. Thesaurus terms may vary between data-bases according to the indexing system used, therefore, each data-base was searched individually using the specific thesaurus terms that corresponded to the data-bases indexing system. Shaw et al s (2004) recommended list of search terms for qualitative literature, were used in this review to facilitate a comprehensive electronic search. The reader is referred to table 2 for the final search strategy. Studies were limited to those

published in the English language and all key search terms were exploded , where applicable, to prevent relevant articles being overlooked.

INSERT TABLE 2 HERE

Step 2: The titles and abstracts of identified articles were reviewed according to the inclusion and exclusion criteria outlined below and duplicates removed. This produced 28 potentially relevant articles.

Step 3: Paper copies of the 28 articles were obtained and further assessed for suitability; from this process 7 met the inclusion criteria. Table 3 details the excluded articles and the reasons supporting this decision.

INSERT TABLE 3 HERE

Step 4: 2 further articles were identified through a visual search of the reference lists of retrieved studies and reviews. Despite meeting exclusion criteria for this systematic review, the reference lists of review papers were searched to ensure no relevant articles were overlooked. Key journals were hand searched for potential articles: *Journal of Reproductive and Infant Psychology* (from July 1996 to November 2005); *Journal of Obstetrics and Gynaecology* (from 1994 to 2005) and; *Birth* (from 1996 to December 2005). No further articles were identified from this hand search, resulting in 9 studies to be included in the final review.

Article inclusion and exclusion criteria

Studies were included if they had:

- Stated the use of a recognised qualitative methodology for data collection and analysis, in title, key words, abstract or text.
- Published in the English Language in a peer reviewed journal.
- Focused on fathers subjective experiences of the labour and delivery process.

Articles were excluded if:

- The publication was a case study, dissertation, review or book chapter.
- The focus of the research was on the outcomes following the birth, or on pre-term labour/still-birth/health problems in the infant.
- The study did not report the use of a recognised qualitative methodology for data collection *and* analysis.
- The study solely used quantitative methods or relied heavily on quantitative data analysis techniques (e.g. content analysis)
- The study was not published in the English Language or in a peer reviewed journal.

Data Abstraction

Table 4 shows the information obtained through the data abstraction process.

.....
INSERT TABLE 4 HERE
.....

Quality Assessment

Articles were assessed by two independent raters (the author and one other rater with knowledge of qualitative methodology (CD)), using the CASP assessment tool (Appendix 2.2). The CASP questionnaire consists of 10 questions. The first 2 questions are general screening questions and the remaining 8 relate in more detail to the method.

To pass the screening questions, studies had to justify the relevance of the research through clearly defined aims/objectives and also provide discussion on the appropriateness of qualitative methodology for the research aims. Papers included in this review were considered by both raters to meet these criteria.

The approach to assessing papers involved consideration of the strengths and weaknesses of the research against each of the eight CASP question areas (Appendix 2.2), ranging from the appropriateness of the research design to the value of the research.

Individual papers tended to show conspicuous strengths in some areas and not in others, therefore it was not considered appropriate to categorise papers under a general quality rating. Instead, reviewers assessed the extent to which the paper addressed each of the 8 CASP questions independently.

To achieve this raters read each paper individually and recorded the evidence they found to support each question (the reader is referred to Appendix 2.3 for a description of the evidence considered by the raters in support of each question area).

Following this the rater allocated a quality rating for each question (ranging from strong, moderate or weak) to reflect the extent to which the paper had addressed the question area. The raters later discussed their findings and reached 100% agreement as to the papers quality rating for each of the 8 questions. The reader is referred to appendix 2.4 for a full explanation of the quality rating system.

RESULTS

The following section presents a discussion of the results under each of the 8 CASP question areas. One limitation to be acknowledged at this point is that the review is restricted to information contained within the published articles. Therefore a paper may have limited information relating to the methodology due to imposed word limits or the style of publication. The reader is referred to Table 5 for a tabulated summary of CASP question area ratings derived from the review process.

INSERT TABLE 5 HERE

Appropriate research design

Appropriate research design was characterised by the extent to which the research design addressed the aims of the research. It was clear that the research design for every paper supported data collection pertaining to the research aims, although the degree with which studies justified their choice of research design varied, for example, by discussing how they decided which methods to use.

Of the nine studies, three were considered to provide a strong justification for their chosen methodological approach; these included Draper (2003), Moran-Ellis (1989) and Williams and Umberson (1999). In addition to a research design that supported data collection pertaining to the research aims, these papers provided information on the strengths/applications of their chosen approach, which they further justified in

comparison to other methods and/or in relation to the research aims. For example Draper (2003) used a longitudinal ethnographic research design and justified this by stating:

an ethnographic approach was chosen in order to understand not only how men make and mark their transition to fatherhood but also to examine how this experience of transition is influenced by changing fathering practices in contemporary western culture. Although traditionally associated with describing other cultures there is now a developing literature on ethnography's usefulness in describing contemporary cultures and sub-cultures (Draper, 2003, p 745).

To further support their choice Moran-Ellis (1989) and Draper (2003) made several references to the literature base to justify their research methods. All three papers were therefore considered to demonstrate considerable rigour regarding the appropriateness and thoroughness of their research design.

Three studies (Chapman, 1991, 1992, 2000) were considered to provide a moderate amount of information to justify their chosen research design. These studies provided information on the strengths/applications of their chosen research approach. For example Chapman (2000, p. 135) states grounded theory methodology was used for data collection and analysis. This approach .. is used to generate explanatory theories about social and psychological phenomena (Chentiz and Swanson, 1986) ..

Chandler and Field (1997), Hallgren et al (1999), and Wilkaner and Theorell (1997) were

classed as providing weak evidence to support their chosen research design. In these it was clear that the research designs allowed data collection pertaining to the research aims, but no explicit reasoning was provided to justify their choice of design e.g. Chandler and Field (1997, p18) stated that this study had a descriptive exploratory design, and data were gathered using in-depth interviews . This sentence demonstrates that although the researcher has detailed their chosen method, no explanation is provided as to why in-depth interviews are well suited to an exploratory design, or indeed, why an exploratory design was suited to the research aims.

Sampling

The criteria for an appropriate sampling strategy included a) an explanation of how the participants were selected b) an explanation of why the participants selected were the most appropriate and c) a discussion around issues of recruitment such as drop-out rates.

Three studies (Chandler and Field, 1997; Chapman, 1991; and Williams and Umberson, 1999) provided a moderate degree of evidence to support the appropriateness of their sampling strategy. These papers explicitly stated or described their sampling strategy/procedure in addition to providing some explanation as to why that strategy was appropriate. For example Williams and Umberson (1999) adopted a purposive sampling approach and also explained why the participants they selected were appropriate. Participants in this study were selected from similar socio-economic backgrounds and the authors explained that this would ensure that any gender differences observed were not due to differences in the demographic composition of the groups (Williams and

Umberson, 1999, p.152).

The remaining six papers were considered to demonstrate weak evidence that they had applied an appropriate recruitment strategy. Whilst these papers made reference to a recognised sampling strategy/procedure and provided some information on the sample size, demographics and location of recruitment they failed to provide explicit reasons for choosing this strategy/selection criteria. It is noted that Chapman (1992) makes reference to an earlier study by the same author in 1991 where the recruitment strategy was noted to be outlined in more detail.

Data Collection

The principle data collection question related to whether or not the data were collected in a way that addressed the research issues.

In order to answer this question several aspects were considered. These included: justification for the data collection setting and methods chosen, the descriptive clarity of the data collection method, form of collection, and discussion of specific factors such as modifications made to the methods during the study or data saturation in grounded theory studies.

Overall, this area of methodology varied greatly both within and between studies. Three studies: Chandler and Field (1997), Wilkander and Theorell (1997) and Williams and Umberson (1999) provided strong evidence that the data collection methods were closely

related to the research issues.

All of these studies discussed in detail where and how the data were collected and made the methods used explicit. For example, Williams and Umberson (1999) used a semi-structured interview format for data collection and provided specific examples of the questions asked. In addition, these studies attempted to justify the chosen methods of data collection with reference to the practical benefits of a technique (e.g. the use of in-depth interviews to gather a broad range of information) and/or the literature base.

One study (Chapman, 1991) was thought to provide weak evidence relating to this issue. Whilst this study explicitly stated how the data were collected it provided no further information on the interview method used e.g. question areas.

The five remaining studies satisfied a range of criteria under this question heading, by providing moderate evidence for their method of data collection. Such studies provided the reader with a specific method of data collection (e.g. semi-structured interviews), included an explanation of how this method was conducted and described the form of data with clarity (e.g. audio recordings were transcribed verbatim).

It was noted that of the studies that applied grounded-theory research methodology, none made specific reference to the concept of data-saturation.

Reflexivity

This question was designed to help the reviewer think about research partnership relations and the researchers own interpretive processes. Evidence supporting

consideration of this issue included critical examination of the researchers interpretive processes, role, and influence at various stages of the research process; in addition to researcher responses to events during the study and consideration of the implications of any changes in the research design.

This aspect of the methodology was severely lacking in all of the papers reviewed. Seven of the papers were considered to provide no evidence relating to a critical examination of researcher s potential impact in terms of the location for data collection, or the role of the researcher in the research process.

Two papers were considered to have weakly addressed this issue (Hallgren et al, 1999; and Chapman, 1992). Chapman (1992, p. 119) stated findings are limited by the potential for researcher bias accumulated during 20 years of clinical experience in labour and birthing units but again the author does not elaborate on this point to discuss how their position might have impacted on the findings or the participants experience. Whereas, Hallgren et al (1999) provided details on how a change in the methodology from interviewing fathers individually to interviewing the couple together, might have impacted on the fathers willingness to discuss less positive aspects of their experience.

Some researchers (e.g. Williams and Umberson, 1999, p.166) reflected on the potential impact of the recruitment strategy on the composition of the study sample. Such discussion identifies the concept of recruitment bias that is common to qualitative research rather than addressing the direct effect of the researcher on this process.

Ethical Issues

This section of the CASP guidelines examines whether the paper has taken ethical issues into consideration. Factors addressing this issue include: whether there were sufficient details of how the research was explained to participants to evaluate whether ethical standards have been maintained, whether informed consent was obtained, if ethical issues raised by the study were discussed, and if the study had received approval from an ethics committee.

Three papers (Chapman, 1991, 1992, and 2000) were determined to demonstrate weak evidence that they satisfied the above criteria. These papers simply reported that the research study was explained, and signed consent was obtained (Chapman, 1991, p.25). In addition, two studies (Moran-Ellis, 1989; and Williams and Umberson, 1999) made no mention of ethical considerations.

Whilst most papers mentioned that the research was explained to participants before their recruitment to the study, the reviewers felt that in many cases there was insufficient information provided to assess whether or not ethical standards, such as the participant's right to withdraw from the study or steps to reduce coercion and protect confidentiality had been maintained.

Three studies were considered to provide moderate evidence. Draper (2003, p.745) reported that men were informed of my intention to tape record the interviews but that

they could request it be turned off at any point . Participants in this study were also informed that their anonymity and confidentiality would be preserved at all stages of the research (Draper, 2003, p.745) this was considered evidence to demonstrate that information was given to participants to maintain ethical standards.

Hallgren et al (1999) and Wilkander and Theorell (1997) did not meet the above criteria but did indicate that approval had been obtained from an ethics committee. Approval from an ethics committee would suggest that this study had satisfied the aforementioned criteria and it was therefore awarded a moderate rating.

Chandler and Field (1997) was the only study thought to demonstrate strong evidence that ethical issues had been considered. This paper reported that at each contact the informants right to withdraw or not to answer certain questions was reaffirmed (p.19) written consent was obtained from all participants and approval received from the Faculty of Nursing Ethical Review Committee.

Data Analysis

This question area had six sub-categories to aid the reviewer in assessing the rigour applied to the analysis process. The following six aspects were considered: a detailed description of the analysis process, a clear explanation of how categories and themes were derived, a clear explanation of the selection of presented data, sufficient data presentation to support the findings, consideration of contradictory data and a critical examination of the researcher s interpretive processes and/or their influence on the

research.

To meet the inclusion criteria for this review, studies were required to cite a known qualitative approach in relation to their research methodology. Of the nine studies reviewed five adopted a Grounded Theory approach, two adopted an Ethnographic approach, one utilised a Hermeneutic method and one used Inductive Analysis.

Most studies provided at least one reference to the original text outlining their chosen approach. For the Grounded Theory studies these included Strauss (1987), Glaser and Strauss (1967), Glaser (1978), Charmaz (1983) and Marshall and Rossman (1989). The Hermeneutic method cited Ricoeur (1976) whilst the inductive analysis paper used Patton (1987). Interestingly, neither of the Ethnographic papers (Draper, 2003 and Chandler and Field, 1997) were noted to reference a core text or research article pertaining to their chosen method of data analysis (e.g. thematic and theoretical analysis). This made it difficult for the reader to develop a better understanding of the methods they cited during the analysis process.

The studies varied in the level of description provided regarding the analysis process. Whilst every article specified an analytic technique, two papers (Moran-Ellis, 1989 and Williams and Umberson, 1999) were considered to provide weak evidence to support a rigorous data analysis. These papers cited well known techniques for data analysis, that would allow a reader to source the relevant text and develop a better understanding of the approach used. The description of the data analysis procedure, however, lacked sufficient

detail to allow the reader to confidently understand how these techniques were utilised. These papers were, therefore considered to lack transparency of the analysis process within the write-up.

One important aspect of qualitative analysis is the use of selected data excerpts to demonstrate the research process and support the findings. The papers varied in how they presented excerpts from participants. All nine studies provided direct quotes to varying extent within the write-up. Most papers presented quotes within a given context, for example, Chapman (1991, p.27) discusses sub-themes of information and provides quotes directly relating to each issue. This aided the transparency of the analysis process by making it easier to see how statements emerged or what participants really meant. In addition, some papers, such as Chandler and Field (1997), Draper (2003) and Moran-Ellis (1989) gave anonymous references for these quotes providing evidence of an audit trail for the analysis process, whilst others simply provided a quote.

Moran-Ellis (1989) provided an interesting and thorough description of their findings without providing direct quotes or observations to support each of the themes described. Moran-Ellis was therefore considered to be the only paper not to provide sufficient data to support their reported findings.

Five studies were considered to provide strong evidence of a sufficiently rigorous data analysis procedure. These papers all provided an in-depth description of the analysis procedure, for example, Hallgren et al (1999) provided a step by step description of the

methods used, complimented by tables to demonstrate how themes of differing levels of abstraction were obtained from the original data. Four papers within this category demonstrated increased rigour by discussing contradictory suggestions for the conclusions drawn.

Two papers (Chapman, 2000 and Draper, 2003) were considered to demonstrate moderate evidence in support of a rigorous data analysis section. These papers provided a moderate description of the analysis process, the data presented was organised clearly under themes with sufficient data in the form of quotes to support the findings.

One main weakness across all nine studies was the lack of consideration given to the researcher role regarding potential influence on the analysis and selection for data presentation.

Findings

This section was designed to help the reviewer evaluate the clarity with which the findings were presented.

All of the studies reviewed were thought to present explicit findings in relation to the original aims of the research. Papers differed to the extent that they discussed the credibility of their findings and evidence both for and against these.

Hallgren et al (1999), Chapman (1992), Wilkander and Theorell (1997), and Chandler

and Field (1997) were considered to provide strong evidence in with regard to this area. These studies provided adequate discussion of the evidence both for and against the researcher s arguments in addition to discussion regarding the credibility of their findings with reference to one or more specific technique, such as triangulation.

In comparison, three papers were considered to provide moderate evidence in relation to this issue. These papers discussed either the techniques used to enhance credibility or the evidence both for and against their findings.

Two papers (Williams and Umberson, 1999 and Draper, 2003) were considered to offer weak support for their findings due to a lack of discussion regarding specific techniques to enhance credibility or evidence both for and against their findings.

Value of the research

The principle question in this section related to whether or not the research makes a valuable contribution to existing knowledge or understanding and the extent to which it identifies new scope for research and the transferability of results to other populations or uses.

Four papers (Chapman, 1992; Moran-Ellis, 1989; Williams and Umberson, 1999; and Wilkander and Theorell, 1997) provided strong evidence supporting the value of their research by discussing the original contribution the research makes to existing knowledge and understanding, identifying new areas where research is required and discussing the

transferability and multiple uses of the research findings.

The rest of the papers were considered to provide moderate evidence supporting the value of their research. The reviewers noted that most of the studies in the moderate category made general reference to the need for further research, without specifically identifying new areas for research.

SUMMARY

The review process suggests that the 'rigour', 'credibility' and 'relevance' of qualitative research exploring paternal experiences of the labour and delivery process can vary greatly both within and between studies. This supports a comment made by Pope and Campbell (2001) that the quality of qualitative research in Obstetrics and Gynaecology can vary greatly in its standard.

Overall, the articles reviewed were thought to demonstrate stronger evidence of rigour, credibility and relevance pertaining to three aspects of the methodology, namely, the clarity of findings, the overall value of the research and the data analysis technique.

In contrast, the majority of papers also demonstrated weak evidence or no evidence at all of rigour with regard to their sampling strategy, reflexivity and ethical practice within the write-up. It was also noted, that studies lacked discussion regarding the justification of their chosen qualitative approach in relation to other qualitative methods.

Evidence for the appropriateness of the research design was mixed with three studies falling into each of the quality categories (strong, medium and weak).

Why articles might demonstrate weaker evidence according to the CASP guidelines on issues relating to their sampling strategy, reflexivity and ethical practice is worthy of consideration. Possible reasons might include word count restraints or the prioritisation

of research findings and their respective value within the research community. The weighting placed on explicitly addressing different methodological considerations within other areas of qualitative research might prove an interesting topic for future review.

Interestingly, papers appeared to consistently lack evidence pertaining to specific CASP guideline considerations. With regard to sampling these considerations included: adequate justification for the sampling strategy/selection criteria adopted and discussion around recruitment. In relation to reflexivity these included the examination of the researcher's role and their response to research events. Whereas, when appraising the ethical considerations presented, articles consistently demonstrated weak or no evidence regarding information on the explanation offered to participants, discussion of any ethical issues raised by the study, and stating whether or not permission was granted by an ethics committee.

In summary, it is hoped that by identifying the varying degrees to which articles explicitly addressed aspects of rigour, credibility and relevance within their research, this review can act to highlight areas that future qualitative publications within Obstetrics and Gynaecology might wish to address in more detail.

NARRATIVE SYNTHESIS AND CLINICAL RECOMMENDATIONS

The following section provides a narrative synthesis on the main recurring themes across the nine research articles appraised in this review. In addition, a summary of the clinical recommendations derived from each study is provided. The usefulness of such recommendations should be considered within the context of the research, including issues such cultural variations, differing health care practices and systems, the publication date and the rigour, credibility and relevance of the research methodology as discussed above. A summary of clinical recommendations under each heading is provided in Boxes one to four.

1. Shared experience of labour and delivery

Policy changes since the 1970 s have removed some of the barriers to men s involvement in the labour and delivery process. Perhaps as a reflection of increasing paternal involvement most fathers (in the articles reviewed) described their childbirth experience as one that was shared with their partner.

The research suggests that men and women, as part of a couple can share similar preparatory expectations for the birth. Moran-Ellis (1989) found that men and women s anticipatory birth schemas were fairly similar, indicating a basis for a shared birth experience that develops prior to the event.

Chapman (1991, p.25) commented that most of the fathers who were present for the

labour and delivery process viewed it as a couple experience . Chapman develops this concept within the theme of co-labouring .

Chandler and Field (1997, p.19) remark that whilst fathers viewed themselves as part of a labouring couple this perception was not always reflected in the staff approach, and some fathers described their experience as one of a labouring woman with a partner present (Chandler and Field, 1997, p. 23).

Aspects of the shared experience were exemplified via the interactions between the father and their partner. For example Chapman (2000, p. 138) commented that how the woman responded to pain or the absence of pain had consequences for the man's reactions to his partner, and therefore his labour experience . This suggests that for some fathers their experience was regulated by and mirrored that of their partners.

In an earlier study Chapman (1991) reported that some fathers' experiences can be guided by their partner through tasks including gate-keeping, leading and informing the father therefore sharing information and aspects of experience.

Fathers in Hallgren et al's (1999) study were found to report varying levels of involvement in the childbirth process. The authors conceptualise this as vital involvement , which was found to serve a protective function enabling men to better manage stressful aspects of the birth experience. Therefore, Hallgren et al advise that men's perception of involvement in the birth process should be assessed and facilitated

where appropriate.

Box 1 Clinical recommendations: Shared experience of labour and delivery

- Child-birth preparation could be focused on the positive shared aspects for couples and providing couples with options suitable for both their needs to help them cope with more stressful aspects of the experience. (Hallgren et al, 1999)
- Fathers can benefit from being included in conversations about the birth process (Chandler and Field, 1997)
- Fathers may benefit from information on how labour pain can affect women and how they can best cope with these changes (e.g. through supporting their partner, or accessing support themselves) (Chapman, 2000)
- HCPs can assist men in identifying a comfortable labour role and how to support their partners and access support for themselves this can facilitate men's ability to co-labour (Chapman, 1991)
- The ability to labour as a couple can be enhanced by pain relief (Chapman, 2000).

2. Expectations and reality

Three papers (Chandler and Field, 1997; Hallgren et al, 1999; and Moran-Ellis, 1989) specifically explored how men's expectations for the birth related to the actual experience.

In general, fathers appeared to hold expectations about how they might cope during the birth, and evaluated their actual experience based partly in comparison with these prior expectations.

Chandler and Field (1997) report that when labour began fathers often perceived themselves unable to meet the expectations they had set for themselves as their partners

supporter, advocate and comforter and one major theme was the fathers perceived inability to comfort their partners during labour.

Moran-Ellis (1989) found that certain aspects of the labour process differed from how fathers had expected them. These included that the decision to go into hospital was made in conjunction with hospital advice rather than autonomously by the couple, and that some fathers roles during the labour were wider ranging than they had expected. Moran-Ellis concludes that difficulties can arise when the birth process becomes different to that they expected, and if they are unable to find new ways of acting that are relevant to the new birth situation as opposed to the previous birth goals.

In Hallgren et al s (1999) study men felt unprepared for an unpredictable process, the experience of time and pain, their partners reactions and their own reactions to the experience.

Box 2 Clinical recommendations: Expectations and reality
<ul style="list-style-type: none">• It may be important to promote awareness of men s childbirth expectations during ante-natal classes, and at follow-up to assess father s experiences during and after the birth process. (Hallgren et al, 1999)• During the pre-natal period HCP s can discuss the range of experiences fathers might encounter during labour, including their own emotions when their partner is experiencing pain and planning strategies for dealing with the work of labour (Chandler and Field, 1997)

3. Roles during labour and delivery

Two papers specifically aimed to investigate the roles adopted by men during the labour and delivery process (Chapman, 1992 and Moran-Ellis, 1989), however, most articles commented to varying degrees on this factor. Moran-Ellis (1989) concluded that if the labour differed greatly from the fathers expectations, then previous birth roles were abandoned and new ones adopted. The range of birth tasks/roles adopted by fathers included: making decisions, physical activities, companionship, acquiring technical knowledge and adopting a guardianship role.

Chapman (1991) aimed to gain a deeper understanding of expectant fathers views of the labour and birth experience. Chapman's paper describes three roles adopted by fathers during the labour and delivery process (the coach, the teammate, and the witness). These three roles were characterised as follows: the coach viewed themselves as leaders or directors, the teammate viewed themselves as helpers or followers, whilst the witness acted as a companion to observe the birth of their child. Interestingly, Chapman (1991) comments that within these roles there were varying types and degrees of engagement linked to the role adopted. For example, coaches were both physically and mentally engaged throughout, whereas teammates fluctuated between high and low levels of physical engagement depending on the partner's needs and the amount of direction received. In contrast, to both the teammate and the coach roles, witnesses usually remained at low levels of engagement until the second stage of labour when they described high degrees of mental engagement. In her 1992 paper Chapman discusses two of these roles in more detail. Chapman concludes the role adopted by expectant fathers

can depend on the man's personality, the couple's expectations of the labour experience and the couple's relationship. More specifically Chapman, (1992) identifies that mutuality and understanding within a couple's relationship was strongly related to the role adopted by the father during labour.

Wilkander and Theorell (1997) also identify the roles of coach, team-mate and witness within their study and suggest that the team-mate role was more common among fathers who generally reported a more positive birth experience and less crying in their infant within the first year of life.

In contrast to a specific role task or approach, Hallgren et al (1999) concluded that men who perceived their role as one of involvement in the process were able to manage overwhelming feelings of helplessness during childbirth and support their partners resulting in a more positive birth experience.

Chandler and Field (1997) expand upon the roles discussed by Chapman (1991) to suggest that men do not adopt one fixed role for the duration of the birth experience. Chandler and Field (1997) instead reported that the men in their study appeared to alternate between roles depending on the demands placed on them during the birth experience.

Chapman (1991) does, however, comment that some fathers in her study were required to adapt their expected role and redefine this via a process Chapman (1992, p. 27) termed

searching for a place . This concept shares similarities with Chandler and Field s (1997) finding that men s feelings of helplessness in relation to their role often marked a process of adaptation, whereby expectant fathers realised that labour was more demanding than they had anticipated. This process of adaptation links back to the comments made in Moran-Ellis (1989) paper, which describes expectant fathers adopting new roles and abandoning expected roles in response to their experience of labour and delivery.

<p>Box 3 Clinical recommendations: Roles during labour and delivery</p>
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| <ul style="list-style-type: none"> • Fathers feelings of inclusion can be promoted by asking men what role they want to take during the labour experience (i.e. active passive) (Chapman, 1991) • Fathers can benefit from information about how they might support their partners during the birthing process (Chandler and Field, 1997) • Men may choose to adopt a variety of roles flexibly to help them adjust to their experience. Childbirth education should perhaps therefore place equal emphasis on all possible roles (e.g. team mate, coach and witness). (Chapman, 1991) • Fathers may benefit from the opportunity to discuss their role expectations prior to the birth and assess their experiences during the birth process. (Hallgren et al, 1999). This may be especially important for men who convey a lack of involvement. |
|---|

4. Medicalisation

Throughout the review it was noted that studies made repeated mention of expectant father s interactions with medical staff and their contact with different types of medical technology.

One example of this issue is the way in which fathers used medical technology to enhance their experience. For example some women had their contractions monitored

electronically partners often used this technology to anticipate the next contraction and warn the woman (Moran-Ellis, 1989, p. 286).

In Chapman (2000) the findings suggest that medical intervention in the form of pain relief enhanced expectant father s experience of the labour and delivery process by improving interactions with his partner and reducing the sometimes overwhelmingly negative experience of having to watch their partner in pain.

Some studies discussed the positive role of medical staff in guiding fathers through their experience, and helping them adapt to the situations encountered. For example Chapman (1991, p.26) discusses the concept of the fathers partner acting as a labor guide with nurses, midwives and doctors reported to be secondary guides. Labour guides were described in this article to set the pace for the man s experience through three activities termed gatekeeping, leading and informing.

Wilkander and Theorell (1997) comment that staff behaviour is observed by fathers and often interpreted in relation to control. They report that fathers reported an acute awareness of staff behaviour and tended to interpret signs of anxiety in the midwives as an indication of insecurity. In addition, the same authors comment on the links between medical involvement and control, reporting that some fathers strongly perceived medical procedures as out-with their control, which exacerbated feelings of helplessness during the birth.

Williams and Umberson (1999) specifically investigated the impact of medical technology on men's experiences of childbirth. They concluded that medical intervention and technology positively contributed to fathers' perceptions of the importance of their roles in the labour and delivery. In addition, they state that the medicalisation of childbirth may have resulted in a partial levelling of the playing field by increasing fathers' involvement in the childbirth process via foetal ultra-sound, electronically tracking of contractions, and EFM's in comparison to their partners (p.164).

**Box 4 Clinical recommendations: Medicalisation
(including medical technology, intervention and interaction with staff)**

- HCP's should have an understanding of the important role some fathers play in their partner's decision to have a medical intervention e.g. an epidural (Chapman, 2000).
- Midwives are ideally placed to explain medical technology to expectant fathers and therefore improve men's involvement in the delivery process. (Williams and Umberson, 1999).
- Staff should be trained to be aware of their own behaviour in the delivery room and how this behaviour affects parents in general and fathers in particular (Wilkander and Theorell, 1997)

DISCUSSION

As the amount of published qualitative health research increases, approaches to considering the value of such research are increasingly useful for clinicians and researchers alike (Yardley, 2000).

The development of the CASP guidelines has provided the opportunity for reviewers to take into consideration several broad question areas. These can be used to prompt discussion and evaluation of research articles, whilst allowing the researcher to refrain from making judgements on more subtle aspects of a research methodology, which might be better suited to a scale fully incorporating that particular research approach and theoretical perspective.

Limitations

This systematic review has only included published studies and therefore excluded full project reports as suggested by Jones (2004). This review is therefore limited to providing a critique of the write up of qualitative research.

This review attempted to be inclusive by incorporating a range of qualitative methodologies. That said, studies which utilised a qualitative method of data collection without making direct reference to a known qualitative methodology (e.g. grounded theory), were excluded from the review. The exclusion of such papers was arguably justified in this review as it was based solely on methodology.

The use of quality criteria for appraising qualitative research can be a helpful method of synthesising study findings however, it is also acknowledged that qualitative research is not a unified field. The tendency to approach such research using a unified set of assessment criteria might therefore become unhelpful.

The researcher therefore justified the use of the CASP guidelines as they offer a published set of broad questions that have been carefully considered by a reputable research organisation, for the exact purpose of understanding qualitative research. In addition, the guidelines allowed the researcher to flexibly appraise a range of qualitative methodologies using the same ten question areas pertaining to the rigour, credibility and relevance of the research. This approach represents a replicable and transparent method of appraising qualitative research, and is not considered to be a fully comprehensive or definitive guide. There is potential for the CASP guidelines to be interpreted differently by different researchers, this is due, in part to the ambiguity of some question areas. The current review attempted to improve the transparency of decision making by providing a break down of the issues considered when appraising articles according to the CASP question areas.

Due to the variation within and between studies, this review chose to evaluate each article according to the eight topic areas outlined by CASP. It is recognised that this is only one way of using the CASP guidelines to understand qualitative research, future reviewers may wish to adopt an approach that allocates an overall quality rating to a study

following consideration of the CASP guidelines.

Conclusions

This review has provided a systematic appraisal of nine qualitative research articles examining men's experiences of the labour and delivery process. In addition, the review draws together the main findings from the papers through discussion of four topics that occur repeatedly throughout the literature, and summarises the clinical implications arising from these qualitative research articles.

It is hoped that this review can be helpful across three main areas; firstly it may encourage other researchers to consider the systematic review of qualitative research methodologies and the ways in which this can be most useful from both an academic and a clinical perspective. Secondly it may act to highlight methodological considerations that future qualitative publications might wish to address in more detail, and finally, it is hoped that the review serves a clinical purpose in synthesising the main findings from research in this field and presenting the clinical recommendations presented within this selection of literature.

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Table 1

Table 1. Database and date searched	
PsychINFO (1966 to January 2006 week 4),	January 2006
British Nursing Index (1985 to January 2006)	January 2006
MEDLINE (1966 to January 2006 week 3)	January 2006
EMBASE (1980 to January 2006 week 4)	January 2006
CINAHL (from 1982 to December 2005 week 2).	January 2006

Table 2

Search terms used for electronic literature search

No	EMBASE (1980 2006)	MEDLINE(R) (1966-2006)	PsychINFO (1985-2006)	British Nursing Index (1985-2006)	CINAHL (1982-2005)
1	Qualitative stud\$.mp	exp QUALITATIVE RESEARCH/	exp QUALITATIVE RESEARCH/	Qualitative stud\$.mp	exp Qualitative Studies/
2	Nursing methodology research.mp	exp NURSING METHODOLOGY RESEARCH/	Nursing methodology research.mp	Nursing methodology research.mp	exp Research Nursing/
3	exp QUESTIONNAIRE/	exp QUESTIONNAIRE/	exp QUESTIONNAIRES/	exp RESEARCH METHODS/	Exp QUESTIONNAIRES/
4	exp ATTITUDE/	exp ATTITUDE/	exp ATTITUDES/	exp PATIENT ATTITUDES/	exp ATTITUDE/
5	Focus group\$.mp	exp FOCUS GROUPS/	Focus groups.mp	Focus group\$.mp	exp Focus Groups/
6	Discourse analysis.mp	Discourse analysis.mp	exp DISCOURSE ANALYSIS/	Discourse analysis.mp	exp Discourse Analysis/
7	Content analysis.mp	Content analysis.mp	exp CONTENT ANALYSIS/	Content analysis.mp	exp Content Analysis/
8	Ethnographic research.mp	Ethnographic research.mp	exp ETHNOGRAPHY/ or Ethnographic research.mp	Ethnographic research.mp	exp Ethnographic Research/
9	Ethnological research.mp	Ethnological research.mp	Ethnological research.mp	Ethnological research.mp	exp Ethnological Research/
10	Ethnonursing research.mp	Ethnonursing research.mp	Ethnonursing research.mp	Ethnonursing research.mp	exp Ethnonursing Research/
11	Constant comparative method.mp	Constant comparative method.mp	Constant comparative method.mp	Constant comparative method.mp	exp Constant Comparative Method/
12	Qualitative validity.mp	Qualitative validity.mp	Qualitative validity.mp	Qualitative validity.mp	exp Qualitative Validity/

13	Purposive sample.mp	Purposive sample.mp	Purposive sample.mp	Purposive sample.mp	Purposive sample.mp	exp Purposive Sample/
14	Observational method\$.mp	Observational method\$.mp	exp OBSERVATIONAL METHODS/	Observational method\$.mp	exp Observational Methods/	exp Observational Methods/
15	Field stud\$.mp	Field stud\$.mp	Field stud\$.mp	Field stud\$.mp	Field stud\$.mp	exp Field Studies/
16	Theoretical sample\$.mp	Theoretical sample\$.mp	Theoretical sample\$.mp	Theoretical sample\$.mp	Theoretical sample\$.mp	exp Theoretical Sample/
17	exp PHENOMENOLOGY/	Phenomenology.mp	exp PHENOMENOLOGY/	Phenomenology.mp	exp PHENOMENOLOGY/	exp PHENOMENOLOGY/
18	Phenomenological research.mp	Phenomenological research.mp	Phenomenological research.mp	Phenomenological research.mp	Phenomenological research.mp	exp Phenomenological Research/
19	Life experience\$.mp	Life experience\$.mp	exp LIFE EXPERIENCES/	Life experience\$.mp	exp Life Experiences/	exp Life Experiences/
20	Cluster sample\$.mp	Cluster sample\$.mp	Cluster sample\$.mp	Cluster sample\$.mp	Cluster sample\$.mp	Cluster sample\$.mp
21	Grounded theory.mp	Grounded theory.mp	exp GROUNDED THEORY/	Grounded theory.mp	exp Grounded Theory/	exp Grounded Theory/
22	Thematic analysis.mp	Thematic analysis.mp	Thematic analysis.mp	Thematic analysis.mp	Thematic analysis.mp	exp Thematic Analysis/
23	Narrativ\$.mp	Narrativ\$.mp	exp NARRATIVES/	Narrativ\$.mp	exp Narratives/	exp Narratives/
24	Audio recording\$.mp	Audio recording\$.mp	Audio recording\$.mp	Audio recording\$.mp	exp Audiorecording\$.mp	exp Audiorecording/
25	exp INTERVIEWS/	exp INTERVIEWS/	exp INTERVIEWS/	exp INTERVIEWS and INTERVIEWING/	exp Interviews/	exp Interviews/
26	Or/1-25 ¹	Or/1-25	Or/1-25	Or/1-25	Or/1-25	Or/1-25
27	exp BIRTH/	exp PATURITION/ or birth.mp	exp BIRTH/	birth.mp	exp Childbirth/	exp Childbirth/
28	exp DELIVERY/	exp DELIVERY, OBSTETRIC/ or delivery.mp	delivery.mp	Delivery (Pregnancy).sh or delivery.mp	exp DELIVERY/	exp DELIVERY/
29	exp LABOR/	exp LABOR, OBSTETRIC/ or labor.mp	exp LABOR (CHILDBIRTH/	exp LABOUR/	exp Labor/	exp Labor/
30	Or/ 27-29	Or/ 27-29	Or/ 27-29	Or/ 27-29	Or/ 27-29	Or/ 27-29

¹ Search terms were combined with a Boolean OR on Medline, Embase, PsychINFO, British Nursing Index and CINAHL

31	exp FATHERS/		exp FATHERS/		Father\$.mp	exp Fathers/
32	exp MALE/		exp MEN/	exp HUMAN MALES/	Men.mp or Male.mp	exp Male/
33	Or/31-32		Or/31-32	Or/31-32	Or/31-32	Or/31-32
34	And/ 26, 30, 33 ²		And/ 26, 30, 33	And/ 26, 30, 33	And/ 26, 30, 33	And/ 26, 30, 33

² Search terms were combined with a Boolean AND on Medline, Embase, PsychINFO, British Nursing Index and CINAHL

Table 3: Table detailing excluded articles and the reason for their exclusion

First author and year	1	2	3	4	5
Allen, N. (1999).					✓
Balisnomo, J.E. (2003)					✓
Blackwell, J. (1977).					✓
Brown, I. (1980).			✓	✓	
Carbines. M. (2004).					✓
Chapman, L.L. (1990).					✓
DeMontigny, F. (2004).		✓			
Edmunds, J. (1999).					✓
Griesemer, B., (1999).	✓				✓
Hinnefield, S., (1999).	✓				✓
Koppel, G.T., (2001).			✓		
May, K, A. (1984)				✓	
Nichols, M, R. (1993)				✓	
Nolan, M. (1994).	✓				
Reed, R., (1999).					✓
Shannon-Babitz, M. (1979).	✓				
Somers-Smith, M.J. (1999).		✓			
Tiedje, L.B. (2001).	✓				
Waldenstr om, U. (1999).				✓	
Walker, J.M. (1995).		✓			
Wilson , A., (1999).					✓

KEY:

1. The publication was a case study, dissertation, editorial, review or book chapter.
2. The focus of the research was on the outcomes following the birth, or on pre-term labour/still-birth/health problems in the infant.
3. The study did not report the use of a recognised qualitative methodology for data collection *and* analysis.
4. The study solely used quantitative methods or relied heavily on quantitative data (e.g. content analysis)
5. The study was not published in the English Language and/or in a peer reviewed journal.

Table 4: Evidence table for included research articles

First author	Year	Sample	Age range	Main aim or purpose	Method of data collection	Method of data analysis	Summary of main themes/findings
Chandler, S.	1997	T1 = 8 fathers T2 = 6 fathers Total = 14 first time fathers	T1 = 30-42 (Mean 33.3) T2 = 26-37 (Mean 33.5)	To describe first time fathers' expectations and experiences of their partners' labours and deliveries and to examine the meaning of the experience for first time fathers.	Ethnographic in-depth Interviews Two time points 35-37 weeks gestation and 4 weeks after the birth	Process described: transcription, line by line analysis, codes assigned to emerging themes, themes compared within and between interviews, model constructed	Fathers viewed themselves as part of a labouring couple Chronological model provided: Common themes: a) Its happening b) More work than anticipated c) Increased fears d) Hidden fears and emotions e) Lack of inclusion f) Increased excitement g) Relief: we've made it h) Family beginnings: time to get acquainted
Chapman, L.	1991	20 couples mixed first time and multi-time fathers	Fathers = 25-41 (Mean = 33)	To describe and explain the expectant fathers' experience during labour and delivery	Interviews and observations of couples at one of 5 hospitals in San Francisco Bay area. Approximately 4 weeks after birth. Both parents present during interview	Grounded theory (Strauss, 1987)	The author describes the expectant fathers' experience as part of a triple helix travelling in a uni-directional path through time. The spirals of the helix are made up of the labour path, the women's path and the expectant fathers' path. The author asserts that when expectant fathers are present they are co-labouring in one of three major roles, coach, team-mate or witness with differing degrees of engagement.
Chapman, L.	1992	20 couples mixed first time	Men: 25-41 (Mean = 33)	To describe and explain the expectant fathers' experience during labour and delivery	Interviews and observations of couples at one of 5 hospitals in San Francisco Bay area.	Grounded theory (Strauss, 1987)	The roles adopted by expectant fathers were related to the degrees of understanding and mutuality within the couples' relationships. These labour roles emerged from the behaviours described

		and multi-time fathers			Approximately 4 weeks after birth. Both parents present during interview		by the men: coach, team-mate and witness. Coaches led or directed their partners through labour and birth, team-mates looked to others to lead them through the experience and were less concerned with the need to be in control, witnesses viewed themselves as companions with a supportive role. The majority of men took the role of witness, and the author concludes that it is time to re-evaluate current expectations of the father in the role of coach.
Chapman, L.	2000	17 couples, mixed first time and multi-time fathers	16-55 (mean = 35)	To describe and explain expectant fathers experiences during labour when their partners receive labour epidurals.	Semi-structured interview 4 weeks post-partum	Grounded theory (Strauss, 1987)	Two major concepts were identified: losing her and she s back. The men reported that these were the two critical points at which the epidural affected their experience. The theory cruising through labour explained the fathers experiences
Draper, J.	2003	18 fathers mixed first time and multi-time fathers	20-50. (Mean not provided)	To explore men s experiences of the transition to contemporary fatherhood	Longitudinal ethnographic semi-structured interviews with the father alone, conducted at 3 time points. Twice during pregnancy and once post-natally.	Descriptive categories	The author posits that the labour and birth presents the greatest challenge to body borders and boundaries. The labouring body was described by the category boundaries broken . The author concludes that during labour awareness of the potential impact of the woman s broken body boundaries upon men should inform labour support that is tailored to the individual needs of men.

Hallgren, A.	1999	11 fathers mixed first time and multi-time fathers	21-49 (Mean not provided)	expectations and experiences of childbirth preparation and childbirth of Swedish men	Interviews at 3 time points before (27 th and 30 th week of gestation) and after childbirth preparation classes and between 1 and 3 weeks after the baby was born. Interviewed both alone and with partner depending on couples preferences.	Hermeneutic method (Ricoeur, 1976).	Participation in childbirth was more demanding than expected for all of the 11 men. They felt unprepared for an unpredictable process, the experience of time, pain, the woman's reactions and their own reactions. The main concept was vital involvement which described the level of involvement fathers reported in relation to the birth process. The paper draws heavily on the concept of vital involvement (Erikson, 1986).
Moran-Ellis, J.	1989	11 couples first time fathers	Ages not provided	To explore and describe fathers' expectations of his role during childbirth prior to the event couples' perceptions of the role the father had actually played during the event	2 in-depth interviews. 1 before the birth with the father only, 1 after the birth with the couple together.	Longitudinal, grounded theory Charmaz (1983) and Glaser and Strauss, (1967, 1978)	Pre-birth expectations were classified into 5 categories. There was congruence between maternal and paternal pre-birth role expectations. In post-birth interviews the decision to go into hospital rarely ran smoothly, the father's role was highly dependent on the type of delivery however, activities and actions such as communication with hospital, controlling access to pain relief, gatekeeping and guardian ship were all identified. The principle finding was that if labour went according to how the couple had imagined then the father worked in ways to help the women achieve the goals agreed pre-birth, however, if labour went differently to the plan then the previous roles were abandoned and a new role adopted. Fathers saw their role as an active and central one.
Wilkander, B.	1997	109 fathers	Ages not provided	To explore and describe the	Semi-structured interview conducted	Inductive analysis (Patton, 1987)	A core category of control was identified, 7 sub categories were

		no information provided as to whether participants were first time fathers		positive and negative events that behind fathers good or bad experiences during the labour and delivery and to study the roles fathers adopted during the delivery.	when the infant was between 6 months and 1 year of age This phase was part of a larger quantitative questionnaire study of families with an excessively crying infant.	referenced under grounded theory (Strauss and Corbin, 1990).	discussed (mother complications during delivery, infant complications during delivery father's helplessness, fathers' guilt feelings, fathers' feelings of cooperation, positive behaviour in midwives and obstetricians, negative behaviour in midwives and obstetricians). Complications during delivery were related to fathers' negative experiences. Staff behaviour was found to be observed by fathers and interpreted in relation to control.
Williams, K.	1999	T1 = 15 couples T2 = 14 couples First time fathers	Fathers aged :24-53, (mean = 32.5)	To examine the influence of medical technology on the pregnancy and childbirth experiences of both expectant mothers and their husbands	In-depth interviews at 2 time points (3 rd trimester and 2-4 months after the birth). Interviewed participants separately. Focus on perceptions of involvement and control over pregnancy and birth process.	Grounded Theory (Strauss, 1987 and Marshall and Rossman, 1989)	Interview data provides information specifically on the following areas: foetal Ultrasonography, Electronic Foetal Monitor, and the epidural. The authors assert that medicalisation exerts a form of social control that mothers are more vulnerable to when compared to fathers. The evidence from the study suggests that medicalisation of pregnancy and childbirth may result in a partial levelling of the playing field for mothers and fathers who have physiologically different levels of involvement in the birth process. Medical intervention was found in fathers to positively contribute to perceived involvement and create a role for them to play which might otherwise be absent.

Table 5: Tabulated summary of CASP ratings derived from the review process.

QUALITY CRITERIA	Chandler and Field (1997)	Chapman (2000)	Chapman (1991)	Chapman (1992)	Draper (2003)	Hallgren et al (1999)	Moran-Ellis (1989)	Wilkander and Theorell 1997	Williams and Umberson (1999)
Appropriate Research Design	<i>Weak</i>	<i>Moderate</i>	<i>Moderate</i>	<i>Moderate</i>	<i>Strong</i>	<i>Weak</i>	<i>Strong</i>	<i>Weak</i>	<i>Strong</i>
Sampling	<i>Moderate</i>	<i>Weak</i>	<i>Moderate</i>	<i>Weak</i>	<i>Weak</i>	<i>Weak</i>	<i>Weak</i>	<i>Weak</i>	<i>Moderate</i>
• Stated sampling strategy	✓	✓	✓	✓	✓	✓	✓	✓	✓
• Justification for selection criteria	✓	×	✓	×	×	×	×	×	✓
• Discussion of recruitment	×	×	×	×	×	✓	✓	×	×
Data Collection	<i>Strong</i>	<i>Moderate</i>	<i>Weak</i>	<i>Moderate</i>	<i>Moderate</i>	<i>Moderate</i>	<i>Moderate</i>	<i>Strong</i>	<i>Strong</i>
• Setting for data collection	✓	✓	✓	✓	×	✓	×	✓	✓
• How data collected	✓	✓	✓	✓	✓	✓	✓	✓	✓
• Justification of methods	✓	×	×	×	×	×	✓	✓	✓
• Methods explicit	✓	✓	×	✓	✓	✓	✓	✓	✓
• Explanation of modified methods	✓	✓	✓	✓	N/A	✓	✓	×	×
• Clear data form	✓	✓	✓	✓	✓	✓	✓	✓	✓
• Discussion of data saturation	✓	×	×	×	N/A	N/A	×	×	×
Reflexivity	N/E ³	N/E	N/E	<i>Weak</i>	N/E	<i>Weak</i>	N/E	N/E	N/E
• Examination of researchers role	×	×	×	✓	×	×	×	×	×

³ N/E = no evidence

QUALITY CRITERIA (Continued)	Chandler and Field (1997)	Chapman (2000)	Chapman (1991)	Chapman (1992)	Draper (2003)	Hallgren et al (1999)	Moran-Ellis (1989)	Wilkander and Theorell (1997)	Williams and Limbertson (1999)
	<i>Moderate</i>	<i>Moderate</i>	<i>Moderate</i>	<i>Strong</i>	<i>Weak</i>	<i>Moderate</i>	<i>Strong</i>	<i>Strong</i>	<i>Strong</i>
• Contribution to existing knowledge	✓	✓	✓	✓	✓	✓	✓	✓	✓
• Identification of <u>new</u> areas for research	×	×	×	✓	×	×	✓	✓	✓
• Discussion of transfer and other uses	✓	✓	✓	✓	×	✓	✓	✓	✓

CHAPTER THREE

MAJOR RESEARCH PROJECT PROPOSAL

Complicated Childbirth: A qualitative comparison of men and women s experiences

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For details of amendments made to this proposal in accordance with recommendations from

Yorkhill Ethics Committee (see Appendix 3.1)

For details of subsequent ethical approval from Yorkhill Ethics Committee and Research and

Development approval from Yorkhill Division and Primary Care Division of Greater Glasgow

NHS (see Appendices 3.4 and 3.5 respectively)

SUMMARY

Complicated childbirth, involving operative and instrumental delivery can be a distressing experience for both mothers and fathers. Research has shown that parents find complicated deliveries significantly more stressful than normal vaginal delivery (Chan and Paterson-Brown, 2002). Studies that have investigated complicated birth have mainly concentrated on either men or women, and the care guidelines produced so far have tended to focus on women (Reynolds, 1997).

The few studies that have looked at both men and women's experiences of complicated childbirth have generally concentrated on caesarean section deliveries, where the father is often absent (due to the anaesthesia administered to the mother). These studies suggest that male and female perceptions of birth as well as their coping strategies do differ greatly (Lohr et al (2000).

There seems to be a need for in-depth information about the experience of complicated childbirth involving instrumental delivery, where fathers are able to remain present throughout the majority of the birth.

The current proposal will outline the need for qualitative research in this area in order to expand our understanding of the unique needs of men and women, as well as the shared needs of the couple.

AIMS AND OBJECTIVES

Aims

The aim of this study is to explore the perceptions and coping styles of both parents following complicated childbirth (involving obstetric intervention) and to compare the specific reactions of mothers and fathers. The study will explore how the environmental factors, which are linked to complicated childbirth (e.g. medical equipment and intrusive procedures), are interpreted and appraised by the parents. The outcome of this interaction will be explored in terms of how the participants felt and acted in response to the birth (e.g. feelings of stress).

Objectives

- To describe and explain mothers and fathers experiences of complicated childbirth, involving obstetric intervention.
- To identify potential sources of stress and the reasons behind why these factors were perceived as stressful.
- To compare and contrast these experiences based on gender.
- To present these findings in the form of a conceptual framework that will inform peoples understanding of complicated childbirth.

INTRODUCTION

Women and complicated birth

The development of post-partum psychological distress, and mental health problems such as PTSD in women has a growing research base. The literature repeatedly finds strong associations between complicated deliveries and psychological distress. Bailham and Joseph s (2003) review reports that approximately a third of those who experience a birth involving obstetric and/or gynaecological procedures may go on to develop PTSD symptomatology. This review concludes that mother s who experience obstetric intervention, fear for self and baby, perceptions of loss of control, cognitive vulnerability, low level of support, and increased interactions with medical personnel are at greater risk of psychological distress (Bydlowski and Raoul-Duval, 1978; Ballard et al, 1995; Soet et al., 2003, Menage, 1993 as cited in Bailham and Joseph, 2003). While this review provides an insight into the aspects of birth, that can predispose women to developing PTSD, the paper lacks discussion about the fathers experience of the birth. In addition, the remit of the review restricts its discussion mainly to outcomes rather than process issues, which can be equally important in our understanding of psychological problems.

In a recent quantitative study Creedy et al (2000) recommend a review of obstetric intervention during labour and delivery in order to provide effective care for women during and after childbirth. This study identified factors that can contribute to psychological distress following labour and birth, which included the level of obstetric intervention experienced and the women s perception of intra-partum care. Unfortunately, the study lacks suggestions or guidelines for the care of women in this period, and does not fully address the potential for father s to experience psychological distress.

Men and complicated birth

Although few studies have looked at male experiences of complicated delivery, the research on childbirth in general suggests that men have unique psychological needs during the perinatal period, which frequently go unacknowledged and which require further identification (Chandler and Field, 1997; Koppel and Kaiser 2001; Puddifoot and Johnson 1999).

Research reports that attendance at the birth of their child can be a stressful and demanding experience for men (Chandler and Field, 1997). For example, Skari et al., (2002) found that clinically important psychological distress (including intrusion, avoidance, anxiety, depression, social dysfunction and somatisation) was reported by 13% of the fathers (n=122) a few days after birth.

One study which examined fathers experiences of complicated birth was conducted by Koppel and Kaiser (2001). The births in this study were by caesarean section, and due to the surgical procedures involved, most of the fathers were not allowed to be present. In this sense the study lacks information on father s who witnessed the birth process, but provides a valuable insight into the impact on father s who are not allowed the opportunity to be involved. The results suggested that father s recalled moments of extreme stress, which they felt unable to cope with, and which seemed to go unacknowledged by staff. These factors are not dissimilar to the predisposing factors, which can lead to psychological distress in women following childbirth, including a fear of death of self/partner and/or child (Koppel and Kaiser, 2001), and a reduction in perceived control (Green et al 1998).

An additional similarity between men and women s experiences of childbirth is that both

parties are likely to experience increased levels of distress if obstetric interventions are required. For example, Chan and Paterson-Brown (2002) report that fathers found operative and instrumental delivery significantly more traumatic, when compared to vaginal delivery. Vehvilainen-Julkunen et al (1998) conclude that further studies are required to examine how best midwives can support fathers throughout labour.

Couples and complicated birth

Men and women play different roles in the birth of their child. However, alongside their unique coping styles and perceptions, they will often have a shared plan of the birth, with shared expectations of the care they will receive in the process (Chandler and Field, 1997).

Lohr et al., (2000) examined the perception of premature birth by fathers and mothers. They combined qualitative and quantitative methods to examine each parent's perception and coping mechanisms. The authors reported that fathers and mothers' perceptions of premature birth, as well as their coping strategies differed greatly. This study provides a direct comparison of men and women and suggests that men may be equally distressed by complicated birth, but may present with this psychological distress in a different manner from women and are therefore overlooked in daily clinical practice. Due to the nature of delivery, most fathers in this study were not present during the birth of their child. The current proposal hopes to build on this by including fathers who have been present throughout the main duration of the birth.

Chan and Paterson-Brown, (2002) conducted a questionnaire study with 121 couples following the delivery of their babies. A strength of this study is that it looked at a range of birth situations, covering spontaneous vaginal delivery, caesarean section and instrumental

deliveries. In addition, the study analysed the data for men and women separately to allow for gender comparison. The paper highlights the emotional impact of the birth experience on men. It finds that fathers who chose to attend childbirth had very positive experiences overall. Those attending normal vaginal delivery felt that they were more helpful, less anxious and found the experience less traumatic than fathers who attended an assisted or operative delivery. Unfortunately the paper does not provide in-depth information/detail on why men and women found instrumental and caesarean sections significantly more distressing, in terms of the aspects that they found stressful or difficult to cope with.

PLAN OF INVESTIGATION

Methodology

The current study intends to use a cross-sectional, retrospective qualitative methodology as complicated deliveries cannot be predicted in many cases. Due to the lack of literature in this field, the research methodology is in keeping with an exploratory approach. This is not designed to test existing hypotheses but rather provide explanations and understandings of what men and women experience when the birth of their child becomes complicated (Pope and Campbell, 2001).

Participants

The aim is to recruit ten couples (n=20), who have experienced a complicated delivery, in addition to two couples (n=4) recruited for the pilot stage. Participants will be recruited from the Queen Mother's Hospital, Yorkhill, Glasgow. The numbers of participants in qualitative studies are generally much smaller than in quantitative survey research. The average number of participants in D. Clin. Psy. Theses generally lies between eight to twelve, whilst twenty to fifty participants have been recruited in larger studies (Turpin et al, 1997; Kuzal, 1992; Patton, 1990).

Measures

Socio-demographic and specific medical data on the birth will be obtained from discussion with participants and their midwives. This will include; age, gender, time since birth, cause of birth complication and obstetric intervention used to facilitate the birth. It is considered good practice to gather socio-demographic measures providing descriptive data on the research participants and their life circumstances (Elliot et al, 1999).

Raw data will be gathered from semi-structured interviews. There are a number of advantages to using semi-structured interviews, including that they are an open and flexible research tool, which documents perspectives not usually represented (Banister et al, 1994). Previous studies have involved joint interviews where both partners are present (Chapman, 1992, Moran-Ellis, 1989, Somers-Smith, 1999). This can lead to inaccurate data collection if the individual conceals their true emotions from their partner on certain issues for personal issues (Chan and Paterson-Brown, 2002). Joint interviews can also make gender comparisons difficult as individual data becomes enmeshed in the one interview. Therefore couples will be interviewed separately. It is acknowledged that some couples may be reluctant to be interviewed separately, however, this method has been used successfully in previous studies, with couples finding the experience a positive one (Lohr et al, 2000).

The interviews will comprise of a brief introduction and background to the study followed by a range of seed questions centred around the topic of complicated childbirth. The seed questions will cover the following categories: the experience of labour and birth (with particular emphasis on perceived sources of stress), coping styles during labour and birth, feelings about medical intervention and staff approach, and experiences in the four weeks following the birth. Follow-up questions or probes will be used sensitively to draw out topics and gather more detailed information. A strength of this approach is the ability to uncover unanticipated ideas or aspects of the research question not previously considered (Review, BJOG, 2001).

One aspect of grounded theory is that the researcher is involved simultaneously in data collection and analysis (Charmaz, 1995). As a consequence of this iterative process it is anticipated that the questions might change in focus over the course of the research.

RESEARCH DESIGN AND PROCEDURE

Preparation

Qualitative research requires an in-depth engagement with the topic in question (Yardley, 2000). Time will be spent consulting professionals in the field to provide ideas for seed questions that can be incorporated into a pilot interview guide (Burman, 1994). This process will also sensitise the researcher to male and female responses and behaviours during labour and birth. During this time the researcher will familiarise the Midwifery team at the Queen Mothers Hospital with the research, and provide them with the information leaflets outlined later in this proposal.

Sampling and recruitment of participants

A purposive criterion sampling strategy will be adopted. Couples who meet the inclusion criteria (see below) will be approached by midwives 24 hours after the birth. If interested in being involved couples will be given a detailed information leaflet about the project by their midwife (See Appendix 3.2). Potential participants will be given a 24 hour window between expressing an interest in the study and being asked to sign a consent form. Once this time has passed, those parents still interested in taking part will be asked by the researcher to sign three consent forms; one for them to keep, one for the researcher to keep and one to go in their hospital records (see Appendix 3.3). All participants will be made aware that they can opt out of the study at any time without having to give a reason. This will include withdrawal of their data post-interview. The researcher will then contact the participants in writing, offering them a date and time for an interview. This date will follow the mother's six week check up at the hospital to ensure that all underlying medical problems have been addressed. Participants will be given the following options concerning when they would like to be interviewed a) the same

day as the mothers six week appointment b) a day time appointment at the hospital c) an early evening appointment at the hospital.

Participants will be asked to select their preferred option for interview and indicate their preferred mode of contact (either telephone, e-mail or letter). Following this a date and time for the interview will be confirmed. A Chartered Clinical Psychologist will be available for consultation during these times should the need arise.

Inclusion criteria

- The couple can read and speak English.
- The couple have legal capacity to consent (above 16 years of age).
- The couple gave birth to a healthy infant with the father present for most or all of the labour and birth.
- The birth of their child required one or more of the following obstetric interventions: ventrouse delivery; forcep delivery; episiotomy.
- Both members of the couple are be willing to be interviewed separately

Exclusion criteria

- Couples who experienced the death of their baby.
- Couples with any plans for foster placement or adoption of the infant.
- Unassisted vaginal delivery or caesarean section (planned or emergency) Caesarean deliveries were considered outside the remit of the present study, mainly because fathers are often excluded from the birth due to the general anaesthetic (administered to the mother).

Setting and equipment

Interviews will take place at The Queen Mothers Hospital in an allocated room. Tape recorders and microphones will be required to audiotape the interviews.

Interview stage

Two couples will be recruited for the pilot interviews according to the sampling method outlined previously. The interviews will be audio-taped, fully transcribed and anonymised. All information will be kept in accordance to the data protection act. Feedback on the results will be provided to both the professionals and the participants involved. This will take the form of a written summary of the main findings. The summary will be posted to both participants and professionals who will then be contacted by their preferred method and asked for information on the accuracy of the interpretation, and any additional comments they would like to make. Any recommended additions or changes will be accommodated at this point. This will provide respondent validation (Mays and Pope, 2000) and allow participants an opportunity to highlight issues they feel may have been neglected or missed.

Following the pilot stage, ten couples (n=20) will be recruited and interviewed according to the same protocol outlined above. The feedback stage will also apply to these participants, and will take place when data collection is complete.

Data Analysis

The data from audio recordings will be transcribed verbatim using a word processing package. The transcripts will be analysed according to gender and using grounded theory methodology (Strauss and Corbin, 1998). This entails:

- *Open coding* - the process of breaking down, comparing, conceptualising and categorising

data.

- *Axial coding* - the process of analysing connections between categories and their components.
- *Selective coding and development of theory* - the process of selecting a core category and systematically relating it to the other categories. The core category is central to the phenomenon being studied and best integrates the analytical story to the data.

The process of coding and retrieving data as well as building a theory will be complemented by the use of a computer software program; QSR NUD*IST. This will allow an audit trail to be constructed and will increase the efficiency of data analysis.

Constant comparison method (Strauss, 1987) will be used a) to initially make comparisons within each gender set, and b) to compare data sets with the developing theory. This process will allow gender specific core categories and data to be developed. Once the key themes and concepts have been derived for each gender, the themes can be compared and contrasted using a variable matrix method of data presentation (Miles and Huberman, 1994). This will allow a within and between case analysis to be conducted. The findings will be collated to produce a model of the important themes that men and women report in the interviews.

Methods to enhance reliability and validity

- *Respondent validation* Consenting participants will be sent an anonymised summary of the initial findings and will be encouraged to provide their own comments. This will act to provide alternative perspectives and inform the developing theory.
- *Multiple coding* One third of the data will be analysed by the research supervisor. This will act to address the issue of subjectivity and researcher bias.
- *Deviant case analysis* A method for improving the quality of explanations in qualitative

research is to search for elements in the data that contradict or seem to contradict the emerging explanation of the phenomena under study. This helps refine the analysis until it can explain all or the vast majority of cases under scrutiny (Mays and Pope, 2000).

- *Multiple viewpoints* Triangulation is often used for this purpose, however, the use of different data sources (e.g. medical records) is not appropriate for this study. Instead, a variety of viewpoints will be collected throughout, from health care professionals as well as the mothers and fathers themselves.
- *Detailed procedure* A detailed description of the research process will be provided to enhance the trustworthiness of the overall study, and the transparency of the methodology (Lincoln and Guba, 1985).
- *Audit Trail* An audit trail will be provided so that someone else could repeat each stage of the research including the analysis. This will be achieved through the use of detailed notes and computer aided analysis which tracks the coding process, allowing the analysis stage to be re-traced.

Practical applications

Complicated childbirth is a distressing life event for parents which is experienced differently by mothers and fathers (Lohr et al, 2000). A significant minority of men and women experience psychosocial adjustment issues following a complicated birth (Skari et al, 2002), however, the reasons behind these adjustment issues may be different for men and women.

It is widely acknowledged that in order to meet the needs of childbearing couples it is important to have an understanding of men's experiences (Chapman, 2000). However, few studies provide an understanding of how these experiences compare and contrast to those of women.

Health care professionals working in this field require guidelines to increase their awareness of the issues and aspects of care that are important to men and women, as individuals and as a couple, during this period (Chapman, 2000). This study will provide in-depth information, about how obstetric interventions may affect men and women s perceptions of labour and birth, by highlighting the aspects of this birth experience that parents interpret as stressful and attempting to explain why this might be the case. It is hoped that this insight will help professionals in a range of fields to better understand the psychological care needs of couples who experience a complicated delivery.

This study will also provide an example of qualitative methodology, which meets the criteria that Elliott (1999) recommends as good practice in qualitative research, and will hopefully provide a basis for future research studies, which will be able to adapt these guidelines into screening tools and assessment measures.

Time scale

Ethical approval will be applied for in June/July 2005. Once approval has been granted the semi-structured interview schedule will be piloted. Recruitment of participants will begin between July and August 2005. The data collection process will start in September 2005 and continue through to March 2006, with ongoing data analysis. Write up will begin in May 2006 and continue through to July 2006.

Ethical considerations

Ethical approval will be sought from Yorkhill Research Ethics Committee, Yorkhill NHS Trust and from Greater Glasgow Primary Care NHS Trust. The timing of the interviews is an

important aspect of this study. Having taken the advice of two Clinical Psychologists working in this field it has been decided that couples should be interviewed four to six weeks following the birth. This is in line with previous studies such as Chapman (1991) who suggests a four-week interval between the birth and the interview. If the couples were to be interviewed sooner than this, they may lack the ability to reflect on what had happened or be unable to engage in the process (Ehlers and Clark, 2000). Psychological support will be offered to individuals should they present with a psychological problem or request counselling, this will be provided by a Clinical Psychologist, currently working in Peri-natal Mental Health at The Queen Mother s Hospital.

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CHAPTER FOUR

MAJOR RESEARCH PROJECT

Men and Women s experiences of instrumental delivery: A qualitative study

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Psychology (see Appendix 4.1)

ABSTRACT

Growing rates of operative deliveries across the UK have led to discussions around the medical, psychological and social impacts of different modes of delivery. Research into the psychosocial aspects of men and women's experiences of instrumental delivery (involving forceps or ventouse) is currently underdeveloped. In this qualitative study, twenty first time parents (10 men and 10 women) who had experienced an instrumental delivery were interviewed separately using semi-structured interviews. Data analysis was informed by grounded theory methodology and analysed using QSR NUD*IST 4.

The core category accommodating medical intervention emerged as central to men and women's experiences of labour and instrumental delivery. The importance of accommodating medical intervention and the factors that can facilitate this process are highlighted in a conceptual framework to aid understanding of how instrumental delivery can affect both men and women's perceptions of the labour and delivery, including their ability to move on from the birth and enjoy early parenthood.

Key words: instrumental delivery, men and women, parents, accommodating medical intervention.

INTRODUCTION

Whilst the majority of births in the UK occur spontaneously, recent statistics indicate a growing proportion may involve a caesarean section or instrumental delivery (forceps or ventouse assistance) (Department of Health DoH, 2006). Instrumental and caesarean deliveries tend to be performed if a spontaneous birth poses a greater risk to the mother and/or baby than an assisted one, and these are often referred to collectively as operative deliveries (Chamberlain and Steer, 1999).

Whilst the medical aspects of operative delivery have been widely researched and best practice guidelines published (Royal College of Obstetricians and Gynecologists, 2005), research on understanding parental experiences and the associated psychosocial impact remains underdeveloped (Murphy et al, 2003; Bahl et al, 2004).

Research suggests that whilst the majority of parents report the birth of their child to be a positive and exciting time, for some it can also be a stressful and demanding experience. Skari et al (2002) report that clinically significant psychological distress can occur in a minority of parents a few days after birth, and is more likely to be experienced by mothers than fathers (Skari et al, 2002).

Research that has investigated different modes of delivery during childbirth suggests a link between increased obstetric intervention and higher levels of psychosocial distress in

men (Chan and Paterson-Brown, 2002) and women (Fisher et al, 1997; Maclean et al, 2000) post-delivery.

Bailham and Joseph (2003) stress that the parental appraisals of events surrounding the labour and delivery can be just as important as the delivery method itself. In their literature review of post-traumatic stress disorder following childbirth they concluded that mothers who experienced obstetric intervention, fear for self and baby, perceptions of loss of control, cognitive vulnerability, low levels of support and increased interactions with medical personnel are at a greater risk of psychological distress. The importance of control has also been supported by qualitative research. For example, Allen (1998) interviewed 20 women who had perceived their labours to be traumatic. Allen commented that all participants reported feelings of not being in control (of either events and/or their own behaviour) coupled with feelings of helplessness during the labour.

Qualitative methodologies have become increasingly popular within health service research (Mays and Pope, 2000). This is often because most qualitative approaches place an emphasis on 'providing rich descriptive accounts of a phenomenon under investigation' (Smith et al, 2003, p.1.), and therefore promote in-depth understandings and new perspectives relating to individual experiences. As such, qualitative methods have been used to explore men's (Koppel and Kaiser, 2001) and women's (Murphy et al, 2003; Berg and Dahlberg, 1998) experiences of operative delivery during childbirth. Such papers follow on from a tradition of using qualitative methods to investigate men (Chandler and Field, 1997; Chapman, 1991, 1992, 2000; Hallgren et al, 1999) and

women s (Essen et al, 2003; Mackey, 1998; VandeVusse, 1999) experiences of childbirth in general.

In a recent qualitative study, Murphy et al (2003) asked women about their experiences of operative delivery. The study reported that most of the women felt unprepared for the event and thought that the information provided during antenatal classes did not always cater sufficiently for operative delivery.

Some qualitative studies have explored parental experiences specifically relating to caesarean section for both women (Ryding et al, 2000) and men (Koppel and Kaiser, 2001). Ryding et al (2000) found that women who reported that they never lost confidence in themselves or in staff and enjoyed meeting their baby had a lower incidence of traumatic stress six months post delivery than women who reported disappointment or fear during delivery.

The fathers in Koppel and Kaiser s (2001) study reported extreme stress when excluded from the operating theatre. This stress was explained by fathers primary concerns for their partner s health and then concern for the baby. A finding that is not dissimilar to the fear for self and baby reported in the literature on women s appraisals of stressful birth experiences (Bailham and Joseph, 2003; Allen, 1998).

The longer term implications of operative delivery have been investigated by Bahl et al (2004) who conducted a postal questionnaire survey of 283 women three years post

delivery. The authors report that 32% of women wished to avoid a further pregnancy, often due to a fear of childbirth and conclude that the psychological impact of operative delivery requires urgent attention.

Considering that the father's presence at the birth of his child might now be viewed as a social norm (Draper, 1997) and in light of discussions to increase training in instrumental delivery methods (American College of Obstetricians and Gynaecologists - ACOG, 2000 as cited by Bahl et al, 2004) it is important that we gain a better understanding of how fathers experience operative delivery (Murphy et al, 2003). It has been suggested that an understanding of both parents' needs during childbirth can promote a more positive birth experience and contribute towards adjustment to parenthood (Nichols, 1993). To the author's knowledge, however, a qualitative methodology has not yet been used to specifically explore both men and women's experiences of instrumental deliveries.

AIMS AND OBJECTIVES

Aim

The aim of this study was to explore and describe men and women s experiences of instrumental (vacuum/ventouse or forceps) delivery.

Objectives

1. To explore and describe parental experiences of instrumental delivery.
2. To explore potential sources of stress and the reason these factors were perceived as stressful.
3. To explore similarities and differences between men and women s experiences.
4. To present these findings in the form of a conceptual framework that will inform understandings of instrumental delivery.

METHODOLOGY

Methodological Approach

Due to the shortage of literature on this subject, a qualitative methodology was adopted to provide rich data that could inform an emerging understanding/theory of men and women's experiences of instrumental deliveries. The study was designed and carried out in accordance with the Critical Appraisal Skills Programme guidelines (CASP, 2002).

The methodology was informed by the principles of grounded theory (Glaser and Strauss, 1967; Strauss and Corbin, 1998), as opposed to an ethnographic or interpretative phenomenological (IPA) approach. This approach was chosen because the goal of the research was to build a conceptual/theoretical framework to aid understanding about a relatively under-researched area and grounded theory offers an established approach to the systematic generation of theory from data.

Participants

Twenty first time parents (ten couples) were recruited from postnatal wards at a large maternity hospital in Glasgow. Participant characteristics are displayed in Table 1 to provide descriptive information in order to situate the sample (Elliot et al, 1999). All couples lived together, eight of which were married. Eight births required instrumental delivery using forceps, one of which involved attempted ventouse delivery, and the remaining two required ventouse assistance. The main reasons for instrumental delivery

were prolonged second stage of labour and/or foetal distress. Nine women received an episiotomy and all opted in to epidural pain relief. All births were overdue and seven of the ten births were induced.

INSERT TABLE 1

Sampling and Recruitment Procedure

A purposive theoretical sampling strategy was adopted (Strauss and Corbin, 1998). The researcher sought couples across a range of instrumental delivery experiences (e.g. forceps and ventouse, theatre versus labour suite deliveries, intended home versus hospital births) to gain a better understanding of emerging concepts and inform the developing theory.

Of the 26 couples approached, 15 agreed to participate. Reasons for non-participation included being discharged before the researcher could approach the couple and not wanting to discuss the birth experience. Of the 15 that originally opted in, two were excluded due to postnatal maternal or infant ill-health, two could not be contacted, and one moved abroad before the interview could take place.

Inclusion criteria for involvement in this study were: first time parents: the ability to speak and read English; capacity to consent; that the infant was healthy; the father was

present for most of the labour and birth; the birth required a ventouse and/or forceps delivery.

Couples who experienced the death of their baby or had plans for foster placement or adoption of the infant were not included in this study. This was because the experiences of such parents might cover aspects separate to the proposed research aims.

Couples who met the inclusion criteria were offered an information leaflet about the study by their midwife approximately 24 hours post delivery (minimum). Forty eight hours post delivery (minimum), couples were approached by the author and informed written consent was taken. Interviews were arranged four weeks post delivery at a time and place to suit each couple. This followed G.P. confirmation that mother and baby remained healthy. All couples chose to be interviewed in their own homes and most opted for evening appointments. A four week interval was chosen to allow parents time to reflect on their experience and consider their decision to participate.

Qualitative research requires an in-depth engagement with the topic in question (Yardley, 2000). Time was spent consulting with professionals in the field and shadowing midwives to sensitise the author to parental experiences surrounding labour and delivery.

Data Collection

Reflective accounts of experiences were gathered using semi-structured interviews as these offered an open and flexible research tool and enabled the collection of rich and

descriptive data (Banister et al, 1994). A semi-structured interview guide was constructed in consultation with a range of professions (including clinical psychology, midwifery, and medical sociology) and used flexibly as a guide to prompt the interviewer. The interview guide consisted of open ended questions across the chronological domains of the pregnancy, the labour and delivery, and the postnatal period. These topic areas were covered to place the delivery in context of the individuals wider experience (see Appendix 4.2 for a copy of the final interview schedule).

Data collection and analysis occurred simultaneously as part of an iterative process (Charmaz, 1995). The interview schedule, therefore, evolved as new categories emerged and different types of information were sought to confirm or disconfirm the developing theory. Two clinical psychologists and one experienced qualitative researcher reviewed the schedule during regular supervisory meetings.

Men and women were interviewed separately for two main reasons. Firstly joint interviews can lead to a censorship of individual accounts if one person conceals their true emotions from their partner (Chan and Paterson-Brown, 2002) and secondly, because individual data might become enmeshed within one interview making it difficult to explore gender specific experiences.

The researcher spoke to the couple together and each parent individually, both prior to and following the interviews, in order to reiterate ethical issues and answer any questions. The researcher kept notes of non-verbal information during the interview and completed memos in the form of a contact summary (Miles and Huberman, 1994) following each interview.

Interviews were digitally recorded (Sony ICD-MS515 digital recorder). The average time was similar regardless of gender (Fathers: average = 41:48 minutes, range = 8:33 59:25; Mothers: average = 41:40 minutes, range = 18:41 58:38).

Data Analysis

Following each interview the audio-recording was transcribed verbatim on to a word processing package (Microsoft Word©).

The author began by reading each transcript and writing descriptive open codes in the margin to highlight what Dey (1993) describes as bits of data i.e. single words, lines and/or paragraphs which described an event or aspect of experience (please see appendix 4.3 for an example of coded transcript). Once identified, open codes were given a numerical reference to increase coding efficiency.

Codes sharing a similar meaning were grouped together to form categories, for example, the open codes of normalising , being assertive and thinking positive were grouped within a sub-category termed active coping strategies and later linked with avoidant

coping strategies under the category of coping strategies . As data collection progressed relationships between categories were re-analysed to form higher order/main categories of meaning. For example, the category of coping strategies , was associated with aids to coping and related to the main category termed coping with the experience . The process of relating categories to their sub-categories is known as axial coding (Corbin and Strauss, 1998).

The researcher returned repeatedly to the interview data to check the content and connections between categories and sub categories. Glaser & Strauss (1967) described this method of continually comparing concepts with each other as constant comparative method .

It was possible to compare and contrast data in several ways i.e. within individual interviews, between interviews and with the developing theory. The author kept memos (i.e. notes and diagrams) of categories and ideas on how different aspects of parental experiences related to each other. This helped to facilitate a process of integrating categories and refining the emerging theory (Strauss and Corbin, 1998).

The computer software program, QSR NUD*IST V4 (non-numerical unstructured data indexing searching and theorising, 1997), was used throughout the analysis to aid data management, increasing the efficiency of data analysis and providing an audit trail to be constructed.

Ethics

Ethical approval was obtained from Yorkhill Ethics Review Committee. Written and informed consent was taken from all participants by the researcher. Issues such as informed consent, the right to withdraw, confidentiality, and anonymity were addressed in an information leaflet and reaffirmed verbally. A Clinical Psychologist was available for consultation should parents have required psychological support. To ensure anonymity, identifying information was removed from transcriptions and participants were given anonymous identifiers (e.g. F1 and M1 referred to the first father and mother interviewed).

Quality Checks

Two couples (N=4), chosen for their differing birth experiences were asked for their feedback on the developing theory during a telephone call. This provided respondent validation considered to act as a quality check (CASP, 2002), and helped inform the developing theory. The researcher fed back the main categories to participants individually, and asked them to highlight any aspects they disagreed with. All categories were agreed with. Additional comments were collected and added to the respective categories of inclusion-exclusion, handing over control and placing trust in staff and absence of concern. Multiple coding for two transcripts, the collection of a variety of viewpoints, and regular supervision with an experienced qualitative researcher helped to expand the emerging theory. Throughout the analysis the researcher searched for elements in the data that seemed to contradict the emerging explanation (deviant case

analysis). This helped to refine the analysis until it explained all parental experiences (Mays and Pope, 2000).

Theoretical saturation was tentatively reached by couple nine in that relatively few of the new codes improved understanding of the findings. Couple ten was additionally recruited, and no new categories emerged from this interview.

Reflexivity

One aspect important to qualitative research is the ability to be reflexive and aware of one's contribution to the construction of meanings throughout the research process (Mays and Pope, 2000; Yardley, 2000). The age, gender, and background of the researcher (female, 25 years, trainee clinical psychologist who had not experienced childbirth) may have influenced participants' experiences of being interviewed and the information they relayed as well as the researcher's own interpretation of the findings. Regular supervision and independent coding provided opportunities for the researcher to reflect on her interpretations. Reflexivity can also include issues relating to the participant-researcher relationship (CASP, 2002). Overall, participants reflected that it had been good to talk over the experience, with some mentioning that they had been able to discuss aspects of experience that they hadn't had a chance to before.

FINDINGS

A framework to describe accommodating medical intervention

The proposed framework aims to describe the process of accommodating medical intervention, which emerged as central to both men and women's experiences of instrumental delivery. An illustrated summary of this framework is provided in Figure 1. The framework consists of six related categories of experience (relationships between categories are represented by arrows and sub-categories are presented as bullet points). The main categories consist of: preparation for the birth, the relationship context, engagement with increasing medical intervention, coping with the experience, reactions to instrumental delivery, and reflecting and moving on from the birth.

INSERT FIGURE 1

Each of the categories and their component sub-categories are discussed in more detail below. Excerpts from transcripts are provided. These have been chosen as representative of key categories. Within the excerpts one second pauses are indicated using [-], two second pauses as [--] and so on. Figures 2, 3 4 and 5 are provided to illustrate the sub-categories and further sub-elements of the more complex main categories.

The Core Category: Accommodating Medical Intervention

Accommodating medical intervention was defined as a rich and ongoing process which enabled parents to integrate the experiences associated with medical interventions into the wider birth experience. This concept emerged as parents described reactions, events, and emotions in relation to accommodating a range of medical interventions (e.g. induction, pain relief, episiotomies) as part of their labour and delivery experience and therefore their perception of instrumental delivery was imbedded within this context. Accommodation of medical intervention was viewed as a fluid concept with parents describing varying degrees of accommodation throughout their birth experience.

Certain aspects helped parents to accommodate varying degrees of intervention leading to a more positive birth experience. These included: flexible preparation; feelings of engagement; utilising coping strategies; reacting beneficially; and feeling able to reflect positively and move on. For some parents one or more of these aspects became compromised, making it more difficult for them to accommodate medical intervention.

The experience of accommodating interventions early on in the labour seemed to facilitate accommodation of instrumental delivery: *I think I was more accepting of the possibility of an intervention because I had already had the process of the induction and the breaking of the waters and the epidural I think because you have already made a number of decisions about intervention that you hadn't wanted to make* (M2: 191-194).

The proposed framework therefore indicates that the earlier the process of

accommodation of medical intervention begins, the better placed parents might be for a more positive instrumental delivery experience.

Relationship Context

General contextual factors are acknowledged throughout the framework, however, parents awareness of their partners experience and their inter-dependent roles seemed to act as an important background influence relating to the accommodation of medical intervention.

Awareness of partners experience

An awareness of what their partner might be experiencing during the labour and delivery elicited emotions and actions from parents that influenced their experience. This category was reported more saliently by men who were acutely aware of their partners experience in relation to pain: *She felt utterly hopeless in that respect you know thought that she just couldn't (F1: 618); I thought oh god poor (partner) he's had to watch it live it must have been pretty gruesome (M10: 376).*

Relationship roles

Parents mentioned aspects of their role as part of a relationship. Women seemed to adopt an indirect role by determining how included they wanted/were able to let their partners be during the birth: *I understood what the epidural would do that it would help and I think ultimately I said to (my partner) that I want you to make this decision (M2:*

136-137). Men discussed adopting a role that was in line with their partner's needs and preferences, and as such inter-linked with her ability to include him in the process:

trying to understand the medical issues as well as maybe trying to seem like you are very focussed and supportive (F1: 555).

Preparing for the Birth

Parents described preparing for the birth to differing extents during the pregnancy. Aspects of medical intervention were accommodated to varying extents within preparation and this related to the following three sub-categories.

Birth expectations

Parents described having certain birth expectations, which included birth plans, predictions, hopes, and preferences. Minimal medical intervention was seen as preferable by parents, however they also reported keeping a relatively open mind: *We had the birth plan but we knew we might have to change that as time went on but the intention was to have a relatively medicine free delivery as possible* (M7: 12-14). Parents reported that the preference for minimal intervention was based on certain preconceptions, including a hope that minimal intervention would mean fewer risks for their baby *the potential risks for the baby put me off* (M2: 58). For women, minimal intervention was also associated with a preference for increased movement during delivery and the hope of a less complicated recovery.

Accessing the medical system

This category was defined as attempts to engage with medical services with the aim of preparing for the birth. Examples included attending antenatal classes, opting in to scans, and taking advice from health care professionals: *we were going down the hospital path if you like [-] the sort of box standard route that you go down pretty much just going along with the advice at the time* (F1: 112-113).

Limits on preparation

Parents described difficulties preparing for the birth due to the perceived unpredictability of the event itself: *there are so many variables that no-one can predict* (F6: 355-366). In line with this parents queried the usefulness/effectiveness of trying to prepare for such an unpredictable event. Aside from this factor, externally and internally imposed limitations on preparation were reported.

Externally imposed limitations (e.g. difficulties accessing services, lack of information provided) were mentioned by parents. External limitations hindered accommodation of medical intervention by limiting access to preparatory information: *they never mentioned forceps I think these things y know you get shown round the ward and they kind of get hidden out of the way [--] I think these are things they kind of don t want you to see* (F5: 59-61); *I think there is a bit of a culture of secrecy about induction* (M2: 512-513).

Conversely, parents also described their own limitations on preparation (self-imposed limitations). These included not considering medical intervention as a potential outcome:

I suppose we said y know we will cross other bridges as and when we come to them[-] just work on the assumption that everything was gone go ok and that it wouldn t need intervention (F10: 55-56), and women uniquely reported a sense of trying to shield themselves from anxiety provoking information: I decided not to read as much as I could have and I skipped lots of chapters as I say I was too frightened that if I thought too much about it I would work myself up into a panic (M4: 57-58).

Engagement with Medical Intervention

This category was defined as how ready, willing, and able men and women were to engage a range of medical interventions (from induction to forceps and ventouse), and the extent to which they perceived a sense of involvement with the procedures (see Figure 2). Engagement facilitated accommodation of interventions through four processes described below:

INSERT FIGURE 2

Balancing feelings of control and trust:

Parents noticed reductions in personal control with induction, forceps and ventouse interventions: *I mean ultimately I wasn t in control it wasn t me that was delivering the baby (M7: 207).*

Interestingly with reductions in control women tended to describe having control over some aspects of their experience and not others e.g. *I had control over the decision making process but felt physically I had no control at all* (M2: 290-291), whereas for men reductions in control seemed more absolute: *totally out of control absolutely no control psychologically physically nothing no control at all* (F4: 208-209).

Importantly reductions in personal control were not necessarily distressing or problematic for parents who described efforts to balance out reductions in personal control by placing their trust in staff and handing over control to them: *you do surrender yourself to the doctors [-] but you have to do that it s a totally out of the ordinary thing* (F6: 359-360). Women also described placing their trust in and handing over control to their partners. These efforts helped to maintain a sense of control albeit in the form of external control . Trust in staff was therefore interlinked with parental perceptions of external control: *you don t really mind what the doctors are doing the midwives had been good and you just as I say put your trust in them* (F6: 168-169).

Conversely, decreased personal control seemed to become problematic if parents found it difficult to place their trust in staff. These parents explained that such difficulties that led to a reluctance to hand over control and engage with the intervention process: *he came in and said we are going to have to use forceps and I was like I don t want them I m really reluctant.. I was thinking in my head I have to trust him I have to trust him although I wasn t feeling it* (M1: 310-317).

Positive interactions with staff (e.g. professional relaxed manner, being listened to and supported, being encouraged, and provided with information) were important in enabling parents to trust staff, which in turn facilitated their engagement with intervention: *I think that was important [-] people listening to what I said and acknowledging what it was like for me being kind made it easier for me to say right ok [-] I completely trusted certainly the two midwives who were in the delivery room* (M10: 297-299). Conversely negative interactions with staff contributed to difficulties trusting them.

Acceptance of medical intervention the perception of necessity

When faced with the prospect of medical intervention all parents described a personal recognition/acceptance that medical intervention was necessary. This was affected by several influences.

The main influence reported by parents was that of wanting the baby out : *I pretty much wanted to see the baby out for both his sake and (my partners)* (F1: 385-386); *to use forceps I was very disappointed but I also wanted her out just for her own sake as well as my own* (M2 200-201). This influence was considered important as it tended to over-ride any concerns or hesitations: *Surprisingly to me I was quite happy to go along with the doctors call I normally would just question why and how but at the time it seemed like an emergency* (F1: 379-378).

Generally speaking, parents who: perceived the risks of not intervening as greater than those for intervening; appraised the intervention as routine and normal; had experienced a

lengthy labour; whose partners accepted the need for medical intervention and described focussing on the end point seemed to find it easier to accept medical intervention. Whereas parents who described: high levels of distress and fatigue; difficulties with making decisions; a focus on the risks of intervention; and for whom intervention represented a large deviation from their birth plan found it more difficult to accept medical intervention.

Information and explanations: being kept in the loop

Timely and appropriate information and explanations, matched to parental preferences was reported as helpful by parents when the prospect of an assisted delivery became a reality. Parents commented on both the content and style of information provision in relation to medical interventions.

Preparatory information about procedures and a time frame (however approximate) was reportedly extremely helpful in terms of information content. Some women, however, found it difficult to take on board information at times due to a fear it might increase their anxiety, because they wanted the procedure to be speeded up, or simply because they were in too much pain/too tired.

Staff who spoke calmly, whilst making eye contact and, where possible checked parental understanding following the explanation, reportedly improved parental feelings of engagement with the intervention experience: *everyone was really kind and really*

focussed on what was going on they were very much eye contact we are going to do this to you we are going to do that (M7: 110-111).

Inclusion-exclusion

This category was seen as relevant to men's experiences. All fathers agreed that the focus of medical attention should be on their partners and that as a consequence they expected to be excluded to some degree, however, fathers also stressed that they remained emotionally involved in the process and this made feelings of exclusion difficult to manage: *Ok you maybe not pushing the baby out but you are certainly going through the same if you take the physical aspect out going through the same emotions* (F4: 86-87).

Men whose partners required a forceps delivery in theatre described greater feelings of exclusion as they were asked to wait outside the operating theatre before being called in. This exclusion provoked feelings of distress in fathers as it fuelled concerns for their partners whilst hindering their ability to be supportive: *that was me by myself and that was very traumatic coz I could hear (my partner) still having contractions before the anaesthetic took effect so she was quite audible and I just thought y know I should be there with her so that was very hard to deal with and quite distressing* (F7: 225-228).

Reacting to Instrumental Delivery

This category was defined as the experiences and reactions of parents reported in relation to forceps and/or ventouse and the period immediately afterwards (refer to Figure 3). Parents described both difficult and beneficial reactions to events surrounding the delivery, which tended to respectively hinder or help accommodation of medical intervention.

INSERT FIGURE 3

Difficult reactions

The following reactions were perceived as difficult because they all elicited negative emotions usually linked to increased concerns for self/partner and or baby.

Parents described shock at the force used during the intervention. Parents explained that their initial shock was due to increased concern for their baby. For women it was also associated with a fear for their own wellbeing linked to the physical sensation of the procedure: *I was really shocked by the whole procedure it was not what I imagined it would be at all it was really [-] violent [-] thinking god they re going to pull my baby s head off I thought god they re really going to hurt (my baby) that can t be right and then I thought [-] that s going to be mashing up my insides (M10: 311-320).*

Parents also reported distressing images and sounds in relation to the delivery. This category seemed more salient for men: *I honestly expected to see the baby s head dangling from the end [-] sounds horrible but that s the amount of force and then the*

noise of the pop and then seeing the doctor hit the wall and then the mess that followed it was like something out of a horror film (F1: 415-419).

One reaction that uniquely reported by women and not related to concern for self or baby was that of negative self-evaluation . Women described a sense of disappointment in themselves when it became apparent that intervention would be required: *there was nothing I could have done to make the process go more as I d hoped but there is at that point in time when you are feeling a bit vulnerable a bit of disappointment in my own body (M2: 230-232).*

Immediately following the birth, women often required a level of after-care (i.e. suturing). For some this elicited increased concern for partner/self as the after-care was viewed as an indication that something might be wrong *well after the birth when we were still in theatre I got quite worried then because it was quite a while I was still in there and then they were stitching me up and I was still bleeding and then they had to find out why I was still bleeding (M9: 197- 198).*

Fathers uniquely reported a time when they were left holding the baby whilst their partners received medical attention. This time was initially joyful for all fathers, but for some became distressing if they perceived their partners health to be at risk *they handed him to me and I was pretty much shoved in the corner and there were quite a few people fussing about (my partner) and I sort of started to look at the floor and my shoes*

and saw the blood and . she was white and I could see the blood draining out of her and I started to get quite upset (F1: 496-500).

In contrast, those women who were unable to hold their baby immediately post-delivery due to medical attention on the mother found this separation from their child distressing and described wanting to be with my baby : *at that time when they were sewing me up and putting these things through me and I was thinking I want to hold the baby I want that you know I ve just gone through this and now I m not even allowed to hold the baby (M1: 371-373).*

Concern at the immediate appearance of baby was reported by some fathers due to bruising caused by forceps delivery. This concern was short-lived and began to subside as the marks faded and the baby was given a good bill of health. Interestingly, this concern was not noticed in women s transcripts.

Beneficial reactions

Importantly, despite some difficult experiences, parents mainly reported an *absence of major concern* relating to instrumental delivery *I saw it as something to get the baby out so it didn t matter [-] I wasn t too worried about that I wasn t in any pain so I was quite relaxed (M8: 103-104).* This was mainly linked to effective pain relief administered to the mother, engagement with the process, and more aids than barriers to coping. Quicker and less forceful experiences of intervention that were in line with parental expectations were especially linked to lower levels of concern: *it really didn t*

bother me at all I think it s because it s how I expected it to be so it really didn t bother me at all (F2: 233); *it was just over so quick I have no idea how long it was but it felt like ten minutes* (M6: 312-313).

The sub-category of *feeling positive and emotional* was identified for parents following the birth: *just emotional [-] that was just the most amazing feeling ever obviously I cried the tears it was just amazing just brilliant* (F5: 265-266). Women tended to report feelings of relief, prior to the elation and joy, and then a general sense of fatigue *relief was probably the biggest thing* (M10: 364).

Coping with the Experience

Two sub-categories were identified under this category: aids and barriers to coping and sources of stress (see Figure 4).

INSERT FIGURE 4

Aids and barriers to coping

The main barriers to coping with the labour and instrumental delivery were emotional stress/distress and fatigue/pain.

Whilst fatigue was experienced by both men and women: *it s tiring which makes it hard because you re trying to be supportive and everything but you are knackered [-] so your mind starts to go and your not really on the ball* (F6: 101-102); *I was just completely*

beaten with tiredness (M6: 166). Pain was a unique barrier for all women *I was still having painful contractions which were becoming increasingly difficult to cope with* (M10: 80).

Emotional stress/distress was important as, at high levels, it interfered with some parents abilities to utilise their coping resources *I had got into quite an emotional state that I wasn't able to really help I've spoken to my partner about this and she wasn't aware of it but I wasn't able to calm myself down and be able to support her* (F7: 310-312).

The main aids to coping included positive interactions (with staff and partner), pain relief, and adopting coping strategies.

Pain relief was described as helpful by most parents, however for some parents pain relief led to unpleasant side effects for women making the intervention less helpful. In addition, positive interactions with staff characterised by support, encouragement, and information also aided parents ability to cope with the experience (as discussed by eight women and nine men).

Parents described adopting various active and avoidant coping strategies. The following active strategies seemed helpful to both men and women: normalising, being assertive, seeking social support/talking to staff, thinking positive/focussing on end point, keeping calm, and using humour. In addition men reported acting as their partner's advocate *the doctor would explain it to me and I would say it to my partner* (F7: 145-147), and

adopting supportive tasks *rubbing her back and all these sorts of things you learn in antenatal classes* (F2: 115) also helped them to adopt a role and therefore cope better with the experience.

With regard to avoidant coping strategies men described *hiding true emotions* : *I still wanted to show no fear because I thought if she's relying on me for strength and I leave the room whilst it's happening she's going to panic* (F1: 322-324). Both men and women reported using visual avoidance: *throughout the whole procedure I had my eyes squeezed tight shut willing it to be over* (M10: 244-245); *you just bite the bullet and direct my sight somewhere else* (F1: 324-325).

Sources of stress/distress

Men and women reported similar sources of stress yet often from differing perspectives. Pain is an example of this. Women reported the physical experience of pain stressful: *I just couldn't continue in this horrendous pain* (M10: 128), whilst men explained that watching their partner in pain was stressful *To watch somebody go through that much pain was stress* (F1: 210).

The sources of stress common to all men and women related to concerns for mother/self and baby. For some experiencing/witnessing medical interventions was stressful but this was linked to the fact that it increased concerns for mother/self or baby. In addition, men experienced increased stress relating to waiting for the delivery itself as the labour was prolonged in most cases.

Reflecting and Moving On

This category was defined as parental reflections regarding the overall birth and their experiences in the first four to five weeks postnatally. Parents mentioned aspects that influenced the content of their reflections and experiences making it easier or more difficult to move on from the birth and enjoy early parenthood. Figure 5 provides a diagrammatic representation of the sub-categories relating to reflecting and moving on .

INSERT FIGURE 5 HERE

Reflecting and moving on with relative ease:

This category included the positive reflections discussed by parents regarding their birth and the aspects that assisted them to enjoy the first few weeks of parenthood. Many parents held positive memories of aspects of their birth experience reflected through sub-categories such as Putting the birth in context , positives outweigh the negatives , and positive future birth expectations .

Parents described finding a context for their birth experience, and men often used analogies *like I ve got a jackpot lottery ticket here and I ve written my car off that s what it felt like a strange feeling I was so happy [-] I was scared I was fearful but also elated just strange I can t put it into words except through that analogy (F4: 265-269)* or relate the experience to past challenges they had encountered. Whereas women tended to make sense of instrumental delivery in the context of its necessity *If I didn t have*

forceps erm yeah sure it would have made a big difference I suppose but at that stage . the priority was getting the baby out safely and they did what they had to do (M8: 434-436).

A sense that the positives outweigh the negatives seemed highly relevant to parents *I reflected a little bit on the labour and how it hadn t been necessarily the most positive experience but it was positive in the fact that she came out and it was well managed and we were delighted (M2: 271-273);* and that a future birth would be a mainly positive experience: *if someone says to me you are going in to have a baby and this is going to be the procedure erm this is how its going to come out and if that s the way its going to happen again I d be happy enough (F9: 383-384).*

In addition, some parents found that being kept busy with parenting tasks helped them to move on from the birth: *because there is a practical need of having to take care of her and because she s such a successful result I don t dwell on it (M2: 490).*

Reflecting and moving on with relative difficulty

Difficulties moving on from the birth experience were related to aspects that either reminded parents of less positive birth memories or hindered their ability to enjoy early parenthood.

Some women did not find it as easy to reflect and move on due to initial low mood: *I did feel what am I doing here I did have that feeling of no self worth kind of low and*

maybe I should have just died...it was just a bit of post-natal depression I wouldn't keep thinking like that (M8: 374-375).

Parents described at least one aspect of their stay in hospital that was stressful within a context of a mostly helpful and positive stay. Examples included a lack of personal space or privacy and that their concerns were not validated by staff. The main difficulty important to both men and women was stress in relation to breast feeding. Parents described a desire for their baby to be breast fed, yet some mothers experienced difficulties initiating breast feeding. Both men and women in these couples described distress at seeing their baby hungry and not feeling able to provide them with food. These parents described feeling pressured to continue breast feeding efforts rather than change to formula and received contradictory information surrounding breast feeding that exacerbated their worries and stress.

Mothers described experiencing pain and discomfort in the four weeks post delivery, however for some women this led them to reflect of the less positive aspects of their birth experience. Some men also explained how seeing their partners discomfort following the birth was difficult and impacted to some extent on their early parenting experiences: *the stitches didn't heal the way they wanted and that was off putting just the fact I wanted her to heal for herself because you're physically fine the baby's happy and physically fine and obviously you want your partner to be the same way so the three of you can be together but there has been this shadow hanging over (my partner) that she's not well sometimes and the pain can take over and she will go to bed (F1: 709-714).*

Those parents who reported being unwilling to experience a second instrumental delivery tended to describe certain negative expectations. These parents described long labours without initial pain relief administered to the mother, forceps delivery, birth injuries to the mother, breast feeding difficulties, negative experiences of hospital care and maternal lowered mood in the initial post-natal period. The women additionally reported a fear of intense pain and recurrent damage to themselves and concerns about the healing process following the birth.

DISCUSSION

The main aim of this study was to explore and describe men and women's experiences of instrumental delivery. As such a qualitative approach was adopted to provide rich in-depth interview data regarding this life event.

With reference to the additional objectives of this study; stress was explored as a reaction to more difficult aspects of the labour and delivery experience, but also in relation to barriers for coping. Similarities and differences between men and women's experiences were analysed and the results presented in the form of a conceptual framework describing accommodation of medical intervention.

Most parents interviewed in the current study reported difficult and stressful moments as part of a mainly positive experience. A minority however, reported some positives as part of a mainly difficult and highly stressful experience. This reflects quantitative research studies reporting that obstetric intervention during childbirth can contribute to psychosocial distress in a minority of men (Chan and Paterson-Brown, 2002) and women (Fisher et al, 1997; Maclean et al, 2000; Menage, 1993).

Accommodation of medical intervention was seen as the ability to integrate increasing levels of intervention into the overall birth experience. The proposed model consists of six main aspects that influenced the process of accommodation. For some parents one or

more of these aspects became compromised, leading to difficult and stressful experiences.

Several aspects of parental experiences were found to be helpful in promoting accommodation of medical intervention and subsequently a more positive birth experience. Many of these have been documented in previous literature investigating women's experiences of childbirth including: the importance of keeping an open mind regarding the need for medical intervention (Murphy et al, 2003) and maintaining a sense of control and confidence in staff (Ryding et al, 2000; Bailham and Joseph, 2003). Interestingly the current study found the concept of handing over control important in maintaining a sense of external control, and facilitating engagement with intervention.

Parents who received appropriate and timely information also reported a more positive experience and a sense of engagement with interventions. It is suggested that the importance of the content and style of information provided to parents cannot be underestimated. This finding fits with research into fathers' experiences of caesarean section and their view that honest, calm and frank information would have helped them to cope (Koppel and Kaiser, 2001).

In comparison, some aspects of parental experiences increased the difficulty with which parents were able to accommodate medical intervention and enjoy their birth experience.

As reported previously for women (Murphy et al, 2003) most parents in the current study reported feeling unprepared for instrumental delivery and that there was a lack of preparatory information regarding instrumental delivery. This finding is complicated by the fact that preferences for information are highly individual and some women in the current study reported avoiding information in an effort to reduce preparatory anxiety, or simply being unable to take on board a useful level of information during labour and delivery.

Importantly, both men and women reported that the experiences perceived as most stressful were those where they became concerned for the health of their partner/self respectively and/or their baby. This finding is consistently reported within the research literature into maternal anxiety and stress following childbirth (Bailham and Joseph, 2003; Allen, 1998). The current study adds to this by suggesting that men are also prone to distress in relation to these concerns, and is demonstrated through paternal reports that exclusion from the delivery location was stressful as it provoked concerns for their partner and child. This finding has been supported previously through research into men's experiences of caesarean section (Koppel and Kaiser, 2001).

Men and women also reported appraisals of concern for self/partner and baby in relation to increased medical attention towards the mother following the birth, the force used during interventions, and negative images and sounds. It is hoped that these results may provide a better understanding of why some expectant fathers (Chan and Paterson-

Brown, 2002) and mothers (Fisher et al, 1997; Maclean et al, 2000) may find instrumental deliveries more stressful than unassisted vaginal deliveries.

Parents who described difficulties moving on tended to report stress relating to breast feeding problems, and for women increased pain during delivery and during the healing process. These issues are known to occur more frequently in women who have instrumental as opposed to unassisted deliveries (Johanson et al, 1993) and, as suggested in the proposed model, may impact on parental enjoyment of early parenthood.

The current findings provide an interesting contrast to some other research findings. For example, it has been found that in a proportion of women negative birth experiences have been linked to maternal reluctance to have a second child (Bahl et al, 2004). In the current research project, this finding was not observed in those who reported predominantly difficult and distressing deliveries. These parents did, however, discuss a strong reluctance for a second instrumental delivery but not to avoid a subsequent pregnancy. This might be due to the fact a non-clinical sample was used and a reflection of parental abilities to accommodate intervention to some extent.

When discussing the differences between men and women's experiences, the perception of inclusion and exclusion relating to men's birth experiences is represented in the literature (Koppel and Kaiser, 2001; Hallgren et al, 1999). As reported by Chandler and Field (1997) men in the current study uniquely reported hiding their true emotions as a coping mechanism during labour and delivery. For women pain was a barrier to coping

and accommodating medical intervention , and this has been associated with less positive birth experiences in previous qualitative research (Allen et al, 1998). Finally, some women in the current study experienced a sense of personal disappointment relating to the need for an instrumental delivery. This might add to the research base, which already suggests that disappointment is an important emotion affecting women s experiences of caesarean section (Ryding et al, 2000).

Critical reflection

It is acknowledged that whilst the proposed model presents an understanding of men and women s experiences of instrumental delivery, the findings and terminologies used might reflect the researcher s clinical background and training. Efforts were made to establish this understanding collaboratively with participants, for example by using open questioning techniques and respondent validation. Whilst the usefulness of respondent validation is arguably limited as a credibility check (Mays and Pope, 2000), the author found that participant s views on the interpretation helped clarify her understanding and further ground the developing theory within the participants experience.

Limitations

The experiences of instrumental delivery explored and reported in this study are restricted with regards to several issues. Parents were self-selected in that they opted into the research project, and the findings may have missed parents who were less willing to discuss their experience for various reasons. In addition, different findings may have

been reported according to different inclusion criteria, a different hospital site or geographical location.

The inclusion criteria were arguably justified in accordance with the aims of the research and in line with ethical considerations. Future research, however, may wish to investigate different groups of expectant mothers and fathers (e.g. parents presenting with psychological difficulties; those for whom the pregnancy was unplanned or unwanted; younger parents; and lesbian and gay parents).

The current study chose to interview first time expectant parents at one point in time. In a review of the literature on father's birth attendance Draper (1997) cites Lemmer (1987) who recommended an increase in longitudinal studies, and this may be of interest for future research studies in addition to exploring the experiences of multiparous parents.

Implications

The willingness of men as well as women in the current study to discuss their birth experiences supports previous research that suggests as many as 66% and 58% of first time mothers and fathers respectively want to talk about the delivery (Olin and Faxelin, 2003). The current results suggest that men and women may benefit from a service to access more information so that they can gain a better understanding of their labours. On a wider scale the clinical question exists regarding the timing, content and quantity of information that is seen as optimal.

Those aspects found to help promote a more positive instrumental delivery experience by facilitating the accommodation of medical intervention might be used to inform health care professionals (HCP s) understanding of parental experiences. This study has hopefully provided an understanding of the positive as well as difficult experiences of men and women in relation to instrumental delivery. This might be especially topical given the discussions around increasing training in instrumental delivery methods (ACOG, 2000 as cited in Bahl et al, 2004).

Conclusions

This study has highlighted that whilst the physical elements of men and women s experiences of instrumental delivery are inherently different, the psychological and emotional aspects show many similarities. All parents in the study reported some difficult experiences regarding instrumental delivery, yet most were able to accommodate these as part of the wider birth process. For some parents the ability to accommodate medical intervention was compromised, and possible reasons for this have been discussed with reference to the literature. The importance of accommodating medical intervention and the factors that can facilitate this process have been highlighted in a conceptual framework to aid understanding of how instrumental delivery can affect both men and women s perceptions of the labour and delivery, including their ability to move on from the birth and enjoy early parenthood.

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Table 1: Participant characteristics and birth information

Participant code (F=father M=mother)	Age at interview	Type of obstetric intervention used during delivery	Highest educational qualification
F1	31		University Degree
M1	35	Mid cavity forceps	University Degree
F2	32		University Degree
M2	32	Ventouse	Phd
F3	26		Standard grades
M3	21	Ventouse	Standard grades
F4	45		University Degree
M4	45	Low cavity Forceps	University Degree
F5	35		Higher Grades
M5	35	Low cavity Forceps	Higher Grades
F6	27		Masters Degree
M6	28	Low cavity Forceps	University Degree
F7	35		University Degree
M7	36	Low cavity Forceps	University Degree
F8	32		University Degree
M8	34	Low cavity Forceps	University Degree
F9	30		Higher Grades
M9	31	Mid cavity forceps	Higher Grades
F10	32		Masters Degree
M10	31	Mid-cavity Forceps	University Degree

**Figure 1: A framework describing
accommodation of medical intervention**

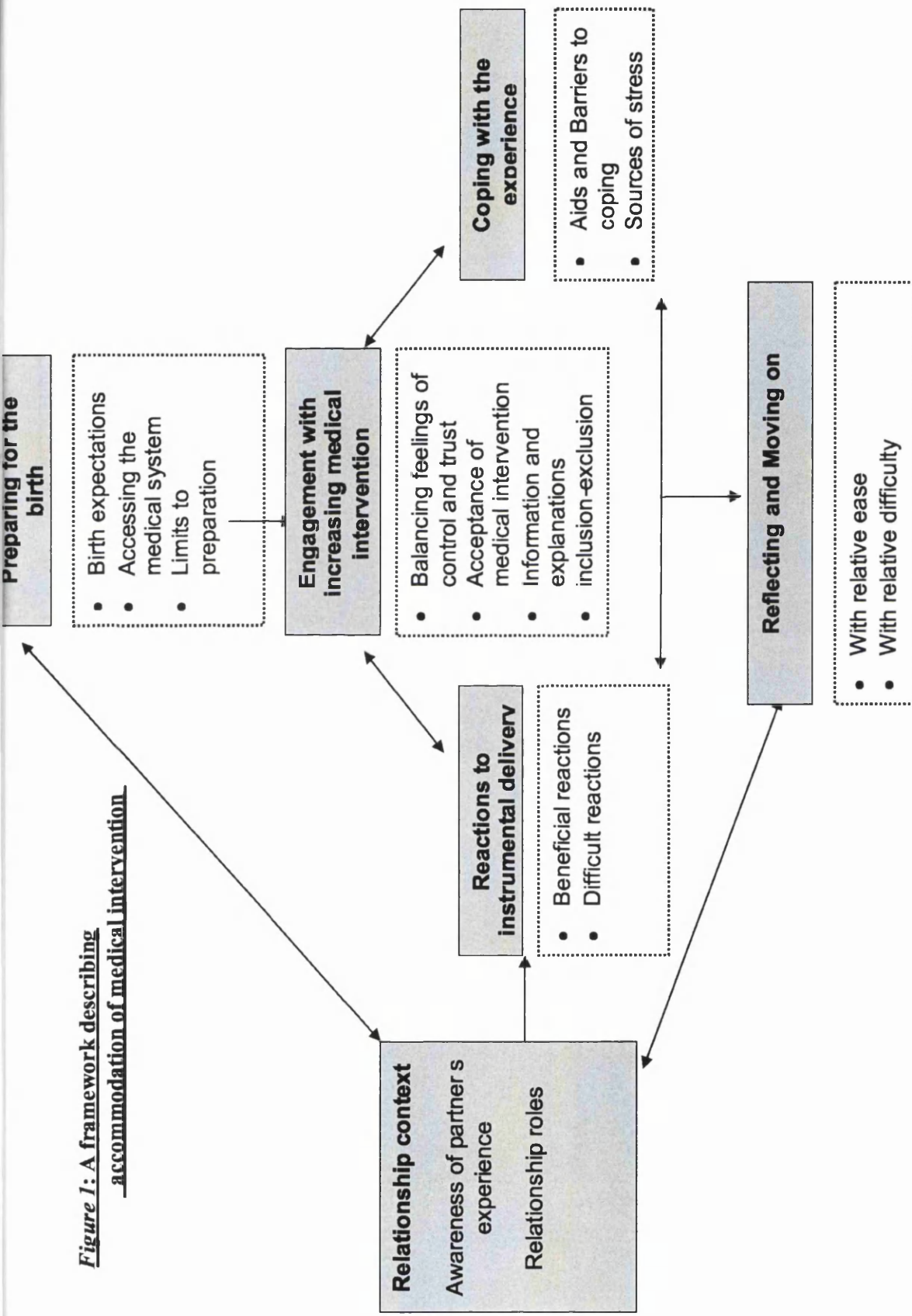


Figure 2:
Main category engagement with medical intervention
and associated sub-categories

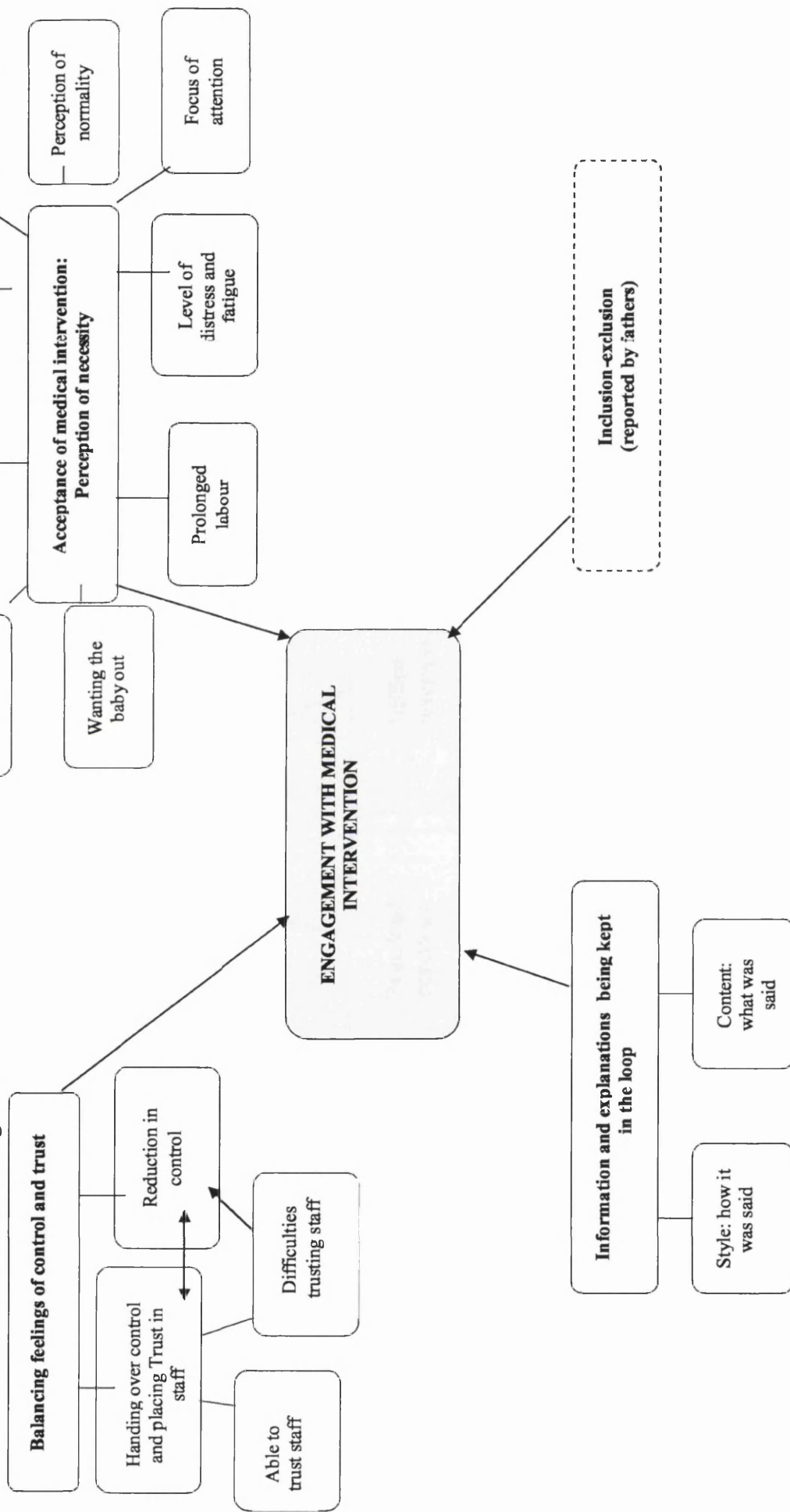


Figure 3: Main category
Reacting to instrumental delivery
and associated sub-categories

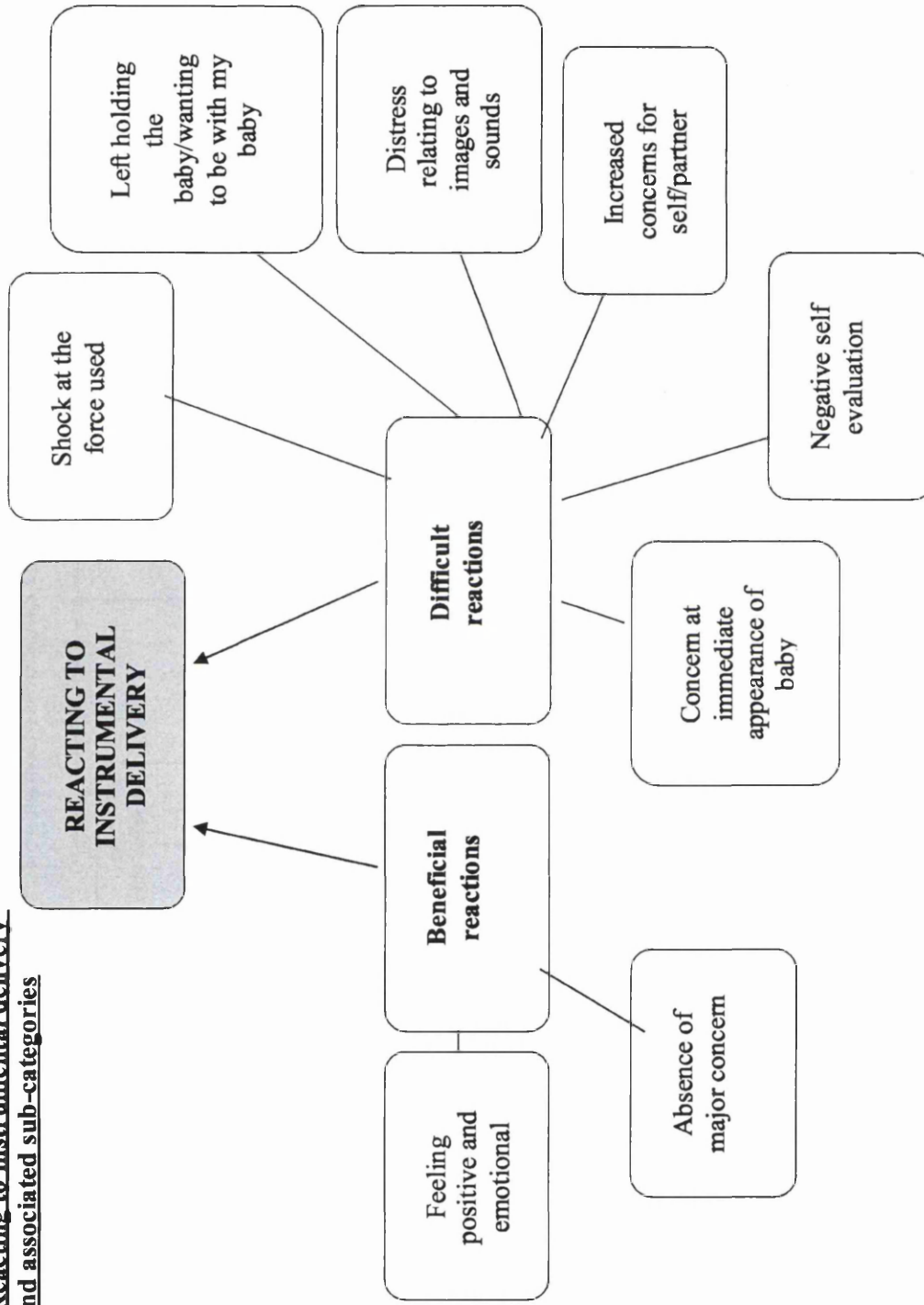


Figure 4: Main Category coping with the experience and associated sub-categories

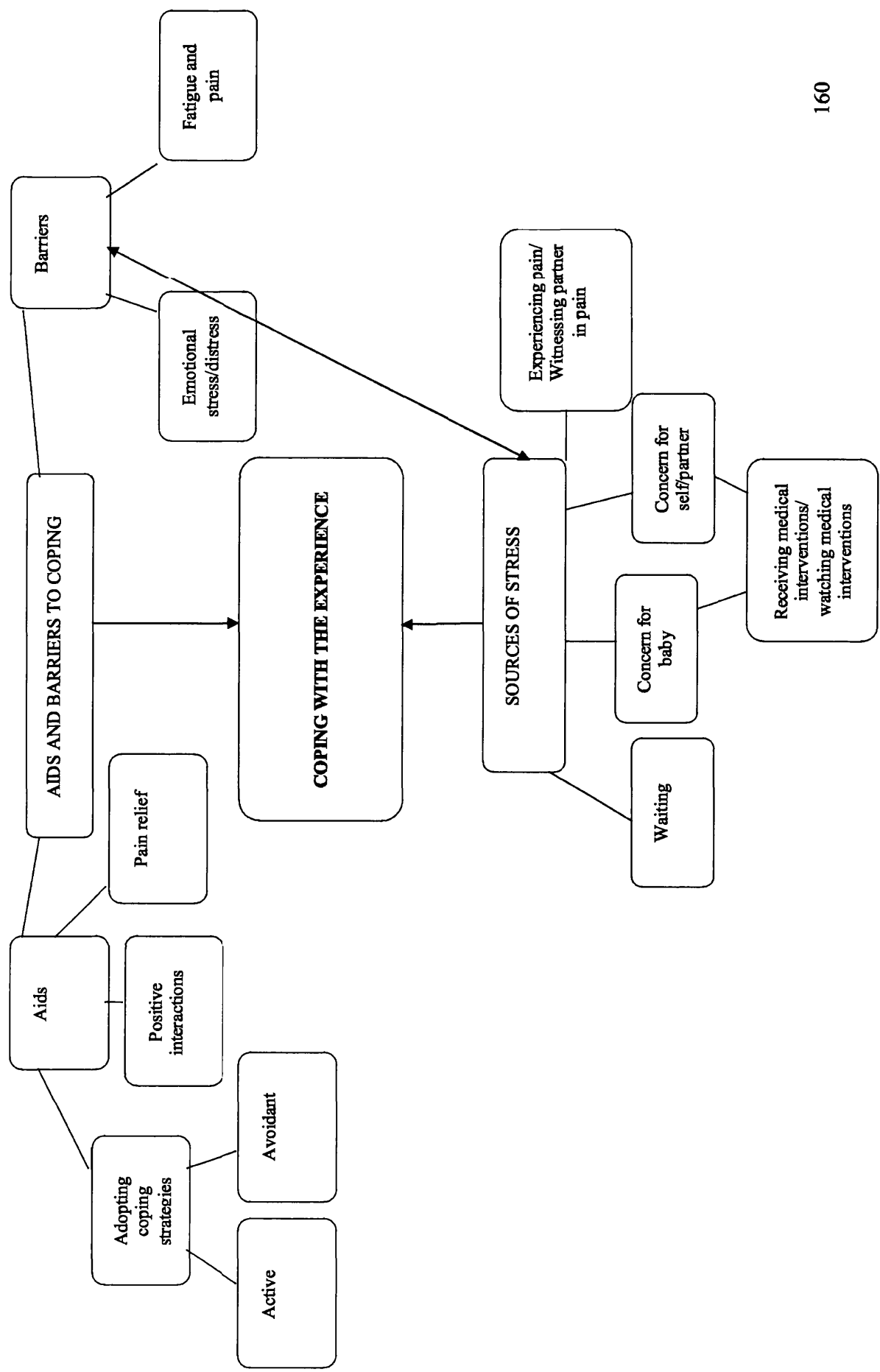
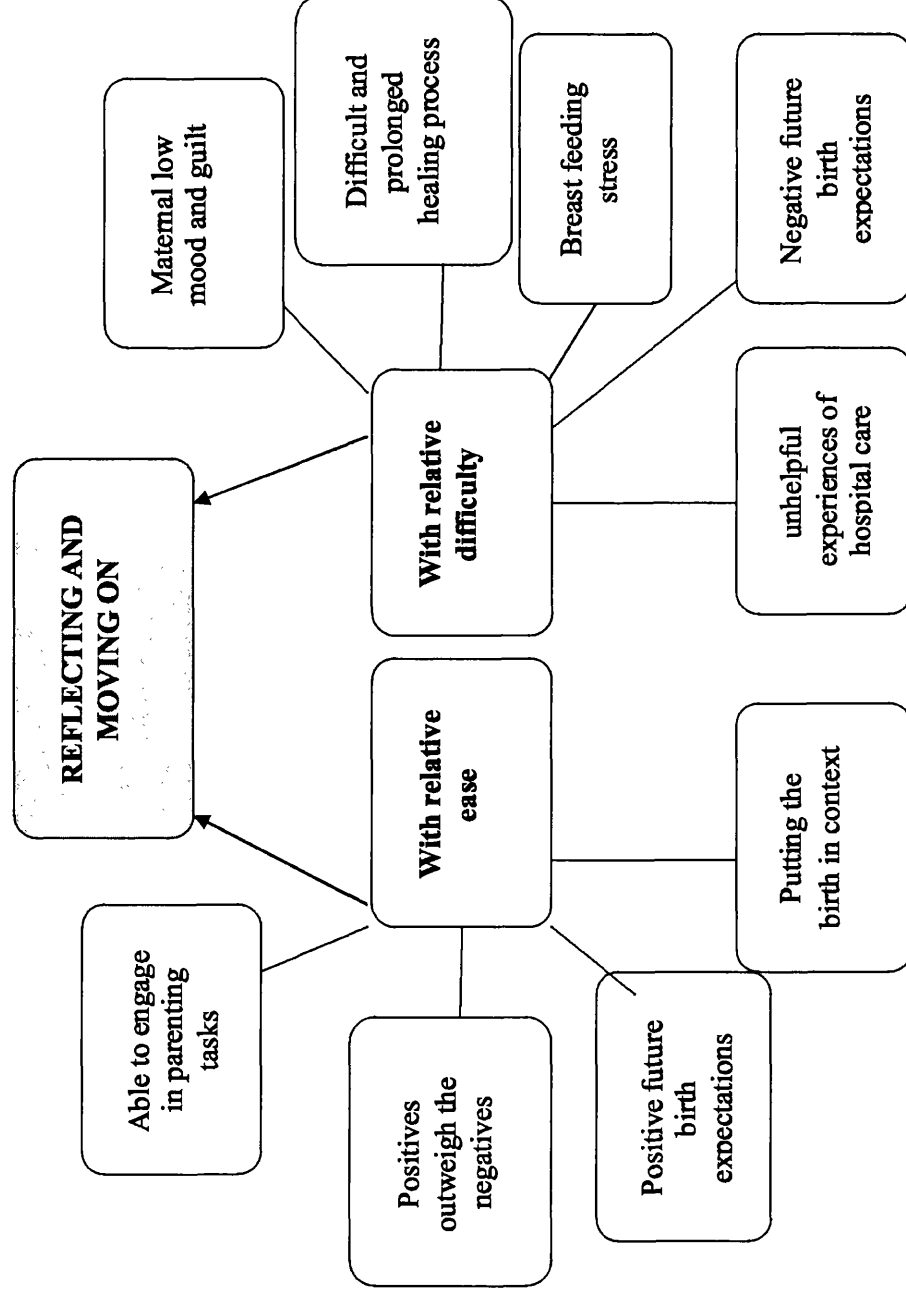


Figure 5: Main category reflecting and moving on and associated sub categories



CHAPTER FIVE

Single Case Research Study Abstract

The effectiveness of controlled crying for sleep problems in a child with chronic illness: A single case design

Experimental Case Study submitted in partial fulfilment of the requirements for the degree of Doctorate in Clinical Psychology

Address for Correspondence

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ABSTRACT

Objective: To investigate the effectiveness of a controlled crying intervention for sleep problems in child with chronic lung disease. **Methods:** A single case extended AB design was used resulting in three-phases A (assessment) B¹ (psycho-education) B² (controlled crying intervention). Sleep diary data were recorded throughout, and measures of maternal stress, anxiety, depression and dysfunctional cognitions about child sleep were taken following each phase. **Results:** The intervention was effective in addressing the night-time settling and waking problem for the child in question. Whilst maternal anxiety levels improved following the intervention, other aspects of maternal mental health including parenting stress, doubt in parenting ability and low mood remained relatively unchanged. **Conclusions:** In order to maximise the benefits of paediatric sleep management interventions it is important to consider maternal stress, doubt and low mood relating to parenting a child with chronic health difficulties.

CHAPTER SIX

APPENDICES

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APPENDIX ONE

Appendix 1.1: Guidelines for submission to Clinical Psychology Forum

Appendix 1.1: Guidelines for submission to Clinical Psychology Forum

Clinical Psychology

Clinical Psychology is produced by the Division of Clinical Psychology of The British Psychological Society. It is edited by Lorraine Bell, Jonathan Calder, Lesley Cohen, Simon Gielthorpe, Laura Golding, Helen Jones, Craig Newnes, Mark Rapley and Arlene Verete, and circulated to all members of the Division monthly. It is designed to serve as a discussion forum for any issues of relevance to clinical psychologists. The editorial collective welcomes brief articles, reports of events, correspondence, book reviews and announcements.

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- If sending hard copy, make sure it is double spaced, on a reasonably sized font and that all pages are numbered
- Include a word count at the end (including references)
- Spell out all acronyms the first time they appear
- Include the first names of all authors and give their employers, and remember to give a full postal address for correspondence
- Give references in *Clinical Psychology* style, and if a reference is cited in the text make sure it is in the list at the end
- Don't include tables and figures unless they save space or add to the article
- Ask readers to request a copy of your questionnaire from you rather than include the whole of it in the article
- Give a 20-word abstract at the beginning of the paper

APPENDIX TWO

Appendix 2.1: Guidelines for submissions to the Journal of Reproductive and Infant Psychology

Instructions for Authors:

*****Note to Authors:** please make sure your contact address information is clearly visible on the **outside** of all packages you are sending to Editors.***

Journal of Reproductive and Infant Psychology welcomes reports of original research and creative or critical review articles which make an original contribution. Articles should not currently be submitted for publication elsewhere.

Topics of interest to the journal include medical, behavioural, cognitive, affective, dynamic, psychological, societal and social aspects of: fertility and infertility; menstruation and menopause; pregnancy and childbirth; antenatal preparation; motherhood and fatherhood; neonatology and early infancy; infant feeding; early parent-child relationships; postnatal psychological disturbance and psychiatric illness; obstetrics and gynaecology including preparation for medical procedures; psychology of women.

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Studies of both human and animal subjects are welcome.

Papers should be sent in the first instance to the Editor:

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Contributions should be as concise as possible and should not normally exceed 5000 words or the equivalent lineage including tables and figures. The title should be brief but precise. Each paper should be accompanied by an abstract of not more than 200 words.

Papers should be typed on A4 or equivalent paper, on one side, double spaced with margins of not less than 3.5 cm. Sheets should be numbered consecutively at the head. The top copy and two good copies should be submitted.

Papers are refereed anonymously. The author's name and address should therefore appear under the title on a separate page. The title and abstract should appear on the first page of text. Authors who wish to ascertain in advance the criteria on which submissions are judged may obtain a copy of the blank referee's form from the editors.

Tables should be typed double spaced on separate sheets, or spaced sufficiently to be distinct in the case of small tables. They should be numbered in sequence in arabic numerals and referred to in the text as 'Table 1' etc. Large tables of more than six lines should be titled in order to make the contents comprehensible independently of the text.

Diagrams, graphs, drawings and half-tone illustrations should be on a separate sheet labeled 'Fig. 1' and so forth. Each sheet should carry at the top the title of the article. Where possible they should be submitted as artwork ready for photographic reproduction, larger than the intended size. Where more than one figure is submitted, they should as far as possible be to the same scale. When submitting articles on disk (see below) figures should be supplied as separate TIFF or EPS files if possible.

References in the text should cite the author's name followed by the date of publication unless there are more than two authors where only the first author's name should be given followed by 'et al'. References should be listed at the end of the paper in alphabetical order by first author, but including all authors, in the following format with titles of articles, books and journals given in full.

Berryman, J.C. and Windridge, K.C. (1993) Pregnancy after 35: a preliminary report on maternal-fetal attachment. **Journal of Reproductive and Infant Psychology**, 11: 169-174.

Berryman, J.C., Thorpe, K.J. and Windridge, K.C. (1995) **Older Mothers: conception, pregnancy and birth after 35**. Pandora, London.

Reid, M. (1990) Prenatal diagnosis and screening. In Garcia, J., Kilpatrick, R. and Richards, M.P.M. (Eds), **The Politics of Maternity Care**, pp. 300-324. Oxford University Press, Oxford.

SI units should be used for all measurements. Imperial measurements may be quoted in brackets. Where studies involve small numbers of subjects, both numbers and percentages of groups should be given.

Authors are advised to avoid sexist sentiments and language, except insofar as these form part of a study.

After notification of acceptance of a paper, authors should, if possible, send a copy of the final version in PC format as a word-processed document on a 3.5" or 5.25" floppy disk (Apple Macintosh formats can be accepted, but not Amstrad's Locoscript on CF2 disks) to the accepting editor.

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Appendix 2.2: CASP Assessment Tool

Critical Appraisal Skills Programme (CASP)

making sense of evidence

10 questions to help you make sense of qualitative research

This assessment tool has been developed for those unfamiliar with qualitative research and its theoretical perspectives. This tool presents a number of questions that deal very broadly with some of the principles or assumptions that characterise qualitative research. It is *not a definitive guide* and extensive further reading is recommended.

How to use this appraisal tool

Three broad issues need to be considered when appraising the report of qualitative research:

- **Rigour:** has a thorough and appropriate approach been applied to key research methods in the study?
- **Credibility:** are the findings well presented and meaningful?
- **Relevance:** how useful are the findings to you and your organisation?

The 10 questions on the following pages are designed to help you think about these issues systematically.

The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions.

A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

The 10 questions have been developed by the national CASP collaboration for qualitative methodologies.

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Was there a clear statement of the aims of the research?

☐ Yes

☐ No

Consider:

- what the goal of the research was
- why it is important
- its relevance

Is a qualitative methodology appropriate?

☐ Yes

☐ No

Consider:

- if the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants

it worth continuing?

Detailed questions

Appropriate research design

Was the research design appropriate to address the aims of the research?

Write comments here

Consider:

- if the researcher has justified the research design (e.g. have they discussed how they decided which methods to use?)

Sampling

Was the recruitment strategy appropriate to the aims of the research?

Write comments here

Consider:

- if the researcher has explained how the participants were selected
 - if they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
 - if there are any discussions around recruitment (e.g. why some people chose not to take part)
-

Data collection

5 Were the data collected in a way that addressed the research issue?

Write comments here

Consider:

- if the setting for data collection was justified
- if it is clear how data were collected (e.g. focus group, semi-structured interview etc)
- if the researcher has justified the methods chosen
- if the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, did they use a topic guide?)
- if methods were modified during the study. If so, has the researcher explained how and why?
- if the form of data is clear (e.g. tape recordings, video material, notes etc)
- if the researcher has discussed saturation of data

Reflexivity (research partnership relations/recognition of researcher bias)

6 Has the relationship between researcher and participants been adequately considered?

Write comments here

Consider whether it is clear:

- if the researcher critically examined their own role, potential bias and influence during:
 - formulation of research questions
 - data collection, including sample recruitment and choice of location
- how the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Ethical Issues

7 Have ethical issues been taken into consideration?

Write comments here

Consider:

- if there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- if the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- if approval has been sought from the ethics committee

8 Was the data analysis sufficiently rigorous?

Write comments here

Consider:

- if there is an in-depth description of the analysis process
- if thematic analysis is used, if so, is it clear how the categories/themes were derived from the data?
- whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- if sufficient data are presented to support the findings
- to what extent contradictory data are taken into account
- whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Findings

9 Is there a clear statement of findings?

Write comments here

Consider:

- if the findings are explicit
- if there is adequate discussion of the evidence both for and against the researcher's arguments
- if the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- if the findings are discussed in relation to the original research questions

Value of the research

10 How valuable is the research?

Write comments here

Consider:

- if the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature?)
- if they identify new areas where research is necessary
- if the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Appendix 2.3: Explanations of quality check list criteria

For each of the ten CASP questions the raters individually considered the extent to which a paper addressed the following aspects.

APPROPRIATE RESEARCH DESIGN

Key: was the research design appropriate to address the aims of the research?

Consider:

- Does the paper explicitly link the research design to the aims of the research?

SAMPLING

Key: was the recruitment strategy appropriate to the aims of the research

2a) How participants were selected (sampling strategy)

- Does the paper describe their sampling strategy or reference a known technique (e.g. theoretical, snowball or convenience)

2b) Why participants were the most appropriate.

- Does the paper give reasons justifying the selection criteria or sampling approach?

2c) Discussion around recruitment.

- Does the paper say how many people approached refused to take part in the study, and the reasons behind any refusals to participate?

DATA COLLECTION

Key: were the data collected in a way that addressed the research issue?

a) Was the setting justified?

- Was the data collected at the participant's home or a location of their choosing?

b) Was it clear how the data were collected?

- Does the paper state the method of data collection (e.g. semi-structured interviews, observation) and provide some information to clarify this technique (e.g. a topic guide)?

c) Does the paper justify its chosen data-collection method?

- Does the paper give at least one reason for choosing the methods outlined?

d) Is the form of data clear?

- Does the paper give the form of data e.g. tape recordings?

For Grounded Theory studies only:

- e) Were the methods modified throughout the study?
 - Is there evidence to show the interview schedule changed in light of data collection?
- f) Is there any discussion of theoretical saturation?
 - Does the study discuss theoretical saturation or mention that data collection stopped when no new themes emerged?

REFLEXIVITY

Key: has the relationship between researcher and participants been adequately considered?

- a) Did the researcher examine their role, potential influence?
 - Does the paper discuss how the researchers own background/perspectives might have affected the research questions or data collection location/methods?
- b) Researcher response to events/implications of changes in design.
 - Does the paper provide information on the researchers perspective on events during the study (e.g. through reflexive logs) *or* if changes were made to the design, how these might impact upon the results?

ETHICS

Key: have ethical issues been taken into consideration?

- a) Is there sufficient detail of how the research was explained to participants to ensure that ethical issues were addressed?
 - Is it clear whether or not participants were given information which included reference to ethical issues? (i.e. right to withdraw, voluntary participation, confidentiality?)
 - Was informed consent/assent obtained?
- b) Issues raised by the study
 - Does the researcher comment on strategies used to address power imbalances or the effects of the study on participants?
- c) Ethical approval
 - Is a specific ethics committee mentioned in the write-up as having given ethical approval?

DATA ANALYSIS

Key: was the data analysis sufficiently rigorous?

- a) Is there a good description of the analysis process?

- Is there enough information to allow the reader to understand the techniques described?
- a) If thematic analysis is used is it clear how themes were derived?
- Does the paper provide a written description (e.g. started with open coding, codes and categories derived were revised, then axial coding from which themes were derived) and/or the use of diagrams or matrixes to illustrate the process
- b) Is it clear how the data presented in the article were selected from the original data set?
- Is data organised under a themes with an anonymous reference (e.g. gender, age, what the person is talking about/witnessing) to place the quote/observation in context
- c) Are sufficient data presented (representative/illustrative quotes) to support the findings?
- Does the paper provide at least one quote per theme described?
- d) Do the themes/derived theory take account of contradictory data?
- Does the paper provide evidence that it has extended themes so that they account for as much of the data as possible (sometimes referred to as negative case analysis)?
- e) Does the researcher provide a critical analysis of their own role and any influence this may have had on the data analysis procedure?
- Does the paper provide information on the researcher s background/perspective and how this might have influenced their analysis in terms of the emerging themes etc?

FINDINGS

Key: is there a clear statement of findings?

- a) *Are the findings explicit?*
- Are the results presented in a way that makes the findings clear and understandable to the reader?
- b) Is there adequate discussion both for and against the researcher s arguments?
- Does the paper discuss both contradictory and supportive evidence for the data collected (with or without reference to the literature)?
- c) Are the results credible?
- Are there any details on measures to improve the quality of the research (e.g. multiple coding checks, triangulation or respondent validation)?
- d) Does the researcher discuss the results in relation to the original research aims?
- Does the paper make any reference back to the aims of the study and discuss how the findings relate to these aims?

VALUE

Key: How valuable is the research?

- a) Does the researcher discuss the contribution of the results to existing knowledge?
- Are the clinical implications discussed or have the results extended pre-existing theory or developed new theory?
- b) Does the researcher state new areas for research?

c) Has the researcher discussed whether or how the findings can be transferred to other populations or considered ways in which the research may be used?

For each of the 8 main questions in the CASP guidelines (also outlined above in more detail to aid discussion) each reviewer should make a judgement as to whether all, most, some or none of the relevant parts to each question have been considered and discussed.

This should allow the reviewer assess whether the paper demonstrates strong, medium or weak evidence that it has addressed each question area. Conclusions can be recorded by writing strong , medium or weak by the side of each question on the rating sheet.

N.B. It should be noted that a study can meet a number of criteria poorly or few criteria well and this should be reflected in the final decision as to the level of evidence the study demonstrates in support of each question area.

Appendix 2.4: Explanation of Quality Ratings System

Studies were awarded a quality rating of strong, moderate or weak depending on the extent to which the study addressed each CASP question area. The following section presents the types of information raters considered merited each of these quality ratings, for each question area.

Research design

Weak: It is clear that the research design allows data collection pertaining to the research aims, but no explicit reasoning is provided to justify the choice of design.

Moderate: It is clear that the research design allows data collection pertaining to the research aims, in addition the paper provides information on the strengths/applications of such an approach.

e.g. grounded theory methodology was used for data collection and analysis, this approach to qualitative analysis is used to generate explanatory theories about social and psychological phenomena (Chentiz and Swanson, 1986) .. (Moran-Ellis, 1989)

Strong: It is clear that the research design allows data collection pertaining to the research aims. The paper provides information on the strengths/applications of such an approach *and* the approach is further justified in comparison to other methods and/or in relation to the research aims.

an ethnographic approach was chosen in order to understand not only how men make and mark their transition to fatherhood ..although traditionally associated with describing other cultures there is now a developing literature on ethnography s usefulness in describing contemporary cultures and sub-cultures (Draper, 2003)

Sampling

Weak: The study explicitly states or describes the sampling strategy or procedure without providing explicit reasons for choosing this strategy/selection criteria.

Moderate: The study explicitly states or describes the sampling strategy or procedure *and* provides reasons for choosing the strategy/selection criteria.

Strong: The study explicitly states a sampling strategy or sampling procedure, *and* provides reasons for choosing this strategy/selection criteria *in addition* to some discussion around recruitment e.g. drop out rates.

Data collection

Weak: The study explicitly states how the data were collected e.g. interviews but provides no further information on the methods used e.g. topic guides.

Moderate: The study explicitly states how the data were collected, *and* the methods used for data collection.

Strong: The study explicitly states where the data were collected, how data were collected, the methods used for data collection and justifies these chosen methods.

Reflexivity

Weak: The study acknowledges the potential for the researcher's position to influence the study without stating how this might have impacted on the study or the participants *or* the paper comments on how changes in the design might have impacted on participants and the findings.

Moderate: The study discusses how the researcher might have influenced the research design/findings *or* the paper discusses with clear details how the researcher responded to events during the study or the implications of any changes in the research design.

Strong: The study discusses how the researcher might have influenced the research design /findings *and* the paper discusses with clear details how the researcher responded to events during the study or the implications of any changes in the research design.

Ethical Issues

Weak: The study provides evidence that informed consent was taken without providing further information on ethical issues.

Moderate: The study provides evidence that informed consent was taken and provides further mention of ethical issues (i.e. right to withdraw, voluntary participation, confidentiality?) when describing how the study was explained to participants *or* a specific ethics committee is mentioned in the write-up as having given ethical approval.

Strong: The study provides evidence that informed consent was taken and provides further mention of ethical issues (i.e. right to withdraw, voluntary participation, confidentiality?) when describing how the study was explained to participants *and* a specific ethics committee is mentioned in the write-up as having given ethical approval.

Data analysis

Weak: The data presented is organised under clear themes with a reference to place the quote/observation in context and the paper provides at least one quote per theme described. The description of the analysis process (when provided) lacks sufficient detail to allow the reader to understand the techniques used.

Moderate: The data presented is organised under themes with a reference to place the quote/observation in context and the paper provides at least one quote per theme described *and* the study provides a moderate description of the analysis process including, where relevant a written description of thematic analysis.

Strong: The paper provides a strong description of the analysis process including, where relevant, a written description of thematic analysis. The data presented is organised under themes with a reference to place the quote/observation in context and the paper provides at least one quote per theme described. It was considered additive if the paper provided evidence that it had considered contradictory data in relation to the analysis process.

Findings

Weak: The paper provides explicit findings and discusses the results in relation to the original research aims.

Moderate: The paper provides explicit findings and discusses the results in relation to the original research aims. In addition the paper provides an adequate discussion of evidence both for and against the researcher s arguments *or* specifically mentions at least one measure taken to address the researchers influence over the interpretive process.

Strong: The paper provides explicit findings, with adequate discussion both for and against the researcher s arguments. The paper specifically mentions at least one measure taken to acknowledge the researchers position and discusses the results in relation to the original research aims.

Value

Weak: The paper simply discusses the contribution of the results to existing knowledge.

Moderate: The paper discusses the contribution of the results to existing knowledge and states new areas of research *and* discusses the transfer of findings to other populations/considers other ways in which the research may be used.

Strong: The paper discusses the contribution of the results to existing knowledge, states new areas for research and discusses the transfer of findings to other populations or considers other ways in which the research may be used.

APPENDIX THREE

Appendix 3.1: Details of amendments made in accordance with recommendations from Yorkhill Ethics Committee

The following amendments were made to the original proposal in accordance with ethics recommendations

1. The pilot study section of the design was removed.
2. Dr. Joan Burns was listed as a Yorkhill supervisor.
3. The term complicated delivery was omitted from the proposal and where appropriate replaced with instrumental delivery .
4. the recruitment procedure was changed to include: an information leaflet given to parents by their midwife a minimum of 24 hours post delivery; consent taken by the main researcher a minimum of 48 hours post delivery; a letter sent to the mother s G.P requesting confirmation of maternal and infant health three weeks post delivery; receipt of G.P. confirmation before proceeding to interview stage;
5. it was made clear in the information leaflet that: the study was being conducted as part of an educational qualification; that each interview would last between 45 minutes 1 hour; and that parents should feel free to bring their baby with them to the interview.
6. Episiotomy alone was been excluded from the inclusion criteria.
7. The fact that couple s will not be interviewed together has been stipulated in the parent information sheet as has the fact that they are welcome to bring their baby with them.
8. It was clarified that tapes / transcripts will not be destroyed after the study and will be kept for 10 years in accordance with research governance regulations.
9. It was stipulated that the researcher would specifically ask parents if they were involved in any other research projects

Appendix 3.2: Information Sheet
NHS Men and Women's Experiences of Instrumental Delivery

Greater
Glasgow



Information Sheet for Parent's - August 2005

Introduction

Thank you for taking the time to read this leaflet. I work at the University of Glasgow and I am about to begin a study which will look at men and women's experiences of childbirth. The study hopes to improve Health Care for couples by providing professionals with a better understanding of how men and women feel about the birth of their child. Your views are important to the study and I would like to have the opportunity to speak with you about them. To help you decide whether or not to take part, this leaflet will outline why the research is being done and what it will involve. Please take your time to read this leaflet carefully and if you would like any more information about the study feel free to ask your midwife or contact me, Ruth Hurrell (my contact details are provided at the end of this leaflet).

What is the purpose of the study?

Pregnancy and childbirth can be a time of excitement and happiness, but giving birth can also be a stressful experience for couples. In order to provide the best possible care, it is important to listen to your experiences.

Who has been asked to participate?

All couples at the Queen Mother's Hospital who have recently experienced a birth involving the following procedures: forceps delivery or ventouse delivery (with or without an episiotomy).

Do I have to take part?

No, it is your choice whether or not to take part. If you do decide to take part you will be given this leaflet to keep and will be asked to sign a consent form. You are free to change your mind at any time without giving a reason, and this will not affect the standard of care you receive.

What happens if I take part?

I am interested in listening to your birth experience in your own words. I will invite you and your partner for an interview that will be held at the Queen Mothers Hospital or at your own home should you prefer. You would only have to attend once. At the start of the interview, I will introduce myself and the study, and you will both have an opportunity to ask any questions you might have. I will then ask to speak to each of you individually about your experience of childbirth. You are welcome to bring your baby with you to the interview. The interviews will be audio-recorded and will last as long as you want them to, although I expect that most will last about 45 minutes to an hour each.

When will the interviews take place?

You will be offered a variety of dates and times for an interview, so you can choose the best time for you. This will be arranged four to five weeks following the birth of your child at a time that suits you.

What do I have to do?

Apart from talking about your childbirth experience there is nothing else you need to do. You will be sent a copy of the results from the study. Following this I would like to telephone you to ask for your thoughts on the issues raised, but you do not have to take part in this process.

What are the possible disadvantages of taking part?

One possible disadvantage is that it will take about an hour of your time. In addition, some people may find talking about the birth of their child upsetting. If you think that you would benefit from further support, I can refer you to a Clinical Psychologist at the Queen Mothers Hospital who will offer you an appointment to discuss any issues.



What are the possible benefits of taking part?

Many parents gain a lot from discussing their birth experience and the issues that are important to them. The interviews would offer you a chance to talk through your experience and highlight any aspects of your care that you thought were particularly good, or could be improved. The information from this study may contribute to a better understanding of what parents experience during this time.

Will my taking part be confidential?

Yes. All the information which is collected during the course of the research will be kept strictly confidential. Identifying information will be removed from the interviews so that you cannot be recognised. All information will be kept in a locked filing cabinet in accordance with the UK data protection act.

What will happen to the results from the research study?

The study will last about a year from beginning to end, to allow time to collect all the information and write up the results. The main findings will form a journal article, which will be produced in June or July 2006. The article may contain anonymous quotes from the research to illustrate the main issues raised, but participants will not be identified. You are welcome to receive a free copy of the article should you wish.

Who is organising and funding the research?

The Department of Psychological Medicine, University of Glasgow are funding this research project, as part of my postgraduate studies in Clinical Psychology and this study will form the basis of the research part of my Clinical Psychology training. The study has been reviewed and approved by the Yorkhill Ethics Committee.

Complaints Procedure

If for any reason you are unhappy about the way this research has been conducted you can contact Mrs K. Colquhoun, Complaints Officer at Yorkhill on 0141 201 0000. Alternatively, you can contact Dr. Andrew Gumley in confidence. Dr. Gumley works for the NHS and is not connected with this study.

By Post: Dr. A. Gumley, Research Director, Department of Psychological Medicine,
Academic Centre, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow,
G12 0XH.

Telephone: 0141 211 3930

E-mail: A.Gumley@clinmed.gla.ac.uk

Contact details for Ruth Hurrell

By Post: Ruth Hurrell, Department of Psychological Medicine, Academic Centre,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

Telephone: 0141 211 0607 / 07906415957

E-mail: 0304872H@student.gla.ac.uk

Thank you for taking the time to read this leaflet

Consent Form

September 2005

Title of project: Men and Women's Experiences of Instrumental Delivery

Name of Researcher: Ruth Hurrell

Please initial box

1. I confirm that I have read and understood the information sheet dated August 2005 for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
3. I agree to take part in the above named study
4. I give permission for the main researcher (Ruth Hurrell) to contact my G.P. in three weeks time in order to confirm my child's health status.
5. I give permission for the main researcher to contact me in order to arrange a date and time for interview.

☐☐☐☐☐

Name of participant

Date

Signature

Name of person taking consent

Date

Signature

Witness

Date

Signature

1 for participant; 1 for researcher; 1 to be kept with hospital notes.

Copy to be sent to participants G.P.

Father's D.O.B.....

Child's name and D.O.B.....

Contact address.....

.....

.....

.....

Contact telephone number.....

G.P.'s Name.....

G.P. Surgery address.....

.....

.....

G.P. Surgery telephone number.....

.....

23 September 2005

Ms Ruth Hurrell
Trainee Clinical Psychology
Department of Psychological Medicine
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 OXH

Dear Ms Hurrell

Full title of study: Men and Women's Experiences of Instrumental Delivery
REC reference number: 05/S0708/64

The Research Ethics Committee reviewed the above application at the meeting held on 22 September 2005.

Ethical opinion

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

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form. (Yorkhill)

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Application		13 September 2005
Investigator CV		13 September 2005
Protocol		13 September 2005

Participant Information Sheet	13 September 2005
Participant Consent Form	13 September 2005
Response to Request for Further Information	23 September 2005
Other	23 September 2005

Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

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

Statement of compliance

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

05/S0708/64

Please quote this number on all correspondence

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

Yours sincerely


Chair

Email: liz.meenagh@yorkhill.scot.nhs.uk

Enclosures: Standard approval conditions [SL-AC1 for CTIMPs, SL-AC2 for other studies]
Site approval form (SF1)

Copy to: Rae
Greater Glasgow Research and Development Committee
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH
[R&D Department for NHS care organisation at lead site]

Appendix 3.5: Research and Development Approval

Primary Care Division

Research & Development Directorate

Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH
Tel: 0141 211 3600
www.nhs.uk



Ms Ruth Hurrell
Trainee Clinical Psychologist
Department of Psychological Medicine
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Date 28 October 2005
Your Ref
Our Ref BR/AW/approve
Direct Line 0141 211 3661
Fax 0141 211 3814
Email annette.watt@gartnavel.gla.ac.uk
gartnavel.gla.ac.uk

Dear Ms Hurrell

Project Reference Number: 05CP13

Project Title: Men and women's experiences of instrumental delivery

Thank you for completing the Research & Development (R&D) Management Approval Application for the above study. I am pleased to inform you that R&D management approval has been granted by Greater Glasgow Primary Care Division subject to the following requirements:

- You should notify me of any changes to the original submission and send regular, brief, interim reports including recruitment numbers where applicable.
- Your research must be conducted in accordance with the National Research Governance standards. (see CSO website: www.show.scot.nhs.uk/cso)
Local Research Governance monitoring requirements are presently being developed. This may involve audit of your research at some time in the future.
- You must comply with any regulations regarding data handling (Data Protection Act).
- Brief details of your study will be entered on the National Research Register (NRR). You will be notified prior to the next submission date and asked to check the details being submitted.
- A final report, with an abstract which can be disseminated widely within the NHS, should be submitted when the project has been completed.

Do not hesitate to contact the R & D office if you need any assistance.

Thank you again for your co-operation.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Brian Rae'.

Brian Rae
Research Manager

Yorkhill Division

Research & Development Office

Dalnair Street

Glasgow

G3 8SJ

Tel: (0141) 201 0005

E-mail: alison.wood@yorkhill.scot.nhs.uk

Ms Ruth Hurrell
Trainee clinical Psychologist
Department of Psychological Medicine
Academic Centre, Gartnavel Royal Hospital
Glasgow, G12 0XH

5th December 2005

Yorkhill R&D Management Approval

Dear Ms Hurrell,

**Re: Men & Women's experiences of Instrumental delivery.
R&D Project Number: 05/CP/02**

Thank you for submitting a protocol and a copy of your ethics submission for the above project to the R&D Office. I am pleased to inform you that your project has been approved by the Yorkhill Division R&D department. This letter ensures that you and the researchers working with you, who hold substantive or honorary contracts, are indemnified by the NHS under the CNORIS scheme. This means you can proceed with your project at Yorkhill once you have written confirmation of ethical approval.

Amendments – The R&D office needs to be kept informed of any changes to the project for example regarding patient recruitment, funding, personnel changes or your project status. If changes are made to the protocol they will need to be considered by the ethics committee.

Should you have any queries please contact the R&D office quoting the Project ID number. Please let me know if the R&D office help in any way with the study. May I wish you every success with your research.

With very best wishes,
Yours sincerely,



Dr. Alison Wood
Research & Development Manager

cc: Mrs Annabel Watt