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The ontology of early labour (and the difficulties of talking about it): Using interview methods to investigate uncertain and gendered concepts

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Abstract

This article presents reflections on the process of collecting interview data about fathers' experiences of 'early labour'. Early labour is the first phase of labour, defined in textbooks by regular contractions and cervical dilation of up to 4 cm. Women are typically encouraged to stay at home during early labour and only travel to hospital when they are in 'active labour'. Maternity services (and other providers of antenatal education) devote a great deal of attention to educating parents-to-be about the phases of labour and about how to recognise the 'right time' to travel to hospital but 'early' admission remains a problem. Prompted by suggestions in the existing literature that male partners may influence when women seek admission, my research set out to explore fathers' understanding and experiences of early labour. However, interviewing fathers about early labour was challenging and, in this article, I will argue that this was due to a particular configuration of practical, epistemological and ontological issues. I argue that early labour is a slippery and uncertain concept beyond the clinical context and that Mol's 'multiple ontologies' provides productive tools for reflecting on the difficulty of asking about early labour, keeping early labour in focus during the interviews, and finding early labour in the data. However, the gendered nature of reproductive social research requires additional analysis to understand the gender dynamics at work when asking about reproductive research objects of multiple or uncertain ontologies.

Keywords

Ontology, interviews, research methods, fathers, early labour, gender

Introduction

This article presents reflections on the process of collecting interview data about fathers' experiences of their partners' 'early labour'. I explore the experience of being a female social researcher investigating a topic and a concept that is both embedded in and defined as a problem by maternity care. Early labour refers to the first stage of labour, from labour onset to 4 cm cervical dilation and usually involving contractions of increasing intensity and frequency. The operationalisation of early labour in maternity care is fraught with difficulties around supporting women during early labour and encouraging admission to hospital only when women are in the inaccurate 'active' stage of labour. Early labour researchers, mostly within a midwifery research tradition, have explored women's and midwives' views and experiences of current practice around managing early labour. My research aimed to address a gap in the existing literature by talking to fathers about their experiences of 'early labour'.

Disciplines are often bound up with particular 'ways of seeing' as well as particular norms and rules (Sayer, 2000: 84). Therefore, my approach was in no small way shaped by my background and training as a qualitative, social researcher. Medical sociology specifically 'presses the importance of the patient perspective as a corrective to the power of biomedicine and the medical profession' (Law and Singleton,

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2005: 348) and I looked to whose perspectives had so far been investigated in relation to early labour and resolved to fill a gap in the literature. Fathers' voices had yet to be heard and as key supporters of women in labour their perspective has potential to illuminate 'the problem' of early labour. However, early labour proved difficult to talk about.

Here, I explore the practical challenges I encountered, and I argue that they were underpinned by epistemological and ontological tensions within the concept and the research process. Research is underpinned by frameworks of ontology (theories about the nature of reality) and epistemology (theories about knowledge) (Braun and Clarke, 2013). If realist frameworks dominate in obstetrics, and 'early labour' is defined within this discipline as a 'real' (pre-social, independent of human ways of knowing) physiological event, by adopting a qualitative approach to early labour (as others have done) this realist concept is supplanted into a relativist or interpretivist research framework in which reality is seen as dependent on ways of knowing about it. Talking about early labour in semi-structured interviews presented particular problems related to the gender dynamics of the interview encounter and the ontological uncertainty of the concept itself once it moves beyond the clinical context. Annemarie Mol's (2007) 'multiple ontologies' provides a theoretical lens through which to revisit the practical and methodological challenges I encountered.

This article is not an attempt to reanalyse the data through an ontological lens, rather to examine the methodological problems that I struggled with in talking about early labour and to explore how issues of ontology might be at play. While the challenges explored here are rooted in the specific example, they also speak to broader issues encountered by social researchers of reproduction who work within and between biomedical concepts, clinical practice and lived experiences of childbearing.

In what follows, I first introduce the background literature around early labour and fathers and labour. An outline of the research project is provided before introducing Mol's multiple ontologies. The analysis is presented in three sections, exploring issues around: asking about early labour; keeping early labour in focus; and finding early labour in the data. In the conclusion, I reflect on the benefits and limitations of using Mol's multiple ontologies as a theory to think through difficulties in interview studies about reproductive biomedical concepts whose ontology may be understood as uncertain or incoherent across sites. I also argue that ontological complexities intersect with gender dynamics in the research process to make this topic particularly difficult to talk about.

Background

Early labour

McIntosh (2013) ties the concept of 'early labour' to the shift from home to hospital birth. In the early 20th century, early labour was not seen as a discrete stage but a private experience for the individual. With the move to hospital birth, early labour becomes defined as a 'problem' for women and hospitals to be managed: 'Women were increasingly expected to have enough knowledge of the features and stages of labour to be in the "right" place (hospital) at the "right" time (established labour)' (McIntosh, 2013: 8). This is a project of education that is still ongoing. As a social researcher, I understand early labour as a historically specific social construction that attempts to divide labour into distinct stages.

In practice, women in the United Kingdom, and many other European countries, experiencing signs of early labour (including usually mild contractions, sometimes their waters breaking or a 'show') are advised to phone the labour ward to receive advice from a midwife about managing signs of labour at home and when to travel to hospital. Early labour is a stage of labour during which women are strongly encouraged to stay at home rather than seek admission to hospital. Women coming to hospital during early labour is conceived of as a problem for several reasons: 'early labour' provides a means for hospitals and midwifery units to manage their workload and focus care on women in 'active labour'; and there is evidence that being admitted to hospital in early labour puts women at greater risk of intervention during labour (Holmes et al., 2001) (although this must be balanced with the risks attached to unattended birth at home or in transit (Rodie et al., 2002)). When women phone the hospital for advice, a midwife assesses their labour progress by talking with women and asking questions, ideally through at least one contraction. When women travel to the hospital or midwifery unit, midwives have more techniques to read the stage of labour from women's bodies including observing women's demeanour, and cervical dilation assessed by vaginal examination.

Policies of managing early labour in this way lead to dissatisfaction among women (Green et al., 2012; Nolan and Smith, 2010). Women find it difficult to determine the 'right' time to transfer to hospital and they are placed in the position of having their assessment of whether labour has started confirmed or discounted by maternity staff (Winter and Duff, 2009). They feel they must wait for permission to 'go in' and are aware of the possibility they will be sent home if they arrive at the maternity unit 'too early', that is, before active labour. This means that in early labour some women can feel unsupported, vulnerable and even unwelcome at the hospital (Cheyne et al., 2007; Eri et al., 2010, 2015; Green et al., 2012; Nolan and Smith, 2010).

Initiatives often focus on education of women about what early labour is, and how they should respond to the signs of early labour. However, education is only one piece of the puzzle. Early labour is an ephemeral concept with an uncertain relationship with the material body. It varies in length and intensity. Clinical understandings of early labour are based on partogram models that plot cervical dilation against clock time, setting norms for how long each 'stage' should take (Karacam et al., 2014). These allow little room for individual differences and take no account of environmental

factors that may speed or slow labour, and they have recently been criticised by the World Health Organization as unrealistic (WHO, 2018). Qualitative research has found that the stages of labour do not resonate well with women's embodied experiences of labour, ensuring women are reliant on professional assessment (Dixon et al., 2013). Little is known about how men understand 'early labour'.

Men, masculinity and (early) labour

There is growing recognition of the need to examine men's experiences in relation to reproduction and childbearing (Culley et al., 2013; Dermott and Miller, 2015; Marsiglio et al., 2013) because men are both physically and sociologically relevant to women's experiences. However, we also know that engaging men in reproductive research can be challenging as it may be seen as women's domain (Law, 2016). Requests to interview men about pregnancy or maternity care are 'sometimes met with surprise, or even disbelief, garnering responses such as: "Are you sure that it is me you want to talk with and not my wife?"' (Kristensen and Ravn, 2015: 728). It remains more unusual for reproductive research to focus on men relative to women (Almeling and Waggoner, 2013).

Eighty-two percent of men accompany their partner during labour (Redshaw and Henderson, 2014). In recent years, there has been multi-disciplinary interest in the role of men in labour and birth, with particular attention paid to the tensions between the male role in labour and heteronormative or hegemonic masculinity. Qualitative research has found that men feel marginalised during labour (Ekström et al., 2013; Ives, 2014; Premberg et al., 2011) and can feel powerless and uncertain about their role (Chin et al., 2010; Ives, 2014). Men sometimes feel that their role is as protector of mother and baby, but this can conflict with their deferential role in labour, their partner's right to bodily autonomy and women's authority over pregnancy (Ives, 2014; Premberg et al., 2011). Norms of masculinity demand stoicism even at this emotionally intense time, and men may be 'forced to hide strong feelings behind a calm and secure façade in order not to worry the woman during labour. Nervous feelings, anxiety, irritation and frustration are suppressed' (Premberg et al., 2011: 851) or else men risk being told to leave the room and 'pull themselves together' (Premberg et al., 2011; see also Dolan and Coe, 2011).

To date, qualitative research has tended not to divide labour into stages focusing almost entirely on men's role during active labour. As a result, I would argue, research has neglected the early phase of labour (and indeed the third stage, delivery of the placenta). Research has focused on hospital birth and implicitly on, what midwifery and obstetric models refer to as the 'active' stage, and up to birth. This may have the effect of over-emphasising men's experience as one characterised by feelings of helplessness and marginalisation. Researchers have begun to raise the question of whether male partners may be influential in decisions to prematurely seek admission to hospital in labour because of their own anxieties and a wish to have professional care for their partner (Barnett et al., 2008; Eri et al., 2010; Nolan et al., 2011a, 2011b, 2012) but mine is the first interview study examining men's views and experiences of early labour.

The research project

I aimed to address these gaps in the literature with an interview study taking an exploratory qualitative approach underpinned by an interpretivist philosophy in which 'early labour' was seen as a historically contingent social construction. The key research aims were to explore men's experiences of being with their partner during early labour, to explore early labour in social and relationship context, and to offer sociological insights into early labour from the perspective of fathers. The study received ethical approval from the Research Ethics Committee of the Faculty of Medicine and Health Sciences, University of Nottingham, UK.

The inclusion criteria were that participants had accompanied their female partner during labour and had at least one child aged 12 months and under. Fathers whose children were born at home or where labour had been induced were excluded as these types of birth raise different kinds of issues compared to spontaneous labour where the intention is to travel to the place of birth (hospital or midwife unit). Calls for participation were circulated widely via a national think tank, local peer support groups, parent and baby groups, a parenting charity, an antenatal educator for men, social media and snowballing. Twelve fathers were recruited over 12 months.

Participants' babies were aged between 3 weeks and 12 months old. Ten interviewees were first-time parents and two had an older child. Of the first-time parents, all but one had attended privately provided antenatal education. Eight participants reported that they planned a hospital birth, and four had planned birth in a midwife-led unit (two of these transferred to hospital during labour). The reported length of time couples had stayed at home varied from less than an hour to a day or more.

One-to-one semi-structured interviews were carried out by the author between February 2015 and January 2016. Interviews were carried out face-to-face wherever possible (10 interviews) and by telephone if travel time was impractical (2 interviews). Participants were all living in England. Interviews were conducted at a time and place convenient to the participants. In most cases this was at home, but interviews also took place at their workplace, at my University office, and in a café. When interviews took place in the participants' homes, it was at their discretion whether their partner was present during the interviews; two participants had their partner in the room with their baby and three more had a partner and baby in the house with them, but not in the room where the interview took place.

Interviews were professionally transcribed and anonymised. Transcripts were analysed thematically (Braun and Clarke, 2006, 2013) guided by the research focus and existing literature about fathers, fatherhood and masculinity, early labour care, and experiences of labour.

The substantive findings will be reported in a companion paper. In this article, I present reflections on the specific challenges of the research process. I want to suggest that a combination of gender, topic and ontological issues contributed to a range of difficulties around asking about early labour, keeping early labour in focus and finding early labour in the data. By reflecting on the research process, and 'thinking with' (Jackson and Mazzei, 2012) Mol's (1999, 2007) theory of multiple ontologies as well as the methodological literature around how researcher identity shapes research encounters, I seek to explore why those challenges arose.

Mol's multiple ontologies

Social science, it has been argued, attends primarily to epistemological issues. It most commonly asks *how* things work, and in particular the multiple perspectives that actors may have, rather than ontological questions about *what* things are (Epstein, 2016). I am interested in how fathers experience early labour and their role within supporting their partners and navigating maternity services. In contrast, Mol (2007) creates a theoretical repertoire for thinking through the: 'ontological politics of medicine' (p. viii). Applying this approach to atherosclerosis, she seeks to demonstrate that not only do clinicians, patients, laboratory scientists and so on have different perspectives on this disease but that 'atherosclerosis' *is* a different object in different sites across the hospital. Her approach is praxiography – she attends to how objects are *enacted* in a network of practices. The result is that something that is purported to be one thing is shown to be multiple objects rather than multiple perspectives on a singular object.

Mol's framework for examining the multiple ontologies of medical objects has been applied to reproductive social research on topics including abortion (Beynon-Jones, 2013) and foetal magnetic resonance imaging (MRI) (Reed et al., 2016). Mol's example condition, atherosclerosis, is enacted in the clinical consultation by a particular set of reported symptoms including pain on walking; whereas in the pathology lab, under a microscope, atherosclerosis is a thickening in the leg arteries. I argue, following McIntosh (2013), that early labour only really emerges *as a thing* when labour and birth moves to the hospital. There are various practices through which early labour is enacted, including telephone triage, vaginal examination and admission policies. In this sense, early labour fits the multiple ontologies framework very well. It is an object that exists to the extent that it is enacted within a number of contemporary practices around birth.

Mol (2007) creates a 'patchwork image' of atherosclerosis (p. 151) in which objects with the same name are enacted differently in different sites. Multiple objects are different and yet related (Mol, 1999: 77); multiple but not 'fragmented into many' (Mol, 2007: vii). Coherence between the patches is a job of work: 'Coordination into singularity … is a task' (Mol, 2007: 70) and 'processes of singularization are always fragile achievements – when they are achieved at all' (Woolgar and Lezaun, 2013: 325). There is always the threat of 'incommensurability' (Mol, 2007: 85) between such multiple objects. That atherosclerosis is a different object in the laboratory to the clinic is not necessarily a problem so long as patients are diagnosed and treated; so long as they are able to move between sites smoothly. Mol's approach implies a shift from different perspectives on a singular object, to how multiple objects with the same name cohere, or not, between sites with the potential for tensions, dependencies and clashes between objects with the same name.

My aim here is not to reanalyse my data with an alternative theoretical frame, but to use Mol's theory to think through the challenges of interviewing fathers about early labour, and more broadly of interviewing people about reproductive concepts or objects that are ontologically uncertain or complex. I offer a novel application of 'multiple ontologies' to reflect on methodological challenges experienced in relation to researching men and early labour. I explore the research encounter as a site where 'early labour' is enacted, drawing on Mol's theoretical repertoire to explore early labour as both a multiple object and an object that tends to intangibility in the research interview. I also draw out the intersections of uncertain ontologies with the gender dynamics of interviewing.

Interviews: talking about early labour

Data were collected through semi-structured interviews. In these interviews, talking about early labour with fathers was difficult. In the sections below, I explore the challenges of asking about early labour, of keeping the focus on early labour and of finding early labour in the resultant data. In each section, I reflect on my experiences drawing on Mol's work on multiple ontologies and on the wider methodological literature around researcher identity and the co-construction of meaning in the research encounter.

Asking about early labour

At the recruitment stage, I began to get a sense that 'early labour' as a term was potentially problematic for my interviewees. Confusion arose in initial communication about the study about whether the focus was on premature labour or the early phase of labour. Although the focus and aims of the research were clarified at recruitment and consent, in some interviews, direct questions about early labour drew puzzled looks and questions of clarification.

I experimented with ways of asking about 'early labour':

'What did you expect early labour to be like?'

> ‘How did you first know your partner’s labour was starting?’
>
> ‘Did you come across the idea that there were different stages of labour?’

As this term was not part of the vernacular for my participants, I was conscious that I did not want to reify the maternity services’ definition of the concept; however, it was not always easy to articulate alternatives. Early labour is defined in the midwifery and obstetric literature by cervical dilation of 4 cm or less and yet cervical dilation is a poor measure to employ in a retrospective interview study. It is almost completely inaccessible to couples as a marker of labour progress. Some men did punctuate their accounts very occasionally with estimates of cervical dilation, recalling being told by a midwife how ‘far along’ their partner was. This reliance on expert diagnosis of labour progress inevitably appeared later in their narrative once their partner had been assessed by a midwife in person so had limited utility for talking about this phase before active labour.

Social or behavioural markers of early labour were also problematic. Asking about labouring at home, for example, assumed that couples had followed guidance from healthcare professionals to stay at home during this stage of labour. This was not always the case. The time spent at home after the first signs that labour was starting varied from less than an hour to more than a day. In some circumstances, it would clearly have been entirely inappropriate to stay at home, for example, when labour started preterm. Admission to hospital was also not a reliable marker as, despite policies about not admitting women in early labour and sending couples home after assessment, this did not always happen in practice and other factors like how busy the ward was and how far the couple had to drive home seemed to play a role in the decision-making.

When I asked about some of the specific tasks associated with early labour, such as calling the hospital or midwife unit for advice, men often asked if they could check specific details with their female partners, focusing the interview on recalling ‘facts’ rather than exploring meaning-making and expressing a sense that they did not feel ‘expert’ in this topic:

> I can’t remember the process … did I phone them? … I think we just went straight to the hospital. Do you mind if I ask [partner]? Just quickly. Is that ok? (Participant 5)

The most successful strategy was a chronological approach. Participants were able to talk about when they first became aware that their partner experienced signs of labour and we could talk about thoughts and feelings at that time and take a step-wise approach to what happened next. The difficulty in this approach was identifying when ‘early labour’ might have become ‘active labour’. There was no clear dividing line in their accounts. I return to this issue below.

Men were most clear about early labour in relation to antenatal education. They could describe what they had learned about the stages of labour:

> [Julie]: Did you come across the idea that there were different stages of labour?
>
> Participant 3: Yes, very much so, yes, especially when in hindsight … you go ‘oh yes, at the beginning there’s a bit of oh and at the end it was not so much oh, it was more arrgh’
>
> [Julie]: Did you get a sense that there was a thing called ‘early labour’? [from antenatal education]
>
> Participant 7: Yes, in that until you reach a certain dilation … you can just relax and just keep things calm … and only once you reach a certain point do you need to check into the hospital.

However, they had all found the knowledge harder to put into practice than they had imagined, and some talked about recognising early labour, and responding appropriately, as a kind of test:

> [W]ith your first one you never really know when is the right time to go to hospital … so you’re in this sort of trap of getting it right. (Participant 5)

I became concerned that this sense of being tested risked being replicated in the interview context. Interviewers must facilitate a conversational space where participants feel comfortable to share their experiences in their own words (Pezalla et al., 2012). Asking about early labour directly seemed to induce, for some participants, a worry about getting it ‘right’. I was left with an uncomfortable feeling that I was testing their knowledge of an obstetric model rather than exploring participants’ own understandings, meanings and experiences. An impression that may have been exaggerated by the gendered dynamics of the interviews.

Interviewers are instruments of data collection (Pezalla et al., 2012). Structural factors, such as gender, age and class, shape the social dynamics of interviews and therefore our data (Arendell, 1997; Broom et al., 2009; Manderson et al., 2006; Sallee and Harris, 2011). The usual gendered power balance can shift when female researchers hold the expertise in the topic being studied and initiate a study involving male participants (Arendell, 1997). However, here it is impossible to disentangle the dynamics at work as they relate to gender but also topic and biography. While learning about labour is one way in which fathers can establish an identity as involved parents (Ives, 2014), men tend still to position women as the experts in maternity matters (Kristensen and Ravn, 2015). Therefore, gender and ‘maternal status’ may be particularly relevant in reproductive research (Frost and Holt, 2014). Participants would have been aware of my affiliation with a university, probably of my affiliation with a division of midwifery which might be considered to have some ownership of the concept of early labour. The role of self-disclosure in building rapport has been debated in the methodology

literature. Feminist approaches suggest that a degree of interpersonal connection is conducive to creating a safe environment for the interview, whereas others have argued that self-disclosure can portray the interviewer as more knowledgeable than the participant and so have a distancing effect (Pezalla et al., 2012). In seeking to establish a sense of commonality with interviewees, I sometimes mentioned that I am a parent – usually in the context of empathising with the difficulty of finding free time for something like a research interview in the challenging early days of parenting. This may have had the effect of identifying me as someone who probably had first-hand experience of labour. My gender, professional and maternal identity may therefore have combined to position me as an 'expert' on labour who was 'testing' their understanding of the stages of labour. Biography, in other words, interacts with topic in the research context (Pini, 2005: 212).

I proceeded cautiously with the interviews, trying to be sensitive to participants' knowledge and experiences and mirroring the language that they used to describe their experiences as far as possible. However, I was mindful of ensuring my participants and I were talking about the same thing. Recognising and valuing different perspectives on a research object is central to qualitative interpretivist study design and yet it does require a degree of common language to talk about the issues at hand. Using Mol's framework, 'early labour' seems to be much less tangible as an object in the context of the home and (heterosexual) relationships when compared to the 'early labour' presented to men in antenatal education. In methodological terms, Mol's socio-material framework is less dependent than interviews on an ability to name a shared object of interest in so far as it includes ethnography or praxiography, and so an object can be effectively researched if you can recognise it when you see it. However, Mol also suggests that interviewees can be treated as auto-ethnographers and any interview relies on a (at least partially) shared understanding of the concept or topic under investigation. Mol's framework reminds us that objects with the same name can be radically different objects in different sites or, as I want to argue, may not exist at all except as something that is stated as existing in an educational programme. I want to suggest that it may be productive to think about the research interview as another site in which the research object is enacted and ask questions about the extent to which the 'early labour' enacted in interviews was, and should be, coherent with the early labour of maternity services. This is an issue I return to below.

Keeping early labour in focus

It was hard to keep the focus of interviews on early labour. 'Early labour' was a term that few men spontaneously used in their birth stories. However, difficulties of keeping it central to the interview was more than a question of terminology, rather it appeared to also be related to the nature of the research object and the pertinence of the topic to participants.

The nature of early labour itself may make it difficult to talk about. Early labour as a set of signs and symptoms exists in women's bodies, so men will inevitably be at least one step removed from the physiological event (acknowledging that there is also variation in early labour among women and uncertainties around recognising and managing early labour among clinicians). Turning to the wider research methods literature, my experience of the interviews resonated with Law and Singleton's (2005) account of researching alcoholic liver disease in which they found it 'difficult to keep the condition in focus' (p. 331). In common with my experience, interviews often slipped into related topics and largely did not attend specifically to alcoholic liver disease; interviewees gave wildly different accounts of the condition. Law and Singleton (2005) consider what they call technical and managerial factors in these difficulties but conclude that issues of ontology are at play. Alcoholic liver disease, they argue, is a messy, fluid, somewhat unconventional object that is hard to recognise within the framework of social scientific methods.

Focusing on early labour in men's experience proved difficult. Mol's framework of multiple ontologies would suggest the need to focus on practices by which 'early labour' is enacted. While all participants had a strong sense that it was important for them to 'be there' throughout labour, their accounts of early labour suggested that it was a time of waiting more than acting. Indeed, some men talked about their discomfort with doing 'nothing' as labour started

> it's started, you know, surely … we shouldn't just be relaxing we should be doing something now. (Participant 2)

Generic tasks, tasks that might be undertaken at times other than during labour, like organising childcare, running a bath or packing bags fell to them but this was also a time when some men slept or finished work tasks so that they would be ready for what they saw as a more important role of supporter and advocate at the birth. If they made phone calls to the maternity unit for advice, they reported being asked to pass the phone to their partner. Where the embodied experience of early labour may be said to be being 'enacted' within the body of a woman, men's struggle with being rather than doing during this period means that their accounts did not resonate with enactment because the period was difficult to recall or frame as relevant. Hence, the phenomena of early labour appearing to be ontologically empty for men.

Mol (2007) argues that objects come into being, and disappear, by virtue of the practices through which they are enacted. Objects can be more or less tangible in a particular site depending on the techniques used to make it visible or knowable. When men see little role for themselves in early labour, perhaps early labour itself also slips from view. However, I think there is also an issue of pertinence here.

Interviews commenced with an opportunity for participants to tell the story of their child's birth in their own words. Some started their narratives on the day of the birth, others further back in the pregnancy, giving me a sense of the overall story as well as insights into the aspects of the experience most salient to the participant. Early labour rarely featured prominently. The next step in the interview was to return the conversation to the topic of early labour, something that was particularly interpersonally and ethically challenging with those participants who had disclosed other, sometimes very difficult, experiences later in labour or after the birth.

With caveats about how it was 'much worse' for women, fathers talked about feeling helpless and being marginalised during active labour and immediately after the birth:[1]

> It's a male thing to want to get involved and to want to solve the problem, which you can't do, and if you do try and do that I think you're going to get in the way. (Participant 12)

> I think it's quite an intense environment to be in, well obviously for both of us, more so for [my partner], but me just kind of speaking [to partner], getting nothing back and she's really focused on giving birth and I was just feeling like a spare part. (Participant 1)

Clearly issues remain around birth partners' experiences of and roles within labour and birth. In terms of the research encounter, acknowledging these difficult experiences, which were personally very meaningful but also already well documented in the existing literature, made it very difficult to return the conversation to early labour.

In the consulting room, Mol argues, patients must enact atherosclerosis by telling appropriate stories and the doctor must ask good questions and listen attentively in order for two objects called 'atherosclerosis' to cohere and for the patient to be diagnosed and treated. We might extrapolate from this to these research interviews where it became a task of coordination to patch together two (or more) objects to bring the interview back to the focus of the research in a way that was meaningful and had utility for both fathers and the researcher. I turn to analysis in the final section below.

Analysis: finding early labour(s) in the data

The interviews were analysed using thematic analysis (Braun and Clarke, 2006, 2013). The challenge was to locate and analyse 'early labour' in the data. After immersion in the data, the first step was selective coding to identify passages of text relevant to early labour. The component parts of this code were not only explicit use of the contested term 'early labour' but also other markers of the ways in which early labour is managed by and with healthcare services: telephone triage, clock time, contractions, travel to hospital, vaginal examination and cervical dilation, admission to hospital or being sent home. Themes were then constructed from the data within those codes. This approach was valuable to confirm, extend or challenge existing research in the field. It enabled me to attend to issues of men's understanding of 'early labour', men's role in early labour and their potential influence on women seeking admission to hospital. However, I was also aware of the limitations of this approach. It risked confining interpretation of the data within a predetermined research agenda, one largely defined by a service-focused, midwifery research concern. By focusing on how early labour is enacted in practice, focusing on concrete tasks and activities of early labour, I seemed to be giving early labour a tangible quality, an ontology, that I felt was contradictory with the variety of experiences and the uncertainty with which men themselves engaged with this concept in the interviews. Silences around early labour are just as important to pay attention to:

> not much goes on really [laughing]. The contractions are quite a long way apart, your wife may or may not need you because there's not too much going on (Participant 11).

One final analytic approach to the data was to look at the narrative shape of the data, at the contrast between early and active labour. The dividing line between the two stages was impossible to locate precisely in the data. This approach showed labour to be a continuum that is not easily divided into stages although there was a similar trajectory to most of the narratives, summed up by this quotation:

> Early labour is early labour, it's just the calm before the storm, so don't let it stress you out. (Participant 7)

This quotation, and others like it, suggests to me that early labour is of less concern to my research participants than it is to maternity services and indeed maternity researchers. Researching education, Tanggaard (2007) describes the ways in which she was made aware of her assumptions about the focus of her research – 'learning' – and how these were challenged in the context of interviews with apprentices:

> Apparently, learning is a central concept for the teachers, whose primary task it is to ensure that the apprentices learn as students in vocational school. It is also a central concept for the researcher who earns her money by contributing to research on learning and teaching; however, for the apprentices, learning is not of explicit and isolated interest. (p. 164)

This resonates with early labour research where there is a risk that the agenda is set by the needs of maternity services rather than women and their partners. Nonetheless, maternity services do currently organise their provision in this way and there are benefits for women from spending the early part of their labour at home in terms of less intervention in labour (Holmes et al., 2001). Birth partners, including fathers, potentially have an important role in supporting women at home. Perhaps the question becomes how, as a qualitative researcher, to meaningfully engage with policy and practice without losing what Donmoyer (2012) calls one's 'methodological soul'. The problems to which sociology is applied are

often generated in other areas of practice or other disciplines, and health and illness is a prime example (Holmwood, 2010). It is not at all unusual for sociologists researching reproduction to focus on the objects of biomedicine as their research topics, while retaining a critical understanding of the concepts, conditions and diseases that feature in their research. However, '[r]esearchers generally treat social concepts as if they are real enough to be named, investigated, and analysed' (Carter and Little, 2007: 1326). There are good pragmatic reasons for this. Terms like 'early labour' operate as short hand and translate well across disciplines although they can also obscure the complexities and critical understandings behind and within the terminology on all sides. The complexity that qualitative researchers often embrace does not always translate easily into enactable changes for policy and practice (Donmoyer 2012). Speaking to policy sometimes requires us to work with concepts and models that are problematic or inadequate (Hylton and Long, 2016). But there is also a politics around researching such problematic concepts. Warin and Gunson explore their experiences of researching 'obesity'. As social scientists they recognise that their research agenda is set by biomedicine and, although they have a critical perspective on the concept and the stigma it engenders, they reflect on their own 'complicity in constructing and reproducing obesity as a "problem" by conducting their research' (Warin and Gunson, 2013: 1688).

A desire to influence practice for the benefit of women and couples motivates my research. However, researchers are also under pressure to comply with the audit culture of UK research in which economic and social impact are assessed, and this reinforces trends towards interdisciplinary, applied research and relatively short-term, utilitarian goals (Holmwood, 2011). This arguably limits research approaches that might more fundamentally challenge biomedical concepts. Perspectivalism – as employed in this study – risks leaving objects poorly understood or unchallenged. It does not multiply reality, only the 'eyes of the beholders' and seeks to attribute value to a range of standpoints (Mol, 1999: 76). The object of inquiry

> is only looked at. As if in the middle of a circle … no one ever touches the object. In a strange way that doesn't make it recede and fade away, but makes it very solid. Intangibly strong. (Mol, 2007: 12)

Early labour research needs, in my opinion, to both seek improvements for women and couples in the current system and challenge the problematic construction of stages of labour that have little resonance or utility beyond the clinical context. I continue to wonder what kind of thing 'early labour' *is* outside of the maternity services framework.

Discussion

Investigating men's understandings and experiences of early labour allows me to add another piece to the puzzle of early labour research. I identified a gap in the literature and set out to address that gap. However, this perspectivism was ultimately somewhat unsatisfying. This was partly because of pragmatic challenges; however, persistent difficulties in talking about early labour led me beyond epistemological issues to consider problems of ontology.

Mol's theoretical repertoire of multiple ontologies provides one way of rethinking the difficulties of talking about early labour. It prompts different sorts of questions, not about perspectives on a singular object, but about how multiple objects called by the same name are enacted by different people, in different spaces. Mol's framework would suggest that there are tensions, or failures in translation, between the 'early labour' of maternity services and of parents. Ontological approaches 'stimulate an alertness towards forms of difference that cannot be reduced to a disparity of "worldviews"' (Woolgar and Lezaun, 2013: 322). My interviews suggest that 'early labour' all but disappears as an ontological phenomenon in the experience of fathers. A socio-material approach to early labour may produce novel insights, but for now I am concerned with the research interview as a site for enacting early labour.

Questions of ontology may prompt us to consider the complexity of doing qualitative reproductive research where biomedical terms may not translate well to participants and may refer to something different in the personal lives of participants compared to the work life of healthcare professionals, or may only tentatively cohere as an object at all. Interviewers should consider how their own ontological assumptions and interview practices enact their research object in the research encounter.

It has been valuable to think with Mol's multiple ontologies and primarily through her example of atherosclerosis, but this condition is not, I would argue, gendered in the same way as topics around reproduction. As such, additional insights were provided by the methodological literature around how the social identities of both interviewer and interviewee shape the research process. The literature around interviewing men suggests that the usual gendered power dynamics can be altered in the case of women interviewing men (Arendell, 1997). In interviewing men about 'early labour', a particular, complex set of intertwined dynamics were in evidence, encompassing gender, maternal identity, topic and the uncertain and messy ontology of the research object. The challenges of this project suggest the need for social researchers of reproduction to reflect on how their own research practice reproduces or challenges norms, values and power dynamics within biomedicine and the clinical context.

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Note

1. Albeit they were relatively uncritical of this, reflecting previous research in the field (Dolan and Coe, 2011; Ives, 2014; Johansson et al., 2015).

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