The Midwife's Coracle.

A phenomenological study of midwives' experiences of emotionally supporting motherhood

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Thesis for PhD

Contents

List of Tables

Abstract

Background

An initial review of the literature pertaining to the emotional health of women in their transition to motherhood was undertaken. It became clear that this is an emotional time for women where they are particularly at risk of becoming distressed (Drift 2004) and if women are emotionally distressed at this time it may have long term implications for mother (Drift 2004), baby (Miller et al 1993, Lemaitre-Sillere 1998, McMahon et al 2001) and family (Burke 2003, Tammentie et al 2004a, Tammentie et al 2004b). This understanding led to an exploration of who might provide for the emotional health needs of women at this time. Midwives were identified as key professionals because of their regular contact with women through pregnancy, labour, birth and early childcare. The literature review indicated that midwives were providing for the emotional needs of women but there was no indication of how, despite the recent studies conducted into the emotion work of midwives by Hunter and her colleagues (Hunter 2001, 2005, 2006, Hunter and Deery 2009).

Design

This study has been conducted using the Husserlian philosophical approach with Giorgi's psychological method (Giorgi 1985). Eight community midwives were recruited following a presentation at their community midwifery team meeting at a local NHS Trust and subsequent 'snowballing'. Unstructured interviews were conducted with them in 2004 in order to explore their experiences of providing emotional support to women who were becoming mothers.

Findings

A general structure was developed along with four constituents: these were 'tipping the balance to showing emotionally supportive care', 'showing emotionally supportive care', 'struggles in showing emotionally supportive care' and 'emotional experiences'. The descriptions of experiences shared by the midwives led to an understanding that emotional support is a special type of care. This occurs in an intimate relationship supported by a 'circle of care'. The midwives use their communication skills with the aim of facilitating comfort and

ameliorating emotional distress. To give this care, midwives needed to go through a process of 'tipping the balance' but even after this was enacted, they still struggled in providing this care. They appeared to particularly struggle with maintaining their 'with woman' ideology within their current professional culture.

Recommendations

There is a need for midwifery to consider how midwives might manage their 'with woman' care within health and social care services. For the midwives in this study, having the autonomy to manage their own diaries and caseloads along with good working relationships with their colleagues was facilitative. This was a small study in one geographical area but it clearly indicates the need for further research in this area.

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Preface

As a young child I had taken responsibility for and cared for my younger brother, and later my mother too. When my brother had a nightmare I was there with him, comforting him; this continued into his adolescence. I enjoyed caring for and nurturing animals, watching them develop and grow and have babies. Early in my teenage years I looked forward to having babies and children of my own to care for. I had a strong sense of my own and others' spirituality and was drawn to organised religion to gain support and understanding. I strongly believed that all life was precious and all had the same intrinsic worth. Organised religion offered a way to manage my own life and a framework in which to demonstrate to others my care and concern.

Although there have been many influences in my life, now I have reached middle adulthood, I still hold the same values of those early years. My explorations of theology, philosophy and psychology have offered me frameworks in which to understand how my view of the world and people fit with others. I could be considered a Christian, an idealist or a humanist. I hold values and beliefs that belong to these world views but the way I conceptualise the world would not fit into any of these in any orthodox manner.

Before marrying and having children I became a nurse, mostly due to pressure from others who felt I fulfilled this stereotype. I was unsure about this, but after I had tried other occupations allowed myself to be led. I did not understand what mental health nursing was when I began but had always been motivated to help those in distress. I found that people who were mentally distressed appreciated and responded to my respectful caring and I think my ability to see the good in people helped. I gained both self esteem and spiritual fulfilment through my interactions with them.

Sadly, I experienced postnatal depression when becoming a mother; this was not particularly surprising given my emotional sensitivity. I have also worked with women who have experienced emotional distress around the time of motherhood and I wanted to help them. To do this I needed to know what emotional support is offered to women at this time. My experience was that there was none generally available: that was a long time ago but it remains vivid in my mind.

To conduct a rigorous scientific study I believe, due to my psychology training, that I would need to put on one side all of my previous experiences, values and beliefs about the world. Despite this I realise all the influencing factors in my life will have played their part in the study I am undertaking and, as has already been established, my research question has been generated through them. The method I use to undertake this study will also be subject to my world view or conceptual framework. The path I undertake may be influenced by these preconceptions but there is also the possibility that through the journey of this study, my values and beliefs will also develop.

Chapter 1

Introduction

Background

The journey to motherhood is an emotional one for both the woman and those caring for her (Mercer 2004, Wilkins 2006) and the woman's emotional experiences can have significant consequences for the child (Miller et al 1993, Sinclair and Murray 1998, Lemaitre-Sillere 1998, McMahon et al 2001). I have had a wide variety of experiences within the area of maternal emotional distress, from personal experience to caring for women suffering significant levels of distress whilst working as a mental health nurse.

Emotional experiences can be life enhancing or create extra challenges for the person. It is these challenges that have been most explored in women's transition to motherhood. The term 'baby blues' has been used to refer to emotional lability in the early days after the birth of a baby and it is believed to affect between 50 and 80 percent of women at this time (Lawrie et al 2002). Given the large number of women experiencing some sort of emotional upheaval around the time of giving birth it may be considered 'normal' to experience some emotional lability. There are only a small number of women believed to experience severe mental illness at this time (less than 1%: Dennis and Kavanagh 2001).

Regardless of whether a woman falls into the category of having a smooth transition to motherhood (20%-50%), becomes severely mentally ill (less than 1%), or is somewhere in between, there is growing concern for women who experience emotional distress around the birth of a baby. This is highlighted by mental health services, as identified in the National Service Framework for Mental Health (DoH 1999), maternity services that recognise the impact psychological problems have on the maternal death rate (Drife 2004) and those concerned with child development (McMahon et al 2001).

Therefore a process of understanding what those who are trying to help women at this emotional time are doing needs to be conducted. During the antenatal period and in the early days after the birth of a baby the most prominent health professional is the midwife. So this study is focusing on their work with women. It also seemed appropriate to explore what midwives were doing in what they thought of as 'normal' situations to offer a basic foundation for future development. At the time of conception and start of this study there was little literature in the field of emotion work in midwifery (Hunter 2001), therefore an exploratory design was needed. This led to research questions rather than a stated hypothesis.

Aim of this study

To provide an account of how midwives experience participating in giving emotional support to women who are becoming mothers for the first time.

Objectives of this study

To gain descriptive accounts of midwives' perceptions of their lived experiences specifically focused on giving emotional support to women becoming mothers for the first time in what may be considered 'normal' situations.

To gain descriptions from the midwives' perspective of their actions and interactions with women at this time.

To seek both the commonality and uniqueness within the experiences described by the midwives.

To identify the influential elements and the context within which it occurs.

Literature Review

Introduction

This literature review is wide ranging to offer an understanding of not only the anticipated phenomenon but also its context. It is generally accepted that the transition to motherhood is frequently emotionally fraught and that midwives may be in a position to provide for the emotional needs of women, due to their ongoing contact. There were no previous studies found that led to an initial understanding how and when these needs were addressed. This has led to quite broad questions being asked of the literature and to a phenomenological research methodology.

It is believed that these broad questions follow a logical pathway to understanding both what is being studied (the phenomenon) but also the context in which it occurs.

What is a midwife and midwifery?

Within this section is a consideration of the development of midwives as professionals and the impact of policy and legislation on them. This leads into an overview of current professional midwifery practice. It is important to explore the development of the profession and the impact of institutions, including government. This is because there appear to be competing cultures or ideologies within midwifery. The two stated opposing ideologies are 'with institution' and 'with woman' (Hunter 2004).

Midwife n. person (usu. woman) trained to assist others giving birth; hence midwifery (2) n. ME, prob. F. obs. Prep. mid with + wife woman, in a sense 'one who is with the mother' (Sykes 1982: 640)

Introduction

"Midwifery is a vocation in which a midwife's knowledge, clinical skills and judgement are put in the service of bringing new life into the world, of protecting and restoring a mothers' well-being." This quote was from Baroness Julia Cumberlege, who was the chair of the expert maternity group that was undertaking a review of childbirth services, as a foreword for a midwifery text (Page and McCandlish 2006: ix). She went on to say that midwives undertake their task in a turbulent world and the NHS, in which most of their care takes place, is in crisis. She said that due to scientific advances there are also unrealistic expectations placed on midwives (Page and McCandlish 2006).

Page and McCandlish (2006: xiii) stated that the 'essential elements' of midwifery are:

Working in a positive relationship with women

Being aware of the significance of pregnancy and birth and the early weeks of life as the start of human life and the new family

Avoiding harm by using the best information or evidence in practice

Having adequate skills to deliver effective care and support

Promoting health and well-being

They write that being a midwife is about mutual trust, assisting women around the time of childbirth recognising the physical, emotional and spiritual aspects of care needs. Being a midwife, being 'with woman', implies a relationship of knowing each other (Page and McCandlish 2006). This is working in a 'with woman' way. These statements, however, do not seem to be fully supported by all educational texts for student midwives. Books such as "Core skills for caring and assessment" (Way 2000) are totally focused on medical-technical care. It includes activities such as measuring blood pressure and the administration of medication.

It has been highlighted that in developed countries such as Britain it is becoming more and more difficult to work in a 'with woman' way (Page and McCandlish 2006) and this can be seen to be even more problematic in the most affluent countries such as the U.S.A. (Wolf 2001). The current context in which midwives attempt to offer 'with woman' care can be better understood through its historical roots. Thus, the next section will explore the development of midwifery as a profession and then will move on to consider the development of legislation and policy that influences the care midwives give today.

The development of midwifery as a profession

The professional role of midwives has changed over the years and, in fact, it was only in the twentieth century that midwives gained the status of being professionals. Midwives as autonomous professionals developed due, in part, to increasing medicalisation and acknowledged experts managing and taking control of (expert-led) childbirth. Between the First and Second World Wars, in the 1920s and 1930s, there was a focus on the risk for mother and baby, which led to the perceived need for doctors to be involved in childbirth. The involvement of doctors led to increased hospitalisation of women and encouraged an expert-led approach to maternity care (Littlewood and McHugh 1997). Midwives were an intrinsic part of these developments and medicalisation influenced their journey to professionalism. It has been an eventful process influenced by social need, politics and religion (see below).

There is evidence of wise women assisting other women in childbirth for as long as documentation has been available reaching back to what may be considered the beginnings of civilisation in Mesopotamia. Even ancient religious texts such as The Old Testament of the Bible consider reproductive functions which suggest that women led men astray resulting in their expulsion from the Garden of Eden (Rhodes 1995). Religious doctrine has had implications for those supporting women in childbirth in Christian or Jewish societies for two reasons. Firstly, for leading men to sin women were condemned to great pain in childbirth and secondly, they were viewed as more susceptible to evil. For orthodox followers

this put the wise women caring for women in childbirth in a precarious position, as both midwives and mothers were already seen as tainted by original sin and therefore at high risk of demonic possession. The Catholic Church was powerful in Europe in the 15th century, which led to a wide acceptance of the Malleus Malificarum (1486) which identified midwives as likely candidates as witches (Littlewood and McHugh 1997). The oppression perceived by some prominent midwives (Kirkham 2000) may have its early roots here in religious texts.

In the Middle Ages midwives continued to carry out the role of caring for women in childbirth. They had no training, were mostly illiterate, as were most of the population, and clearly took the role of midwife; with woman. These midwives also had a religious role in that part of their job was to baptise sickly babies so that their souls would not be lost. In 1513 Eucharius Rosslin (a doctor) wrote a book for midwives called The Rose Garden of Pregnant Women and Midwives. Despite this book being written by a man, for midwives and women, doctors or males were virtually never admitted to the room of a labouring woman. Rosslin's book stated that the midwives role is to "instruct and comfort the party" (Rhodes 1995: 15). Comfort was achieved by offering good food and drink, expressing sweet words and gentle stroking.

William Harvey was the next significant figure in Britain in the development of midwifery as a profession. European midwifery followed a slightly different and less medicalised path. He, again, was a doctor but was seen as the founding father of British Midwifery due to a chapter on midwifery in his book 'On the generation of Animals' in 1651. Interestingly, at this time assisting women in childbirth was still the realm of women, with the Royal College of Physicians (founded 1518) stipulating that physicians were not to attend women in childbirth and if the midwife needed assistance she must call on the barber surgeons or apothecaries. Despite this there is documentary evidence of male midwives assisting women in childbirth at this time (Rhodes 1995).

The central figure in midwifery in the 18th century was William Smellie who became known as the Master of British Midwifery. He began teaching midwifery to both men and women, in separate classes, in 1741. He wrote books to facilitate the learning of his students: in 1742 'A course of lectures upon midwifery' and in 1752 'A treatise on the theory and practice of midwifery'. His male midwives were trained to use instruments, such as forceps, and dealt with difficult births, whereas the female midwives helped women with normal births. Whereas previously the labour room was reserved for women, this changed with the training of male midwives. The male midwives were called in when the female midwives were having problems. This can be seen to drive a wedge between the sexes and sometimes created antagonism in the birthing room (Rhodes 1995). There was still a strong Christian ethos in British society and this identified that childbirth facilitated the way to salvation for women as long as they retained a subordinate position to men (Littlewood and McHugh 1997).

In the early19th century there was recognition of the need to organise and structure medicine. At this stage women were not allowed to become doctors and these "gentlemen of enlarged academic education" (Rhodes 1995: 85) were advised not be involved in the labouring of women. Seventeen acts of parliament were enacted between 1840 and 1858 in an attempt to regulate and structure medicine but it was not until 1886 that midwifery (now known as obstetrics) was included as an area of study for doctors (Rhodes 1995).

Maternal and infant deaths were high in the 19th century and the poor were particularly at risk. This became a significant problem when the government was seeking men to fight in the Boer War and found few fit enough to provide a good army. This led to legislation relating to childbirth (Littlewood and McHugh 1997). Alongside this there was pressure from obstetricians who called for the training and regulation of midwives to be in the same manner as doctors. Educated, middle and upper class midwives were quick to take up this challenge with many completing the voluntary London Obstetrics Society examination

prior to compulsory training commencing (Rhodes 1995). This was the foundation for the development of midwifery as a profession in the 20th century.

Through the centuries it can be seen that women have been subordinated and there appears to have been some fear attached to them, particularly those who assisted in childbirth, leading to the suggestion they may be witches. It might also be suggested that, despite professionalising midwifery and childbirth being considered a way to improve care, it is another way of controlling feared women.

The impact of policy and legislation on midwifery

In 1902, in England, the government passed the first Midwives Act. The first midwives act separated two of the main roles of the wise women, which were laying out dead people and assisting in childbirth. The Act said the same person should not undertake both these roles (Littlewood and McHugh 1997). It may also be seen as the start of men and medicine taking over what was a woman's domain (Mander and Reid 2002). The Act also involved the setting up of a Central Midwives Board in England and Wales; registration with the board was necessary in order to practice as a midwife. It can be seen that gone were the days of the wise women or, as they were known at the time, the handy women. It has been suggested that women who came from the middle and upper classes were in league with their male counterparts, the doctors, to remove competition and establish their place as professionals (Leap and Hunter 1993).

The Central Midwives Board set standards for entry to the midwives' register including training and certification along with guidelines for removal from the register. The Midwives, who had supported this introduction, found that as well as removing the competition of the handy women, who had been used as the scapegoat for the high maternal mortality rate (Leap and Hunter 1993), they also had their own scope of practice limited. These professional midwives were now only allowed to work with women who were experiencing 'normal' childbirth; they had to call a doctor if there were any complications (Mander and Reid 2002). Although midwives, wise women, and handy women had over a few

centuries called on male dominated professions to assist in childbirth when they needed to, at this stage there became a compulsion. This formalised compulsion to pass on difficult births can be seen to have its origins with Smellie in the 18th century. Smellie taught male midwives to use the technology of the day to assist difficult births whereas he taught female midwives to assist normal births with little or no technological intervention.

The third Midwives Act was implemented in 1926. This saw a formalisation of the teaching of midwives along with an identified midwife teachers' certificate and the fining of unregistered people attending births unless it was an emergency situation (Leap and Hunter 1993). The start of the medicalisation of births had already begun but was increasing in momentum, with 15% of births occurring in institutions in 1927, increasing to 24% by 1932 and 45% by 1944 (Leap and Hunter 1993). This had increased to 64% by 1952 (Rhodes 1995). During this period, in 1929, the College of Obstetrics was established (Littlewood and McHugh 1997). The 1930's saw a swing towards childbirth and care being the realm of experts supported by the introduction of a governmental department committee on maternal mortality and morbidity.

The founding of the College of Midwives, which set the training and standards for midwives, occurred in 1933. They focused on the provision of antenatal care and more expert intervention in childbirth. Antenatal care or pre-maternity care proliferated at this time with Ballantyne, an obstetrician, in 1923 laying down that the aims of this care should include: "removal of dread, reduce discomfort, treating syphilis and toxaemia early, increase normal pregnancies and labours, reduce still births, and reduce maternal mortality" (Rhodes 1995: 123). This was particularly interesting due to its emphasis on psychological as well as physical well-being but then, as now, antenatal services received criticism for its lack of achievements.

The National Health Service was introduced in 1948 and midwifery services were included in this. By the 1960's there was a call for all births to be in

hospital and in the 1970's and '80's with increasing medical interventions available and consumer led health care this gained momentum (Peel Report 1970, Court Report 1976, Welburn 1980 cited in Littlewood and McHugh 1997).

As can be seen, midwifery has a long history, but as a profession most development was in the 20th century. The 20th century saw huge changes in the care of women in their transition to motherhood, through the assuming of professional status by midwives and the medical interventions in childbirth. With medical developments such as antibiotics and blood transfusions, mortality rates decreased. This may be the reason women increasingly wanted to give birth in hospital. They saw hospitals as safer than their own homes, showing a cultural change in childbirth (Rhodes 1995).

The belief in medical science may have taken away some of the fears of childbirth clearly described by many women (Leap and Hunter 1993). There were, of course, other pressures on women leading to their desire for experts to support them in childbirth and care. Women had little information or understanding of their bodies and sexual functioning in the first part of the twentieth century (Leap and Hunter 1993). At the same time as having little knowledge, social pressure was being placed on women to take responsibility for the health and well being of their children, with fear of their children being removed or themselves being prosecuted (Littlewood and McHugh 1997). Women were encouraged to stay at home after the Second World War which added to this pressure. Men, such as John Bowlby, proposed that if women were not in continuous relationship with their small children, the children would become mentally ill and socially deviant (Bowlby 1951).

Since the 1950s the risk of death during childbirth has decreased and routine processes have been developed to care for women in pregnancy, labour and the early postnatal days. Professional midwives and obstetricians are now taking women through these processes and increasingly using technological screening

of both mother and baby. This can be seen to be leading women to feel that they were objects being processed through a factory (Rhodes 1995) and it has led to an increase in psychological problems for women (Littlewood and McHugh 1997). During this period "the woman's whole life changes immeasurably", due in part to great mental and emotional upheavals, after giving birth to a baby (Rhodes 1995: 176). A lack of recognition of these emotional and psychological factors may have led to recent figures which suggest most maternal deaths in the UK are due to mental health and psychological problems (Drift 2004).

Some have suggested that the emotional or psychological problems experienced by women may be influenced by the medicalisation and the medical power base which puts women and midwives in an oppressive position (Mander and Reid 2002, Littlewood and McHugh 1997). Despite the publication of the Winterton Report in 1992 and Changing Childbirth in 1993 (DoH 1993) advocating a 'woman centred' approach within midwifery there are those that would suggest this appears to be mostly rhetorical (Mander and Reid 2002).

In 1991 The Winterton Committee produced its report on its investigation of maternity services (Tew 1998). The committee looked at five areas: "preconception care, antenatal care, birth, postnatal care and neonatal care" (Tew 1998: 214). Importantly, this committee considered a wide breadth of evidence including visits to inspect maternity care overseas, research based evidence, and the views of women's groups, nutritionists and midwives. The report recommended continuity of care and carer (which they believed was best undertaken by midwives) and that women should be given choices related to their care, allowing them to feel in control. The committee noted that obstetricians, general practitioners and midwives were all attempting to protect their professional role rather than promote what was most beneficial to women. The Royal College of Midwives, although acknowledging and supporting the desires of women, stipulated that midwives should be allowed to overrule these desires if they thought it necessary through their professional knowledge and skills (Tew 1998).

The committee's recommendations were quite far reaching, removing some of the power from both general practitioners and obstetricians in favour of midwives. They identified that maternity care for women experiencing normal pregnancy and birth should be provided by midwives, which was the case at the beginning of the century.

In response to the Winterton Report, the Department of Health set up an Expert Maternity Group to consider how the wide-ranging recommendations could be put into practice. This group produced a report in 1993 called 'Changing Childbirth' (DoH 1993) and its main recommendations are worth considering here.

The key principles of maternity care identified in the Changing Childbirth report were that women should be the focus of maternity care: that it should be women-centred. Maternity services should be easily accessible to all women and they should be involved in the development and planning of their care (Henderson and Jones 1997). The report stipulates that women should know who is going to support them in labour and who the lead professional is in planning their care. Women should have the right to clear unbiased information. Obstetricians' skills should be used for complicated births but care should be more community orientated and practice should be evidence based. Perhaps the sting in the tail is that care providers need to demonstrate that their care provides value for money. The Royal College of Obstetricians were unhappy with a couple of elements of this report. These concerns centred on the implications that they would not have jurisdiction over normal births and that home births were recognised as a safe alternative to hospital births (Henderson and Jones 1997).

Alongside these influential maternity focused reports the 1990's saw massive changes in the structure of the National Health Service, which started with the publication of the white paper 'The New NHS – Modern and Dependable' (DoH 1997). This identified the need for patient-centred care and aimed to exchange

the internal market developed by Margaret Thatcher's conservative government for a more integrated approach. This can be seen to lead to the establishment of clinical governance and quality evidence-based care through the publication of 'A First Class Service' (DoH 1998). Introduction of bodies such as the National Institute of Clinical Excellence (NICE) and structures such as the National Service Frameworks (NSF) were developed to ensure evidence-based quality care was accessible by all, regardless of where they lived.

The National Service Framework (NSF) for Children, Young People and Maternity Services in England was published by the Department of Health in 2004 with the expectation of the recommendations being implemented in all Trusts providing care for these groups by 2009. In Standard 11 of this NSF, it clearly states that psychological and emotional needs of the mother should be assessed and care provided through a multidisciplinary team-based approach. NICE published guidelines for antenatal care in 2003 and followed this up with guidelines for postnatal care in 2006. The antenatal guidelines, whilst stating the need to address women's anxieties promptly, do not encourage screening for psychiatric illness in the antenatal period to predict postnatal mental health problems, as there is no evidence that this is effective. They do, though, clearly state that if the woman has previous mental illness she should be referred for specialist assessment (Sidebotham 2004).

These guidelines offer extensive information on medical-technical midwifery activities. Perhaps the romantic view of nursing and midwifery as vocations with women caring for others in an intuitive manner, still encouraged by some midwife academics (Ólafsdóttir 2009) was just a myth and flawed by human inadequacies. This will be considered again in the section labelled "Intimate relationship - use of self" (page 98).

Despite the extensive guidance on medical-technical care there has been reference throughout the centuries to the need for those caring for women becoming mothers to be kind, offering soothing words and reducing distress.

Unfortunately, with the progression of the professionalisation of midwifery and the medicalisation of childbirth, it is suggested that maternal emotional distress has increased (Littlewood and McHugh 1997), perhaps indicating that this kind caring is not occurring.

This overview has considered the development of midwifery from the wise women and handywoman to the twenty-first century professional midwife (Leap and Hunter 1993, Rhodes 1995, Littlewood and McHugh 1997, Tew 1998) with an array of skills supported by a wealth of policies and procedures (DoH 1993, 2004, NICE 2003, 2006, ICM 2006). There is general agreement that the transition has not been a smooth one; there is evidence of conflict between midwifery and other health professions and internal conflict between midwives and handywomen. The literature highlights that the role of those who support women becoming mothers has changed with technological interventions and education. Despite these changes it is still the midwife who, out of all the other health care professionals, has most contact with women at the vulnerable time of becoming a mother.

Current midwifery practice

On consideration of current midwifery educational texts, the development of the profession, legislation and policy, it can be agreed that midwives assist women during pregnancy, birth and the early days after the birth of the baby. How this is undertaken is now guided by government bodies through legislation and policy. The primary guiding policies at the present time (2009) are The National Service Framework (NSF) for Children, Young People and Maternity Services (DoH 2004), Antenatal Care (NICE 2003) and Routine postnatal care of women and babies (NICE 2006). Interestingly, the NICE guidelines do not use the term midwife when outlining postnatal care whereas the NSF clearly does.

The NSF (DoH 2004) offers a vision for maternity care which promotes a flexible and individualised service for the journey through pregnancy and motherhood with a particular focus on those women who are disadvantaged or

vulnerable. Whilst midwives would appear to agree that flexible individualised care is important, they do not appear to wholly agree that there is a need to focus on the disadvantaged and vulnerable. Some suggest that all women need support as regardless of which socio-economic group they are in there will be differing but similarly problematic struggles with becoming a mother in the current social climate (Cattrell et al 2005).

The NSF (DoH 2004) also states that women should be 'supported' and 'encouraged' to have as 'normal' a pregnancy and birth as possible. Both midwifery and obstetric care should be based on evidence of good outcomes, clinically and psychologically, whilst putting equal emphasis on preparation for parenthood. This could be seen to have, unsurprisingly, a high correlation to the NICE antenatal (2003) and postnatal care (2006) guidelines with their focus on women-centred care and informed decision making. Despite this similar philosophical stance, a more detailed reading of the guidelines could lead the midwife to believe they should focus on screening and examination in the antenatal period and information giving in the postnatal period.

The antenatal guidelines give a clear outline of the appointments for the midwife to undertake during this period, giving both a schedule and content list. The postnatal guidelines likewise inform the midwife of the activities they should undertake and the skills they should employ in their appointments with woman. The postnatal appointments involve information giving to empower women to assess their babies and their own health problems. The skills needed by the carer of women at this time are to be able to physically examine mother and baby, support breast-feeding and recognise domestic and child abuse. Sidebotham (2004) does, though, remind midwives that these are only guidelines and that they should make their own professional judgements.

For some, the reading of the NICE guidelines may suggest that the role they are describing, which could be labelled 'being professional', is not the same one described at the beginning of this section where Baroness Julia Cumberlege used

words such as ‘vocation’ and ‘restoring well-being’. There has been a lot of discussion within midwifery literature related to these two contrasting views of the midwife. The two views are the professional, technically and biomedically orientated midwife and the midwife practising ‘being with woman’. The NSF appears to offer a way of viewing midwifery that is both ‘with woman’ and ‘being professional’ but these two contrasting ways of viewing midwives will continue to be discussed throughout this literature review.

Summary

The role of the midwife has developed since the beginning of civilisation. It has mostly been the role of women to support others in childbirth and over the centuries they have faced extensive subordination. This may still influence women in the current society and midwives. Despite this subordination midwives have gained professional status, but this appears to have created a further dilemma for midwives over what a midwife is.

A midwife may be a person who comes alongside a woman as she moves along her journey to motherhood, developing an intimate relationship with each other, or they may be a technologically and biomedically knowledgeable and skilled professional, or perhaps a unique blend of both. I believe it is possible to be both, but that would make a midwife a very special kind of person.

This section has explored what a midwife is, according to the available literature including government initiatives and professional body guidance. There are those that suggest that the philosophy of care a midwife should adhere to is being ‘with woman’, offering understanding, kindness and comfort (Leap and Hunter 1993, Rhodes 1995, Kirkham 2000, Page and McCandlish 2006). Others imply that the focus or philosophical underpinning a midwife should have is a professional one with a greater emphasis on biological and technical care (DoH 1997, 1998, 2000, NICE 2003, 2006). There are, though, those who recommend a mixture of the two approaches (DoH 2004, ICM 2006). These two ideologies or philosophies of care will be revisited in the section entitled “What are

midwives' experiences of supporting women?" (page 103). The most powerful of the influences on what a midwife is could be seen to be government-funded sources (NICE, DoH, NHS) who employ most midwives. This could lead midwives to believe that the professional ideology should be adopted; this would then influence how they behave and what they do.

The next question to be considered in this literature review is 'what does a midwife do' this includes a more detailed examination of their role. It explores both the detail of what literature says a midwife should do and the studies that examine what they are actually doing.

What do midwives do?

It was important to assess if giving emotional support to women becoming mothers was part of a midwife's role and, if so, how they are taught to provide it. Therefore this section explores what a midwife does. The Nursing and Midwifery Council (the governing body of midwives in the UK) states that a midwife "will work in partnership with women and their families to give support, care and advice during pregnancy, labour and the postnatal period" (NMC 2009).

In the previous section it was acknowledged that there are two competing philosophies or ideologies underpinning midwifery care. The NMC stipulation, above, needs to be followed regardless of the ideological stance of the midwife. It can be seen that within both of these ideologies midwives are expected to "work in partnership with" women and their families and they therefore need to develop a partnership or relationship with women. To provide support, care and advice, as stated, within both ideologies, midwives need to be technologically and bio-medically knowledgeable. With this basic understanding, what a midwife does is going to be explored in more detail in this section in order to identify if offering emotional support to women is part of the modern midwife's role and, if it is, how they do it.

The International Confederation of Midwives (ICM), which works with all United Nations agencies and represents 72 nations of the world, produced a definition of the midwife and outlined the preparation that is required for the role (ICM 2006). They also identified key midwifery concepts such as respecting dignity and advocating for women, the scope of midwifery practice and the midwifery model of care. What is particularly significant for exploring what a midwife does, is the provision of the essential competencies for basic midwifery practice. These competencies also fulfil the guidance of the NMC code of conduct (NMC 2008). The ICM gives 6 competencies, which are broken down into basic knowledge and skills, additional knowledge and skills, and professional behaviours. The competencies include a sound knowledge base from all areas that may influence the woman's experiences from biological to

cultural. They state that midwives need knowledge of and skills in pre-pregnancy care and family planning, care and counselling during pregnancy, care during labour and birth, postnatal care and care of the new born (ICM 2006).

Midwives in the UK are also guided, as previously indicated, by a number of governmental papers, particularly Changing Childbirth, which advocates choice, continuity, and control for pregnant women, which they say facilitates women-centred care (Department of Health 1993). These elements, along with the NICE guidelines and NSF, will directly influence what a midwife does and when. It is also important to recognise that these guidelines do not explicitly conflict with the competencies laid out by the ICM.

Accepting the above, midwives should provide women-centred care and information to facilitate women's informed decision making. They should provide and organise care, manage common symptoms of pregnancy, and perform clinical examinations and screening using evidence based approaches (NICE 2003). The postnatal care giver should provide individualised negotiated care; as part of this, timely information including the signs and symptoms of potentially life threatening ill health of mother and baby should be given. They should also promote breast-feeding. Women should be asked about their support needs and coping strategies and be encouraged to tell health care professionals about their mood, emotional state and behaviour that is outside of their normal pattern. It is important to remember that it is not stated in the postnatal guidelines that a midwife must undertake this role (NICE 2006).

Some overarching skills can be seen in the above lists, which are assessment, provision and evaluation of evidence-based care in negotiation with women to ensure women-centred individualised care. To achieve this, midwives, or those caring for women at this time, need to develop partnerships or relationships with women, supported by good communication skills including information giving and information receiving ability. Alongside this, they appear to need clinical skills such as examination and evidence appraisal skills. The vision provided by

the NSF (2004), which is supported by the key concepts of the ICM (2006), both of which name midwives to provide this care, would support the need for the above but also highlight a need to emphasise the care needs of vulnerable and disadvantaged women, encouraging women to have 'normal' births and helping parents prepare for parenthood.

These guidelines are quite extensive and studies have been undertaken to explore if midwives are fulfilling them and which guidelines are considered by them to be the most important. Butler et al (2008) set out to find which of the competencies outlined above were the most crucial for those completing their midwifery programmes to work as registered midwives. They found, by conducting a qualitative study, that a wide range of midwives felt that the most crucial elements of being a midwife were being a safe practitioner, having the right attitude and being an effective communicator. Being a safe practitioner had three dimensions, which were having a reasonable degree of self-sufficiency, using up-to-date knowledge, and self and professional awareness. To achieve this it was stated that the new midwives needed to have 'the right attitude' which was to be caring, kind, compassionate and empathetic. Without good communication skills it was felt that safe practice and the right attitude would be very difficult to demonstrate.

Despite all the above expectations of a midwife, the one concept that could be seen as central and is regularly used to describe what midwives do is *care* (McCourt et al 2000, Stewart 2004, Page and McCandlish 2006). This is the same for nurses. Indeed the Nursing Midwifery Council (NMC 2008) identifies that the role of midwives and nurses is to provide care. Therefore this would appear to be an appropriate concept to explore first in more detail when considering what a midwife does, in order to allow a greater understanding, in contrast to offering lists of guidelines and recommendations as above.

Care

"Consistent professional care is a form of love. It entails a personal commitment by the person offering care which cannot be captured solely in the language of contract"

(Campbell 1984: 6).

Care or caring can be seen to be a rather nebulous term, being applied to both personal attributes and overt behaviours; it can be both noun and verb. Despite this, most people believe they have a sense of what 'to be caring' means: it is only when there is an attempt to develop a clear definition that addresses all elements of care that problems occur. This can be seen in The Nursing and Midwifery Council's (2004: 13) leaflet, which provides the code of professional conduct for nurse and midwives; it offers "to provide help or comfort" as a definition of care.

There are a number of basic and introductory texts that explore the concept of caring. One such text (Richards 1999) suggests that there are a number of factors which influence care, particularly the caring relationship. The factors include elements such as time available, the care setting, needs of caregiver and receiver, support for both and the skills and expertise of the caregiver. The skills and expertise the caregiver should possess are sensitivity, understanding of care needs and an ability to respond to these needs. For the caregiver to be able to respond to the client's care needs they should develop their communication skills including empathy and self-awareness (Richards 1999). This demonstrates that caring is a complex and skilful task; despite this there seems to be a general assumption that these are skills or attributes that people possess naturally, that do not require learning and do not attract status (Bolton 2000, John & Parson 2006).

Care and caring are identified as the central process in all the helping professions (Morrison 1992). There have been a number of theorists and researchers interested in the phenomenon of caring, including theologians such as Campbell

(1984), nurses such as Leininger (1985), and midwives such as McCourt et al (2000).

Theories related to care have developed over the last few decades; in the 1970s Madeline Leininger proposed a cultural theory of care and Jean Watson the theory of human caring. In the 1980s Simone Roach established her theory of human caring in nursing and in the 1990s Boykin and Schoenhofer their theory of nursing as caring (McCance et al 1999). These theories originated from differing conceptual origins but have similarities in that they all at least imply that nursing care is humanistic in nature and involves "attitudes and values on the one hand and activities on the other" (McCance et al 1999: 1392).

The theory developed by Leininger (1985), initially a mental health nurse, originated from an anthropological perspective and was labelled 'the theory of cultural care'. Her theory considered the universality and diversity of caring leading to a culturally sensitive approach in nursing. Watson's theory (1985), again a mental heath nurse by background, was based on a form of humanism and has origins in the philosophy of being and knowing but she also acknowledges the influence of Leininger in her theory development (Cohen 1991). She offered ten carative factors and a focus on transpersonal caring. Her carative factors can be seen to have a strong spiritual element based in existential phenomenology and humanism. There have been at least forty studies conducted using her theoretical framework, which have had a significant impact on nursing (Smith 2004).

Roach, like Watson, was influenced by the philosophical approach of phenomenology, particularly Heideggerian, and also has a clear focus on theology (McCance et al 1999). Watson, though, appears to have been more influenced by the theory of Carl Rogers, the humanist. Roach identified that caring is not unique to nursing but is unique within nursing, which has also been said of midwifery (Lundgren 2004). She conceptualises caring in her 'five Cs'; compassion, competence, confidence, conscience and commitment (McCance

1991). Boykin and Schoenhofer's (1993) theory of caring can be seen to reflect some of the views set out by Roach in that they, too, identify caring as a human mode of being. Caring is an essential feature of human being and it is a shared experience between carer and cared-for. All four of these theories recognise the importance of the relationship between carer and client, highlighting the overarching acceptance of humanistic theory in caring (McCance 1999).

Caring from a theological perspective has been labelled 'moderated love' (Campbell 1984, Kendrick and Robinson 2002). In fact there have also been nursing theorists (Freshwater and Stickley 2002, 2004) and midwifery theorists (Hall 2001) who have suggested that the caring relationship is a type of loving relationship. This, though, can create problems for some and so there have been attempts to re-label this caring relationship to remove the sexual implications of this 'moderated love', both sexual stereotyping and romantic love (Campbell 1984, Morrison 1992). Given professional traditions, policies and legislation within which 'moderated love' occurs it has been suggested that the professional caring relationship is labelled the 'skilled companion' (Campbell 1984).

Kendrick and Robinson (2002) wrote that instead of reframing loving care, as suggested by Campbell and supported by Morrison, that the caring relationship should be accepted as a loving relationship. This type of love would be recognised as *agape* as accepted within the Christian tradition, and the relational ethic applied. The relational ethical principles of inclusive community, social freedom and equal respect might address the concerns about the sexual views of love.

It is quite interesting that, for some, there is a need to remove any link between sexuality and caring whilst there is a body of literature that recognises and rejoices in the sexual nature of professional midwifery care (Devane 1996, Robertson 2000, Hall 2002, Williams 2004). It may be that midwifery care is different from the types of caring that are seen in other helping relationships.

The caring relationship has been likened to the relationship between mother and child; it is seen as a mothering relationship. There is a debate within midwifery about whether it is appropriate for midwives to take on a mothering role. Some midwives suggest that it is unhelpful for midwives to 'mother' women becoming mothers (Kirkham 2000) and other caring theorists (Campbell 1984) support this. This is because it is seen as unhelpful to infantilise adults who need help and care. Some midwives, though, suggest the midwife behaving as a good mother towards women becoming mothers can act a role model for them and provide support (Hildingsson and Häggström 1999).

Although the relationship between midwife and woman is unique (Lundgren 2004) there are many elements of the care of nurses and midwives that overlap (Way 2000). Indeed, less than a hundred years ago midwifery was seen as a branch of nursing (Leap and Hunter 1993). Therefore the theories discussed above and research into nursing care can be helpful to explore when considering the caring undertaken by midwives, as long as there is recognition of the uniqueness of the midwife-woman relationship (Lundgren 2004).

Nursing research informs us that physical nursing activities or care can be seen as an outward symbol of caring and offer a bridge to a woman's or patient's inner world but to be effective in providing care there is also the need for good interpersonal skills (Morrison 1992). Despite this a distinction should not be made between 'instrumental' (nursing tasks) and 'expressive' (interpersonal communication) roles within nursing, as both can and do have an impact on caring and the achievement of comfort (Benner 1984). This can be seen to relate directly to midwifery's instrumental and expressive care.

For some the experience of being cared for is an experience of overwhelming vulnerability, due in part to the illness that brought them into care but also to their vulnerability to professional carers. The care environment was not seen for some as a place of comfort but as a place of fear and anxiety (Morrison 1992). To address this, patients developed survival tactics but also identified their

respectful admiration of the nurses. Carers should therefore recognise the patient's lifeworld experiences and consider this when providing care. This had been recognised previously and it had been suggested that "caring cannot be controlled or coerced; it can only be understood and facilitated" (Benner 1984: 171). The development of strategies to understand care is important and meanings and commitments should be taken into account, both personal and cultural for client and carer (Benner 1984).

Summary

As has been seen so far, caring is considered to be a key element of health professionals' work. As would be expected, this is true for midwives. However, there does not appear to be a consensus about what this entails for them (McCourt et al 2000). There are, though, theories of caring that can guide the carer, which have some overarching elements. These elements appear to be that being caring is part of being human; it is humanistic in nature and involves a state of mind and certain behaviours. Despite a lack of consensus over what good midwifery care is, this is what women expect (McCourt et al 2000).

Caring in midwifery

A significant study was undertaken to explore caring in midwifery by McCourt et al (2000). In part of their main study they interviewed 20 women from a number of minority ethnic groups, who had all given birth in the previous three to six months. The data was analysed using a grounded theory approach. From this group of mothers a number of dimensions and attributes of caring arose. The themes from the analysis were: choice and knowledge (self or expert knowledge), concepts of care and support, communication and information, professional attitudes and relationships with women, continuity of carer, and confidence and trust. From these themes, six dimensions and attributes of caring, it was identified what these women would have liked in the midwives caring for them. They would have liked the midwives to have an attitude of friendly presence and to respect their knowledge and themselves. The women wanted to be supported psychologically and physically by the midwife who should offer the

kind of help they needed when they needed it rather than at the midwives' determination (McCourt et al 2000). The desires of this group of women relate very closely to the four theories of nursing care and the theologian's 'moderated love' or agape.

These women felt that care involved reassurance that they would know who was caring for them. The midwives would be able to provide physical and practical care at a high standard and the women would be treated honestly. Along with this, these women thought that good communication skills and interest in their pregnancy were elements of caring. Good communication skills in health care professionals have already been identified as necessary (Morrison 1992, Morse et al 1992, Richards 1999) but this study identified the importance for midwifery specifically.

The implications from research studies (Morrison 1992, Morse et al 1992, McCourt et al 2000) and the Government initiatives (NICE 2003, 2006, DoH 2004) are that midwives need to develop relationships with women in which they demonstrate expertise and good communication skills along with respect, empathy and interest. As care, including expertise and good communication, is considered to be demonstrated through the midwife-woman relationship, the next subsection will explore the available literature in this area.

The midwife-woman relationship

The midwife-woman relationship has been identified as the central element of midwifery care in numerous studies (Fleming 1998b, Fraser1999, Walsh 1999, Pairman 2000, Kirkham et al 2002, McCourt 2005, Hunter 2006). There is also evidence to suggest that the relationship between midwives and women affects the quality of the childbirth experience for women (Anderson 2000, Hunter 2001). Despite the significance of this relationship, it has received little research attention (Hunter 2006). Indeed Kirkham (2000) was surprised when editing her book 'The Midwife-mother Relationship' that a book of its nature was not

already available. A browse through the midwifery educational text also demonstrates a lack of focus on this important area of midwifery practice.

In her book, Kirkham and her colleagues explore the nature of the midwife-woman relationship and the confounding factors such as the driving force within health services where the aim is to achieve the maximum health gain for the minimum use of resources. Developing relationships can be resource heavy and, given that pregnant women are not generally unhealthy, a paradox may occur. In the twentieth century, health provision, including midwifery, was hierarchically organised with medicine holding the more senior positions with most authority. This could lead to those lower on the hierarchical ladder adhering to, and accepting, the value base of the more dominant groups and suppressing their own values. This is suggested to have occurred within midwifery, leading to the relationships between midwives and mothers becoming in some ways oppressive, with mothers being treated like children (Kirkham 2000).

A caring and supportive relationship between midwives and women can be difficult to achieve and maintain within the current culture in health (Fraser 1999, Levy 1999c, Kirkham 2000, Kirkham et al 2002a, Stapleton et al 2002a). This can lead to stress and tension in midwives (Hunter 2006) and a perception of this work as low status. It would appear that the value of the development of midwife-woman relationships in maternity care is only acknowledged when absent (Kirkham 2000). This can be seen to lead midwives to alienate women from their own experiences in favour of the expert's experience (Wilkins 2000). The lack of opportunity for women-centred care appears to be particularly problematic in large institutional maternity provision (Hunter 2004). Despite midwifery's traditional knowledge and research knowledge complementing each other, the authoritative knowledge of the organisation appears to prevail (Kirkham 2000).

A review of studies pertaining to the relationship between midwife and woman, although evidence is limited and inconclusive, suggest that from the woman's

perspective, active presence, mutuality and intimacy are pivotal in the development and maintenance of the relationship (Hunter 2006). Evidence regarding the midwives' perspective on this relationship is likewise limited and the studies available suggest that the relationship may be influenced by situational factors and that there may be differences between midwives' reports and women's perceptions (Fleming 1998a, Fleming 1998b, Kirkham et al 2002a, Hunter 2006).

A large study, conducted in New Zealand and the UK, explored the relationships between women and midwives (Fleming 1998a). Two hundred and fifty midwives and two hundred and nineteen women were interviewed and the data analysed using a grounded theory approach with elements of interpretative phenomenology. The core categories found were attending and presencing, supplementing and complementing, and reflection and reflexivity. Linking the core categories was the social process of reciprocity. There were also found to be discrepancies between the reports of midwives and women (Fleming 1998a). The study on the whole though, does appear to correlate with Hunter's (2006) review, which identified 'attending' as important and the centrality of reciprocity within these midwife-woman relationships. A qualitative study using a feminist approach was also conducted in New Zealand (Fleming 1998b). This study employed individual interviews, videotapes and group interviews with 12 midwives and 20 women. This, like the previous study (Fleming 1998a), was focused on the relationship between midwives and women. Within this study, again, contradictions in the perceptions of the midwives and women on their relationships were found (Fleming 1998b).

This subsection focusing on the midwife-woman relationship has highlighted the cultural problems for the midwife trying to undertake this way of working (Kirkham 2000, Wilkins 2000, Hunter 2006). Sadly, even when the midwife does believe she has achieved a reciprocal relationship it may not be perceived as such by the woman (Fleming 1998a, Fleming 1998b, Kirkham et al 2002a, Hunter 2006). Despite this, both midwives and women appear to need a

reciprocal relationship within which midwives offer active presence and intimacy (Fleming 1998a, Hunter 2006).

The different types of midwife-woman relationships have been simplistically labelled reciprocal, unsustainable exchanges, and rejected exchanges (Hunter 2006). Only reciprocal relationships are said not to create emotion work for midwives. The conversational styles within these interactions have been categorised into 'partnership', where midwives are collaborative and participative, 'professional', where midwives provide expert guidance and 'disciplinary', where midwives provide expert surveillance (McCourt 2005). The most common style found to be used by midwives is the professional style but situational factors did seem to influence how collaborative the interaction was and the midwives seemed unaware of the style they were adopting. It would appear that the disciplinary style is the one most likely to be rejected given its impact on health promotion (McCourt 2005). The reciprocal relationship and partnership interactional styles intuitively go together. It may be that the effort to achieve this type of relationship leads midwives to adopt the professional style but this could be unsustainable in longer term or supportive relationships.

Despite the mismatch between midwives' and women's perceptions, it would appear that both recognise the importance of this relationship and the cultural problems associated with it. To develop and maintain therapeutic or trusting relationships it is recognised that the midwife needs to have good communication skills (Morrison 1992, Richard 1999, McCourt et al 2000). The next subsection will therefore explore in more the detail the evidence demonstrating the communication skills of midwives.

Communication skills

When people such as midwives and women come together there is always communication whether this is directed towards something or someone or not; it could be the communication of being tired or busy or perhaps alert and interested (Kirkham 1993). Communication skills are used extensively in midwifery

(Kirkham 1993, Pairman 2000), indeed they are one of the three crucial competencies that a new midwife needs (Butler et al 2008). Despite this there is a lack of clarity about the techniques used (McCourt 2005). Communication is of primary importance to the women but they have had mixed experiences of this in the care they received (Fraser 1999).

A study was undertaken using semi-structured and structured interviews and women's case notes (Fraser 1999). Forty-one women were interviewed during pregnancy, in hospital following birth and in their homes two to three weeks later. These produced data that was analysed using a software package that facilitates data handling in a method similar to that of grounded theory. Themes were sought which were grouped into categories and subcategories.

The women all expressed the desire to feel special and for the caregiver to help them relax, to be in control and to advocate for them. Seven of the forty-one women were unhappy with the communication skills of the carer and three were particularly upset with what they saw as "inappropriate attitudes between the professional groups" (Fraser 1999: 103). Although the midwives were seen to be clinically competent, some of the women were critical of the support and information that they were given. Half the women gave up breast feeding, stating that the primary cause was due to inadequate help. Some women also identified that some midwives were task orientated and that informed choice was just rhetoric.

Communication has been found to be important regardless of the care setting (Kirkham 1993, Fraser 1999, Walsh 1999). Walsh's study was developed to compare the experiences of women who had previously given birth to their babies supported by conventional care but this time were cared for within a partnership caseload model of care. Walsh's study (1999) used an ethnographic approach; he interviewed ten women 8-12 weeks after the birth comparing this scheme with previous experience of conventional care. Within the partnership caseload scheme the women felt that their relationships with the midwives were

personal and intimate and labelled the relationships as friendships. The women felt valued, respected and cared for; some felt empowered and in control. It would appear that where special schemes like this one are set up to address the recommendations of the Changing Childbirth document (DoH 1993) they are well evaluated, but that may be due to extra resources being made available and more innovative and enthusiastic midwives taking part. Despite the differences in the women's evaluations of care between Fraser's and Walsh's study, communication and the relationship between midwife and woman were said to be important.

The environment in which the relationship is enacted appears to influence communication (Kirkham 1993). When midwives visited women in their homes the atmosphere was more relaxed and conversation more fluid, facilitating the opportunity for the women to ask questions at their own pace (McCourt 2005). A relaxed approach using general conversation by the women and midwives can also act as a tool to maintain normality of the childbirth process and to maintain an atmosphere of calm (John and Parsons 2006). Interestingly, this approach can comfort people who are suffering ill health as well (Williams and Irurita 2004).

For most health care professionals, understanding of their communication skills has developed from psychological theory and research, particularly from the Humanist tradition such as Rogers (1950) and Egan (1977). According to the Humanists, there are four core conditions to therapy or therapeutic communication, which are: empathy, genuineness or congruence, warmth, and unconditional positive regard (Stewart 2005: 108). A general adoption of psychological approaches by other health care professionals can, though, be problematic (Morse et al 1992). In particular the adoption and pressure to engage unquestioningly with the concept of empathy may be a problem. It is questionable whether health care professionals, other than therapists, should accept that there is a need to demonstrate empathy as this might put too high a

burden on them. This might then lead to ill health or avoidance of care by the professional (Morse et al 1992).

Egan (1977) took the foundational work of Rogers (1950) and developed it to form the role of the 'skilled helper'. He developed both instructors' manuals and student worksheets to facilitate the development of communications skills. Neither Rogers (1950) nor Egan (1977) see these skills to be the exclusive property of psychotherapy; they recognise they can be used by anyone who wishes to help others. There is a wealth of psychological literature pertaining to communication skills but those from the humanist tradition of psychology are the most commonly taught to health care professionals.

This subsection has considered communication skills, in a general sense. It is clear that communication is a crucial element of showing care. When the care giver communicates effectively, particularly demonstrating positive regard, being honest and warm, the experience of the receiver is enhanced. The rest of the discussion on communication has been separated into specific areas. They are listening, touch and information giving.

Listening

> "*It is as though he/she listened and such listening as his/hers enfolds us in a silence in which at last we begin to hear what we are meant to be"*
>
> (Lao-Tse cited Nelson-Jones 1995: 40).

Listening is probably the most important part of communication (Burnard 2002) and there is specific guidance for listening and attending available, particularly in psychological literature (Egan 1977).

Competence in and the ability to develop relationships are both influenced by the listening skills (Hall 2001, Williams and Irurita 2004) as described by Egan

(1977). Despite the limited available literature these appear to be the skills that midwives are using; midwives can be seen to use open ended questions and focus on the woman to explore and understand the woman's perspective (Lundgren and Dahlberg 2005). Appropriate non-verbal interactions such as listening facilitate the feeling of being valued in a patient, which can be seen to play a part in developing personal control and emotional comfort (Kirkham 1993, Hall 2001). The non-verbal abilities that facilitate this feeling of being valued are having eye contact, sitting in close proximity, and displaying gentleness and concern through touch, active listening and smiling (Williams and Irurita 2004).

Communication skills are accepted as being of paramount importance to women, yet some of them have been unhappy with the communication skills of their caregiver in maternity services (Fraser 1999). Women described poor communication skills and included statements such as "she didn't relate to me", and "staff on the ward knocked my confidence". They were also critical of the attitudes of the caregivers and included statements such as "treated me like a naughty child" and "rude and shouted at me". Women identified that good communication involved abilities such as; "able to explain things" and "being a good listener" (Fraser 1999: 102).

Good communication has also been found to improve the experiences of labouring women (Hall 2001, Lundgren and Dahlberg 2005); talking and touching increased comfort and when a woman is more distressed purely listening is more helpful (Schuiling and Sampselle 1999). Most of the women in Fraser's study (1999) were impressed with their overall care but sadly Kirkham et al (2002a) found, when evaluating the implementation of an information leaflet, that midwives were focused on tasks rather than listening to the women.

There is evidence that good communication is not being experienced by all women who access maternity services and listening is probably the most important skill within communication. Therefore it can be assumed that some midwives are not actively listening to women. There is evidence to suggest that

listening is important to facilitate a feeling of being valued (Kirkham 1993, Fraser 1999, Hall 2001, Williams and Irurita 2004) and a feeling of comfort (Schuiling and Sampselle 1999). Gaining respect or being valued is an underlying philosophy of the NSF (DoH 2004) and comfort is stated by the midwives' professional body (NMC 2004) to be the aim of midwives. Listening could therefore be said to be central to 'what midwives do', but according to this literature that is not always the case.

Touch

"The need to be touched, held, nurtured is with us from the very beginning to the end of our life"

(Campbell 1984: 110).

Touch is an important component of the therapeutic relationship along with other non-verbal responding, which could include: postural echo, nodding, smiling and the use of silence (Egan 1977). Touch is an extremely valuable tool when attempting to emotionally care for a person but the carer needs to be sensitive and assess when touch is appropriate (Kirkham 1993, Morse 2000). Within our Western culture many are uncomfortable with touching those they do not know well but touch should depend on the physical and psychological condition of the person as well as this cultural element.

Two types of suffering have been identified and labelled emotional and enduring suffering (Morse 2000). Enduring suffering is where a person shuts off their emotions to cope whereas emotional suffering is where a person releases their emotions. Enduring suffering is where a person is protecting themselves from suffering, and to provide comfort at these time carers use strategies to support this to show respect for the person. Strategies usually accessed at this stage are encouragement and praise. Whereas when a person is suffering, emotionally responding to their situation, care givers physically support the person by hugging, holding and extensively using touch.

Midwives use touch, not only to address observed cues of suffering, but also as a means of developing rapport with women (Kirkham 1993), this calls for extra effort (John and Parsons 2006). They developed rapport, which they believed was an important part of developing a therapeutic relationship, through "basic care, touch, facial encouragement, chit chat and sharing part of *themselves*" (John and Parsons 2006: 268). Likewise people who are unwell feel valued and comforted through displays of gentleness and concern by using touch (Williams and Irurita 2004).

Kitzinger (1977) reminds midwives that touch is important in showing care for women. She even identified different types of touch midwives might use including comfort touch, diagnostic touch and physically supportive touch. It is, though, important to be insightful about when it is appropriate to touch and when to use which type of touch (Kitzinger 1977, Morse 2000).

Touch can therefore be seen to be an important element of a midwives communication as part of their therapeutic relationships (Kitzinger 1977, Morse 2000, John and Parsons 2006). Whilst there needs to be recognition that touch should be used sensitively, if done so, it may offer considerable comfort to the woman (Kitizinger 1977, Schuiling and Sampselle 1999, Morse 2000, Williams and Irurita 2004, John and Parsons 2006).

Another important area in the communication of midwives is information giving. There is great emphasis from the modern NHS, professional bodies and government guidelines for health care professionals, like midwives, to ensure, as part of their communication with their clients and before commencement of any treatment, that they give accurate information and gain informed consent. This will therefore form the next subsection of this literature review.

Information giving

Giving information has been widely discussed in midwifery literature, some of which highlights the powerful positions of those who hold information or knowledge (Lomax and Robinson 1996, Levy 1999a,b,c,d,e). Information giving is highlighted in government guidelines (NICE 2003, 2006, DoH 2004) and it has been identified that information giving is the main feature of the 'booking visit' (McCourt 2005) which is where women are first registered for maternity services.

Although there is a wealth of literature on communication and information giving, these terms are singularly unhelpful in understanding what midwives actually do (Robinson and Lomax 1996). To address this concern conversation analysis has been used to develop a greater understanding (Lomax and Robinson 1996). Videotaped postnatal consultations between midwives and women in both hospital and the women's homes were taken. It was found that when the data was analysed using a conversation analytical style of data analysis, midwives were not adhering to the women-centred approach advocated in either hospital or home setting (Lomax and Robinson 1996), unlike previous and subsequent studies' findings (McCourt 2005).

McCourt (2005) conducted a study to explore whether the booking appointment or first appointment for the pregnant women to meet with the midwife and exchange information was the same experience for all the women within the same geographical area. This observational study was developed as there seemed to be an inconsistency between an audit of case notes and the opinions of the women using the service. The audit found no difference between 'case load' and 'conventional care' whereas the women felt there was a better quality of care within 'case load care'. Forty appointments were observed and it was found that the interactional style of the midwives was different for 'case loading' and 'conventional care' (McCourt 2005).

In conventional care in hospital and clinic settings, the interaction styles were led by history taking followed by information giving and then an opportunity to ask questions. It was formalised and structured, whereas the case-load appointments in the women's own homes were quite different, the information giving and receiving was more fluid and variable (McCourt 2005).

Despite the credibility of McCourt's study (2005) it needs to be accepted with caution as midwives have been found to take control and set the agenda for the interactions within the midwife-woman communication and information giving (Lomax and Robinson 1996, Levy 1999b). It was found that midwives dictated the agenda and did not explain it or ask the women for their opinion. In hospital and home visits the timing of the interactions were decided by the midwives; the women were not given a time for these meetings and they occurred regardless of what the women were doing. The midwives dictated closure on the interactions with consent assumed rather than sought. They also did most of the talking. They talked at length while the women attended fully but when the women talked the "midwife did not attend fully to client talk, frequently turning away and writing notes. In fact given the frequency of this activity by midwives it would not be unreasonable to suggest that midwives invite clients to speak at length in order that they may accomplish clerical aspects of the visit" (Lomax and Robinson 1996: 254).

Unfortunately the literature on information giving shows a lack of consistency with some suggesting that differences in approach are due to the situation (Walsh 1999, McCourt 2005) and others stating that midwives take control regardless of the setting (Lomax and Robinson 1996). It is suggested that it can be difficult for women to gain the information they feel they need due to complex power relationships, which underlie information-giving behaviour (Kirkham 2000, McCourt 2005).

Levy (1999a,b,c,d,e) explored information giving in her study, and has written a number of papers related to information giving as a means of developing

informed choice. Levy (1999d,e) conducted a study using grounded theory to explore the information-giving practices from the perspective of midwives (1999d) and from the perspective of the women (1999e). She observed the midwives and women in 12 booking appointments, as in McCourt's (2005) and Lomax and Robinson's (1996) studies, but she also interviewed each of them individually. Levy (1999d,e) found that giving of information is not as simple a process as other studies may indicate (Lomax and Robinson 1996, Walsh 1999, McCourt 2005). She identified powerful forces involved in information giving, which involved the gate keeping role taken by midwives and the manipulation of the information giving agenda by them.

Midwives used a process called 'protective steering' to facilitate informed choice (Levy 1999d). This process involved three main activities, which were orientating, protective gate keeping and raising awareness. The midwife, in order to undertake this highly complex activity with limited time, 'picked her line' between orientating, gate keeping and raising awareness. Orientating was where the midwife found out the position of the woman, her expectations, and how these related to the organisation and the midwife through what Levy labelled 'sensitising'. To achieve this within a limited time scale the midwives accessed techniques such as 'stereotyping' and 'territory mapping'. The midwife, through setting the agenda for information giving, elucidating and offering choices, conducted the activity of raising awareness. The other activity undertaken, labelled 'protective gate keeping' is where the midwives provided information but also guarded and controlled it. This 'protective steering' was undertaken to ensure that safe, realistic and acceptable choices were made for the woman, midwife and organisation.

Information giving, as has already been established, is a significant part of a midwife's role, so any exploration of what a midwife does needs to consider this area. Levy's study offers the best available understanding of what may be happening when midwives give information and offers an explanation of why midwives have been found not to give all the available information to women.

Her study also offers another insight into the culture in which midwives are offering emotional support.

Alongside the process identified as 'protective steering' (Levy 1999d) is a study that offers the experiences of the woman in the same phenomenon. This process arising from the experiences of women has been labelled 'maintaining equilibrium' (Levy 1999e). This was explored using grounded theory and the core categories found were actioning, contextualising and regulating information. Each woman maintained equilibrium by dealing with information by actioning, contextualising and regulating it to protect and keep safe herself, the baby and her family, at what was, for her, a time of great transition. In each of the activities of maintaining equilibrium the women used different strategies.

Levy's research (1998a,b,c,d,e) is helpful in offering a deeper understanding of what might be happening in the studies of Lomax and Robinson (1996), Walsh (1999) and McCourt (2005). In their studies (Lomax and Robinson 1996, Walsh 1999, McCourt 2005), women appear to be naive participants or recipients of midwives' advice, which does not appear to be the case in Levy's studies. All of these studies, including Levy's, highlight the powerful position of those holding knowledge or information. Levy offers a view of information giving and receiving as a complex interaction with both parties taking active roles with their individual agendas, not one where midwives hold all the power and control.

This allows for a greater understanding of the findings of the evaluation of evidence-based leaflets that were developed to inform choice in midwifery care. The Midwives Information and Resource Service (MIDIRS) and the NHS Centre for Review and Dissemination developed 10 research based information leaflets to help women make decisions on the choices available to them on their journey to motherhood. A number of papers have been published from this evaluation with O'Cathlain et al's (2002) randomised controlled trial and Stapleton et al's (2002a) qualitative study published in the British Medical Journal. Alongside this a series of articles were published in the British Journal of Midwifery

(Kirkham et al 2002a,b, Stapleton et al 2002b,c). Sadly the desired improvement of informed choice in midwifery care does not appear to have been achieved and these authors spell out their explanations for this.

The leaflets were not distributed in the way that had been anticipated due to the culture within maternity services. The hierarchical power structure, which placed obstetricians in the most authoritative positions, led to them defining the norms of practice (Stapleton et al 2002a). The midwives appeared to identify strongly with the medical and organisational power groups to avoid creating problems for themselves and the women they were caring for (Stapleton et al 2002b). They clearly identified the impact of stepping outside of the practice norms set by the medical team and organisation, such as their work being more scrutinised and the women being 'struck off' GP lists (Stapleton et al 2002b). Stapleton et al (2002c) go on to describe how the organisational impediments such as the midwives' conversational styles further reduce the opportunity for the change the leaflets might bring. This, together with time pressures and the belief that in litigious situations technical interventions would be seen more positively, acted to reduce the impact of the leaflets (Stapleton et al 2002a).

Kirkham et al's (2002a) paper entitled 'Checking not Listening', attempted to explain one element of this major study. They found that midwives were 'checking rather than listening' to women, they were doing obstetric observations rather than listening to the woman's needs, desires and concerns. The article clearly explains this discrepancy and offers the women's perception on why this occurred. The women saw the midwives as overworked and powerless, despite the midwifery rhetoric for woman-centred care. It may also be that midwives were attempting to improve their status by undertaking tasks that were more in keeping with medicine.

It could be suggested that the process of 'protective steering' (Levy 1998d) was being undertaken by the midwives in Stapleton et al's study (2002a,b,c). The midwives could be viewed as guiding the women to gain what they believe is the

best they can within the boundaries of the medical and organisational systems. Elements of 'maintaining equilibrium' (Levy's 1998e) in the women could also be identified in the evaluation of these information giving leaflets (Kirkham et al 2002a, Stapleton et al 2002a).

The tightrope walking identified in Levy's studies and Kirkham et al's (2002a) findings add weight to what has been labelled the 'inverse law' in midwifery care (Kirkham 2002b). This 'inverse law' refers to where the midwives stereotyped women into categories. These categories resulted in women of lower social economic classes receiving less information and support despite recognition that they might need more. Giving information and support took more time and so it was only the women who sought information that were responded to. Interestingly Kirkham et al (2002b: 509) state "this accommodating style of communication was accentuated if a male professional partner was present". Stereotyping can be seen as negative if it leads to discrimination but people use it extensively as a shortcut when time is limited (Barker 2007); it may also indicate discrimination and a gender bias (Kirkham et al 2002b).

Whilst information giving is recognised an essential part of a midwives' role (DoH 2004, NICE 2004, 2006) there is a lot of discussion about whether accurate information is being given (Kirkham et al 2002a, Stapleton et al 2002a) and whether this is being undertaken in a woman-centred manner as stipulated (Lomax and Robinson 1996, Walsh 1999, McCourt 2005). The explanation for this discrepancy may be found in the culture in which midwives are working (Levy 1999d, Kirkham 2000, McCourt 2005, Kirkham 2000) and the needs of women (Levy 1999e). The conclusions drawn from these studies, such as cultural pressures and that both midwives and women bring agendas to their interactions, can offer insight into other midwifery activities. It is also important to remember that information giving is one way in which to offer support and provide comfort (page 87).

It has been suggested that despite the importance linked to this part of a midwife's role, or 'what they do', by government, it may be seen as lower importance to midwives than other activities such as examination skills (Kirkham 2002a).

Despite the emphasis in ICM competencies (2006), NSF (2004), NICE guidelines (2003, 2006) and other midwifery literature (Fraser 1999, Butler et al 2008) on women-centred, individualised negotiated care, many foundational midwifery textbooks focus on physical care activities. Johnson and Taylor (2006) along with Way (2000) have no sections or chapters discussing communication or relationships. Other texts such as Wickham's (2005) and Fraser and Cooper's (2003) midwifery texts do offer some information on communication and midwife-woman relationships but it is still limited.

It appears that knowledge of, and skills in, physical processes are considered to be of high importance in the education of midwives. A newly qualified midwife might also be led to believe that this is the main focus of their role despite the findings of Butler et al (2008). It is therefore important that this knowledge and these skills are considered here when exploring what a midwife does.

Examination – clinical skills

Foundational midwifery texts are mostly separated into what the midwife should know and do at each stage of a woman's journey to motherhood. Some texts include pre-pregnancy and family planning but most have chapters on pregnancy, birth, postnatal period and baby related matters (Fraser and Cooper 2003, Wickham 2005, Johnson and Taylor 2006). The knowledge and skills expounded by these texts are prolific but the expectation is that the midwife is able to "diagnose and monitor pregnancies, labours and post partum progress" (Fraser and Cooper 2003: 3). Midwives should recognise changes and abnormalities and how to deal effectively with these. To do this they need to understand the normal functioning of the woman including their biology, psychology, and social and spiritual functioning. The journey to motherhood is a

'normal' process but the midwife's role is to check that things are progressing normally and only if they are not to intervene. The midwife enhances this process by offering information and education to women throughout.

Midwives employ what may be considered nursing skills as well as skills specific to women on this journey (Way 2000). These core skills (those used by nurses and midwives) include checking vital signs (temperature, pulse, blood pressure etc), infection control, wound management, drug administration, nutrition and elimination (Way 2000). Those more specific to midwifery may include abdominal examination (checking fundal height etc), assessment of foetus or baby (vital signs and movement etc), and vaginal and breast examination (Johnson and Taylor 2006).

It is a commonly held belief that midwives deliver babies (NMC 2009) but midwifery bodies (ICM 2006) and guidelines (NSF 2004) highlight that labour and birth are normal processes and that women only need assistance when things are not going as they should be. Despite government and professional body emphasis on negotiated care and education, midwifery educational texts appear, given the extent of the focus, to indicate that the biomedical knowledge and skills are the primary area for education. This focus on activities related to biomedical knowledge and skills can also be seen in some midwifery studies (Marsh and Sargent 1991, Kirkham 2002a).

Another part of a midwife's role is to promote health, according to the educational texts, which includes promoting 'normal' birth (NSF 2004, ICM 2006). The next subsection is therefore going to explore this area of 'what a midwife does'; heath promotion, particularly birth and the midwife's role in promoting its normality.

Normal birth

There appears to be some lack of clarity over the term “normal”. Normal behaviour in psychology has been much debated and a number of theories have arisen (Barker 2007). Similarly the definition of ‘normal birth’ in midwifery has also caused some debate. Midwifery is one of the few health care professions whose focus is on normality – the normality of birth. Most health care professionals focus on abnormality; distress, deviance, dysfunction or dangerous behaviours.

Despite the emphasis from midwifery bodies and government initiatives to promote ‘normal birth’ this remains problematic within our society. Not only are there problems with a clear definition for midwives to work with but there are also other cultural factors that need to be taken into account. These factors include the risk aversive, litigious culture (Fraser and Cooper 2003, McGuinness 2006) but also the women who are giving birth have expectations from their mothers of medical intervention (Skinner 2005). This becomes even more problematic when women might choose to have a caesarean rather than a vaginal birth when there is no medical necessity (Fraser and Cooper 2003). There is actually no conclusive evidence to support what normal birth is or when it should occur (Fraser and Cooper 2003, Phipps 2005).

As already stated providing a definition of normal birth is problematic. Downe (2006), though, suggests that there are three methods that could be used to define normal birth. The first is focused unidimensional clinical definitions such as the one used by the World Health Organisation. They state normal birth is “spontaneous in onset, low risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and baby are in good condition” (WHO1997 cited Downe 2006: 352).

The second definition is focused on multidimensional factors, such as the one from the Royal College of Midwifery (RCM). This includes elements such as

time in labour and risk status, but the RCM also states that birth is dynamic with a symbiotic relationship between mother and baby. The third definition is labelled 'Life course multidimensional'. This takes into account all the processes involved and the impact of the baby on the family with due consideration of the woman's experiences from her early childhood to the future (Downe 2006).

The definition of normal birth is so problematic that some prefer to be guided by a couple of principles: intervention should only occur if there are clear evidence-based clinical indicators, and to provide enough support to ensure that inappropriate intervention is unnecessary (Page 2000), which is difficult with care being restricted by current practices. Downe (2006) offers a way forward to achieve a useful definition. Whilst she recognises that what she is suggesting may be seen as a 'dream world' she is not apologetic for this. She suggests that birth ought to be seen as unique normality and as "an ordinary drama – not a crisis and not as a routine event, but as a one off exciting event, full of possibility" (Downe 2006: 354).

'Unique normality' (Downe 2006) may address both the specialness of each woman and the normality of their experience. This can be achieved by avoiding rigid rules and developing authentic respectful relationships between midwives and the women and families they care for (Downe 2006). Skinner (2005) would support Downe's way forward and she goes on to suggest that to promote normal birth midwives need to fit midwifery services to women and not fit women to the midwifery services.

Another significant area of health promotion specific to midwifery is the promotion of breast-feeding. This is again is supported by the ICM (2006), NSF (2004) and the postnatal guidelines (NICE 2006). The next subsection will therefore consider the literature related to the midwives' role in this area.

Breast-feeding

Breast feeding has been promoted by midwifery bodies for a number of years with the International Confederation of Midwives adopting a policy of promotion in 1984 (Fraser and Cooper 2003). The midwife's role in promoting breast-feeding is twofold (Fraser and Cooper 2003). Firstly the midwife needs to ensure that the baby is adequately fed at the breast and secondly to ensure that the mother has the skills to feed the baby herself. To do this the midwife needs to encourage and reassure the woman; offering her emotional support. The midwife should also educate the mother on how to attach the baby to the breast to reduce any discomfort. It may also be necessary for the first few feeds for the midwife to help attach the baby, offering an explanation of what she is doing (Fraser and Cooper 2003).

Despite research evidence to support the importance of breast feeding, many mothers chose not to do so. Fraser's (1999) findings suggest that this was, in part, due to a poor relationship between mother and midwife. The numbers of women breast-feeding is, however, increasing (Infant feeding survey 2000).

Summary

This section has considered what a midwife does; what the midwife's role is. Their professional bodies (ICM, RCM) as well as government initiatives (NICE 2003, 2006, NSF 2004) guide midwives to work in partnership with women. The role laid out for midwives by this guidance is complex and skilful.

The central concept of midwifery is 'care' and it is regularly used to describe what midwives do (McCourt et al 2000, Stewart 2004, Page and McCandlish 2006). The midwife-woman relationship has been identified as the central element of this 'care' provided by midwives (Fleming 1998b, Fraser1999, Walsh 1999, Kirkham 2000, Pairman 2000, McCourt 2005, Hunter 2006). There is also evidence to suggest that this relationship affects the quality of the childbirth experience for women (Anderson 2000, Hunter 2001) which increases its significance in the midwives' role. A caring and supportive relationship between

midwives and women can be difficult to achieve and maintain within the current culture in health (Kirkham 2000) and this can lead to stress and tension in midwives (Hunter 2006).

To develop and maintain the midwife-woman relationship, midwives extensively use their communication skills (Pairman 2000). They are recognised as one of the three crucial competencies that a new midwife needs (Butler et al 2008). Despite this there is a lack of clarity about the techniques midwives use (McCourt 2005) but there appears to be some indication that they are using the skills described by Egan (1977). Communication is seen as of primary importance to women too but they have had mixed experiences of this in the care they have received (Fraser 1999).

Some women accessing maternity services (Fraser 1999, Kirkham 2000) have not experienced good communication including listening, which is an important skill within communication (Burnard 2002). There is evidence to suggest that listening is important to facilitate a feeling of being valued (Kirkham 1993, Fraser 1999, Hall 2001, Williams and Irurita 2004) and a feeling of comfort (Schuiling and Sampselle 1999, Morse 2000, Hall 2001). Likewise touch can also be seen to be an important element of midwives' communication (Kitzinger 1977, Morse 2000, Hall 2001, John and Parsons 2006). When midwives use their communication skills, particularly touch, sensitively, it offers considerable comfort to the woman (Kitizinger 1997, Schuiling and Sampselle 1999, Morse 2000, Williams and Irurita 2004, John and Parsons 2006).

Information giving is also recognised an essential part of a midwives' role (NICE 2003, 2006, DoH 2004). There is a lot of discussion related to whether accurate information is being given. It has been found that this is not always the case (Kirkham et al 2002a, Stapleton et al 2002a). While some suggest that information is being provided in a woman-centred manner as stipulated (Walsh 1999, McCourt 2005) there is also evidence that this may not be happening (Lomax and Robinson 1996). The explanation for this discrepancy may again be

found in the culture in which midwives are working (Levy 1999e, Kirkham 2000, McCourt 2005) and the needs of women (Levy 1999e).

Alongside the development and maintenance of a therapeutic relationship, midwives also undertake other activities such as physical examination, wound management, drug administration, infection control, nutrition (Way 2000) and health promotion (Johnson and Taylor 2006). As part of their health promotion activities midwives are expected to promote normal birth and breast feeding (Johnson and Taylor 2006).

In conclusion this literature review has identified that what midwives are expected to do is skilful and complex but despite midwives frequently believing they are achieving expectations despite the toll on themselves, woman do not always perceive them to be doing so. There are many who would suggest that given the culture within which midwives are working it is not possible for them to care for women using the women-centred approach advocated.

The simplest way of describing the midwife's role or 'what midwives do', is to provide care to facilitate women's movement through the transition to motherhood safely. To undertake this monumental task midwives need a sound knowledge base, a caring attitude and good communication skills (Butler et al 2008). So what is motherhood?

What is motherhood – becoming a mother - and how is it experienced?

Introduction

The phenomenon being explored is 'how do midwives give emotional support to women becoming mothers', which could be phrased 'achieving motherhood'; this would suggest there is a need for this term to be clarified. This section explores the information available pertaining to motherhood and how women experience it. The section concludes by considering what a good mother is. This is particularly pertinent as the literature suggests that women become depressed and emotionally distressed as their expectations of themselves are too high. The women try to achieve an idealised stereotype of the 'good mother' (Brown et al 1997).

Mother n. 1. Female parent 7. Hence ~ hood n.

Motherly a. having or showing the good (esp. tender or kind) qualities of a mother (Sykes 1982: 660)

"Becoming a mother affects your life in ways you cannot even begin to imagine. It is one of the most dramatic and profound personal transformations a woman can ever experience. It will change your way of thinking in areas you believed had nothing to do with mothering. It will change how you view the world. It will change how you relate to other people. It will change how you see your past, present and future.

Your experiences will take you on a breathtaking journey as intense in joy and euphoria as in pain and confusion"

(Leonhardt-Lupa 1995: 1).

What is motherhood?

Motherhood has been described as the ultimate achievement and fulfilment of a woman's life but others see it as an ultimate example of female oppression (Marchant 2004).

Motherhood has been said to be impossible to define in any helpful way (Ball 1994) but Marchant (2004: 74) offers a definition "motherhood implies the act of having given birth". This simple definition corresponds closely with the dictionary definition but it is important when developing a detailed understanding to consider what it means to the person experiencing it (Ball 1994). Motherhood, when considering more carefully the experiences of women, may be a process involving both physical and psychological changes through pregnancy, giving birth and nurturing a child, rather than just the end point of birth. It is also acknowledged that birthing can be described as a process rather than an event. It is recognised that motherhood involves strong emotions alongside physical, sexual and spiritual changes (Ball 1994, Atkinson 2006, Page and McCandlish 2006).

The term motherhood can be seen as problematic if accepted as 'the act of having given birth' as within our society, there are many women who undertake the role of 'being a mother' without having given birth. Hence the focus in the literature has been on mothering instead of motherhood (Marchant 2004). Mothering can be seen as a way of caring exhibited through altruistic, undemanding, selfless love (Marchant 2004). This distinction between mothering and motherhood is useful but it may be more useful for this study to consider motherhood as being or becoming a mother and mothering as the actions in response to it, such as loving and caring.

Motherhood has been part of political ideology since the mid-twentieth century (Magill-Coerden 2006). Through this, motherhood has been promoted as an idealised state where mothers appear unrealistically happy and healthy and this expectation of emotional fulfilment in motherhood has led to disillusionment

(Magill-Coerden 2006). It could also be suggested that the origins of this disillusionment, unhappiness, or something that could be labelled depression are in the nature of care provision – its medicalisation (Littlewood and McHugh 1997). There has been a lot of discussion surrounding this area. Miller (2007: 337) labels it the "unrealistic assumptions embedded in gendered discourses that pattern women's lives".

There appear to be two major discourses in motherhood through which this disjunction between expectations and experiences can be explored; they are the discourses of medicine and nature. The medical discourse can be seen in the professionalisation or expert led maternity care (Littlewood and McHugh 1997). The nature discourse establishes becoming a mother as natural or instinctual (Miller 2007) which can be seen in the political ideological stance (Magill-Coerden 2006). This may be seen to present motherhood in a rather negative way with women encouraged to have certain expectations that cannot be achieved. The reader, though, can be reassured that although the majority of women experience what is labelled the 'baby blues' in the first week after the birth (Lawrie et al 2002), for many, the experience of becoming a mother is a positive one (Fullerton 1997, Green and Kafetsios 1997).

There is general agreement that there are social expectations of mothers – those who experience motherhood (Marchant 2004, Magill-Cuerden 2006, Miller 2007). Magill-Cuerden (2006) states that to be a 'good parent' the person needs to conform to social expectations. Marchant (2004: 75), highlighting this, presents a table of what are considered to be socially normal and deviant behaviours attributed to mothers. To be considered normal women are expected to be maternal, home centred, care about their families and men, controlled by their bodies, inferior to men and submissive. Deviant women are those who reject the caring role and are career orientated, not accepting an inferior position or bodily limits and are over assertive.

From this brief overview, motherhood could be seen to be a process as well as an event. The event is the giving birth and the processes are the physical and psychological changes through pregnancy and birth to the early days of being a mother. All of these are experienced within a political and social environment, which has clear expectations of the woman.

To gain a more in-depth understanding of motherhood, the becoming and being a mother, there is the need to explore the experiences of women at this time (Ball 1994). This exploration will occur in the next subsection.

The experiences of women becoming mothers

Most research in this area has been undertaken using a qualitative methodology, but not the same methodology; studies have used narrative analysis of a longitudinal study (Miller 2007), content analysis (Cronin 2003), phenomenology (Bondas and Eriksson 2001) and grounded theory (Barclay et al 1997). They have also been conducted in different countries involving the UK (Miller 2007), Ireland (Cronin 2003), Finland (Bondas and Eriksson 2001) and Australia (Barclay et al 1997). They can all, though, offer some insight into the phenomenon of how women experience becoming a mother, and are explored below.

A total of fifty-five women becoming mothers in Australia were organised into nine focus groups and were asked about their experiences (Barclay et al 1997). The emergent core category was labelled ‘becoming a mother’; all the other categories fed into it. There were six other categories; ‘working it out’, ‘alone’, ‘realising’, ‘loss’, ‘unready’, and ‘drained’. Many adjectives typified each of these categories. For example, for ‘alone’ the list offered were: isolating, trapped, suffering, confused, vulnerable, being there, feeling supported, safe, frightened, resentful.

The core category of 'becoming a mother', offered the story line for the phenomenon. Despite biologically becoming a mother, the women did not appear to become a mother emotionally and personally until some time afterwards (Barclay et al 1997). When the women recognised the impact of being a mother it came as a shock. Eventually they tune in to their babies as they work out how to be a mother. This social process was both maturational and developmental (Barclay et al 1997).

Forty women's experiences of pregnancy were explored using a phenomenological approach (Bondas and Eriksson 2001). Pregnancy is a particularly emotional time for women as demonstrated by their scores on the Edinburgh Post Natal Depression Scale (EPNDS) (Evans et al 2001). There are, though, many concerns with using this scale within clinical practice as it was developed as a research tool (Adams 2002).

Bondas and Eriksson (2001) found ten emerging themes in this study, which were clustered into three categories. The category 'the perfect baby' included the themes of promoting the health of the unborn baby, health as no longer taken for granted and changing health behaviours. The category 'an altered mode of being' included the themes changing body, variations in mood, ill health as part of being pregnant and worries. The third category, 'striving for family communion', incorporated the themes of the evolving significance of the baby, dreams, expectations and planning, and changing relationships.

The essence or invariant meaning that was derived emerged from within the cultural context of the women. The essential structure of the women's lived experience was one of "wishing for a perfect baby in an altered mode of being while striving for family communion" (Bondas & Eriksson 2001: 835). On a superficial level, these first two studies (Barclay et al. 1997, Bondas and Eriksson 2001) appear to have very different findings but it is important to be aware that Bondas and Eriksson were only considering pregnancy whereas

Barclay et al were consider pregnancy, birth and the early days post birth. Both indicate that this is a time of some anxiety for the women.

Motherhood was also explored by Cronin (2003) using content analysis of focus groups and interviews. The key themes are different to those found by Bondas and Eriksson (2001). An exception to this, though, is their theme of 'altered mode of being' and like Bondas and Eriksson (2001), Cronin (2003) highlighted the significance of family. The participants in Cronin's study, instead of discussing their hopes and dreams, talked of their struggles and the support they received. The differences may be in part due to Cronin's study having a focus on need whereas Bondas and Eriksson's study was more open. Another influential factor could be that Bondas and Eriksson only collected data from women prior to the birth and Cronin collected the women's experiences about pregnancy, birth and early motherhood after they had given birth.

There were four concepts in Cronin's study (2003); birth and hospitalisation, support, motherhood and psychological issues. Within each of these there were a number of key themes found. The major findings seem to be very similar to those of Barclay et al (1997). Given that both Cronin and Barclay et al conducted their studies after the women had become mothers and had been through the process of pregnancy, birth and the early days afterwards it is less surprising that the findings are more similar to each other than with those of Bondas and Erikisson (2001). The women in Cronin's study (2003) found that coping with the lifestyle changes was difficult but that they gradually adapted to their new roles as did those in Barclay et al's (1997) and Miller's studies (2007).

Miller (2007) used a longitudinal narrative approach in her study of women's experiences. She collected their stories by conducting individual interviews. Three semi structured interviews were conducted with the seventeen participants; one prior to the birth (after approximately 8 months of pregnancy), the second after a six-week postnatal check and the third when the baby was approximately 8 months old.

This narrative approach led to an exploration of the experiences of the women (Miller 2007). In their transition to motherhood, the women initially try to do the right thing and be responsible, which is similar to the women in Bondas and Eriksson's (2001) study. Initially they appear to trust the official discourses of motherhood that birth and mothering will come naturally to them and if they should have problems then medicine will address these. Although these views were not highlighted in previous studies, Miller suggests these are social discourses of our society. The women held the belief that they would remain in control of their bodies and confidently know what they were doing. From this starting point, the women's experiences of birth were not what they expected and they felt let down by both their own bodies and the professionals.

During the birth of their babies the women experienced loss of control and felt failures. Eventually the women gained confidence in their ability to mother and developed relationships with their babies. These findings during and after the birth are the same as Barclay et al's (1997) main findings and similar to Cronin's (2003) except they are couched in different terms, probably due to differing methodological approaches.

Cronin's study (2003) is much more pragmatic than the more interpretative study conducted by Miller (2007) or the descriptive study of Bondas and Eriksson (2001). Her focus was on the needs, perceptions and experiences of first time mothers. As with Barclay et al (1997) and Miller (2007) she found that the new mothers experienced shock but for Cronin (2003) and Miller (2007) this was primarily due to the birth experience and for Barclay et al (1997) it was the realisation of what motherhood entailed.

Barclay et al (1997) and Miller's (2007) studies may appear to be a rather negative view of motherhood in comparison to Bondas and Eriksson (2001). This is, perhaps, unsurprising since Bondas and Eriksson's participants were looking forward, with some anxiety, to the event and the others were considering

the event in retrospect. Many of the struggles and concerns, though, for the women are similar in all of these studies. Despite some negativity they all suggest women eventually work things out and are able to mother their babies. Achieving motherhood for all the women involved quite monumental changes in all areas of their lives. After an unspecified time they appeared to adjust to these to strive to become what has been labelled 'good mothers'.

Given that motherhood has been accepted by this study as both becoming and being a mother and the literature seems to suggest that women at this time strive to become a 'good mother' (Brown et al. 1997, Bondas and Eriksson 2001, Marchant 2004, Magill-Cuerden 2006, Miller 2007) it is important that this concept is explored and understood. The next subsection will therefore explore the literature to gain an understanding of what a good mother is.

To be a 'Good Mother'

> *"the 'good mother' is required to be loving and caring, to have 'never ending' supplies of patience...remain calm and relaxed at all times…good listener and communicator…sensitive to children's' needs"*

(Brown et al 1997: 5).

Popular online magazines such as Parenting inform women that to be a good mother they need to be "adaptable, patient, loving, compassionate, empathetic, kind, strong and determined" (Suttie-Gunson 2007: 1). Suttie-Gunson (2007) says that a good mother will sacrifice anything for her children, that she loves them unconditionally, and forgives them any pain they cause. She advises women to follow their own instincts and they will be good mothers. This is in contrast to a number of studies that suggest it takes time for women to reach an intuitive responding to their babies (Barclay et al 1996, Cronin 2003, Wilkins 2006, Miller 2007).

There are many cultural images of motherhood and mothers like those above from media images to early childhood fairy tales of romantic love and 'happy ever after' marriage and motherhood. "Society tells us that motherhood is natural and blissful. The beautiful Madonna adorns church frescos. Smiling sun-kissed supermodels hold their babies in a modern mimicry of this ancient motif." (Stewart 2004: 107).

Whilst most would recognise these as idealised images, feminists inform us that women have internalised these images and carry a vision of the perfect mother into their journey to motherhood (Stewart 2004). Whether the extreme view offered by feminists is accurate or not, conversations with those becoming mothers inform us that there is a sense of the 'good mother' that they are trying to achieve (Miller 2007).

Brown et al (1997) explored the concept of 'good mother' considering whether there were significant changes to this over the previous decades given the social and cultural changes. These changes, according to Brown et al (1997), included women taking more professional roles outside of the home, and rights to equal pay and opportunities. Brown et al (1997) explored whether the women who became depressed during early motherhood did indeed have a more unrealistic view of motherhood than those who did not develop depression; a commonly held belief. To do this they initially conducted a survey of recent mothers which included an assessment using the Edinburgh Post Natal Depression Scale (EPNDS). They then did a follow up study again sending out questionnaires including the EPNDS. This involved ninety women, forty-five of whom scored more than twelve on the EPNDS and so were considered likely to be experiencing depression. Once the scales were completed each respondent was interviewed using semi-structured interviewing.

An exploration was undertaken as to whether there were two differing discourses of the good mother; the original good mother being the stereotype prior to recent but huge societal changes and the new good mother the stereotype after these

changes. The old or original good mother was identified as being a woman who focused on love and security for her child and other passive attributes such as patience and reliability. The new good mother was said to be interested in her own independence and individuality: she focused on providing stimulation for her child's development.

Despite the identified new stereotype of a 'good mother', all the women (Brown et al 1997) accepted a stereotype most like the traditional view of a 'good mother'. That is, they believed a mother should primarily be loving and caring with never-ending patience. The mother should be calm and relaxed at all times, be a good communicator, and be understanding and sensitive to the needs of the child. Instead of leaving this stereotype, to associate themselves with a new stereotype of modern mothers who were independent and stimulating, they seemed to have included the stimulation and guidance in the original stereotype.

Unlike predictions of a change of stereotype to correspond with societal change the women (Brown et al 1997) assimilated new ideas into an existing concept. Piaget (Barker 2007) might suggest the new stereotype was not distinct or different enough to cause cognitive dissonance or unbalance their equilibrium and lead to accommodation of a new schema or stereotype. The women had assimilated new thoughts into an old schema, in this case the stereotype of a good mother.

Despite a generally accepted belief that women who suffer from postnatal depression after the birth of their baby have significantly more unrealistic expectations of motherhood, there was no difference between those with depression and those without. The women who scored highly on the EPNDS and the women who did not held the same stereotype of a 'good mother' (Brown et al 1997). This stereotype of the good mother seems to be pervasive and enduring, with Campbell (1984) saying that mother love is different to other sorts of love. He describes it as maternal tenderness, the mother as comforter, interpreter and as a warm presence in a frightening world. Marchant (2004), twenty years after

these assertions by Campbell, in a recent midwifery text, offers a similar description of the good mother. She states that mothering is altruistic caring, undemanding and selfless love.

A good mother is totally loving, caring, patient, kind, selfless, sensitive, understanding and so much more according the stereotypes held by woman, told in stories, text books and promoted in the media. To add to this, there is also the pressure of the baby or child being damaged without it; “Everything depends on the mother” (Russell cited by Exley 2004).

Summary

This section has explored what motherhood is, the experiences of women becoming mothers and the expectations of mothers including those expectations which they put on themselves (Brown et al 1997).

Motherhood is the process of becoming a mother through pregnancy, birth and the early days after the birth as it takes women a little time after the birth to adjust and become a mother (Barclay et al 1996, Cronin 2003, Wilkins 2006).

There is general agreement that there are social expectations of mothers – those who experience motherhood (Marchant 2004, Magill-Cuerden 2006, Miller 2007). Motherhood is enacted within a social and political arena, which influences the dominant discourses on mothering (Littlewood and McHugh 1997, Magill-Cuerden 2006, Miller 2007). With monumental changes occurring for the women (Barclay et al.1996, Bondas and Eriksson 2001, Cronin 2003, Miller 2007) and cultural pressures influenced by the dominant discourses of medicine and nature (Miller 2007) women strive to be good mothers (Brown et al. 1997, Bondas and Eriksson 2001, Marchant 2004, Magill-Cuerden 2006, Miller 2007). The ‘good mother’ appears to be an unachievable generally held stereotype.

Midwives can be women and mothers too and are also influenced by this culture and this will need to be considered when attempting to understand how they support women becoming mothers, which is explored in the next two sections.

A mother is:

"she is their earth…

she is their food and their bed and the extra blanket

when it grows cold in the night; she is their warmth and their health and their shelter"

(Hathaway cited by Exley 2004).

What is emotional support?

This section explores the theories of working with emotions. Its subsections include emotion work of health professionals, which leads into a focus on the emotion work of midwives and then considers the outcomes of emotion work for them. The next subsection is emotional support, the focus of this study, offering the current understanding of this. The final subsection is comfort, considered to be the aim of nursing and midwifery care (NMC 2004).

Introduction

The transition to motherhood is seen as an emotional time, midwifery professional bodies and government initiatives all indicate midwives need to work with these emotions. It is working with the emotions of women and their support that is the focus of this study. Emotional support is not a simple term to define; therefore this section will offer a discussion of the term and related concepts.

There has been some significant progress in understanding the emotion work of midwives since commencement of this study but this has primarily been in regard to how midwives manage their own emotions and the effort this requires (Hunter and Deery 2009). It is important to explore the whole area of midwives' work with emotions to gain a greater understanding of my specific area of focus.

Emotions and emotion work

Hochschild's (1983) cultural theory of emotional labour or emotion management has been influential in the development of understanding of emotional labour or emotion management in all areas of western society. She does not distinguish between emotional labour and emotion management and uses the terms interchangeably but she uses the term emotional labour to label her theory. She does, though, differentiate between emotional labour and emotion work, defining emotional labour as emotion management in the public arena and governed by

display and feeling rules. Emotion work is what is undertaken in the private arena.

Hochschild's (1979) theory of emotional labour offers categories from which to understand emotions. She suggests that emotional behaviour, as with other cultural behaviour, follows certain rules. Hochschild (1979) describes what she labels 'display' rules and 'feeling' rules. Display rules are similar to the social rules identified by Goffman (1959) and have been categorised as 'superficial acting'. These are the rules for the explicit behaviour that a culture or organisation requires of a person in a given situation. Feeling rules can be recognised as 'superficial acting' or 'deep acting' and these inform the person about how they should feel. Superficial acting is where the person outwardly behaves as if they hold a certain feeling but may not feel it inside, whereas deep acting is where the person adapts their inner feelings to that which is expected. Hochschild (1983) highlights that in the current culture more organisations are setting feeling rules for their employees alongside display rules. She also highlights that if a person performs the feeling rules of an organisation by deep acting, they may be a risk of losing their 'self' or personal integrity.

Feeling rules underpin ideologies and can be considered as part of an interpretative framework. An interpretative framework can be explained in terms of 'framing rules' and 'feeling rules' (Hochschild 1979). Display rules offer guidance on how to behave but are not a focus within this interpretative framework. Framing rules are general rules, which offer definition and meaning to a situation, whereas feeling rules offer an understanding of what might be an appropriate way to feel in a given situation. For example an interpretative framework for a midwife might be where the framing rules define a situation as one in which she has responsibility for the woman and provide the meaning that a woman is distressed. Feeling rules may tell the midwife that she should feel caring and compassionate towards the woman. This may lead to the midwife using emotional labour or management if this is not how she feels.

Framing and feeling rules are, according to Hochschild (1983), used extensively in social situations, but she was particularly interested in the commercialisation of these rules and the effort involved in emotional labour. She found that employers who were buying the emotional labour of their employees expect not only a certain type of behaviour in their staff but also that their staff are sincere and feel the dictated emotion.

This can be seen in therapeutic relationships in health care. The counselling theories of Rogers (1951) and Egan (1977) both expect the counsellor to offer non-judgmental positive regard for the client regardless of what the client may have done. This has to be offered congruently; with sincerity. The counsellor in a counselling situation (framing rule) therefore has to feel positive regard for the client (feeling rule). Although Rogers and Egan were not using Hochschild's interpretative framework, their theoretical stance can be interpreted using it. Hochschild's theory has been applied to health care, including midwifery, by a number of authors but most significantly by Hunter (2001, 2004, 2005, 2006) who's work will be considered later in this chapter.

Health care professionals' emotion work

Researchers and writers in health care have built on Hochschild's foundational sociological work. There has been a lack of distinction amongst these authors over the definition of the terms emotional labour, emotion work and emotion management (Mann 2004, 2005, Hunter and Deery 2009). Despite this lack of clarity over definition, there appears to be agreement that whilst emotional labour is essential, it creates a great deal of work stress for the provider (Smith 1992, Mann 2005, 2004, Hunter 2006). To explore this area of health professionals' effort in more detail it would be helpful to consider the earliest literature available first.

Nursing seems to provide the earliest exploration of this area in health care. One of the earliest nurses to explore this area was Pam Smith, in 1992; she explored the literature on emotional labour. This was undertaken to establish whether it

was the same as what is labelled “nursing care”, which is regarded as essential for patient well being. Smith was considered to be an influential leader in the exploration of emotional labour in health care, so much so, that she was invited to write the preface for the groundbreaking midwifery book by Hunter and Deery in 2009. Smith (1992) concluded that nursing care and emotional labour are essentially the same experiences in different situations. She also said that giving emotional labour was, at times, at great cost.

More recently a study was undertaken to explore the area of work with emotions undertaken by nurses (Bolton 2000). The nurses in this study had some overlap in their workload to midwives in that they mostly cared for women who had miscarriages and fertility issues (ICM 2006 identify that the midwives’ role incorporates working with these women too). Nurses appeared to offer emotion work as a ‘gift’ to those for whom they cared, a term also used by Hochschild (2003). These gynaecological nurses, who were interviewed and observed, had differing amounts of experience and were from different points on the hierarchical nursing ladder. Ideologically, nursing is seen as feminine (framing rule) with the associated qualities of being caring, loving and kind (feeling rules) (Bolton 2000). It is seen as a vocation (framing) which raises a number of expectations of nurses by those being cared for and the nurses of themselves. Nurses believe they should always be kind and caring but also calm and detached (feeling rules) (Bolton 2000). These are the feeling rules (Hochschild 1979) for this nursing group. This untaught but professionally acknowledged expectation is suggested to be necessary but may invoke as already identified (Hochschild 2003, 1983, 1979, Mann 2005, 2004, Hunter 2006, 2004) what has been labelled as emotional labour or emotion work.

The nurses in this study were undertaking what Hochschild would label emotional labour but they were seen to be doing more than managing their emotions. They were offering something extra that was labelled a ‘gift’. Nurses were undertaking emotion work as well as emotion management or emotional labour, to use Hochschild’s definitions. The nurses offer their ‘gift’ of emotion

work to each other in a reciprocal manner but they offer it to patients and their families with little or no expectation of reciprocity, hence the term 'gift' (Bolton 2000). Hochschild (2003) identified similar situations where usually gifts are reciprocal but sometimes the gift is given without expectation of reward when she was exploring emotions in the private arena, which she labelled emotion work. One quote from a ward sister was "the essential basis of nursing is caring. You can't be a nurse if you don't care" (Bolton 2000: 583).

As already highlighted, nursing care and emotional labour can be considered synonymous (Smith 1992). Most of the nurses in Bolton's study recognised that caring for patients brought them anxiety but also brought the greatest potential for job satisfaction. Hochschild (2003) wrote the sharing of gifts is a cultural phenomenon but offering a gift is sign of love. "The sense of genuine giving and receiving is a part of love. So it is through the idea of a gift that we use culture to express love" (Hochschild 2003: 104). As seen when exploring care, Campbell (1984) wrote that care is a type of moderated love (page 35).

It can be dangerous for caring professions, such as nursing, to focus too much on professionalism and technological skills (Bolton 2000) and some nurses defend their professionalism but celebrate their ability to 'care too much' (Bolton 2000). This appears to directly link with the dilemma experienced by many midwives.

Midwives experienced two competing ideologies of 'being professional' and 'being with woman' (Hunter 2004). These competing ideologies create emotion work for midwives, which can be explained in terms identified by Hochschild (1979). Hochschild (1979), as already stated, recognised that feeling rules and framing rules underpin ideology. If a midwife was experiencing ideological dissonance they might have had competing framing and feeling rules. The nurses in Bolton's study were aware of this dissonance and chose their set of feeling rules and, therefore, their ideological stance. In Hunter's study (2004) qualified midwives tended to accept the ideology of their work base (both framing and feeling rules) but student or junior midwives needed to work with

both competing ideologies. Hochschild and Hunter would recognise this as leading to extra emotional labour and maybe emotion work.

Emotion work in midwives

A review of the current knowledge of emotion work in midwives was conducted by Billie Hunter in 2001. She chose to use the term emotion work as she saw midwives as undertaking their role in both public (hospitals) and private (personal homes) places. Despite the quality of the childbirth experience and the relationship between the mother and midwife being crucial for the mother's well being this emotion work was under-represented in research. There was a high level of emotion work for midwives and this was likely to increase with changes occurring in the maternity services, with the focus on holistic care, caseload management and the need for continuity (Hunter 2001). Hunter understood emotion work or emotional labour to be anything that has an impact on the midwives' emotional state but she does not offer a definition of emotion. She was more concerned with the midwives' perception of their emotional state and appears accepting of their interpretation of this.

There is a need to develop midwives' understanding of emotion in the work place for the well being not only of the mothers but also of themselves (Hunter 2001). The expectation is that this increased understanding will improve the midwives' working lives and allow them to meet the needs of the women and families with whom they work. This is crucial, as a negative experience during this time for the mother, whether during pregnancy, birth or post birth, may lead to emotional distress (Barclay et al 1996, 1997, Shields et al 1997).

Hunter has conducted a number of studies in the area of emotion work since 2001 and has had a number of related papers published. In 2004 she presented a paper entitled "The Conflicting Ideologies in Midwifery as a Source of Emotion Work for Midwives". In this paper, Hunter's (2004) findings are interesting in that the expectation is that emotion work has its source within the relationships

between client and professional, whereas she found that the emotion work was primarily due to co-existing conflicting ideologies.

In 2005 Hunter went on to explore the area of conflicting ideologies further and, through her studies, she identified that relationships between midwifery colleagues were of key importance. These relationships can clearly be seen, particularly in hospital based care where hierarchical relationships enforced a convergence of these ideologies, to produce dissonance in the more junior midwives. Senior midwives were found to use unwritten rules and sanctions to maintain their senior positions (Hunter 2005) which can be seen to be similar to the strategies undertaken by those providing flight attendance training (Hochschild 1983, 2003). They underpinned these strategies by referring to their greater clinical expertise and experience. The student and junior midwives rarely challenged this authority but used subversive techniques to create a sense of compliance, 'playing the game', where they were attempting to achieve the 'with women' ideology within the 'with institution' environment.

It would appear the student midwives were maintaining their personal integrity by playing a part, surface acting or using display rules (Goffman 1959, Hochschild 1983, Mann 2004). It would appear, though, that these studies of midwives' struggles with ideology are more similar to the emotional labour described by Hochschild (1979) rather than the emotion work or 'gift' (Bolton 2000, Hochschild 2003) despite Hunter (2005) labelling it emotion work. It may be that the junior or student midwives expected a reciprocal emotional exchange with their senior colleagues to allow them to offer the 'gift' to women as seen previously (Bolton 2000, Hochschild 2003).

Hunter continued to explore the emotion work of midwives and in her study published in 2006. She again used an ethnographic approach to develop an understanding of community-based midwives focusing on their relationship with the women for whom they were caring. This is particularly important, as

national and international policy is to work in partnership with women (NICE 2003, 2006, NSF (DoH) 2004, ICM 2006).

The concept of reciprocity is useful in understanding the relationship between midwives and women (Hunter 2006). Women find their relationship with midwives to be of key significance and midwives have the power to mar the woman's experience. Interactions varied quite considerably in different situations and with different women. Midwives attempted to adjust their behaviour to 'fit' with the woman's. They used a number of strategies to gain rapport such as self-disclosure, humour and teasing. The relationships were emotionally rewarding for the midwives when the women allowed them to exhibit an individualised approach and were receptive to midwifery advice (Hunter 2006). Hunter (2006) identified four key interactional styles: balanced exchange, reverse exchange, rejected exchange and unsustainable exchange.

It is only the balanced exchange or a reciprocal relationship that offers a clear rewarding experience for the midwife, all the others create emotion work for them (Hunter 2006). This is a simplistic model and midwife-woman interactions are more complex (see section on midwife-woman relationship page 40) but it can provide a method for further exploration of this complex social process (Hunter 2006).

The gift of emotion work is a gift of love; it is something extra, which can be sustained by gratitude and appreciation (Hochschild 2003). It is culturally determined and so gender, social class and power have an impact on what is expected (both display and feeling rules) and culture is always on the move. Cultural changes within our society expect women in the twenty-first century to control their "feelings of fear, vulnerability and the desire to be comforted" (Hochschild 2003: 24). Despite this, when a middle class woman offers comfort by emotion management, traditional views still exist and it is then not appreciated and gratitude is not given as it is not seen as extra or a gift (Bolton 2000, Hochschild 2003, John and Parsons 2006). There is, though, a positive

way forward through midwifery organisational structures, which facilitate the recognition of the importance of the reciprocal relationship where recognition and appreciation can be demonstrated. If a case loading approach is used, some of the problems are ameliorated (McCourt and Stevens 2009).

It can be seen from Hunter's studies (2001, 2004, 2005, 2006) that emotion work is widespread in midwifery and can be created by any significant interactions between midwives and others (colleagues or clients). There is general agreement that emotion work is costly but is important to ensure quality care (Smith 1992, Bolton 2000, Mann 2004, Hunter 2001, 2004, 2005, 2006).

Outcomes for the midwife of offering emotional care

There are three types of emotional outcome between behaviour and feeling, which are emotional harmony, emotional dissonance and emotional deviance (Mann 2004). Emotional harmony is where the emotion portrayed is the one the person is feeling. Emotional dissonance occurs when feeling rules and organisational rules dictate a person should behave and feel a certain way but this is not how the person would like to behave or how they feel. Emotional deviance occurs when the person is expressing their emotions in a way that they feel is appropriate and is the way they feel but does not match the organisational rules or expectations. Both emotional dissonance and deviance could cause distress for the carer whether midwife, nurse or counsellor.

Emotion work can be seen as a double edged sword in that it may achieve the necessary outcomes but it may prove too costly for the psychological wellbeing of the person enacting it. There are studies demonstrating a link between emotional labour stress and 'burn out' (Sandell 1997, Mann 2004) and it may be that if emotion work is unrecognised it may incur greater cost, as it is practised in both public and private arenas.

The interactional cognitive phenomenological model of Folkman and Lazarus (1991) could be helpful when trying to establish effective ways of dealing with the stress induced by emotional labour or work (Mann 2004). Some coping strategies for dealing with emotional labour could be strategies such as cognitive restructuring to acknowledge emotional labour as a high status activity and a skilled part of a person's job. These could be labelled problem-solving coping strategies. Other coping strategies commonly used for other situations can also be helpful, such as time-out, emotional release, rationalising and humour (Mann 2004) these can be labelled emotion-focused coping (Folkman and Lazarus 1991). These may also be useful to help midwives cope with emotion work or offering the 'gift'.

The approach of my study is to explore the 'lifeworld' of the participants, which makes room for whatever understanding they may have of their work with emotions. The descriptive phenomenological approach of this study gives midwives the opportunity to describe their perception of how they provide emotional support to women becoming mothers. This could include their understanding of what motherhood is, when it occurs, whether this induces emotion work in them and how they cope with that. Using the descriptive phenomenological lifeworld approach the only assumption is that there may be similar features experienced by all midwives but there will be contextual differences for them. This lifeworld approach is one that may be acceptable for the differing disciplines (philosophy, anthropology, sociology and psychology) that claim a stake in developing understanding emotions and emotional interactions (Strongman 1996).

Summary

Hochschild (1979) offered an early theory of the manipulation of emotions for commercial reasons. This commercialisation or professional use of emotions can be seen in health care (Smith 1992, Bolton 2000, Mann 2004, 2005, Hunter 2005, 2006). This emotional labour (in the public arena) or emotion work (private arena) can be seen to be a great effort for health care professionals as for the

flight attendants in Hochschild's seminal study. Hochschild (2003) and John and Parsons (2006) go on to warn those expecting a manipulation of emotions, particularly emotion work at a deep acting level, in professionals without appreciation and recognition that there may be detrimental effects for those offering this 'gift'.

Emotional support

Support v.t.n.

1. Carry, hold up, keep from falling or sinking
2. enable to last out, keep from failing, give strength to, encourage
3. endure, tolerate
4. supply with necessities, provide for
5. lend assistance or countenance to, back up, second, further
6. hear out, tend to substantiate or corroborate
7. keep up or represent adequately (Sykes 1982: 1072)

When asked to "describe how they provided emotional support, they identified 'ways of being, doing and knowing' that could be considered therapeutic emotional labour" (Bone 2009: 59).

As can be seen in the above quote it is difficult within midwifery literature to distinguish what is emotional support and what is labelled therapeutic emotional labour. Indeed Smith (1992) stated that emotional labour and nursing care were the same thing, just labelled differently according to context. The dictionary definition also does not give a precise understanding of support; it offered 11 options of which 7 are given above. Whereas with other words it is clear which meaning is appropriate in a given context for the word "support" this is not the case. All of the above definitions could apply to the context of offering emotional support. This problem with definition can also be found in midwifery literature (Mander 2001).

The early work of Oakley (1988, 1992) and her colleagues (Oakley et al 1990) has demonstrated that social support is important for mother and baby. This does not, though, appear to need to be undertaken by midwives. Within midwifery there is a limited consensus on what support is and how it should be provided but women have identified the need for support in a number of areas on their transition to motherhood (Edwards 2000). Women wanted supportive midwifery practices, emotional, spiritual and physical support and supportive qualities in their midwives. Supportive qualities appear to include listening, respect, acceptance and being given clear information. Supportive midwifery practices include providing an environment that focused on a normal birth, reduced fear and increased confidence and trust. These can all be seen as elements of a therapeutic midwife-woman relationship (Kirkham 2000), which could be considered the core of midwifery care. They have also been recommended throughout the literature in midwifery over the centuries (Rhodes 1995) and are still recommended by midwifery professional bodies (ICM 2006) and government (NSF (DoH) 2004, NICE 2006).

Some have suggested that emotional support is differentiated from other support by its being 'emotionally sustaining' whereas other support is more practically orientated. Emotional support might comprise listening, demonstrating concern and intimacy. It has also been suggested that emotional support might be a more ongoing process rather than a one off event (Mander 2001). Despite the lack of clarity over the term support and other terms such as social support, emotional support, therapeutic emotional labour or emotional care all of these terms seem to be aiming for the same goal. The goal would appear to be for emotional well being and comfort in the woman, which will be considered in the next subsection.

For this study the term "emotional support" was not defined for the participants but from reviewing the literature it appears to be the actions taken in response to perceived emotional needs and can include therapeutic emotional labour. Therapeutic emotional labour can be accepted as the effort a carer puts into their

interactions to help the other person with their emotions. The term emotional care will be used in a wider context and may include emotional support, the assessment and evaluation of this, emotional labour and emotion work.

Comfort

Introduction

Comfort is another area in which literature from nursing is more readily available, although there have been a number of studies in midwifery considering the goal of comfort for women in labour. Therefore a review of literature from other caring professions will initially be considered, particularly nursing, and then the focus will be drawn in to the achievement of comfort in midwifery.

"Comfort is a concept that involves the enhancement of strength and health……. Comfort may be considered the ultimate state of health and therefore may be viewed as the goal of nursing" (Morse et al 1995: 19).

The Nursing and Midwifery Council (2009) states that midwives should provide care for the women and families they work with and they define care as providing help and comfort. This could be seen as a circular discussion; midwives need to provide care, which is comfort, and to achieve comfort they provide care. Therefore a more detailed examination is needed.

Despite comfort being difficult to define, as there are a number of theoretical approaches to understanding it, Morse et al (1994) have offered an insight into this concept. They said "Comfort, paradoxically, appears to be a state of embodiment that is beyond awareness, and comfort is best recognised when the patient first leaves the state of discomfort" (Morse et al 1994: 190). They explain that comfort comes from the Latin word *confortare*, which means to strengthen. From their study they identify that patient comfort is linked with strengthening or empowering the person in relation to their body.

Discomfort can be considered to be a mostly corporeal experience (Morse et al 1994) but some suggest it has mind, body and spiritual elements (Schuiling and Sampselle 1999). A person's experiences of their body when well or comfortable is limited but when in discomfort this changes (Morse et al 1994). Nine themes of discomfort have been found; dis-eased body, disobedient body, deceiving body, vulnerable body, violated body, enduring body, betraying body, resigned body and betraying mind. This was established by interviewing patients who had experienced extreme pain or discomfort and traumatic injuries or life threatening illness. Through these interviews how the patient gained comfort was explored within each of the nine areas (Morse et al 1994).

Within the theme of the dis-eased body, comfort was gained from information about the illness and a belief in the care giver's ability to provide appropriate care. It is not the activity of care that is important: it is the way in which it is undertaken. If it is undertaken 'for' and 'with' the patient instead of 'to' the patient it restores the patient's integrity and assists in moving them towards recovery. Similarly in the theme of the disobedient body it is the opportunity to gain some control that facilitates a sense of comfort. The vulnerable body is seen in situations where pain or the anticipation of pain becomes all-consuming; comfort at these times is gained from feeling safe, secure and trusting of the care giver. When the anticipation cannot be removed the caregiver can offer comfort by protecting, bolstering and advocating for the patient (Morse et al 1994).

Another of the nine themes is the violated body. There are times when a person needs to have interventions or examinations that are considered to violate the body. Patients can comfort themselves at these times by distancing themselves from their bodies (Morse et al 1994). The presence and connection with a caregiver can aid this by allowing the person to feel safe and secure enough to relinquish part of their body for a short while. Nurses achieve this connection by their use of their hands, eyes and voices (Morse et al 1994). There are times when a patient knows that they cannot remove themselves from their discomfort

and have to endure it, which is another of the identified themes. Comfort was gained at this time by refocusing attention on something that offered hope.

The resigned body occurs when the body has permanently changed and the person needs to come to terms with this to achieve comfort using a tolerance of self and keeping going. The last three themes are all to do with the body and mind betraying the person. The deceiving body is where the person feels well but actually the body is deteriorating. The person can be comforted here by recognising that this is a normal function of bodies or by having check-ups and tests to demonstrate that the body is not deteriorating in an excessive manner. The betraying body occurs when the person believes that they are coping well but their body is showing signs of a lack of coping. This can occur in less noticeable ways such as appearing tired but may occur in psychosomatic illness such as heart attacks and migraine. Comfort could be gained in these situations by raising the person's awareness and facilitating their acceptance of appropriate help such as counselling and relaxation exercises (Morse et al 1994).

Women experience pain in childbirth and for some this is experienced as extreme suffering, and the understanding of suffering and comfort from the above nursing perspective is useful for the midwife to understand. Comfort can enhance the ability to cope with great pain and empower women (Schuiling and Sampselle 1999). To participate in decision making, to plan and feel in control, will enhance the comfort felt by women at this time. To have control is a concept that occurs frequently in midwifery literature (DoH 1993, Levy 1999a,b,c, DoH 2004, McCourt 2005). In the literature on comfort such as Morse et al (1994) and Williams and Irurita (2004), control is also described as a means of facilitating comfort.

Other theoretical approaches to comfort include the idea that to facilitate comfort the comforter needs to "provide support, relieve pain and anxiety, communicating, using touch and comforting family and friends" (Schuiling and Sampselle 1999: 79). Touching and talking are the main components of

facilitating comfort and listening is important for the most distressed (Schuiling and Sampselle 1999). These behaviours also link well with the findings and theory of Morse (2001, 2000). She would agree that touching and talking are major elements in attempting to facilitate comfort and with those who have lost control, she identified nurses use "comfort talk register, eye contact and touch" (Morse 2001: 52).

Research pertaining to comfort in childbearing is scarce and despite comfort meaning more to women than elimination of pain the limited publications available were focused on this (Schuiling and Sampselle 1999). The elimination of pain has been the focus of the medical profession to achieve comfort but this limits the understanding of suffering and comfort (Morse 2001). Comfort for women appeared to include reduction of tiredness, not being hungry and a feeling of being relaxed (Schuiling and Sampselle 1999); this has been acknowledged throughout the centuries (Rhodes 1995). Women also sought a supportive presence and a caring approach, which could be considered to be the same as Morse et al's (1994) statement of the need for presence and connection.

Nursing literature (Morse et al 1994) suggests suffering causes the person to focus on the corporeal but comfort allows the person space to focus on other areas of their lives. Comfort from a midwifery perspective appears to involve mind (psychological), body (corporeal) and spirit (soul). A state of comfort in the mind involves a feeling of peace and security, freedom from anxiety or worry. Within the body it involves physical needs being met such as hunger, thirst, sleep, air and freedom from illness. Spiritual comfort involves a feeling of hope and expectation, a transcendence from pain and being at one with one's god (Schuiling and Sampselle 1999).

Midwifery and nursing theoretical approaches to suffering and comfort are very similar despite their differing focus (Morse et al 1994, 1995, Schuiling and Sampselle 1999, Morse 2000, 2001). Morse and her colleagues' (1994, 1995, 2000, 2001) focus was on developing a theory of suffering and comfort gained

from the experiences of patients and nurses. Schuiling and Sampselle (1999) focused on identifying the activities of midwives in their attempts to facilitate comfort for women during childbirth. Elements of Morse's (2000, 2001) enduring and emotional suffering can be seen in Schuiling and Sampselle's (1999) paper.

Summary

This section of the literature review has considered theories and research pertaining to the work with emotions undertaken by health care professionals including midwives. Hochschild (1979) offered an early theory of the manipulation of emotions for commercial reasons. She found that employers who were buying the emotional labour of their employees expected not only a certain type of behaviour in their staff but also that their staff were sincere and felt the dictated emotion. She developed an interpretative framework for understanding emotional labour, which include framing and feeling rules. These are, according to Hochschild (1983), used extensively in social situations. This commercialisation or professional use of emotions can be seen in health care (Bolton 2000, Mann 2004, 2005, Hunter 2005, 2006).

The terms emotional labour, emotion work and emotion management have been used interchangeably (Hunter and Deery 2009) whereas Hochschild (1979) used emotional labour and emotion management synonymously but distinguished between emotional labour and emotion work. Emotion work occurs, for her and Hunter (2001, 2004, 2005, 2006), in the private or home arena and emotional labour in the public arena. This emotional labour and emotion work can be seen to be a great effort for health care professionals (Bolton 2000, Mann 2004, Hunter 2004, 2005, 2006, John and Parsons 2006).

For employers who expect a manipulation of emotions at a deep level without appreciation or recognition there may be detrimental effects (Hochschild 2003, John and Parsons 2006) including 'burn out' for their staff (Sandell 1997, Mann 2004). For midwives it is not only the 'gift' of emotional care that creates

emotional labour or emotion work. It can be seen from Hunter's studies (2001, 2004, 2005, 2006) that emotion work is widespread in midwifery and can be created by any significant interactions with people (colleagues or clients). Midwives experience two competing ideologies of 'being professional' and 'being with woman' and these can be seen to increase the emotion work within midwifery peer groups (Hunter 2004).There is, though, general agreement that emotion work is costly but is important to ensure quality care (Smith 1992, Bolton 2000, Hunter 2001, 2004, 2005, 2006, Mann 2004).

None of the concepts explored in this section have clear definitions but relevant literature has been explored in an attempt to gain some clarity. For this study the term emotional support was not defined for the participants but from reviewing the literature it appears to be the actions taken in response to perceived emotional needs. Therapeutic emotional labour can be accepted as the effort a carer puts in to their interactions to help the other person. The term emotional care will be used in a wider context and may include emotional support, the assessment and evaluation of this, emotional labour and emotion work. Emotionally supportive qualities appear to be listening, touch, being respectful, acceptance and being given clear information (Schuiling and Sampselle 1999, Edwards 2000, Morse 2000). These should be undertaken whatever the midwifery task may be, such as clinical examinations (Morse 2000). Supportive midwifery practices are providing an environment that focuses on the normality of motherhood including the birth, reduced fear and increased confidence, control and trust (Rhodes 1995, Edwards 2000, Kirkham 2000, NICE 2004, ICM 2006).

Despite the lack of clarity over the term support and other terms such as emotional support, therapeutic emotional labour or emotional care all of these terms seem to be aiming for the same goal. The goal would appear to be for emotional well being and comfort (NMC 2004).

Nursing literature (Morse et al 1994) suggests suffering causes the person to focus on the corporeal, comfort allows the person space to focus on other areas

of their lives. Comfort from a midwifery perspective appears to involve mind (psychological), body (corporeal) and spirit (soul) (Schuiling and Sampselle 1999). A state of comfort in the mind involves a feeling of peace and security, freedom from anxiety or worry. Within the body it involves physical needs being met such as hunger, thirst, sleep, air and freedom from illness. Spiritual comfort involves a feeling of hope and expectation, transcendence from pain and being at one with one's god (Schuiling and Sampselle 1999).

This section of the literature review has considered the question 'what is emotional support?' It is a complex concept and is difficult to define concisely. The research in this area appears be focused on individual elements of emotional support rather than attempting to offer an overarching understanding. There does, though, appear to be some consensus around emotionally supportive qualities (listening, touch, being respectful), that it takes effort (emotional labour, emotion work), and the aim of its provision is comfort. The next section will, using a logical process, move on to what the experiences are of midwives who provide this support.

What is midwives' experience of giving emotional support to women becoming mothers?

Support is quite an ambiguous term with many definitions but there were some studies considering midwives' experiences. As highlighted earlier, in 'What do midwives do?', midwives provide care through their midwife-woman relationships, therefore this section has a subsection of 'intimate relationship', as these relationships could be considered intimate. This is further explored in the subsections 'use of self' and 'physical proximity'. The literature on midwifery care frequently highlights the context in which the care occurs and there has been a lot of discussion on the professional culture within midwifery. This is suggested to have a direct impact on the midwives' experience of offering care or supporting women (Kirkham 1999), so the last subsection in this section is professional culture.

Introduction

Despite the word "support" being frequently used within midwifery literature, there is limited understanding of what the midwife is doing or experiencing when giving this support, as seen in the previous section. As recognised in the previous section Oakley's (1988, 1992) foundational work recognised the importance of support but there are few recent studies, particularly when considering emotional support. Hunter's review of the emotion work of midwives in 2001 found there to be a dearth of evidence. Since this exploration there has been an increasing desire to explore this area of a midwife's work to gain a better understanding.

Hunter has continued her research over the years since 2001 and published many journal articles and spoken at midwifery conferences (2001, 2004, 2005, 2006), and others such as John and Parsons (2006) have also undertaken research in this area. Hunter and her colleagues recently published a book (Hunter and Deery 2009) bringing together the current understanding of the emotion work of

midwives. The research of Hunter and her colleagues offer a fairly comprehensive view of the emotion work of midwives but the focus appears to be on the impact on the midwives rather than explaining what they are doing and how they are doing it.

The experiences of midwives supporting women becoming mothers

Prior to Hunter's research there was very limited literature in the area of emotional work in midwifery and the emotional support offered by midwives. One of the studies that were available, although quite different in approach to that of Hunter, was Hildingsson and Häggström's study in 1999. This was a significant piece of research undertaken in Sweden. Hildingsson and Häggström explored the experiences of seven midwives supporting women during pregnancy. They used a hermeneutic phenomenological approach, which allowed them to gain some insight into how midwives fulfilled their supportive role. Their findings, as with complementary studies by Bondas and Eriksson (2001) and Barclay et al (1997) of women's experiences, may be different to the experiences of midwives in the UK due to cultural differences but they could offer some valuable insights.

Hildingsson and Häggström (1999) found that the midwives in their study took on a role of the 'good mother' which for them was both exhausting and time consuming but also joyful. As part of this role the midwives were said to encourage autonomy whilst offering advocacy. They also found, in contrast, the role of 'good mother' played by the midwives could also restrict autonomy and integrity which is advocated within midwifery education. It also led midwives to admonish the women at times.

Fifteen subcategories were found and they were organised into four themes. The four themes were 'caring actions based on ethical reflections and situational insights', 'prospective fathers', 'involvement and advocacy', and 'reflective evaluation of work'.

Caring actions based on ethical reflections and situational insights involved a wish to be 'good'; the midwives wanted to do their best for the women. It is interesting that both the mothers and midwives wanted to achieve something they label as 'good', the good mother, the good midwife. The midwives verbalised their personal responsibilities and the ethical demands on them (Hildingsson and Häggström's 1999). Alongside this they respected the woman's autonomy and supported her right to make informed choices. To achieve being a good midwife, to address the ethical demands and support autonomy, the midwives gained knowledge about the women's situations and their need for support.

Prospective fathers did appear in the interview transcripts but not in an explicit manner; the scripts needed to be searched to find their presence. The theme of involvement and advocacy involved recognition that the midwives held a professional as well as personal role in their support of the women. They used both professional and personal time to provide the care they felt was needed. Their advocacy role also had a number of parts. They advocated for the rights of the baby to receive good care; likewise the woman and the baby's father. Alongside this they advocated for the woman and the baby's father by empowering them to make choices.

The midwives evaluative reflection on their support of the women identified that it was an important task to allow the growth and development of the women. They also reflected on the opportunities to achieve job satisfaction and the lack of opportunities. The workload was burdensome and the midwives felt undervalued but also found it rewarding and joyful (Hildingsson and Häggström 1999).

The study by Hildingsson and Häggström (1999) was the only one that focused specifically on midwives experiences of supporting women becoming mothers but others offer valuable insights into how midwives experience offering emotionally supportive care. Those that will be discussed here are by John and

Parsons (2006) which focused on the emotion work of midwives and Bone (2009) which focused on the care deficit in maternity units in the US.

John and Parsons (2006) conducted their study in the UK with midwives and women on a delivery suite in a low risk obstetric unit. They used an ethnographic approach observing and interviewing ten midwives and the women they were working with. Four interlinking themes were identified and were 'presentation of self, establishing rapport and personal and professional emotion' and 'pulling the shutter down' from the midwives and 'perceptions of shadow work' and 'the maintenance of normality' from the mothers.

Hildingsson and Häggström's (1999) and John and Parsons' (2006) studies revealed an attempt by the midwives to develop rapport. This was expressed by the midwives Hildingsson and Häggström interviewed as getting to know the woman's situation and needs. Rapport for those spoken with and observed by John and Parsons (2006: 268) was expressed as "basic care, touch, facial encouragement, chit chat and sharing part of themselves". These can be seen as very similar approaches to those used in relationship development (in 'What do midwives do?' page 40) and providing comfort as discussed in the previous section ('What is emotional support?' page 87).

Another more recent study conducted in the US also had some similar findings (Bone 2009). Although it was undertaken with nurses, they were fulfilling what would be considered a midwifery role on a labour ward in the UK. As part of this study the nurses were asked to describe how they provided emotional support. The nurses identified "'ways of being, doing and knowing', that could be considered therapeutic emotional labour" (Bone 2009: 59). According to Bone (2009: 60) these ways of being, doing and knowing are "intuitive, relational, experiential and situated".

Bone found that it was difficult to distinguish between emotional support and just chatting. Chatting has been identified as a technique for offering emotional

support (John and Parsons 2006) so there may not be any need to differentiate between them. The nurses described their activities in a way that minimised the value attached to them, which could be seen to devalue emotional support, by using the term 'just' frequently (Bone 2009). Emotional support appeared to be incidental in relationship to other activities such as measurement and documentation.

The nurses Bone interviewed described 'being there' and listening as helpful in emotional support but that it was more about how things were done rather than a distinct activity that facilitated calm or relaxed behaviour in the women. This has already been highlighted by Morse (1994) in providing comfort. They also described using their intuition, perceptiveness or a sixth sense to guide them. Hildingsson and Häggström (1999: 85), like Bone (2009), described midwives using intuition or some other kind of interpretative tool as "they heard something between the words the woman said". This use of self, making the relationship between midwife and women more intimate, will be considered in more detail in the next part of this section.

The studies by Hildingsson and Häggström (1999), John and Parsons (2006) and Bone (2009) all identified that offering this care was stressful, exhausting and undervalued and led to emotional labour and emotion work in midwives (see previous section, page 80).

Intimate relationship – use of self

The intimate relationship between midwife and woman has been recognised by a number of writers (Walsh 1999, Kirkham 1999, Pairman 2000, Hunter 2001, McCourt and Stevens 2009). It has also been established that within this intimate relationship midwives use something of themselves, self disclosure (Kirkham 2002, Hunter 2006, John and Parsons 2006) or intuition (Fleming 1998a, Hildingsson and Häggström 1999, Callister and Freeborn 2007, Bone 2009, Ólafsdóttir 2009).

In Hunter's study (2006) disclosure about themselves became an important element of the midwife-woman relationship and where this was balanced – a reciprocal relationship – the midwives incurred less emotional toll and more job satisfaction. Although Fleming (1998a) does not discuss disclosure she does identify that interdependence occurs and that the social process of reciprocity is key to the therapeutic relationship. She also identifies midwives as seeking to use intuition or a sixth sense to guide their care.

In their study, Hildingsson and Häggström (1999: 85) described the midwives use of intuition or some other interpretative tool as "they heard something between the words the woman said…". When they discussed this intuition it was related to how the needs of the women were identified. The midwives in their study, through their narratives, identified being close friends, and having a strong bond with the women that they were caring for (Hildingsson and Häggström 1999), which has also been identified by other researchers (Walsh 1999, Pairman 2000, Ólafsdóttir 2009).

Ólafsdóttir (2009) undertook an ethnographic narrative study of midwives' stories to uncover the social and cultural world of childbirth. She felt she was particularly focusing on the spiritual elements of their stories and within this study she found that midwives felt guided by intuition or a sixth sense, as has been recognised elsewhere (Fleming 1998a, Callister and Freeborn 2007). The midwives who were expressing these feelings said they had close relationships and it was through this that they developed their intuition. On exploration, Ólafsdóttir found that there were three ways of intuitive or inner knowing. These were intuition based on practice experience, intuition based on spiritual awareness and intuition based on connectiveness with women, but these were overlapping and interrelated (Ólafsdóttir 2009). It may be due to this that these three types of intuition that they are seen as elements of the same phenomenon (Hall 2001) but it is worth considering them separately.

Inner knowing based on practice experience is where the practitioner internalises their knowledge derived from clinical experience and then use this at a subconscious level. This has been highlighted in previous texts, most notably the groundbreaking nursing book by Benner (1984) who used Carper's (1978) ways of knowing as a foundation and entitled her book 'novice to expert' where she demonstrated this type of knowing in expert nurses. Benner's (1984) understanding of nurses' development, as with Smith's writing on emotional labour, has provided a base for the development of understanding of midwifery practice (Wilkins 2006, Callister and Freeborn 2007).

Inner knowing or intuition based on spiritual awareness has received little scientific research and can be labelled as supernatural. The other type of inner knowing Ólafsdóttir identified is based on connectiveness with woman, and has received some attention in recent years. Ólafsdóttir (2009) identified this as interconnected with other types of knowing including scientific, experience, spiritual and professional knowledge, which the midwife uses in a joined-up way with the woman. This appears to be the type of intuition described by Callister and Freeborn (2007) and Fleming (1998a). It has been suggested that intuition can be learnt and if it is developed in midwifery practice it could lead to increased connectiveness in midwife-woman relationships, the organisation of care to be women centred and the use of less techno-medical intervention in childbirth (Hall 2001).

The midwives in Ólafsdóttir's study suggested that they were 'crazy' due to their stories of using intuition or a sixth sense when working with women. They appeared to undervalue the use of intuition and the emotional care they gave in response to it. This devaluing of emotional support or care can be seen in most of the literature pertaining to this area (Bolton 2000, Kirkham 2000, Hunter 2001, 2006, John and Parsons 2006, Bone 2009). The comments by the midwives about the care they were providing can also be seen to maintain this undervaluing.

Despite their use of their existential selves to form relationships midwives avoided talking about their own pregnancies and births. This is because it was seen as problematic for midwives to express personal views and so they usually chose to give the organisational 'good answer' (Kirkham et al 2002).

Midwives may experience emotional and spiritual moments when supporting women but within their intimate relationship with women they also experience intimate physical closeness.

Intimate relationship – physical closeness

Close physical proximity can be a means by which to create a feeling of comfort but this proximity could be influenced by cultural expectations (Williams and Irurita 2004). It is generally assumed that the British public needs a greater personal space than other Europeans but within midwifery and nursing these cultural expectations need at times to be put on one side. This could be considered to create a paradox in that close proximity facilitates comfort, but invading a person's personal space could lead to embarrassment and discomfort.

This physical closeness can be experienced in midwifery care and may provoke embarrassment and discomfort, particularly in the recognition of the sexual nature of childbirth. It is important, though, that midwives acknowledge this sexual component of childbirth and recognise that it may cause emotion work for them as they attempt to provide appropriate care (Hunter 2006).

The sexual nature of midwifery work has long been acknowledged, as motherhood, which midwives support, is the outcome of sexual behaviour. The links between midwifery and sexuality go further than this though. The physiological changes that can occur in childbirth may be similar to those of female orgasm and may lead to similar behaviours such as rhythmic breathing and noises being made (Devane 1996). Also sexual behaviour such as kissing, cuddling, nipple and clitoral stimulation can start and progress labour through

hormonal release (Robertson 2000). The vaginal examination has also been identified as an activity that can create anxiety for both midwife and woman and can be distressing, uncomfortable and embarrassing for the woman. The transition of the vagina from an area of sexual pleasure, which is explored in private, to a functional area that is open to inspection from strangers, can be particularly difficult for all involved. Partners can be seen to turn away so as not to watch vaginal examinations and midwives can be seen to use coping strategies such as infantilising the women (Devane 1996).

The vaginal examination can be seen in one of the themes of suffering when considering comfort – the violated body (Morse et al 1994). To create comfort in this situation, people tend to distance themselves from what is happening, and when they cannot achieve this, caregivers can help create comfort through presence and connection using their voices, hands and eye contact.

It is not just pregnancy and birth that have sexual elements; the breasts are for most couples a part of sexual interactions and this can lead to relationship problems if a woman is breast feeding (Devane 1996, Hall 2002).

Physical proximity is a necessary part of most midwives' roles and it may be found that this is an area for which they need to offer emotional support. As part of this support the inner knowing and intimate midwife-woman relationship described above may overcome the embarrassment felt by midwives or women in close physical proximity. Indeed many writers suggest that if touch is used sensitively it can facilitate comfort and understanding (Kitzinger 1977, Morrison 1992, Morse 2000, Williams and Irurita 2004, John and Parsons 2006).

This section of the literature review has considered the experiences of midwives giving emotional support to women becoming mothers. It can be seen that to offer emotional support midwives use a lot of effort, particularly in their relationships with the women. These relationships are intimate in nature, both physically and emotionally. The midwives appear to access elements of

themselves such as self disclosure and intuition to connect with women to support them. Given the available literature the experiences of midwives cannot be fully explored without considering the context in which they work. Most researchers, when writing about the emotional care given by midwives, highlight the impact that the context of the care has, or what has been labelled the professional culture of midwifery (Kirkham 2000, Hunter 2004, 2005, Bone 2009).

Professional culture in midwifery

As explored in the first part of this literature review entitled 'What is a midwife?' the development of midwifery as a profession was not a smooth, uneventful, process. Events such as the midwives acts and policy development influence the midwifery culture experienced by midwives today. The midwives acts were enacted to develop a trained and disciplined profession where the midwives' first loyalty would now be to their profession rather than to the women for whom they cared (Kirkham 1999). The introduction of the National Health Service (NHS) led to an increase in midwives and an increase in the power the organisational system had over them. Both the NHS and language used can be seen as male engendered, forming an early wedge between 'being with women' and 'being professional' (Kirkham 1999). The issue of patriarchy in health and caring has been raised by a number of other writers (Morrison 1992, Littlewood and McHugh 1997). In her review of the literature Kirkham (1999) acknowledges midwives as being an oppressed group which can lead to 'horizontal violence' and fear of change. Horizontal violence is where an oppressed group do not have the power to change their situation and so monitor and criticise each other rather than those oppressing them.

Kirkham (1999), in her ethnographic study, interviewed 168 midwives from diverse areas to seek their understanding of the midwifery culture in the NHS in England. This data was analysed using a grounded theory approach. She found ten categories. The first category she discusses is 'service and sacrifice' which is where midwives continue to offer care and commitment irrespective of personal

sacrifice. This can be seen in other studies as well (Hildingsson and Häggström 1999, Bolton 2000, John and Parsons 2006).

Midwives' perception was that they needed to be selfless and self-sacrificing, and not to seek support. Alongside this, experienced midwives said that when colleagues said they were being supportive they interpreted it as monitoring and policing. This led to great pressure to conform to behavioural norms. In this culture, where there is pressure to conform, the midwives achieved doing 'good' by stealth. This doing 'good' by stealth was a strategy that midwives used with obstetricians to protect women but it would appear that they were now having to use it with their supervisors too (Kirkham 1999). This has also been seen in other studies (Hunter 2004).

Midwives were experiencing an overwhelming sense of helplessness and that the market, management and the culture of midwifery reinforced this sense of oppression. The culture of midwifery is one where the traditional values of midwives to support and care continue, but in an organisation that has very different values. The midwives' role is to facilitate confidence and increase the ability of the women they care for, but loyalty to their organisational culture prevents them from seeking, or seeing themselves as deserving of, this support and care (Kirkham 1999).

The oppressive culture in midwifery clearly outlined by Kirkham in her study can be found in most of the literature pertaining to research into women-centred care in midwifery. It may, though, be too simplistic to identify this oppression as caused by one factor, as suggested in Kirkham's study; the NHS management. Throughout the development of professional midwifery there have been many influential factors affecting the professional culture, including midwives from different socio-economic groups (Hunter and Leap 1993), inter-professional rivalry (Rhodes 1995, Tew 1998), political agendas (DoH 2004) and what women want, which is again influenced by their cultural expectations (Hochschild 2003).

Despite the current political climate encouraging midwives to be women-centred and to encourage 'normal birth', choice, control and breast feeding (DoH 2003, 2006, ICM 2006) there is still the expectation that this will occur within a goal-orientated, audit-driven and litigious social climate (Kirkham 2000). Kirkham (2009) does offer a way forward based on midwifery research and reflecting on the authors writing in Hunter and Deery's book 'Emotions in midwifery and reproduction' (2009). She states there is the need for political changes to allow trusting, ongoing relationships and autonomy of practice through decentralisation and reduction of high-tech solutions. Kirkham (2009) also highlights changes that midwives need to undertake. They need to reduce defensive habits and learn creative emotional responses through skilled facilitation and excellent role models.

Summary

There has been increased interest by midwifery researchers in the area of emotional labour and emotion work, leading to a number of recent texts. Despite this there remains a limited description of what midwives do when providing emotional support or care for women who are becoming mothers. The early work of Oakley (1988, 1992) highlighted the importance of support for women and the phenomenological study of Hildingsson and Häggström (1999) exploring the midwives experiences are a useful starting point. The research of Hunter and colleagues has, more recently, opened up the area to scrutiny (Hunter and Deery 2009).

The three main studies here offered a good insight into the midwife's experiences of giving emotional support to women becoming mothers (Hildingsson and Haggstrom 1999, John and Parsons 2006, Bone 2009). The workload was experienced as burdensome and the midwives felt undervalued but they also found their work rewarding and joyful. Emotional support appeared to be incidental in relationship to other activities such as measurement and documentation. It was more about how things were done rather than a distinct

activity that facilitated calm or relaxed behaviour in the women (Bone 2009). The midwives also described using something of themselves, making the relationship between midwife and women more intimate (Hildingsson and Häggström 1999, John and Parsons 2006, Bone 2009).

The intimate relationship between midwife and woman has been recognised by a number of writers (Walsh 1999, Pairman 2000, Hunter 2001, Kirkham et al 2002, McCourt and Stevens 2009). It has also been acknowledged that within this intimate relationship midwives use something of themselves, self disclosure (Kirkham 2000, Hunter 2006, John and Parsons 2006) or intuition (Fleming 1998, Hildingsson and Haggstrom 1999, Ólafsdóttir 2009, Bone 2009).

Physical proximity is a necessary part of most midwives roles and it may be found that this is an area for which they need to offer emotional support. As part of this support the inner knowing and intimate midwife-woman relationship described above may overcome the embarrassment felt by midwives or women in close physical proximity. Indeed if touch is used sensitively it can facilitate comfort and understanding (Kitzinger 1977, Morrison 1992, Morse 2000, Williams and Irurita 2004, John and Parsons 2006).

From the available literature it can be seen that central to midwifery care, including offering emotional support, is the relationship between the midwife and woman. All of the authors in Hunter and Deery's (2009) book and numerous other texts acknowledge the impact of culture on this relationship and therefore any research in the area of emotional support should consider the cultural context.

It is also important when undertaking an exploration of emotional support to consider whether it is necessary and what the outcomes of giving it might be, so the next section will consider these.

How might emotional support help women become mothers?

There appeared to be no available specific literature on how emotional support by midwives may help women become mothers. Despite this, there are studies that explore the support needs of women and possible implications of a lack of support (Barclay et al 1996). Women who lack appropriate support are at risk of developing emotional distress and postnatal depression. If this is persistent it can lead to profound effects on mother and family and the development of the baby (McMahon et al 2001).

Introduction

The midwife-woman relationship has been identified as the central element of midwifery care in numerous studies (Fleming 1998b, Fraser1999, Walsh 1999, Pairman 2000, Lundgen 2004, McCourt 2005, Hunter 2006). The evidence suggests that the relationship between midwives and women affects the quality of the childbirth experience (Anderson 2000, Kitzinger 2006, McCourt et al 2006, Edwards 2009) and that this experience stays with women throughout their lives (Lundgren 2004).

Despite the emphasis on 'women-centred care' and the need for an intimate relationship between midwife and woman, there are some that are cautious of this approach. Carolan and Hodnett (2007) provide evidence that women want the opportunity to engage in the decision making process, to be provided with consistent (care to be consistent not carer), respectful and informative care. They suggest this may not be the same as the intimate 'being with woman' care advocated by the promoters of women-centred care. Those encouraging this type of care, though, may well respond to this by stating that the relationship they are striving for is the best way of achieving what women want.

Women appeared to have unrealistic expectations of themselves and others (Cronin 2003, Miller 2007). This could suggest that midwives need to facilitate more realistic discourses but also support control and confidence. These are not the only psychological needs for women (Barclay et al 1997, Cronin 2003); they experience feelings such as loneliness, tearfulness and depression. Indeed the studies exploring the experiences of becoming a mother indicate an emotional struggle with adjustment to motherhood (Barclay et al 1996, 1997, Bondas and Eriksson 2001, Cronin 2003, Miller 2007).

There is some contention about whether emotional distress around the time of becoming a mother is a 'normal' part of the transition or whether it is pathological given that most women experience some emotional lability or the 'baby blues', around 50 – 80% of women (Evins and Theofastous 1997). The prevalence of depression has been suggested to run at 10% of births (Lawrie et al 2002), with post-partum psychosis affecting less than 1% (Evins and Theofastous 1997). These figures may be just the 'tip of the iceberg', if the work of Whitton, Warner and Appleby (1996) is taken into consideration. Their study suggests that out of the women identified as having problems, only 32% of the woman believed that they had postnatal depression and only 12% had spoken to a health care professional about it. Barclay and Lloyd (1996) suggest that if the figures are as high as suggested then postnatal depression is either endemic or that psychiatric labels are being inappropriately applied. Others such as Lawler and Sinclair (2003) suggest that women need to go through a type of grief process to adjust to a new way of being in a new world.

However the distress is labelled, if emotionally supportive care can prevent or reduce its occurrence, it would appear prudent to offer this type of care. Barclay and Lloyd (1996) identify that becoming a mother is a huge transition involving physiological, psychological and social reorganisation. All transitions take some time to achieve the adjustment but the transition to motherhood involves a change in assumptions about the world and an acceptance that the transition is lifelong.

Becoming a mother can include feeling drained, unready, and alone and involve some sense of loss (Barclay et al 1997). Loss of previous relationships with partners and friends, loss of lifestyle, time, freedom and confidence can all be part of the experience (Barclay et al 1997). Women who experience this loss as distress also experience unsettled behaviour in their babies (McMahon et al 2001). For some women these feelings dissipate over a short period of time but for others they can take months to overcome. This occurs at a time when a woman is expected to feel full of joy as a result of her baby (Barclay et al 1997).

Emotional distress, which is labelled as depression, has been found to have long-lasting effects on the baby or young child. Given the infant's extreme dependence on the mother and their sensitivity to interpersonal contacts, the emotional distress of mothers can have a profound impact on the infant (Cox et al 1987, Field et al 1988, Oates 1994, Murray and Cooper 1997). Cognitive development of these young children can be significantly impaired in comparison to those children whose mothers who had not experienced distress (Murray and Cooper 1997, Sinclair and Murray 1998). When the infants of distressed mothers were assessed for their interpersonal functioning, they were found to have a lower rate of interaction, poorer concentration and less effective sharing, and to engage in more negative responses. They were also less sociable to strangers (Burke 2003).

Studies of attachment behaviours demonstrated more children of emotionally distressed or depressed mothers to be insecurely attached (Murray 1992, Teti et al 1995, Murray and Cooper 1997, Burke 2003). These children were also more likely to have behavioural problems and exhibit aggressive behaviour but this can be mediated by parental conflict resolution (Hipwell et al 2005). These findings fit well with the theoretical work of Bowlby and the experimental studies of Ainsworth (Papalia et al 1998).

Attachment is where the infant and mother are in a continuous relationship, where the infant experiences warmth and intimacy and both find satisfaction and enjoyment (Bowlby 1951). This theory of attachment developed over a number of years and a model of how a lack of early attachment could have long-term effects on the person was presented (Bowlby 1969). This was called the internal working model. This suggested that early life experiences lead the infant to develop beliefs and expectations about the world and relationships. If the infant has received continuous love from its mother it will develop the belief that people can be trusted, that they are worthy of love and that people care. The infants then carry this forward to future relationships including their own parenting. These expectations lead to a perception of the world as being benevolent which is self-reinforcing.

An assessment strategy called "The Strange Situation" was developed to measure attachment (Ainsworth and Wittig 1969). This was where young children, that were twelve to eighteen months old, were put into a strange situation and were observed. There were eight episodes of observation but it was the final reunion with the mother from which the classification of category was derived. If the child was securely attached (type B – 66% of children) they were distressed when the mother left and greeted her happily on return. Avoidant attachment (type A – 20% of children) was recorded when the youngster was not distressed on departure and avoided the mother on her return. In anxious resistant attachment (type C – 12%) the child was distressed before the mother left and on her return they seek her attention but resist it by struggling or kicking.

The figures gained from the 'strange situation' are similar to those identified by Bowlby (1951) who suggested that 60% of children are securely attached and therefore at reduced risk of becoming mentally ill or socially deviant. His theory would therefore indicate that 40% of children are at risk and more recent studies suggest that children whose mothers experience emotional distress or depression are likely to be in this group (Murray 1992, Teti et al 1995, Murray and Cooper 1997, Burke 2003).

A longitudinal study was conducted of the five-year-old children of a group of women who experienced postnatal depression and a group of well women (Sinclair and Murray 1998). The children of the women who had experienced some level of distress, which was labelled postnatal depression, were found to have difficulty adjusting to school. Whilst this was more problematic for boys in both groups and those with lower socio-economic status, there was a raised level of disturbance in the children whose mothers had experienced depression. There are also higher levels of aggression expressed in children exposed to maternal depression (Hipwell et al 2005).

Evidence consistently demonstrates that the infants and children of women with high levels of distress go on to have developmental and behavioural problems (McMahon et al 2001, Lemaitre-Sillere 1998, Miller et al 1993). It has also been found that a mother with postnatal depression can have an impact on the whole family (Tammentie et al 2004a, Tammentie et al 2004b, Burke 2003).

Mediating factors for this distress were; the nature of the mother baby interactions, prior experience with other people's babies and the nature of the support available to the mother (Barclay et al 1997). Some of the women identified their mothers as their most important support, but the support offered by midwives and nurses was inconsistent. Postnatal emotional support from the woman's partner was also found to reduce the experience of depression (Lemola et al 2007). The implications are that midwives and nurses should be educated to assist women integrate and resolve their labour experiences and realise the magnitude of the changes a new mother faces (Barclay et al 1997). The NICE guidelines for postnatal care direct midwives not to use formal debriefing techniques after the birth but encourage midwives to check for signs of mental ill health (DoH 2006). Some women need additional emotional and practical support and midwives need to recognise the impact of the individuals' social circumstances (Barclay et al 1997). Morrissey (2007) would agree with Barclay et al's recommendations, particularly facilitating midwives to recognise the

enormity of the transition for women, but he states that 'being with women' through the transition is the most helpful way to promote their mental health.

The 'with woman' ideology of midwifery and 'women-centred' philosophy stated in government and professional body guidance for midwives is the approach necessary for managing and reducing emotional distress (Morrissey 2007).

Summary

There is evidence which supports the need for midwives to offer emotionally supportive care for women becoming mothers to reduce or ameliorate emotional distress for the well being of mother (Barclay et al 1997, Cronin 2003, Miller 2007), baby (McMahon et al 2001, Lemaitre-Sillere 1998, Miller et al 1993) and family (Tammentie et al 2004a, Tammentie et al 2004b, Burke 2003). It is suggested this can be achieved by facilitating the 'with woman' ideology (Morrissey 2007).

Summary of literature review

This literature review has considered a number of questions pertinent to this study.

What is a midwife and midwifery? Midwives and midwifery over the twentieth century and into the twenty-first century have moved from handywomen or wise women who laid out the dead as well providing maternity care, to the modern autonomous professional (Leap and Hunter 1993, Rhodes 1995). They are supported by a plethora of policy and guidance information (DoH 1993, 2004, NICE 2004, 2006). There continues, though, a debate about the ideological underpinning of midwives and midwifery, which influences what they are and what they do. At the beginning of this section Baroness Julia Cumberlege used words such as 'vocation' and 'restoring well-being'. Similarly, Page and McCandlish (2006) described a midwife as being 'with woman' and implying a

relationship of knowing each other. There is an alternative view of midwives and their role; one of being a professional, technically and biomedically orientated midwife. The NSF appears to offer a way of viewing midwifery that is both 'with woman' and 'being professional' but these two contrasting ways of viewing midwives provide some of the context or culture within which this study occurs.

What do midwives do? Midwives' professional bodies (ICM, RCM) as well as government initiatives (NICE 2003, 2006, NSF 2004) guide the midwife to work in partnership with women. The role laid out for midwives by these bodies is complex and skilful. The literature review in this section moved through a consideration of caring including the midwife-woman relationship and the necessary communication skills. It also considered the knowledge and skills needed to undertake examinations, and those needed to support normal birth and breast-feeding, all of which are stated as being part of the midwife's role.

The simplest way of describing the midwife's role, or what they do, is to provide care to facilitate women's safe transition through various stages to motherhood. To undertake this midwives need a sound holistic (biology, psychology, sociology, cultural and spiritual) knowledge base, a caring attitude and good communication skills (Butler et al 2008). Given the context provided above and the role of the midwife, it appears there is a clear indicator that midwives should provide emotional support as well the other types of support that women need in their transition to motherhood.

What is motherhood – becoming a mother? The transition to motherhood for the women in a number of studies involved quite monumental changes in all areas of their lives (Barclay et al 1997, Bondas and Eriksson 2001, Cronin 2003, Miller 2007). Eventually, after an unspecified time, the women appeared to adjust to these and to strive to become what has been labelled 'good mothers'. Motherhood is enacted within a social and political arena, which influences the dominant discourses on mothering (Miller 2007). There are strongly held

stereotypes on what a good mother is and how women will achieve this (Marchant 2004). The becoming and being a good mother discourses can lead women to have unrealistic expectation of their transition to motherhood and motherhood itself. The lack of fulfilment of their expectations can lead to unhappiness with maternity services, emotional distress and, for some, depression (Brown et al 1997).

What is emotional support? None of the concepts explored in this section have clear definitions but a discussion of the relevant literature was explored in an attempt to clarify them. There remains a lack of agreement on the term to be used in midwifery care for working with the emotional needs of women and to define how midwives manage this. As Hunter (2001, 2004, 2005, 2006) undertook most of the early research in this area of midwifery her term is the one adopted primarily in this study. She used the term 'emotion work' based on the differentiation of terms used by Hochschild (1979). It was recognised that providing emotional support could be an immense effort for midwives especially if they adopted the ideology or feeling rules of being with woman within a professional culture.

Supportive qualities, including those which emotionally support women, appear to be listening, being respectful, acceptance and giving clear information (Schuiling and Sampselle 1999, Edwards 2000, Morse 2000). These should be undertaken whatever the midwifery task may be. Supportive midwifery practices included providing an environment that focused on the normality of motherhood, including the birth, reduced fear and increased confidence, control and trust (Rhodes 1995, Kirkham 2000, Edwards 2000, NICE 2003, ICM 2006). If the premise that comfort or reduction of emotional distress is the aim, the literature in this area would guide midwives to express care through touch, giving time and comfort talk (Morse 2000).

What is the experience of midwives supporting motherhood? There has been increased interest by midwifery researchers in the area of emotions and emotion work leading to a number of recent texts (John and Parsons 2006, Hunter and Deery 2009). Despite this there remains a limited description of what midwives do when providing emotional support for women becoming mothers. The early work of Hildingsson and Häggström (1999) is a useful starting point and the research of Hunter and colleagues have opened up the area to scrutiny. From their writings it can be seen that central to midwifery care, including offering emotional support, is the relationship between the midwife and woman. The three main studies considering midwives' experiences by Hildingsson and Häggström (1999), John and Parsons (2006) and Bone (2009) all identified that offering support to women becoming mothers was stressful, exhausting and undervalued and led to emotion work but was still fulfilling.

All of the authors in Hunter and Deery's book (2009) and numerous other texts acknowledge the impact of culture on this relationship and therefore any research in the area of emotional support should consider the cultural context.

How might emotional support help women becoming mothers? No studies specifically focused on how emotional support by midwives may help women become mothers were found. Despite this there were many related studies that explore the support needs of women and possible implications of a lack of support (Barclay et al 1996). Women who lack appropriate support are said to be at risk of developing emotional distress and postnatal depression (Brown et al 1997). If this is persistent it can lead to profound effects on mother, family and the development of the baby (McMahon et al 2001, Burke 2003).

It is also recommended that midwives recognise the enormity of the impact of the transition to motherhood for women and provide education and support for them (Barclay et al 1996, Sinclair and Murray 1998, McMahon et al 2001, Burke 2003, Tammentie et al 2004a). Morrissey (2007) would agree with these

recommendations, and he goes on to state that 'being with women' through the transition is the most helpful way to promote their mental health.

This is a broad literature review as there is limited literature on the specific phenomenon being studied. It should provide a good background for the study and offer a sound context.

As acknowledged above there has recently been an upsurge in interest in the area of emotion work in midwifery but most of this has focused on the emotional toll for the midwife. There have only been two recent studies that could be said to offer some detail on what midwives are doing when they offer emotional support. Those are the studies by John and Parsons (2006) and Bone (2009). These studies were not undertaken to describe how midwives give emotional support to women becoming mothers despite Bone actually asking midwives as part of her study how they provided emotional support to women. Both of these studies were also undertaken in controlled environments – in hospital settings.

There is a need for a clarification, a clear picture or description of how midwives give emotional support to women becoming mothers. This will allow some reflection on the services being provided by midwives at present.

Delineation of the phenomenon of this study

In this literature review there would appear to be some expectation that midwives emotionally support women becoming mothers. Midwives certainly have close contact with women on their journey to motherhood. Although this expectation may be held by women and some midwives it may not be held by midwifery services as a whole, with the move towards medicalisation and professionalism. There does, though, appear to be evidence that midwives offer emotional support to women. There is little clarity on how this is undertaken and, given the studies by Hunter and colleagues, it is possible that this activity may create emotion work for the midwives. When delineating the phenomenon it is also important to

recognise that it is unclear from the literature when a woman becomes a mother, despite there being a wealth of evidence on the impact motherhood has on a woman.

The current understanding of when, how and if midwives provide emotional support to women becoming mothers is unclear. The information in this literature review, along with the original rationale, has led to the following research question to elucidate the phenomenon: "How do midwives emotionally support women becoming mothers for the first time?" It is believed that this question will allow a delineation of the phenomenon and has led to the following aim and objectives.

Aim of this study

To provide an account of how midwives experience participating in giving emotional support to women who are becoming mothers for the first time.

Objectives of this study

To gain descriptive accounts of midwives' perceptions of their lived experiences specifically focused on giving emotional support to women becoming mothers for the first time in what may be considered 'normal' situations.

To gain descriptions from the midwives' perspective of their actions and interactions with women at this time.

To seek both the commonality and uniqueness within the experiences described by the midwives.

To identify the influential elements and the context within which it occurs.

Chapter 2

Methodology

Given the literature available there appeared to be a need to identify how midwives provide emotional support for women becoming mothers. A method was needed to understand this phenomenon.

Unfortunately there was a dearth of literature on how midwives give emotional support to women and also how they are supported and cope in what is considered an emotional occupation (Hunter 2001). Given the lack of previous literature and lack of a previous theory from which to develop a hypothesis a positivist approach to understanding how midwives provided emotional support to women was not indicated. Also, in this study, the aim was not to seek causal explanations or to test hypotheses or predictions (Holloway and Wheeler 1996) therefore a qualitative approach was chosen.

Creswell (1998) offers the researcher the opportunity to choose between five qualitative traditions in qualitative inquiry and research design. He identifies that different authors and different disciplines have organised or classified qualitative approaches in a variety of ways. He believes, though, that these five are the most popular and representative of different discipline orientations. The five traditions he offers are; biography, case study, ethnography, grounded theory and phenomenology. Others, such as Holloway (2005) offer different qualitative approaches for the researcher to choose between.

Holloway (2005) focuses on research in health care which might have influenced her choice of approaches. Her five qualitative approaches are phenomenology (descriptive and hermeneutic), grounded theory, ethnography, narrative analysis and action research. As can be seen she does not consider biography and case study (these have, though, been suggested as methods of data collection) but she does offer the other three of Creswell's along with an additional two. Rapport

(2004) suggests that there are new approaches to qualitative research in health and social care and these include developments in: phenomenology (descriptive and hermeneutic), discourse analysis, narrative analysis, interpretative anthropology, social action research and a new form of aesthetic enquiry.

There are many approaches to qualitative research in health and social care but given those identified by Creswell, Holloway and Rapport, ethnography, grounded theory, narrative approaches, phenomenological approaches and action research were the ones considered for this study. Biley (2004: 139) says that despite many texts offering clear guidance on valid qualitative research approaches there is the need to push "beyond the quantitative and qualitative continuum into the realm of the aesthetic". This approach is labelled a new form of aesthetic enquiry in Rapport's book (2004). Whilst an interesting concept, it was unclear how it would help me achieve the aim of this study. Therefore I explored how the other five approaches already identified may be useful to me.

The five traditions have developed from different disciplines. Ethnography developed through sociology and perhaps primarily through cultural anthropology (Creswell 1998) which can be seen to be similar to the interpretative anthropological approach identified by Rapport (2004). The historical roots of grounded theory lie in sociology and social psychology (Holloway and Todres 2003) whereas narrative analysis has long roots in literary studies but since the 1980's has become prominent initially in sociology and more recently in the social sciences (Elliot 2005). Action research can be considered to have arisen from the need for changes in education but was quickly adopted by health and social care (Freshwater 2005). Phenomenology probably stands out from the others due to its foundations in philosophy and psychology but, as with the other traditions, its development has also been influenced by sociology (Creswell 1998). Within each of the approaches identified there are differing methods, which is important when considering which approach to use in a study; the method needs to not only address the aims but also be acceptable to the participants. Unless one considers literary analysis, for example of poetry,

the development of the phenomenological tradition would appear to have the longest history with its origins in the ancient Greek philosophers.

Creswell (1998) suggests that the three traditions of ethnography, grounded theory and phenomenology not only have differing origins but also different foci in their approach. The same could be said to be true of narrative approaches and action research. It is perhaps prudent to consider action research first as it appeared to be the least likely to facilitate the achievement of the aim of this study.

The focus of action research is to bring about change and to manage it with the aim of improvement (Freshwater 2005). This study's aim was to gain an in-depth understanding of the phenomenon as it is unclear what is happening at the moment. Therefore to undertake an approach that is focused on change would be inappropriate. To gain understanding of a phenomenon or experience has, though, been explored using ethnographical approaches.

Holloway and Todres (2003: 348) identified that the goal for ethnography was to "describe, interpret and understand the characteristics of a particular social setting with all its cultural diversity and multiplicity of voices". It has also been stated that the focus for ethnography is "describing and interpreting a cultural and social group" (Creswell 1998: 65). The goal or focus of ethnography identified by these authors does not address the aim of this study in full. It may be that the phenomenon of emotional support at this time is entirely culturally determined and can only be understood as a cultural nuance. Indeed the literature available would suggest that culture has a massive impact on motherhood, child rearing and the guidance or support they are given. Using an ethnographic approach, though, with a primary focus on social or cultural issues may miss any intrapersonal or other existential elements.

Similarly grounded theory appears sociologically based. Glaser and Strauss (1967), the founders of grounded theory, state that the aim of theory development

in sociology is to predict and explain behaviour, allow the practitioner understanding and control of situations and provide further opportunity for research. This can be reduced to "predict, explain and be relevant" (Glaser and Strauss 1967: 5). They clearly state that they have developed a research method for sociologists and only sociologists can undertake sociological grounded theory. Their approach of developing theory from data rather than starting with a theory with which to explore the data has been accepted by other disciplines. Other groups, such as health professionals, have undertaken grounded theory research but Holloway and Todres (2003: 348) explain that the grounded theory developed by Glaser and Straus aims to "develop a theory of how individuals and groups make meaning together and interact with each other".

The focus of this study is to gain an understanding of how midwives interact with women. I sought to gain this understanding from the individual experiences of the midwives. This would allow me to consider all dimensions of this experience from an insider point of view. I am seeking to understand both the individual and the shared meanings. I do not hold the presupposition that all meaning is developed through interaction. Whilst understanding will be developed through the data from the field it is the meaning of the midwives experiences that was sought; not necessarily the meaning shared between midwives and women. It was possible that there may be an essential existential component. Another of the approaches identified above is a narrative methodology.

Narrative approaches can offer an understanding of the individual and their link with their culture (Sparkes 2005). They, like action research, can be undertaken using both qualitative and quantitative analysis. Narrative analysis can occur through structural models such as consideration of genres, the dynamics of the plot, and plot coherence. It can also be undertaken through a focus on content and form (Elliott 2005). Narrative analysis, at first consideration, may be considered useful given the recognition that becoming a mother is grounded in the culture of the society the woman is living in or grew up in.

For me as a researcher, I struggled to accept either detailed discourse analysis or the open genre or dynamics of the plots as suitable methods to understand how midwives offer emotional support to mothers. Content analysis and discourse analysis seem to focus on the minutiae and, whilst useful for some enlightenment, I do not believe they would do justice to experience. Conversely, I find using plot dynamic, coherence or form too subjective or interpretative. I believe, like Frankl (1959), that we are all searching for meaning. I find myself driven to understand and find meaning in what is said to me and as part of this I need to understand the meaning the other person holds as they perceive it. The term "subplot" suggests deception or intrigue; that whilst a person is offering their story, there are underlying messages they are either trying to hide or are unaware of. This approach does not appeal to my trust in others' consciousness of their experiences or appear to offer the rich meaning of the experiences I would hope for.

Creswell (1998: 65) identifies the focus of phenomenology as "understanding the essence of experiences about a phenomenon" and Holloway and Todres (2003: 348) say its goal is to "describe, interpret and understand the meanings of experiences at both a general and unique level". Both of these definitions, I believe, are acceptable to address the aim of this study. To gain an understanding of the phenomenon at a general and unique level would ensure that as complete an understanding as possible is achieved. To be able to gain meaning at both a general and unique level offers those who work in the area a clear focus when considering how to use their understanding. Moran (2002: 1) says that "Phenomenology may be characterised initially in a broad sense as the unprejudiced, descriptive study of whatever appears to consciousness, precisely in the manner in which it appears" which gives an indication of how this understanding can be achieved. Philosophical understanding of phenomenology expresses the spirit of my interest in developing a descriptive account of the midwives' experiences.

All of the above research traditions can be considered equally valuable but Creswell (1998) and Holloway and Todres (2003) agree that the tradition or approach adopted should depend on the aims of the study.

Phenomenology appeared to be the tradition that would be most useful in achieving the aim of this study. It was important to initially explore its foundations and how it could be employed. The literature pertaining to phenomenology is vast, spreading over several hundred years and, if the philosophical origins are considered, thousands of years.

Husserl (1859-1938) is considered the founder of phenomenology but it is worth recognising that he was a student of Brentano and developed some of his philosophical thinking with him, so it will be helpful to consider this formative influence.

Franz von Brentano (1838-1917) could be considered a significant philosopher; important in the development of qualitative research methods despite his approach being labelled descriptive psychology. He, like many others, was influenced by the writings of Aristotle but he also approved of the models of scientific philosophy developed by Aquinas, Descartes, the Empiricists and Comte (Moran and Mooney 2002). Despite approving of Descartes' model of scientific philosophy, he opposed the Cartesian view that physical events differ from mental events. Brentano considered both mental and physical events as presentations but that people only have an indirect knowledge of the external world and a direct knowledge of their inner world. This can be seen to have similarities with the Kantian doctrine. Kant proposed that people only have an accurate view of how things appear to them rather than an objective perception of the thing itself (Moran and Mooney 2002).

Brentano revived the concept of intentionality; he argued that all physical and mental phenomena are based on presentations and these presentations are intentional. Brentano (1995: 35) said "By presentation I do not mean that which

is presented, but rather the act of presentation. Thus, hearing a sound, seeing a coloured object, feeling warmth or cold, as well as similar states of imagination are examples of what I mean by this term. I also mean by it the thinking of a general concept, providing such a thing actually does occur". He recognised the importance of intuition rather than deduction in the development of understanding which, along with his revival of intentionality, were to form the foundation not only of Husserl's phenomenology but also those who followed him. Brentano lectured to other significant figures such as Freud, Hofler and Stumpf but it was Husserl, another of his students who took his lead (Moran and Mooney 2002).

Despite the foundational work of Brentano and earlier philosophical debates Husserl (1859-1938) is seen as the founder of phenomenology. His background was in mathematics but after studying with Brentano he developed an interest in logic and he wrote extensively on this, rejecting the then current psychological literature and empirical explanations of logic. Some of his early writings included mereology, the relationship between whole and parts (Husserl 1989), intentionality and intuition (Husserl 1983), and these were to play an important part in the development of his method to gain understanding or meaning. Husserl officially presented his work as a radicalised form of transcendental idealism but his work showed other elements to be important; corporeality, intersubjectivity and experience of otherness (Husserl 1989).

Husserl's Logical Investigations 1900-1901 in two volumes offered a new approach to thought and knowing, which he called phenomenology but which is strongly related to Brentano's descriptive psychology. Husserl was, however, highly critical of the psychology of the time, which was based in empiricism and the psychological attempts to find facts. He was strongly of the opinion that there was more to understanding logic than facts (Zahavi 2003). In Volume 2 he wrote of his six investigations including mereology, intentional structure and intuition. In this volume he was moving further away from Brentano's descriptive

psychology to a pure phenomenology equating it to a pure mathematics using intuitions which are ideal and universal.

Husserl (1970: 74) said that unlike psychology "phenomenology does not discuss states of animal organisms but perceptions, judgements, feelings as such, and what pertains to them a priori with unlimited generality, as pure instances of pure species, of what may be seen through a purely intuitive apprehension of essence, whether generic or specific. Pure arithmetic likewise speaks of numbers, and pure geometry of spatial shapes, employing pure intuitions in their ideational universality".

In the same text, Husserl stipulates that all scientific investigation must be presupposition free but he also appears to suggest that this is as long as it does not inhibit the elucidation of the phenomenon. He stated "an epistemological investigation that can seriously claim to be scientific must, it has often been emphasised, satisfy the principle of freedom from presuppositions. This principle, we think, only seeks to express the strict exclusion of all statements not permitting of a comprehensive phenomenological realisation" (Husserl 1970: 75).

The existential phenomenologists, such as Heidegger and Jaspers, have suggested that to be presupposition free is impossible, with Gadamer suggesting that understanding is always a play between tradition or prejudice and possibility of new understanding (Moran and Mooney 2002).

As already identified, intentionality is a key concept within phenomenology; it was revived by Brentano and accepted by Husserl. In Husserl's Logical Investigations (Volume two) he considers intentionality in some detail. According to Husserl, intentionality does not refer to the general concept of the term intention, which is accepted as meaning deliberate or goal orientated; it refers to the essence of consciousness (Husserl 1970a). Consciousness is always focused towards something, it has intentionality, whether that is in an imaginary

world or in the concrete world. All the activities of consciousness are directed towards something at a level other than the thought of activity; it transcends the act (Giorgi and Giorgi 2003a). An example which might clarify this is that a person experiences love, but consciousness does not experience this in isolation. If consciousness experiences love it is an experience directed at someone or something. This direction of consciousness is its intentionality. Husserl (1970: 84), in his exploration of intentionality, cautions that "there are essentially different species and subspecies of intention" but retains the belief that intentionality is the key to unlock consciousness. Intentionality is also a core element of philosophical understanding for the phenomenological philosophers who were to follow Husserl including Heidegger, Sartre and Merleau-Ponty (Langdrige 2007).

Husserl came to see phenomenology as a unique way of studying meaning as it shows itself to consciousness, it could be considered the 'science of science'. His philosophical project was epistemological; it was focused on how we could know. This led to his exploration of the relationship between the knower (noesis) and the known (noema), which posed the problem of how can an objective understanding of the noema be developed if it is always related to the noesis.

Husserl (1970b) states that ordinarily we only have one way of experiencing things, we see only the thing "itself present" or the noema through the noesis. This occurs when the person is in the 'natural attitude'. "A person in the natural attitude…executes the act of experiencing, referring, combining; but while he is executing them, he is looking not toward them but rather in the direction of the objects he is conscious of" (Husserl 1981: 128). In the natural attitude the whole essence of a phenomenon cannot be explored as the knower has organised the experience of the phenomenon to bring it into existence, rather than its original state of being a presence (Giorgi 1997). "On the other hand, he can convert his natural attentional focus into the phenomenologically reflective one" (Husserl 1981: 128).

The extent to which one can move away from the natural attitude is controversial, but after further reading of Decartes and Kant, Husserl reconceived phenomenology as a transcendental science where the natural attitude was bracketed and essentiality achieved when in the reflective attitude (Moran and Mooney 2002). When bracketing of the natural attitude is achieved the researcher is in a position of presuppositionlessness, *epoche* is the result; a place where doubt is the core (Langdrige 2007). Husserl (1970) identifies this epoche as a 'withholding of the natural' and that this is the first step to gain understanding and meaning of a phenomenon.

Husserl (1981) wrote that Descartes came close to finding a pure phenomenology and so he used Descartes' method, of describing mental events, whilst rejecting the Cartesian aims. To achieve the reflective attitude Husserl (1981: 130) stated that the "actuality of all of material nature" is capable of being and should be put on one side "for us the objective world is as if it were placed in brackets". The reflective attitude then transcends the everyday experience or the natural attitude (Husserl 1983). Husserl called this method phenomenological reduction (Husserl 1981: 129).

Husserl (1983: 149) said his procedure was "that of an explorer journeying through an unknown part of the world, and carefully describing what is presented along his unbeaten paths, which will not always be the shortest. Such an explorer can rightfully be filled with the sure confidence that he gives utterance to what, at the time and under the circumstances, must be said – something which, because it is the faithful expression of something seen, will always retain its value – even though new explorations will require new descriptions with manifold improvements".

Husserl was a philosopher, not a researcher, and his focus was on consciousness and logic, developing a pure phenomenology to establish truths grounded in his transcendental idealism. His later work focusing on lifeworld has been more

accessible to researchers. In this work he recognised the centrality of the lifeworld which he offered as a corrective to reductive scientific approaches. This approach offered a science that fulfilled rather than dehumanised human experience (Moran and Mooney 2002).

Lifeworld (lebenswelt) is the world as experienced by people; within the lifeworld people may experience any phenomenon and he sought to understand the lifeworld by exploring the meaning of these experiences. Husserl (1983) developed the term 'lifeworld' to indicate the concept of the stream of experiences before they are categorised in any way. He wrote that when in a phenomenologically reduced state categorisation could be suspended and an essential view of the phenomenon might be gained. He wished to elucidate this lifeworld to gain understanding of what may be essential to the phenomenon (Husserl 1983). Husserl (1970: 70) also said that "in addition to the difficulty of reaching firm results, capable of being self evidently reidentified on many occasions, we have the further difficulty of stating such results, of communicating them to others". Heidegger and other philosophers who were to follow Husserl found this form of idealism difficult to accept (Heidegger 1962).

Many philosophers have continued to build on the work of Husserl in the development of phenomenology. The most influential is probably Martin Heidegger. He suggested that phenomenology is a "methodological conception" (Heidegger 1962), the 'how' of research (Moran and Mooney 2003). Heidegger (1889-1976) was a student of Husserl and became his assistant and, with Husserl's encouragement, eventually took on Husserl's Professorship when he retired. Fairly soon after this Heidegger not only changed the direction of his philosophy, a 'turning', but also joined the Nazi Party (Moran and Mooney 2003).

Heidegger explored the etymology of phenomenology and said it was the exhibiting of an entity as it shows itself. With this recognition, he said that only through phenomenology could ontology (developing an understanding of being)

be achieved (Heidegger 1962). He refers extensively to the concept of *dasein* (human existence/being) which he identifies as always 'being-in-the-world' and that people have a kind of caring involvement with it (Heidegger 1994).

Heidegger suggested a person is self-interpreting, embodied and 'is in time' (temporal). Whilst Husserl had accepted that a person is temporal he believed that all phenomena had essential features which could be considered timeless. The individual variations, though, were related to context including time. This new way of viewing the person led to the development of phenomenological method and due to Heidegger's philosophical understanding this was called the Hermeneutic or Interpretative method of enquiry (Holloway and Wheeler 1996). This hermeneutic (the art of interpretation) approach can be seen to have its origins in the phenomenology of Scheler and the hermeneutics of Dilthey (Moran and Mooney 2002). Heidegger (1962: 286) said "the meaning of phenomenological description as a method lies in interpretation…the phenomenology of Dasein is a hermeneutic".

Husserl acknowledged his form of phenomenology as transcendental but Heidegger was not happy with this 'modern' approach and he went on to state that Husserl's philosophical approach was just another idealist philosophy (Moran and Mooney 2002). He did not believe that people could understand the world without interpretation developed from their history and previous experience. Whereas Husserl was seeking to establish universals or essences through his transcendental approach, Heidegger and his followers believed general or universal laws were not achievable. Heidegger and those who followed him were labelled the existential phenomenologists as they sought to understand the nature of existence or being with the recognition that they could not be separated from their context or place in time (Langdridge 2007).

While there are a number of areas of philosophical agreement between Husserl and Heidegger, such as their understanding of intentionality, categorical intuition and the sense of the a priori, there are also a number of significant differences.

Even where there is agreement over the existence of a concept such as intentionality, Heidegger offers a critique of how it is used by Husserl. Heidegger (1994) stated that Husserl has just taken on the concept of consciousness from Descartes and Kant, which leads to a focus on achieving certainty. Heidegger identifies that this focus on certainty results in intentionality becoming orientated towards intentional knowing. He said that "it is a methodological misunderstanding to make the investigation of emotional experiences simply analogous to knowing" (Heidegger 1994: 209).

The detailed debate over these concepts lies in the realm of philosophy but it is useful to recognise that Heidegger and subsequent philosophers believed they were developing their ability to understand people within a phenomenological tradition. Some writers have focused on the difference between Husserl and Heidegger and others on the overlap in their philosophies but perhaps most pertinent for researchers is the different interpretative and descriptive phenomenological approaches (Zahavi 2003).

At the beginning of the twentieth century many phenomenological philosophers further developed the work of Husserl and Heidegger, but Heidegger's hermeneutic approach appears to have been more widely accepted than Husserl's transcendental approach. The First and Second World Wars were, though, to have a great impact on these thinkers. Heidegger joined the Nazi Party whereas others were imprisoned (Ricouer & Levinas), were killed (Stein in Auschwitz), signed a declaration to say they were not Jews (De Beauvoir) or fled Germany (Arendt) (Moran and Mooney 2003). Prior to the Second World War the centre of phenomenology was Germany (the German phase) but after this exodus the centre appeared to be situated in France (French phase).

The twentieth century phenomenologists developed differing views of phenomenology but all, from both phases, offered criticisms of Husserl and Heidegger. Gadamer (1989), of the German phase, along with Heidegger, believed language to be the medium of the hermeneutic experience but that

ongoing conversations lead to joint meaning; a "fusion of horizons". Gadamer (1989: 383) stated that "a conversation has a spirit of its own, and the language in which it is conducted bears its own truth within it – i.e., that it allows something to 'emerge' which henceforth exists". Gadamer agreed with Heidegger's view that understanding can only be gained when placed historically and culturally. He also agreed that understanding is the core of human existence (Langdridge 2007).

Merleau-Ponty, of the French phase, is recognised as being a follower of Husserl but rejected the transcendental approach of Husserl's philosophical phenomenology. Like Heidegger he accepted Husserl's concepts of intentionality, bracketing and the lifeworld, or to use a Heideggerian term, being-in-the-world (Moran and Mooney 2002). He, like Gadamer, was an existentialist and was concerned with understanding existence and his work developed from the foundations laid down by Husserl and Heidegger. Directly in opposition to Descartes' dualism, he identified consciousness as embodied; nature and culture as being primordially intertwined (Merleau-Ponty 1963).

Levinas (1906-1995), along with the other twentieth century phenomenologists, such as Gadamer and Merleau-Ponty, was also critical of elements of Husserl and Heidegger's work. He admired Husserl's account of intuition but, along with Heidegger, was critical of Husserl's transcendental idealism. Levinas went on to suggest that Husserl's understanding of 'otherness' was subjective in that the other was construed through individual transcendental consciousness (Levinas 1969) – thoughts generated by the subject. Levinas (1983) was also unhappy to accept presupposition of the phenomenologists that consciousness was intentional. This was partly due to his reflections on otherness with particular reference to the other's face. Levinas suggested (1983) that there is meaning beyond the intentional act and there is more to meaning than noesis and noema. He pointed to the face of the other as an explanation of this: "the face signifies beyond, neither as an index or as a symbol but precisely and irreducibly as a face that summons me…In this summons, the question harkens back to its

primordial, underived meaning" (Levinas 1983: 113). He suggested there is something of the self that is more than conscious knowing.

Phenomenology has offered an interesting direction for human science, for example, sociologists Ricoeur and Schultz utilised this philosophy to proceed with their research. In psychology Giorgi transformed and continues to transform the philosophy of Husserl in a way that is useful in the study of human science for those with nursing and psychology backgrounds, and I have both. This has not been without its critics; Paley (1997) writes that nursing studies that claim to be phenomenological should not be considered linked to Husserlian philosophy. Giorgi (2000) strongly refutes this stating that if nurses undertook a phenomenological research more closely allied to Husserl's method they would be conducting philosophy not nursing research.

Giorgi (1997) wrote that for a researcher to undertake Descriptive Phenomenological research in human sciences such as psychology, there are certain philosophical concepts that need to be acknowledged and accepted. These have been explored in more detail earlier but it is worth restating them here using Giorgi's explanations. Consciousness exists and is intentional – it is always directed towards an object. Intuition brings things or objects to consciousness where they are categorised and become experiences; they are things in the natural attitude. A phenomenon is the intuition about the object before categorisation and the experience (Giorgi 1997).

These basic phenomenological concepts along with an understanding of phenomenological method need to be understood in order to be able to use this approach in human science research (Giorgi 1997). The basic Husserlian method is 1, phenomenological reduction, 2, description, 3, search for essences. This method was used by philosophers who were undertaking personal explorations, but in health and social care or human sciences to understand a phenomenon there is frequently the need to explore other people's descriptions. This is one of the fundamental differences between Giorgi's and Husserl's method. It is also

one of the criticisms levelled at phenomenological nursing research by Paley (1997) who stated that he could not find any justification for using descriptions from others. Giorgi (2000) countered this with reference to Jasper and Spiegelberg who identified 'vicarious experiencing', 'co-operative encounters' and 'co-operative exploration' and the study of empathy by Stein as others to support his view.

Giorgi's (1997) method involved collecting descriptions or interviews from people in the natural attitude. The researcher then takes on the phenomenologically reduced attitude to undertake analysis of these descriptions or transcripts. He recognised that Husserl identified different levels of phenomenological reduction; phenomenological psychological reduction (brackets world but not empirical subject), eidetic reduction (reduction to essences), transcendental phenomenological reduction (deepest level bracketing everything). Giorgi (1997) stated that at least the minimal level of phenomenological reduction is needed for a study to be phenomenological, bracketing the world but not the empirical subject. He (Giorgi 2000) also explains that with the scientific phenomenological method there is not the expectation that researchers would seek to achieve transcendental phenomenological reduction (the bracketing of the ego or subjectivity itself). This, he identified, was strictly philosophical phenomenology. He justifies this acceptance of lower levels of reduction to seek understanding of a phenomenon by considering some of the writings of Husserl, who also practised this more mundane phenomenology at times.

Another difference between philosophical phenomenology and Giorgi's method is that the philosophical approach seeks more universal and foundational essential features of phenomenon whereas in human science findings are narrower and more focused, they are more contextualised. This scientific approach accepts the development of meaning units that presuppose the assumption of the discipline and the phenomenon. The search is for scientific essences not philosophical ones.

Whilst phenomenological philosophers may make existential claims, Giorgi stated (1997) that the only claim that can be made using his method is that concrete experiences have been gained that indicate what the person was present to. This in some part addresses one of Paley's (1997) concerns that descriptions are not gained in a phenomenologically reduced attitude but as already stated the descriptions collected are from people in the natural attitude (Giorgi 2000).

Giorgi's method:

Collection of verbal data

Reading of the data

Breaking down of the data into some kind of parts

Organisation and expression of data from disciplinary perspective

Synthesis or summary of data for purposes of communication (Giorgi 1997: 245)

These stages will be further clarified in the method section.

Chapter 3

Method

Overview of the method

The method used in this study was an application of Amedeo Giorgi's descriptive phenomenology (1985, 2000, 2003a). His method is based on the philosophical phenomenology of Husserl, as described in the methodology chapter. Giorgi's method differs from the Husserlian approach in some important ways, which may encourage some to suggest that it is not pure phenomenology. Giorgi explains that these differences are necessary in order to facilitate the use of philosophical phenomenology by scientific researchers.

Husserl aimed to gain universal essential features of phenomena (Husserl 1970) but Giorgi's aim is to gain, through scientific phenomenology, a 'generality' of features (Giorgi and Giorgi 2003b). Husserl's philosophical phenomenology can be seen to be seeking universal truths or an understanding of 'the thing itself'; hence the suggestion that Husserl was a radical idealist (Moran and Mooney 2002). Giorgi does not claim this for his scientific method; instead of universal essences he seeks generally applicable features. Therefore this study will use the term 'constituents' rather than 'essences' when the features of the phenomenon are discussed.

This leads to the most obvious modification made by Giorgi (1985) of Husserl's philosophical phenomenology, which was that his research process or empirical phenomenological approach allowed researchers to develop their understanding of other peoples' lived experiences. Husserl's philosophical phenomenology was developed to facilitate the philosopher in their exploration of their own lifeworld in a phenomenologically reduced attitude. Giorgi's method allows for descriptions to be collected from people in the natural attitude (Giorgi 2000).

Giorgi provides, in a number of texts, a description of his method including a staged approach to analysis (for some examples see Giorgi 1985, 1997, 2000, 2003a). The method is laid out below and the stages of analysis will be explored later in this chapter.

Collection of verbal data

Reading of the data

Breaking down of the data into some kind of parts

Organisation and expression of data from disciplinary perspective

Synthesis or summary of data for purposes of communication (Giorgi 1997: 245)

The collection of verbal data is described in the following sections labelled 'Sampling strategy and rationale', 'Recruitment strategy and rationale', 'Data collection strategy and rationale', 'Phenomenological interviewing' and 'Formulating the request for a description of the experience'. An overview of this can be found in 'The procedure and sample'. The other areas named above are explained in 'Data analysis'.

Aim of this study

To provide an account of how midwives experience participating in giving emotional support to women who are becoming mothers for the first time.

Objectives of this study

To gain descriptive accounts of midwives' perceptions of their lived experiences specifically focused on giving emotional support to women becoming mothers for the first time in what may be considered 'normal' situations.

To gain descriptions from the midwives' perspective of their actions and interactions with women at this time.

To seek both the commonality and uniqueness within the experiences described by the midwives.

To identify the influential elements and the context within which it occurs.

Sampling strategy and rationale

The sampling strategy for this study could be labelled purposeful or criterion-based, in common with most qualitative research (Holloway and Wheeler 2002). This is due to specific criteria or participants purposely being sought out. It was necessary for this study to use this approach, to ensure that participants had experienced the phenomenon being studied. The criteria used needed to and did include that the participants were midwives and that they had had sufficient opportunity to experience the phenomenon of giving emotional support to women becoming mothers for the first time. This led to two criteria; the participants had to be midwives and have at least two years experience. As the literature was unclear when women became mothers, whether at conception, the point where the foetus could survive outside the womb, at birth or some time afterwards, the midwives who worked primarily in one area such as labour wards were discounted. After discussing this with midwifery colleagues I made the decision to ask community midwives who, I was informed, usually have relationships with the women throughout the period when a woman may be considered to become a mother. Community midwives care for women from confirmation of pregnancy through to the early days after the birth.

It has been recommended that when undertaking a descriptive phenomenological study that researchers use Maximum Variation Sampling (Langdridge 2007). This is where the participants have a common experience (for example emotional support of women) but that a demographically broad range of people experiencing this phenomenon as possible is included. This should allow the identification of the invariant features of the phenomenon. Todres (2005), whilst not arguing against this, guides the researcher to seek quality of

description rather than quantity of descriptions. Langdridge (2007) acknowledges, though, that maximum variation is not always achievable within the small studies that need to be undertaken for practical reasons. Both Langdridge and Todres also accept that these small studies can offer good insights into the given phenomena.

I therefore decided to seek a group of midwives who had had the opportunity to experience this phenomenon within a selected environment: in this case one National Health Service (NHS) Trust. This was for pragmatic reasons but it should facilitate the recognition of some general features of the phenomenon with the acknowledgement that there may be others. It could be suggested that I chose a particular culture within which the midwives were experiencing the world and given that I have chosen to do this it will be acknowledged within the findings. The context is as important as the features of the experience for gaining understanding of the scientific phenomenology (Giorgi and Giorgi 2003b). A more detailed discussion of the sample can be found later in this chapter.

Recruitment strategy and rationale

The recruitment strategy was chosen as a pragmatic approach and to ensure adherence to ethical principles. The community midwives at one of the local NHS Trusts had a regular monthly meeting. The managing midwife suggested this would be a good opportunity to recruit midwives to the study. She arranged for me to present my intended study to the community midwives at this meeting as they regularly received presentations about research, equipment etc. at this time. Some of the midwives appeared interested in the study and took away information sheets and my contact details.

From the presentation two midwives contacted me to express their interest in becoming participants. No other midwives came forward from the presentation but the first two midwives, after they had been interviewed, said they would

discuss the study with their colleagues and give them my details. It was from this approach that the rest of the participants were gained, which has been labelled chain referral or 'snowballing' (Holloway and Wheeler 2002). This is said to be useful when it is difficult to access participants or where anonymity is important. The midwives in my study were not anonymous to me, as they all signed consent forms, although they remain so to any other reader. I would also have had difficulty accessing more participants without this snowballing process therefore my sample could be said to be difficult to access.

Snowballing does have intrinsic problems such as it may produce a homogenous research group; a similarly thinking or behaving group of participants. The participants could all have a similar view of the world and belief system that might be quite different to the rest of the cultural group. It may also encourage those who have either a very positive view of the phenomenon and want to encourage others to become involved in it or the opposite. For this study a positive or negative view should not have had any impact as it seeks to gain the meaning of the phenomenon and, if it exists, what it looks like. Despite this, if the participants all had a similar view of the phenomenon this may have influenced their description of it and therefore influenced the meaning gained in the findings.

These limitations are acknowledged, but there will always be problems with samples in qualitative research as the rules for sampling are less rigid than quantitative approaches (Holloway and Wheeler 2002). Given this there is an obligation on the researcher to make clear the strategies used to facilitate transparency and inspection of rigour.

Data collection strategy and rationale

Once midwives were recruited to the study they were invited to take part in a one to one unstructured interview (Holloway and Wheeler 2002). However Langdridge (2007: 65) recommends semi-structured interviewing for

phenomenological research offering "a trade off between consistency and flexibility". For this study I did not want to consider a trade off, I wanted to offer maximum flexibility and maximum consistency. I did not assume how the interviews should progress, only that the midwives would offer descriptions of their experiences of what they thought emotional support for women becoming mothers was to them. This allowed the participants maximum flexibility. The consistency can be seen in that I conducted all the interviews and only asked one question, I attempted and believe I was successful in not leading the midwives. Despite this, Taylor (2005) considered the argument that no interview can be truly unstructured. She identified that interviews may be semi-structured, loosely structured or in-depth. Taylor (2005) unlike Langdrige (2007) goes on to say that phenomenological interviewing is the nearest to being unstructured and is often described as in-depth.

The interviews took place in an area mostly free from disturbances and of the midwives' choice. Most interviews were conducted in their workplace so that there was as little disruption to their work timetable as possible but some chose to be interviewed in my office at the university.

Phenomenological Interviewing

Taylor (2005: 39) offers a quote from Oakley (1981: 31) to introduce the qualitative interview, which is that it "is rather like a marriage: everybody knows what it is, an awful lot of people do it, and yet behind each front door there is a world of secrets". For the qualitative interviewer undertaking a scientific study, the secrets need to be laid bare to allow inspection and facilitate credibility of the findings.

Most of the literature pertaining to qualitative interviewing explains how it is a skilled activity that needs practice (Rubin and Rubin 1998, Robson 2002, Taylor 2005, Langdrige 2007). Giorgi offers limited guidance on phenomenological interviewing but does provide instruction that the researcher should gather

concrete experiences of the given phenomenon. What is sought is a "detailed description of the subject's experience and actions, as faithful as possible to what happened as experienced by the subject" (Giorgi 1997: 245). He also says there are "no perfect descriptions, only adequate or inadequate ones" (Giorgi and Giorgi 2003b: 248). Despite his limited explanation of the interview process he does offer many examples. There is however a wealth of other literature on how to conduct the qualitative interview.

Phenomenological interviewing is much like other qualitative interviewing as it involves some sort of relationship between interviewer and interviewee (Taylor 2005). The interviewer needs to be mindful of any power imbalances that may be present, for example the interviewer may be seen to have greater control and status than the interviewee. This could lead to the interviewee being reticent to share any controversial information. The qualitative interviewer also needs to have well developed communication, particularly listening, skills. The phenomenological approach to interviewing is one of data collection, collecting descriptions of experiences to develop understanding of the interviewee's lived experience (Taylor 2005).

Taylor (2005) offers a description of phenomenological interviewing, stating that it should be non-directive and not be contaminated with the researcher's own assumptions. This non-contamination can be seen to be similar to the bracketing that has been discussed in the methodology chapter and will be discussed more in the analysis section. Husserl, in his philosophical phenomenology, describes different levels of phenomenological reduction or reduced attitude, which can be achieved by bracketing. His writing indicates that the philosopher must be in the reduced attitude (to bracket out all previous knowledge and experience) when seeking to explore their lifeworld, ideally to the level of transcendental reduction. As already outlined at the beginning of this chapter, Giorgi has modified this approach to facilitate the use of phenomenology by scientific researchers. In this, he guides the researcher to psychological reduction rather than transcendental reduction.

Researchers could also use this psychologically reduced attitude when collecting data. This was how I interviewed the participants; I approached the phenomenon with a naivety, putting to one side my previous knowledge and experiences to approach the interview without presupposition of what they would describe.

Taylor (2005) describes the phenomenological interviewer as using some of the well-established listening skills outlined by Egan (1977) such as reflecting back and paraphrasing. She also identifies the use of techniques such as probing but as the interviewer I prefer to use the term "Socratic dialogue" where I am asking for further clarification and detail of what has been said. Reflexivity is also considered an important skill for the phenomenological interviewer (Langdridge 2007) where interest, understanding and warmth are conveyed to the interviewee.

This in-depth interview using specialised communication skills usually consists of one very open question (Todres and Holloway 2003, Taylor 2005). This was the approach I aimed at when collecting the data for this study.

Formulating the request for a description of the experience

The first step to data collection is to articulate the experiential phenomenon of interest (Giorgi and Giorgi 2003a, Todres and Holloway 2004, Taylor 2005). This was identified for this study as – How do midwives provide emotional support for women becoming mothers? Once the experiential phenomenon is clearly identified there is the need to establish how descriptions of the phenomenon may be gathered. As has already been explained this study is using an in-depth, unstructured interview approach but this requires a stimulus question to guide the interviewees to describe their experiences of the phenomenon.

It is important to clearly articulate the stimulus question to be posed so that the descriptions gathered give a detailed account of the area of interest or

phenomenon (Todres and Holloway 2004, Taylor 2005). Ideally there should be one stimulus question to develop an understanding of one phenomenon (Giorgi 1997) although at a later stage it may be recognised that more than one phenomenon is being described. Todres (2005) makes it clear that the stimulus question should lead the person to describe a specific kind of experience.

The formulation of the stimulus question for this study took some time and discussion to ensure that there was a shared understanding of the phenomenon from which to gain descriptions. After several attempts at wording the stimulus question a tentative decision was made that the following was to be asked of the midwives:

"Describe an experience in which you felt that a woman needed you to provide her with emotional support in becoming a mother."

After the first two interviews, with community midwives Annabel and Betty, it appeared that this stimulus question was not allowing direct access to the desired phenomenon and so after consultation with midwives and available literature the question was changed to:

“Describe an experience in which you felt that a woman needed you to provide her with emotional support in becoming a mother for the first time”.

The other midwives were interviewed using this stimulus question and they appeared to give clear descriptions of the desired phenomenon. When the first two interviews were reconsidered, after the collection of these further descriptions, it was acknowledged that Betty had provided a description of the phenomenon and so her interview was incorporated into the analysis. Despite many similarities and the ability to place data gained from Annabel into the constituents it was decided not to use her description as she had decided herself that she had not provided the woman with emotional support.

The procedure and sample

For this study community midwives were sought as participants; eight midwives were interviewed. They were recruited according to the recruitment strategy already outlined.

Written consent was gained from the midwives prior to the interviews and again after the interview to allow them to reconsider whether they wanted the descriptions shared with me of their experiences to be used (consent form Appendix B). They were told verbally and on the written information sheet of their right to stop the interview at any time.

The interviews were tape recorded and lasted approximately an hour. All the midwives were working in the community and had at least two years experience; this was part of the selection criteria and stated in the information leaflet (Appendix C). They were all recruited from one NHS Trust. There were no other inclusion / exclusion criteria or demographic details requested therefore table 1 (below) is complied from the researcher's diary and information given by the midwives during the interview.

	Annabel	Betty	Carol	Diane	Emily	Fiona	Gina	Hetty
At least 2 years experience *	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Community Midwife*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Working same NHS Trust*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Female	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Location of support given	Home Phone Surgery	Home	Home	Home	Home	Home	Home Phone	Home
Mother	Not known	Not known	Not known	Not Known	Yes	Yes	Not known	Not known
Discussed personal experiences with mothers	No	No	No	No	Yes	Yes	No	No
Interview part of findings	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Interviewed on NHS property	No	Yes	No	Yes	Yes	Yes	Yes	Yes
Interviewed researcher's office	Yes	No	Yes	No	No	No	No	No

Table 1: midwife participants - * demonstrates inclusion criteria

Data gathering

A mutually agreed time and place was organised by telephone for the interview to take place. The researcher arrived in good time for the interview and on arrival the room was organised so that the microphone was in a convenient place and the seating arrangements were comfortable. The researcher ensured the midwife understood what they were participating in and answered any questions. When both midwife and researcher were sure that they mutually understood what was expected the midwife was asked to sign a consent form and the tape recorder was turned on.

Only the stimulus question was used, although the interviewer did make encouraging expressions such as soft noises, nodding and smiling. Paraphrasing and reflecting back digested meaning were also used to develop the conversation and the descriptions were tape-recorded. These encouragements by the interviewer were explicitly recorded within the transcripts as Giorgi clearly states that the interview should be transcribed "precisely as it took place" (Giorgi and Giorgi 2003b: 25). Encouragement was provided in an attempt to facilitate further description, to clarify rather than to direct the respondent, at the same time as remaining focused on the phenomenon (Todres 2005).

After the interview the researcher thanked each midwife for her time and asked her to re-sign the consent form if she was happy for the interview to be used as part of the study. The midwife was also asked at this time if she would like a copy of the transcript. All the interviews were transcribed from the audiotapes by me.

Ethical issues

An ethical opinion was gained from the Local Research Ethics Committee (LREC): without a positive opinion the study would not have gone ahead. As part of this process there was the need to demonstrate that all possible ethical dilemmas had been considered and addressed. These dilemmas were twofold: one part was to ensure participant safety and the other to ensure that organisational issues were addressed.

The first consideration of the LREC is to ensure the protection of the participants in the study, including a safe environment, a skilled interviewer and a plan of how to deal with any distress that might be triggered by the discussions. The other part of their process was more structural and organisational. Permissions needed to be gained from the midwives and those managing the midwives and responsible for their safety at work. A health and safety risk assessment was

undertaken and written permission was sought and gained from the midwives, their midwifery manager and clinical lead.

The study was expected to and did comply with both the research governance of the university supervising the study and the research governance of the Trust who employed the midwives. An honorary contract of employment was also sought and gained to allow access to the midwives on NHS property. The ethical principles of The British Psychological Society and the Nursing and Midwifery Council were adhered to as these are not mutually exclusive and I am a member of both professional bodies.

Written consent (see Appendix B) was gained from the participants, who were fully informed of the aim of the study and methods to be used and that the findings would be made available to them (see Appendix C). The midwives were offered a copy of the transcripts taken from the interviews to allow them to reflect and comment on if they wished. Only two of the midwives asked for a copy of their transcripts but neither offered any comment on them. A plan was set in place so that if a midwife should become distressed during the interview it would be stopped, immediate support would be offered and the potential for further needs discussed. This plan did not need to be put into action for any of the interviews but one midwife's emotional needs were explored at the end of the interview as she did not seem happy with herself. She said she did not need any further intervention from me and identified her own support mechanisms if she felt these were needed later.

It was recognised that not only the midwives themselves needed to have their confidentiality ensured in line with research governance but also the women they were talking about. The midwives were briefed in advance of the interview not to disclose information that could identify the women they were discussing. This did not occur during the interviews but to reduce the risk of identification further some of the midwives speech is not included in the transcripts in appendix A. In line with our code of conduct, if a midwife had disclosed information that raised

concern for the safety of others I would have been obliged to disclose this information and the midwives were informed of this in advance of the interviews. Neither my supervisors nor I identified any issues of concern when we discussed the interviews. All the information received was and is regarded as confidential and no midwife or mother is identifiable from the data used in the study or will be in the subsequent finding dissemination. To ensure this pseudonyms have been given to each of the midwives and due to the personal nature of their descriptions, some of the raw data has been removed but the associated meaning unit remains (Appendix A).

All participants had the opportunity to withdraw from the study at any stage and all information has been and will be kept confidential. All the interviews were conducted by me and only I have access to any data that may link participant with interview and this is kept in a securely locked drawer to which only I have access. The tape recordings of the interviews will be stored for two years and the hard copies of the transcriptions will be stored for five year after the study in accordance with university policy (Bournemouth University 2003).

All the regulations associated with conducting the study were complied with and the study was undertaken. There are, though, other ethical considerations that were taken into account but were not laid down as necessary, regulated for or checked. These ethical issues related to the proper use of the descriptions shared and the responsibility of the researcher to 'stay true' to the shared experiences and not to manipulate them in a manner that would misrepresent them. The midwives in this study described their experiences in the hope that they would be beneficial either to other midwives or the women in their care and it was important that the trust bestowed on the researcher was not misplaced. These issues would be hard to regulate for but it is important that they are raised and considered. It is believed that the experiences shared by the midwives in this study were respected and have maintained their essential features throughout the analysis.

Data analysis

The data collected from the interviews with the midwives was analysed using Giorgi's data analysis process, see table 2.

Stage	Giorgi's steps to data analysis	How this was undertaken in this study
1	Reading whole transcript which becomes an intuitive reference for the parts or constituents	The transcripts were read and reread to gain a holistic understanding of the midwives' experience
2	Delineating meaning units	These were identified by a line in the column of the transcript to indicate where one meaning unit ended and another began
3	Transforming meaning units	These can be found in the third column of the analysis tables and is where the meaning units are transformed into a more transferable language
4	Transforming into psychologically sensitive units	These can be found in column four of the analysis tables and is where using imaginative variation the meaning units become psychologically sensitive expressions of the phenomenon
5	General Structure	This is provided in the findings section as an understanding of the phenomenon considering the meaning units from all the transcripts.

Table 2: Data Analysis

Giorgi's step by step approach outlined in the table above facilitates analysia of the collected experiences of the given phenomenon (Giorgi and Giorgi 2003b) and has four or five steps dependant on whether step three above is undertaken. I chose to undertake the five steps to help clarify the process. Throughout the five steps the empathic attitude (Todres 2005) or scientific phenomenological reduction (Giorgi and Giorgi 2003b) was maintained. Phenomenological reduction is the means by which the researcher captures the total experience of the phenomenon without making the meanings hierarchical as occurs in the

'natural attitude'. The reduced attitude (psychological phenomenological reduction) using Giorgi's research method (Giorgi 1985) involves bracketing or suspending any presuppositions that the researcher may have about whether the phenomenon exists or any related theory pertaining to it.

Stage one - Reading whole transcript: an intuitive reference for the parts or constituents

The first of these five steps was to read the transcripts searching for a basic sense of the whole (Giorgi and Giorgi 2003b). At this stage it became clear from the transcripts that there was an identifiable phenomenon. The midwives all identified different contexts in which they offered emotional support but in each of their experiences shared with me there were similarities. A sense that there was a distinct phenomenon of offering emotional support in the context of becoming a mother was felt. This allowed an intuitive reference from which the detail could be explored (Todres 2005).

Stage two - Delineating meaning units

The next step (stage two) of the descriptive phenomenological psychological method is to determine or delineate meaning units from the transcriptions. There are no objective meaning units; this is just a method or tool to assist the researcher (Giorgi and Giorgi 2003b). These meaning units are not indisputable; they just assist the researcher in their attempt to understand the phenomenon. The meaning units are judged by their outcome (the general structure formed and essential features identified), not by the replicability of those identified (Giorgi and Giorgi 2003b).

The meaning units determined in the reduced attitude were noted where I recognised a change in meaning in the narrative related to the phenomenon being studied. This continued until all the transcriptions had been changed into meaning units. The meaning units are usually distinguished in the text by slashes

or numbers, in this study lines have been used, see emboldened column in table 3 below for an example.

Number of meaning unit	**Transcription with lines between delineation of meaning units**	Transformed meaning units	Psychologically transformed meaning units
48	**Again it caused for an enormous amount of patience**	This situation needed an enormous amount of patience	Betty needed to exercise an enormous amount of patience to support this woman and her husband
49	**because these people feel that they are being a nuisance and that is the natural reaction but with this couple they have**	Betty thought the woman and her husband felt they were being a nuisance	Betty was concerned the woman and husband would feel as if they were a nuisance.
50	**Luckily they never felt they needed to apologise to me so hopefully that was because they didn't feel that I was being short with them or losing my patience.**	As the couple did not apologise to Betty for being a nuisance she believed she had been patient with them.	Betty judged she had been patient with couple by their not apologising.

Table 3: illustrating steps 2 – 4, step 2 is highlighted

Stage three - Transforming meaning units

In the third stage or step, the meaning units were transformed into more concise and easily accessible language. This is not always necessary but as the midwives were thinking about the experience as they were describing it their language was not always coherent. See column three, emboldened text in table 4 below for an example.

Number of meaning unit	Transcription with lines between delineation of meaning units	**Transformed meaning units**	Psychologically transformed meaning units
	Oh dear.		
8	So I wondered um actually post delivery I think she was a bit depressed	**This situation gave concern to Emily and she thought the woman was a bit depressed post birth.**	Emily thought this went on to have an effect on the woman's mood after birth.
9	Because she comes from quite a quite um er good socio economic group. As they have got everything, the house, young couple, career minded and everything like that and I think, I think a lot of this surrounding midwives was to do with the changes of leaving working and becoming a mum	**The woman and her partner were from a good socio economic group. They were a young couple, career minded with a house. Emily therefore thought that some of the distress over changing midwives might be due to leaving work and becoming a mum.**	Emily thought that due to the woman's socio-economic group the distress was probably due to leaving work and becoming a mother.
	Right…		
10	And all those things and it was the only way she could express all those things by fixing on this idea of changing midwives….	**Emily suggested the woman had focused her stress on the issue of changing midwives.**	Emily thought that the woman was expressing her underlying stress through the current situation.
	Right….		

Table 4: illustrating steps 2 – 4, step 3 is highlighted

Stage four - Transforming into psychologically sensitive units

The fourth step in the analysis is labelled by Giorgi and Giorgi (2003b: 252) as the "transformation of meaning units into psychologically sensitive expressions". This requires the researcher to maintain the attitude of reduction at the same time as using free imaginative variation. For both Husserl (1983) and Giorgi (2003b), to undertake phenomenology the use of imaginative variation was a necessity. Free imaginative variation is where the researcher, using their imagination, explores the meanings derived from the descriptions to identify their limits or

boundaries. For each transformed meaning unit I asked myself if this statement meant this would it still be an element of this phenomenon. See the fourth column, emboldened, in table 5 below for examples.

Number	Transcription with lines between delineation of meaning units	Transformed meaning units	**Psychologically transformed meaning units**
3	She got herself in a terrible state about it and	The woman was very distressed about the situation	**The woman was very distressed about the situation**
4	then it was probably with a lot of talking and everything that to try to describe the system to her because midwives can't cross massive boundaries and so when somebody moves it can be quite difficult and but it did effect her whole pregnancy	Emily talked to the woman a lot to explain the midwifery system which does not allow crossing large boundaries so when someone moves to a different location it is difficult. This situation affected the whole of the woman's pregnancy.	**Emily took time to explain the midwifery system but this did not seem to ameliorate the woman's concerns.**
5	For a good few weeks the way she felt about everything. She felt like she had been let down by the system, it sounds bizarre but she actually moved so really I found it a bit difficult trying to explain to her that midwives can't cross county boundaries and stay with her,	Emily found it strange that the woman felt let down by the system given that she had chosen to move after Emily had explained.	**Emily found it difficult to understand why the woman felt 'let down'**
6	yes it is your first pregnancy and yes it is nice to have continuity but if you choose to move areas there is not a lot we can do.	Emily recognised that it was the woman's first pregnancy and continuity of care is nice but there was little she could do to change the situation	**There was little Emily could do to change the situation but she did recognise the woman's feelings.**

Table 5: illustrating steps 2 – 4, step 4 highlighted

As the researcher I needed to make implicit factors explicit and transform the everyday language used by the respondents into psychologically meaningful language (Giorgi and Giorgi 2003b). Todres (2005) suggests the researcher may

go beyond the language used by the respondent to offer a sense of meaning for a particular expression but the focus must remain on the phenomenon being studied. In this study I carefully transformed the meaning units from the midwives' narratives into psychologically sensitive expressions. Sometimes this resulted in a reduction in the words used but sometimes offering this expression increased the wordage.

Stage five - aiming at a general structure

The fifth and last step in the analysis as outlined by Giorgi and Giorgi (2003b) is the development of the psychological structure or the general structure of the experience or phenomenon. This has been described above when considering the organisation of the meaning units as it is not possible to create a general structure in a linear manner using a phenomenological approach if a communicative harmony between whole and parts is to be achieved. The general structure developed in this study offers a generality across cases whilst acknowledging individual variations. Using free imaginative variation, the transformed meaning units were gathered together in a search for constituents which would come together to create this general structure. Through a process of moving between transformed meaning units within a transcript and then between transcripts, essential features, labelled here 'constituents', started to emerge. These constituents were gathered together to form the general structure of the phenomenon, which is the fifth and final stage of Giorgi's stages of analysis (Giorgi and Giorgi 2003b).

"Constituents" is the label used in this study for what Husserl would label "essences". "Constituent", something making up part of a whole, or a component, leads to different expectations than "essence", a term used by Husserl, and facilitates recognition of the difference between philosophical phenomenology and scientific phenomenology. Husserl sought underlying essences that were unchanging in a given phenomenon. I cannot make that claim for this study. For this study the constituent is a part of the whole, the general structure of the phenomenon, a component, but both the constituent and general

structure are context bound. I cannot make the broad claims for this study that Husserl aimed at for his philosophical phenomenology. The whole, the general structure, can be seen to be more than the sum of its parts, or constituents. The reader will see that the constituents do not appear with clearly defined boundaries within the general structure; there is a blurring of the boundaries of the constituents as they come together to form the whole, the general structure.

This was a long and tentative process as it was important to ensure the individual elements or meaning units were not disregarded as a sense of the phenomenon was emerging as a whole or general structure. Throughout the process there was a continuous moving between whole and parts to ensure a harmonious relationship developed. This allowed for the development of generalised features of the phenomenon within the given context to be captured in the general structure whilst the individual variations of these features could be further explored within the constituents.

The constituents that developed out of the meaning units were tentatively labelled but this labelling changed as the general structure was emerging. The emergence of the general structure influenced the constituents and likewise the constituents influenced the general structure. This moving between whole and parts can be seen in the development of the meaning units as well as the development of general structure and constituents. Below I provide an example of how the general structure changed through going back and forth between formulation and further reflection, to ensure significant detail was not lost.

General structure

As the women progressed on their journey to motherhood they were led by midwives who held some firm beliefs. The midwives believed that the women were unprepared for what lay ahead and that any preparation that they offered would be inadequate as everyone's perception of experiences is different. Along with this belief, midwives held that a continuous relationship played a necessary part and this needed to occur in the family home for the midwife to conduct their

art. The midwives also endeavoured to make the women feel normal and in control as they believed this would reduce the emotional toll.

Constituent firmly held beliefs

As the women progressed on their journey to motherhood they were led by midwives who held some firm beliefs.

Item 1 – firmly held belief that emotional support is a journey

…emotional support is not a one off event but a process; becoming a mother is a journey (Carol 40). Carol said "it's not just one episode there is not just one isolated episode, they will find it is the whole moving through the processes that they weren't expecting" (Carol 40).

Item 2 – firmly held belief of what constitutes a normal birth

A particular instance of differing perceptions was where a mother thought her birth to be traumatic and the midwife could not understand this despite the mother describing the events in detail. Midwives appeared to hold firm beliefs about what constituted a normal birth.

She continued to find it difficult to understand why the new mother found the "normal birth" traumatic (Carol 12). This struggle with understanding continued for Carol although the woman explained in detail her experience of the birth (Carol 14).

Item 3 – firmly held belief that emotional support should be given in the woman's own home

The midwives firmly held the belief that home visiting was necessary to offer emotional support and offered explanations for this belief. In fact none of the midwives described giving emotional support anywhere except the home

situation and said that when they recognised the women needed emotional support they organised a home visit.

Fiona said “in an ideal world you would be more able to support emotionally if you are able to do more home visits” (Fiona 10).

By general structure f (each major review of the general structure was given a letter label progressing through the alphabet) the meaning units of constituent “firmly held beliefs” had been taken into other constituents such as “Showing emotionally supportive care” and “Struggles in showing care”. This was because the term “firmly held beliefs” was useful in developing understanding of the phenomenon but it could be considered an interpretation of the midwives’ descriptions. It was the going backwards and forwards between transcripts and general structure that raised this awareness.

Despite seeking a general structure to aid understanding of the phenomenon the value of this is reduced if the individual variations are not taken into account. It is important to recognise, for example, that the midwives in this study were seeking to facilitate comfort in the women. It was also important to recognise that individual activities were undertaken to achieve this dependant on their individual contexts, which includes characteristics of the midwife, the woman and the environment.

Initially I gathered together the meaning units under the following headings: “Triggers to offering emotional support”, “Process of emotional support”, “Normality”, “Control”, “Perceptions”, “Moment of realisation”, “Preparation”, “Underlying issues”, “Time”, “Communication skills”, “Interprofessional working”, and “Evaluation”. All of these can be found in the general structure and constituents in the findings section of this thesis, but as the general structure was developing these constituent labels became unhelpful for the development and changed.

A reorganisation of the meaning units to allow for a more psychologically insightful understanding of the phenomenon was undertaken and new groups of constituents developed. These were labelled: “Kinds of context”, “Understanding”, “Perception”, “Judgement”, “Values”, “Kinds of interaction”, “Support”, “Emotions”, and “Dilemmas”. This organisation of the meaning units was again useful for the development of an understanding of the phenomenon but still did not allow for a clear, articulate, communicative way in which to present the phenomenon.

Another attempt at organising the meaning units into constituents to facilitate a clear communicative understanding of the phenomenon was undertaken whilst the previous organisations and an understanding of the whole was kept in mind. This time the constituents were: “Freeing the way to showing care”, “Everyone’s perception is different”, “Firmly held beliefs” (see example above), “Showing care”, “Emotional experiences”, and “Struggles in showing care”. These constituents offered a structure on which to develop the general structure. Once the general structure was developed they did change again slightly to: “Showing emotionally supportive care”, “Tipping the balance to allow showing emotionally supportive care”, “Struggles in showing emotionally support care”, and “Emotional experiences”. These constituents include all the previously organised meaning units in a more manageable structure.

The development of these constituents entailed a going back and forth from parts to wholes to ensure a harmony between them. This took a long time as I tried to understand what the midwives were expressing. This harmony between whole and parts allows the reader to situate each meaning unit within the context of the experience and within the constituents and general structure.

The general structure across the individual cases and constituents that have been developed from the experiences shared with me by the midwives in this study is in the next section, entitled “Findings”. There was no clear advice on whether to present the general structure first to offer the prominent features of the

phenomenon or whether to present the constituents with their individual variants first, leading into the general structure. As both were developed together in an organic intertwining manner it would have been good to present both at the same time but this was not considered possible with this medium for presentation. Finally the decision was taken to present the general structure first and then move on to the constituents which offer the individual variants, as this was felt to more fully address the communicative concerns.

Chapter 4

Findings

Preamble

The general structure for this study has been constituted using the descriptive phenomenological approach and as such has been derived from midwives' descriptions of their lifeworld experiences. These accounts were shared with me in response to my asking them to describe an experience where they gave emotional support to a woman becoming a mother for the first time. The general structure has therefore been gained from their perceptions of these experiences; they have described their perception of an occasion of this phenomenon.

The transcripts, natural meaning units, psychologically reduced meaning units and analysis can be found in appendix A. In a couple of the transcripts the actual words used in a few natural meaning units have been removed to ameliorate the risk of either midwife or mother being identified. The associated reduced meaning unit has not been removed so that it is clear what information has been used to facilitate the development of the phrase for psychological reduction and imaginative variation.

Firstly the general structure is presented offering a distillation of the phenomenon of how midwives give emotional support to women becoming mothers for the first time. In line with Giorgi's (2003b) recommendations, there is no reference to particular cases as the emphasis at this stage is to concentrate on the overall structure of the phenomenon in the most succinct way as a framework for more detailed analysis in the next stage. Following the general structure, therefore, is an elaboration of it, considering each of the constituents of the general structure in turn. This elaboration will open up the general distillation to a consideration of the individual variations within each constituent, facilitating a greater understanding of the parts that make up the whole phenomenon.

General structure

I asked the midwives to describe an experience in which they felt they had given emotional support to a woman becoming a mother for the first time. I did not give them any guidance on what motherhood was or when this was achieved or how it could be recognised, nor did I give them a definition of what emotional support was.

The midwives were happy to talk to me about their work but they struggled initially to try to think of one experience. They explained that becoming a mother was a journey but along this journey there were significant moments when the woman was more vulnerable. Despite this they did not seem to believe that giving emotional support was a core part of their role. This belief, alongside the belief that not all women needed emotional support, led them to look for reasons or justifications for tipping some sort of balance to provide this type of care when they recognised it was needed.

The midwives provided emotional support alongside their regular duties, which seemed to be focused on technical, biomedical assessment and support and information giving. This created one of many struggles for the midwives because giving emotional support took time and this was not always available within their regular working hours. When the midwives had tipped the balance and made the decision to offer emotional support they gave this care within an intimate therapeutic relationship, which they situated within a circle of care involving the woman's family and other professionals.

This therapeutic relationship, whilst using many similar techniques as other therapeutic relationships, had some significant differences from them. The therapeutic relationship developed by midwives to offer emotional support to women becoming mothers was more intimate both physically and psychologically. The midwives touched and talked about areas of the woman's

body reserved for their closest relationships and they gave of themselves through self-disclosure and intuition. They were women with women, identifying their oneness and seeking to come alongside the women like a coracle safely holding them above water to reach firm, safe and secure ground. The midwives were providing the platform for motherhood by sharing of themselves, their knowledge and experiences to facilitate understanding and comfort in the women. This opened the possibility for the women to recognise that the strange and new experiences on their journey were normal, and to gain an internal sense of peace.

The midwives indicated that motherhood involved recognition of the significance of the women's new role that could be labelled 'being with baby' and an adaptation to this. They spoke about the women's feelings of shock and the unrealistic expectations they had. The midwives, by offering emotionally supportive care, tried to facilitate in the women a recognition and acceptance of their new role and more realistic expectations by developing their understanding and offering reassurance. It was gaining some comfort whilst achieving and living this new role, this new way of being, that the midwives sought for the women. They offered emotional support to ameliorate emotional distress in the women in what might be considered a time of emotional turmoil and which the women might experience as a time of inner insecurity and lack of control.

Giving emotional support to women was costly to the midwives, creating many struggles for them, both implicit and explicit. Explicitly issues such as finding time within their regular working hours and abiding by professional expectations were a struggle but there were also implicit struggles the midwives faced. These appeared to include the general belief that to provide emotional support there needed to be an ongoing relationship between one midwife and one woman and the belief that emotional support should ideally be provided in the woman's own home. Another significant struggle encountered by the midwives was the ability for them and the women to understand each other's worldviews. Despite this, these struggles did not seem to impede their offering emotional support when

they recognised the women needed it. The struggles encountered by the midwives could simply be expressed as a struggle between 'being one woman with another' and 'fulfilling professional expectations'. The midwives seemed to manage this struggle by developing their own personal rules or using their intuition.

The midwives described the journey to motherhood as full of emotional experiences for all the women involved including themselves. Providing emotional support created affective changes in the midwives. Some of these would be considered pleasant and these seemed to enhance the relationship, facilitating rapport to develop between woman and midwife. This rapport appeared to encourage the midwife's desire and confidence in her emotional support of the woman. The midwives also had to manage their response to the emotions they believed the women were experiencing. The emotions perceived to be expressed by the women not only led the midwives to offer emotional support but also allowed to them to evaluate their care.

The midwives offered emotional support to women in their transition to motherhood when they perceived insecurity, or lack of understanding or ability to cope with the transition in the women. The midwives undertook this both by trying to facilitate in the women the recognition that their experiences were normal and coming alongside and being with them.

An elaboration and evidence of the constituents

The next section will consider the individual variations associated with the phenomenon through an exploration of the constituents and their associated meaning units (evidence). The general structure already stated above provides the invariant meaning, a distillation of the phenomenon, and is seen as the whole description of the phenomenon. The constituents are an elaboration providing not only the invariant experiences but also individual variations of this and can be seen as parts of the phenomenon. The constituents and general structure were developed through a going backwards and forwards between whole and parts

seeking a communicative harmony. The constituents can clearly be seen in the general structure but not as neatly delineated sections. There is a blurring of constituent boundaries within the general structure and as expected the whole (general structure) provides more than a joining together of the parts; it has gestalt.

This is also true for the individual meaning units; the constituents are more than a collection of meaning units and there is a blurring and overlapping between the constituents the individual meaning units are part of. The general structure provides a view of the relationship between constituents as well as the constituents themselves: likewise the constituent offers not only evidence of the meaning units used but also the relationship between them. Each constituent offers a greater understanding of the phenomenon by offering individual variations. Four constituent parts were found in this study and they will be considered in turn, they were:

Constituent one: Tipping the balance to giving emotionally supportive care

Constituent two: Showing emotionally supportive care

Constituent three: Struggles in showing emotionally supportive care

Constituent four: Emotional experiences

Constituent one: Tipping the balance to giving emotionally supportive care

Overview

The judgement to offer emotionally supportive care was not an easy one for the midwife to make. She was faced with her professional belief that family or friends should offer emotional support, which weighted the balance against showing this type of care. Alongside this was the belief that not all women needed emotional support. The midwife can be seen as managing herself, keeping herself in balance, and balancing workload, professional expectations,

personal integrity and personal emotional state. When there needed to be a movement towards providing emotional care, the midwives' equilibrium gained within what appeared to be a technical medical focus moved to a more emotional focus. To support this shift or movement and to regain equilibrium the midwives offered themselves a reason to offer this type of care. They gave themselves reasons, such as that the woman had had a traumatic birth, physical illness or a lack of social support. These sorts of reasons were not always available and if the midwife could not find a suitable reason she gave herself permission by saying the woman must have 'underlying issues'.

Constituent

It was stated that not all women need midwives to emotionally support them. Fiona said "a person who is very confident and outspoken and in which case you won't need emotional support" (Fiona 39) (39 refers to the meaning unit number and these can be found in appendix A). In agreement with this Hetty suggested that women who needed this type of care were those with limited social skills and education and no support network (Hetty 53). Emily, though, highlighted that it was difficult to assess who would need extra support as the woman she described was from a good socioeconomic background with family support but she needed extended support and visiting (Emily 14 & 16). The suggestion that not all women need emotionally supportive care from midwives was also demonstrated in the descriptions the midwives gave of when they provided this type of care.

Each midwife described a distinct situation in which she offered emotional support to a woman becoming a mother. Despite the obvious differences in these situations there did appear to be an acknowledgement that emotional support should be offered to women experiencing significant problems. Where a significant problem could not be identified the midwife suggested that the woman might have 'underlying issues' (Carol 14 & 20, Emily 10, Fiona 19). This could lead to the conclusion that midwives need to have a justification for offering this special or extra care or to 'tip their balance' which results in the

need to adjust their fulcrum or focus of care. This need for justification could be considered to be part of the culture either of midwifery within the local environment or more generally. Another element that appears to run through the descriptions is that the midwives were concerned for the emotional well being of mother and baby.

All the midwives except Hetty described either the woman already being emotionally distressed or at risk of becoming so. This could lead to the conclusion that the midwives offered emotionally supportive care to reduce or ameliorate both emotional distress and the risk of it and to provide comfort. Hetty, whilst not describing emotional distress in the woman, was concerned for her due to her vulnerability which included mental and emotional health (Hetty 28 & 33) and both Hetty and Betty, due to their concerns for the mother, had significant concerns for the baby.

Emily and Carol both felt that underlying issues influenced the emotional support needed by the women they were caring for (Emily 10, Carol 14 & 20). Fiona also felt underlying issues may have had an impact on the emotional support needed by the woman she spoke about, as pregnancy and birth can bring "back ghosts from the past that you didn't even realise were there" (Fiona 19). Concern that women may become postnatally depressed was also a trigger that tipped the balance to providing emotionally supportive care for Gina, Betty and Emily but some indication of this can also be seen in Diane and Fiona's descriptions.

The midwives provided emotionally supportive care alongside their other professional or caring activities. Within their professional role the midwives were involved in supporting education for student midwives (Betty 73) and, in the form of antenatal or parent craft classes, providing education for women (Emily 37, Fiona 31, Hetty 20 & 21). Most of their appointments, though, appeared to be focused on checking the well being of the woman and baby (Betty 17 & 55, Diane 37, Emily 27 & 29, Fiona 7 & 27, Gina 19, Hetty 8). The

midwives conducted their activities within a stipulated geographical area and in the antenatal period mostly in clinics (Carol 16, Diane 14, Emily 4 & 5). These appointments appeared to be conducted within fixed time constraints (Emily 52, Fiona 11, 13, 40, Hetty 3). Another part of the midwives' role was to ensure appropriate information was passed on to other professionals involved in the woman's care (Betty 60, Carol 52, Emily 17 & 20, Gina 7, 14, 17, 24, Hetty 5, 34, 38).

Within their regular professional caring activities the midwives appeared to weigh up the decision whether to emphasise emotionally supportive care or not using an informal process. As part of this weighing up they assessed if the women had had a normal birth (Carol 8) or had had some scope for making choices through their journey to motherhood (Fiona 20). There appeared to be conflict between their perception of their professional role and their desire to offer this more intimate and emotionally supporting relationship. This was highlighted in what appeared to be a generally held professional belief that family or friends should offer emotional support (Carol 29 & 27, Emily 32 & 33, Hetty 15 & 23). The belief that family or friends should give emotional support to the women weighted the balance against emphasising emotional support in their interactions, and to compound this weighting it was suggested that not all women need this kind of care.

It was acknowledged that it was difficult to predict whether a woman might need emotional support (Fiona 6) and the midwives sometimes assessed that emotional support would be unnecessary when later this was found to be incorrect (Emily 13). To swing the weighted balance to justify them providing emotional support the midwives appeared to need to provide a justification as demonstrated in their describing specific reasons in their descriptions.

The midwives appeared to desire to offer emotional support as demonstrated by their willingness to provide a reason such as 'underlying causes' when no other

reason was easily available. They appeared to need to provide a justification for giving this type of care.

Constituent two: Showing emotionally supportive care

Overview

Essentially, the phenomenon of giving emotional support to women becoming mothers can most usefully and simply be labelled a type of showing care. This care is enacted by the midwives through the extensive use of their communication skills, as can be seen in other therapeutic relationships. The relationship between midwives and women, though, can be considered more intimate in nature due to physical and personal proximity. Midwives provide this care within a circle – the circle of care, which involves other professionals and the woman's family. As the midwives provide this care they appear to seek to promote feelings of comfort and control in the women in what can seem like a time of inner insecurity, lack of control and emotional turmoil. This is to facilitate their journey to motherhood, as emotional distress at this time can have long term consequences such as postnatal depression.

Constituent

Each midwife described a different situation in which she offered emotional support. Despite the differing contexts it became apparent that central to the phenomenon of emotional support was showing care. The midwives described how they performed this care primarily through their extensive communication skills to build supportive therapeutic relationships. They used speech, movement and touch in their attempts to facilitate comfort in the women becoming mothers. Comfort appeared to involve a lack of distress, an acknowledgement by the women of their changed situation and the ability to cope with the demands of motherhood. This feeling of comfort was partly evaluated through the woman's perceived expressed emotions.

Whilst the focus of the communication was to facilitate comfort and reduce distress, the content of the communication varied but all the midwives talked at length about their information-giving activities with each midwife offering individualised information according to their perception of the woman's needs and the situation.

Betty's information giving and communication had some distinct features, as the woman she was describing had specific communication problems, which led to Betty extensively using her non-verbal skills and extended explanations (this can be seen particularly in meaning units 26 and 27). "I used to use sign language umm which (laughs) was my own form of sign language it wasn't a formal sign language and so um it's a sort of acting I suppose really to which she used to laugh her head off. But she would be able to demonstrate to me that she was with what I was saying or doing via my hand" (Betty 25, 26). Emily (particularly meaning unit 4) said that her information-giving involved explanations about maternity services and Gina identified that she offered information to facilitate choice and control for the woman for whom she was showing care (34). Hetty's explanation of her use of information giving was again to develop understanding and empowerment but Hetty also expressed this as an opportunity for developing "circular conversations" and facilitating the development of alternative perspectives on the situation (Hetty 47 & 48). This can be seen to be a similar approach to the one used by Carol (36) who sometimes needed to interrupt the flow of the conversation to clarify issues.

The midwives used other proactive communication interactions including giving permission (Fiona 35) and praise (Gina 57 & 58) but they all used unobtrusive interactions such as listening. Carol clearly articulated this perceived need for being heard or listened to in her statement; "she needed a lot of listening…lots of support" (Carol 7, 24). Carol also pointed out that listening to the women's stories was not a chore that was enjoyable (37). However, Carol did say that during this time of listening she wrote notes, some of which were necessary for her records but others for the woman's benefit (38).

Fiona said that she felt that listening to the woman was an important activity, allowing the woman time to ask questions regardless of how "daft" the woman might feel the questions were (7). Hetty likewise highlighted the importance of being able to ask questions and said it could be part of group support for women. Hetty went on to say that women who have good social skills and are educated could gain support by asking questions in regular parent craft classes. Young women who are vulnerable with limited skills could feel isolated in these groups, which could reduce their self-esteem (Hetty 20). For these women a special group was available where they could gain support through this opportunity to ask questions in a safe environment (Hetty 19 and 21) and Hetty encouraged the young woman she was caring for to attend this (17).

Along with the other midwives Hetty acknowledged the importance of listening. She said she felt that she created her caring relationship by listening (41). Hetty said she needed to listen to the woman, as it was "her body, baby and world" (Hetty 41), so it was important that she listened to the woman's perceptions. Some of this sentiment appeared to be shared by Diane who said "she didn't have to listen to everything I was telling her, it was her baby and she knew it in a way that I never do" (Diane 40). For Hetty this listening also allowed her to gain a sense of what was happening, which she said, was important when offering care (43).

Another approach discussed was sitting and talking, which appeared to be different from listening, and information giving, despite them being part of this activity. Emily explained that sitting and talking about general things helped to build the relationship (53). Despite this relaxed approach Emily was conscious of not disclosing certain things about herself particularly her own pregnancies (42), and of the importance of where she sat (47) and what she wore (46). Fiona and Betty, too, described this type of showing care; they said they simply sat down and had a cup of tea and talked about general things. Fiona went on to say

she did this to develop a comfortable atmosphere and when the visit ended they returned to general conversation; it had come "full circle" (26 & 57).

There was awareness that these activities took more time than would be expected at a regular appointment but giving time appeared to the midwives to be an important element of showing this type of care. Fiona, when she was aware that the woman she was caring for needed this extra support she offered her time before approaching questions that she needed to ask about the pregnancy (27). Fiona explained that the care she gave this woman did not impinge on her personal time (44) but that there are occasions where she would allow her support to use personal time (45). This became a dilemma for Fiona as she said to offer emotional support she should be allowed to undertake home visits as she did with this woman but that she might be able to offer the necessary support by being accessible (42). Fiona said she and the woman she was caring for both felt that the opportunity she had to do home visits in this case was a privileged position (41).

Betty and Hetty both talked of their working outside their working hours giving extra time to the women they were caring for. Betty said "that's the most important we have never ever cut back on the time allowed her" (Betty 7). She believed that giving time and individualised care was essential (72). Betty felt that due to the autonomy she has within her role she was able to achieve giving the woman the time she needed (74). Hetty too felt giving time was important and said that she did not put a time limit on her visits, which she thought was important but this meant she was sometimes late for her next appointment (45). Carol, along with Betty, identified the autonomy within her role; she explained how she had the ability to control the time available to her to support the women she was caring for. Carol went on to explain that she could extend the visiting period from 10 days up to 28 for women "who are not quite sure of themselves, not quite comfortable with themselves" (51).

The midwives, within their caring relationship with the woman, were mindful of the full extent of their communication including body language. They described how they utilised their non-verbal skills to develop these relationships. They identified the use of touch to support and reassure, along with smiling and eye contact. Betty explained that when she recognised that the woman was concerned she held the woman's hand to support her (20) and went on to give the woman hugs (27) which she believed enhanced their relationship and improved the woman's self-esteem. Gina also talked of holding the woman's hand to support her (41).

Most of these communication skills used by the midwives may be observed in other therapeutic relationships but there were components identified by the midwives that made their caring relationship distinct. Their emotional support or showing care could be considered to be more intimate than other helping relationships due to their extensive use of their existential selves through self-disclosure and intuition and due to their physical proximity. Through this type of care the midwives were trying to reduce the risk of emotional distress occurring or ameliorate distress already present. The journey to motherhood is for some a time of great emotional turmoil which can impede the woman's ability to safely achieve the adjustment to a new way of being: motherhood. This can lead to long term consequences such as postnatal depression (Gina 43).

This use of existential self was clearly articulated by Emily who said she was just a person and used self-disclosure to aid the relationship and offer emotional support but she avoided talking about her own pregnancy (41 & 42). Emily's disclosure, as a working mother, enabled her to chat with the woman and for them to identify with each other; talking and sharing (54). Fiona also said she felt it was important to be seen as a person, not just a professional, and shared her personal experiences with the woman, allowing them to relate to each other (50, 51, 54). This, Fiona believed, facilitated emotional support. A number of the midwives also identified the use of intuition or gut instinct, which they felt, was a part of their caring responses. Gina used the term "intuition" (68, 72, 73, 74, 75)

whereas Hetty used the term “gut instinct” (11 & 50) but both seemed to have similar meaning.

There was close physical proximity and contact between the midwife and woman. The midwife also had close physical contact with the baby once it had arrived. This was part of their role as midwives but they also used their physical interventions to provide emotional support to the women. Most of the midwives identified using the routine physical examinations and assessments in their attempts to recognise and support the women with her emotions. Emily (27 & 29) and Fiona (27) explained how they used an approach of conducting the physical examination and talking at the same time. This they felt relaxed the woman and then the woman felt more comfortable and started to disclose her worries. They went on to say the women identified issues that concerned them during routine physical examination when they were more relaxed. Gina clearly articulated the intimate nature of some of these examinations (19, 20, 22, 23, 32, 33).

Betty mentioned her role in physical examination of the baby (17 & 31) along with Diane who weighed the baby to reassure the mother (37). Diane also identified giving physical assistance to the mother with breast feeding (24 & 28). Physical and practical assistance was seen as part of giving emotional support to the women particularly around baby feeding. It was recognised that if the baby was well fed it reduces the stress and emotional distress of the parent (Carol 46). Those midwives who chose to describe giving emotional support to woman after the birth focused a lot of their attention on supporting and encouraging the woman with feeding the baby.

Alongside this universal use of themselves the midwives also drew on a number of other resources as part of the act of showing emotionally supportive care. The relationship between midwife and woman was nurtured and supported by other professionals and the woman’s family where this was available. The midwives involved these others in a ‘circle of care’ to ensure that no needs were

unfulfilled. This circle, whilst facilitating fulfilment of the women's and babies' needs, could also offer support and reassurance to the midwife, as expressed by Betty (4 & 34). Betty formed a "circle" of professionals working together to care for the woman and within this circle Betty also felt supported, she felt able to sit down and talk to her colleagues at any time (69).

Family members were also part of this circle of care, assisting the midwives in their showing care and receiving care in return; Gina, Fiona and Betty particularly identified this. Gina offered information and activities for the partner (8, 9, 10, 11, 12, 18), Fiona involved the husband so he could support his wife (22, 23, 24) and Betty recognised that the husband could support her and his wife with his smiles (36 & 37). For Betty as with Gina and Diane this did not always reduce their workload. Betty found herself torn between explaining information to the husband first so he could support his wife and attempting to explain more slowly to both of them together which would take longer to reduce the concern (39 & 40). Gina needed to spend time talking to the husband to reassure him when she could have been focused on attending the woman (12 & 18). For Diane it meant that she arrived at the woman's home with inaccurate information (12 & 13).

Through their close relationships the midwives can be seen to be attempting to facilitate a feeling of comfort in the woman by providing her with recognition that her perceptions of her experiences were understandable and not a sign of deviance or disorder. Fiona believed there were a lot of common thoughts and feelings amongst new mothers, which allowed her to say to the woman that it was fine to feel the way she did (55). Fiona said it was incredibly reassuring to be told there is nothing wrong (34). Betty also believed that it was important for women when they are vulnerable, such when they are pregnant or the early days after birth to feel normal (28).

The midwives could also be seen to promote a feeling of control to allow the women to feel they had some command over what may have felt like a time of

insecurity and lack of control. This can clearly be seen in Fiona's case; she said that the woman she was caring for had been in control of her life, that she had made her own decisions and organised her life but since being pregnant "she didn't feel in control" (32). On reflection Fiona believed the woman's emotional distress was due to her feeling that she was not in control (Fiona 32). Likewise Gina attempted to give choice and control to the woman (34, 49 & 50), whilst acknowledging she did not have the capacity to accept it, to ameliorate the risks of emotional distress (43). Hetty also offered additional skills and choice to the woman she cared for, she used complementary and unconventional therapeutic approaches (29 & 32) which she said the woman found helpful.

The midwives used themselves extensively, their knowledge, skills and experiences to give emotional support to the women. This was conducted within a circle of care and promoted a feeling of control and comfort in the women facilitating their journey to motherhood.

Constituent three: Struggles in showing emotionally supportive care

Overview

In the midwives' descriptions of their experiences can be found both implicit and explicit struggles in giving the care they felt the women needed. Explicitly there were issues such as following their professional role but implicitly there were general beliefs that appeared to be held by them, such as continuity of care and home visiting. Another significant struggle was that midwives and woman did not always understand each other's worldviews. Although this was a struggle it did not appear to impede their care, whereas the struggle between 'being with woman' and 'being professional' was more influential. To manage the tension between 'being with woman' and 'being professional' the midwives developed their own personal rules or used their intuition.

Constituent

Once the midwives had gone through the process of tipping the balance to provide emotionally supportive care there were other hurdles for them to leap. These hurdles or struggles appeared to create extra personal emotional work for them. The midwives all explicitly identified personal struggles but there were common struggles related to their beliefs about how maternity care should be provided.

The common struggles were more implicit than the explicit struggles relating to the specific situations and included emerging beliefs. The midwives believed that emotional support was not a one-off event; it should be a continuous activity over a period of time. This was clearly expressed by Carol who said "it's not just one episode there is not just one isolated episode, they will find it is the whole moving through the processes that they weren't expecting" (Carol 40). The midwives and at least one of the women believed that continuity of care should consist of one midwife caring for a woman throughout pregnancy and into the early days after the birth. Despite this belief in the need for continuity some of the midwives appeared to accept this might not occur during labour and birth, at least it was not explicitly identified as necessary by any of the midwives in this study.

Another belief was that home visiting was necessary to offer emotional support, and the midwives offered clear explanations for this belief, unlike other beliefs. None of the midwives described giving emotional support anywhere except the home situation and said that when they recognised the women needed emotional support they organised a home visit. Fiona said "in an ideal world you would be more able to support emotionally if you are able to do more home visits" (Fiona 10). Some of the reasons offered for home visiting were that it facilitated relationship development (Emily 52), it allowed women to be more comfortable (Fiona 9, Hetty 4, Emily 51) and moved the perceived power base from the midwife, giving control to the woman (Emily 50). It was suggested that home visiting allows the women to receive the emotional support they need but this

was not always achievable due to workload pressure (Fiona 11). Despite this view Fiona did think it was possible to offer emotional support within the constraints of the service, by being accessible through the use of devices like a mobile phone (Fiona 42).

The midwives sometimes struggled with understanding the women's worldview and vice versa. This hindered their ability to show emotional support and prepare the women for what lay ahead. Alongside this the antenatal classes facilitated by the midwives were considered by them to be inadequate, despite their efforts, in preparing women for their journey into motherhood.

A particular instance of differing perceptions was where a mother thought the birth of her baby had been traumatic whereas Carol believed the birth to be normal (Carol 12). This created concern for the midwife, as she could not understand the mother's perspective despite her describing the event in detail. Another example was where a woman and the midwife had opposing perceptions of their interactions. Emily had felt that after her first meeting with the woman and general explanations that they had got on "absolutely fine" (Emily 18) and so was surprised when the Health Visitor, who had been to visit the woman passed on the information that the woman was "really upset" (Emily 20). The Health Visitor had explained to Emily that the woman felt let down by the system (Emily 19).

The midwives gave accounts of where the women had unrealistic expectations of them. These expectations were quite varied, but most related to expectations that the midwives could not fulfil (working across boundaries (Emily 6), continuous attendance (Diane 3), knowledge about anything related to pregnancy (Emily 56)). However, one related to the woman not expecting to be offered that care that was available to her (Hetty 7). Carol also suggested that the woman she was caring for was unable to accurately perceive the guidance being given by a group of midwives (Carol 22). The midwives also identified that women have certain expectations about their personalities; they have a stereotype of

midwives. Each of the midwives who mentioned this said they did not fulfil the stereotyped personality of a professional midwife. Emily said, “a lot of women say they expect a midwife to be very posh and umm very umm prissy” (40) which she did not believe herself to be. Whereas Hetty said that she believed women expected them to be focused on the baby and physical health issues (Hetty 6, 7 & 8).

Antenatal or parentcraft classes were an area within which the midwives expressed their frustration at not being able to adequately prepare women for the journey to motherhood mentally and emotionally. Carol explained that despite offering information about pain and other issues at classes (Carol 16) the woman was still shocked (Carol 15). Carol felt that despite her explanations the woman still developed expectations of herself that she was unable to fulfil and this created the need for emotional support later. Likewise Emily said that the woman she was working with had expectations of how things would be after the baby arrived (Emily 11) and despite Emily’s attempts to ease her into understanding in antenatal classes (Emily 12) the woman was still unhappy and needed extra support. Fiona appeared to sum the situation up when she stated that each experience is too different to be adequately prepared for through group antenatal classes (Fiona 31). Although Betty was not talking about antenatal classes she also found problems with information giving and understanding which meant that she had to take much longer explaining and a higher need for emotional care.

The lack of understanding of each other’s world views also compounded another area in which the midwives struggled. Time was limited and the midwives explained how offering emotional support was time-consuming (Betty 56, Carol 48). Despite the midwives’ struggle with the limited resources available, both affective and professional, this did not appear to impede their care.

A more influential struggle in showing care for the midwives appeared to be the struggle between what they believe the professional expectations are and their

desire to come alongside women. This can be seen in a few ways. Betty and Hetty both describe having to behave in certain ways due to professional expectations. Betty did not encourage the woman to breast feed despite the woman appearing to want to do this and Betty believing it would not be a problem (Betty 6, 10, 11) because the paediatrician had told the woman not to breast-feed. Hetty had to take a role she was uncomfortable with due to professional expectations (Hetty 35, 36, 37) and due to other professionals' concerns for the baby.

The existential presence offered by midwives showing care created another struggle, as the midwives did not appear to have a clear sense of boundaries, creating tension between 'being with woman' and 'being professional'. One area in which this can be seen is Diane's dilemma of whether she had 'helped' the woman too much; she was concerned whether she should step back and facilitate independence in the woman or engage in physical or practical interventions (Diane 44). This dilemma could be seen to interfere with spontaneous care.

This struggle with professional boundaries can also be seen in another area. The midwives seemed drawn to using their personal experiences, feelings and intuition as women to come alongside other women and support them but they were concerned whether this would be in conflict with what they believed their profession expected of them. For some this led to a cautious approach to caring which can be seen through Hetty's explanation of the restrictions due to professional boundaries, but she recognised that there was a need to work within a structure (Hetty 55). The struggle with the existential use of self can be seen to be summed up in Fiona's words. Fiona said "I suppose that is why it is emotionally draining at times, exhausting, because it is quite a thin line between giving emotional support and relating part of your own life but also keeping a distance" (Fiona 53) thus recognising the professional distance and the closeness of emotional caring.

To deal with the dilemma or struggle between being 'with woman' or 'being professional' the midwives developed personal rules for themselves, such as Emily who said she used self disclosure to aid the relationship (Emily 41) but she avoided talking about her own pregnancy (Emily 42). Hetty recognised that the relationship she had with the woman was not what was expected (Hetty 54) but that she used her gut instinct to guide her (Hetty 50). Likewise Gina accessed her instincts to guide her (Gina 68); she also identified that the woman was driven by her instincts as well (Gina 36).

Constituent four: Emotional experiences

Overview

Midwives appeared very conscious of the emotions experienced by the women they were offering emotional support to and within themselves. They were able to identify a wide range of emotions in both the women and themselves. The midwives and women influenced the emotions experienced by each other and when a good rapport was gained it appeared to lead to a greater desire or confidence in the midwives to continue to show emotionally supportive care. This recognition of emotions experienced by the women allowed the midwives to evaluate their care. If the mothers appeared happy the midwives felt they had been successful.

Constituent

Being 'with woman' can be an emotionally charged journey where the midwife and woman share moments of intimacy and emotion, both pleasure and despair. The midwives described a wide range of emotions in themselves and the women. When the women were experiencing positive emotions the midwives felt they were doing their job well but when the women were experiencing negative emotions the midwives questioned the effectiveness of their interventions.

It was accepted that becoming a mother was a journey but despite this some midwives identified that there was a critical moment of realisation for the

women, which was clearly articulated by Carol (Carol 42). "I think there is a time after the birth when realisation comes….the scans and all those sort of things they start to sort of prepare them but it's not until they get this baby crying in their arms that the realisation comes ……" (Carol 43). At this moment some women appeared vulnerable and lacking confidence which increased the need for the midwives to offer emotional support. Fiona explained that at this moment the woman "suddenly feeling very very inadequate" (Fiona 29) and the woman had an "emotional panic" (Fiona 30).

The women experienced a range of emotions from guilt, fear and distress to being peaceful, happy and cheerful. Although midwives were attempting to facilitate comfort (Fiona 33, Gina 66) and positive emotions (Betty 25, Diane 14 & 15) this did not always occur. One particular midwife appeared to have induced fear, which she appeared to have been the only one able to dispel, which she did by offering and granting permission and reassuring the woman (Diane 23). Diane explained "and she said to me I hope you are not going to tell me off" (Diane 18) and "she was also feeling a bit guilty because she thought I was going to tell her off" (Diane 21 & 22).

When the women and midwives gained a good rapport (Betty 25, Gina 70) they both achieved positive emotional outcomes (Betty 66, Gina 65) and this appeared to lead to a greater desire or confidence in the midwife to continue to care for the woman. This sharing of good moments was important for the midwives in their showing care as it reassured and guided them (Diane 45, Emily 60, Gina 51, 55, 64). Gina particularly identified this, she explained that this sharing of emotional moments with other women had facilitated the development of an intuition that guided the support she offered (Gina 73, 74, 75). Midwives sometimes concealed their own emotions of anxiety (Diane 44) and being patient (Betty 50) but when the women were happy the midwives said they felt they had supported the women effectively and were satisfied (Diane 45, Emily 60, Gina 51, 55, 64).

Summary of Significant Findings

The most significant findings from this study are what midwives do or how they provide emotional support, the struggles they go through to provide this type of care, and how they measure whether they have achieved it.

Struggles midwives go through to provide emotional care

Midwives struggle with managing the boundaries between 'being professional' and 'being with woman' because of a professional culture which appears to lead them to believe that their role is a more biological, technological one. Because of this struggle there is often a moment of conscious decision in which the midwife defines the situation as 'needing something different' and there is subsequently a shift towards the more ambiguous 'being with woman' role. The midwives need to justify this shift to themselves because they do not experience the focus on an 'emotionally supportive' role as an encouraged professional priority by their setting.

This shift or movement towards emotional support requires significant changes in the midwives' attitude, behaviour and place of care giving. Instead of leaning towards this type of care which may 'tip the balance' of the midwives' professional consciousness too far, there is the need for a shift in the position of the fulcrum. Once this shift or movement has occurred the midwife is in a position where there is no clear definition of boundaries for her and she relies on her on own personal rules or intuition.

How midwives provide emotional support

A distinctive feature of 'what midwives do' when emotionally supporting women is to provide a form of care that 'normalises' the woman's fears about certain kinds of distress related to becoming a mother, such as her ability to cope with pain or loss of control, or to care for and relate to her baby. A further distinctive feature of 'what midwives do' when emotionally supporting women concerns the quality of the caring relationship that includes a certain kind of intimacy and a

certain kind of ‘use of self’. This intimacy is both physical and psychological. There is a special kind of interplay between intimate physical contact with the woman and a sharing of personal information, self disclosure, or intuition by the midwife. This intimate relationship involves a sharing of emotional moments and interconnection, not sexual in itself but relating to sexuality. It is the facilitation of the woman’s journey to a new way of being promoted by the midwife being in a connected way ‘with her’.

Deepening Rapport

A deepening rapport between midwife and woman is a crucial measure for the midwife of the success of her endeavour to emotionally support the woman. This is important to the midwife as a way evaluating the direction of her emotional support, comparable to more technical measure of progress of physical maternal health.

Chapter 5

Discussion

Introduction

As has been seen throughout this thesis there is an element of fluidity between general structure and constituent, meaning units and constituents, and meaning units and general structure. This is also reflected in the literature review and this discussion. The literature review blurs from "What is a midwife / midwifery?" into "What do midwives do?" and again there is a blurring between what midwives do and the section on the experience of midwives offering emotional support.

This discussion starts with the identification that the aim and objectives of the study were achieved. The aim and objectives link well with both the questions in the literature review and the findings. Each section will consider the aim and objectives alongside the findings and is structured using the same questions as the literature review.

A unique understanding of the phenomenon of how midwives provide emotional support to women becoming mothers has been gained. Some elements of the findings can be found in other texts, such as the struggle midwives undergo in their work with emotions (Hunter and Deery 2009, Hunter 2006). This study, though, offers a unique detailed description of how midwives, within their context or culture, provide emotional support to women. Within these descriptions there are some activities that have been highlighted in other research but they have not been provided together as they have here, in one comprehensive description, in the 'general structure'. Indeed this overlap with findings from other studies can offer some reassurance that this study did explore the phenomenon sought.

It is generally recognised that midwives have struggles within their role and that they will experience emotional moments in themselves and those with whom they work. Both of these are constituents in this study but there are other influential elements of the phenomenon identified here that have not previously been described, such as 'tipping the balance'. There is also some debate in the literature whether midwives should and do offer emotional support and what this study does is offer an explanation of what is happening in this situation from the midwives' perceptions.

The findings of this study provide a general structure, the common features of the phenomenon and four constituents which offer the individual variations they are:

Constituent one: Tipping the balance to giving emotionally supportive care

Constituent two: Showing emotionally supportive care

Constituent three: Struggles in showing emotionally supportive care

Constituent four: Emotional Experiences

Constituent one - Tipping the balance to giving emotionally supportive care (TTB).

Within this constituent is described the professional culture in which emotional support is being given and its influence on professional activities. This is also, partly, considered in the constituent struggles in emotionally supporting women.

The midwives indicated that it is difficult to assess when and if women will need emotional support and that some women will not need it. It is believed that when and if women need emotional support it should be given by family and friends. When the midwives recognised the women needed emotional support from them they provided a reason for offering it, leading to an understanding that a justification is needed to offer this type of care. Acceptable justifications, for the midwives, could be that the woman was young, or had had a traumatic birth or health problems but if they could not find a suitable reason they said there must

be ‘underlying issues’. Seeking a reason or justification can be seen to demonstrate that the midwives desire to offer emotional support.

This constituent is discussed mostly in the section of the discussion labelled ‘what is a midwife / midwifery’, as this section considers the historical perspective and how that has influenced current culture in midwifery.

Constituent 2 - Showing emotionally supportive care (SESC).

This constituent offers the detail of what emotional support looks like and how it can be observed. It incorporates the common elements found in the general structure but also the individual variations. In this discussion it is explored in light of the available literature primarily in the section ‘what do midwives do’ as this gives the detail of what they do including emotional support. It is also, partly, discussed in the sections ‘what is emotional support’ and ‘what is the experience of midwives giving emotional support’. It was found that midwives appear to be seeking to offer comfort and ameliorate emotional distress in women becoming mothers and this is discussed in the section ‘how might emotional support help women becoming mothers?’

Constituent 3 - Struggles in showing emotionally supportive care (SSESC).

A number of struggles were recognised in the descriptions gained from the midwives, in this study, and they are described in this constituent. These mostly appeared to involve the ideological stance of the midwives.

Also within this constituent is offered an explanation of how midwives deal with these dilemmas; they use personal rules or instinct. This constituent is mostly discussed in the section labelled ‘what is the experience of midwives supporting motherhood? The ideological underpinning of midwifery, which is discussed in relationship to the midwives’ struggles, is explored in the section ‘what is a midwife / midwifery?’

Constituent 4 - Emotional Experiences (EE).

This constituent highlights the emotional nature of midwifery, with both midwives and women experiencing many emotions on the journey to motherhood. It recognises that there are times on this journey when women are more vulnerable and that this is particularly so when women have a sense of realisation of motherhood. The midwives' descriptions allow an understanding that a good rapport between women and midwives leads to positive outcomes for both and that the expressed emotions of women allowed them to evaluate their emotional care. This constituent, therefore, is discussed in a number of sections of the discussion including 'what is the experience of midwives supporting motherhood?' and 'how does emotional support help women?'.

Aim of this study

To provide an account of how midwives experience participating in giving emotional support to women who are becoming mothers for the first time.

Objectives of this study

To gain descriptive accounts of midwives' perceptions of their lived experiences specifically focused on giving emotional support to women becoming mothers for the first time in what may be considered 'normal' situations.

To gain descriptions from the midwives' perspective of their actions and interactions with women at this time.

To seek both the commonality and uniqueness within the experiences described by the midwives.

To identify the influential elements and the context within which it occurs.

The aim and objectives of this study were achieved. Two of the objectives were achieved through the descriptions collected in unstructured interviews with community midwives. The midwives described their perceptions of their lived experiences specifically focused on emotional support of women becoming mothers in what may be considered 'normal' situations. Along with this, their perspective of their actions and interactions with women at this time were also described. The findings provide an account of how midwives experience providing emotional support to women becoming mothers, identifying influencing elements and the context within which it occurs. The general structure offers the commonality of these experiences whilst the constituents provide the uniqueness.

What is a midwife and midwifery?

This question provided some of the context and culture within which this study occurs.

Throughout history there has been acknowledgement that women support women in childbirth (Rhodes 1995). Over the past century the role has faced many pressures politically (Tew 1998), spiritually (Rhodes 1995, Littlewood and McHugh 1997), from medicine (Littlewood and McHugh 1997) and midwives themselves (Leap and Hunter 1993). There has been a move from the wise women supporting and caring for the woman providing practical and spiritual care with little education to the professional, educated, technically knowledgeable midwife of today (Leap and Hunter 1993, Rhodes 1995, Littlewood and McHugh 1997). These beginnings appear to have led to what can be identified in the literature as a divided or dual ideology in midwifery.

There are those that suggest that the philosophy of care a midwife should adhere to is being 'with woman' offering understanding, kindness and comfort (Leap and Hunter 1993, Rhodes 1995, Kirkham 2000, Page and McCandlish 2006).

Others imply that the focus or philosophical underpinning a midwife should have is a professional one with a greater emphasis on biological / technical care (DoH 1997, 1998, 2000, NICE 2003, NICE 2006). There are, though, those that recommend a mixture of the two approaches (DoH 2004, ICM 2006). The most powerful of the influences on 'what a midwife is' can be seen to be government-funded sources (NICE, DoH, NHS) who employ most midwives. This could lead midwives to believe that the 'professional' ideology should be adopted; this would then influence how they behave and what they do.

This is the culture within which the midwives who shared their descriptions for this study are working. It may also be that there are more cultural issues within the small geographical area or group within which they work as well and there can certainly be seen to be some ideological aspects to their care that appear to sit outside this dichotomy. These do not, though, appear to be particularly related to the small geographical area the midwives were recruited from as they appear to correspond with widely available literature, particularly 'Changing Childbirth' (DoH 1993).

As with the literature available, the midwives in this study struggled with the two explicit underpinning ideologies. This can be clearly seen in their decision-making when assessing whether to offer emotional support, demonstrated in the constituent 'tipping the balance' (TTB) and it is also identified in the constituent 'struggles in showing emotionally supportive care' (SSESC).

In the constituent 'tipping the balance' (TTB page 164) the midwives initially highlighted that it was difficult to assess whether women needed emotional support as they stated that not all women need this type of care, particularly those who are confident and articulate. If women do need emotional support the midwives appeared to believe family or friends should provide it.

The literature available, in contrast, indicates that all women need emotional support (DoH 2004, ICM 2006, Page and McCandlish 2006). The same

literature also encourages the midwife to support the woman's family. The NSF (DoH 2004) also points out that there are some women with greater need of emotional support, particularly those who are socially disadvantaged, which is recognised by Hetty in TTB. Despite this, much of the midwifery literature guides the midwife to develop technical, biomedical care (DoH 1997, 1998, 2000, Way 2000, NICE 2003, 2006, Johnson and Taylor 2006).

The midwives in this study all provided a detailed reason for offering emotional support to the women they were caring for, which could lead to the conclusion that they needed to offer a justification for providing this type of care (TTB page 164). When the midwives could not find an adequate reason they suggested that the woman might have underlying issues that created this extra need in her.

The need to provide a justification may be due to the extra resources needed; as will be seen in subsequent sections, the midwives in this study required additional resources. This too, though, can be seen to be influenced by the midwives' beliefs about care, who should provide it, how and where. The ideological underpinning of midwifery care for these midwives appears to be more complex than the rather simplistic 'with profession' 'with woman' dichotomy.

Each midwife offered a different reason for providing emotional support, which ranged from a lack of support from family and friends, to youth, traumatic birth, physical health problems and 'underlying issues' (TTB page 164). The search for a justification, particularly the use of 'underlying issues' if a more individual reason could not be found, can be seen as an indication that the midwives wished to provide emotional support as they actively sought reasons to offer it. It could also be suggested, if it is accepted that midwives are struggling with opposing ideologies, that the midwives were using subversive techniques or 'doing good by stealth' to work in a 'with women' way (Kirkham 1999, Hunter 2004).

Despite the resource issue raised above and the associated ideological stance of the midwives in this study, it can still be seen that they struggled with what the boundaries were between being professional and being with women. This struggle with opposing ideologies can be seen as influential in the provision of emotional support. This can be seen in the general structure (GS page 161) and the constituent 'Struggles in showing emotional support to women' (SSESC page 175).

There is some suggestion in the literature that a midwife could work within both ideologies at the same time (NSF DoH 2004) but the midwives in this study do not appear to be considering this at an explicit level; it appears to be influencing them on a more implicit level. The midwives did not explicitly acknowledge their desire to work in a 'with woman' manner but the descriptions they give of their thoughts and behaviours could lead us to believe that they were attempting to work in a 'with woman' way in a 'with profession' culture.

The descriptions by the midwives demonstrate that they needed to take a step or move towards the decisionto offer emotional support, shifting their fulcrum to maintain balance, and they needed to provide an explanation for this. This does not appear to occur in other studies such as Bolton's study (2000) or Bone's study (2009) where it is suggested by their participants that emotional support is given during regular activities, but these are undertaken in a more supportive manner. It does need to be acknowledged, though, that the midwives in this study were community midwives and that they had the autonomy to manage their provision of care, which may not have been available to those working in a ward environment such the participants of Bolton and Bone.

Summary

The literature appears to suggest that all women should be given emotionally supportive care (DoH 2004, ICM 2006, Page and McCandlish 2006) and the midwives in this study appear to desire to provide it; as seen by their seeking a justification. Their decision-making was difficult, which can also be seen in

their need to provide a reason for providing this type of care. This may be due to the opposing ideologies of 'with profession' and 'with women' but may also be due to other ideological beliefs. These appear to be based, partly, on the Changing Childbirth (DoH 1993) document and other associated literature about how care should be provided, which increases the resources needed to provide emotional support.

What do midwives do?

Introduction

This question facilitated the understanding that emotional support was a necessary part of the midwives' role, which is to provide care to facilitate women's safe transition through the stages to motherhood. To undertake this role fully midwives need a sound holistic (biology, psychology, sociology, cultural and spiritual) knowledge base, a caring attitude and good communication skills (Butler et al 2008).

The midwives' professional bodies (ICM 2006, RCM) as well as government initiatives (NICE 2003, 2006, NSF 2004) guide the midwife to work in partnership with women. The role laid out for midwives by this guidance is complex and skilful.

Care

The central concept of midwifery is 'care' and it is regularly used to describe what midwives do (McCourt et al 2000, Stewart 2004, Page and McCandlish 2006) it is also what the governing body for midwives, The Nursing Midwifery Council (NMC) states that they do (NMC 2008). Care is a difficult concept to define but nursing and theological theories of care suggest it is part of human nature, it is a humanist response (McCance et al 1999) and can be considered a form of love (Campbell 1984, Kendrick and Robinson 2002, Freshwater and Stickley 2002, 2004). Central to the provision of midwifery care is the midwife-woman relationship (Fleming 1998b, Fraser 1999, Walsh 1999, Pairman 2000,

McCourt 2005, Hunter 2006). This relationship not only provides the basis for care giving; it also affects the quality of the childbirth experience for women (Anderson 2000, Hunter 2001). The centrality of the midwife-woman relationship can clearly be seen in the descriptions given by the midwives in this study.

Midwife-woman relationship

All the midwives in this study described their relationships with the women they were caring for when explaining their emotional support, as identified in the general structure (page 161) and described in the constituent 'showing emotionally supportive care' (page 168). The relationships initially did not run smoothly for them and there was little evidence, in the beginning, of reciprocity to facilitate a mutually gratifying care experience (Fleming 1998a, Hunter 2006). This can be seen by some of the struggles the midwives encountered as described in the constituent 'struggles in showing emotionally supportive care' (SSESC 175).

Despite this the midwives did eventually gain a more reciprocal relationship but this took, as Hunter (2006) would predict, some emotion work. All of the midwives, in this study, can be seen to be putting effort into their relationships, particularly their communications. Betty needed to put effort into communicating and made extensive use of non-verbal communication behaviours, whereas Carol, Fiona and Emily struggled with understanding the women for whom they were caring. Diane struggled with finding the right way of helping, and communication again became difficult. Gina, in a very stressful but exciting situation, rapidly developed a therapeutic relationship and Hetty took on a rather maternal role.

All of these midwives' relationships could be considered to be 'unsustainable exchanges' as identified by Hunter (2006) except, perhaps, for Emily whose relationship may fall into the category of 'rejected exchange' (Hunter 2006). Using McCourt's (2005) styles of conversation it can be seen that the midwives

were using different approaches. Despite all the midwives suggesting they wanted to work in a partnership manner (Partnership: participative or collaborative) with the women, this is not apparent in all their interactions. Certainly Carol, Emily and Gina appear to be trying to use this approach although still showing signs of the professional approach. Betty and Hetty could be seen to be using a professional style (professional: expert guidance) and Diane may even be perceived to be disciplinary from the woman's point of view (disciplinary: expert surveillance). Despite the differing styles at the beginning of the relationships all the midwives, except perhaps Hetty who appeared to continue to have a motherly or professional relationship with the woman, appeared to indicate that the relationships became more reciprocal and partnership-like towards the end of their interactions. The changes in the relationships appear to be due to the emotion work invested by the midwives.

In the previous section 'What is a midwife / midwifery?', it was recognised that midwives are providing care within competing ideologies, which can make developing and maintaining the midwife-woman relationship difficult to achieve within the current culture in health (Kirkham 2000). It can also lead to stress and tension in midwives (Hunter 2006). Despite this it can be seen that the midwives in this study, when they perceived the need for emotional support, used time and effort to develop an intimate relationship with the women they were caring for.

The literature shows that to develop and maintain the midwife-woman relationship midwives needed to extensively use their communication skills (Pairman 2000); despite this there was a lack of clarity about the techniques midwives use (McCourt 2005). The midwives in this study did indeed extensively use their communication skills and described in detail the skills they were using to develop and maintain these relationships – see constituent 'Showing emotionally supportive care' (page 168).

Communication skills – non-verbal

Sadly it has been found that some women do not experience good communication skills in the midwives caring for them (Fraser 1999, Kirkham 2000) but the midwives in this study described using the skills proposed by theorists and trainers such as Rogers (1951) and Egan (1977) most of the time.

Listening is probably the most important communication skill (Burnard 2002) and the midwives in this study also recognised this and described undertaking this activity. Listening is important to facilitate a feeling of being valued (Fraser 1999, Williams and Irurita 2004) and a feeling of comfort (Schuiling and Sampselle 1999, Morse 2000). The midwives in this study, though, also described listening whilst undertaking other activities such as note taking and physical examinations. This is not what Rogers and Egan would identify as active listening and although the midwives believed note taking and physical examinations facilitated a feeling of comfort or relaxed attitude this is not upheld by other midwifery studies (Lomax and Robinson 1996). Savage (2004) also suggests that it may not be a sense of relaxation that facilitates the women disclosing problems when being physically examined but a feeling of vulnerability. Physical examination and the removal of clothes may be a removal of a defence or barrier to disclosure; when the clothes are removed and the bodies seen, so are the emotions exposed.

Despite this, evidence suggests it is not what is done but the way in which it is done that is important. Clinical activities such as physical examination and the observation of vital signs can all offer a sense of comfort. The midwives in this study usually described undertaking physical examinations and clinical observations in a caring manner, which may be considered emotionally supportive (Morse et al 1994, Bone 2009).

Touch is recognised as an important non-verbal communication skill (Kitizinger 1977, Morse 2000, John and Parsons 2006). When midwives use their communication skills, particularly touch, sensitively, it offers considerable

comfort to women (Kitizinger 1977, Schuiling and Sampselle 1999, Morse 2000, Williams and Irurita 2004, John and Parsons 2006). The midwives in this study described many occasions where they used touch in a sensitive manner to support the women they were caring for. Betty described holding the woman's hand and hugging her to develop their relationship and improve the woman's self esteem and Gina described holding the woman's hand to support her (SESC page 168).

Betty described her use of touch; therapeutic touch has been said to enhance a feeling of comfort, peace and calm (Hayes and Cox 1999). Newell et al (1997: 253) state that touch is a "key primal instinct" and an important element of mother-baby interactions. It could be suggested that Betty was responding to emotional distress through an instinctual response and the response that reassures babies also reassures and induces peace and calm within adults too. Betty said "at the end of that particular visit, as I did for all the others, I gave her a cuddle which drew us close together and it made her feel, I think, that she wasn't being ostracised" (27). Betty explained that, as described by John and Parsons (2006), she developed a rapport with the women through her use of touch.

The midwives in this study can be seen to be trying to achieve comfort in the women to whom they offer emotionally supportive care, which they are doing through their use of their non verbal skills, especially listening and touch (Schuiling and Sampselle 1999, Morse 2000, Williams and Irurita 2004).

Communication skills - verbal

Communicating, particularly information giving, is recognised as an essential part of a midwife's role (NICE 2003, 2006, DoH 2004) and the midwives in this study described at length their information giving. There has been a lot of discussion in the literature about whether informed decision making is being fully supported by midwives. It has been found that, despite there being a wide evidence base to support decision making in becoming a mother, this has not always been given accurately to women (Kirkham et al 2002a, Stapleton et al 2002a). While some suggest that information is being provided in a woman-

centred manner as stipulated (Walsh 1999, McCourt 2005), there is also evidence that this may not be happening (Lomax and Robinson 1996). The explanation for this discrepancy may again be found in the culture in which midwives are working (Levy 1999d, Kirkham 2000, McCourt 2005) and the needs of women (Levy 1999e).

The midwives in this study can also be seen to be caught in the dilemmas found in other studies of when, what and how to give information. Some give the information they think is needed, when they think it is needed, like the midwives in Levy's study; this is labelled 'protective steering' (Levy 1999d).

Facilitating choice and control are key issues in midwifery care, in line with government directives, and using information giving to support and empower women has been identified in research studies (Levy 1999a, 1999b, 1999c, McCourt 2005) and this appears to be influential in the care given by the midwives in this study. Although it is important to be aware, as Lomax and Robinson (1996) pointed out, that information giving is quite an ambiguous term.

All the midwives in this study discussed their information giving activities. Despite apparent similarities there appear to be subtle differences in their approaches. This can be seen in Hetty and Gina's information giving shown in the constituent 'Showing emotionally supportive care' (SESC page 168). Hetty did not appear to be demonstrating a belief in the woman's ability, which is considered important to develop a woman's autonomy (Hildingsson and Häggström 1999). Despite this Hetty said she was guiding the woman to make good choices in what may be considered to be similar approach to the midwives in Hildingsson and Häggström's study (1999) where the midwives took on the role of 'good mother'. She may also be considered to be enacting 'protective steering' or 'picking the line' (Levy 1999d) where midwives attempted to meet the wishes of women steering them through dilemmas by managing their information giving.

Gina's motivation for information giving appears to be twofold; she was giving information to gain informed consent as well as offering choices to reduce the risk of emotional distress later. It may be considered that Gina's lack of 'protective steering' (Levy 1999d) for the woman created extra stress and reduced ability to make decisions, given Gina's acknowledgment that the woman was only able to respond at an instinctual level at her stage of labour.

'Protective steering' can also easily be seen in Emily's statement "Well I invited her to classes that we run in the area and then specifically to the classes we run in that area. Lots of the women get choices, so they can go to the hospital or go to local classes or NCT but I felt for her it would better to come to the local ones. Where she could meet the other women who were pregnant and living in the same area, people living near her and so she agreed to come to those" (37).

This behaviour could also be seen in Betty's description but her reason for protective steering could be seen to be different. Betty recognised the woman she was caring for wished to breast feed and despite Betty's belief that this would not be a problem she apparently chose not to inform the woman of this as the paediatrician had informed the woman that she should not breast feed. There appeared to be an implied expectation that Betty should not work against the organisational hierarchy. Betty said "The lady also wanted to breast feed and although I, as a midwife, could say that research shows that it possibly, probably could have been ok……. She had been strongly advised by paediatricians that she was absolutely not to and so from that point of view she needed quite a bit of some support in that" (10).

This also correlates with Stapleton et al's papers (2002b,c); they identified that midwives were impeded from offering certain information due to organisational impediments (2002c) and that they fell in line with medical and organisational power holders (2002b). It was suggested that midwives did this to protect the women (protective steering by Levy 1998d) and to protect themselves (Stapleton et al 2002b).

As can be seen from the above there is evidence, in this study, of protective steering in information giving, but as information giving was not the focus of the interviews in my study, the understanding gained is limited. Despite this it is an activity that was mentioned by all the midwives when they understood the focus was on emotional support. This could lead to the understanding that the midwives saw information giving as playing a significant role in emotional support. It is generally assumed that to have information allows for informed choices and a feeling of control, which is advocated by both midwifery literature (Kirkham et al 2002a) and government policy (DoH 1993). This also can be seen as part of the belief system of the midwives in this study that appears to have some of its foundations in the Changing Childbirth document (DoH 1993).

Choice, control and continuity appear to be a mantra adopted by the midwives in this study. As part of this, information giving is said to be pivotal. Whether this is what has led the midwives in this study to discuss information giving at length or not, it can be seen to play a part in the literature associated with emotional support and comfort (Morse et al 2000, McCourt et al 2000, Williams and Irurita 2004).

McCourt (2005) identified in her study that conversation and information giving in the home setting was more flexible, fluid and variable. This may account for all the midwives in this study talking about information giving but giving differing accounts of it. They all chose to offer emotionally supportive care in the women's own homes. Giving emotionally supportive care, according to the midwives in this study, needed to occur in the woman's own home. This again appears to part of their ideological stance.

In the literature review it was established that midwives' role includes many activities such as physical examinations and health promotion including promoting normal birth and breast-feeding. The midwives in this study also described some of the activities they undertook as part of their role which appear

to include those discussed in midwifery literature. This provides more of the context in which they provide emotional support.

Summary

The core term for what midwives do is care (NMC 2008, ICM 2006). This is done through the midwife-woman relationship but it is considered difficult to achieve in the current culture of opposing ideologies (Hunter 2004) and NHS management (Kirkham 1999). What midwives do is provide care to facilitate women's transition to motherhood safely; this is a skilful and complex role. This can be seen through the literature and the descriptions from the midwives in this study. The descriptions of the midwives in this study also demonstrate that for them there is another element of this already acknowledged skilful and complex role.

The midwives demonstrate that emotional support is also provided through this caring relationship but the emotionally supportive midwifery relationship is special. It is more intimate and has closer physical proximity than other therapeutic relationships, which will be explored later in this discussion (section 'What is the experience of midwives emotionally supporting women becoming mothers?' Page 216). This relationship is developed and maintained through skilful communication. The midwives described their communication skills, both non-verbal and verbal. Non-verbally they listened, gained eye contact and sensitively touched women in accordance with their perceived need. Despite these descriptions there is evidence in the literature that when midwives believe they are doing this they are actually focused on other things (Lomax and Robinson 1996) and not actively listening (Egan 1977). This study, though, is exploring the midwives' lifeworld experiences and will therefore accept their view, despite their statements that they are conducting other activities at the same time as listening. Certainly the midwives, in their descriptions, do appear to be undertaking these other tasks in a supportive manner.

The midwives managed situations to provide this extra support by making time and visiting the women at home, which they believed facilitated a more relaxed environment where women felt more in control. Control and choice, advocated by professional bodies (ICM 2006) and government (DoH 1993), was further enhanced by the midwives' verbal skills and information giving. This is another area of contention in the literature as it has been found that midwives do not always give all the information to women so that they can make complete informed decisions. The protective steering identified by Levy (1999d) could also be seen in the midwives in this study's findings. It was unclear whether the midwives in this study were consciously using protective steering to emotionally support the women but they clearly identified moderating and managing the information they gave and appeared to believe they were doing what was best for the women.

In their attempts to do their best for the women and offer emotionally supportive care they appeared to be trying to achieve safe motherhood and comfort. They appeared to be trying to achieve this by extra activities such as home visiting, as well as conducting their regular activities such as physical examinations, measurements and health promotion.

What is motherhood – becoming a mother?

Introduction

Motherhood is enacted within a social and political arena, which influences the dominant discourses on mothering. The transition to motherhood for women, as demonstrated in a number of studies, involves quite monumental changes in all areas of their lives. Eventually, after an unspecified time, the women appeared to adjust to these and to strive to become what has been labelled 'good mothers'.

This section of the literature review explored what motherhood is, the experiences of women becoming mothers and the expectations of mothers,

including those expectations which they put on themselves (Brown et al 1997). Motherhood can be seen to be the process of becoming and being a mother through pregnancy, birth and the early days after the birth, as it takes women a little time after the birth to adjust to being a mother (Barclay et al 1996, Cronin 2003). For the midwives in this study motherhood involved recognition of the significance of their new role that could be labelled 'being with baby' and an adaptation to this (Findings chapter, general structure, page 161)

As has already been acknowledged, it is the role of the midwife to facilitate this in a safe manner, which could be considered to mean with minimal distress. The midwives in this study spoke about the women's feelings of shock and the unrealistic expectations they had of themselves; the midwives appeared to try to address this by giving emotional support. By offering emotionally supportive care, they tried to facilitate in the women a recognition and acceptance of their new role and more realistic expectations. It was gaining some comfort whilst achieving and living this new role, this new way of being, that the midwives sought for the women (general structure page 161).

Given that the midwives in this study were not provided with a definition of what motherhood or becoming a mother is or when it occurs, it was left to them to make that decision. They chose to describe giving emotional support at different times along the continuum of conception to early days after the birth. This supports the suggestion that becoming a mother is a journey or that the moment that a woman becomes a mother differs from one woman to another. Indeed one midwife actually stated that becoming a mother was a 'journey' (general structure page 161 and EE page 180). Although this needs to be accepted with some caution, as it was my assumption as the researcher and in all the literature that women were going through a process or journey to become a mother, it was not a one off event.

The midwives in this study similarly stated that there is a moment of realisation when the woman is more vulnerable (General structure page 161, EE page 180).

In their descriptions this realisation could occur during pregnancy, during the birth or in the days after the birth, which is upheld by previous literature (Barclay et al 1997, Cronin 2003).

Becoming a mother was the core category of Barclay et al's (1997) research findings; it offered the story line for the phenomenon. Their other categories included being alone, unready, drained, loss, working it out and realising. Barclay et al (1997) identified that despite biologically becoming a mother the women did not appear to become a mother emotionally and personally until some time afterwards. They identified that when women had the realisation of being a mother, they experienced shock. Eventually the women 'tuned in' to their babies as they worked out how to be a mother.

The findings highlighted by Barclay et al's study are mostly supported by the midwives in this study who, as stated, recognised a moment of realisation at which time the women needed additional emotional support. This increased need led to increased emotion work for the midwives in this study. They recognised, though, that it was not only this time of increased need in which they needed emotional support but also in the ongoing social process identified by Barclay et al (1997).

There is general agreement that there are social expectations of mothers – those who experience motherhood (Marchant 2004, Magill-Cuerden 2006, Miller 2007). Motherhood is enacted within a social and political arena, which influences the dominant discourses on mothering (Littlewood and McHugh 1997, Magill-Cuerden 2006, Miller 2007). With monumental changes occurring for the women (Barclay et al.1996, Bondas and Eriksson 2001, Cronin 2003, Miller 2007) and cultural pressures influenced by the discourses of medicine and nature (Miller 2007) women strive to be good mothers (Brown et al 1997, Bondas and Eriksson 2001, Marchant 2004, Magill-Cuerden 2006, Miller 2007). This 'good mother' appears to be an unachievable stereotype.

The stereotype of the ‘good mother’, along with the medicine and nature discourses of becoming mother, can be recognised in the descriptions of the midwives in this study. They acknowledged them and attempted to gain more realistic expectations in the women they were caring for (SSESC page 175). It can be seen that they also believed that women having too high expectations of themselves leads to emotional distress and perhaps postnatal depression (SESC page 168).

Despite the assumption that unrealistic expectations of self and other leads to emotional distress and postnatal depression, this is not supported by Brown et al (1997). They found that most women, regardless of whether they had depressive symptoms or not, held the same idealistic stereotype of a mother. It may be that there is another underlying cause for women to become depressed around the time of having a baby but the midwives in this study appeared to accept this ‘given’ knowledge or assumption. This may cause them to try to address the issue of unrealistic expectations to reduce emotional distress whereas they could, more effectively, be addressing another issue. They do not commonly offer another reason but some of the explanations for the need for emotional support may offer further understanding of why women become depressed at this time. For example, Emily described a feeling of lack of control influencing the women and certainly control is seen as important in midwifery literature. This is discussed in the section ‘What is the experience of midwives supporting women?’ (page 218).

The emotional support offered by the midwives in this study did appear to increase comfort and positive affect so it may be that despite their focus on expectations the emotional support they offer is sufficient. Interestingly, the midwives also described women as having stereotypes of a midwife but they did not feel these were accurate representations of themselves. The midwives tried to change these stereotypes too by sometimes disclosing information about themselves and by showing care. It would appear that stereotypes affect all those involved with the transition to motherhood, as motherhood is enacted within a

social and political arena (Littlewood and McHugh 1997, Magill-Cuerden 2006, Miller 2007).

The midwives struggled to prepare women for motherhood by attempting to change these stereotypes and women's expectations but appeared to believe that whatever they did it would be inadequate. All the midwives in this study identified how, despite their efforts, antenatal classes appeared to be ineffective in preparing women for their journey into motherhood. This is well supported by evidence in the literature; there is a wealth of evidence to suggest antenatal classes are ineffective (Barclay et al.1997, Bondas and Eriksson 2001, MacArthur et al 2002) and likewise the education after the birth of the baby (Fraser 1999). Hunter (2006) would recognise this as increasing the emotion work of the midwives.

Women who were offered individualised antenatal care in their own homes were more satisfied with their preparation than those attending a clinic or hospital (Fleming 1998b, McCourt 2005) and this is what the midwives in this study chose to do when they could identify a justification for this extra care (see section on home visiting page 219) .

Summary

The midwives in this study appear to accept that attaining motherhood or becoming a mother is a journey and women have achieved it when they developed recognition of the significance of their new role of 'being with baby' and adapted to this. Despite becoming a mother or motherhood being a journey, there is a moment of realisation when the women are more vulnerable and needy. This understanding is supported by previous literature (Barclay et al.1996, Cronin 2003, Miller 2007). To give emotional support to women on this journey the midwives in this study attempted to facilitate realistic expectations in the women to reduce the risk of postnatal depression. This, though, is not totally supported by literature as Brown et al's study (1997) suggests that all women have an unrealistic idealised stereotype of motherhood that none could achieve

but this is held regardless of whether the women experiences depression or not. Despite the midwives in this study trying to achieve emotional well being by trying, in part, to change a non-influential variable their interactions with women do appear to offer them emotional support.

What is emotional support?

Introduction

Emotionally supportive qualities appear to be listening, touch, being respectful, acceptance and giving clear information (Schuiling and Sampselle 1999, Edwards 2000, Morse 2000). These should be undertaken whatever the midwifery task may be, such as clinical examinations if the aim is to offer comfort (Morse 2000). Supportive midwifery practices include providing an environment that focuses on the normality of motherhood (including the birth), reduced fear, and increased confidence, control and trust (Rhodes 1995, Edwards 2000, Kirkham 2000, NICE 2003, ICM 2006).

Working with emotions

The development of theories related to emotions, as with the midwifery evidence base, proliferated in the twentieth century. This was in an attempt to understand, change and manipulate emotions for a variety of reasons. One theory that is particularly relevant to midwifery and the understanding of emotional support is Hochschild's (1979) sociological theory of the manipulation of emotions for commercial reasons. As discussed in the literature review, she found that employers who were buying the emotional labour of their employees expected not only a certain type of behaviour in their staff, but also that their staff are sincere and feel the dictated emotion. She developed an interpretative framework for understanding emotional labour, which include framing and feeling rules. These are, according to Hochschild (1983), used extensively in social situations. This commercialisation or professional use of emotions can be seen in health care (Bolton 2000, Mann 2004, 2005, Hunter 2005, 2006).

The terms emotional labour, emotion work and emotion management have been used in this study in the way Hochschild (1979) established, with emotional labour being the manipulation of emotions in the public arenas and emotion work the manipulation of emotions in private arenas. Hunter uses the term emotion work extensively in her studies, which I am not sure is totally compatible with her statement that midwives work in public and private arenas. Certainly, though, the midwives in this study can be seen to be offering emotional support in private arenas; when they realised the women needed emotional support they arranged to visit them at home. The midwives in this study can therefore be considered to be undertaking emotion work. This emotional labour or emotion work can be seen to require great effort for health care professionals (Bolton 2000, Mann 2004, 2005, Hunter 2005, 2006, John and Parsons 2006).

The focus of this study was not on the emotion work of midwives per se but how they provide emotional support to women. Despite this, it is important to recognise that the literature available highlights that the manipulation of emotions can be at great cost to the carer. The midwives in this study can be seen to manage their emotions to facilitate emotional well being of the women; they could be considered to be offering the 'gift' of emotion work (Bolton 2000, Hochschild 2003).

When the 'gift' of emotion work is appreciated and recognised the midwife is in turn supported in her work but where this does not happen there may be detrimental effects (Hochschild 2003, John and Parsons 2006) including 'burn out' (Sandell 1997, Mann 2004). For midwives it may not only be the 'gift' that creates emotional labour or emotion work. Midwives experience two competing ideologies of 'being professional' and 'being with woman', which can be seen to induce emotion work (Hunter 2004).

In Hunter's studies (2001, 2004, 2005, 2006) emotion work has been found to be widespread in midwifery and can be created by any significant interactions with people (colleagues or clients). There is general agreement that emotion work is

costly but is important to ensure quality care (Smith 1992, Bolton 2000, Mann 2004, Hunter 2001, 2004, 2005, 2006). The midwives in this study did recognise that extra resources were needed to offer emotional support but only a couple of the midwives acknowledged the extra effort that was needed to deal with other professionals. This can be seen in the descriptions of Betty and Hetty who both felt uncomfortable and were having to use emotion work to manage the situation, but they appear to have been unaware of this (SSESC page 175).

Mostly, the midwives in this study expressed the belief that their colleagues were supportive and they involved them in what was labelled a 'circle of care'. This circle was developed by the midwives to address the needs of the women and their families but it also provided support for the midwives (see SESC page 168).

None of the concepts associated with the emotion work of midwives have clear definitions and those available were not provided for the midwives when they were asked to describe their action and interactions. For this study the term "emotional support" was not defined for the participants but from reviewing the literature it appears to be, in a very brief definition, the actions taken in response to perceived emotional needs. Therapeutic emotional labour can be accepted as the effort a carer puts in to their interactions to help the other person, particularly in the public arena such as hospitals and clinics. The term "emotional care" has been used in this study in a wider context and includes emotional support, and the assessment and evaluation of this (see literature review page 75).

As identified from the literature, emotionally supportive qualities appear to be listening, touch, being respectful, acceptance and giving clear information (Schuiling and Sampselle 1999, Edwards 2000, Morse 2000). These can be undertaken whatever the midwifery task may be, such as clinical examinations (Morse 2000, Bone 2009). The midwives, in this study, all describe these interactions with the women even when they were involved in more clinical interventions (see SESC page 168).

Supportive midwifery practices include providing an environment that focuses on the normality of motherhood (including the birth), reduced fear and increased confidence, control and trust (Rhodes 1995, Edwards 2000, Kirkham 2000, NICE 2003, ICM 2006). All the midwives in this study demonstrated their focus on normality and at times struggled with the women's perception that their experience was not normal. Fiona highlighted that is was important for women to be told there was nothing wrong and Betty stated it was important for women to feel normal (see SESC page 168).

When it was recognised that the women did not find their experiences to be normal, the midwives endeavoured to persuade the women that they were. Where this was not achieved, this became a trigger to offering emotional support and created emotion work for the midwife. All the midwives in this study could also be seen to be trying to facilitate reduced fear, increased confidence, control and trust as recommended by their professional body, government guidelines and research evidence (Rhodes 1995, Edwards 2000, Kirkham 2000, NICE 2003, ICM 2006).

Comfort

Despite the lack of clarity over the term "support" and other terms such as "emotional support", "therapeutic emotional labour" or "emotional care", the enactment of all these terms seems to be aiming for the same goal, which the midwives in this study also appeared to be aiming for. The goal would appear to be for emotional well being and comfort in the woman (NMC 2004). This is clearly stated in the general structure in the findings of this study (page 161).

As identified in the literature review, nursing literature (Morse et al 1994) suggests suffering causes the person to focus on the corporeal, comfort allows the person space to focus on other areas of their lives. Comfort from a midwifery perspective appears to involve mind (psychological), body (corporeal) and spirit (soul) (Schuiling and Sampselle 1999). A state of comfort in the mind involves a feeling of peace and security, freedom from anxiety or worry. Within the body it

involves physical needs being met such as hunger, thirst, sleep, air and freedom from illness. Spiritual comfort involves a feeling of hope and expectation, transcendence from pain and being at one with one's god (Schuiling and Sampselle 1999). As already identified, the midwives in this study appear to aim to facilitate comfort in the women for whom they offer emotionally supportive care. Their interventions to achieve this appeared to correspond well with the literature available on how people need this to be offered to them (Schuiling and Sampselle 1999, Morse 2000, Williams and Irurita 2004).

Morse et al (1994), in their study, used nine themes to explore comfort, one of which was the disobedient body, to address the dis-eased body theme. In this theme comfort was gained from information about the illness and a belief in the caregiver's ability to provide appropriate care. Information giving has already been considered in this discussion as all the midwives, in this study, described their information giving activities (see page196). Both Williams and Irurita (2004) and Schuiling and Sampselle (1999) highlighted information-giving as an element of providing comfort. They also recognised the need for those being cared for to feel confident in their caregiver's ability to provide that care. Only one of the midwives in this study indicated that there may be an issue of confidence in the service or ability of the midwives and that was Emily. Emily felt the women she discussed had been unhappy with their maternity care (SSESC page 175).

Emily went on to discuss how she had worked with women to develop a trusting relationship using her information giving, self-disclosure and communication skills. Using her emotion work and emotional support Emily said the woman was "Much more relaxed, less tearful" and went on to have a good birth experience.

Morse et al (1994) stress it is not the activity of care that is important, it is the way in which it is undertaken. If it is undertaken 'for' and 'with' the patient instead of 'to' the patient it restores the patient's integrity and assists in moving

them towards recovery. This would also appear to be the aim of women-centred care in midwifery. The midwives, in this study, appeared to be aiming to work 'for' and 'with' the women they were caring for. An example is where Diane was working 'for' and 'with' the woman to overcome some of her struggles. She said "we um talked it through to deal with that and um we talked through coping with the baby being awake at night and tips for that, just sitting and talking about getting enough sleep and making sure she was getting enough sleep during the day time" (Diane 6, 7).

The opportunity to gain some control over themselves or their environment facilitated a sense of comfort for some patients (Morse et al 1994). The midwives in this study also appeared to be attempting to facilitate control in the women they were caring for. This is considered in more detail later in this section (page 213) and in the section 'What is the experience of midwives supporting mother hood?' (Page 218). This was done to reduce emotional distress and increase comfort for the women.

The ill or 'diseased body' (Morse et al 1994) (or in the midwifery situation it may be emotional and or physical pain) seems to take control of the person's whole being, and for the person to regain some understanding of their body offered them some comfort. The control and information giving apparently sought, and provided by the midwives in this study for the women they care for, would also have an impact on the comfort experienced (Morse et al 1994, Schuiling and Sampselle 1999, Williams and Irurita 2004). The 'vulnerable body', another of Morse et al's themes (1994), is seen in situations where pain or the anticipation of pain becomes all consuming. Certainly the midwives in this study recognised vulnerability in the women they were caring for and this led them to offer emotional support.

Comfort at times of vulnerability is gained from feeling safe, secure and trusting in the caregiver. The midwives in this study all appeared to be seeking to develop trusting therapeutic relationships with the women for whom they cared.

When the anticipation of pain cannot be removed, the caregiver can offer comfort by protecting, bolstering and advocating for the patient (Morse et al 1994). Each of these again can be found in the midwives descriptions, Hetty described how she protected the young woman from being in uncomfortable situations (protecting), Diane described reassuring the mother that as mother she knew her baby (bolstering) and Hetty needed to advocate for the woman with other professionals.

All the areas highlighted as important for facilitating comfort within the person (Morse et al 1994, Schuiling and Sampselle 1999, Williams and Irurita 2004) have been seen in the descriptions from the midwives in this study, when they were offering emotionally supportive care. These activities included giving information, control, developing trust along with the communication skills of touch, voice and eye contact to focus the women.

Normality to develop comfort

The midwives in this study identified the need to allow the women to have a sense of normality to create comfort in them. They felt it was important that the women should feel that their experiences were normal and the midwives also tried to encourage the women to believe that their births were normal. Carol (31) said, “I think really we need to make them feel they are normal and are not abnormal in any way; that this is normal”.

John and Parsons’ (2006) study provided the women’s perspective on the importance of being treated as if they were normal and the midwives behaving as if they were having normal conversations. The midwives in their study also identified that they were trying to ensure the experience was normal for the women. The experience of being ‘normal’ appears to have a duality of meaning within midwifery in that the midwives appear to try to facilitate a ‘normal birth’ and the experience of ‘being normal’ also appears to mean the woman not being distressed or believing that there is anything wrong with her. They appear to use

both meanings of normal and attempt to achieve both types of normality to facilitate the women gaining comfort (Morse et al 1994).

It is again difficult to know if the midwives hold the belief that they should encourage the sense of normality because they are led to do so by government guidelines or whether there is another ideological reason for this. The 'with woman' ideology supports the belief that becoming a mother is a normal process, not a medical condition requiring intervention. This is an ideological standpoint that is being increasingly promoted by government as well as midwives (NSF – DoH 2004).

A feeling of control to facilitate comfort

The midwives in this study could also be seen to promote a feeling of control to allow the women to feel they had some command over what may feel like a time of chaos and powerlessness (SESC page 168).

Control, though, appears to be a somewhat illusory thing and there are a number of papers in the literature focusing on control within midwifery (Lomax and Robinson 1996, Fleming 1998a,b, Levy 1998a,b,c,d, Walsh 1999, Green et al 2000, McCourt 2005). This appears to be mostly due to the call for continuity, control and choice in midwifery through documents like Changing Childbirth (DoH 1993). Some studies suggest women are gaining control in midwifery and in doing so creating extra problems for midwives. Fleming (1998b) found that some women are assertively making demands and taking control, which has coerced midwives to take on work that overloads them. There was no indication from the midwives' descriptions in this study that they felt coerced into providing extra care. Despite this Emily did feel that the women she was caring for had unrealistic expectations of the midwifery service which created the woman's initial distress.

Other studies suggest all the control lies with the midwives (Lomax and Robinson 1996, Levy 1998c) and others state that women and midwives have no control - it is all in the hands of medicine and the managers (Kirkham et al 2002). Levy's (1998d,e) work would paint the picture of control not belonging to anyone; it is taken, given and passed around like some high stakes complex game. Perhaps the best that midwives can achieve is the 'feeling of control', for themselves and the women for whom they care, as that is all that is available within the complexities of the current culture, as was implied at the beginning of this discussion (see What is midwifery? page188).

Interestingly, the comfort the midwives are seeking to achieve by offering emotionally supportive care is said to facilitate a feeling of control in the women for whom they are caring (Schuiling and Sampselle 1999). This may lead to the conclusion that if midwives focus on their supportive skills there will be little need for them to advocate for women and empower them.

As was highlighted previously, facilitating control in those suffering can produce a sense of comfort (Morse et al 1994) and the midwives in this study can be seen to be trying to achieve this despite enacting protective steering (Levy 1998c).

Summary

The findings from the constituent 'Showing emotionally supportive care' are discussed in this section and are a major part of the general structure. The details of the interactions are discussed in the section labelled "What do midwives do?". The objectives to "gain descriptions from the midwives' perspective of their actions and interactions with women becoming mothers focusing on emotional support" and to "seek both the commonality and uniqueness within the experiences described by the midwives" are also considered in this section. The two elements of "showing emotionally supportive care" that are not discussed in this section are self-disclosure and intuition, which will be discussed in the next section.

This discussion facilitates an understanding that the midwives in this study are conducting all the expected activities that a carer needs to provide, to give emotional support to someone to gain comfort and emotional well being. This has been acknowledged through both nursing and midwifery literature. There are, though, a couple of areas of concern in the literature and both of these are apparent in this study as well. The one is information-giving, which was also highlighted in the previous section of the discussion ('What do midwives do?'). The midwives in this study, as with previous studies, appear to be enacting protective steering when giving information and this can be seen to reduce the woman's ability to make informed decisions and access control. It could be suggested that the midwives in this study, as with others, are managing the information giving and maintaining an element of control instead of facilitating empowerment and control in the women.

The maintenance of control by midwives may also reduce the comfort that is achieved, given the literature on gaining comfort. This does not appear to be the perception of the midwives in this study, though. They believe, given the positive emotional expressions by the women they were caring for, that they have facilitated comfort and safe motherhood by reducing distress.

The other area of concern arising from this comparison of the findings of this study against previous literature is the emotion work undertaken by the midwives. The midwives in this study appear to be offering women the 'gift' of emotional support, which has an associated emotional toll. For some of the midwives in this study this is ameliorated by close relationships with their colleagues or the woman and her family and encouragement and endorsement from them. They offered the appreciation and recognition needed. Other midwives, in this study, particularly Hetty, appear to have little support and increased stress placed on them by other professionals. In fact it can be seen that all the midwives in this study, through all the constituents, are trying to behave in a 'with woman' manner at the same time as trying to adhere to the 'being

professional / with institution' manner. This was highlighted in the general structure and the individual struggles are raised in the constituents.

What is the experience of midwives supporting motherhood?

Introduction

There has been increased interest from midwifery researchers in the area of emotional labour and emotion work, leading to a number of recent texts. Despite this, there remains a limited description of what midwives do when providing emotional support or care for women becoming mothers. The early work of Oakley (1988, 1993) and Hildingsson and Häggström (1999) on support is a useful starting point and the research of Hunter and colleagues (seen in previous section – 'What is emotional support') has further opened up the area to scrutiny.

The literature available suggests that supporting women on their journey to motherhood is stressful, exhausting and undervalued and leads to emotion work (Hildingsson and Häggström 1999, John and Parsons 2006, Bone 2009). This support is also enacted in a culture with opposing ideologies that appears to focus on technical biomedical interactions or interventions (Hunter and Deery 2009).

The three studies found that offered a good insight into the midwife's experiences of giving emotional support to women becoming mothers were Hildingsson and Häggström (1999), John and Parsons (2006) and Bone (2009). The workload was experienced to be burdensome and the midwives in their studies felt undervalued but also found it rewarding and joyful. This is only partly seen in the midwives in this study; they appeared to find the workload great and needed, at times, to use personal time to support women but they did not state that they felt it was undervalued (SESC page 168).

Given the midwives in this study's need to offer a justification for this type of care, it could be assumed that it is only valued or acceptable in certain

circumstances. This was discussed in section labelled 'What is midwifery?' (page 188) and from the constituent 'Tipping the balance' (page 164). When the midwife assessed a particular need in the woman they then felt it was acceptable to offer them the 'gift' of emotional support. As with the nurses in Bolton's study (2000) it was not perceived as burdensome to offer the 'gift' to women or babies in need but there may have been with others, such as colleagues, a need for reciprocity. Certainly some of the midwives in this study indicated that they received reciprocal support from their colleagues, which supported them in their role, in their circle of care (SESC page 168).

Emotional support appeared to be incidental in relationship to other activities such as measurement and documentation for the midwives in the literature review (Bone 2009) but this was not found in the midwives in this study. It can, though, be seen that these other tasks were of priority. This may be due to the midwives knowing that emotional support is the focus of my study and my specifically asking about their emotional support. Emotional support for the midwives in the studies of Bone (2009) and John and Parsons (2006) was identified in how things were done rather than in a distinct activity to facilitate calm or relaxed behaviour in the women. Although the midwives in this study identified specific activities this could also be seen in their behaviours to some extent.

Comparisons between the studies needs to be a cautious one, though, as the midwives in my study were working in the community, where flexibility and autonomy were probably more in evidence. The midwives in this study certainly described having autonomy and room for flexibility. There is perhaps a closer relationship between this study and the one by Hildingsson and Häggström (1999), as the midwives in their study were also working in the community. The midwives in Hildingsson and Häggström's study, like those in my study, did undertake extra activities rather than just adjust how they undertook their regular activities.

One midwife – one woman (continuity of care)

The midwives and at least one of the women in this study believed that continuity of care should consist of one midwife caring for a woman throughout pregnancy and into the early days after the birth (SSESC page 175). This is in contrast to Fleming (1998a) who suggests that there does not need to be a continuous relationship throughout pregnancy and birth, as strong relationships can develop very quickly; it is more important to gain a trusting relationship through an interdependent or reciprocal relationship. In support of Fleming's (1998a) findings it has been found that when people are in states of heightened anxiety, they find the people they come into contact with more attractive. One of the most powerful factors influencing affiliation is anxiety (Gross 2001).

Green et al (2000) in their review of continuity of care suggest that there has been no firm definition of what constitutes continuity. They suggest continuity of care means care that is not fragmented, which is what they identify that women do not want. Continuity of care, though, has been seen to mean continuity of carer (Green et al 2000), with some recognising this to mean midwifery care being given by one midwife, as indicated by the midwives in this study. The continuity of care message was developed from women consistently saying they "did not like fragmentation, inconsistency, long waiting times and being treated like a number. They wanted to be treated with respect and dignity" (Green et al 2000: 186). Continuity of carer was seen to be a way of overcoming fragmentation of care and a method for developing a relationship between carer and woman to allow mutual respect to develop. Continuity of carer may seem to be focusing on one element of what women were saying when another may be more important to them. Many studies support Green et al's (2000) assertion that what is important to women is to be treated with respect and dignity and that they want to feel special (Fraser 1999, Walsh 1999, McCourt et al 2000).

Continuity of care was an element of care recommended in the Changing Childbirth report (DoH 1993). Since this time it would appear that continuity of care has become part of the underlying philosophy of midwifery practice

(Pairman 2000) and one that appears to be accepted into the belief system of the midwives in this study. There does not appear to be any evidence that what the midwives in this study hold as important – continuity of care – is not so. There is, though, evidence to suggest that it puts increasing pressure on an already pressured midwifery service (Sandell 1997, Green et al 2000).

Home visiting

Another belief was that home visiting was necessary to offer emotional support, and the midwives in this study offered clear explanations for this belief, unlike other beliefs. None of the midwives described giving emotional support anywhere except the home situation and said that when they recognised the women needed emotional support they organised a home visit.

The reasons offered for home visiting were that it facilitated relationship development; it allowed women to be more comfortable and moved the perceived power from the midwife, giving control to the woman. It is acknowledged by a number of writers that there is power associated with midwifery knowledge and values, which are recognised by women and midwives (Fleming 1998a). However, Kirkham et al (2002) found that women's perception was that midwives had very little control and the power was with the doctors. This could support the Professional and Disciplinary interactive styles (McCourt 2005) discussed in the section focused on relationships between midwives and women (page 193). The midwives in this study suggested that home visiting addresses this power imbalance and allows the women to receive the emotional support they need but this was not always achievable due to workload pressure. It has been said that community-based maternity provision equates with caring and hospital-based maternity services equates with curing (McCourt and Percival 2000).

All of the emotional support described by the midwives in this study was conducted in the woman's own home. These occasions of information giving in the home environment were found to be flexible and adapted to the woman, and

proceeded as a conversation where the woman was given time to seek the information she needed (McCourt 2005), although this is contested; see section on information giving (page 196).

Home visiting was thought to improve health and developmental outcomes of the baby but this was not supported by Doggett, Burrett and Osborn (2007) in their Cochrane Review of home visiting of pregnant women who had drug and alcohol abuse issues. They suggested that there was insufficient data to suggest that home visiting was beneficial for the mothers' and babies' health. Although Doggett et al (2007) identified a lack of evidence to support home visiting facilitating the well being of women and their babies there are other studies, which did not fulfil the criteria of the Cochrane Review, (Kitzman et al 2000, 1998, Olds et al 2002, 2004) that support the view of the midwives in this study.

To offer home visiting in the antenatal period is not general practice in the UK (Walsh 1999). However in the few published studies where this does occur it is well evaluated by the women (Walsh 1999, McCourt 2005). Fleming (1998b) also found women appreciated having antenatal appointments at home in her study in New Zealand.

Walsh (1999) pointed out that women in his study appreciated the home visits in the antenatal period as they gave the partners and other children the opportunity to get involved. Some of the midwives in my study also recognised the importance of involving partners, some of whom needed support and others supported the midwife in offering emotional support. They became part of the circle of care (SESC page 168).

The midwives in this study valued home visiting to give emotional support to women becoming mothers. Despite this, midwives like Fiona identified that she did not have the time to conduct the home visits she would like and the NICE guidelines for antenatal care (NICE 2003) appear to make little room for this activity. "Not antenatally, because my timetable just does not permit it because I

can 8, 10 women in clinic in a morning whereas if I visit 8, 10 women at home the time taken travelling between the two I would just never be able to cope with the number of hours that would involve" (Fiona 11).

This belief by the midwives in my study when trying to comply with NICE guidelines, could create extra struggles in their providing emotionally supportive care. This is especially so when it is recognised that the guidelines from NICE stipulate who is and is not at higher risk and therefore in need of extra appointments. The midwives in this study recognised that it was not always those women who fit at-risk stereotypes who need extra support. They identified that it was difficult to assess who would need extra care and who would not (TTB page 164).

Intimate relationship – use of self

Emotional support which is provided through an intimate relationship with the women is facilitated by home visiting. The intimate nature of this relationship between midwife and woman has been recognised by a number of writers (Walsh 1999, Pairman 2000, Hunter 2001, Kirkham et al 2002, McCourt and Stevens 2009). It has also been acknowledged in a number of studies that within this intimate relationship midwives use something of themselves, self disclosure (Kirkham 2002, Hunter 2006, John and Parsons 2006) or intuition (Fleming 1998, Hildingsson and Häggström 1999, Callister and Freeborn 2007, Ólafsdóttir 2009, Bone 2009). Hunter (2001) acknowledged the intimate nature of the midwife-woman relationship, explaining that this was part of the emotion work of midwives. The midwives in my study when providing emotional support also used something of themselves with the women to develop their relationships and guide their care (SESC page 168).

Despite the midwives in this study sharing personal information about themselves, they, as was found in a previous study (Kirkham et al 2002b), chose to omit discussing personal birth experiences. This may be due to pressure for midwives to give the 'good answer' expected by the organisation on this

particular topic (Kirkham et al 2002b). This could suggest, again, that midwives' practice, including those in this study, is being influenced by the 'being professional / with institution' ideology. The midwives in this study did not identify this as a reason for not sharing this part of themselves; they suggested it was due to all births being different.

In Hunter's study (2006) self disclosure became an important element of the midwife-woman relationship and where this was balanced – a reciprocal relationship – the midwives incurred less emotional toll and more job satisfaction. Although Fleming (1998a) does not discuss disclosure she does identify that interdependence occurs and that the social process of reciprocity is key to this therapeutic relationship. She also identifies midwives as seeking to use intuition or a sixth sense to guide their care.

Hildingsson and Häggström (1999: 85) described the midwives in their study using intuition or some other interpretative tool as "they heard something between the words the woman said…". When they discussed this intuition it was related to how the needs of the women were identified. The use of intuition has been found in other studies (Callister and Freeborn 2007, Ólafsdóttir 2009) and was found in this study as well. Intuition appears to guide the midwives' care and give them a sense of what is needed and how things will be.

The three ways of intuitive knowing are intuition based on practice experience, intuition based on spiritual awareness and intuition based on connectiveness with women, but these are overlapping and interrelated (Ólafsdóttir 2009). Inner knowing based on practice experience is where the practitioner internalises their knowledge derived from clinical experience and then use this at a subconscious level. This appears to be what Gina was describing. "I think there comes an intuition about when things are going right or when things are going wrong and because as a team we go to each others because at the actual birth there is 2 midwives there, so I've been to numerous of those with my colleagues. Sharing

the births with them, I can't pinpoint what instinctively makes me feel" (Gina 72, 73).

"I always trust what my gut is saying that's what it is about and you know I suppose it is part of a spacious relationship and you know they know they have access if they have a problem" (Hetty 50, 51). It may be that Hetty is describing intuition based more on connectivenss with women. None of the midwives in this study described intuition based on spiritual awareness but this may be due to some of the issues raised by the midwives in Ólafsdóttir's study (2009), particularly that people would think they were crazy. Despite this the midwives in this study did describe having close relationships with the women they were offering emotional support to and it may be that given the level of intimacy they may have shared more connectiveness and spiritual awareness than has been explicitly identified in their descriptions, as this was not asked of them.

The midwifery literature acknowledges the use of self, whether through self-disclosure or intuition, to develop the midwife-woman relationship to show care, which was also described by the midwives in this study. It is acknowledged that this use of self is undervalued and gains little or no status (Bolton 2000, Kirkham 2000, John and Parsons 2006). The midwives in this study did not appear to seek value and status in offering this type of care as with the midwives in Cattrell et al's study (2005). They appeared to be seeking the time in which to offer it. Maybe if this type of care was given more status and valued the midwives would be given the resources to provide it.

Intimate relationship – physical proximity

Physical proximity was recognised as a necessary part of most midwives' roles but it may be found that this is an area for which they need to offer emotional support, as the midwives in this study identified how intimately close they were. As part of this support, the inner knowing and intimate midwife - woman relationship described above may overcome the embarrassment felt by midwives or women in close physical proximity.

Indeed many writers suggest that if touch is used sensitively it can facilitate comfort and understanding (Kitzinger 1977, Morrison 1992, Morse 2000, Williams and Irurita 2004, John and Parsons 2006). Midwives in this study identified that physical proximity was part of their experiences with the woman and her baby (SESC page 168)

Williams and Irurita (2004) acknowledged close physical proximity as a means by which to create a feeling of comfort but they also pointed out that this proximity could be influenced by cultural expectations. Hunter (2006) indicates the sexual nature of childbirth as another element of midwifery care that may provoke embarrassment and discomfort. She believes midwives should acknowledge this sexual component of childbirth and recognise that it may cause emotion work for them as they attempt to provide appropriate care. This did not, though, appear to be an area of concern for the midwives in this study and they appeared quite comfortable with discussing the intimate nature of their contact with the women.

Differing perceptions between women and midwives

An experience for some of the midwives in this study that caused them some concern or stress was the lack of understanding between themselves and the women of each other's worldviews. Examples are that Carol could not accept the woman's view that her birth was traumatic and that Emily could not understand why the woman she had met was distressed about their interaction (SSESC page 175).

These examples offer a demonstration that, at times, midwives struggled to understand the women's perceptions and frequently the women were unable to understand what the midwives were trying to communicate to them. Interestingly McCourt (2005), in her study which focused on interviewing and observing midwives, recognised that it was the interactions that led the midwives to believe the meeting had gone well. She said that a good visit equated with a 'good'

client who was “relaxed and confident, who asked the appropriate questions tended to put the midwife at her ease too” (McCourt 2005: 1316). It may be that due to Emily gaining articulate, relaxed and confident responses from the woman, she believed the appointment had gone well whereas the woman had left unhappy.

This lack of mutual understanding has been found in other studies. Fleming (1998b) and Kirkham et al (2002b) also found, when interviewing women and their midwives about their experiences of midwifery care, that there were a number of contradictions. The midwives and women had different expectations and reflections on their experiences. This desire or perceived necessity for the women to understand the midwives’ perspective and the need for midwives to understand the women’s experiences created extra effort and emotion work for the midwives in my study. This lack of understanding can also be seen in the midwives’ attempts to prepare women for motherhood as seen in the section labelled ‘What is motherhood?’ (page 201).

Use of personal rules or instincts

The midwives in this study did not appear to have a clear understanding of how to manage their emotional support, despite the prolific amount of polices and government guidance available on midwifery care. This appeared to be the situation, as the midwives described personal rules or instincts guiding them to manage their relationships instead of describing guidance or knowledge (SSESC page 175).

Becoming a mother is widely acknowledged as an emotional time and those supporting women at this time may not only experience the women’s emotions but also personal emotions as well.

Sharing of emotional moments

The women and midwives in this study appeared to experience a range of emotions from guilt, fear and distress to being peaceful, happy and cheerful. Although midwives were attempting to facilitate comfort and positive emotions, this did not always occur. Indeed one midwife appeared to have induced fear. Diane explained "and she said to me I hope you are not going to tell me off" (Diane 18) and "she was also feeling a bit guilty because she thought I was going to tell her off" (Diane 21 & 22) (Findings chapter EE page 180).

Hildingsson and Häggström (1999) also identified midwives in this position. They found that when the midwives in their study took on the role of 'good mother' they sometimes admonished the women in their care. It may be that the woman Diane was working with saw her as a critical mother figure rather than a partner in her care. This situation can be seen to have occurred for Diane as she was attempting to promote independence in the woman by providing her with information about breast feeding as guided by both the Nice guidelines (2006) and her professional bodies (RCM, ICM 2006).

Diane can be seen to be struggling not only with the emotions generated, fear and anxiety, but also with how to resolve the problems for the woman. She is obviously, from the woman's perspective and her own words, attempting to act in accordance with two competing groups of rules which come from the differing ideologies in midwifery. Organisationally and personally she feels she should be promoting total breast feeding of the baby but at the same time she is attempting to behave within the ideology of 'with woman' as discussed by Hunter (2004). As one woman with another she appears to desire to achieve comfort in the woman and reduce her distress.

This dissonance between conflicting ideologies can be seen to be creating emotional conflict and work for Diane. She appears to desire to tell the woman she should give herself more time, to carry on trying to fully breast feed, as this will be more fulfilling for her and the baby. Diane, though, recognises the

anxiety in the woman and compromises her own feelings and the organisation's standpoint, to address the feelings of the woman. Diane then uses a common coping strategy, as described by Mann (2004), of rationalisation to reduce her own and the woman's dissonance, as the woman, as well as feeling fearful of Diane, was also feeling guilty. Diane achieved this rationalisation by saying that, as the mother, the woman knew what was best for her baby.

As can be seen through Diane's interactions, holding opposing ideologies without the recognition of this by policy makers, mangers and educationalists can lead to limited support and guidance and problems in care giving. Another example of the midwives working with the feelings of the women they were caring for is demonstrated by Betty. Betty said "luckily they never felt they needed to apologise to me so hopefully that means, was because they didn't feel that I was being short with them or losing my patience. Because they kept thanking me all the time, 'thank you for doing this' and 'thank you for doing that' and all the time they were really thankful and very grateful so hopefully, you know, that was the support that I gave but hopefully that I didn't make them feel, you know, that they were being a nuisance" (Betty 50, 51).

Betty clearly described the couple as being very grateful for her help, she believed this demonstrated she was doing a good job but it did create emotion work for Betty. An indication of this can be found in Betty's comment that she hoped she did not make them feel they were being a nuisance. This obviously was not a balanced relationship, which is advocated by Hunter (2006). Betty appeared to have to put a lot of effort into all the care given to this couple, including emotional support. Betty, herself, acknowledged it took extra time and effort to communicate with them. She did, though, appear at times to be using 'feeling rules' as she was acting in a manner she felt she needed to (Hochschild 2003, Savage 2004). Betty does not say she felt 'short' or at risk of being 'impatient' with them but she does indicate she is concerned that they may feel she is. She assesses whether they feel she is impatient by their need to apologise, which they do not do. It could be, though, that their need to constantly express

gratitude is demonstrating this. This obviously caused emotion work for Betty as she tried to facilitate a feeling of being valued and worthy in the couple at the same time as having to put in a lot of effort to provide the care they appeared to need. "I didn't find the experience of looking after her in any way traumatic in fact quite the opposite I found it quite enhancing really because they were such a delightful couple and because she was, both of them were very receptive" (Betty 66). Betty clearly identified that the emotional responses of the woman indicated to her that she was providing emotional support and that she had gained a rapport with her.

Good rapport leads to positive outcomes

This study offers a detailed account of the midwives' experiences. The context or culture has been discussed in the sections "What is a midwife?" and "What do midwives do?". The detail of how midwives give emotional support to women becoming mothers was discussed in "What do midwives do?". The struggles they experience when providing this care is discussed in "What do midwives do?" and in this section – "What is the experience of midwives giving emotional support to women?". Experience of providing emotional support to women becoming mothers is exhausting and time consuming but can bring pleasure to both. It involved emotion work for the midwives in this study but when a good rapport developed it facilitated comfort. This appears to relate to what Hunter (2006) calls a balanced reciprocal relationship. Fleming (1998a) and Pairman (2000) also recognise the desirability of reciprocity within the midwife-woman relationship.

A reciprocal relationship is the one in which the midwife needs to do least emotion work and is therefore most emotionally healthy for midwife and woman (Fleming 1998a, Pairman 2000, Hunter 2006). The midwives in this study did not appear to have totally reciprocal relationships but this may be due to them identifying times where they needed to offer emotional support. However they did conclude their description with the indication that they achieved a more reciprocal relationship by the end of their care.

Emotion work

Theories associated with emotion work were considered in the section of the discussion entitled 'What is emotional support?' (page 206) and so will not be discussed here but this section will consider the detail of the midwives' experiences in relationship to their emotion work. As already established, emotion work can be experienced in response to 'feeling rules' associated with care for women and 'feeling rules' associated with colleague's expectations (Hunter 2004).

The midwives in this study dealt with many struggles and expended emotion work effort in their desire to offer emotionally supportive care. In doing this the most influential struggle was the struggle between what they believed their profession expected of them and their desire to come alongside women. They appeared to believe that their profession expected them to 'toe' the organisations 'line', not to undermine colleagues (whether midwives or doctors), and to see a large number of women with a professional distance, a clear boundary between professional and client (see section "What is emotional support" page 206).

Clear boundary between professional (midwife) and client (woman)

Hildingsson and Häggström's (1999) midwives did not seem to have this struggle between being professional and being with woman. They identified that midwives in their study were taking on a 'good mother' role with the women they were offering care to, but Hunter (2006) suggests this is problematic in the current health care climate in the UK. Hunter (2004) explains that midwives are expected to work in partnership with women rather than to 'mother' them.

The midwives in this study appeared to believe they need to be both professional and knowledgeable, and 'with woman' and caring. They sought a relationship of partnership (Fleming 1998b) and to come alongside women (Fleming 1998a). Bolton (2000) recognised this need to balance being a professional within an

organisation and its expectations, at the same time as offering human caring. She identified that whilst the nurses in her study offered a "gift", an extra element of care, it did not receive status and was not required by the organisation, but they felt it was necessary. Unlike the midwives in this study they did not struggle with this; they did not concern themselves with whether offering this care would reduce their professionalism. Indeed they said that they did not believe anyone could be a nurse unless they were prepared to offer this extra care from within themselves. It might therefore appear that this struggle with ideologies is to do with the midwifery profession rather than the task undertaken, as the task these nurses were undertaking were similar to some conducted by midwives.

The midwives in this study seem drawn to using their personal experiences, feelings and intuition as women to come alongside other women and support them, but they were concerned whether this would be in conflict with what they believed their profession expected of them. For some this led to a cautious approach to caring which can be seen through Hetty's explanation that she recognised some of the restrictions placed on her due to professional boundaries but she also recognised that there was a need to work within a structure.

Diane and Hetty, both of whom could be seen to taking on the role of the 'good mother', experienced this problem. Whilst they desired to encourage and support the women to achieve independence, there remained the desire to offer care. Making the decision of when to stand back and when to intervene was difficult and created a struggle for the midwives. This becomes particularly apparent in Diane's desire to help and practically assist the woman she was caring for, conflicting with the recognition that she must facilitate independence.

Hildingsson and Häggström (1999) also identified that playing the role of 'good mother' had some negative consequences such as midwives admonishing the women. In my study, whilst Diane was attempting to balance helping and

facilitating independence, the woman became fearful of 'being told off' by Diane which may indicate that she appeared to the woman as a critical mother figure.

Whether Diane and Hetty are considered to be working in a motherly, 'good mother', manner or not, in them can be seen some of the struggle midwives have with attempting to maintain professionalism and simultaneously come alongside the women and offer emotionally supportive care.

Toeing the organisational line

Carol needed to put effort into emotion work due to others, apparently colleagues, upsetting the woman she was caring for. She said "different people were coming in; one would say this, one would say that and so she had a lot of upset about that. And then um I think one person in particular upset her" (Carol 9, 10).

This demonstrates that it is not just the midwife-woman relationship that creates emotion work as identified by Hunter (2004); it can also be colleagues. Carol went on, as with Diane, to use rationalising to cope with the situation. Carol appears to have experienced some dissonance between different sets of 'feeling rules', or it may be the ideologies (Hunter 2005). Carol desired to support and defend her colleagues at the same time as advocating for and supporting the woman. This led Carol to rationalise the woman's experience through saying her colleagues were unable to make the experience different and the woman lacked the ability to manage the situation. Carol then went on to defend the woman by suggesting that other women might have the same inability and the woman probably had 'underlying issues' which also offered a reason for this inability.

For Emily too there was a dissonance due to her desire to follow the 'with woman' ideology and the need to also follow the 'with institution' ideology (Hunter 2005). For her, as with Diane, there was the need to draw on 'feeling rules' which can, as in the case of Diane, be contradictory if opposing ideologies

are held. This can cause increased emotion work and stress and may lead to burn out. Managing the differing ideologies identified by Hunter (2005) can be seen as being problematic for the midwives.

In Emily's situation she needed to provide emotion work due to the organisational structure not being what the woman had hoped for. Emily said "Yeah, she had moved, she felt that the midwife she had met first off, although we got on very well, she felt that, you know, she just felt that, I have gone through my history with this one midwife and now have to again. She got herself in a terrible state about it" (Emily 2, 3).

Emily, like Diane and Betty, used rationalisation to cope with this dissonance. Betty and Hetty also experienced emotion work due to organisational / professional expectations. Betty and Hetty both describe having to behave in certain ways due to professional expectations. Betty did not encourage the woman to breast feed despite the woman appearing to want to do this and Betty believing it would not be a problem (Betty 6, 10, 11) because the paediatrician had told the woman not to breast-feed. Hetty had to take a role she was uncomfortable with due to professional expectations (Hetty 35, 36, 37) and due to other professionals' concerns for the baby (Findings chapter SSESC page 175).

For all the midwives, personal dissonance between being 'with institution' and 'with woman' and the application of the relevant 'feeling rules' that were generated by their decision to offer emotional support did not appear to impede their care.

Emotion to evaluate care

When the women and midwives in my study gained a good rapport or balanced reciprocal relationship (Hunter 2006), both achieved positive emotional outcomes (Fleming 1998a, Pairman 2000) and this led to a greater desire in the

midwife to care for the woman. Despite the relationship between the midwives and the woman in this study not being truly balanced, especially initially, they did eventually appear to become more reciprocal relationships (Findings chapter EE page 180).

The midwives in this study used the responses of the women extensively to evaluate their care. When the woman seemed happy the midwives assessed themselves to have done a good job. Gina felt she had done a good job because the mother was happy "I asked her how she felt about things so that she could express whatever she was feeling um she was just happy about things then" (Gina 54, 55). Diane also said "But then I did feel satisfied I left her feeling happy with the decisions she had made, she felt that she had made the right decision really" (Diane 45).

Summary

Midwives in this study appear to have a number of significant factors influencing their experience of giving emotional support to women becoming mothers. They appear to be influenced and guided by research particularly that which underpins policy. An example is the need for control, choice and continuity in Changing Childbirth (DoH 1993) but not the associated research that is not in the guidance that suggests it is consistency of care not continuity of carer that is desired (Green et al 2000). They adhere to the midwifery research that suggests home visiting is the best place to offer care (Fleming 1998b, Walsh 1999, McCourt 2005) which is only implicitly supported by NICE guidelines and NSF. These guide midwives to ensure care is provided particularly to needy groups of women in a flexible manner. They are strongly guided by institutional rules, whether explicitly or implicitly laid down. As all the midwives in this study appear to be following the same guidance, there appears to be some sort of unstated 'framing rules' accepted.

Despite this they are also led by the women's expressed emotions, intuition and personal rules to come alongside and share of themselves. Through this apparent

need to follow policy and institutional expectation as well to follow their intuition midwives find they experience the need to provide emotion work as well as therapeutic emotional labour. Nurses working in similar situations appear to come together and state that their professional expectation of each other is to offer the 'gift' of emotion work, recognising it takes time and effort which, in turn, reduces some of the emotional labour (Bolton 2000).

Although midwives' experience of providing emotional support is that it takes extra time and effort, it is not totally unrewarded. Despite literature suggesting the work is unrecognised and under valued (Bolton 2000, John and Parsons 2006), the midwives in this study appear to gain a reward from the women's expressions of pleasure, comfort and rapport gained and not from the institution for whom they work. For two of the midwives in this study their emotion work was recognised and appreciated by the women.

The experiences of giving emotional support to women becoming mothers for the midwives in this study are different from those of the midwives in Hildingsson and Häggström's (1999) study, probably due to cultural differences, but how they summed it up would be similar. To offer this type of care, was summed up by stating "to be a 'good mother' demands an involvement that can be both emotionally exhausting and time-consuming but also joyful" (Hildingsson and Häggström (1999: 88).

How might emotional support help women becoming mothers?

Introduction

The midwives in this study described not only what they did but also why and how and indicated what they hoped to achieve by their interventions. They appeared to be trying to achieve emotional well-being; reduction in emotional distress, and comfort, and to reduce the risk of postnatal depression.

Emotional distress in women

All the midwives except Hetty described either the woman already being emotionally distressed or at risk of becoming so. This could lead to the conclusion that the midwives offered emotionally supportive care to reduce or ameliorate both emotional distress and the risk of it and to provide comfort. Hetty did not describe the woman she was caring for as experiencing emotional distress but she offered emotional support due to the woman's vulnerability which included her mental and emotional health. Also both Hetty and Betty, because of their concerns for the mother, had significant concerns for the baby (TTB page 164).

Women who lack appropriate support are said to be at risk of developing emotional distress and postnatal depression. If this is persistent it can lead to profound effects on mother, family and the development of the baby (McMahon et al 2001). It is recommended, therefore, that midwives recognise the enormity of the impact of the transition to motherhood for women and provide education and support for them (Barclay et al 1996). Morrissey (2007) would agree with Barclay et al's recommendations, and he goes on to state that 'being with women' through the transition is the most helpful way to promote their mental health.

There is evidence that supports the need for midwives to offer emotionally supportive care for women becoming mothers to reduce or ameliorate emotional distress. This is to promote the well being of mother (Barclay et al 1997, Cronin 2003, Miller 2007), baby (Miller et al 1993, Lemaitre-Sillere 1998, McMahon et al 2001) and family (Burke 2003, Tammentie et al 2004a, Tammentie et al 2004b). It is suggested this can be achieved by facilitating the 'with woman' ideology (Morrissey 2007). This appears to be the main motivating factor for the midwives in this study; they appear concerned that women will become depressed in the postnatal period which will have a long-term negative impact on their child's development. "…they can get extremely distressed post natally

because it wasn't the birth they had planned and um I was maybe trying to forestall this as well that I had experienced before with this kind of scenario" (Gina 43, 44).

Summary of Discussion

As has been seen throughout this thesis there is an element of fluidity between general structure and constituent, meaning units and constituents, etc. This is also reflected in the literature review and discussion. The literature review blurs from "What is a midwife / midwifery?" into "What do midwives do?" and again there is a blurring between what midwives do and the section on "What is the experience of midwives offering emotional support?".

It can be seen in this discussion that, in a similar manner to previous literature, the midwives in this study appear to be influenced by the apparently opposing ideologies of 'with women' and 'with institution / profession'. There is some suggestion in the literature that a midwife could work within both ideologies at the same time (NSF DoH 2004) but the midwives in this study do not appear to be considering this at an explicit level: it appears to be influencing them on a more implicit level. They offer justification for showing emotionally supportive care or tipping the balance, which may be due to these differing ideologies. This may also be due to limited resources and the midwives, due to their belief system (ideological stance), see emotional support as more resource intensive than regular care. This is supported by most evidence (Hildingsson and Häggström 1999, Bolton 2000, John and Parsons 2006) but not by the most recent literature available on emotional support (Bone 2009).

The literature does appear to suggest that all women should be shown emotionally supportive care (DoH 2004, ICM 2006, Page and McCandlish 2006) and the midwives in this study appear to desire to show it; as seen in their seeking a justification.

The core term for what midwives do is *care* (ICM 2006, NMC 2008). This is done through the midwife-woman relationship but it is considered difficult to achieve in the current culture of opposing ideologies (Hunter 2004) and NHS management (Kirkham 1999). Midwives generally provide care to facilitate women's transition to motherhood safely, which is a skilful and complex role. This can be seen through the literature and the descriptions from the midwives in this study.

Emotional support is also provided through this relationship but the emotionally supportive midwifery relationship is special. It is more intimate and has closer physical proximity than other therapeutic relationships. This relationship is developed and maintained through skilful communication. The midwives described their communication skills, both non-verbal and verbal. Non-verbally they listened, gained eye contact and sensitively touched women in accordance with their perceived need. The midwives in this study, despite describing themselves as listening, were sometimes undertaking other tasks at the same time and so they may not actually be actively listening (Egan 1977) as suggested by previous literature (Lomax and Robinson 1996). This study, though, is exploring the midwives' lifeworld experiences and will therefore accept their view despite the apparent inconsistency that they are conducting other activities at the same time as listening. Also, the midwives in this study do indicate they are undertaking these other activities in a supportive manner.

The midwives managed situations to provide the extra support labelled emotional support by making time and visiting the women at home. They believed this facilitated a more relaxed environment where women felt more in control. They further enhanced control and choice, advocated by professional bodies (ICM 2006) and government (DoH 1993), through their verbal skills and information giving. This is another area of contention in the literature as it has been found that midwives do not always give all the information to women so that they can make completely informed decisions. The protective steering identified by Levy (1999d) could also be seen in the midwives in this study. It was unclear whether

the midwives in this study were consciously using protective steering to give emotional support to the women but they clearly identified moderating and managing the information they gave and appeared to believe they were doing what was best for the women.

In their attempts to do their best for the women and offer emotionally supportive care they appeared to be trying to achieve safe motherhood and comfort. They appear to be trying to achieve this at the same time as conducting their regular activities such as physical examinations, measurements and health promotion. They also appear to be trying to use all of these regular activities in a way that would facilitate safe motherhood and comfort as was seen in Bone's study (2009).

It was accepted that motherhood or becoming a mother is a journey, and women appear to have achieved it when they develop recognition of the significance of their new role of 'being with baby' and adapt to this. This understanding is supported by previous literature (Barclay et al 1996, Cronin 2003, Miller 2007). To emotionally support women on this journey, the midwives in this study attempt to facilitate realistic expectations in the women to reduce the risk of postnatal depression. This, though, is not supported by literature as Brown et al's study (1997) suggests that all women have an unrealistic idealised stereotype of motherhood that none could achieve, and this is held regardless of whether the women experience depression or not. Despite the midwives in this study trying to achieve emotional well being by trying, in part, to change a non-influential variable, their interactions with women do appear to offer them emotional support.

Midwives in this study appear to have a number of significant factors influencing their experience of giving emotional support to women becoming mothers. They appear to be influenced and guided by research, particularly that which underpins policy. An example is the need for control, choice and continuity in Changing Childbirth (DoH 1993) but not the associated research that is not in the guidance,

that suggests it is consistency of care not continuity of carer that is desired (Green et al 2000). They adhere to the midwifery research that suggests home visiting is the best place to offer care (Fleming 1998b, Walsh 1999, McCourt 2005) which is only implicitly supported by NICE guidelines and NSF. These guide midwives to ensure care is provided particularly to needy groups of women in a flexible manner. They are strongly guided by institutional rules whether explicitly or implicitly laid down. As all the midwives in this study appear to be following the same guidance there appears to be some sort of unstated 'framing rules' applied.

Despite this they are also led by the women's expressed emotions, their own intuition and personal rules to come alongside and share of themselves. Through this apparent need to follow policy and institutional expectation, as well to follow their intuition, midwives find they experience the need to provide emotion work as well as therapeutic emotional labour. Nurses working in similar situations appear to come together and state their own professional expectations and provide this within the boundaries of the institution. This is regardless of whether the institution supports it or not and offer the 'gift' of emotion work recognising it takes time and effort (Bolton 2000).

Although midwives' experience of providing emotional support takes extra time and effort, it is not totally unrewarded. Despite literature suggesting the work is unrecognised and undervalued (Bolton 2000, John and Parsons 2006) the midwives in this study appear to gain a reward from the women's expressions of pleasure, comfort and rapport gained and not from the institution for which they work. For two of the midwives in this study their emotion work was recognised and appreciated by the women, which led to their pleasure in the care they provided.

The experiences of giving emotional support to women becoming mothers for the midwives in this study are different from those of the midwives in Hildingsson and Häggström's (1999) study, probably due to cultural differences,

but how they summed it up would be similar. To offer this type of care, they stated "to be a 'good mother' demands an involvement that can be both emotionally exhausting and time-consuming but also joyful" (Hildingsson and Häggström 1999: 88).

This study has clearly addressed the aim and objectives that were set:

Aim of this study

To provide an account of how midwives experience participating in giving emotional support to women who are becoming mothers for the first time.

An account of the midwives' experiences can be found in the general structure and constituents in the findings chapter.

Objectives for this study

To gain descriptive accounts of midwives' perceptions of their lived experiences specifically focused on giving emotional support to women becoming mothers in what may be considered 'normal' situations.

These are in the appendix A and the analysis can also be seen in the method and findings chapter. Although the constituent "Tipping the balance" may lead to the assumption that the midwives were not describing 'normal' situations I believe this has been achieved. The midwives point out that becoming a mother is a journey and all women have a time of realisation when they become more in need of emotional support and some have family and friends who can provide this. The midwives believed that the births the women experienced were also normal. The abnormality would appear to be the perceived need to provide emotional support, not that the midwives were looking for women who had a particular problem to describe.

To gain descriptions from the midwives' perspective of their actions and interactions with women becoming mothers focusing on emotional support.

The midwives described their perception of their actions and interactions, which can be seen in the raw data in appendix A and in the analysed data in the findings chapter. These have been discussed in light of previous literature in the discussion chapter.

To seek both the commonality and uniqueness within the experiences described by the midwives.

The commonalities of the experiences of the midwives are distilled in the general structure of the findings chapter and the uniqueness within the experiences is found in the constituents.

To identify the influential elements and the context within which it occurs.

The midwives were asked to describe their experiences of providing emotional support to women becoming mothers and so they may not have identified the influential elements and the context, but it can clearly be seen from the raw data and the findings that this was achieved. The context is collated and described mostly in the constituent "Tipping the balance" and influential elements such as governmental guidance can be implicitly seen in some of the activities they describe.

Chapter 6

Limitations

The limitations of this study will be considered in two sections: firstly, limitations related to methodological issues and secondly, elements of this specific study.

Methodological Issues

Given the method for this study there was no opportunity to investigate whether there were any discrepancies between midwives' reports and what might have been observed. As the aim of this study was to explore the midwives' lived experiences, which are taken to be what they say they are, this does not invalidate the findings. Despite a number of studies demonstrating inconsistencies between what midwives report, observations of practice and what women report (Fleming 1998a, b, Kirkham et al 2002a) it would still appear to be valid to gain an insight into the phenomenon of emotional support given by midwives using this method. An understanding of the phenomenon itself from the midwives' perspective was the aim of the study. Although women may have reported the individual episodes described by these midwives differently, it would appear from other studies (Fraser 1999, Walsh 1999, Williams and Irurita 2004, Williams and Irurita 2005) that what is reported here as emotionally supportive by the midwives is recognised as such. Observations and the women's perspective would not have raised awareness of many of the other elements of the phenomenon that have grown out of this study, such as the approach they use to offer emotional support and the strategies they use to manage their 'with woman' relationships.

As identified above, there was no opportunity to check the veracity of the descriptions shared by the midwives in this study. This was, though, not a major concern. Using a Husserlian philosophical approach, it is accepted that there will

not only be individual variants based on previous knowledge and experience but differing ways of expressing this. The role of the researcher is to suspend or bracket their previous knowledge and assumptions and offer the underlying essential structure of the participant's lifeworld. It is therefore midwives who can evaluate the veracity of this structure. Once the structure has been elucidated to others they can then decide how well the midwives' lifeworld experiences correspond with their own. Furthermore Giorgi (2000: 6) says that factual veracity is irrelevant: "the epistemological claim is for the situation as meant and intended by the subject".

A more concerning issue using this method, as with many other methods, is when to stop collecting descriptions. Perhaps the next description would offer a wonderful new insight. The idea of saturation is used in other methods and is similar in some ways to the phenomenological principles guiding when to stop collecting descriptions. Despite this, phenomenology could use just one detailed description to gain an understanding of the essential structure of an experience (Giorgi 1985). In phenomenology the principle is to generate the essence of the phenomenon within its given context in such a way that different possibilities can be demonstrated. This allows for individual variations in lifeworld experience. This study could not claim to have gained the essential structure of the phenomenon but it can claim to have gained an understanding of the phenomenon as concretely lived by those participating, and this was the intention. Some may continue to be concerned that only eight midwives were interviewed. These interviews can also be seen to be context bound, as with most psychological phenomenology, but particularly as all the midwives worked in a similar area, for the same organisation and all were community midwives. Further studies may clarify the extent to which this study was context bound.

There may also be concerns that one researcher conducted the identification of all the meaning units, whilst this provides consistency it might not provide the reliability sought by quantitative researchers. Giorgi and Giorgi (2003a) allow

for this in the method, they suggest that the meaning units are only a tool to develop understanding, not the findings themselves.

Trustworthiness continues to be debated between quantitative and qualitative researchers and, in fact, within each of these approaches. Giorgi (2000) offers a rebuttal to those who criticise the credibility of phenomenology; he suggests that there are many similarities between Husserlian phenomenology and quantitative empirical approaches with both requiring the researchers to use a scientific method. He goes on to suggest, though, that for phenomenology no epistemological claim is made that the situation was the way the subject describes – it is the subject's perception. Giorgi (2000) writes that factual verification is irrelevant as phenomenology seeks meaning (interrelationship between person and environment). Therefore, although phenomenology, like quantitative methods, uses a scientific approach, it is unacceptable to suggest that it is untrustworthy due to a lack of generation of facts. Giorgi (2000) suggests that despite phenomenology generating understanding and meaning about presences, it is replicable, which is evidence of reliability.

Limitations related to sample

As already discussed the sample number of participants was small but there are other issues related to the sample that need considering. The midwives in my study were volunteers and there may be a number of reasons that would lead them to offer to take part. It may be that they are particularly enthusiastic midwives who wished to talk about their emotional care of women as they felt this was part of their role they did well. It may also be that they wished to offer more emotional care than they were able to, which led them to volunteer. These issues might be of more concern if a different approach to the study had been used but in phenomenology the essential features of the phenomenon should be the same regardless of the intentions of the participant, what would differ is the individual variations.

Limitations related to method

It is possible that the midwives' interpretation of the research question was different to that intended. They may have thought the underlying assumption of the question was that not all women need emotional support as I asked them to describe a specific example. It may be that the question was interpreted as 'how do you give emotional support to a woman who is having a baby when they are emotionally distressed or emotionally suffering?'. However, comments such as 'it is a journey' and 'not a one off event' may encourage the reader to accept that this was not the case. It may also be that the most memorable times of offering this care for the midwife was when the women had a specific problem. This may have had an impact on the findings but it should be quite limited as the common elements of the phenomenon should the woman experience a problem would be the same regardless of the problem.

An important skill for the person doing the analysis is to be able to 'bracket' previous knowledge and experiences of the phenomenon. Some, such as Heidegger, believe that all thought is an interpretation and might therefore suggest that it would be impossible to totally 'bracket' previous knowledge and experience. This skill is not underestimated, I put a great deal of effort into setting on one side my previous experiences; knowledge was easier. I may not have totally 'bracketed' my experiences but I certainly attempted to do so. My supervisors were also able to assist in my checking and challenging me as to whether my own experiences had influenced my development of the essential elements of the phenomenon. Husserl allows for different levels of bracketing and I do not believe I could achieve the highest level of transcendental reduction but I believe I was able to achieve psychological reduction (Giorgi and Giorgi 2003a). I approached the phenomenon with a naivety, putting to one side my previous knowledge and experiences to approach the interview without presupposition of what they would describe.

Despite the naivety with which I approached the interviews there were still many elements of 'me' to be found; at times I responded to comments by recognising

them as humorous and on limited occasions I gave something of my thoughts. This would not be considered a rigorous phenomenological approach. I do not believe this changed what the midwives would have said and on the whole it made the interview more like a conversation. This can be seen to relax the participant and facilitate their 'opening up' and sharing information but there is a risk of leading or 'contaminating' the findings. The reader can decide how much I have influenced the interviews as the transcripts are transparent in that I have recorded in them all that I have said as well as the midwives. See appendix A.

I asked midwives to describe a time when they gave emotional support to a woman becoming a mother. This might have led them to the assumption that a woman is a mother as soon as she has given birth especially as I indicated the midwives could use any moment they felt relevant. I could also have inadvertently led them to believe I understood becoming a mother as a process. Despite my concerns over this in the interviews the midwives are quite clearly stating they believe becoming a mother is a process, not a one off event, and they also qualify this by stating that within this process is a moment of realisation. I do not believe I could have led them to say this as I was unaware that this might be the situation.

The recruitment process may also have created a homogenous group of midwives as they were recruited using a rather pragmatic snowballing approach where midwives were asking their colleagues to take part. It is unlikely that this would have greatly influence the general structure of how midwives provide emotional support to women but may have influenced constituents such as tipping the balance and possibly some of the struggles they encounter. This can only be determined by disseminating the findings of this study and by evaluating whether the general structure identified here is experienced by others.

As identified in the literature review there are some findings that have been established in other studies and this offers some reassurance that the findings are related to the phenomenon being explored.

Limitations related to the evidence base

Another area that might have limited this study was the lack of literature in other related areas to aid in the exploration of the context within which the phenomenon occurs. There appears to be very little literature in the area of midwives' experiences of what their role is and how they undertake this especially in the area of emotional support. More problematic was that there were areas of conflict in the literature available. This was particularly the situation between midwives' and women's perceptions in information giving and other communications.

Also, given the literature, there were other demographic details that would have been useful to collect, such as how long the midwives had worked for the same NHS Trust, whether they had children themselves and whether their base was the hospital or a GP surgery. Although this information would have been interesting to explore, given the literature it should not have altered the general structure but may have influenced the individual variations.

General limitations

On reflection there are elements of this study that could have been more fully explored. A more interpretive approach may have allowed for an interesting exploration of why the midwives chose to describe the incidents that they did. It could have been suggested that Annabel chose this particular woman as she had taken some effort to support her and she wanted to talk to someone about her. It was not until Annabel had had the opportunity to reflect on her care that she had a better understanding of it herself which created negative emotions for her.

Betty was very pleased with the care she had managed to provide and wanted to share that with others; similarly Fiona and Hetty wanted to demonstrate that they were doing it the way it should be done. Gina's experience was a recent one with which she was quite excited and she wanted to share this experience with

someone. These, though, are just my thoughts, reflections, and interpretations and do not change the commonalities or individual variations established of the phenomenon which was the aim of the study. Despite the differing motivation for choice of experience to describe there were obvious commonalities which also provide some reassurance for me that I have gained descriptions of the intended phenomenon.

Chapter 7

Conclusions

This study has sought to understand how midwives give emotional support to women becoming mothers. This understanding has been achieved by midwives sharing descriptions of their lifeworld experiences. I have tried to portray these descriptions faithfully so that the original meanings are not lost. I believe they demonstrate the struggles and joys of this complex undertaking.

The midwives appear to need to make a decision or 'tip the balance' to offer emotional support. This decision to offer emotional support appears to be influenced by complex power relationships, limited resources and historical context. There also seems to be an underlying belief in some midwives that they should not need to provide emotional support, which is also supported by some midwifery literature. There are multifaceted pressures on the midwives. These pressures can be identified as traditional knowledge, research knowledge, political influences and organisational power, from which their professional culture is developed. These are counterbalanced by the midwives' personal desires to care and provide comfort.

It can clearly be seen in the findings and descriptions that the midwives in this study used themselves extensively, their knowledge, skills and experiences to give emotional support to the women through their intimate caring relationships. Their behaviour can be seen through their descriptions to be influenced by the current culture within health care and their underpinning ideologies. There is a debate in the literature over issues such as information giving, continuity, control and choice and the descriptions of the midwives in this study do not offer any further clarity over these issues. They appear to be trying to offer accurate information, continuity, control and choice at the same time as exhibiting the behaviours explained in the literature as demonstrating that this is not occurring.

They appear to be using ‘protective steering’ (Levy 1999d) and not actively listening (Egan 1977).

This study highlights that midwives are providing emotional support through their intimate relationships with women; this is not a new revelation but a detailed description of how they do this has not previously been available. The midwives in this study can be seen to be using their intimate relationships developed through their extensive communication skills to create a sense of comfort for the women. From the available literature and the midwives’ descriptions it can be seen that the midwives have a good understanding of how to achieve this and are putting this into effect. The midwives use their personal experiences, their touch, voices and eye contact to create comfort. As identified by Morse et al (1994) comfort can be created using different activities depending on the person’s state of being. The midwives in this study along with the midwives in other studies use their intuition to guide some of this decision making (Fleming 1998a,b, Hildingsson and Häggström 1999, Callister and Freeborn 2007, Bone 2009, Ólafsdóttir 2009).

The midwives in this study explained how they conducted their emotionally supportive relationships within a ‘circle of care’ to promote a feeling of control and comfort in the women. They identified how they worked collaboratively with other professionals to build this circle. The midwives, in this study, also appeared to encourage involvement of families, particularly the woman’s partner within this circle. Emotion work can be seen to have been needed, though, due to colleagues and the women they were caring for.

There were a number of struggles experienced by the midwives in this study when they offered emotional support. These appear to be struggles that relate to the midwives’ belief systems or ideologies and the women’s perceptions and expectations. These struggles, though, did not appear to impede their showing emotional support.

In the study by Hildingsson and Häggström (1999) the midwives used personal time to supplement their professional time to ensure the women gained the care they needed. This could also be seen in the midwives in this study. This can have a detrimental impact on the health of the midwives as the stress and exhaustion can lead to serious ill health such as heart attacks, depression and immune problems (Roberts et al 2001).

The midwives in this study experienced many emotions in themselves and the women for whom they were caring. This again is not new or surprising; it has been accepted for a long time that becoming a mother is an emotional time. The expression of emotions, though, helped guide the midwives to who needed emotional support, their interventions and evaluations of their care. Working with their own and the women's emotions created extra work for the midwives.

At times the midwives experienced some dissonance when attempting to work with the differing ideologies of 'with profession / institution' and 'with woman'. Importantly for all the midwives in this study, personal dissonance between being 'with profession / institution' and 'with woman' and the application of the relevant 'feeling rules' that were generated through the women's distress did not appear to impede their care.

The midwives recognised that there were times when their emotion work was likely to increase and this appeared to occur at the moment of realisation that they had become a mother occurred, at some point between becoming pregnant and the early days after the birth. A reciprocal relationship is the one in which the midwife needs to do least emotion work (Fleming 1998a, Pairman 2000, Hunter 2006) and is therefore most emotionally healthy for them. The midwives in this study did not appear to have reciprocal relationships initially but they appear to gradually develop them using their emotional support and emotion work.

The sharing of good moments with the women in a reciprocal manner was important for the midwives in this study in their showing care, as it reassured and guided them. The midwives sometimes concealed their emotions as part of their emotion work to facilitate the well-being of the women but when the women were happy the midwives said they felt they had supported the women effectively and were satisfied.

The question for this study, "How do midwives give emotional support to women becoming mothers for the first time?", has been answered and it has achieved its aim and objectives. Although there is an overlap in the findings with some previous studies there are some new findings and where there is an overlap this study can offer further clarity.

New understanding

This study has provided a detailed description of what emotional support looks like; a description of what is happening. The midwives develop intimate relationships with women in which they can normalise their fears and achieve a rapport fulfilling the 'with woman' ideology. It offers an understanding of the decision-making process midwives go through to offer emotional support. This appears to involve the midwives seeking to find an organisationally acceptable reason or justification for giving this type of care. This study also gives an indication of how midwives manage a 'being with women' ideology, within a professional culture. They appear to do this by developing personal rules and using their intuition to develop a deep rapport with women, which holds significance for their own well being too.

Offered further clarity - understanding of previous findings

This study offers further insights into the emotion work of midwives and how they manage this and what enhances their ability to provide emotional care. Midwives experience emotion work and emotional labour from various sources including management, colleagues and women. Their autonomy and ability to manage their own diaries is supportive for them along with their personal rules,

intuition and having reciprocal relationships with colleagues and the women. When the women they are in a relationship with appear happy and are comfortable the midwives too feel encouraged.

The culture and associated ideologies within midwifery services highlighted by others such Kirkham has been identified but this appears not to be something that is acknowledged explicitly by the midwives in this study. These midwives appear to be accepting of the need for justification for offering emotional support.

The midwives in this study can be seen to be experiencing a wide spectrum of emotions and have to work with the emotions expressed by the women. The working with emotions or emotion work discussed by authors such as Hunter may actually at times be supportive for the midwives as well as causing them extra effort and stress. Midwives who, through their intimate relationships and emotional support, develop a rapport with women can join them in their joy over the new birth and share the relief of smiling and tears.

Chapter 8

Recommendations

Developing services using the significant findings of this study

Midwives struggle with managing the boundaries between 'being professional' and 'being with woman' because of a professional culture which appears to lead them to believe that their role is a more biological, technological one. Due to this struggle there is often a moment of conscious decision in which the midwife defines the situation as 'needing something different' and there is subsequently a shift towards the more ambiguous 'being with woman' role. The midwives need to justify this shift to themselves because they do not experience the focus on an 'emotionally supportive' role as an encouraged professional priority by their setting.

Despite recent publications such as the NSF and NICE guidelines, there continues to be a lack of clarity for midwives. If maternity services and the midwifery professional bodies decide that emotional support is part of the midwives' role (and they appear to do so) perhaps a focus on decision-making rather than specific clinical guidance in midwifery practice development would be helpful.

This shift or movement towards emotional support requires significant changes in the midwives' attitude, behaviour and place of care giving. Instead of leaning towards this type of care which may 'tip the balance' of the midwives' professional consciousness too far, there is the need for a shift in the position of the fulcrum. Once this shift or movement has occurred, the midwife is in a position where there is no clear definition of boundaries for her and she relies on her on own personal rules or intuition.

The personal rules and intuition of midwives need to be recognised and recorded in maternity services to ensure quality care is given and to guide future practice. This may be difficult for midwives to do at present given the culture they believe themselves to working in.

A distinctive feature of ‘what midwives do’ when providing emotional support to women concerns the quality of the caring relationship that includes a certain kind of intimacy and a certain kind of ‘use of self’. This intimacy is both physical and psychological. There is a special kind of interplay between intimate physical contact with the woman and a sharing of personal information, self disclosure, or intuition by the midwife. This intimate relationship involves a sharing of emotional moments and interconnection, not sexual in itself but relating to sexuality. It is the facilitation of the woman’s journey to a new way of being promoted by the midwife being in a connected way ‘with her’.

If this type of relationship is accepted as the most helpful one for women, and it certainly seems to be one the midwives strive for when offering emotional support, maternity services will need to consider how it can be facilitated as at the moment it requires additional resources due to home visiting.

A deepening rapport between midwife and woman is a crucial measure for the midwife of the success of her endeavour to give emotional support to the woman. This is important to the midwife as a way evaluating the direction of her emotional support, comparable to more technical measure of progress of physical maternal health. It also appears to decrease the stress of emotion work for the midwife.

Given that rapport is a crucial measure for midwives in evaluating their emotional support and maintaining well being, services should consider how it can be supported and documented to facilitate quality future practice.

Further research

A distinctive feature of ‘what midwives do’ when giving emotional support to women is to provide a form of care that ‘normalises’ the woman’s fears about certain kinds of distress relative to becoming a mother such as her ability to cope with pain, loss of control, or to care for and relate to her baby.

The ‘normalisation’ of experiences is well documented in mental health care but not in midwifery care and as this is an approach that midwives appear to be using it should be investigated further to develop quality evidence based care.

Once midwives shift their focus or move towards emotional support they are in a position where there is no clear definition of boundaries for them and they rely on their on own personal rules or intuition.

It is important to find out firstly if intuition is guiding decision making and secondly, if it is, how can it be better understood. When a better understanding is gained it may then be necessary to undertake studies to explore how to facilitate it or how to ameliorate it.

Protective steering was also apparent in the midwives in this study but it appears to go against the recommendations of giving women all available information to make choices for themselves. The studies in this area are quite old and it might be useful to understand if it is in the best interests of women to use protective steering or another approach.

Chapter 9

Reflections on my journey

In the preface I acknowledged the preconceptions that I held at the start of this journey. I was prepared for them to evolve as I progressed but what I have found is that there are philosophical standpoints that 'fit' with my worldview. I had a 'eureka' moment when finding Giorgi's book (1985) on psychological phenomenology which led me to explore some of the work written by Husserl. My belief that all people have the same intrinsic worth, and deserve to be treated with respect and compassion has become more established; it has deepened. These beliefs can be seen to be part of my conceptual framework with its roots in Christianity and humanism. Whilst I have tried to put these on one side during the data collection and analysis (bracketing) they have still influenced the way in which I have interacted with the midwives and cared for their descriptions. I have felt honoured that they have described things that have excited and concerned them to me.

My one overriding concern throughout this process has been my ability to express myself coherently and with the passion I feel. I am aware that my writing has developed but instead of raising my confidence in my writing ability this journey has confirmed that I still have a long way to travel to achieve the aesthetic and cogent style I aspire to.

My compassion for women in emotional distress has not diminished and I hope that this study helps with midwives' and others' recognition that emotional support is necessary. While listening to midwives talk about their experiences and reflecting on their descriptions, I have visualised what was happening for them and the women and the environments in which they were giving this type of care. I have had visions of friendly dogs greeting midwives, relieved women and midwives included in exciting moments.

I initially interviewed a midwifery tutor to check whether my phenomenological interviewing skills were adequate. Her description of giving emotional support to a woman led me to visualise a romantic scene. I was put in mind of a summer garden, with wild flowers swaying in the breeze and warm sweet scents floating on the air. I could visualise two women lying on big soft pillows with happy children playing around them. The woman was not distressed and she felt the care and compassion of the midwife. I wanted to be her and feel the peace and comfort she was feeling through the interactions of the midwife.

These first images of emotional care were superseded by something more powerful but equally romantic for me. I visualised the midwife holding the woman in the cup of her hands gently moving her forward at the same time as protecting her and keeping her safe. These images of emotional care led me to remember scenes from my childhood. Standing on the banks of, what seemed to me, the vast river Severn.

The Severn frequently broke its banks putting people and animals at risk and at the times of the bore sounded like an express train charging up from the sea. It was exciting but very frightening and I remember times of scrambling up the bank as quickly as I could to flee the bore. On this beautiful and enchanting river, during these dangerous times, and during the summer months when it seemed to lazily meander along, could be seen little coracles slowly and doggedly moving across it.

These little coracles, either round or kidney shaped, found on the English and Welsh rivers offered me a metaphor for my phenomenon. The coracle, like the emotional care of women becoming mothers, has a long history, going back thousands of years. Both the coracle and ‘with woman’ care can now be seen as traditional arts and crafts.

There is some debate about how long coracles have been made and used by people but there is evidence of them in both oral and written history. The earliest

written description of a coracle can be found in a special type of Welsh poem in 1188 (Badge 2009).They have been used to bring people and animals to places of safety and collect food resources. Coracles need to be small, manoeuvrable with one paddle, light enough to be carried by the paddler (Badge 2009) and be made of locally sourced products.

Given the above definition it can be seen that types of coracle can be found in a large number of countries throughout the world each with their own name for this little boat. When I was a child, fisherwomen could be seen on Welsh rivers (Teifi, Tywi and Taf) and rarely on the English Severn. These tough women, like the handywomen (early midwives), have now mostly gone and those remaining need licences to fish (midwives are now registered or licensed).

There are many small similarities between the use of a coracle and the way a midwife uses herself to support, nurture and move forward women but for me it is the image that is powerful. The strong currents of the river could sweep away a struggling person but with a skilful paddler they can be supported across the river to firm ground where they can find their feet. I can visualise the woman sitting in the middle of the little rounded boat. It is made of the products that are locally available and flimsy until crafted into this little haven. The skilful midwife manoeuvres the little 'hands cupped together' shaped vessel slowly and steadily, supporting the woman so that she can regain her strength and forge a new way of being with her baby.

The link between coracles and the emotional care of midwives may appear a little tenuous but the more I reflected on my romantic childhood vision of these traditional little vessels, and those who paddled them, the more I could see how midwives became and used themselves as coracles for women. Sometimes this was when the sun was shining and the river calm but also at times when the river was raging and the woman was fearful and distressed. The link for me was on an esoteric level but also offered a vehicle for description. The metaphor worked

for me personally on more than one level and I hope it will do the same for the reader.

Perhaps my journey has led to my being more fanciful, less realistic and more idealistic but it has certainly not diminished my concern for women who become emotional distressed on their journey to motherhood.

Epilogue

Central to the phenomenon of giving emotional support to women becoming mothers

Is a special kind of care,

Shared with women through an intimate relationship,

And organised by midwives in their ‘circle of care’.

The midwives offered reasons to give women emotional support,

Tipping their weighted balance

Moving towards a more personal kind of care,

Attempting to justify a gift of ‘being there’.

Midwives when practising their art and showing this special kind of care

Used all the skills at their command;

Their speech, their touch, their experiences and intuition,

To give women comfort during times that were hard to bear.

The midwives supported the women on their journeys to motherhood,

Coracle-like; holding them,

Across the turbulent waters to safer firm ground,

Mother and baby a relationship between them now found.

Being alongside women on their journey can be difficult to undertake,

Sharing emotional moments,

Uncertainty and confidence; pleasure and despair,

But when the women experienced comfort the midwives were happy with their care.

Chapter 10

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Appendix A

This appendix contains the transcripts of the interviews with the midwives; they demonstrate the raw data, transformed meaning units and the psychological reduced meaning units. The psychologically reduced meaning units are colour coded to enable an overview of the constituents and the coding is as follows:

Yellow – tipping the balance to giving emotionally supportive care

Green – giving emotionally supportive care

Red – struggles in giving emotionally supportive care

Pink – emotional experiences

Where raw data has been removed is indicated by XXXXXXXX.

Interview transcript A

Midwife = Annabel

(Not used in findings but it can be seen that there are elements in this interview that closely relate to general structure and some constituents).

Meaning Units	Transformed meaning units	Psychological reduced meaning units
(short dialogue about signing consent form) Ok……..		
So is there an experience that you can think of that you can describe for me?		
Yes. There is one that happened quite recently it was um it was a woman in her forties who became… unexpectedly …pregnant	Identified a particular case she wished to describe.	
It was her first baby…		
But she's a…husbands never…. Planned to have ….children… I think he was more adamant than her and she was very….. when I went to see her for the initial visit it was about 14 weeks she very ambivalent about the pregnancy..	outlines the background details of the case. A woman in her forties who is ambivalent about her unexpected pregnancy.	

umm she had had a screening because of her age and was…I think was relieved that everything was all right but in a way would would possibly have liked a reason to terminate the pregnancy	was unsure whether the woman wanted to continue with her pregnancy and believed she may be seeking a reason to terminate the pregnancy.	
she was definitely not …….um……..happ y to be pregnant… so it is a difficult situation especially because…..even.. I mean most women even if the pregnancy isn't particularly planned have by the time I usually meet them they've you know become reconciled and usually are quite pleased even if it wasn't but she was one of the first.	felt that this woman's situation needed more consideration because although she had worked with women that were initially unhappy about their pregnancy they had usually reconciled themselves to it and become pleased by the time she met them.	
people I've met that was really still so.. ambivalent about the pregnancy and she remained very…….detached… almost throughout the entire…….pregnancy… there were some pregnancy complications and she did end up having an elective caesarean section which was partly through her choice she didn't want to….particularly want to labour and because there was this sort of question about whether she would be able to birth normally she chose to have it a caesarean section so I saw her through the pregnancy but not so much towards the end of the pregnancy because of the complications she was being seen in the hospital a	suggested she had had a lack of experience of women who felt like this despite being an experienced community midwife. implied that for the woman not to be focused on the pregnancy caused her concern. gave an explanation for the woman having a caesarean section but went on to say that this was not the whole reason. Annabel suggested that the woman had this procedure partly through personal choice. suggested that the woman did not wish to go through the labour of becoming a mother. explained her contact with the woman was limited towards the end of	

lot by the consultant so I saw her, I knew she was having a caesarean and then I saw her at home afterwards which was just before Christmas..	pregnancy due physical complications.	
So was there one stage during the time you were meeting her were you felt had to give her particular emotional support?		
I think it was more……..yes I felt I needed to give her emotional support but it was almost to try and……persuade her to see the reality of what was happening she seemed……. She seemed very detached from the pregnancy, she could see as lots of women do as far as the birth but again seemed very ambivalent about what would happen after the birth	felt that she needed to give the woman emotional support as she believed the woman needed to acknowledge and accept the realities of becoming a mother. believed the woman was only acknowledging the process up to giving birth but was not considering being a mother.	
So what did you do? You say you tried to make her the reality, how did you do that?		
Just talked.. just talked to her about it.. just talked just brought very sort ordinary things like to try and get…talked about equipment for the baby and had she and her husband been out shopping for things for the baby and that sort of thing to try to get her to acknowledge that this baby was going to impact on their lives	said she used her interpersonal skills, talking, to enable the woman to acknowledge the reality of her situation. She did this by talking about practical things about the baby. Annabel also tried to talk to the woman about her relationship with her husband and how this might change after the birth of the baby.	
it was a very strange situation because she was so emotionally distant from it all and she wasn't the sort of person that was very easy to support emotionally she	Although thought it was important to support this woman because of her detachment from the realities of what was happening to her Annabel	

was a very closed sort of person if you know what I mean it was	found this very difficult. Annabel said she had difficulty emotionally supporting the woman because the woman appeared closed and unwilling to discuss issues that Annabel felt was important.	
… but… but by the end of the pregnancy we had built up a relationship and she did phone me several times…..towards the end of the pregnancy to to run things past me but mostly on the sort of the physical side of things about the caesarean about rather than you know she really didn't seem to want to you know its very difficult to give emotional support people	said that despite finding this difficult she did believe that she had gained an element of a therapeutic relationship, as the woman would telephone her to ask questions.	
who don't want seem to require it. Even though, even though you might feel they require it	Annabel felt that the woman required emotional support but Annabel believed the woman did not think she needed it.	
Yeah and I suppose that's what I'm looking at you know when you believe someone needs emotional support even though		
but they're… because I did ask, we do have a midwife counsellor, I did have the midwife counsellor in at one time and I did ask her at one time if she would like to talk to the counsellor because she was very 'I don't need anything like that, I'm fine'	Annabel was so concerned about the woman and her lack of skill in emotionally supporting the woman that she asked for assistance from the midwifery counsellor but the woman refused this help.	
So what was she doing that made you think that she wasn't coping?		
It was just her, um her whole, attitude to what was going on it was very, it was	Annabel continued to be concerned because she felt the woman did not appear	

like, it was like it was happening to someone else she almost dissociated herself from what was happening	to be acknowledging what was happening on any level.	
and I think that is why she wanted the caesarean it was almost like going through labour would be very much, I mean going through labour is a very emotional time and the psychology and the whole and I felt it was almost like the caesarean was somebody would cut out her baby and would be like you know.	Annabel believed that the woman wanted to have a surgical intervention to remove the baby so that she would not need to engage with her emotions.	
So did you discuss with her having a caesarean section?		
Yes, Yes and she said that was what she wanted	Annabel said that the woman was quite clear that she wanted a caesarean section.	
did she explain to you why she wanted a caesarean section? Was she able to do that?		
She explained… and there were some medical indications and she had never, never envisaged herself having a child and so therefore she could not envisage going through the labour process, and and I think really that was what she was talking about but because she thought it something that would never happen to her and didn't want that to happen to her	Annabel described the woman's explanation for her choice was that she had medical reasons and had never seen herself having a child. This led to the woman not being able to accept the idea of going through labour. Annabel thought that the woman never expected to have children and did not want to have children.	
and so what was your response when she was expressing that to you?		
Well I talked to her, I talked to her about the pros and cons of having a normal birth as apposed to having a caesarean section about the	Annabel when the woman expressed these thoughts to her said she talked to the woman. Annabel said she explained the advantages	

physical side the physical sort side effects but also the problems that are associated with a caesarean section and umm I don't like the bonding word but that that you know women who have caesarean sections often have more problems relating to their babies	and disadvantages of having a 'normal' birth. Annabel believed that women who have caesarean sections have more physical problems and attachment problems.	
so explained that to her, how did she react to that?		
she didn't she felt that as that was what she wanted that it would actually improve that relationship, she thought that going through a birth that she didn't want to go through would not actually benefit	The woman was quite sure that having a caesarean section was in hers and the babies best interest and expressed the view that going through a birthing process she did not want would be detrimental to her relationship with the baby.	
and so that may be slightly different from what you believed was best?		
YES.	There was a difference of opinion between Annabel and the woman	
so did cause any conflict for you in that you were trying to support her		
it caused conflict for me because I thought, I thought she would better off, that's sounds paternalistic doesn't it or materialistic	Annabel felt that due to her experience and knowledge that she knew what was best for the woman.	
Well we all have beliefs about things…		
Yeah, I would, I would I thought she would have done better to go through the birth process, I would I would thought it would actually…… but there comes a time when you have to back off because even though your own beliefs are quite strong you can't , you don't want to alienate, you've got to	Annabel strongly believed that it would be best for the woman to go through the labour process but acknowledged that there comes a time when a midwife has to stop trying to change the beliefs of their clients.	

respect their own wishes to a certain extent as well you've ... you could say as a health professional I think you would physically be better and as a midwife I think you'd emotionally be better but in the final analysis it is her decision.	Annabel said that although she could justify her beliefs about what the woman should do it is important to respect the beliefs of her clients to ensure that the client is not alienated.	
So how did she cope with that whole discussion? Did it raise any emotional issues/differences…?		
Not really as I said she was ….very closed off as I say she was happy to discuss some things…. But if you tried to get under under the skin a bit and really try to find out what was going on then then she didn't want to go any further	Annabel did not feel the discussion she had had with the woman had any emotional impact on the woman. Annabel believed this was due to the woman not allowing anyone in to her emotional world.	
So what happened for you emotionally the because you have this feeling that this is best and you are trying to help her with what you believe is best for her…… Did you find that frustrating or.?		
Very Frustrating and sometimes you do feel almost resentful that they won't take the advice you are ..you because you're trying..it's a very hard thin because you're I know	Annabel felt very frustrated and resentful that she had tried to help the woman but her support had been ignored.	
, I know I'm quite bad at not listening to people when they're not doing what I want them to do…	identified that she was not good at listening to other people when they do not accept her guidance.	
If that makes sense um and I have quite strong beliefs about…. birth….. but	said she had strong beliefs about birth.	
Yeah..so what do you believe are the best ways for her to go forward what would be the best way for her?		

It's hard because I mean she was a very determined person she had her own very strong feelings about what she wanted and what she didn't want as I say she was in her forties and had a high powered career she was very much used to being in control of her life	found this relationship very difficult because the woman also had strong feelings about her birth. Annabel identified that woman was able to be strong and determined due to her age, career and experience.	
and the idea I think the idea of the caesarean sort of fitted in with that she'd know what day she was going in she'd be able to make all her arrangements and it was all nicely packaged for her rather than the great unknown of going through labour and birth and also the other thing was I'd never met them as a couple I mean most of the women I do see antenatally on at least one occasion you usually meet the partner they come along for an antenatal session or….	Annabel thought that the woman's birth preference was influence by her desire for control over her life as she had previously experienced it. Annabel said this was very different from her expectations of the process. Annabel identified there was another issues that raised her concern for the woman and that was that Annabel had not met the woman's husband.	
so the partner wasn't there when you had this discussion?		
I didn't meet the partner until after the birth	Annabel did not meet the husband until after the birth of the baby.	
Right, did that cause any concerns for you?		
It seemed to me that she was very much on her own but she wasn't getting support from him she didn't seem, she didn't, well she had family but they weren't local. They were very much a couple and they tended to associate with older couples she she didn't seem to have any friends with children or anyone you could perhaps see her	Annabel was concerned that the woman was unsupported by others, husband friends or family.	

getting more support from		
So you felt she had a lack of support from elsewhere so it made you..		
Even more pressurised into trying to sort of offer emotional support to her but it's very difficult when when people don't feel they need it	The lack of support from other led Annabel to feel pressured into offering emotional support but that this support was unwanted.	
Yeah, so how did that progress for you did you go in there initially determined, what happened for you..		
What at the end?		
well as you went through the process..		
As I went through the process?		
as you were talking to her?		
I think in the end I respected her wishes even though I didn't think she was going the right way about things you have to put on one side your feeling	Annabel felt that her own feelings had to be put on one side and the feelings of the woman had to be respected.	
so you came to some sort of resolution that was one that she had chosen but what happened to you in that process?		
I was disappointed that I hadn't been more influential and perhaps that I didn't empathise with her enough, that perhaps I could have done things differently	Annabel felt disappointed about the support she had given for two reasons, that she had been unable to changes the decision of the woman and that she had been unable to empathise with the woman.	
right, what was it that made you feel you could have approached it differently?		
Just her reactions to her trying to to me trying to influence her	Annabel felt she could have approached the apparent needs of this woman differently.	
So what was that response, you were saying that she wasn't responding that she		

had shut down, is that the reaction you were talking about?		
yes, yes that she just didn't want to talk about it any more she'd go so far and no further, she just didn't want to talk about it any more	This was due to the woman's resistance to talking about emotional issues.	
So how long did this turmoil go on for you?		
About six weeks, because she went to the hospital at 34 weeks pregnant and they found she had this low lying placenta which might or might not lead to her having a caesarean section. She actually ended up having a caesarean when she was about 7 or 8 days overdue, because they kept on waiting to see if she went into labour but she didn't	Annabel remained concerned for the woman over an extended period of time. The woman did have a caesarean section but it occurred 7-8 days after the due date.	
At what stage did you reach this resolution of accepting her decision?		
I don't know that I did	Annabel does not believe that she ever came to a stage where she accepted the woman's decision but she felt the woman believed that she had.	
Do you think she thought you did? (Yes)		
when do you think that happened?		
When she told me she was going to have an elective caesarean. She phoned me up and said I'm going in on Wednesday to have the caesarean because labour hasn't happened and they are worried about the baby's head being high and various other things so I said fine I'll see you afterwards.	The woman informed Annabel by telephone that she would be having a caesarean section. Annabel believed this was the point at which the woman thought Annabel had accepted her decision.	
so that was a decision made to you over the		

telephone….		
Yes it wasn't face to face		
so she was obviously aware you were encouraging her to have a different style of birth		
umm, umm yes this is quite a negative, isn't it when we talk about emotional support, it is quite a negative experience	Annabel felt this was a negative experience.	
ummm, if you want my opinion, I think we can choose to interpret things in different ways…		
Yes, I mean I feel it is very negative, I feel perhaps its because I feel very negative about what's happened		
um yeah but you could choose to interpret that differently, it could be considered an excellent learning experience…		
that's true yes,		

Interview Transcript B

Midwife = Betty

Const. No.	Transcription (1)	Meaning units (2)	Psychologically reduced (3)
	I'm not specifically looking for where a mother has had a depressive illness or anything like that it is really looking at emotional support that you have given at any stage to a woman becoming a mother and what I want you to do is identify a specific incident where you felt you needed to give emotional support and describe that for me in as much detail as you can		
1 (TB)	I have got a lady I'm thinking of, the client I have I had I just er discharged her is a thirty one year old lady who is having had her second baby she comes from a country where she doesn't speak any English and doesn't understand any English.	Betty identified a client to talk about who is thirty, it is her 2nd baby, she does not speak English and does not understand it. Her first child does not live with her; it is in her place of birth.	Betty chose to describe an experience of supporting a woman with particular social needs.
2 (S)	She has an English partner who is extremely supportive and very loving. XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX The baby was this gentleman's child.	She has a supportive partner (husband) who is the baby's father, he does speak English and they have a loving relationship.	The woman has a supportive, loving husband but they have language difficulties with each other.
3 (TB)	Err the big problem XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX this came as an enormous shock she which came up in routine testing she had absolutely no idea that she had anything wrong with her until the results of her booking bloods came back.	The woman found she had significant health risks at routine maternity testing and this was an enormous shock to the couple. The hospital midwife broke the news to the woman and her husband together at the hospital.	The woman's main problem was that she had significant health risks that she was not aware of prior to routine maternity tests.

	Where upon the midwife at the hospital umm got in touch with her got her husband to bring her into the hospital and broke the news to her because obviously he could not be told first		
4 (ES)	Throughout the pregnancy obviously this lady has been worried sick about the health of her baby and from this I have been really working very closely with GP and the health visitor so that we could form as we do in the practice where I work a little circle of people around her and her husband	This knowledge caused great concern for the client throughout the pregnancy. Betty formed a circle of professionals working closely together to support the client and her husband. The circle included Betty, the GP and the health visitor.	Betty formed a circle of professionals working together to care for the woman and her husband.
5 (ES)	and one of the things that we found particularly helpful to her and obviously secondary to us is er lifeline, it a language line, it's a line where you can link up with an interpreter so that we can explain things easily to the lady um without any misgivings that she can understand exactly what we are saying and we can understand what she is saying as well cause obviously it is two way.	This circle used language line to ensure the client understood the information that they were giving her and she could express her concerns. This reduced the concern of the professionals involved.	The circle of professionals used other facilities as well which they found reassuring.
6 (S)	So during her pregnancy she was obviously extremely concerned XXXXXXXXXXXXXXX hospital and has been taking medication regularly it was then decided that the lady should have a caesarean section so whereas she her first child normally vaginally she was now being subjected to major surgery and umm this had to be explained to her.	The client was commenced on medication for her condition. The client had had a normal delivery with the first child but with this baby the team had decided she was to have a caesarean section.	It was decided that the woman should have caesarean section and subjected to major surgery, which the woman needed to be supported with.
7 (ES)	I think the support the main support we have given this	The main support offered this client was time, this	The main support offered to the woman

	lady is the fact that we have given her time, that's the most important we have **never ever** cut back on the time allowed her, I've always allowed at least two hours for each visit and if it was less than that then so be it and that was good but if it wasn't then may be I got	was never been shortened for any reason. This entailed setting aside 2 hours for a visit. Visits did not always take this amount of time, which was good, but it was there if needed.	was time. Betty set aside extra time for this woman.
8 (ES)	but she needed adequate explanation all the time	Betty felt it was important to give adequate explanations at all times	Ensuring adequate explanations were given was part of Betty's care
9 (ES)	and I think also to make sure that she knew that we weren't afraid of her because of her illness er umm there were things like you know umm not wearing gloves at every opportunity, accepting a cup of tea in the house, small things that people probably don't realise that do really make a big amount of difference.	Betty ensured she did not appear afraid of the client's condition by not wearing gloves and accepting cups of tea. Betty believed small things like this make a big difference.	Betty felt it necessary to demonstrate she was accepting of the woman by small gestures such as accepting a cup of tea.
10 (S)	The lady also wanted to breast feed and although I as a midwife could say that research shows that it possibly, probably could have been ok she had been strongly advised by paediatricians that she was absolutely not to and so from that point of view she needed quite a bit of some support in that she to make sure that	The client had wanted to breast feed, which Betty was happy with due to the research she had read but the paediatricians said she was not to do so. This incurred the need for extra support.	The woman had wanted to breast feed, which Betty was happy with due to the research she had read but the paediatricians said she was not to do so and this increased the need for Betty to provide more support for the woman.
	Interruption tape stopped and started again		
	Shall we start again		
11 (S)	So she had actually told she shouldn't breast feed her baby and so this was another issue that she needed to guided and supported through	The woman was told not to breast feed her baby which meant she needed guidance and support.	Being told not to breast feed created another problem needing guidance and support.
12 (ES)	because of her lack of understanding of the English language giving her a picture	Teaching the woman to make up bottle feeds was quite difficult and	Betty used demonstration to support the woman

	book to copy how to make up bottles was a pointless exercise because the bottle the pictures don't adequately show what you have to do and so I went through this on numerous occasions and actually showed her how to make up bottles I also told her about making sure the baby had one bottle per feed	necessitated Betty demonstrating it a number of times and also explaining feeding regimes.	and facilitate her understanding.
13 (S)	but she misinterpreted that by making up two bottles to last the whole day and so consequently the baby got thrush. Umm which then led to more issues because when the baby got thrush she automatically thought the baby had developed XXXXXXXXXXXXXXX umm it needed a lot of explanation to reassure her that the thrush had absolutely nothing XXXXXXXX	The woman misunderstood the information given and the baby got thrush this led to her being concerned that the baby had contracted her condition. Betty felt this was unlikely as the baby had been treated from birth.	Despite Betty's efforts the woman continued to struggle to understand some of the necessary information. This then created the need for more support.
14 (ES)	and also I got the GP round umm who very kindly came within half an hour of me calling even though it was 7 o'clock at night umm to reassure that her the baby was ummm ok	Betty called the GP who attended the woman's home within half an hour to assess the baby's condition despite it being late in the evening as they both felt that it was necessary to reassure her.	Betty called on other professionals to support her information giving and to check her assessments to reassure the woman.
	That's quite interesting area for me, do you think you describe for me what happened from when you arrived to what happened whilst you were there?		
15 (ES)	Well on this particular day umm because I knew I wouldn't be visiting till late I had rung the lady in the morning and her husband had answered the phone and said everything was fine and actually the baby was feeding well and was perfectly well	On the day that this had occurred Betty had known she would be late and so had telephoned the client in the morning to check everything was all right. The husband answered the phone and said everything was fine,	As Betty's knew she would not arrive at the woman's home until late she telephoned her. Once the woman's husband had reassured Betty that mother and baby were all right she

	in itself and I told and my bleep was on for them and they were to bleep me if they needed me but that I would come between 5 and 5.30 to them that I would get there and where I was	the baby was feeding well. Betty informed them of when she would attend and how they could contact her if necessary	ensured the woman knew how to contact her if she needed to.
16 (ES)	I arrived at 5.30 and did a routine check of the lady that we do and was able to give her the thumbs up that everything was fine because I didn't use language line everyday because of the expense and obviously conscious of their phone bill umm but I gave her the thumbs up and she was happy with that and	Betty arrived on time and conducted the regular checks on the woman. Betty demonstrated that the check was all right by doing a 'thumbs up' sign to the client. Betty had devised a system of signs with that the woman was happy with, as using the language line every visit was very expensive for the couple.	On arrival Betty conducted the routine checks on the woman and conveyed this information to her.
17 (ES)	then I picked the baby up and checked the baby and just through routine checking found the baby had got umm a white coating on its tongue so I explained to the father in English what was the matter and that I wasn't sure if it was the drugs the baby was on that XXXXXXXXXXXXXXX or whether it was just routine. One of these things that just happens and	On doing the routine check of the baby Betty found that it had a white coating on its tongue. Betty explained to the father what the problem was and that she was unsure of what had caused it but it may just be due to routine problems.	Betty noticed a problem with the baby but was unsure what had caused it and shared this information with the father due to the language issues with the woman.
18 (ES)	I did reassure him that I would be getting the doctor just to cover myself.	Betty explained that she needed to check with the GP.	Betty reassured the woman's husband
19	I then needed to go on language line to explain to the lady umm because she could obviously see I was talking to her husband so I went on language line and spoke to her and got the interpreter and luckily it was the same interpreter every	. As it was important that the woman understood what was happening Betty used the languageline. She was pleased they had got the same interpreter every time as this had allowed a rapport to develop	Betty worked closely with other specialists gaining a rapport with them to support the woman.

	time which was good. Not only did I get a rapport with the interpreter but so did the lady. Although they were totally anonymous to each other and	despite being totally anonymous.	
20	I held her hand and passed the phone backwards and forwards and	Betty held the woman's hand as they passed the telephone backwards and forwards	Betty held the woman's hand to support her whilst developing the woman's understanding of the situation.
21	each time I passed the phone for explanation I made sure I asked the question was there anything she wanted to ask. And when she, she did ask questions	Each time Betty explained something via the interpreter she made sure she said 'is there anything else you want to ask'	Betty regularly checked as the explanations continued whether there was anything else the woman needed to know.
22	XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX I explained to her that the baby was going to have another blood test in about another 6 weeks time that was from that particular date and um that we should know by about 3 months but that the baby was already on medication XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX	The woman asked questions of Betty about whether the baby had her health problem and Betty explained the process by which the baby was being monitored	Betty answered the woman's questions and gave explanations.
23	I was going to get the doctor and that we would give her the thumbs up if it was ok and	Betty explained she had called the GP and that when the GP had checked the baby they would make a 'thumbs up' sign if everything was all right.	Betty ensured she could quickly and easily give the woman information to reassure her.
24	when we come off the phone she was um much happier because she had obviously cried when I first mentioned that there was an infection umm because she is so very	The woman was obviously happy with this because she had cried when Betty found something wrong and after the telephone call	Betty thought the woman was happy with her explanations as she had cried when Betty had noticed the problem but appeared

	terrified that her baby will be affected. So we came of the phone and umm she seemed a lot happier	she appeared happier.	happier now.
25	but by this time I had got a very good rapport with this lady because I er on days when I didn't need to explain crucially to her I used to use sign language umm which (laughs) was my own form of sign language it wasn't a formal sign language and so um it's a sort of acting I suppose really to which she used to laugh her head off.	Betty felt she had a good rapport with the woman as they had developed their own sign language and the woman had enjoyed this so much it made her laugh.	Betty felt she had a good rapport with the woman as their interactions made the woman laugh.
26	But she would be able to demonstrate to me that she was with what I was saying or doing via my hand and	The woman also used a type of sign language to communicate with Betty.	Betty and the woman had a particular non-verbal method of communicating.
27	at the end of that particular visit as I did for all the others I gave her cuddle which drew us close together and it made her feel, I think, that she wasn't being ostracised	At the end of the visit Betty gave the woman a cuddle, Betty felt this enhanced the relationship and improved how the woman felt about herself.	Betty hugged the woman which she believed enhanced their relationship and improved how the woman felt about herself.
28	And I think that this is what is so important with somebody that is vulnerable for whatever reason when they are pregnant, is that they are not felt feel different. They are felt to feel just normal which they have, you know that individual woman whatever their problems are.	Betty felt it is particularly important with people who are vulnerable when pregnant that they do not feel different. It is important women feel normal whatever their problems	Betty felt it was important for vulnerable pregnant women to feel they were normal.
29	So I was with the lady till gone 7 o'clock that night because of having to use the language line but once I had come off it and she was reassured I rang the GP umm who happened to be within the vicinity and who came straightaway.	Once they had finished with the language line and the woman was reassured Betty contacted the GP who came straightway	Betty ensured the woman was reassured before accessing additional support
30	And she was able to say she	the GP was able to	Another member of

	didn't think it was to do XXXXXXXXX the drugs or the it was just one of those things and	reassure them all that the infection was nothing to do with the mother's condition.	Betty's 'circle of care' was able to reassure Betty, the husband and the woman that the problem was minor.
31	we got some medication so we could start the medication as soon as possible umm which happened to be the next morning because they needed to be shown how to give it. Umm because of the language barrier umm you know the sign language, umm it was umm showing them how to do it rather than speaking but you know we had a lot of conversation	The GP prescribed some medication for the baby, which they started the next morning. This was given the next morning, as Betty needed to show them how to administer it.	Treatment for the baby started the following morning due to the time needed to support the woman adequately.
32	By the end of my visiting over a 7-month period she had got umm one or two words of English that she understood umm. My grasp of XXXXXXXXXX but umm nevertheless we managed to make sure we had a good rapport.	Despite not speaking the same language Betty said they had a lot of conversation and by the end of the 7 – month period of visiting the woman had learnt some words of English and Betty some words of the woman's language. Betty felt they had a good rapport.	Betty visited the woman over a 7month period and despite the language barrier Betty felt they had a good rapport.
33	Into all this situation came the Health Visitor who when I handed over to her it just sort of slid right over and they had got a good rapport with the Health Visitor as well.	The hand over to the health visitor went smoothly and a good rapport had been developed with the health visitor as well	Betty ensured a smooth hand over to the health visitor and the development of a good rapport with her.
34	So not only did we have the GP who is umm who's specialist subject is sexually transmitted diseases he works at the GUM clinic at Bournemouth so he's got a very enhanced knowledge of that subject so he could guide	The GP had specialist knowledge of the woman's condition and so he could give the specialist support to Betty and the health visitor who both had good relationships with	The circle of professionals Betty had co-ordinated to support the woman provided a good network of support.

	and advise us but he also sees the worries that these people actually have and so from that point of view and the Health Visitor being very close to the lady as well we got this really good network that we have been able to… to …put over……	her. This Betty said was a good support network.	
	So when you came to visit to check the baby on that evening was he able to (it was a lady)		
	Oh sorry I fall into the usual trap, was she able to explain to the lady what the problems were or did you have to go back to the language line?		
35	No, what what happened was that the GP actually told me and while the GP was still there I sign laguaged to the lady umm that everything was Ok and basically it was a thumbs up with a smile on my face umm and so I sort of went like this and like this (shows a thumbs up sign and a big smile) everything's fine and she was fine	When the GP told Betty, whilst in the woman's home that everything was all right with the baby Betty signed this to her. She did this with a 'thumbs up' sign and a smile on her face.	Betty used her non-verbal language to support the woman.
36	her husband was saying to her "it is good", "it is good" so again he was brought into that but it was very much treating them together because they both obviously needed to know what was going on.	Her husband was there and said to her 'it is good'. He was part of interaction as Betty felt it important that they were considered together	Betty involved the woman's husband in reassuring his wife. She felt he had an important role to play and informed them both together.
37	But the greatest difficulty was for me was I think umm not knowing who to talk to first because one automatically feels one wants to explain to the person who speaks your own language but it meant that at times the lady would have to wait or be it only a couple of minutes it meant she would have to wait	The biggest problem Betty found with this situation was not knowing who to speak to first. Her automatic desire was to explain in English but that would mean that the woman would have to wait. This may be seen as the mother of the baby being	The language problems caused difficulty for Betty in her support of the woman and she was concerned that at times this may make the woman feel pushed into second place.

	so as a mother she was sort of being pushed into second place	put in second place.	
38	but I worked out by explaining to the husband first he could then enable me to put her mind at rest because they again had got their own way of communicating. Because although he doesn't speak XXXX and she doesn't speak English they have their own way of communicating. So by telling him first and then telling her I could get him on side to boost the reassurance for her.	Betty decided that if she spoke to the husband first that he could help reassure his wife as well. Although he did not speak her language he did have his own form of language with her.	Betty worked with the woman's husband to reassure her.
	So presumably you are having to deal with his anxieties as well as hers..		
39	Yes but umm its not fair to say ones using him but yes most definitely to allow his anxieties but normally one would think it better to talk to the lady but if she is sat there and he is sat there and not knowing what is being said and he is worried she is going to look to him and see a worried face.	Betty felt she was in some way using the husband to help with his wife but she felt it was important to deal with his anxieties first in this situation so that he did not increase the concern of his wife when she looked at him for reassurance.	Betty felt it was important to initially focus on the husband's anxieties in this situation to reassure the woman.
40	Whereas in this instance by using a few minutes to explain to him to get him to understand and be reassured so when I'm telling her when she looked at him she could see a happy face, a relaxed face which meant it could reassure her so its like a back handed way of doing it although it meant that just for a few minutes you know she was in the dark..	Betty felt the woman could more quickly be reassured by spending a few minutes explaining to the husband despite this meaning that the client spend a few minutes of not understanding.	Betty felt she could reassure the woman more quickly if she explained to the husband and then the woman could see his smiling face and know everything was all right.
	You said that ummm it was caused by some mix up with her organising the bottle		

	feeding how did you establish that was the cause		
41	Yes Well because two days before I had gone in and umm and signed if she had had a good night and she said no, she said she was tired, I asked if she was ok and she said she was tired and so I said you have had a bad night and she nodded and so I said how many times did the baby wake up and all this is like sign language and she indicated 4 times.	Two days previous to this episode Betty had conducted a home visit and the woman had signed to her she had not had a good night sleep and she was tired. Betty established this was due to the baby waking four times in the night.	Two days before the episode Betty described the woman had not had a good night sleep as the baby had woken four times.
42	and so I asked her how much, how many bottles the baby had had because sometimes the baby wakes up and they don't feed the baby, so you know mums and dads if they think it just needs a nappy change, I asked her how many bottles the baby had had and she said one. So I said to the husband what did you both do the other 3 times and he said we gave it a bottle and I said but you said it only had one bottle. And then the penny dropped they had made up an 8 ounce bottle and it the baby each time until it had finished the bottle.	Betty asked how many bottles the baby had been given when it had woken up. The woman said that the baby had had only one bottle so Betty asked what had they done on the other wakeful occasions. She said they had given the baby the bottle. Betty realised that one 8 once bottle had been made up and had been offered to the baby each time that it woke.	Betty spent time finding out the detail of the situation.
43	So from that it wasn't being re-sterilised and this is a very very common way of baby's getting thrush.	From this Betty realised that the bottle was not sterile each time it was used and this is a common reason for this type of infection.	Finding out the detail of the situation allowed Betty to understand the problem.
	Right so you went through the process of explaining?		
44	So then I went back to square one and I took them into the kitchen and I got every bottle I could find there which is 8 bottles and I made 8 bottles up for them and explained	Betty then realised she needed to explain in more detail how to bottle-feed the baby but recognised part of the problem was that the	Once Betty realised what had caused the problem she took time to demonstrate and explain how to stop it from

	they had to have one bottle per feed unfortunately the gentleman the father was umm….. slightly intellectually challenged	father of the baby was intellectually challenged.	happening again taking into account all the issues the woman and her husband had.
45	Ummm not in a formal way would not call in retarded ohh I don't know what I'm saying I don't know what the normal term	Betty searched for a term to use to describe his abilities.	
	Do you mean he had a learning disability?		
46	Yes, he didn't have a learning disability he just wasn't a great student	The father had learning difficulties.	There were a number of factors outside of the main maternity issues that had a big impact on the amount of support Betty needed to offer the couple. Due to these explanations needed to be lengthy and repeated.
47	So it needed to be explained to him more than once because he said oh I know how to make a bottle up because I had shown him how to make a bottle up but because I had shown them how to make one bottle up they interpreted it as that the baby would only have one bottle. So I had to make up 8 bottles to explain if the baby has 8 feeds it has one bottle per feed.	This meant that everything had to be explained more than once and Betty needed to ensure there was no ambiguity. She had previously demonstrated how to make up a bottle feed to them but they had misinterpreted this leading to the infection.	Explanations needed to be clear and unambiguous to ensure the woman and husband understood.
48	Again it caused for an enormous amount of patience	This situation needed an enormous amount of patience	Betty needed to exercise an enormous amount of patience to support this woman and her husband
49	because these people feel that they are being a nuisance and that is the natural reaction but with this couple they have	Betty thought the woman and her husband felt they were being a nuisance	Betty was concerned the woman and husband would feel as if they were a nuisance.
50	luckily they never felt they needed to apologise to me so	As the couple did not apologise to Betty for	Betty judged she had been patient with

	hopefully that was because they didn't feel that I was being short with them or losing my patience.	being a nuisance she believed she had been patient with them.	couple by their not apologising.
51	Because they kept thanking me all the time, "thank you for doing this" and "thank you for doing that" and all the time they were really thankful and very grateful so hopefully, you know, that was the support that I gave but hopefully that I didn't make them feel, you know, that they were being a nuisance.	The couple expressed their gratitude and thanked Betty profusely and from this Betty felt she was supporting them and hoped they did not feel a nuisance.	The couple expressed their gratitude for Betty's support and thanked her profusely. Betty hoped that due to this they did not feel they were a nuisance.
52	They weren't really it was just didn't cotton on to what I was trying to do but it took me several days to ensure the feeding was I wanted it to be the way it needed to be.	Betty said that they weren't a nuisance it just took her several days to ensure feeding was established the way it needed to be.	Betty explained that due to the issues the woman and her husband had information giving took longer that usual.
	It sounds like a positive experience		
53	Oh yes, it was, I love them to bits and I shall keep in touch I shall go in and see them and because the baby was just beautiful and I've heard from the Health Visitor that she's putting on weight and she is doing well so you know from that point of view they seem to be doing well and they seem to be coping well. So that's another positive thing so you know.	Betty expressed pleasure in her relationship with the couple and her desire to remain in contact with them. She felt the baby was beautiful and that she had heard from the health visitor that the family are doing well.	Betty expressed pleasure of her relationship with the couple and that they were doing well.
	Were there any particular concerns you had as you were going through the discussion with the mother, you appeared to say that it may have been XXXXXX causing the problem for the baby, did this have any particular concerns for you?		

54	It wasn't actually the XXXXXXX it was whether the drugs were having any affect I personally didn't know at that point whether the drugs that the baby was being given ummm er XXXXXXXXXXX. So that's why I got the GP in that night because if it was I would have get myself sorted to get treatment to get it started as early as possible whereas if I could get more information that i.e. the drugs didn't do that and it was just a normal case of normal thrush then I could wait till the morning and get the treatment started then.	Betty said when she had found the infection that she was not concerned it was a sign of the mother's condition but she was concerned that the medication the baby had been put on had caused it. This was why Betty had called the GP. If the infection was related to the baby's medication it may need a quick response but if it was a normal infection then they could take longer to respond.	
55	But it just necessitated, in my book I just felt just needed to make sure that that baby was well covered with any treatment it needed	Betty needed to ensure the baby had appropriate treatment.	
56	. I suppose my only concern was where I was going to go from there after already spending 3 days showing them how to make up bottles, my concern then was how many more times was I going to have to go through it	Betty's other concern after determining the cause of the infection was she had already spent 3 days explaining feeding to the couple, how much longer would it take for them to establish the bottle-feeding.	Betty was concerned about how much extra time she would need to give to this woman and her husband.
57	not from my own point of view but from theirs because I didn't want them to feel belittled umm but I knew I would have to go through it every day until I got it right umm	Betty did not want to belittle the coupe but she knew she would have to go through every day until they could manage.	Betty felt she needed to persevere with demonstrating and explaining to the woman until she could undertake the tasks herself.
58	but also if they were not going to able to cope with feeding the baby err adequately in an acceptable way what was going to be happening with other things	This led to concerns about how they were going to manage with other childcare issues	Betty had on-going concerns about the woman's ability to cope with the baby.

	with bringing up the baby.		
59	She looked beautifully clean and well looked after there was no doubt about that but there are other issues that need to be addressed as the baby gets older so whereas generally that would be outside of my jurisdiction	The baby did appear clean and looked after. Although these and other childcare issues were not part of Betty's role	Betty was concerned how the woman would cope with other childcare issues but they appeared to be doing well.
60	you have to be careful how you feed the general coping pattern over to the next Health Professional that's coming in behind you, you can't just say everything's fine today and then find that things are going completely pear shaped. So I was a little bit worried about the lady's understanding but	Betty felt that she was responsible for passing on relevant and accurate information to the other health professionals that would be involved with the woman and baby but this worried Betty.	Betty felt that she was responsible for passing on relevant and accurate information to the other health professionals that would be involved with the woman and baby but this worried Betty.
61	I felt that later I had addressed it in that anything we told her had to be shown in a practical way to 100%. It wasn't just a case of making up a bottle and saying this is how to make up a bottle it wasn't just a case of talking them through something it was a case of making up 8 bottles to show the baby would need one for each meal	Betty was reassured when she had managed to address the feeding and established any new information for the woman would need to demonstrate in a practical way. Just talking would not be effective.	Betty identified that all information giving to this woman needed to be demonstrated in a clear and unambiguous manner.
62	So those are the sort of thing and also the XXXXXXXX kept coming up from the lady's point of view. It was just worrying it was everything that came up at the moment she was just focusing on that and obviously she is still very traumatised by it	The woman continued to feel traumatised by her health problem identified through midwifery tests.	This initial reason for Betty's extra support continued to concern the woman throughout the care provided.
63	and so I also worried about the potential of her getting post natal depression. Umm especially as she had several bouts of crying which is a	Betty was also concerned about the woman's mental health because she appeared traumatised by the diagnosis by her	Betty was also concerned for the woman's mental health.

	positive in many ways umm the fact that she could let it out umm but because of the concerns that she has	condition and as she had several bouts of crying.	
64	, umm her husband was very laid back about it umm very accepting so he wasn't putting any pressure on her in any shape or form so that was very good.	The husband was very relaxed about the diagnosis, which did not put pressure on the woman which Betty thought was helpful.	Betty found the husband's attitude to be helpful in addressing the emotional well being of the woman.
	So if we are looking at the support available for you to help this lady, you had the language line to give her information…….		
65	Umm I work in a very good team anyway where we all support each other. So if I felt the need I could easily go to one of my colleagues and say could I have a word and I could have sat down at any time	Betty felt supported working with woman as she works within a supportive team. She felt able to sit down and talk to her colleagues at any time.	Betty felt the experience of supporting this woman was self-enhancing and this was due to good teamwork.
66	I didn't find the experience of looking after her in any way traumatic in fact quite the opposite I found it quite enhancing really because they were such a delightful couple and because she was, both of them were very receptive	Betty found the experience of emotionally supporting this woman self-enhancing because she was delightful and receptive.	Betty found the experience self-enhancing due to the personality of the woman.
67	but I think that the support basically came from the Health Visitor and the GP because we had formed a little circle around this lady whoever saw her next would talk to the other two and so we had this unique, we have done it with other lady's that have had problems. If a lady has a wobble and she wobbles when one of us is off duty she can see one of the others. So always if this lady had a concern she was	Betty said most of the support for herself came from the health visitor and GP. They had formed a supportive circle around the woman. This is an approach they had used previously effectively.	Betty felt that the circle of care developed around the woman ensured she had the care she needed.

	able to go to the Health Visitor the GP or me		
68	And whereas primarily it was the GP, Health Visitor or myself she contacted probably because we were female and her own GP is male.	The professionals in the circle of care were all female and this may have encouraged the woman to contact them when she needed support.	Health professionals gender may have influenced who the woman approached for support.
69	Err I think it was just the fact that we could support each other and that we could talk	The ability to support and talk to each other in the circle of care facilitated effective care	The ability to support and talk to each other in the circle of care facilitated effective care
70	it was difficult in the early stages because the lady did not want the GP told XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX which put me in a very difficult position because she didn't want the Health Visitor told either so I was out on my ownyo really but I did have a midwife at the hospital here who was the one that broke the news to them so she and I had several conversations and worried out how we were going to try and tell her the importance of the GP knowing and also the Health Visitor. And in the end she gave permission for us to tell them both. Which I did and we then formed our little circle and so from that point of view it supporting each other as well as her.	Initially the woman would not permit Betty to inform the other health care professionals involved in her of her health problem. The worried Betty as she would be on her own supporting the woman. Betty and the hospital midwife explained how important it was for them to be informed and so the woman gave permission.	To provide the necessary circle of care Betty needed the woman's permission to share information otherwise Betty would be isolated.
	It sounds a very positive situation all round…		
71	Oh yes it was and the Health Visitors that I work with anyway I work with very closely whereas some midwives haven't got that luxury. I also get on very well with the GP umm so from that point of view we were able to discuss things	Betty felt she was very fortunate to have the other professionals in the circle of care that she had as other midwives do not have that sort of support	

	you know and I was able to find out things from him you know it's a two way thing so that I think that's what's so important for the women and this family		
72	in particular is that they are treated as individuals and that they are given time	It is important woman are given individual care and time	Time and individualised care are of particular importance.
73	and some may query my working at 7 o'clock at night, why haven't I gone earlier, well I was actually at the university interviewing prospective midwives students but I kept in touch with them I was accessible to them and I felt it was right, the need was there.	Despite having other tasks to undertake Betty maintained contact with the woman and visited late in the day because she thought that was what the woman needed and so was the right thing to do.	Betty maintained contact with the woman and visited her despite undertaking the other parts of her role during the working day.
74	I hadn't anticipated being there for 2 hours but on the other hand that is something that I can sort out in my own diary at a later date. So if there comes a day when I'm not so busy then I will take the hour back. So I think that's way you have view the job that we're in, that's how I view it, there has to be a bit of give and take you know, if the need is there to have some support then you give it and another time you sort it out accordingly.	Betty felt it was important being a midwife to be flexible with her time so that she could give the care needed by the women she worked with. In this situation she spent two hours late in the day but she said having autonomy within her role allowed her to do this.	Betty felt it was important to be flexible with her time to ensure care needs are addressed but having autonomy in her professional role allowed her to provide the support woman needed when they need it.
	Thank you for sharing that with me it was very interesting. Is there anything else that you can think of that might help with my study?		
75	No, well we will be encouraging the lady to learn English other wise she maybe isolated.		

Interview transcript C

Midwife = Carol

No.	Transcription (1)	Meaning units (2)	Psychologically reduced (3)
	What I will do is prompt you and if you say something I am particularly interested in I will ask you to expand on that but no I don't have a list of questions. I'd like to describe in as much detail as possible your experience of supporting a woman becoming a mother for the first time.		
	Just one experience..		
	Yes just one in as much detail as possible		
	Just one incident or one person?		
	A bit like reflective practice		
1	Yeah, I'm trying to think of an incident because quite often its culmination isn't it and it is like a build up	When emotionally supporting women it isn't usually an incident it is often a culmination.	Emotionally supporting women becoming mothers is a process over a period of time.
	You can describe the build up, it is useful to have the background as well		
2	Ok, this lady um has a chronic condition, a XXXXX, quite an unusual condition, I can't remember the name of it but it's a chronic condition which um can affect pregnancy so	The woman Carol identified has a chronic problem, which may complicate pregnancy so she is a high-risk mother to be.	
3	she is in fact a high risk pregnancy umm she had a lot of care done at the hospital, a lot of care and tests a lot of checks to be done at the hospital but at the same time she came to see us a lot as well. Because she needed	Due to this most of the care was given at the hospital as many tests and checks needed to be done. She also came to Carol a lot as well this was because it was felt continuity of a familiar face was	Despite the need for many hospital appointments due to her health problem Carol saw the woman regularly as well as familiarity was considered to be

	that continuity of a familiar face.	important.	important.
4	She wasn't expecting to get pregnant at that moment in time because of her chronic illness she wasn't expecting to get pregnant. But she did and so it was an unplanned pregnancy and	The pregnancy was unexpected due to her health problem.	The pregnancy was unexpected
5	so she wasn't sure of herself in the first place about being pregnant. And she was also aware that the pregnancy could affect her chronic illness. So she was a bit concerned about that that it might make it worse.	The woman was unsure about herself in the pregnancy and she was aware that the pregnancy could affect her health condition. This led to her being concerned about her health.	The woman was unsure of herself and concerned about her health as the pregnancy could impact on her health condition.
6	Having said that she came to see us a lot during her pregnancy and actually her pregnancy went very well and she had a normal birth.	She went to see the community team a lot during her pregnancy and it actually went very well and she had a normal birth.	The woman was seen a lot during her pregnancy but it went well with a normal birth.
7	But post natally a specific incident is quite difficult to identify but each time I went in …..she needed a lot of listening….lots of support …	Carol felt that postnatally this client needed a lot of support over a period of time. She needed a lot of support and listening to especially about the birth experience.	Carol felt that postnatally this woman needed a lot of support over a period of time. She needed a lot of support and listening to especially about the birth experience
8	her birth experience although was a normal birth was quite traumatic for her. Postnatally, her actual postnatal care in hospital was quite traumatic.	The birth had been quite traumatic for the client despite it being a normal birth. She felt her postnatal care in hospital was traumatic.	Despite Carol believing the birth was normal the client experienced it as traumatic
9	She felt she had not got continuity of care, different people were coming in one would say this one would say that and so she had a lot of upset about that.	She felt she had had no continuity with different midwives saying different thing. The woman was upset about this.	Lack of continuity with different midwives upset the woman.
10	And then um I think one person in particular upset her … when she was getting tired so when I first went in there was a lot to talk about a	The client was upset by one person in particular when she was tired and so when Carol visited postnatally there was a lot	The woman's tiredness influenced the amount of her distress and due to one particular midwife's behaviour

	lot for her to tell me.	to talk about.	Carol believed she needed to facilitate the opportunity to talk at length with the woman
11	And I remember sitting for a bout an hour and just listening to her whole episode which we tend to do if it is the first baby and you do and you particularly do if it is you own caseload. Because you know them you know what their expectations are, you know what they are hoping for and so they want to tell you.	Carol remembered just sitting and listening for about an hour to the whole episode. Carol said this was something she usually did if it was a first baby and particularly if they were on her caseload. This is because she knew them and their expectations and hopes so they want to tell her.	Just sitting and listening about the birth experience is necessary especially with the first time mothers that she was responsible for. Carol needed to do this for about an hour with this woman. The women express their hopes and expectations whilst developing a relationship with Carol and this prompted their desire to talk to her about their experiences.
	So was her birth experience different to what she expected?		
12	I think in terms of it being quite long… she she knew that it might happen but she was just hoping that it wouldn't happen. I don't know why she found it traumatic; it was a normal birth.	Carol thought the birth was different to the woman's expectations and hopes because it was quite long but Carol did not know why she found it traumatic, as the birth was normal.	Carol and the mother had different perceptions of the birth. Carol found it difficult to understand why the woman was traumatised but was aware that the woman had had to have unexpected and unwanted interventions
13	I think everyone's perceptions at different times is different isn't it? Umm she had an epiderual but she was hoping not to have an epidural ??????? (can't hear)…….	Carol said people have different perceptions of things and the woman had had to have an epidural, which she had hoped she would not need.	Carol recognised that individual perceptions of a similar event can be different.
	So was she able to tell you why it was traumatic?		
14	Ummm nnnnnn, I think she tried to umm and I think she had some underlying issues umm yeah I mean she	Despite the woman explaining in detail the birth Carol was still unsure why it was traumatic and	The woman explained about the birth in detail but Carol assumed the woman had underlying

	explained what happened in quite a lot of detail and umm but	suggested the woman may have some underlying issues.	issues, which made the birth traumatic, as she could not explain it in any other way.
15	I think the trouble is that most of us are healthy, even though she a chronic illness it didn't cause her pain and most of us are healthy young women who have not had any pain before to any degree and I think what ever you prepare them for they are still shocked at the pain.	Carol suggested that due to women being mostly healthy they have not experienced pain to the degree of childbirth and are therefore shocked by it.	Carol believed the woman was shocked by the birth, as she had not experienced pain to any degree before.
16	You see and I try to tell them that and I try to say to classes you know how we all health young women and we do not know how we are going to react and tell to have an open mind about it.	Carol explained she tried to tell the women about the pain in classes and how they needed to keep an open mind about how they would cope.	Carol felt that despite trying to educate women like this client about pain the antenatal classes were inadequate.
17	But they do tend to have a sometimes blinkered view. I will cope whatever and then they don't cope and end up with an epidural and are disappointed	Carol believed that this woman like others still have a blinkered view expecting to cope and when they are not able to and need an epidural they are disappointed.	Carol offered an explanation that this woman as with other women believed she would cope and became disappointed when she was not successful.
18	However we have to show them coping mechanisms, we have to try and help them understand the coping mechanisms.	Carol said they did show the women coping mechanisms and try to help them understand	Carol tried to help the women cope through education and demonstration.
19	Umm but she was disappointed I think with that, having an epidural. I'm sure if she had, I am not sure if she was augmented, during the labour in other words the labour was speeded up. I can't remember that. That may be the reason she had to have an epidural, I can't remember	Carol thinks that this woman was disappointed at having to have an epidural and it may be that the labour had been speeded up as well.	Carol identified that coping with pain was one disappointment for the woman but there may have been others that she did not remember the detail of.
20	She was disappointed but I think she was more disappointed with her postnatal care in hospital. Lack of continuity and a	Carol felt the woman was disappointed with the epidural but she thought that the client was more disappointed with the post	Carol felt that the woman was more disappointed with the postnatal care.

	couple of people had been abrupt to her um, I think there was a lot of conflicting advice.	natal hospital care. The lack of continuity, conflicting advise and staff being abrupt with her.	Lack of continuity of care, abrupt staff conflicting advice created distress.
21	Which, which you do tend to get with shift changes quite a lot um and I don't know if it necessarily conflicting advice sometimes it is but sometimes it different peoples conflicting ideas on something	Carol felt that the nature of the ward routines affected this but that the advice was probably not conflicting but differing ideas.	Carol thought that the woman's disappointment was due to misperception rather than inappropriate care.
22	and you need to collect them all and get what you like. But unfortunately you do tend to hang onto peoples words don't you and she was confused by that.	Carol suggested the woman needed to collect these ideas and develop their own but unfortunately she had taken words literally and became confused.	Carol identified that some of the woman's distress was due to her inability to accurately perceive the ideas shared with her.
23	Once you get home, that's the beauty of community really you should be seeing the same midwife all the time so that continuity, the community midwife returns.	Carol said that once the woman was at home she could see the same midwife and have a continuity of care.	Carol believed that once the woman was at home she would not be disappointed or confused, as receiving care from one midwife would ensure continuity.
24	So she did she spoke a lot we spent a good hour just talking it through just her talking and me listening	The woman spent an hour talking things through and Carol listened.	The woman spent an hour talking things through and Carol listened.
25	and then the sleepless nights kicked in and the fact that then she had to, her husband or partner wasn't particularly umm helpful. Her family weren't particularly pro breast feeding they were quite derogatory about breast feeding	This was then compounded by the client getting sleepless nights. The client's husband was not helpful and her family were derogatory about breast-feeding that the client was trying to do	The woman had a number of issues that also went on to impact on her need for support which included sleepless nights, her husband and her family's lack of support
26	and she wanted to breast feed but only if it was going to work, if it was ok. So she said I will have a go at it and if it doesn't work….	Carol said the client only wanted to breast-feed if it was going to work and agreed to have a go at it.	

27	And the family weren't particularly supportive. So if the baby were feeding all night, which is quite normal at that stage the family would chirp up and say …….. and give that sort of comment which is not particularly supportive family in terms of breast feeding and in terms of you know	The family did not support the client in this. When the baby was up feeding all night, which happens with breast-feeding at this stage, the family were unsupportive.	
28	if you look back in history a lot of our mothers have bottle fed. And have you know been encouraged to bottle feed and so you know it's the culture really the bottle feeding culture and that doesn't really help.	Carol offered the explanation that this was due to the generation prior to hers being encouraged to bottle feed babies so it is a cultural attitude, which did not help the woman she was supporting.	Carol explained that the family's lack of support was due to the culture of their generation.
29	So she did have a lot of sleepless nights trouble with coping with tiredness. She had a neighbour that came in quite often but umm she did take washing away and stuff like that but um also spent a lot of time there and also made her more tired. Chatting and all that. So she had the neighbour she had her mum come in quite a bit she was (opposed to it??) she was just (opposed to it??)…..	The woman was having sleepless nights and finding coping with this difficult. The client did have a neighbour that was trying to support her by taking washing away but the time she spent talking made the woman tired. The client's mother was opposed to breast-feeding.	The woman had problems coping with sleepless nights particularly as she felt unsupported by her mother.
	So what was your approach to all this?		
30	Well in terms of breast-feeding obviously encouraging breast-feeding. Umm the sort of strategies we were saying is to try sleeping when the baby sleeps.	Carol said she was encouraging the client to breast-feed. She identified strategies such as sleeping when the baby slept to deal with the tiredness.	Carol encouraged the woman to breast-feed despite family opposition. Carol offered problem-solving approach to tiredness – to sleep when the baby slept.
	You know but the trouble is	Carol believed that women	Women have too high

	that they have very high expectations of themselves and I find this quite a lot with different women is that they expect to give birth and then go back into their normal lifestyle again and even though you have prepared them through antenatal classes of what's to come they still can't seem to get the concept that the baby is going to be feeding 2 to 3 hourly or hourly at some point and there's going to be broken sleep they still can't seem to get that concept of what's going to happen until it happens its like a shock, such a shock.	had very high expectations of themselves. She said that the women expected to give birth and go back to their normal lifestyle. Carol said that despite attempting to prepare them for what is to come in antenatal classes but the women still do not accept it. She said how she informs them of 2 to 3 hourly feeding and broken sleep but it is still a shock. GENERALISED NOT SPECIFIC TO THIS WOMAN	expectations of themselves. Carol said despite offering information about sleeplessness at Antenatal classes women are still shocked
	So given that she was finding it difficult and you were giving information and she was still struggling, how do you deal with that?		
31	Well I think we just have to, I think really we need to make them feel they are normal and are not abnormal in any way that this is normal to actually feel tired and exhausted. In those very very early days it is normal and that	Carol said she just had to get on and deal with the situation. She explained to the woman that the way she was feeling was normal, that it is normal to feel tired and exhausted especially in the early days.	Carol said that it was important to identify the way the mother was feeling was normal.
32	they have got to try and sleep when the baby sleeps because if they don't they are losing out aren't they. They are up all night and obviously losing out on sleep. Or up part of the night so I do try and encourage them because being up and down is normal and try and encourage them to sleep when the baby sleeps.	Carol offered the strategy of sleeping when the baby sleeps because if she does not she will lose out on sleep.	Carol identified practical solutions for dealing with normal problems such as tiredness.

	However I realise some women can't handle, its no good you saying just leave everything because some women can't handle that. And if they are in complete disarray they find that more stressful than to potter around and do a few things, you know its getting a balance between what they can accept as a bit of order, whereas other women wont care at all about disorder and think this is a good excuse for not doing anything…	Carol identified that some women have problems with leaving the home in disarray and sleeping and this can cause more stress. She said it is a matter of getting a balance. Although some women enjoy the excuse for not doing anything.	Some women can find sleeping when the baby is asleep difficult as the use this time to organise the housework and become stressed by using this strategy.
	So for this lady was that a particular problem?		
33	Yes she liked being ordered she was, the other thing was she was a highly career orientated woman when I saw her antenatally she always took the last appointment so that she could come at the last minute from work always very neatly, smartly dressed, um always tired but you know that was the stress of the job, she was in a stressful job. So that was probably a shock as well.	This particular woman liked her home to be ordered. She was a highly career orientated woman and always organised her antenatal appointments to disturb work as little as possible. She was always dressed smartly but always tired. Carol felt this was due to the stress of her job.	Carol identified that this woman was highly career orientated and liked her life being ordered.
34	The fact that she no longer has that um at that point in time she did not have that job she was going back to it…..	Carol believed that not going to work was also a shock for this client.	Role change was also a problem that Carol needed to offer emotional support with.
	So presumably she was quite an articulate woman?		
	Yes, yeah…….		
	So in that time she took, what an hour was it you said?		
	Yes,		
	Explaining what had happened to her, what was		

	your response to her at that time?		
	Er, listening…….		
	How did you show her you were interested in her?		
35	I used a lot of body language, I think you've got to use a bit of eye contact um the use of gestures, nodding and so forth, I tried not to interrupt	Carol said she used body language extensively. She used her eye contact, gestures such as nodding and tried not to interrupt	Carol used her body language extensively such as eye contact, gestures such as nodding and trying not to interrupt
36	although obviously I needed to because sometimes you need to clarify so sometimes you do	Although at times interruption was needed to clarify what was being said but on the whole she tired not to interrupt.	At times Carol needed to interrupt to clarify issues but she tried to avoid this.
37	but on the whole I listened I was interested because I think when its your lady and they have been through a bit of a traumatic time you're interested in them	On the whole Carol listened and she was interested in the woman's story because she was her client and she was interested in her.	Carol did not find listening a chore because she was interested in the mothers she worked with and their stories.
38	so I think it was a bit of body language, listening eye contact, a certain amount I did actually write down. I did obviously put in my records. Although not absolutely everything but I put in a quite a lot ……	. Carol used body language, eye contact' listening skills and kept written records but did not record everything.	. Carol used body language, eye contact' listening skills and kept written records but did not record everything.
	So its sounds as if the birth and the immediate post natal experience was difficult for this lady?		
	Yes, I would say so ……..		
	So would you say that that was the most significant features of her journey to motherhood?		
39	Well I think if you look back pregnant, not expecting to get pregnant, having a chronic illness and whether it will have an effect on the pregnancy, then the birth	There were a number of issues Carol highlighted as significant features of this woman's journey to motherhood. These features were an	There were a number of significant issues in this woman's journey to becoming a mother.

	itself and then the post natal care I think it all…	unexpected pregnancy, her chronic health problem, the birth and the immediate postnatal care.	
40	that's what I say its not just one episode there is not just one isolate episode, they will find it is the whole moving through the processes that they weren't expecting…..	Carol said that becoming a mother is not just one episode but a whole journey. This includes things that they weren't expecting.	Becoming a mother is not a one off event; it is a whole journey.
	Right…..		
41	That comes to a head eventually for her it came to a head at that point	The journey reaches a significant point, it comes to a 'head'	The journey reaches a significant point, it comes to a 'head'
	Right so her transition her journey was over a period of time?		
42	I think so, I think the realisation that she has a responsibility for the baby came bongf there and then and she and her husband were left there on their own. I think probably that realisation was there.	Carol thought that the journey to becoming a mother was over a period of time but a sense of realisation came suddenly when they were left with the baby on their own	Becoming a mother is a journey but there is a moment of realisation. For this woman it occurred when she and her husband were first left on their own with the baby.
43	Although I think she had one particular night in hospital when the baby was upset I think maybe there was some realisation then but I think there is a time after the birth when realisation comes….the scans and all those sort of things they start to sort of prepare them but its not until they get this baby crying in their arms that the realisation comes ……	. Carol thought the realisation might have begun when the woman had a difficult night in hospital. Carol believes there is a time when realisation occurs. The preparation of scans etc start the process but it is not until they are faced with a crying baby in their arms that realisation happens.	This realisation occurs when the parents have a crying baby in their arms regardless of any preparation.
	So your approach to this woman was to use your interpersonal skills to sit and listen to her whilst she talked about things ….um is there any other approaches or mechanisms that you used?		

44	In terms of practicality certainly as for breast feeding, I took a lot of interest in that I have quite a strong interest in breast feeding anyway so I took quite a lot of time umm you know with feeding	Carol said she took a lot interest and spent a lot of time with the clients breast-feeding as she had a strong interest in it.	Carol had a strong interest in breast-feeding and spent a lot of time with the mother focused on breast-feeding
45	watching feed, making sure baby is fixing properly giving practical advice on feeding techniques	Carol spent time watching the client breast-feeding, making sure the baby was fixing properly and giving practical advice	Carol observed the woman breast feeding and gave practical advise
46	umm so that hopefully the baby would feed adequately and the baby would be more settled ultimately.	Carol did this so that the baby would feed adequately and be more settled.	Midwife believed if the baby fed adequately they would be more settled
47	Yeah so I did things practically	Carol said she did practical things.	Carol she practical things to support the woman
48	I did visit, really every day where you can some women you can leave for a few days but certainly this time I did not leave her off for a day	visiting every day, which she didn't need to do with all women	Unlike other woman she cared for Carol felt that this woman needed more time and so she visited every day.
49	She had quite a lot of other symptoms towards the end of visiting she had quite a lot of abdo pain umm nothing you could put your finger on, she had abdo pain but she didn't have an infection, wound was fine er sorry perineum was fine nothing that was particularly but she did have quite a lot of abdo pain but there was nothing practically bowels were fine um but that will settle down eventually	The woman had numerous symptoms towards the end of Carol visiting her such as abdominal pain. Carol could find no physical reason for these symptoms.	Despite Carol's regular visiting and interventions the woman went on to have undiagnosed problems.
	So what do you think was causing that?		
50	Its difficult to say really just a bit of worry or anxiousness whether she wanted visits more, I don't know its difficult to say whether she did have a bit of irritable	Carol did not know why these symptoms were occurring but suggested it may be due to anxiety or irritable bowel or that the client wanted more visits.	Not description of concrete experience

	bowel or whether she just wanted extra visits but nothing was found to be of any significance so		
	And was that a concern for her?		
51	I think there was a bit of concern for her ……was a bit concerned…… so everything settled and down and was fine. Now I can't remember how many days we visited for but I think quite a while because we just carried on we can go up to 28 days but 10 days is the minimum and would think it would be about 18 days that we went up to. And that is what we tend to do if there is anybody who are not quite sure of themselves not quite comfortable with themselves and problems at all on top of the physical problems then just continue visiting I have visited over the 28 days before now	Carol could not remember how many days she visited for but it was more than the minimum. Carol continued visiting past the minimum number of days if the woman was not comfortable or she had physical problems. She sometimes visited over the maximum number of days (28).	Carol visited this woman over the minimum number of days as she did with woman that are no quite comfortable with themselves and have problems.
52	. But usually up to 28 days and of course the health visitors come in around 10 day so we liaise with them very closely and we have a good relationship and we meet most days we see each other so they tend to say how is so and so doing so that's quite good. So there was a good relationship there and the health visitor came in.	The health visitor starts visiting from 10 days and so Carol liases with her; they have a good relationship.	Carol and the health visitor worked alongside each other to support the woman and this was enhanced by a their having a good relationship.
	It sounds like you are suggesting that perhaps this woman was struggling with this adaptation to motherhood or transition due to unrealistic expectations?		
	Yes how you get that realistic expectation over is	Carol agreed that she felt the client had unrealistic	Midwife felt the mother to be had unrealistic

	very difficult, its umm, it's because the media portrays you know wonderful motherhood if you get mother and baby magazine its just wonderful pictures of mothers and babies – hasn't it! And you know there is nothing, you might get the odd picture of somebody looking slightly depressed and so they have got a very rosy um picture. We try and address this in antenatal class but they only hear what they want to hear	expectations which made becoming a mother more difficult. Carol was unsure how to resolve this problem. She felt the media developed some of these unrealistic expectations but despite trying to redress them in antenatal classes she felt the mothers to be only listened to what they wanted to hear.	expectations and was unsure how to reconcile this. Antenatal classes were inadequate despite the efforts of the midwife.

Interview transcript D

Midwife = Diane

Const. No.	Transcription	Meaning Units	Psychologically reduced
	I'd like you in as much detail as possible describe the emotional support you have given a first time mother		
1	This was actually post natally she had already had the baby she was having a few problems with breast feeding (disruption) having problems with breast feeding	Diane identified a woman she offered emotional support to after giving birth to her baby, she was having problems breast-feeding	Diane identified a woman she offered emotional support to after giving birth to her baby, she was having problems breast-feeding
2	…….I had given help with feeding but she was still having problems latching the baby on although every time I was there she was able to latch the baby on with my help she but it seemed when I went away again she had problems	Diane had given help but the woman was still having problems latching the baby on. The woman was able to latch the baby on with Diane's help but when she was not there she had problems.	Diane had offered effective help but when Diane was not in attendance the woman continued to struggle.
3	but of course you can't be there 24 hours a day	Diane explained she could not be there 24 hours a day	Diane explained she could not be in attendance 24 hours a day.
4	so we decided in the end, she decided she would express some milk, she would do it that way to just get over those feelings	Diane with the woman decided to express some milk to feed the baby to overcome her feelings.	Diane with the woman decided to express some milk to feed the baby to overcome her feelings.
5	because she had a few guilt feelings of not being able to get the baby on and not being able to breast feed him that way and not getting that closeness that she would have if she had been able to breastfeed successfully	The woman had some feelings of guilt and fear for her ability to be close to the baby through her inability to breast-feed.	Diane recognised the woman felt guilty and was concerned about her ability to gain closeness with her baby if she could not breast-feed successfully
6	and so we um talked it through to deal with that and um we talked through	Diane talked about the woman's concerns with her including the baby	In response to the woman's concerns Diane sat and talked to

	coping with the baby being awake at night and tips for that, just sitting and talking	being awake at night. Diane sat and talked and offered advice.	her and offered advice.
7	about getting enough sleep and making sure she was getting enough sleep during the day time	Diane discussed with the woman the need to get enough sleep during the day.	Diane discussed with the woman the need to get enough sleep during the day.
8	and because a lot of first time parent tend feel that both them feel that they have to be awake the whole time and doing things together for the baby and I encourage them they need to do it in shifts when the baby is awake so that	Diane encouraged the woman and her partner to care for the baby in shifts to allow them to get enough sleep.	To facilitate getting enough sleep Diane advised sharing the care of the baby.
9	one of them can get some sleep and then take it in turns to do that rather than them both being stressed out and being there with the baby at the same time and neither of them getting sleep and the baby being tired and them both getting tired and over emotional	Caring for the baby in shifts would allow the woman and her partner to get enough sleep to reduce the resulting tiredness, stress and being over emotional.	Caring for the baby in shifts would allow the woman and her partner to get enough sleep to reduce the resulting tiredness, stress and being over emotional..
	So you are using a problem solving approach….		
10	Yeah, just giving them tips that other people could find helpful	Diane said she offered tips that other people had found helpful.	Diane offered advice based on her experience of caring for other woman.
	So are you saying this is someone you have seen recently …		
	Yeah, fairly recently…		
	Can you remember one of the visits that you did recently and take me through that visit describing what happened with this particular lady?		
11	Yeah er so er I'm just trying to think, there was a specific visit where I was actually quite late getting there because er I told the lady I would be there about	This particular visit Diane was quite late arriving. She had expected to arrive at lunchtime but because she was busy Diane had to telephone the woman to	Diane when running late contacted the woman to explain.

	lunchtime and because I had had a busy day I had to phone her and say umm that I was going to be a bit later	explain she would be late.	
	(disruption)		
12	Yeah, so I had phoned her earlier on in the day well actually I spoke to husband and said is everything ok and	Diane spoke the husband on the telephone and he assured her everything was all right.	Diane spoke the husband on the telephone and he assured her everything was all right.
13	I asked had the baby been feeding because I knew there had been some problems with feeding and he said very thing was fine.	Diane had specifically asked about the baby's feeding as she was concerned about this and he said everything was fine.	Diane asked specific information around the areas of concern of the woman's husband to assess her needs.
14	I had to do a clinic so I arrived there quite late and she was quite pleased to see me because she had been getting a bit concerned about feeding the baby and	Diane arrived late but the woman expressed her pleasure in seeing Diane as she was becoming concerned about feeding the baby.	Diane's attendance at the woman's home brought pleasure to the woman as she was becoming concerned.
15	they've got this Boxer dog actually that is always keen to see me and he came bounding up, (giggling) I think this dog is the baby's sibling they treated it like a child before they had the baby so yes the dog was pleased to see me as well.	Diane felt welcomed by the woman's dog as well who appeared to be a significant member of the family.	Diane felt welcomed by the woman's dog as well who appeared to be a significant member of the family.
16	So I think the baby was just about waking up and so was wanting a feed and she felt that during the day that the baby really hadn't been feeding properly because she felt that she wasn't properly latching on when I wasn't there ……	The woman had been concerned about the baby's feeding throughout the day, as she did not feel she could do this properly without Diane's help.	Diane attendance brought relief to the woman as she felt she could not undertake the care properly without Diane.
	Could you explain that a little…..		
	Err, Yeah she just felt that the baby was um that the baby was getting on just having a few sucks and then coming off and not really	Diane explained the difference between when she had helped with the feeding and the when the woman had done it alone.	

	settling down to a good feed as it had done when I had put the baby on the day before		
17	She felt that throughout the night and throughout the day and she actually said to me she did actually express some milk and she actually feel guilty that she had	Due to the woman's concerns she said she had expressed milk but felt guilty about this.	Diane whilst supporting this woman needed to address the woman's feelings of guilt.
18	and she said to me I hope you are not going to tell me off but I did actually express some milk and give the baby some milk from a bottle overnight because I just felt that baby wasn't latching that the baby wasn't feeding properly on me and	The woman was fearful that Diane would 'tell her off' for the way in which she had tried to deal with her own concerns.	The woman was fearful that Diane would 'tell her off' for the way in which she had tried to deal with her own concerns.
19	the baby had been going quite a long time as well between feeds instead of waking and feeding every 2 to 4 hours it had been going 6 hours and she was a bit concerned about that as well	The woman was also concerned about the length of time between the baby feeding as she thought it was too long.	Diane identified other concerns the woman had as well.
20	and thought it could be it wasn't feeding enough and sleeping too much so I reassured her that it was still quite early days, I think we were about day 4.. something like that so it was still quite early days for feeding to be established	Diane reassured the woman by informing her it was still early days for feeding to be established so there may be no problem the amount of feeding and sleeping the baby was doing.	Diane reassured the woman by giving her information.
21	but her milk had come in so she could be able to express quite a lot which she was quite pleased about that she had been able to express quite a lot but she was also feeling a bit guilty	The woman's milk had come in so she was able to express a lot, which she was pleased about but she also felt guilty.	Diane was supporting the woman with her conflicting feelings of pleasure and guilt.
22	because she thought I was going to tell her off and I said no 'I'm not going to tell you off' because had talked about it the day before	Some of the woman's guilt was due to her thoughts that Diane would 'tell her off' for the way in which she had dealt with her concerns. Diane explained she was not going to tell her off as they discussed	Diane had been the source for some of the woman's guilt but Diane addressed this by explaining they had previously discussed this method of coping.

		this method of coping the previous day.	
23	so I said that's absolutely fine if you are happy to do that seeing that the baby has got some milk then that's what you're happy doing and she said 'oh yes because I know that he has had a good feed'.	Diane said that if the strategy she had used had reassured her then that was fine and the woman said it had.	Diane reassured the woman by confirming that if the woman was comfortable with the strategy she was using that was fine.
24	So the baby was stirring and so I said do you want to have a go at feeding baby and she said er yes ok. So we er actually attempted to put baby onto the breast and	Diane offered to assist the woman putting the baby onto the breast	Diane offered assistance
25	she had actually got some nipple shields and she was quite sore and so I thought we could try with a nipple shield and we tried to get the baby on the breast with the shield and	The woman had sore nipples so Diane tried to help her put the baby on to the woman's breast with nipple shields	Diane looked for strategies to help the woman that would not cause her discomfort.
26	the baby was struggling so I suggested getting rid of the nipple shields and having another go and	The baby struggled to get on to the breast with the nipple shields so Diane suggested trying without	As one strategy did not work Diane suggested another
27	the baby really really didn't want to know with the nipple shield and so she said that was the problem I found he really doesn't like it at all which seemed to be the case.	Diane saw that the baby did not like the nipple shield as the woman had found.	Diane and the woman both recognised one strategy would not work.
28	So we discarded the nipple shield and had another go at getting the baby on without the nipple shield and he did actually latch on and	Diane successfully assisted the woman to get the baby latched on to the breast without the nipple shield	With Diane's assistance the woman was successful
29	was 'Oh' I feel really happy I've got him on again. He did have a good feed for about 20 minutes 15 to 20 minutes she said but I think	The woman was really happy that she was able to feed the baby on her breast for approximately 20 minutes.	The woman felt happy when successful
30	…. I said to her well obviously I can't be here every time I can't be here to put the baby on if you struggling so if you want to	Diane said to the woman that she could not be in attendance every time the baby needed to feed. So if she was struggling she	Diane recognised the strategy they had used on this occasion could not be used every time as she could not always

	express, if that's what you want to do	could if she wanted to feed the baby with expressed milk.	be in attendance.
31	and er that what she did and she's now, actually when I discharged her she was completely expressing. But for her she did have these guilt feelings…….	The woman continued to have feelings of guilt due to completely feeding the baby with expressed milk.	Despite the effective strategy identified the woman continued to have feelings of guilt.
	So she was saying that she had guilt feelings?		
32	Yes, yes she did and the way she expressed to me was that she thought I might be a bit disapproving of her because I had said to her its best not to start expressing too early but she did it	The woman's feelings of guilt were linked to her belief that Diane would disapprove of her approach due to advise Diane had given earlier in the relationship	The woman's continued feelings of guilt were linked to earlier advise given by Diane.
33	and so she gave me the impression that I would tell her off for expressing and that she might be a (I can't hear what this word was) But I reassured her that no that was fine.	Diane had the impression that the woman thought she would be 'told off' by her for feeding the baby with expressed milk but Diane reassured her this was not the case.	Diane had the impression the woman thought she disapproved of her strategy but Diane reassured her this was not the case.
	We were talking about you using a problem solving approach earlier and I guess that is probably what you were doing at this stage do you think?		
34	Yeah, ways to get round things looking for another way	Diane had looked for alternative approaches.	Diane had looked for alternative approaches.
	So was she coping with the baby in other ways?		
35	Yes, she was, she was very happy with him, she felt that things were almost too good, sleeping too long and that she was expecting what she had encountered from other people was that she would have quite disturbed nights and that the baby would be crying at night and that she would have to coping with a crying baby and she really didn't have to do that	Diane said the woman was very happy with the baby and things might almost be too good. She had not experienced the problems she had expected.	Diane found the woman was also concerned about the things that were going well due to her expectations.

36	and so it was really the thing that was worrying her the most, the thing that was worrying her was that he wasn't feeding enough and that he wasn't awake enough he was just sleeping and he didn't have any other problems except in that respect and	The main concerns for the woman was whether the baby was feeding enough and the length of time he was sleeping.	Diane was able to identify the main concerns for the woman.
37	his sleep was ok and he was thriving, his weight didn't drop too much. I did actually, I think I did actually weigh him that day as well because she was concerned about the feeding and that was another way of reassuring her that things were going and he was coming along ok. I weighed him and his weight was well within the limits ……	Diane said the baby was thriving. Diane weighed the baby on this visit to reassure the woman that the baby was getting enough food. This was reassuring because the baby's weight was within the expected limits.	Diane reassured the woman by measuring the baby's weight.
	It sounds as if you were still needing to support her with the things that were going well as well as the things that she was concerned about….		
38	Yes, yeah to point out everything that was going well, to point out that there were no problems and that things were going well.	Diane said there was a need to point out the things that were going well for this woman.	To support this woman Diane pointed out to her the things that were going well.
	And how did she appear to you?		
39	She didn't appear to be depressed in any way she appeared as always when I saw her throughout the antenatal period she appeared to be a cheerful person and um and she appeared the whole time to be fairly happy with things but underlying a bit of anxiety about how things were going with the feeding.	Diane said the woman did not appear to be depressed she appeared as she had throughout the antenatal period; cheerful and fairly happy with things. Diane did identify a little anxiety about how things were going with the feeding.	Diane identified a discrete area in which the woman was anxious and needed support.
	So when you say that you were reassuring her were you		

	using this problem solving or were you doing something else as well?		
40	Umm no I think other things such as just telling her that um that she was doing everything and reassuring her that she could make decisions for herself, she didn't have to listen to everything I was telling her, it was her baby and she knew it in a way that I never do and that was absolutely fine everything that she was doing. You know she was achieving good results with what she was doing	Diane offered support by reassuring the woman that what she was doing was fine and she was successful. Diane said to the woman she could make her own decisions and did not have accept everything she said. Diane said it was her baby and she knew it in a way that Diane could not.	Diane offered support by reassuring the woman that she was successful, she could make her own decisions and she had the better understanding of her baby.
	You were verbally confirming what she was doing.		
41	Yeah, yeah, confirming what she was doing and that she didn't have to take restrictive advice, that she could pick things out she could take, you know we could only advise that this might work you could try this but at the end of the day she was doing, what she had decided about what things were going to be useful were but that what she had chosen to do was effective	Diane said that she was confirming what the woman was doing and saying that she could choose. Diane explained to her that her advice could be accepted and may work but the woman's had to choose what would be most effective for her.	Diane encouraged the woman to take control and make her own decisions explaining she did not have to take her advice. She encouraged the woman to make decisions that were most effective for her.
	That she was capable of coming to her own decisions?		
42	Yes, yes she is, just give reassurance.	Diane felt that the woman just needed reassurance.	Diane felt that the woman just needed reassurance.
	So how do you think things went?		
43	I think things went quite well because when I arrived she was not very anxious but slightly worried about what was going on and um whether what she had done	When Diane had arrived the woman was a little worried about the baby and whether she had done the right thing. Diane felt things went well because	Diane felt things had gone well because she had been able to reassure the woman that she was doing well and things were getting better.

	was the right thing to do and I let her feel reassured that the baby was …., that that baby had not lost too much weight that the feeding was going well that she was getting it better.	she was able to reassure her that baby was doing well and things were getting better.	
	On a personal note how did it make you feel?		
44	Umm it generally makes you feel ……. In a way I was perhaps anxious because I always worry when you've got to manually get a baby on and every bodies struggling with this sort of thing, did I do the right thing there because, you think if they can't manage to do it themselves then, you have to try to get them to do it themselves rather than you come round to because you think what good is that actually doing so perhaps I felt I was wrong there perhaps I should have let her really try a bit more herself.	Diane said she had some anxiety over her interactions with this woman because of her manual intervention with feeding. When Diane was thinking about it she thought it might have been better to encourage the woman to try to latch the baby on more herself.	Diane had anxieties about whether she had physically intervened too much.
45	But then I did feel satisfied I left her feeling happy with the decisions she had made, she felt that she had made the right decision really. Expressing, that she would continue to do that, that she was reassured that she hadn't done the wrong thing.	Diane felt satisfied when she left the woman because she felt she had left her happy with the decisions she had made. Diane felt she had left the woman feeling reassured she had not done the wrong thing.	Diane was reassured she had behaved in the best interest of the woman because when she left the client was feeling happy with her decision.
	So for this lady you would suggest this was the most difficult time in her becoming a mother, when she was most in need to support?		
	Umm yeah because I think first time mothers in particular have these issues … finding breast feeding hard (could not heard end of	Diane agreed that this was probably the time when this client had needed the most emotional support. She also said that first time	

	tape)	mothers find breast feeding hard.	

Interview Transcript E

Midwife = Emily

Cons No.	Transcript	Meaning Units	Psychologically reduced
	What I would you to do is think of time when you felt that one of the women you have been working with needed emotional support in becoming a mother that could be anytime when you have been seeing them and you felt they needed emotional support. I would like you to describe in as much detail as possible that time with them. Does that make sense?		
	Right…..		
	I don't have a list of questions it's a case of you describing and I will encourage you to discuss the area I am particularly interested in, Ok?		
1	Well the particular ?primagravida? I'm thinking of had just moved, she was in the early stages of pregnancy at the particular time when she first started needing support was she moved from one midwife to me around about 16 weeks of pregnancy I think I had seen her then and then she was seen at 20 weeks. But for some reason she felt she had been let down by the system because she had been seen by 2 different midwives, she hadn't taken into account that she had…. Moved	Emily identified a first time mother to be, she had recently moved into Emily's area and was in the early stages of pregnancy. Emily said the woman felt 'let down' by the system because she had had to have two different midwives.	Emily identified a time when she could remember offering emotional support to a first time mother to be. This was during the early stages of pregnancy. The woman had felt 'let down' by the midwifery system.
2	…..Yeah she had moved she felt that the midwife she had	The woman was unhappy because she had explained	The woman was unhappy with the need

	met first off although we got on very well she felt that you know she just felt that you know I have gone through my history with this one midwife and now again.	her history to one midwife and now had to do it again to another.	to change midwives.
3	She got herself in a terrible state about it and	The woman was very distressed about the situation	The woman was very distressed about the situation
4	then it was probably with a lot of talking and everything that to try to describe the system to her because midwives can't cross massive boundaries and so when somebody moves it can be quite difficult and but it did effect her whole pregnancy	Emily talked to the woman a lot to explain the midwifery system which does not allow crossing large boundaries so when someone moves to a different location it is difficult. This situation effected the whole of the woman's pregnancy.	Emily took time to explain the midwifery system but this did not seem to ameliorate the woman's concerns.
5	For a good few weeks the way she felt about everything. She felt like she had been let down by the system, it sounds bizarre but she actually moved so really I found it a bit difficult trying to explain to her that midwives can't cross county boundaries and stay with her,	Emily found it strange that the woman felt let down by the system given that she had chosen to move after Emily had explained.	Emily found it difficult to understand why the woman felt 'let down'
6	yes it is your first pregnancy and yes it is nice to have continuity but if you choose to move areas there is not a lot we can do.	Emily recognised that it was the woman's first pregnancy and continuity of care is nice but there was little she could do to change the situation	There was little Emily could do to change the situation but she did recognise the woman's feelings.
7	So that was ok and that settled down but it did stay with her and coloured the whole of her pregnancy.	Things did 'settle down' but the situation went on to effect the whole pregnancy.	The situation went to effect the woman through out pregnancy.
	Oh dear.		
8	So I wondered um actually post delivery I think she was a bit depressed	This situation gave concern to Emily and she thought the woman was a bit depressed post birth.	Emily thought this went on to have an effect on the woman's mood after birth.
9	Because she comes from quite a quite um er good socio economic group. As	The woman and her partner were from a good socio economic group they	Emily thought that due to the woman's socio-economic group the

	they have got everything, the house, young couple, career minded and everything like that and I think, I think a lot of this surrounding midwives was to do with the changes of leaving working and becoming a mum	were a young couple, career minded with a house. Emily therefore thought that some of the distress over changing midwives might be due to leaving work and becoming a mum.	distress was probably due to leaving work and becoming a mother.
	Right…		
10	And all those things and it was the only way she could express all those things by fixing on this idea of changing midwives….	Emily suggested the woman had focused her stress on the issue of changing midwives.	Emily thought that the woman was expressing her underlying stress through the current situation.
	Right….		
11	Because post delivery they needed quite a lot of support with their relationship because it did effect things although they did both, the partner and the young lady had come to classes I don't think they really took on board how much the impact of having a new baby was going to have on them. On their lives as far as sleep deprivation and things like that and	Post delivery Emily felt the couple needed a lot of support with their relationship as the birth had an impact on it. Despite attending classes the coupe had not understood the impact a baby was going to have on them.	The antenatal classes that the woman and her partner had attended had not prepared them for the impact the baby would have on their relationship which meant they needed a lot of support to adjust.
12	that seems to be one of the main problems with emotional support we try to ease them into it gently through pregnancy we talk to them about things and how its going to be but the reality is totally different to when you're actually talking about it.	Emily tried to ease them into an understanding of how things would change but she felt the reality is totally different to talking about it.	Emily's attempt to ease them into an understanding proved inadequate, as talking about something is quite different to the reality of it.
13	So she actually needed quite a few visits. Very often we actually selective visiting now but she wasn't, although on the face of it she would be a ideal candidate because they had absolutely every thing she had good support from her partner, good support from her mum um	Emily used selective visiting and this woman would have appeared a good candidate for this as she good support from her partner and mother but she needed quite a few visits.	Emily expected that this woman, due to her social support network would need fewer home visits but this was not the case.

	and everything like that		
14	She needed more visits than someone who you would class as… um… …who you would typically think on paper this woman is going to need more visits than this woman because of their social circumstances but in actual fact this particular girl needed a lot more visits just to keep her going emotionally	The woman actually needed more visits than would be expected by her social grouping	Despite her social grouping the woman still needed a lot of visits to offer emotional support.
15	and also the partner he needed quite a lot of support.	This woman's partner needed a lot of support as well.	Emily felt that the partner needed quite a lot of support
16	So she we kept her on for a month whereas often we usually discharge people between 10 and 14 days.	This woman was visited for a month whereas usually women are discharged between 10 and 14 days	Emily needed to extend the visiting period for this woman
17	Obviously not intense visiting, initially it was intense visiting and then it was um you know twice weekly really until handover to the health visitor was completed.	Initially visiting was intense but then it went to twice weekly until care was handed over to the health visitor.	Visiting was initially intense but reduced towards discharge.
	Can I take you back to when you first met this lady, do you want to describe for me what happened when you first met her, where you met her etc….		
	She came to see me in the surgery. She had been seen initially by the midwife at about 7 or 8 weeks and she had come to the surgery just to meet me as she had just moved into the area		
18	and we got along absolutely fine I only found out because she said to somebody else that she was really upset about having to change and everything	Emily felt they got on absolutely fine and had found out that the woman was upset about changing midwives from someone else.	Emily felt that she and the woman had got on absolutely fine so was surprised when she was informed that the woman was upset.

19	so I talked to her about it because I didn't know if it was perhaps because she didn't feel she could connect with me but it wasn't that at all…..	Emily talked to her about it because she needed to make sure that the client did not have problem with her.	Emily was concerned about this so talked to woman about it to establish whether she had a problem with her personally. Emily was reassured this was not the case.
	So you found out about it after your initial meeting with her? So you chatted to her about it at another appointment?		
	Yes, yeah,		
	Right, so could you tell me in detail what happened at that appointment then?		
20	Er yes she umm she had spoken to, because she had met the health visitor, she had gone to meet her and give her information as they do and this is when she brought it up. So the health visitor said your lady, she is quite upset because she had been let down by the system	The health visitor had gone to visit the woman with information and at this meeting she had disclosed her unhappiness at the change of midwives which the woman identified as being let down by the system. The health visitor informed Emily of this.	Emily gained information about the woman's feelings from her colleague.
21	So I made an appointment to go and see her at home	Emily made an appointment to see the woman	Emily went to see the woman
22	ensuring first it wasn't me that she had a problem with, because you know you're not going to get anywhere really then and I got someone else to find that out so she wasn't feeling under pressure from me and it wasn't that	Emily ensured by asking someone else to check that the woman did not have problem with her so that the woman did not feel under pressure.	Emily checked with others that the woman did not have a problem with her support so that she did not put pressure on the woman.
23	and I do believe that it went to the heart(?) and everything, she was quite tearful that day and um I think it was, just looking back on it now, probably the relationship between the two of them husband and wife. They were very much able to	When Emily went to see the woman she was quite tearful. Emily realised with hindsight was probably due to her relationship with her husband. Emily thought that the husband was restricting the	When Emily visited she talked with the woman who appeared distressed. Emily believed the distressed was due to problems between the woman and her husband which led to the woman

	go out and do every thing they wanted to do and now he was cocooning her a little bit and um telling her she had to give up work and things like that and I think that that was having a, she was feeling a bit trapped	woman's usual activity; he was cocooning her, which led to her feeling trapped.	feeling trapped.
24	. you know sitting talking	Emily sat and talked with the woman	Emily sat and talked with the woman
	So you made this appointment to see her at her house and you say she was a bit emotional when you arrived so how did you approach that?		
25	Umm …… the way that I tend to act when they are emotional is ….. I don't know how I do it really aww.. its very difficult to say…um	Emily found it difficult to articulate how she was emotionally supportive.	Emily found it difficult to articulate how she emotionally supported the woman
26	, just talking to them, talking to them so they relax with you asking what's the matter is it anything you can help with, is it something they want to talk about or is it something else,	Emily talked and asked questions in her attempts to be emotionally supportive	Emily talked and asked questions in her attempts to be emotionally supportive
27	or shall we do the examination and then chat about the pregnancy after and talk and very often as you talk to them about the examination things will come out as they relax and concentration and they start to relax and talk to you about things….	Emily offered to conduct the examination and chat about the pregnancy afterwards. Talking whilst doing the examination facilitated the feeling of being relaxed and Emily found they then started disclosing their worries.	.Emily used the approach of conducting the physical examination and talking at the same. This relaxes the woman and she starts to disclose her worries.
	So is that what you did with this lady? Did the examination and talked or did you sit down and talk first?		
28	Usually I sit down and with her I sit down and chat about 'how you are feeling' and have you got any particular	Emily initially sat down with the client and asked she was feeling and whether she had any	Emily sat down and chatted to her about how she felt.

	worries and things like that	particular worries	
29	and then go into the examination and come back and usually they'll say I just wanted to talk to you about this or I'm a bit worried about this very often during the examination they will come out with things, just to relax them first and then very often they will disclose things.	During the examination is when woman usually highlights what the are worried about. The examination relaxes them and then they disclose things.	Emily used the physical examination to relax the woman and facilitate her disclosing what her worries are.
	So what sort of things was she saying to you?		
30	Just obviously she had moved to a new house and she did like it very much there but it was on a um new development where there is nobody else so they were the first ones in so she was feeling a bit isolated and her husband was very much a 'go getter' so was working long hours so she was there on her own in this little development.	The woman said how she had moved to the new house, which she liked, but there were few other people around as it was a new development. The woman was feeling isolated and her husband was working long hours as he was a 'go getter'.	Emily listened as the woman explained her situation and her feelings of isolation.
31	Later on on the pregnancy as more people moved into the area she did start to make friends but she was feeling very cut off from her friends and every thing.	Later in the pregnancy more people moved in to the development but at the start she was feeling cut off from her friends.	One of the woman's initial problems was of isolation and Emily offered emotional support for this.
32	Also her mum (brief discussion about confidentiality) had had a water birth and was quite a celebrity due to this as the woman was the baby. I think she felt she had quite a lot to live up to you know she felt she had to have a water birth as her dad had XXXXXXXXXXXXXXX so there was quite a lot of things. So I think she felt under quite a lot of pressure during her pregnancy	Emily thought the woman was under a lot of pressure from her parents.	Another problem that Emily thought she needed to offer support with that the woman seemed to be under pressure from her parents.

33	and her mum was very umm glamorous and so the woman felt she had to be glamorous all the time even though perhaps she was feeling like shit and vomiting and all sort of things like that,	Emily felt the woman was under a lot of pressure because her mother was glamorous so the woman felt she should be despite feeling very poorly.	Emily felt the woman was under a lot of pressure due to unrealistic expectations she put on herself.
34	She came from that sort of background where everything was just so.	. The woman had a background of expecting everything to be 'just so'.	Emily thought the woman had a background of everything needing to be ordered and this put pressure on her.
	So was she very poorly at this stage of pregnancy?		
35	She was just getting over the nausea and every thing you know the fatigue and things were starting to feel better but I think she was starting to felt that her husband was sort of…. Cocooning her… too much and not allowing to get on with …. You know you need to be at home … the little wife at home resting and all those sorts of things. I think she felt that quite hard.	The woman was just starting to feel better physically when Emily started to support her but she was struggling with her husband's expectations of her.	Although the woman was feeling physically better when Emily started supporting her she was struggling with her husband's expectations.
	Was she not that sort of lady to start with?		
36	Well she was working you see and she was a very bright girl and had lots of friends over in the area where they had lived until this complex, it was a very beautiful house and everything. I think they had been in a flat in a more central area as I work 'out in the sticks'. They had been very central in the city and lots of buses and could go to the shops easily….whereas she now feeling cut off.	The woman was intelligent, had been employed and had lots of friends where they had previously lived. The new home was beautiful but the previous accommodation had been a flat in a central location near shops so the woman now felt cut off.	The woman was an intelligent, working woman with an active social life until pregnancy and the house move.
	So how did you deal with the problems she was experiencing?		

37	Well I invited her to classes that we run in the area and then specifically to the classes we run in that area, lots of the women get choices, so they can go to the hospital or go to local classes or NCT but I felt for her it would better to come to the local ones where she could meet the other women who were pregnant and living in the same area, people living near her and so she agreed to come to those.	Emily addressed the woman's needs by inviting her to the local classes they ran. There is lots of choice of classes for women but Emily felt it would be better for this woman to use the local classes so that she could meet other women who were pregnant.	Emily focused on offering the woman specific choices in classes that she felt would address the woman's needs.
38	Which she started coming to at about 26 weeks, so we organise all that and that was about 16 weeks I think. Ummm……. And we put her in contact, told the health visitor and things if there is anything else in the area that she might be able to, there are exercise classes and things like that,	Emily explained the woman's problems to the health visitor, so that she might be able to identify other local activities for the woman.	Emily involved other professional's to ensure the woman had all support she needed.
39	I tried to get her to go to you know gave her all the information about aquanatal and stuff like that	Emily gave the woman information about other activities.	Emily gave the woman information.
	Right so they had all those sorts of things locally did they?		
	A little way away a few miles but she has access to a car		
	Right so there was a lot of information giving?		
	Ummm		
	Umm right so how did you deal with the emotional side, you say you sat down and talked …… and went through some practical things like the examination to help her feel more relaxed……. But what would you say your		

	sort of approach was to her?		
40	I tend to be going, a lot of the girls I see say I am not like a midwife that I am more like someone they would meet on the street (laughs) quite common not what they imagine a midwife to be you know who's very umm. A lot women say they expect a midwife to be very posh and umm very umm prissy and um	Emily does not think she is what most people expect of a midwife. Most of the woman she works with say she is more like someone they would meet on the street, quite common. Emily said people expect midwives to be posh and prissy.	Emily identified she not fulfil the criteria of a stereotypical midwife. She said people expect midwives to be posh and prissy. She does not adhere to women's expectations.
	(giggles) I don't know that I have met a posh midwife..		
41	No well that's what a lot of them say, they er, they umm, they've got a stereotypical view of what a midwife should be, you know when they meet you they realise you are just a person and you know very often I will talk to them about my own family	Emily said people have a stereotypical view of a midwife but when they get to know her they realise she is just a person and she will talk to them about her family.	Emily disclosed information about herself to aid the relationship and develop realistic expectations.
42	and not particularly my own pregnancy because I don't like to, my own pregnancy is different to theirs but every woman they speak to will have a different experience so then just hone in on their own experience so they don't get worried	Emily does not talk about her pregnancy because each pregnancy is different and she focuses on their experience of pregnancy so they do not get worried.	Emily does not talk about her experiences of pregnancy so that the women do not get worried.
43	because women are very cruel to each other, you know emotionally they, especially the 2nd time mums will upset the first time mums	2nd time mums can be quite cruel retelling horror stories and upsetting the 1st time mums.	Hearing other women's stories can be upsetting for first time mothers.
	Oh Dear		
	By giving horror stories, you know, you've got that so you're going to end up like this. I nearly died and der de der de der. They will be very graphic		
	So had this lady heard any of those sort of stories?		

44	No, she had her mums experience with herself you know it was all sort of ……	This woman did not have horror stories to deal with but she did have expectations due to her mother's experience.	This woman expectations based on her mothers experinces.
	A bit too good to be true?		
45	Yeah, maybe and I think she had got this to live up to you know she wanted to birth her baby in the pool she had been birthed in and I think maybe in her mind she was thinking what if I can't. Because obviously we talk to them and say there are times when n may be you wont be able to do that so maybe that was an extra stress, stress on her but trying to explain that her pregnancy is not the same as her mums pregnancy and you can't um compare the two at all and you've just got to put that one out of your mind.	The woman's mother's experience was difficult to live up to. Emily thought the woman was concerned about living up to this experience. Emily talked to the woman about this added stress and how each pregnancy is different and that they cannot be compared.	Emily tried to address the stress caused by the high expectations of the woman. Emily talked to her to try to relieve some of the stress by explaining every pregnancy is different.
	I think the thing that really interests me in what you are saying is your use of yourself, in that you come across in ascertain way and that you think that is helpful in breaking down barriers if you like for people to talk to you and you were also saying about what it is about you that makes that more easy to happen. Is there any more that you can tell me about that? Is there something in your general approach to people, you say you talked about your self and your life…….		
46	Ooh I don't know, well, we don't wear uniforms for a start and I think that makes a big difference especially when you are going in to peoples homes or even you know in surgeries and that	Emily identified that not wearing a uniform was helpful.	Emily believed what she wore was important

	the way you are,		
47	I tend to sit next to them not across a desk we tend to sit next to each other you know ….. you know….	Sitting next to the woman and not across a desk is helpful.	Sitting next to the woman and not across a desk is helpful.
48	I umm so it isn't so much someone coming to see an authoritarian figure who knows best and then they have got no say in anything that goes on in their pregnancy its trying to make it more of a partnership.	Emily felt that working in partnership with woman and being seen as an authoritarian figure was most helpful.	Emily was seeking a relationship of partnership.
49	I give them a lot of information they need and vice versa they give me a lot of information back from women you know. Very often women will tell you things you didn't know.	Emily gave and received information to their mutual benefit.	Emily gave and received information to their mutual benefit.
	So presumably that's what you did with this lady you sat down and used your relaxed style and		
50	Yes and tried to go to their homes as much as possible which is where they feel more relaxed in their own home and also your able to remove some of this…… because you're guest in their home…. It removes some of this power thing that	Emily tried to visit the women at home because they feel more relaxed there and it changes the perceived power.	Home visiting is conducted as much as possible as facilitates the woman being more relaxed and changes the perceived power base.
51	people who go to see the GP or something its their domain you forget things and when you get out you think of I wanted to ask that or I'm going to feel an idiot if I ask that and I think people in their own homes tend to feel more relaxed because they are more in control.	Unlike being in a GP surgery woman are more relaxed and in control allowing them to think of the things that they want to ask and not feel an idiot for asking.	Home visiting allows the woman to be more relaxed and not feel like an idiot for asking questions because she can be more in control in her own home.
	So this meeting had been set up because of a concern how do you feel that went? How did it feel for you?		
52	Umm I think it was good, I	Emily felt the visit was	Emily felt the Home

	think it was valuable because we spent an hour together and so I think it built a bit of a relationship for us whereas if she had come to see me in the surgery we might have had 15 minutes umm you know there wouldn't have been enough time really	valuable, they spent hour together and it allowed them to develop a relationship. A clinic visit would have only lasted 15 minutes, which is not enough time.	Visit helped develop the relationship due to the amount of time available.
53	so just sitting there and having a cup of tea with her not necessarily chatting about the pregnancy chatting about the house and work they are doing on it and which is nothing to do with midwifery	Sitting and having a cup of tea and chatting about pregnancy, the house, work they are doing which is nothing to do with midwifery helps build this relationship.	Sitting and talking about general things help build the relationship.
	Ooo I …		
54	But in some ways it is because all those things impacts on what she was going to buy and when she was giving up work and how she's going, and you know she's asking about how am I going to cope with the baby if I go back to work "oh but you work don't you and you've got children" you know that sort of thing	Emily discussed many general issues with the woman and they identified that one of the woman's concerns, returning to work that Emily had had to overcome.	General chatting and Emily's disclosure enabled them to chat and find common ground.
	Sort of like two women sharing thoughts and ideas..		
55	Just chatting really rather than umm but there is still that umm yes just sharing ideas but umm…errr	Emily spent time chatting and sharing ideas	Emily spent time chatting and sharing ideas
56	but I think sometimes the women think you know absolutely everything there is to know about pregnancy and sometimes they get surprised when I say sorry I can't answer that but I'll go away and find out for you. But I still think they think you know everything there is to know about pregnancy.	Emily feels that women expect her to know every thing about pregnancy and are surprised when she says she does not know something.	Women have unrealistic expectations of midwives.
	Does that feel like some sort		

	of pressure on you?		
57	Umm sometimes but most women will accept I don't know but I rather say I don't know that I can't answer that so I'll go away and find out or find someone who does know for instance women do use us quite a lot as emotional crutches they have our mobile phone numbers so they can phone us at any time provided we are working so	Emily said women do use them as emotional crutches as they have their mobile phone numbers and can phone at any time as long as they are on duty.	
58	this particular girl knows she has got access to me whenever providing that I am working, if she's got a little concern she can always ring me.	This woman knew that was able to contact Emily whenever she was on duty.	The woman knew she could contact Emily whenever she was on duty.
	And um women do ring me about peculiar things so they may have been to the dentist and the dentist has done a filling and they ring me and say I'm really concerned about whether I should have let him do it will it effect the baby. You try and say well the dentist is the professional there and he knows about fillings I don't know about amalgams and all those sort of things he's the best person to ask but they think that we will know everything that happens to them in a pregnancy regardless of whether its an appendix or tooth problems you know, its quite strange really…….	Emily gave an example of clients having unrealistic expectations of her.	
59	So they do have access to us so at the end of that visit she will have my contact number and also an associates number so if I was off she has 2 numbers so there is my	The woman had access to Emily and her associates number if she as off duty after the visit.	When Emily was not on duty she ensured the woman had the telephone numbers of her colleagues.

	associate she can phone and talk to		
	So at the end of this visit how did she seem?		
60	Much more relaxed, less tearful and seemed to understand she had me to phone and that I wasn't an ogre or anything like that	At the end of the visit the woman appeared more relaxed and less tearful, she was aware that Emily was approachable.	At the end of the visit the woman appeared more relaxed and less tearful, she was aware that Emily was approachable.
	(giggles) so that could have been an emotional process for you too, you knew that she wasn't very happy so you knew there might be a problem and you have come out at the end and it sounds like it was quite positive…….. were you aware of any sort of process like that yourself?		
	Yes obviously you do get some women you can't get on with its like that anywhere in life there are some people you can't get on with very often you recognise it and say and offer the women choices	Emily was aware that there are some women that she may be unable to work with but she offers these women choices.	
	There is a lot more on the tape but nothing specific to this episode		

Interview Transcript F

Midwife = Fiona

Const .No.	Transcription	Meaning units	Psychologically reduced
	So if you can try to identify a first time mum, its probably more help if it is someone you have seen more recently as you will be able to remember more details…		
1	Right ok shall I tell you a bit about it then, basically it was her first baby and she was married and her husband was…. It was a planned pregnancy and she had always been very involved with her dogs and her horses and that she managed until her first pregnancy	Fiona identified a married woman that was having her first baby; it was a planned pregnancy. The woman was very involved with managing dogs and horses.	Fiona chose a married woman that was having her first baby. She had managed animals until her pregnancy, which was planned.
2	I saw her throughout the pregnancy for at least nine months	Fiona saw her throughout the pregnancy for at least nine months.	Fiona had an ongoing relationship with the woman.
3	and its and so it was, the important thing was trying to support a girl who was expecting a baby it was a planned pregnancy she had no concern and so she had everything planned but can't predict or understand sometimes that things can't be during pregnancy and even post natally,	The woman had no particular concerns and everything had been planned but she could not understanding that not everything can be predicted or planned during pregnancy and after the birth.	The woman did not recognise that some occurrences in pregnancy and after birth cannot be planned for.
4	she didn't feel the way she thought she was going to feel	The woman did not feel the way she expected to.	Inability to predict feelings had an impact on support needed.
5	its because it doesn't matter how many parentcraft sessions we attend even how many	Fiona said it did not matter how many parentcraft sessions a person attends or even	Despite attendance at parentcraft sessions, family and friends being in a similar situation, talking to

	friends and family in similar situations we to and to a point how much time spent talking to the midwife because everyone experiences situations differently and	how many friends or family are in the same situation or the time spent talking to a midwife every ones experience is different.	midwives each individual women experience situations differently.
6	. so whilst experiencing something completely normal whilst some people will take in their stride whilst other will need that extra support	When experiencing some thing that might be quite normal some people will take in their stride other will need extra support with it	When extra support is needed is difficult to predict as people respond differently to the same situation.
7	. And so whilst they would come to clinic one week and it would be a bog standard, blood pressure check a wee and a weigh and a listen in she goes away quite happily the next visit for no reason what so ever she needs that encouragement to just know how she is feeling is normal	One visit to the clinic may be quite different to the next. The same woman one week will go through a standard process and the next time perhaps need more encouragement to feel she is normal.	Predicting when a woman will need extra support is difficult but when she does she needs encouragement to feel she is normal.
8	that is the biggest thing to know that A there is someone to listen to you no matter to you it sounds daft,	It is important that there is someone there to listen no matter how daft what is being said may seem	Fiona believed listening is important regardless of what is being said.
9	its not because it something that is of concern you need to express that to feel confident and comfortable in the environment to do that and	If something is of concern to the woman then they need to feel comfortable and confident in that environment to express it.	To offer support it is important to enable comfort and confidence to allow mothers to be to express their concerns.
10	that's why I think in an ideal world you would be more able to support emotionally if you are able to do more home visits.	Being able to do home visits would facilitate emotional support.	Home visits facilitate emotional support.
	do you do many home visits?		
11	Not antenatally, because my timetable just does not	Fiona is unable to do home visits antenatally	Fiona does not do home visits antenatally due to

	permit it because I can 8, 10 women in clinic in a morning whereas if I visit 8, 10 women at home the time taken travelling between the two I would just never be able to cope with the number of hours that would involve	due to the time it would take travelling between them. She could see 8 to 10 woman in the clinic which would be unachievable if she were to do home visits.	pressure of workload.
12	but I think women are more able to relax and talk to you and tell you their fears, thoughts, emotions in their own home	Women are more relaxed and able to talk about their fears, thoughts and emotions in their own home.	Women are more relaxed and able to talk about their fears, thoughts and emotions in their own homes.
13	than they are sat in a doctors surgery knowing there are other women out in the waiting room they have also got appointments waiting to see you and you might be running late you know	Women are inhibited talking in the GP surgery because there will be other women waiting outside and you may be running late.	Women feel inhibited to talk about themselves in the GP surgery.
14	and so its hard for them to relax and open up to you	It is difficult for woman to relax and discuss themselves in this situation	Women need to feel relaxed to discuss themselves
15	so whilst we can see women need emotional support we can see its difficult to give it.	Fiona is able to recognise woman need emotional support but finds if difficult to offer this care.	Fiona is able to recognise woman need emotional support but finds if difficult to offer this care
	Did that happen with this lady?		
16	I was fortunate with this lady in that it was actually so I had the time and I think that's why its come to mind really because I am able to reflect on the level of care I was able to give her which I am not now able to give the majority of my caseload as a midwife.	Fiona felt fortunate with this particular woman as she had the time to offer her a level of care she is now unable to do with most of her caseload, which is why she wanted to talk about her.	Fiona felt that with this woman she could offer optimal care that cannot do most of her caseload.
17	Umm because I've probably had women who have needed far more	Fiona recognised she has worked with woman since who have needed	Fiona was not able to offer the level of care she would like usually unlike this

	emotional support in the last year but because of constraints I haven't I have been able to give as much as I would like to do	more emotional support but due the constraints was unable to give this level of care.	situation.
18	and whereas when you are able to sit and talk to someone in their own home because it could	The ability to sit down and talk in a woman's own home is helpful	Sitting down and talking allows assessment of need
19	, emotional support could it could when having a baby bring ghosts from the past that you didn't even realise were there and you know possibly insecurities as a child for example.	Having a baby can bring back ghosts from the past that they did not know were there for example childhood insecurities.	Having a baby can 'bring back ghosts' from the past and mean the woman would need emotional support.
20	Umm that well in this lady's case her life had formed around horses and she had control over them and then suddenly she was into this situation where she didn't have any control in terms of her body, preparation for the baby, her relationship with her husband will change, there are so many different dimensions and she didn't feel in control.	For this woman her life revolved around horses which she was in control of but being pregnant she did not feel in control of her body, preparation for the baby or her relationship changes. She did not feel in control.	Fiona needed to offer emotional support to this woman because she felt she had lost control of her life and appeared to need to have control.
	So did you manage to do some home visits with her then?		
21	I did, yes I did, I did quite a few home visits with her umm and eventually when she had baby she did extremely well umm	Fiona did a number of home visits with this woman who eventually went on to do very well.	Fiona was able to support this woman by doing a number of home visits and the woman did extremely well.
22	but her husband was also extremely supportive cause there again because it was home visits he was able to be there	The woman's husband was very supportive because he was able to be there when Fiona visited	Fiona's management of the woman's care facilitated the husband being supportive.
23	whereas most partners would love to be but find it difficult to take time off work to attend a clinic in the middle of the day for	The husband's attendance would have been difficult with clinic visits. Fiona scheduled her home visits so that he was able	Fiona's management of the woman's care facilitated the husband's attendance at appointments.

	10 minutes. You know whereas I used to be able to say schedule an appointment for 12 o'clock and he'd just pop home for lunch.	to be there as well.	
24	You know it was far easier so I was also able to support him as well that's the other issue that emotional support is not just for women because if you can emotionally support the partner, the mum or whoever the person is likely to be they are then empowered to support the women. So it's an important fact.	This meant Fiona was able to emotionally support the father as well. Fiona felt that the partner or mother or whoever was supporting the woman are likely to need empowering to offer this support.	Fiona felt part of her role was to support and empower the woman's partner so that he could then support the woman.
	So can you remember one of those times when you had gone to visit the home and they were both there and perhaps they needed a bit of extra support, can you remember one of those days and talk me through what happened?		
25	I can remember her, she was always quite quiet, she was quite quiet and so was he by nature but this particular day she was just quieter than normal, it was towards the end of her pregnancy she would probably be 36 weeks and um… she just didn't seem right…	The woman was quite a quiet person and so was her husband. This particular day she was quieter than usual. It was when she was about 36 weeks pregnant. She just didn't seem right.	Fiona noticed that the woman was unusually quiet this visit.
26	and so basically what I did was something quite simple really was to go and sit down with a cup of tea and chat about the dogs and things, things that were familiar to her and with which she felt comfortable, that was the important thing at that	Fiona simply sat down and had a cup of tea with the woman. They chatted about the dogs and things that were familiar to her, which helped her feel comfortable. Feeling comfortable was the important thing.	Fiona sat down with a cup of tea with the woman and chatted about familiar things to develop comfort. Feeling comfortable was important.

	time and I had probably been there		
27	10 minutes to quarter of an hour before I even approached the usual antenatal questions such as 'is baby moving' and then instead of doing it in straight checks I did it bit by bit and	Fiona had been there for between 10 and 15 minutes before approaching questions about the pregnancy and slowly undertook the checks.	Fiona gave time before approaching questions about the pregnancy and when undertaking the checks.
28	I think basically it was just that she suddenly felt she would not cope with the labour, it had suddenly become very real to her. Whereas in months gone by it was somewhere in the future and then all of a sudden it was, I think what it was was entering into the month that the baby was due, if I remember rightly it was that magic. The baby was due in the October so I think it just reaching that 1st of October and thinking cor hold on a minute its getting a bit too close for comfort and	The woman felt she would not be able to cope with the labour. It had suddenly become very real to her. Fiona thought that it had suddenly become real because the woman had entered the month in which the baby was to be born and that the birth was becoming too close for comfort.	As the woman entered the last month up to the birth a realisation had occurred which made her uncomfortable and needing emotional support.
29	suddenly feeling very very inadequate	she suddenly felt very inadequate	The woman suddenly felt very inadequate.
30	and she was sensible and very well read umm and she had done parentcraft classes, so she knew what she wanted in terms of pain relief and everything and she knew everything as far as there was to know about the birth but it still didn't take away the emotional panic if you like.	The woman was well read and had attended parent craft classes so she knew what she wanted in terms of pain relief but this did not take away the emotional panic.	Despite the woman's efforts to understand and Fiona's input the emotional panic still occured
31	It wasn't in terms of how am I going to cope with the baby that wasn't the issue at that point, it was how am I going to cope	The woman was concerned with how she was going to cope with the labour. Fiona identified this is	Fiona recognised that the woman's concerns could not be addressed in classes as they were too individual.

	with the labour and um and that's something you can't cover in classes or you know it something which you because its something that is so individual,	something you cannot cover in the classes, it is too individual	
32	you know umm and you know now looking back it was this control thing. Umm and that's a huge point I think… is being in control but	On reflection Fiona believes this distress was caused from the clients inability to control the situation.	On reflection Fiona believes this distress was caused from the clients inability to control the situation.
33	once she talked it through she seemed to, you could almost feel her calm down	As the woman talked about her concerns Fiona could feel her calm down	Allowing the woman to talk about her concerns facilitated a feeling of calm.
34	and I think it was being able to express to someone and to say that's normal you are quite normal, its ok	Fiona thought that calm was achieved by informing the woman that what she was feeling was normal and that she normal, that the situation was ok.	Fiona thought that calm was achieved by informing the woman that what she was feeling was normal and that she normal, that the situation was ok.
	So you are validating her feelings?		
35	Yes, yes and just to be reassured, what she is feeling is absolutely fine and that's the other thing I think, in a funny sort of way, I suppose it is not the way to express it but it is to give her permission to feel the way she felt. Umm I mean not that she needed permission but to her she suddenly felt better because somebody had said its fine to feel like that	Fiona recognised she had reassured the woman by giving her permission to feel the way she did. Fiona did not think that she should need to give the woman permission but she suddenly seemed to feel better because Fiona had said it was fine to feel the way she did.	Fiona recognised she had reassured the woman by giving her permission to feel the way she did and this made her feel better.
36	because its fear that there is something wrong with you and that you shouldn't think like this and have thoughts like that and	Fiona thought that the woman was fearful there was something wrong with her and that she should not feel the way she did.	Fiona thought that the woman was fearful there was something wrong with her and that she should not feel the way she did.
37	I said that's fine just go with it. She suddenly and	Fiona reassured the woman that it was fine	Fiona reassured the woman that it was fine and she went

	she actually went on to deliver the baby and have a beautiful child.	and she went to deliver and beautiful child.	to deliver and beautiful child.
	(Disruption)		
38	Umm yes so and I think that's the good thing is being able to express and being in comfortable surroundings to express your feelings which is difficult in clinics and surgeries	The good thing is being able to express yourself in comfortable surroundings, which is difficult in clinics and surgeries.	Being in a comfortable environment enables expression of feelings.
39	unless you've got a person who is very confident and outspoken and in which case you wont need emotional support anyway.	This is easier if the person is confident and outspoken in which case they won't need emotional support.	Confident and outspoken people do not need emotional support.
	It sounds as if you were very relaxed and comfortable with the situation….		
40	That's the other thing I think you're right I think it helps the women as well because you know you've not got 3 clients waiting out there you're already running 20 minutes behind umm and so the pressure is off for us as well umm but then that's an ideal world.	Fiona felt that being more relaxed herself because she was not concerned about having women waiting outside or running late helped. This Fiona thought was idealistic rather than achievable.	Fiona felt that she too was more relaxed when visiting a woman in her own home but this was an idealistic approach to midwifery.
41	This lady I know would agree that she was very privileged but saying that	The woman would agree that she was privileged.	The woman would agree that she was privileged.
42	even if you work within the constraints of what we have, I think another thing is to make sure you are easily accessible to someone not necessarily face to face	Working within the constraints Fiona still felt it was possible to offer support by being accessible even if not face to face.	Fiona did think it was possible to offer emotional support within the constraints by being accessible.
	So you explained to this lady how to contact you?		
43	Yes she knew all the time how to contact me umm but I do with all my ladies	This woman knew all the time how to contact Fiona as with all the	Fiona was accessible to the woman via her mobile phone during working

	and they have my mobile number too	women she works with now. They have her mobile phone number.	hours.
44	because it's a work mobile its not as if, it doesn't infringe outside of work umm	It's a work mobile so it does not infringe on personal time.	Fiona's support did not infringe on personal time.
45	and there again if I had a lady who I knew was anxious for whatever reason I often have this if a lady's had a miscarriage and then they are pregnant again and I have another lady who had a baby at 23 weeks the first time and the baby only lived about 10 days umm and she's now pregnant again and well obviously for her umm	Fiona suggested that there may be occasions where she might consider using personal time	Fiona suggested that there may be occasions where she might consider using personal time
46	and there again that they are different you can have somebody in that situation who needs a lot of emotional support and likes to have a chat and go round and listen to the baby and you get another lady in very similar circumstances and she better coping on her own.	For each woman the emotional support they need is different even if they have similar situations.	Emotional supported needed is individual.
47	Umm so I think its important to say yes I am here for you if you want me and the emphasis has to be on them coming to you but being comfortable and able to come to you if they want to. So it is very much individualistic approach.	Fiona says she is here for the woman but it is up to her to contact her. Fiona says that they need to be comfortable and able to contact her. It is an individual approach.	Fiona believes that women should come to her but that she should be accessible and facilitate their being comfortable. It is an individual approach.
	So just going back a bit you gave her time to talk to about things… you looked at some of things she was interested in outside of the pregnancy… then slowly		

	went through the process of the check giving her space to work things through… and doing that in a fairly relaxed…		
48	Very relaxed and low key….	Fiona approach with this client was very relaxed and low key.	Fiona's approach was very relaxed and low key
	Low key..so how did that then progress?		
49	I think to be honest it came to a natural conclusion because we then just went back to general chit chat	The visit can to a natural conclusion because they had come full circle and started general chatting again.	The visited ended with a return to general conversation; it had come full circle.
50	because obviously by now I had got to know her quite well and so um and I do tend to ….. not go in to a lot of detail about my own personal experience but I tend to talk about my children in general terms	By this stage in the relationship Fiona knew the woman quite well. Fiona, without going into detail discussed her personal experiences in general terms.	Fiona talked to the woman about her personal experiences in general terms not in detail
51	, you know that so you that so they basically know that I've got 2 children and so you are able to, they can relate to you as a person	The woman knew that Fiona had 2 children so that they could relate to each other as people.	Fiona used self disclosure so that the woman could relate to her as a person.
	Using some of yourself?		
52	Yes instead of just being the midwife, because I think it is important to see the person, not just the professional person they say but also background, you should be able to chat like this lady and the dogs. I shared my experience of our dog and everything so you are able to relate and I think that is important in emotional support too.	Fiona did not want to be seen as just a professional, a midwife, she felt it was important see the person. Fiona shared her experiences of her dogs so allow them to relate to each other, which is important in emotional support.	Fiona felt it was important to be seen as a person not just a professional and shared her personal experiences allowing them to relate. Relating to each other is important to facilitate emotional support.
53	To relate part of your own life and I suppose that is why it is emotionally draining at times,	Relating part of yourself is important but it is also emotionally draining, exhausting, trying to	Using personal experience while important is also emotionally draining and exhausting because it is

	exhausting, because it is quite a thin line between giving emotional support and relating part of your own life but also keeping a distance	balance the thin line between relating a part of ones own life but also keeping a distance.	quite a thin line between using self-disclosure and maintaining professional boundaries.
	Protecting yourself in some way…..?		
54	Yes that's right exactly, I do, I try to particularly with her just being able to relate a bit of my life if you like to just to help to give a bit of….. a bit of padding around the um you know round	Fiona felt that giving a bit of herself was helpful to provide a bit of 'padding' around the interaction.	Fiona felt that giving a bit of herself was helpful to this woman.
55	the um because they are a lot of common thought and feelings and that takes me back to being able to say that's ok that's fine.	There are a lot of common thoughts and feelings. This allows Fiona to be able say what the woman is saying is fine.	Fiona believed there were a lot of common thoughts and feelings, which allowed her to say to the woman that it is fine to feel the way she did.
56	You know I think that's incredibly reassuring just to know there is nothing wrong with them	It is incredibly reassuring to hear there is nothing wrong.	It is incredibly reassuring to be told there is nothing wrong.
57	So with her is just came to a natural conclusion because we just then almost went full circle if you like so we started off with a bit of the background, then we went through the antenatal checks and the emotional support and then back to where we had started which was general chit chat you know and	This visit came then to a natural conclusion; they had gone full circle. They had progressed through a bit of background discussion, through antenatal checks and emotional support and then back to where they had started	Fiona visit went through a circular process and ended where it stated with general conversation.
58	. I have to say that from experience I have found that most beneficial with some people, you know not with all people but there again that is being sensitive to individuals	Fiona has found this approach beneficial with most woman but recognises the need to be aware of individual differences.	Fiona found this approach useful with some women but not all. There is a need to respond to individual differences.
	So how do you think she felt that went?		

59	I think she felt quite reassured umm and certainly obviously I was in a privileged position as I then saw her after that and then saw her at delivery and then visited her post natally so I was in a very privileged position ummm	Fiona felt that the woman was reassured after her visit but felt she was in a privileged position to be able to follow the woman through ante natal care, delivery and post natally	Fiona felt that the woman was reassured after her visit but felt she was in a privileged position to be able to follow the woman through ante natal care, delivery and post natally
60	as I say she did extremely well and	The woman did extremely well.	The woman did extremely well.
61	I can but deduce from that it must have been beneficial for her to have done because she cope so brilliantly you know very very, you know a water birth for a first time mum, went home within a few hours so has since gone on to have two other children	.Fiona deduced from thewoman's ability to cope, to have a water birth as a first time mum and to do well that the support she offered this woman was beneficial.	Fiona deduced from the woman's ability to cope and to have a water-birth as a first time mother that the support she offered was beneficial.
	(is more on tape but no more description)		

Interview Transcript G

Midwife = Gina

Const. No.	Transcript	Meaning units	Psychologically reduced
	What I would like you to do is to describe this for me in as much detail as possible		
1	The lady I'm going to talk about is a primip is er quite young around twenty / twenty one er married, stable relationship he is in full time employment but he gets moved around so she gets moved around and so she actually came to me part way through pregnancy ……(I can't hear) …. A planned	Gina identified a woman who was a first time mother, just over twenty and is in a stable married relationship. Her husband gets moved around due to his employment so Gina first saw the woman part way through her pregnancy. This was a planned	Gina identified a woman she wanted to talk about, a quiet woman, first time mother, twenty-one or two and in a stable married relationship. It was a planned pregnancy.

	baby She was a first time mum she quiet, she didn't say a lot	pregnancy. The woman was quiet and didn't talk much.	
	So did she visit you here at the surgery or did you visit her at home?		
2	Initially, in fact, all of her care was done at the surgery, it wasn't this surgery it was another one I work in	All of her antenatal care was done in the surgery.	All of her antenatal care was given in a GP surgery.
	So in the time that you were seeing her is there any time that stands out as a time when you needed to give emotional support in becoming a mother?		
3	Her delivery.	The episode Gina wanted to talk about was the delivery.	Gina identified the birth as a time when she offered emotional support to this woman.
	So you delivered the baby?		
4	I did but it wasn't planned but everything was straight forward, the pregnancy was straight forward, she went into spontaneous labour at home and I was on call the night she went into labour	The pregnancy had been straightforward and she had gone into spontaneous labour at home. Gina was on call the night the woman had gone into labour.	Gina delivered this woman's baby as she was on duty; it was not planned that she would.
5	I got the call from ambulance control to say that they had a lady that was distressed with the contractions and that she was wanting to push so I went to her she needed quite a bit of emotional support on the spot because it wasn't what she planned to do she planned to go to hospital.	Gina had received a telephone call from ambulance control saying they had a lady who was in distress with the contractions and that she wanted to push. The woman needed a lot of emotional support as she had planned to give birth in hospital.	Gina had been called to the woman who was in labour because she in distress and wanted to push. Gina felt she needed lots of emotional support because this was not part of the woman's birth plan.
6	She had phoned the hospital and they had said it sounds as if you can stay at home for a bit try a bath, try a paracetamol, it sounds as if you are in early stages and then she just took over….	The woman had phoned the hospital and they recommended staying home and having a bath or to try some paracetamol as it sounded as if she was	The woman followed the advise she had been given by the hospital.

		still in the early stages of labour.	
	It sounds quite exciting…		
	Yes…..		
	Could you talk me through when you got to her house, presumably you had received phone calls…		
7	Yes I got the call, the call I got actually it sounded as if she might deliver before I got to the house. I had been talking on the phone to them and ambulance control had previously told me they were on route and um	Gina said when she got the call it sounded as if the woman might deliver before she got to their house. Ambulance control said they were on their way to the woman's house.	When Gina received the information she was concerned that she might not arrive in time but the ambulance was already on it's way.
8	I was talking to the husband and she was sitting on the toilet saying she want s to have a poo so he was quite nervous obviously so I said to him, I tried to reassure him, things like.. phrases like 'if its all happening mother nature is taking over, she's doing her job, problems in childbirth occur when things don't happen,	Gina spoke to the husband who informed her that his wife was sat on the toilet saying she wanted to open her bowels. He was nervous so Gina tried to reassure him by saying 'if it is all happening then mother nature is taking over, problems occur in childbirth when things don't happen'.	Gina offered verbal reassurance on the telephone to the woman's husband with phrases such as 'if its all happening mother nature is taking over, she's doing her job, problems in childbirth occur when things don't happen'
9	so everything is happening so mother nature is doing a good job, I know you feel unprepared'	Gina demonstrated that she understood by saying "I know you feel unprepared".	Gina demonstrated she understood the husband's concern.
10	I also said you don't need to do anything, if she has the baby before anybody gets to the house you don't need to do anything just lift the baby to her abdomen and dry the baby off and take, use that towel and then throw it away and get another towel to wrap the baby in.	Gina gave advice explaining to the husband that he did not need to do anything, if the baby arrives before the services do just lift the baby onto her abdomen and dry it off using one towel. Then use another towel to wrap the baby in and keep it next to the mothers skin.	Gina explained to the husband what he could do to support his wife.
11	He said 'what do I do with the cord?' 'What do I do	The husband was concerned about the cord	Gina answered to husband's questions

	with the cord?' I said 'you don't do anything just let the baby deliver, put it onto her stomach, dry it, throw that towel away and wrap it, just keep it next to her skin'	but Gina explained he did not need to do anything with the cord, just leave it. Gina again explained what he needed to do.	and explained again what he needed to do.
12	I said 'there is an ambulance on its way so they'll be there very soon so you wont be on your own for long' I said 'but don't worry because everything is happening naturally' …so that was what I said on the phone	Gina reassured the husband that the ambulance was on its way so he would not be on his own for long and there was no need to worry as everything was happening naturally.	Gina reassured the husband by informing him that the health professionals would arrive soon and that there was nothing to worry about as everything is happening naturally.
13	I then leapt in my car and hurried off to where they lived and er on route I	Gina then quickly got into her car and hurried to the woman's home.	Gina hurried to be in attendance.
14	er the ambulance called and said we are at the house and we are going to transfer her in oh..do you want us to transfer her in and I said um well I'm actually in the village so I'll come to house before you transfer her, within two minutes,	Whilst in the car Gina spoke to the ambulance people who asked if she wanted the woman transferred to hospital. Gina said she was already in the village so she would like them to wait until she arrived	Whilst travelling to the woman's home Gina continued to negotiate the care.
15	so I got to the house and she had transferred from the toilet into the spare bedroom and was laid at a funny angle with a cable underneath her and	When Gina arrived the woman had moved from the toilet to the spare bedroom and was laid at a strange angle with a cable underneath her	When Gina arrived at the home she assessed the situation.
16	er she looked very calm but when the contractions I could see they were tense and they were very close together	The woman appeared calm but when the contractions started they appeared intense and close together.	The woman appeared calm but as the contractions appeared intense and close together Gina believed she needed support.
17	. and um to the ambulance guy I said 'I don't think we will be transferring her?' I said I need to do an assessment	Gina said to the ambulance man that she did not think they would be able to transfer the woman but she needed to do an assessment	Gina needed to assess the woman to make care decisions.

18	and so I straightened her out on the bed a bit and I got the husband to move the cable because I did not want her caught up in the cable when she was delivering or while I was assessing her but	Gina straightened the woman on the bed and got her husband to remove the cable. Gina did not want the cable in the way.	Gina organised the woman and her husband.
19	I planned to do an internal assessment to see if we had time to transfer her from the house to hospital because we are talking about a good 15 to 20 minute transfer even at that time of night, it is quite a distance	Gina planned to do an internal examination to see if there was time to transfer the woman to hospital, as it was a 15 to 20 minute journey.	Gina planned to do a physical assessment to facilitate care decisions.
20	so I got her settled	Gina settled the woman ready for the examination	Gina settled the woman ready for a physical examination
21	and the ambulance crew because she had been on the toilet she had got out of the bath and sat on the toilet she had nothing on when we arrived and they had wrapped a blanket round her	The ambulance crew had wrapped the woman in a blanket because when they arrived she had been naked due to getting out of the bath onto the toilet	Other health care professionals assisted in ensuring the woman's mental and physical well being.
22	so I prepared for this internal examination	Gina prepared to undertake the internal examination.	Gina prepared to undertake the internal examination
23	and lifted the blanket away and could actually see the vertex so the baby's head was visible	When Gina lifted the blanket she could actually see the vertex, so the baby's head was visible.	Gina found the physical examination was unnecessary as the situation had progressed.
24	uum so I just looked at the ambulance crew and said we're not going anywhere because the baby is almost here and	Gina said to the ambulance crew we would not be transferring her to hospital as the baby is almost here.	Gina made care decisions based on what she had seen and shared these with the other health care professionals.
25	umm explained to her exactly what I was doing umm I explained exactly what was happening to her that she was very close to having the baby, that we didn't have to transfer her ……how advanced in labour	Gina explained to the woman what was happening to her and that she was very close to having the baby.	Gina explained to the woman what was happening to her.

	she was…….so		
26	she did she had her baby where she was	The woman gave birth where she was.	
	So as for support it sounds as if it was a lot of physical care there when someone is giving birth….		
	Yes		
	The process of giving birth is a physical process so what sort of emotional support were you giving how were you able to give that?		
27	Explaining, well er when the ambulance I said to, I said to er her that I think it would be a good idea to assess you er before transfer	Gina said she offered emotional support by explaining what was happening to the woman	Gina said she offered emotional support by explaining what was happening to the woman
28	you're very controlled although you can see the contractions were very intense so you could be ready to give birth	Gina explained to the woman what she was observing was happening to her.	Gina demonstrated recognition of how the woman was feeling and what this might mean.
29	, so I was explaining to her what I was going to do and why I thought it was a good idea to do an internal assessment	Gina explained what she going to do and why it was necessary to the woman.	Gina explained what she going to do and why it was necessary to the woman.
30	I did actually say you don't have to have it if you don't want, if you want to go to hospital and have your baby you don't …..	Gina did say to the woman that she did not have to accept Gina's decisions she could make other choices.	Gina tried to offer the woman some autonomy.
31	so I said it might, we might have to happen that you deliver in the ambulance if you don't have it and we don't know how close you are to having the baby, so I explained all that to her and then	Gina explained what might happen if she chose to be transferred to hospital to have her baby.	Gina explained why she was making her recommendations.
32	I explained about the internal obviously being in established labour as she was probably very well advanced it may be uncomfortable	Gina explained that the examination may be uncomfortable for the woman as her labour was advanced.	Gina explained that a physical assessment may be uncomfortable for the woman.
33	but if at any time through the examination she that she	Gina said if the woman wanted her to stop at any	Gina gave the woman permission

	wanted me to stop just to stop me and I would withdraw immediately	point just to stop her.	to stop her at any point.
34	but actually trying to make her feel she was in control so that she had choices	Gina tried to offer the woman choices to facilitate a feeling of control.	Gina tried to offer the woman choices to facilitate a feeling of control.
35	even though at that stage of labour as we now know in retrospect it would have been very difficult to have a rational decision a full conscious thinking decision it just have gone.	In retrospect Gina realised it would have been very difficult for the woman to make a rational decision at this point as conscious thinking decision-making would have gone.	In retrospect Gina realised it would have been very difficult for the woman to make a rational decision at this point as conscious thinking decision-making would have gone.
36	I think her instinct was telling her it was time to start pushing	Gina thought the woman was motivated by instinct.	Gina thought the woman was motivated by instinct.
37	um I don't obviously when I saw the baby's head I said to her I can see your baby's head so your baby is coming so you are going well with the labour and actually and everything is actually going well	Gina continued to explain to the woman what was happening that she could see the baby's head and that things were going well.	Gina supported the woman by describing what she could see and telling her things were going well.
38	with the baby's head I think we should deliver here because I am not confident of getting you down the stairs and I said I don't think we will be able to go down to the road so I think it is best if we get you to deliver here and are you alright with that?	Gina explained her decision to get the woman to deliver the baby at home was due to her lack of confidence in being able to get her done the stairs and the road safely. She asked if this decision was acceptable.	Gina explained her decision to the woman and asked if this decision was acceptable.
39	She said yes and umm	The woman agreed with the decision.	The woman agreed with the decision.
41	I was giving her eye contact, looking at her face I was ignoring the rest of the people in the room and making it her decision	Gina gained eye contact with the woman and ignoring the other people in the room so that the woman felt the decision was hers.	Gina used her body language to facilitate the woman believing the decision making belonged to her.
42	and I was holding her hand I took her hand to offer her	When asking the woman what she wanted Gina	Gina supported the woman by holding

	some physical attention I said to her do what you want to do	held her hand offering some physical attention	her hand, giving her physical attention and asking what she would like.
43	Because I do know that some lady's that do have baby's at home and it is unplanned and it completely straight forward they can get extremely distressed post natally because it wasn't the birth they had planned	Due to past experience Gina was concerned because even though this birth was straight forward it was not the birth she had planned which could lead to post natal distress.	Gina was concerned for this woman, as it was not the birth she had planned and this can lead to mental health problems.
44	and um I was maybe trying to forestall this as well that I had experienced before with this kind of scenario.	Gina was trying to reduce the risk of post natal distress which she had experienced previously caring for woman in this situation.	Gina actions were undertaken to reduce the risk of post natal distress.
45	And the fact that she had been on the telephone to hospital earlier telling them what was going on from what she was telling them they were saying stay at home no stay at home until she was ready to push	Gina explained the woman had contacted the hospital earlier but they had advised her to stay at home until she was ready to push	The advice given by the hospital had created this woman's need for Gina's care.
46	so obviously that was some shock especially when it is your first baby I mean I have had women who are having subsequent baby's who are very distressed with short labours so I was very conscious of that.	Gina felt this experience would be a shock for the woman as she was conscious that other women have become quite distressed at short labours.	Gina had previous experience of this situation and was concerned the woman may become distressed.
47	So um it was just eye contact and um touching and then	Gina used eye contact and touching to emotionally support the woman	Gina used eye contact and touching to emotionally support the woman
48	I checked that she was comfortable she was where she wanted to be,	Gina checked that the woman was comfortable and where she wanted to be.	Gina checked that the woman was comfortable and where she wanted to be.
49	she was too far advanced to be able to make many decisions but I felt I was	The woman was too far advanced to make many decisions	The woman was too far advanced to make many decisions

50	making her feel that she was in control and trying to accommodate her wishes	but Gina tried making her feel in control and accommodate her wishes.	Gina tried to support the woman by making her feel in control and trying to accommodate her wishes.
	How did she seem to be responding to that?		
51	Very positively, it was a positive experience as it turned out er she was quite happy with every thing	It was a positive experience for the woman and she turned out to be happy with everything.	The woman appeared to respond positively to this support, she was quite happy with everything.
52	we didn't need to take her to hospital but she didn't need any stitches, her baby was born in good condition so it all went very smoothly really with the minimum of hiccups it was beautiful	The woman did not need to go to hospital and did not need stitches; her baby was in good condition. It all went smoothly, it was beautiful.	The episode went smoothly, it was beautiful.
	Oh right, do you think that is how she would describe it?		
53	Um yes I think so because obviously I did her post natal care as so I was the midwife that was going back to her so I went back to her the following morning first thing umm	Gina did the woman's post natal care and so saw her the next morning.	Gina continued to care for the woman after the birth.
54	then I went back to her later on that day umm because she was just a few hours from delivery so um I did checks on her that day and each time I asked her how she felt about things so that she could express whatever she was feeling um	At these visits Gina was able to check mother and baby and ask her how she felt about things. This gave the mother change to express any concerns.	Gina after the experience gave the woman opportunity to express her feelings.
55	she was just happy about things then	The woman was happy about things	The woman was happy.
56	I was praising her then saying you were a first time mum and you did all that labour on your own I said	Gina gave the woman praise and told her how well she had done to labour on her own as a first time mother.	Gina praised the woman by expressing what she had done well.

57	and didn't need any pain relief. She didn't have any thing drug wise so um I was praising her saying she had done a marvellous job	Gina told the woman all the things she had managed to achieve and praised her.	Gina told the woman all the things she had managed to achieve and praised her.
58	she was lucky as medical staff hadn't got our hands on her	The woman was lucky as she had achieved the birth without medical staff getting their hands on her.	Gina thought the woman was fortunate as she had managed the birth without medical interference.
59	. So it was trying to make it positive and not view it as negative.	Gina was trying to make the woman perceive the birth as positive and not negative.	Gina was attempting to facilitate the woman recognising the experience as positive.
	So she was able to take that on board?		
60	Yes, yes I think the major thing for her was that her baby was alright, she wasn't uncomfortable, physically she wasn't uncomfortable because it had been a straight forward delivery, she hadn't had stitches and there wasn't a lot of mess in the house	Gina thought the important issues for the woman were that the baby was alright, she was not uncomfortable, it had been a straight forward birth, she had not had stitches and there was not a lot of mess.	Gina thought that the woman was happy because the important issues for her had been taken care of.
61	I am very conscious about cleaning things up because it wasn't planned	Gina had cleared up the mess made the previous night, as she was conscious of the need to do this especially as it was not a planned home birth.	Gina addressed simple practical issues.
62	and actually the room we were in was extremely cluttered and it was quite difficult to work in and she was lying on a double bed and her head was up against a wall so I was working at quite awkward angles, I think, there was lots of baby equipment in there, it was the baby's room, it was sorted the next day and all tided up	The room in which the woman had had the baby was rather cluttered which made it difficult for Gina to work in but the following day the room had been organised.	Gina could see that the woman was being practically supported.
63	The baby had arrived on time and she had expected it a few	The baby had arrived earlier than expected	

	days after so she was in the process of sorting it all out when she went into labour	which Gina thought was the reason for the untidiness.	
64	Yes so she did think it positive but um but basically really she was happy the baby was safe	The woman was positive and was happy the baby was safe.	Gina found the woman to be positive and happy the baby was safe after the care episode.
	So you described what was happening and what you did but what was happening for you as you went through all this?		
65	I was quite excited I love home births,	Gina had found the experience exciting and she loved home births.	Gina had found the care episode exciting.
66	I love home births and if a mum is comfortable even if it is unplanned, this young mum did end up feeling comfortable	Gina enjoyed home births if the mother is comfortable and this woman did end up feeling comfortable.	Gina enjoyed home births if the mother is comfortable and this woman did end up feeling comfortable.
67	because I kept giving explanations and reassuring her that everything was going fine, that I was geared up, I had all the equipment and plus the ambulance crew were there, there wasn't any problems with her or the baby umm	Gina kept offering explanations and reassurance. Gina could reassure the woman that everything was going fine and that she had all the equipment she needed and the ambulance crew was there as well.	Gina offered explanations and reassurance to support the woman. Her appropriate resources and other health care professionals supported this.
68	so actually as everything was comfortable I instinctively felt it was going to be a good outcome,	Everything was very comfortable and instinctively Gina felt it was going to be a good outcome.	Everything was very comfortable and instinctively Gina felt it was going to be a good outcome.
69	um I was actually very excited because um this mother had done it all herself I literally just caught the baby I didn't have to do anything for her	Gina felt excited because of what the woman had managed to achieve by herself.	Gina felt excited because of what the woman had managed to achieve by herself.
70	it was a shared experience with her and her husband and	The shared experience with the woman and	The shared experience with the

	I get a kick out of it.	husband Gina particularly enjoyed.	woman and husband Gina particularly enjoyed.
71	I think it was their experience because she laboured on her own so when she tells her story it wont be oh the midwife was wonderful she did this and she did that, it will be well I took a bath and we did that, it was her labour, it belonged to no one else. I enjoy that sort of experience.	When the woman tells her story it won't be the midwife did these things it will the woman and her husband, it belonged to no one else. Gina enjoyed that sort of experience.	Gina enjoyed facilitating the woman and her husband making the experience their story and not a story about a midwife.
	There was one thing you said there that really interests me, you said that you instinctively felt that this was going to go ok, is that something you do a lot within midwifery?		
72	Yes, yes, I think without consciously because I've been a midwife for about 11 years now, I've been in the community for about 6 years and I have conducted about 20 home births as the first midwife but I don't know the number I've attended as the second	Gina has had a lot of experience as a midwife and of home births.	Gina felt her experience, as a midwife was influential.
73	because as a team we go to each others because at the actual birth there is 2 midwives there, so I've been to numerous of those with my colleagues. Sharing the births with them, the ladies I've looked after, I think there comes an intuition about when things are going right or when things are going wrong and	Gina has shared births with many people and believes that through this she has developed an intuition about whether things are going to go right or not.	In sharing many births Gina felt that intuition occurs about whether the outcome will be positive.
73	I can't pinpoint what instinctively makes me feel	Gina cannot identify where this intuition comes from.	Gina could not identify where this intuition comes from.
74	because when I have had,	Gina identified that when	Gina identified that

	when we have had labour they have gone alright we don't have to transfer many its negligible but there have been some labours that have been more difficult than we have anticipated and we have instinctively picked up on this as we go through labour and	things are not going well she and other midwives are able to recognise this instinctively.	when things are not going well she and other midwives are able to recognise this instinctively.
75	in fact we do it in hospital labours as well instinctively I pick up a lot of things and I am learning more and more (goes on to talk about an example of how someone can influence labour progression by there presence impacting on the atmosphere in the room)	Gina recognised that used her instinct in hospital labours too. She went on to say that the approach of midwives she has worked with can have an impact on the progression of labour.	Gina recognised that the skills she used such as instinct was transferable to other environments. Gina explained how the midwife's approach can influence the care needs of a woman.

Interview Transcript H

Midwife = Hetty

(Worst tape for transcribing)

Number	Transcription / meaning units	Transformed meaning units	Psychologically sensitive meaning units
	So what I would like you to do is to think of a woman that you have offered emotional support to becoming a mother and I want you to describe in as much detail a possible a time when you did that preferably with a first time mum a way to go might be to tell me a bit about the woman and her background to start with.		
1	Ok. Ok umm she's single and in a relationship and very young and very nonconversant, she is very shy, very timid, umm so initially wouldn't open up to anybody umm	Hetty identified a woman she had given emotional support to, she is single but in a relationship, she is very young and very shy and timid. She is nonconversant. Initially she wouldn't talk to anybody.	Hetty identified a young, single, very shy and timid woman who would not 'open up' to anyone as an experience of giving emotional support.
2	and scared I think the biggest thing is scared. So it took me a while to actually get to know her background and what have you her umm and	The woman was scared so it took Hetty a while to get to this her background.	Hetty believed the woman was scared which is why it took Hetty a long time to get to know her and her background.
3	when she did start opening up the clinic was not the right place for discussing things so umm mainly because we lacked time	Hetty felt that when the woman did start talking to her that the clinic was not the right place mostly due to the lack of time in clinic.	Time in antenatal clinic was limited so it was not the right place to offer emotional support.
4	so what I did was to arrange to meet her at home and um yeah so it just gave her the opportunity one not be overwhelmed and what have you but to also that she had	Hetty arranged to meet the woman at home so that she did not feel overwhelmed and had the opportunity to discuss things.	Hetty arranged a home visit to address the woman's feeling and give her the opportunity to talk.

	me to discuss issues		
	So you got the impression quite early on that she needed that space to talk		
	Yeah…		
	So what sort of stage did you organise to visit her at home?		
5	Probably after about her 2nd visit because there seemed to be a few issues and I'd spoken to the GP and health visitor	Hetty arranged the home visit after the woman's second appointment and after speaking to her GP and health visitor.	Hetty had discussed the woman with the GP and Health Visitor before she visited her at home.
6	and it I think part of it was that with some girls they put across umm how you know they think you are far too busy to listen to them, you know and	Hetty was concerned that like other young women that she would think Hetty was far too busy to listen to her.	Hetty was concerned that, like other young women, she would think Hetty was too busy to listen to her
7	I always worry about those ones because you know that's already looking at that they do not deserve the time (I can't hear…)	These women worried Hetty because they are suggesting they do not deserve her time.	Hetty was also concerned that this woman may think she did not deserve Hetty's time
	So that's a common issue?		
8	Yeah, yeah, and not just with midwives but with all professionals they feel that you know well we go in there and its just to check the baby is fine and do the blood pressure its purely physical signs but nobody really cares a bout us as people	This is a common problem not just with midwives but with all professionals. The women feel they are just there to check the baby is fine and do physical checks on them. The feel that nobody care about them.	Hetty was concerned that this woman like other young women would think that Hetty as with other professionals was only interested in the baby and physical checks. She was concerned that the woman would think that she did not care about her.
9	and they don't see the world around them and probably that's because that's what they have experienced previously	These young women feel that nobody cares about them or recognises the world they live in probably due to previous experiences.	Hetty was concerned that as with other young women this woman would have experienced professionals as uncaring and not

			recognising her world.
	So for this girl you saw her a couple of times in clinic and then organised to see her at home so that you had more time to talk through things with her……(mmm, mmm) so and presumably that's what she wanted as well?…		
10	Oh god yeah, thing was umm you know she sort of let a few things slip I can't remember exactly what but so that was indicating it wasn't just kind of I know what's best for this girl, you know I don't work that way	Hetty organised a home visit for this woman because she 'let things slip' that made Hetty believe this was what the woman wanted as Hetty did not do things just because she thought they were best.	Hetty had organised the home visit because she believed this was what the woman wanted as Hetty did not provide care on the basis that she knew what was best.
11	you just get a sense of things and I've learnt to trust that so	Hetty had gained a sense of things and Hetty had learnt to trust this.	Hetty felt she gained a 'sense of things' and she had learnt to trust this.
12	one of the other things I was doing at the time was running a young mums group and so was also to approach and discuss with her about that and see if that was appropriate for her because	Hetty was running a young mums group at the time and so was able to use the visit to discuss this with the woman as well	Hetty discussed with the woman other resources to emotionally support her.
13	when we got talking she brought a young man that wasn't the father of the babe and you know um and sort of let slip issues about the partner	When Hetty met the woman she had brought along a young man that wasn't the father of the baby and the woman 'let slip' some issues about the partner.	The woman was attended by a man that was not the babies father and implied that she had some relationship problems with the father.
14	but I realise its none of my business anyway umm	Hetty felt this was none of her business	Hetty believed that the woman being supported by a man that was not the father was not something she should respond to.
15	it it from what she was saying she was quite isolated and	From discussion with the woman Hetty got	Hetty thought the woman was quite

	didn't have many friends and	the impression she was quite isolated and didn't have many friends.	isolated with few friends which impacted on her need for emotional support.
16	that's where the group came in and she started to come along to the group I think she found it quite rewarding	The woman started to go to the group which Hetty thought would be helpful and the woman did find it quite rewarding.	The woman accepted Hetty's guidance and attended the group which she found rewarding.
17	and er initially she I encouraged her and	Hetty needed to encourage her to attend initially	The woman needed encouragement to attend the group initially.
18	we er actually eventually developed quite a strong working relationship I suppose and umm	Hetty felt they eventually developed a strong working relationship	Hetty and the woman eventually developed a strong working relationship.
19	but eventually she did start going independently to the group because that was actually the idea of the group to actually get these girls to give information and get them to work together actually get a wider base so that that was most important	The woman did start attending the group independently. The expectation of the group was that the women would share information and work together.	The woman did eventually attend the group independently and gain support from it.
	It sounds like antenatal classes provide that as well		
20	Yes they do but not if you are 16 and shy and timid you know parentcraft works really well if you have got some….. some…… social skills and if you don't you feel isolated ……(cant hear)…..if they are better educated ……and what have you it can enhance their feelings of low self esteem	Parentcraft can offer support but not if the woman is 16 and shy and timid. Parent craft works well if the women have social skills if not they can feel isolated. For the woman that is less well educated it can reduce further their low self esteem.	Regular parentcraft classes were not appropriate for this woman due to her limited social skills and education as it could leave her feeling isolated and reduce her self-esteem. So to support this woman Hetty encouraged the group.
21	so you know they worry about asking silly questions whereas in the group they never worried about asking silly questions cause what are silly questions, if it needs to be asked who's to say it is silly.	In the group the woman did not worry about their questions being silly because it was accepted if the question needs to asked it is not silly.	The group Hetty encouraged the woman to attend to support her allowed her to feel comfortable with any questions she needed to ask.

	Ok thanks, can we go back to where you went to visit this girl at home could you talk me through what happened there?		
22	Yeah, um yeah she was scared obviously of the birth but she was scared of becoming like her mum umm her mum had been young as well she didn't feel that her mum brought her particularly well because she was quite young and didn't know what she was doing	The woman was scared of the birth but she was also scared of becoming like her own mother. She did not feel her mother had brought her up very well because she too was young and did not know what she was doing.	Hetty found that the woman was fearful of the birth but also due to family issues.
23	….. she left home when she was quite young because she wanted to get away from her mum so she had been in relationships very young and felt that nobody actually cared about her you know but	The woman had left home due to problems in her relationship with her mother, which had led her into other relationships at a young age. Due to this she felt no one cared about her.	Due to problems in her relationships the woman felt that no one cared for her.
24	…… not that she worried about her mum because her mum was getting on with her life	The woman was not worried about her mother because her mother was getting on with her life.	
25	This girl found that quite hard that nobody was interested in her	The woman found it difficult to cope with her belief that no one was interested in her.	Hetty recognised that the woman was struggling with the belief that no one was interested in her.
26	.. So we just talked about things talked about her relationship, what her expectations of pregnancy were, we probably did that not just at first	Hetty during her care talked with the woman about her concerns; her relationship and her expectations of pregnancy.	To help the woman address her concerns Hetty talked with her.
27	and that I actually continued to home visit her most of it was about lack transport and how difficult it was to get there um	Hetty continued to visit the woman at home because it was difficult for the woman to attend appointments.	Hetty supported the woman in practical ways including transport problems.
28	so yeah so the support was actually ongoing through the next pregnancy and now into	Hetty's support for the woman was ongoing with this pregnancy and	Hetty offered ongoing support to this woman due to number of

	her third one. I continued because she had a lot of issues	subsequent ones. This was due to the number of issues she had.	issues she had.
29	one of the things I did with her was cranialsacro therapy	Hetty used cranialsacro therapy to help the woman.	Hetty used complimentary therapies in her emotional support of the woman.
	Sorry I don't know what that is….		
30	Ok it's an old technique of being with someone	Hetty used an old technique of being with someone	Hetty used an old technique of being with someone
31	…(can't hear)… because it is stressful it helps and using breathing techniques um we also did that	Hetty used techniques such as breathing management, which helps with the stress.	Hetty used breathing techniques to help the woman mange her stress.
32	and I gave her a crystal which she held throughout regardless and because of the trust she has she used the stone throughout the birth oh	Hetty gave the woman crystal, which she used throughout the birth because the woman trusted this.	Hetty used unconventional techniques to emotionally support the woman.
33	and afterwards there certainly were a lot of issues, lack of friends and relationship problems um and um attitudes really	After the birth Hetty needed to continue to give the woman emotional support due to issues such as lack of friends, relationship problems and attitudes.	Hetty needed to give emotional support to the woman after the birth due to a number of social issues.
34	so I had to get other professionals involved too well it is not the case…	Hetty needed to involve other professionals as well.	Hetty needed to involve other professionals.
35	I don't get into judging people umm you know a lot of people were judging her	Hetty felt that a lot of people were judging this woman but did not feel she should do this.	Hetty did not feel she should judge the woman but she had to deal with other people's judgements of her.
36	a lot of people were meant to I suppose like how she was and how she was towards the child	Hetty realised that some people were meant to make judgements about the woman and how she cared for the child.	Hetty recognised that some people needed to make judgements about the woman.
37	the trouble is sometimes they will not communicate with some people so I ended up being on side with her which I wasn't entirely happy with	Due to communication problems Hetty found herself needing to take sides which she was not comfortable with.	Due to communication problems Hetty found herself needing to take sides which she

			was not comfortable with.
38	we ended up doing lots of visits with other agencies as well	Hetty had to do a lot of visits with other agencies due to the problems.	Hetty needed to do a lot of visits to the woman with other agencies.
39	and the up shot is her relationship with her child has improved so	The woman's relationship with her baby improved.	The woman's relationship with her baby improved.
40	once she realised this she actually changed and that child now is doing fine and no she's doing well	When the woman recognised the problems she changed and now mother and child are doing well.	When the woman recognised the problems she changed and now mother and child are doing well.
	I think for me what is interesting is how you developed that relationship because you say you sensed there was something not quite right early on then you did these home visits where you got he to start talking to you how did that happen, how did you create that?		
41	I created it by listening, its their bodies, its their baby, its their world	Hetty felt that she created her relationship with this woman by listening. She believes it is the woman's body, her baby, her world so she needed to listen.	Hetty felt that she created her relationship with this woman by listening. She believes it is the woman's body, her baby, her world so she needed to listen.
42	And that doesn't mean I won't ask them straight questions because sometimes they go round in circles well you know sometimes a little throw in things and it will expand things	Hetty does ask straight questions to avoid the conversation going round in circles and to expand it.	Hetty does ask straight questions to avoid the conversation going round in circles and to expand it.
43	but its being able to sense that and the only way you are going to sense it is by listening first and that's what I do	Hetty listens first so that she can sense what is happening.	Hetty listens first so that she can sense what is happening.
44	and I don't put a time limit on that and they know I don't put a time limit on it	Hetty does not put a time limit on her interactions with	Hetty did not put a time limit on her interactions.

		woman	
45	sometimes I may be late but that is part of the package and because I don't put a time limit on it they get to do that and after a while get to work within it. It means that they don't have to rush, they don't have to try and gather as many things as possible to stop	As Hetty does not put a time limit on her interactions with woman it means that she is some times late. That is the package of care Hetty gives; the woman have a much time as they need they do not need to rush but she may be late for her appointment with them.	Hetty allowed the woman as much time as she needed but sometimes she was late for her appointments. This was the package of care she offered.
	And is that what you did with this girl, is that you offered her time (yes), you used your sense of what was happening (yes) and listened to what she was saying (mmm) but occasionally gave some information as well to help guide her thoughts?		
46	Sometimes yeah, yeah, because we can just keep saying the same thing and stop there so that's one of the things I work that is about avoiding stoppers about ok if you are caught with that have a look at it why are you stuck there?	Sometimes the conversation becomes stuck and stopped at one point. Hetty gets the woman to think about why she is getting stuck.	Sometimes the conversation becomes stuck and stopped at one point. Hetty gets the woman to think about why she is getting stuck.
47	And you know what is it about that often when they start looking at it from different angles where its increasing and what the issue is from and it is often not the issue they think it is and once they see that then wooo they are on a roll so	Hetty gets the women to start looking at their issues from a different angle and they find it is not the issue that they thought it was. Once this occurs they can move on.	Hetty facilitates the woman to consider her situation from different perspectives to allow things to move forward.
48	..um.. its just something that comes in….I don't….. I don't go in with that cause if you go in with it colours the way like a construct player you don't look for other explanations so it is just trusting when you start into a relationship	Hetty does not enter the relationship expecting to have to find another explanation for an issue. Initially a relationship is about trust.	Hetty starts her relationships with trust and no other expectations.
49	with anybody it is trusting	A relationship is	For Hetty the

	they will be there umm	trusting the person will be there	relationship is based on trusting she will be there.
50	and I always trust what my gut is saying that's what it is about and you know	Hetty trusts her gut instinct on what is needed.	Hetty trusts her gut instinct on what is needed.
51	I suppose it is part of a spacious relationship and you know they know they have access if they have a problem with my young mums group they knew they could get help	Hetty's relationship with the woman was spacious and as part of this she ensured if the woman had problems she knew how to contact her.	Hetty's relationship was spacious and she ensured she was accessable.
52	and they didn't ever abuse that they knew they could contact me and I so have that and I knew that could help	Hetty's knew that being contactable was helpful and the woman did not abuse this.	Hetty's knew that being contactable was helpful and the woman did not abuse this.
53	You know if they have parents or something that is fine but some don't have that so it is nice its wonderful its about, its spacious	If the women have parents or other support that is fine but with the women that do not have this it is nice to have a spacious relationship.	This woman did not have parent or other support so it was important to have this spacious relationship with her.
54	And I know that isn't what's perceived of us	Hetty did not think her relationship with the woman is what is expected of her.	Hetty did not think her relationship with the woman is what is expected of her.
	I think there is some realisation of blurred boundaries here…		
55	Yes there once again when you start putting boundaries and restrictions in you create problems… yet you know you work within a structure that is set up but you have to	Hetty felt that boundaries restrict midwifery despite recognising the need to work within a structure.	Hetty felt that boundaries restrict midwifery despite recognising the need to work within a structure.

Appendix B

Consent form that has not been completed

Midwife:

Consent Form

TITLE of PROJECT:

How do midwives emotionally support women becoming mothers?

NAME OF RESEARCHER:

Sue Barker

		Please initial box
1.	I confirm that I have read and understood the information sheet (version 27/11) 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.	
4.	I agree to take part in the above study and accept that the interview will be tape recorded.	

Name of Midwife Date Signature

Pre interview

Name of Midwife Date Signature

Post interview

Researcher Date Signature

Researcher and Midwife to have a copy

Appendix C

Information sheet

The names have been removed from this information sheet so that the Trust cannot be identified.

My name is Sue Barker and I am a Senior Lecturer and Research Student at Bournemouth University. I would like to invite you to take part in this research study. This study is being conducted by me in order to gain a PhD. The following information is provided to help you to decide whether you wish to take part in the study. Please consider the information carefully, and you are welcome to discuss this information with colleagues and friends to enable you to make your decision.

Thank you for your time.

Study Title

How do midwives emotionally support women becoming mothers?

What is the purpose of the study?

The aim of this study is to explore midwives' perception of how they facilitate emotional well-being in women becoming mothers. There is minimal literature available on the emotional work of midwives, despite the high level of emotional work undertaken by them. The likelihood is that, with government influenced changes in midwifery together with the significant impact the midwife's relationship has on the mother, this emotional work will increase.

Why have I been chosen?

I am inviting you to take part as you have ongoing relationships with women at this pertinent time and I am hoping to interview 8 to 12 community midwives with at least two years experience as a midwife.

Do I have to take part?
Participation is completely voluntary, there will be no negative consequences of not participating. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form of which you will also receive a copy. You will be able to withdraw from the study at any time without giving a reason.

What will happen if I do take part?
I would like to interview you to gain your descriptions of your experiences and I will need to audio-tape the interview. I will then type up the interview and you will be given a copy if you wish. In terms of confidentiality, my Supervisors and I will read these transcripts, but only I will know whose transcripts we are reading.

What do I have to do?
You will be asked to sign a consent form, as the interview cannot be conducted without you signature. You will need to speak clearly into the microphone so that the speech can be transcribed. It is important that when you are describing your experiences that you do not identify the women in your descriptions. You can use pseudonyms or personal pronouns. After the interview your consent will be sought again, to ensure that you have fully agreed for me to retain the descriptions you have shared.

What are the disadvantages of taking part?
The interview will take some time out of your busy schedule.

What are the possible benefits of taking part?
Your experiences may provide understanding and influence policy and education for the future.

Will my taking part in this be kept confidential?
All information that is collected during the course of this study will be kept strictly confidential. Quotes from interviews may be used to illustrate the study

findings, but any information about you will be anonymised, so that you cannot be identified.

The study has been approved by The Dorset Research Ethics Committee.

What will happen to the results of the research study?

The work will be taken into consideration and fed into further midwifery education and support. I also hope to publish some journal papers about the work. A summary of the results will be made available to those taking part.

Who is organising the research?

I am organising the research with the support of my supervisory team: Clinical Psychologist, Reader in Midwifery, Reader in Social Work and research advisor/midwife.

Who has reviewed the study?

IHCS (Bournemouth University) research Committee, Dorset Local Research ethics committee, obstetric lead and Community Midwifery Manager.

Contact for further information

If you would like more information or like to volunteer you can contact me at Bournemouth University;

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Christchurch Road
Bournemouth
BH1 3LG

Telephone: 01202 504251
e-mail: barkers@bournemouth.ac.uk

Thank you for considering taking part in this study.