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Over-the-counter pain medication in pregnancy

Key words: Pain medication, over-the-counter purchase, safety and effectiveness, survey data, evidence-based midwifery

In this edition of *EBM*, we discuss data from a national survey about low back and pelvic pain in pregnancy, which states that 70% of a convenience sample of UK women suffer from this under-estimated and under-reported condition (Sinclair et al, 2014). This high percentage was previously cited in a Cochrane systematic review by Pennick and Liddle (2013) who reported that 66% of pregnant women suffered from low back pain. The women's descriptions of the pain experienced are most harrowing and they challenge us to develop evidence-informed guidelines and effective management strategies.

In the UK, we look to NICE for guidance on how to manage this problem, but there are no specific guidelines. A guideline for pain in labour (NICE, 2007) comes up when you use the search facility on the NICE homepage, but this is currently under review and will be published in December 2014. Advice and guidance for pregnant women about medication is particularly complex, as the conduct of gold standard randomised controlled trial research for efficacy and effectiveness on pregnant women is taboo.

We need to look at our target population – the current 'Z' generation that is largely intolerant of pain and struggles to cope with it, and has grown up in a culture of 'pill for every ill'. This belief system is fuelled by the widespread availability of over-the-counter (OTC) medications, where tablets are purchased like they are sweets. Medications routinely purchased at garages, street corner shops, newsagents, supermarkets and pharmacies include paracetamol, ibuprofen and aspirin. However, when a woman becomes pregnant, decisions about which of these common medications are safest to use in pregnancy becomes a key question. 'Read the packet,' you would wisely advise and this is exactly what I did in my local supermarket.

I picked up paracetamol (500mg) and was surprised to note absolutely nothing written on the packet related to safety or dosage in pregnancy. This may change in the future, as recent evidence is casting a shadow over the safety of the medication with Liew et al (2014) and Eyers et al (2011) reporting links with paracetamol usage during pregnancy and the development of behavioural disorders in children. The next pain medication selected was aspirin (75mg) and there was a clear statement: 'Medicines should not be taken in pregnancy and when breastfeeding without consulting a doctor.' However, it did not say anything about taking aspirin. I picked up ibuprofen (200mg) and here under WARNING was a clear statement: 'If you are pregnant do not take this product and ask your doctor for advice.' The NHS Choices website has a clear statement: 'The use of ibuprofen in pregnant women, weeks one to 13, increases the risk of miscarriage and the baby could develop a heart defect or other abnormalities, such as defects in their abdominal wall (gastroschisis) or a cleft palate. After 28 weeks, there is a risk of heart problems in the baby, high blood pressure in the baby's lungs, delay in labour and reduced amniotic fluid levels' (NHS Choices, 2014). This advice is taken directly from the Medicines and Healthcare products Regulatory Agency website.

What I had thought to be safe yesterday seems less so today. This does not mean that pregnant women should stop taking prescribed medication or expect to suffer unnecessary pain by refusing all pain medication. Indeed not. If this was so, the chances of raised blood pressure due to pain would increase, leading to the potential for additional harm – higher than the risk of taking two paracetamol? What we have to learn to do is weigh up the individual situation, use the best evidence available, and ensure we have national guidelines and local protocols. Then we should consult with medical colleagues and, most important of all, be confident that it is part of our role to discuss medication usage openly with women. This includes prescribed and OTC medication. From a research perspective, epidemiological studies, such as those conducted by the EUROmediCAT team (euromedicat.eu), are extremely valuable, but it is important to note they are focused on exploring medication outcomes for mothers who have chronic conditions, such as epilepsy, diabetes, asthma and depression. Other key databases for midwives to know about include: Safefetus (safefetus.com), NHS Choices (nhs.uk/conditions/pregnancy-and-baby), FDA for women (www.fda.gov/forconsumers/byaudience/forwomen) and the Organization of Teratology Specialists (mothertobaby.org) and UKTIS (medicinesinpregnancy.org).

Signposting women and professional colleagues to access valid and reliable information about medication usage in pregnancy is our shared responsibility.

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How do women manage pregnancy-related low back and/or pelvic pain? Descriptive findings from an online survey

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Abstract

Background. Low back pain is typically experienced by over 60% of pregnant women and pelvic pain by almost 20% (Pennick and Liddle, 2013). The treatment offered for this condition is mostly physiotherapy, however this is not always effective, or evaluated positively by women. Midwives accept that low back pain and/or pelvic pain (LBPP) is common during pregnancy and that treatment is conservative, often including paracetamol, alongside a variety of physiotherapeutic interventions. However, there is growing concern over the use of medication by pregnant women with LBPP. Therefore, an online survey was undertaken to explore women's experiences of LBPP, treatments used and their perceived satisfaction and effectiveness.

Aim. To determine the treatments women use to manage LBPP in pregnancy, how helpful they find these treatments and how satisfied they are with them.

Method. An online UK survey was designed to investigate the incidence of LBPP among women who have recently given birth within the UK. The survey was developed and distributed using Qualtrics online software and contained 92 items piloted with 10 women who had given birth within the previous two years. The Doctoral Midwifery Research Society website hosted the survey and the popular mother and baby websites Netmums and Bounty advertised the study. Ethical and research governance approval was granted by the University of Ulster. The survey collected data on demographics, birth outcomes, body mass index (BMI), pain, treatments for LBPP in pregnancy, and physical activity levels. Women were eligible to complete the survey if they had given birth in the last two years, could understand and read English and were willing to take part.

Findings. A total of 331 women accessed the survey, 140 were currently pregnant and screened out. The remaining 191 were eligible and 176 questionnaires were fully completed. The mean age was 30.46 (SD 7.60) and 95% of women were white. The sample response was heavily weighted towards England (75%), with smaller proportions of respondents from Scotland (11%), Northern Ireland (8%) and Wales (6%). The average BMI of survey respondents before their most recent pregnancy was 26.

Most women reported being physically active on two days each week, with walking the most popular activity (81%). Mean low back pain intensity was 6.43 on a 0 to 10 sliding scale, mean frequency of low back pain was 7.16, mean pelvic pain was 7.62, and mean pelvic pain frequency was 8. Most women gave birth vaginally (66%), followed by emergency CS (12%), planned CS (8%), forceps (8%), and vacuum (6.29%). Most women (78%) gave birth at 36 to 42 weeks' gestation. A large number of women (110/157) had suffered LBPP before their pregnancy, with many using over-the-counter painkillers. Painkillers were used by 96 women to manage LBPP, and the most frequently used was paracetamol, followed by codeine/co-codamol and non-steroidal anti-inflammatory drugs (NSAID). In total, 46% of women received treatment other than painkillers for LBPP in pregnancy. Qualitative data has revealed a disturbing picture of women's pain and its impact on the quality of daily life.

Implications. Recommendations include the development of evidence-informed guidelines for practitioners and raising awareness of medication safety with mothers.

Key words: Low back pain in pregnancy, pelvic pain in pregnancy, medication in pregnancy, analgesia usage, online survey, evidence-based midwifery

Introduction

Low back pain and/or pelvic pain (LBPP) has been reported as a global phenomenon (Skaggs et al, 2007). It is one of the most frequently reported pregnancy complaints by women in the third trimester (Katonis et al, 2011; Zib et al, 1999) with an estimated time of occurrence between 18 and 25 weeks' gestation. Treatment is complex, as there is a lack of data on the safety of medication usage in pregnancy due to the fact that being pregnant is an exclusion criterion for participation in drug trials. This often leads to inadequate pain management, evidenced in a recent study by Pierce et al (2012), which reported only 25% of women reporting LBPP actually received treatment.

The disability and distress caused by LBPP in pregnancy is increasingly being recognised as an issue that needs to be addressed. This is mainly due to the reporting of research

that demonstrates the impact on daily living for women; reports indicate disability at home and in the workplace, insomnia and increased risk of developing depression (van de Pol et al, 2007; Mens et al, 1996; Fast et al, 1987).

Recent evidence from a Cochrane systematic review reports that more than two-thirds of pregnant women experience low back pain during pregnancy (66%) and almost 20% experience pelvic pain (Pennick and Liddle, 2013). However, despite the frequent occurrence of LBPP during pregnancy and the significant impact it can have on pregnant women's everyday life, at present there are no specific clinical guidelines available on how to manage this condition in the pregnant population. The absence of a clinical guideline has led to the use of a wide range of management strategies, some of which may pose a health risk to the mother and baby or fetus.

Management strategies for LBPP during pregnancy

Women with LBPP seek a range of interventions, including professional, self and complementary treatment in order to manage their symptoms. An Australian study by Stapleton et al (2002) reported that medications, physiotherapy and chiropractic care were among the most frequently used treatments to manage low back pain in pregnancy.

Medications

There is limited literature on the use of medications for LBPP during pregnancy (Vermani et al, 2009), however, there is no robust evidence to state that it is 100% safe. Recent research suggests that there may be links with paracetamol usage during pregnancy and the development of behavioural disorders, such as attention deficit hyperactivity disorder (ADHD), hyper kinetic disorder (HKD) and asthma in children (Liew et al, 2014; Eyers et al, 2011). Qualitative research data has reported cases where paracetamol has not been particularly effective for LBPP in pregnancy (Vermani et al, 2009; Wellock and Crichton, 2007).

Opiate-based drugs, such as codeine, morphine and tramadol, are category 'C' drugs, according, to the Food and Drugs Administration (FDA) classification of pregnancy risk (FDA, 2004; 2002). Category 'C' incorporates drugs which have demonstrated a risk to fetal health in animal studies. However, despite the risk that using opiate-based drugs may pose on fetal wellbeing, the use of such drugs may be appropriate and necessary to manage severe pain during pregnancy (FDA, 1999).

A study by Bateman et al (2014) highlighted the frequent use of opiate-based drugs in pregnant women with back pain. This study reported 37% of women who were prescribed these during pregnancy had back pain and 61% of those women had taken the medication on three or more occasions. There is concern that the continuous use of opiate-based drugs, such as codeine, during pregnancy can lead to tolerance and dependence in the mother, which, in turn, can lead to neonatal withdrawal syndrome (Kennedy, 2011). The use of opiates in midwifery for pain relief is not common practice. However, there is published epidemiological research on the effect of opiates for pain medication by Broussard et al (2011). Their research reported 2.6% of 17,449 case mothers and 2.0% of 6701 control mothers used opiates between one month before pregnancy and the first trimester. Data analysis revealed that use significantly increased the risk of birth defects, such as spina bifida and gastroschisis.

Non-steroidal anti-inflammatory drugs (NSAIDs) are used to treat mild to moderate pain or fever (Kennedy, 2011). The NHS Choices (2014) website has a distinct message about the use of ibuprofen medication: 'The Medicines and Healthcare products Regulatory Agency (MHRA) advises that all NSAIDs should not be used by pregnant women in the first two trimesters of pregnancy unless the potential benefit to the patient outweighs the potential risk to the fetus, and NSAIDs should not be used at all during the third trimester unless on the advice of a doctor.'

In addition, it includes a clear statement indicating that the use of ibuprofen in pregnant women, weeks one to 13, increases the risk of miscarriage and the baby could develop a heart defect or other abnormalities, such as defects in their abdominal wall (gastroschisis) or a cleft palate. There is a clear warning about the potential harm associated with taking ibuprofen after 28 weeks' gestation and the risk of 'heart problems in the baby and high blood pressure in the baby's lungs, delay in labour and reduced amniotic fluid levels' and women are advised only to take the medication on a doctor's advice. More recently, Yates and Simon (2012) have indicated that use of NSAIDs after 30 weeks may increase the risk of premature closure of the ductus arterious and oligohydramnios.

Physiotherapy

Physiotherapy is the global standard treatment provided to women with LBPP in pregnancy and this may be due to its conservative and non-pharmacological nature. Physiotherapy for pregnancy-related LBPP often involves using a combination of home exercises, water-based exercise, use of a pillow, use of a support belt and encouraging women to keep physically active through walking or other gentle aerobic exercise (Stuge et al, 2003). In serious cases, where mobility is severely affected, physiotherapists may prescribe the use of walking aids or wheelchairs.

At present the evidence for the effectiveness of physiotherapy for pregnancy LBPP is conflicting. A systematic review by Stuge et al (2003) reported that there was no evidence of effectiveness for physiotherapy for managing LBPP. A systematic review by Richards et al (2012) reported that the evidence to support the use of physiotherapy was limited and this was supported in the Cochrane review by Pennick and Liddle (2013).

More recently, van Benten et al (2014) conducted a systematic review into the effectiveness of physiotherapy for LBPP in pregnancy and concluded that there was moderate quality evidence from nine trials to support the effectiveness of different forms of exercise for managing the condition. However, this review did not focus on interventions specifically delivered by physiotherapists, but rather interventions that

may form part of physiotherapy treatment. Some of these interventions, such as complementary and alternative medicines (CAM), were delivered by other professionals.

Complementary and alternative medicine

CAM – which includes treatments such as reflexology, osteopathy, chiropractic care and acupuncture – has been used as a management strategy for LBPP. Research indicates that 25% to 30% of women use CAM to manage the condition, despite robust evidence of the effectiveness of CAM therapies for this pain (Sinclair et al, 2014; Wang et al, 2005). Furthermore, pregnant women have been shown to be very willing to use CAM for low back pain during pregnancy, with almost 62% of women in a survey by Wang et al (2005) reporting that they would be willing to try CAM for this pain. A recent systematic review by Close et al (2014), specifically focused on the effectiveness of CAM in the management of LBPP, has reported that there is evidence of the effectiveness of certain CAM therapies.

Most of the randomised controlled trials (RCTs) within this review focused on acupuncture, although there was one supporting the use of osteopathic treatment for LBPP in pregnancy and one RCT supporting the effectiveness of chiropractic treatment. However, Close et al (2014) highlighted that the quality of the evidence for CAM in the management of LBPP was very low and there was insufficient evidence for the development of evidence-informed guidelines for practitioners.

The evidence base for acupuncture is undoubtedly the largest. However, evidence of the effectiveness of other therapies, such as chiropractic treatment, is growing. A recent cohort study on the effectiveness of chiropractic treatment for LBPP in pregnancy by a Swiss team (Peterson et al, 2014) provided evidence of the effect of treatment on a sample of 115 women. Improvement at one week was reported for 52%; one month by 70%; three months by 85%; and 90% at six months. They followed up with the women one year after the birth and reported 88% retention of the effect (significant reductions in numerical rating scale for pain and Oswestry scores ($p<0.0005$)).

Pennick and Liddle (2013) investigated the effectiveness of all interventions for the prevention and management of LBPP and reported similar conclusions to Close et al (2014) in relation to the effectiveness of CAM therapies for managing LBPP during pregnancy. Both reviews found supporting evidence of effectiveness for a small number of CAM therapies for LBPP in pregnancy. It is important to note that CAM has been reported to be helpful for back pain in the general population (Eghbali et al, 2012; Quinn et al, 2008) and a reported strength of CAM therapies is their holistic approach to care that includes attention to the physiological, psychological and emotional wellbeing.

Within the UK, there continues to be a lack of clarity about which treatments women are actually using to manage LBPP and how they rate these treatments in terms of helpfulness and satisfaction. Therefore, we decided to undertake an online survey to explore these issues in more depth.

Aim

The aim of this study was to determine the treatments women use to manage LBPP in pregnancy, to investigate how useful women find the treatments and how satisfied they are with them.

Methods

An online survey was designed to investigate the incidence of LBPP among women who had recently given birth within the UK. It was called 'The Healthy Back in Pregnancy Project' and was designed by a small group of multiprofessional researchers from the University of Ulster, Northern Ireland, who have a special interest in effective and evidence-informed management of LBPP in pregnancy. The instrument included a total of 92 items and incorporated validated items to assess disability, pain management and exercise. The combined instrument was generated using Qualtrics software and piloted with 10 women. The Doctoral Midwifery Research Society (DMRS) website hosted the survey and the mother and baby website Netmums and Bounty were asked to support the survey by placing an information tab and a link to the DMRS website where women could complete the questionnaire. Ethical and research governance approval was granted by the University of Ulster.

The survey also collected data on demographics, birth outcomes, body mass index (BMI), pain, treatments for LBPP in pregnancy, and physical activity levels. Women were eligible to complete the survey if they had given birth in the last two years, could understand and read English and were willing to take part.

Descriptive findings

A total of 331 women accessed the survey, 140 were pregnant and screened out. The remaining 191 were eligible and 176 questionnaires were fully completed. The mean age was 30.46 (SD 7.60) and 95% of women were white. The sample response was heavily weighted towards England (75%), with smaller proportions of respondents from Scotland (11%), Northern Ireland (8%) and Wales (6%). The average BMI of survey respondents before their most recent pregnancy was 26. Most women reported being active on two days each week and walking was the most popular activity (81%).

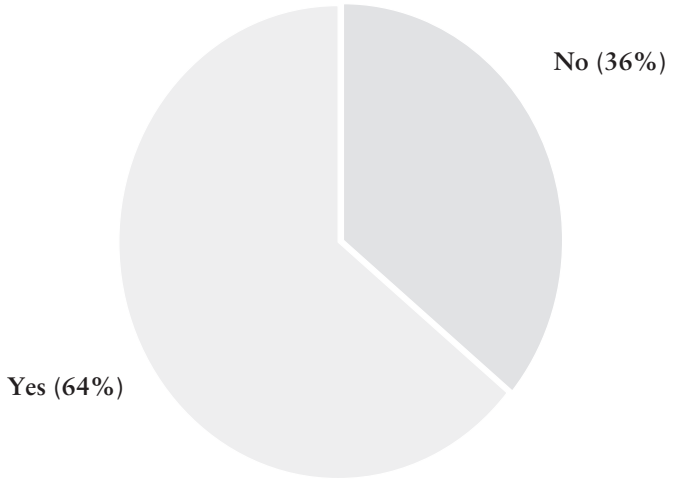
Of those women who reported having experienced LBPP (n=157), 70% (110/157) had experienced it prior to becoming pregnant. Mean low back pain intensity reached 6.43 on a 0 to 10 sliding scale, mean frequency of low back pain reached 7.16, mean pelvic pain reached 7.62, and mean pelvic pain frequency reached 8 (pain was measured using the visual analogue scale for pain with 0 meaning 'no pain' and 10 meaning 'the worst pain possible').

Most women gave birth vaginally (66%), followed by emergency CS (12%), planned CS (8%), forceps (8%), and vacuum (6.29%). Most women (78%) gave birth at 36 to 42 weeks' gestation.

Treatments used for LBPP in pregnancy

Of those women who sought treatment for their LBPP symptoms, most (64%) took painkillers (see Figure 1).

Figure 1. Pain medication taken for LBPP in pregnancy



These were mainly prescribed by the GP (40%), self-prescribed or purchased over the counter (OTC) (39%) (see Table 1). Paracetamol was the most popular painkiller used by women, followed by codeine/co-codamol and then NSAIDs). Physiotherapy (n=58) and GP care (n=31) were the most popular treatments received. Women also reported using CAM therapies. Osteopathy, reflexology and chiropractic treatment were the CAM therapies used most frequently (see Table 2).

Satisfaction and helpfulness of treatments for managing LBPP in pregnancy

In total, 36 responded to an open-ended question at the end of the survey asking if there was any further information they would like to share. Many of these responses focused on the standard care treatment women received for managing LBPP in pregnancy and four themes have been identified.

Normal for them but not for me

Many women commented in depth about the way in which back pain was considered 'normal' by staff but their experience was not normal:

"Didn't think back pain was taken seriously I was just another mum-to-be with a bit of back ache – it was agony some days" (number 94).

"I complained a number of times about back pain in pregnancy and was told it is normal and was not offered any advice on how to cope with it" (number 112).

"This was never taken seriously by my midwife or doctor and I was told that I would have to live with it because it was all part of a normal pregnancy" (number 21).

Pain worsened with treatment

Women described their disappointment with a range of treatments provided by the hospital and their detrimental effect on their pain:

"I have had symphysis pubis dysfunction/pelvic girdle pain (SPD/PGP) for four years now and feel the treatment that the NHS offered is abysmal" (number 21).

"Having physio caused me more pain during pregnancy than I was already experiencing" (number 32).

"Belt provided by physio caused increased pelvic pain" (number 10).

Pain is crippling

Women described their LBPP as being something that has everyday impact and stops them from moving:

"My pelvic pain was excruciating in the third trimester" (number 21).

"I was in so much agony while pregnant – it has put me off having more children" (number 15).

"I suffered from horrible SPD which left me on crutches and housebound for the last 10 weeks" (number 11).

Midwife support was invisible

Women expressed their disappointment and, more importantly, their acceptance of the lack of midwife support:

"Lack of help from the midwife is an inevitable part of pregnancy" (number 17).

"… generally lack of help or support from NHS staff" (number 44).

"I found the lack of information and support very bad... I had never heard of this before [SPD] and was left to do my own research" (number 11).

Discussion

This descriptive account of the survey findings highlighted many issues but it is important to focus on those that are most prominent and of most concern. The use of

Table 1. Prescribed and non-prescribed medication used for LBPP in pregnancy

	Answer	Response	%
1	Yes, by my general practitioner (GP)	37	40%
2	No, I decided to take it myself	36	39%
3	Yes, by my gynaecologist or specialist	11	12%
4	Yes, by another healthcare professional (please specify)	5	5%
5	Other* (please specify)	4	4%
	Total	93	100%

Yes, by another health professional (please specify)	Other* (please specify)
Midwife	Told by a midwife I could take them
Physio	Not prescribed but recommended by consultant and physiotherapist
Pharmacist	I took them on advice of my GP and midwife
Midwife	The codeine and paracetamol were, but not the ibuprofen lysine

painkillers for managing LBPP in pregnancy is increasing and the data from this survey demonstrates that women are self-medicating by buying OTC painkillers (see Table 1). Henry and Crowther (2000) reported that 50% of women use painkillers during pregnancy. However, in this survey of women with LBPP, the use of painkillers was substantially higher (64%). This requires further exploration and research as no medication is considered 100% safe and women are encouraged to avoid medication use during pregnancy (NHS Choices, 2013).

The type of medications used by some women was also an issue, as codeine-based drugs were used by many women – such drugs carry the risk of neonatal withdrawal symptoms and women are more at risk of building up a tolerance and dependence to opiate-based drugs with frequent use (Kennedy, 2011). Research has also shown that this type of drug may increase the risk of birth defects (Broussard et al, 2011). In addition, the side effects of codeine-based drugs, such as constipation, could increase the need for further medication to be taken. The high usage of paracetamol is also concerning, especially in light of the emerging data linking the drug to ADHD, HKD and asthma (Liew et al, 2014; Eyers et al, 2011).

Self-medication and OTC purchasing of medications by pregnant women with LBPP was evident in this study and this is another required area for investigation with the possibility of securing national guidelines for providers and prescribers. This result has previously been reported and research has demonstrated that some pregnant women with LBPP may take more than the recommended dosage of pain medications (Wellock and Crichton, 2007). The findings from this survey are sufficiently convincing to demonstrate the need for much more focused attention and collaborative planning to tackle this issue at the micro, mesa and macro levels.

In those women who report using medications for LBPP during pregnancy, health professionals need to give clear advice on safety and, where possible, offer or suggest an evidence-based non-pharmacological method for managing LBPP. For women who are prescribed medications, full records need to be kept and reviewed on a regular basis at each antenatal appointment.

This survey provided evidence about the frequency of use of physiotherapy and women's perceptions of its usefulness. We know from previous literature that physiotherapy is the most popular form of treatment for LBPP (Stapleton et al, 2002) and, as there is no medication, it is deemed to be 'safe'. Many women (n=25/58) found physiotherapy either useful or very useful for managing their LBPP, however, 10 women did indicate that it was useless (see Table 2).

Physiotherapy may work best as part of a multimodal intervention or a menu of choices that include relaxation therapy, pilates, yoga, exercise in water, CAM and online support. Such multimodal interventions are advocated for treating low back pain in the general population, due to their improved outcomes and an emerging body of evidence suggests that such approaches to LBPP in the pregnant population may yield better results than interventions which focus solely on the physical elements of pain (George et al, 2013; NICE, 2009). Some women sought CAM therapies for their LBPP and found this very helpful, in comparison with those who found physiotherapy to be 'useless'.

While it was evident that women were more dissatisfied with physiotherapy in comparison, it is important to take into account the fact that physiotherapy has been around for many years and women simply may not have the same enthusiasm for this treatment, not to mention the fact that physiotherapy requires the woman to actually self-manage her LBPP in terms of keeping active and doing home exercises. Some women may like a more passive role, such as using CAM, where the pain is treated by the therapist with the woman needing to take little responsibility.

The fact that CAM, when

Table 2. Women's perceptions of the treatments received for LBPP

	Question	Very useful	Useful	Neither	Not that useful	Useless	Total responses	Mean
1	General practitioner	3	13	6	6	3	31	2.77
2	Gynaecologist	1	4	1	1	0	7	2.29
3	Back pain specialist	0	1	1	3	0	7	2.29
4	Physiotherapist	11	14	6	17	10	58	3.02
5	Chiropractor	2	0	0	0	0	2	1.00
6	Homeopath	0	0	0	0	0	0	0.00
7	Reflexologist	1	2	0	0	0	3	1.67
8	Acupuncturist	2	1	0	0	0	3	1.33
9	Aromatherapist	0	0	0	0	0	0	0.00
10	Osteopath	2	3	0	0	0	5	1.60
11	Herbal medicine practitioner	0	0	0	0	0	0	0.00
12	Other, please specify	0	2	0	1	0	3	2.67

used, was deemed to be useful for LBPP, is a key finding, particularly as women most likely funded these treatments themselves, indicating a willingness to pay for pain relief and their pressing need to access treatment which would alleviate their pain. Only 10% of CAM therapies are provided on the NHS (Thomas et al, 2001). The expectation was that women would have been more critical of CAM and its value for money was not realised. CAM is commonly dismissed by healthcare professionals due to a presumed lack of scientific evidence and thus, effectiveness. However, reduction in known stress parameters in response to reflexology, highlighted by McCullough et al (2014), demonstrates that such treatments may have more to offer patients biochemically and psychologically.

The precise reasons for the reported helpfulness and satisfaction with CAM for LBPP during pregnancy were not explored within this survey, but evidence would suggest that pregnant women find the non-pharmacological and holistic nature of CAM appealing (Warriner et al, 2014; Hastings-Tolsma and Vincent, 2013).

The open-ended question towards the end of the survey provided women with an opportunity to provide additional comments. Many of the responses to this question highlight women's general dissatisfaction around the standard of care received and advice provided by NHS staff, including midwives, for management of LBPP and has previously been reported by Pierce et al (2012). There may be many reasons as to why health professionals may not offer advice or treatment for LBPP during pregnancy. Studies have shown that some doubt the presence of it in pregnancy, that they frequently only have self-acquired knowledge of LBPP in pregnancy and they often lack knowledge of available treatments (Pierce et al, 2012; Candelier et al, 2011; Mogren et al, 2010).

The literature, combined with the data from this survey, points to a need for further training to improve the standard and quality of care currently provided to women experiencing this common and often debilitating problem.

There is a need to conduct further research into the best way physiotherapy can be delivered at a clinical level. While there is evidence from RCTs supporting the effectiveness of components of physiotherapy, such as different forms of exercise, it would be worthwhile exploring if such interventions are available to pregnant women from physiotherapists and how these interventions are being provided. Furthermore, some women may suffer more pain following the use of interventions which form part of physiotherapy treatment for LBPP in pregnancy, such as support garments, and this has the potential to increase their use of stronger analgesia with higher risk of harm.

Limitations

It is known from recent evidence reported by Hall and Jolly (2014) and Warriner et al (2014) that many women fail to tell their health professionals about their pain and the authors acknowledge this to be a key question for any future research into back pain in pregnancy.

Conclusion

Women with LBPP during pregnancy need to be listened to and supported appropriately to manage their back pain. Their treatment plan needs to be holistic and woman-centred and women need evidence-based information about medication use in pregnancy to enable them to make choices.

A full history of the pain experienced, including symptoms, such as incontinence, the treatments used, daily impact and the social support provided, as well as the psychological wellbeing of the woman, need to be documented. It is essential to ensure that a full examination by a physiotherapist is undertaken to rule out any pathology when any woman complains of severe LBPP. We need guidelines with appropriate evidence to inform safe and effective management of this under-researched and under-estimated problem. Health professionals are currently in a vulnerable position having limited ability to confidently provide evidence-informed care pathways for women suffering from LBPP.

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'I was meant to be able to do this': a phenomenological study of women's experiences of breastfeeding

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Abstract

Introduction. There is strong evidence demonstrating that human breastmilk provides complete nutrition for human infants. While the rate of initiation of breastfeeding in the UK has increased steadily over the last 25 years, rates of exclusive breastfeeding in the early weeks and months over the same time period have shown only marginal increases.

Method. An interpretive phenomenological approach informed by the philosophy of Martin Heidegger was adopted. The aim was to understand women's experience of breastfeeding. Women were recruited from one city in the East Midlands in the UK, where the prevalence of breastfeeding is decreasing. Potential participants were recruited via health visitors at the primary birth visit. Ethical approval was received from the university and NHS research ethics committees. Data were collected between three and six months after the birth of their youngest child and analysis was guided by interpretive phenomenological principles.

Findings. The women were found to be ill-prepared for the realities of breastfeeding and, for most women, the shock of this experience was overwhelming. In particular there was a lack of understanding and preparation for common problems and a lack of awareness of newborn behaviour. Misunderstandings of newborn behaviour resulted in the women blaming infant-feeding behaviours, such as crying, wakeful states and cluster feeding, on the specific method of infant-feeding. Frequent feeding cues were overwhelming and the women felt overawed by the sense of responsibility. It also led them to question their ability to provide an adequate milk supply.

Discussion. The extent to which inadequate preparation for breastfeeding had a negative impact on the breastfeeding experiences of women in this study was a surprise. Antenatal education should focus more on preparing women for the realities. Education and support for breastfeeding women need to encompass infant-feeding cues and infant behaviours.

Key words: Breastfeeding, infant-feeding, experiences, expectations, qualitative methods, interviews, evidence-based midwifery

Introduction

Research has emphasised the biological nature of infant-feeding and motherhood, and a body of knowledge has developed promoting breastfeeding globally as the optimum method of infant-feeding (Kramer and Kakuma, 2012; WHO, 2011; 2002). Breastfeeding has been suggested to represent both a medical gold standard for infant-feeding and a moral gold standard for mothering (Knaak, 2005). Numerous international, national and local public health policies cite recommendations to increase breastfeeding prevalence. NICE (2006) postnatal care guidance recommends that the UNICEF UK Baby Friendly Initiative should be the minimum NHS standard. Despite this increasing evidence base, and encouraging rises in breastfeeding year on year, there remains a dramatic drop-off during the early postnatal period (McAndrew et al, 2012). This is in stark contrast to other countries. For example, 80% of Norwegian mothers (Lande et al, 2003) and 68% of Swedish mothers (Sveriges officiella statistik och Socialstyrelsen, 2009) are still breastfeeding at six months. Locally, there was evidence of a higher fall-off rate between initiation and six to eight weeks in Lincolnshire (33%) than in England (28%) and the UK (26%) (McAndrew et al, 2012). A study exploring local women's experiences of breastfeeding was designed to consider similarity or differences with national studies (McAndrew et al, 2012).

Method

The theoretical location of the research was interpretive phenomenology, informed by the philosophy of Heidegger (1962). The study was designed to describe and interpret the phenomena of human experience in the world in relation to the phenomenon of breastfeeding. Heidegger's interpretive phenomenological approach focuses on illuminating details within experience that may be taken for granted, with the goal of creating meaning and a sense of understanding.

The question posed was: 'How do women experience breastfeeding?' This requires an answer formulated in terms of description and interpretation, which recognises that the way one person perceives an apparently similar experience (breastfeeding) is not necessarily the way another may see it. According to Rolfe (2002), the sort of understanding that arises from a phenomenological study is but one possible understanding among potential others, thus the authors' study was an important addition to the body of knowledge regarding breastfeeding. Ethical approval was received from the university and NHS research ethics committees.

Sampling and recruitment

Participants were recruited because they had experienced the phenomenon. Women were recruited via health visitors from one city in the East Midlands in the UK, where there

was evidence of a higher fall-off rate between breastfeeding initiation and six to eight weeks (East Midlands Public Health Observatory, 2012). Health visitors identified women at their first visit (11 to 14 days postnatally) who had initiated breastfeeding at birth and were currently breastfeeding. They provided participant information sheets, and those who were interested contacted the lead researcher (RS). Interviews were conducted when the youngest child was aged between three and six months. The number of participants recruited was a compromise between satisfying ethics committees, allowing for diversity of the phenomenon and being manageable in the time available for the study.

Data collection and analysis

Data were collected by interviews. Verbal and written consent was obtained prior to each interview. In total, 22 in-depth interviews were performed and digitally recorded by RS. Although interpretive phenomenology is concerned with elucidation and interpretation of human phenomena (Heidegger, 1962), it also rules out treating women as mere objects. It was a methodological assumption that the interviews would reflect breastfeeding phenomena: that women would share their breastfeeding experiences. The authors asked one opening question: 'Can you tell me about your experience of feeding your baby?' Prompts were used to keep the conversation flowing but, at all times, the authors were cognisant of the aim: to understand the women's stories. Data were collected between July 2009 and January 2010, from women with a range of infant-feeding experiences – women who were exclusively breastfeeding, women who had initiated breastfeeding and then changed to formula, and any combination in between. The inclusion criteria were to have initiated breastfeeding at birth and continued at least until the health visitor's first visit. Setting the upper limit for data collection at six months provided an opportunity to gain perspectives from women who may have breastfed exclusively for six months, which is the current WHO recommendation (WHO and UNICEF, 2003). Setting the lower limit at three months reflects a point at which early weaning on to solid food may occur (Bolling et al, 2007). Analysis was guided by Heidegger (1962), Ashworth (2003) and Greatrex-White (2008). All authors participated in the analysis, which consisted of dialogic and concurrent processes.

Rigour

To enhance rigour, a decision trail was made evident, which is sound phenomenological practice (Sandelowski, 1986), and several steps were followed. Accuracy was assured by using audio recordings, transcribed verbatim. In addition, RS recorded reflective field notes about each interview immediately after the interview had been conducted. Interpretations were constantly cross-checked with the original transcripts, ensuring that the interpretations presented the participants' voices as clearly as possible. Rigour was also enhanced through discussions between all three authors who read all interview transcripts and agreed the emerging themes.

Findings

Demographic data

The demographic data of the 22 women who participated are outlined in Table 1 (pseudonyms are used to protect their anonymity). All the participants had given birth in the local hospital (an obstetric unit with one antenatal/postnatal ward). None of the women had returned to employment at the time of data collection, except for Michelle who had recommenced her undergraduate study at university when her baby was four weeks old. All of the women participating in the study began by breastfeeding their youngest infants and breastfed for at least two weeks; 12 were exclusively breastfeeding at the time of the interview. This paper presents an overarching theme that emerged from analysis of the data. The phenomena of 'reality shock' that emerged has three interlinked themes. These are explained in detail below.

Idealised expectations

There seemed to be a gap between the women's expectations of breastfeeding and the reality. Most of the women knew very little about breastfeeding prior to becoming pregnant, other than knowing it was best for the baby. A total of 13 of the women in this study described how their expectations of breastfeeding antenatally were different from their actual experiences. 'Shock' was commonly used by the women to express their reaction to breastfeeding. They seemed ill-prepared for the realities of breastfeeding, and for most of these women the shock of this experience was overwhelming. During pregnancy, their awareness of breastfeeding grew, but their expectations and anticipation of breastfeeding centred around breastfeeding being 'natural', which they translated as innate ability. Women like Denise, aged 19 with her first baby, had perceived breastfeeding to be a natural process and was frustrated that neither mother nor baby had an innate ability to breastfeed:

"I was getting a little bit… frustrated with myself. I was like, I ought to be able to do this" (Denise).

Jenny, who had worked as an administrator in a human resources department of a large company prior to taking maternity leave with her first baby, also expected breastfeeding to be intuitive, that she would instinctively know how to breastfeed when her baby was born:

"I also thought that breastfeeding would come naturally to the baby. I didn't think like she would have to learn it as well as me. I thought if I just swung my boob near her mouth, she would know what to do and latch on herself" (Jenny).

The portrayal of breastfeeding in the media, such as television programmes, and in the professional literature provided to women antenatally was described by two of the women as unrealistic. Fiona, mother to three children, commented how breastfeeding was portrayed in the media:

"It's not what people expect though. You don't see it much on the telly, not really. When you do see it, it's sort of extremes really" (Fiona).

One mother discussed how she felt the professional literature provided to women was not clear:

"[It's] confusing... nobody says this is your guide, don't

worry. You don't have to do it like this" (Kelly).

Inadequate preparation for breastfeeding culminated in some of the women not feeling prepared for the discomfort of feeding in the early postnatal period, and for the time commitment required for each and every breastfeed. Amita described the physical pain she experienced, particularly in her attempts to latch her newborn baby on her breast in the early postnatal period. It was so painful that she reiterated a number of times in her interview that determination was needed to continue with breastfeeding. Pauline described the physical pain she experienced as 'crunching'. Breastfeeding was also found to be a tiring and exhausting process:

"I'm too tired and it's too much effort to go out" (Jenny).

The women's accounts of their experiences of breastfeeding were often imbued with complex emotions such as guilt and self-doubt, particularly for those women whose breastfeeding experience did not match up to their expectations of themselves. Prior to breastfeeding, Queenie had perceived it as an easy aspect of motherhood. As a qualified social worker, she had professional experience of supporting families with their infants. However, once she engaged in the act of breastfeeding, she discovered that her assumptions had led to unrealistic expectations. Like Denise, Queenie too expressed disappointment in herself as she expected breastfeeding to be a *"bonding time"* but the reality was *"a nightmare"*:

"I didn't even feel as if it was a bonding time with him, I just felt, because it was painful and urm he wasn't being satisfied by it, I just, it was, I suppose I was anxious which didn't help, so I never quite felt that it was our time to connect with each other. It was a nightmare... It was a nightmare to be honest" (Queenie).

Comments from the women indicated that many struggled with the loss of life as it used to be, and felt that they had lost control over their own lives. Painful and frequent attempts to breastfeed and a fractious baby were a major source of distress. Heidi described herself as an independent woman with a successful career. Despite this, she still spoke of the image of the good mother with the perfect baby who fed and slept between feeds, waking with a smile and able to enjoy going to the park in the pram with his parents. She described how this image had a hold over her, how she strove to mirror the image, noting how disappointed she was with herself that she did not achieve this. In her interview she broke down in tears at describing this:

"I was trying my damned hardest, I just couldn't do it, it's just hard [cries]" (Heidi).

For Heidi, breastfeeding was intertwined with her image of motherhood. Having introduced formula feeds at three weeks, and stopping breastfeeding completely after a month, she felt she had failed to attain this ideal and, when interviewed when her son was six months of age, she found recounting her breastfeeding experience provoked some uncomfortable memories:

"It isn't how motherhood is supposed to be" (Heidi).

Enjoyment of breastfeeding was not a common narrative for the women in this study.

Table 1. Demographic details and breastfeeding duration of participants

Participant	Maternal age (years)	Parity	Occupation	Marital status	Youngest child's age at interview (months)	Duration any bf (weeks)	Duration exclusive bf (weeks)
Amita	27	1	Unemployed	Married	6	24	24
Belinda	31	5	Healthcare assistant	Married	6	24	24
Charlotte	24	3	Housewife	Cohabitating	3	12	12
Denise	19	1	Unemployed	Cohabitating	3	12	0
Elizabeth	34	1	Shop assistant	Married	6	24	22
Fiona	34	3	Housewife	Married	6	24	24
Georgina	29	1	Physiotherapist	Married	6	22	16
Heidi	24	1	Insurance advisor	Married	6	5	3
Isla	26	1	Unemployed	Cohabitating	6	4	1
Jenny	30	1	Administrator	Married	4	16	12
Kelly	29	2	Adult nurse	Married	3	12	12
Lindsay	36	1	Graphic design	Married	4	16	16
Michelle	23	1	Student	Married	3	12	12
Nicola	25	2	Credit analyst	Cohabitating	3	4	3
Octavia	24	2	Sales advisor	Cohabitating	4	16	10
Pauline	37	1	Unemployed	Married	3	12	12
Queenie	36	1	Social worker	Married	6	4	2
Rebecca	34	2	Healthcare assistant	Cohabitating	3	12	12
Sharon	26	2	Youth worker	Married	3	12	12
Tanya	16	1	Student	Single	3	12	12
Ulrica	28	2	Office worker	Married	4	16	16
Veronica	26	1	Marketing manager	Cohabitating	3	12	3

However, for a few, the reality of their breastfeeding experience exceeded their expectations. For these women, breastfeeding was better than they had expected, not as difficult and they continued to breastfeed longer than they had planned initially as a consequence.

Incessant demands

The women's descriptions of breastfeeding, particularly in the early days, were imbued with a sense of constantly needing to be present. For some, this led to frustration that they could not escape or hand over to someone else, even temporarily. These feelings were expressed by both primiparous and multiparous mothers. The demands of breastfeeding an infant in the early postnatal period led to some of the women beginning to dread each feed:

"I thought: 'Oh no another breastfeed, got to do it'" (Pauline).

They also expressed feelings of disappointment in themselves and personal failure when they subsequently stopped breastfeeding. Queenie's baby was small for dates, so she was advised by the hospital midwives to put him to her breast and then supplement with a prescribed amount of milk every few hours. This entailed an 'incessant' regime of either expressing or putting the baby to the breast, which she continued on discharge home on the second postnatal day. She was in tears for much of the first few weeks with little sleep. If she did not manage to express enough breastmilk, the baby was given a top-up of formula milk. As a consequence, she began to view feeding as a vicious circle.

Queenie described her struggle to breastfeed, despite severe discomfort, sore nipples and a relentless regime of either expressing or trying to position and attach her newborn son. Despite persevering for four weeks, the occasional formula milk top-up resulted in the baby sleeping between feeds, which reinforced to her that he was 'happier' on formula milk. By four weeks, he was exclusively formula-feeding. Queenie's experience led her to feel resentment towards the healthcare professionals for advocating and promoting breastfeeding to the exclusivity of alternatives, but, at the same time, not being as supportive and helpful as she had envisaged in order for her to establish breastfeeding. She confided that she also felt guilty after she decided to wean her son completely on to formula feeds. However, she was not the only woman to anticipate each breastfeed with *"dread"*, nor was this feeling confined to first-time mothers.

The women commented that they expected difficulties, such as bleeding and cracked nipples, reinforced by the plethora of creams, ointments and aids for breastfeeding (such as nipple shields) in shops. However, they did not expect that the *"difficulty"* that other mothers talked about to be the incessant demand, which led to the women feeling as if their lives were on hold and they were hemmed in:

"My life is him now. I am not important" (Amita).

Veronica, who was still breastfeeding at the time of her interview, adapted to this lack of routine and pattern to breastfeeds:

"I have stopped trying to plan my life completely round when she's going to want her next feed because it seems a bit random anyway" (Veronica).

But for others, their feelings were quite different:

"It just seemed really constant. I just couldn't do anything at all. I couldn't get out... I'm the one with the boobs stuck to the front of my chest... I barely had time to go to the loo, let alone have a shower or do the washing or pop to the shops or do anything you normally would. Which was a really bizarre experience, going from being really independent, driving, full-time job, doing what I want when I want... stuck indoors for three and a half weeks. I'm going to go mad in these four walls" (Heidi).

Onus of responsibility

Some of the women described feeling scared when they were home from the hospital, as they felt they had no one to ask for help, no one on the end of the buzzer, and that they were not prepared, competent or confident with positioning and attachment. For some, the responsibility of breastfeeding in terms of being the sole provider of nutrition for their baby was overwhelming. This was noted in the descriptions given by both first-time and experienced mothers in the study. Belinda, mother of five, described herself as *"a fridge... a larder"*. Pauline described the responsibility she felt:

"A massive responsibility, you know, to make sure the baby's healthy, because the only source of nutrition they're getting is from you, and I think you do feel that responsibility. 'Cos it's, you know, the only way that they're kinda surviving is through the breastmilk" (Pauline).

Throughout Nicola's interview she described how she felt the burden of responsibility as a mother was overwhelming with her first child:

"I was 24 and I was like: 'Oh my God, just left with this baby' and obviously you're tired you know, like oh I've got this massive responsibility, you know... what have I done, do you know what I mean, can I cope with this responsibility? And there was times when I thought: 'You take him. I can't do it'" (Nicola).

She expressed her breastmilk so that she could both involve her partner in infant-feeding, but also to relieve herself of the sole responsibility for feeding with her second child. Octavia found that the introduction of an occasional formula feed enabled her to have a degree of control in her life and a degree of separation from the onus of the responsibility to breastfeed:

"It's kinda given me back my life a bit now" (Octavia).

Veronica found the responsibility for breastfeeding in the night time physically and mentally *"exhausting"*. As a first-time mother, she described feeling isolated in the first few weeks after her daughter was born, ascribing this isolation to her belief that no one could help. She had no family or friends with experience of breastfeeding, and so turned to her health visitor for advice and support. However, her health visitor had not completed the breastfeeding management course and, despite promising that she would request one of her colleagues to contact Veronica, no one did. Veronica had attended antenatal classes, but she was the first one to birth from her group, and did not have the confidence to attend a postnatal group until her daughter was eight weeks old, as she felt

self-conscious about feeding in public.

Some of the women in this study (such as Denise) who were initially judgemental about women who did not breastfeed, discussed how their prenatal and antenatal attitude had changed having experienced breastfeeding for themselves. They talked about the dedication and commitment needed to continue, and that it was not necessarily solely a choice regarding infant-feeding method in the same vein as choosing between tea and coffee:

"Now I've had the chance to look back, it's every woman's choice to do it how it's best for them. You don't know all their circumstances" (Denise).

Three participants (Rebecca, Sharon and Ulrica) strove to outperform and breastfeed longer than other mothers:

"She [first child, aged 18 months] stopped of her own accord. I was a bit miffed because my friend had gone on until her daughter was two and I thought right we'll beat that [laughs]" [Ulrica].

However, while vocalising their goals to breastfeed until their children self-weaned, they also expressed feeling an onus of responsibility and incessant demands, as illustrated later in Ulrica's interview: *"It would be nice for it not to be me all the time."*

Discussion

It is clear from the data that women's experiences of breastfeeding were generally not what they had anticipated. Most participants did not find breastfeeding a natural process, instead it came as a shock. Breastfeeding was challenging. Most of the women found the phenomenon to be something that concerned them greatly. The findings suggest that preparation for breastfeeding is inadequate and misleading. In this study, a more realistic idea of breastfeeding may have helped the women to prepare more effectively for their breastfeeding role. This concurs with previous research that identified a mismatch between women's expectations and the reality of breastfeeding (Hoddinott et al, 2012; Redshaw and Henderson, 2012). While the existing literature has already highlighted inadequate preparation for breastfeeding, the extent to which this had a negative impact on the breastfeeding experiences of women in the authors' study was a surprise.

It has been argued that the UK has a predominately bottle-feeding culture (Bolling et al, 2007; Cattaneo et al, 2005), with women rarely, if ever, witnessing breastfeeding prior to having their own baby. This results in a limited understanding of breastfeeding, gleaned predominantly from healthcare professionals in the antenatal period. This preparation centres around the health benefits of breastfeeding, with postnatal support centering on teaching and support with positioning and attachment. All the women in this study intended to breastfeed, were aware of the health benefits of breastfeeding, and all initiated breastfeeding following the baby's birth, although the women's intention to breastfeed was not necessarily for any longer than the initial postnatal period. Professional and popular messages that promote breastfeeding have been very successful. Midwives have prepared women to initiate breastfeeding, but not to sustain breastfeeding. Steps three and five of the Baby Friendly Initiative 'Ten steps to successful breastfeeding' (WHO, 1998: 5) stipulate that maternity services should 'inform all pregnant women about the benefits and management of breastfeeding' and 'show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants'. However, findings from this study indicate a gap surrounding a lack of understanding and preparation for common problems, and a lack of awareness of newborn behaviour. Misunderstandings of newborn behaviour resulted in the women blaming infant-feeding behaviours such as crying, wakeful states and cluster feeding, on the specific method of infant-feeding. The end result was a vicious circle of dreading feeds. There was a drive in the women's descriptions to establish routine and predictable feeding and sleep patterns. The frequent demands made by their breastfed baby were unexpected and worrying. Frequent feeding cues were overwhelming and the women felt overawed by the sense of responsibility. It also led them to question their ability to provide an adequate milk supply. This concurs with a systematic review of evidence on the concept of insufficient milk syndrome (Gatti, 2008). In social cultures where friends and family have not breastfed themselves, this can lead women to question their abilities to breastfeed further, particularly when infant-feeding behaviours are held in direct comparison with the behaviours of formula-fed infants.

Finding the burden of responsibility as overwhelming has not been explored in relation to breastfeeding in the existing literature. However, loss of former identity in the transition to becoming a mother has been reported elsewhere (Mercer, 2004). Many of the participants in the authors' study felt they had lost some of their self-identity due to breastfeeding, while a few felt that breastfeeding helped them develop a positive identity of themselves as mothers. Cultural representations of femininity are of a superwoman who can cope with caring for a new baby while also completing domestic tasks and caring for others (Ussher et al, 2000). Citing lengthy hours breastfeeding, lack of routine, an inability to undertake household tasks and other family duties, breastfeeding was perceived by many of the women in this study as a chore. These feelings were expressed by both primiparous and multiparous women. The anthropologist Raphael refers to cultures where breastfeeding is universal and seen as natural, but where women view breastfeeding as 'not automatic' (Raphael, 1973: 15). Such societies relieve new mothers of routine domestic tasks and provide practical teaching on baby care. While data were not collected on participants' family networks, the increasing geographic distance between generational family members has been extensively commented on in the literature, particularly in relation to the impact on elderly caregiving. When geographical mobility is combined with the lack of knowledge passed through family generations about breastfeeding, it is easy to see how women can feel ill-prepared, inadequate and overwhelmed.

Limitations

The study presents interpretations of the phenomenon of breastfeeding, as experienced by a small number of women from one city in the East Midlands. These data may not be generalisable to the whole of the UK, however, findings resonate with those of other studies. The interviews were undertaken between three and six months after the birth of the youngest child, which may have affected some women's ability to recall infant-feeding experiences (although a review of 11 published studies has shown maternal recall of breastfeeding initiation and duration to be reliable and valid, especially when the duration of breastfeeding is recalled after a short period (≤3 years) (Li et al, 2005).

Conclusion

While the study involved only a small sample, the findings are likely to be relevant to healthcare staff more widely. In particular, antenatal education should focus more on preparing women for the realities of breastfeeding their newborn, rather than an idealised version. This is a complex challenge as the need is to enthuse women to breastfeed alongside discussing strategies to manage their unique personal and family lives. Midwives should explore the earlier infant-feeding experiences of multiparous pregnant women in order to be aware of previous experiences that may influence perceptions of breastfeeding subsequent babies. An aspect of breastfeeding support in the immediate postnatal period that would be appreciated by women is the provision of a healthcare professional sitting through at least one complete breastfeed. This would provide an opportunity not only to advise on positioning and attachment, but also infant-feeding cues and infant behaviours, using the time as an opportunity to talk with the woman about her expectations, support network and perceptions of infant behaviour. However, postnatal care provision has been the subject of heated debate for a number of years, with researchers noting the low priority afforded to this aspect of maternity care (Bick, 2012), despite *Midwifery 2020* (Chief Nursing Officers of England, Northern Ireland, Scotland and Wales, 2010) affirming the importance of skilled midwifery support and continuity of midwife-led care throughout this period. Findings from this study add to this growing debate.

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Exploring women's experiences of care in labour

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Abstract

Aim. To examine women's experiences of care in labour and identify the issues most important to them.

Background. Ireland has the highest birth rate in the EU. This is predicted to continue to rise over the coming years. This will increase the demand for maternity care within existing or diminishing resources. In light of these pressures, maternity care providers are keen to ensure services meet the needs and expectations of women.

Method. The study design was exploratory and descriptive, using a routine hospital evaluation survey with a convenience sample of pregnant women, who received care in labour at a large maternity hospital in Dublin over a three-month period. Women, on transfer from the delivery ward between one to two hours post-delivery, were asked to complete a short questionnaire about what they thought was good about the labour and the care they received; what aspect of their care could have been improved; and how they could have been better prepared for labour. Data were entered into NVivo 9.0 for content analysis. The collection and analysis of this data was pre-approved by the hospital ethics committee.

Findings. Of the 1654 women approached, 360 women returned completed questionnaires, providing a response rate of 21.7%. Almost half of the 360 women who participated were primiparous. Just over half of participants (53%, n=191) reported they were happy with their experience or referred to positive experiences. A number of factors were identified that contributed to a positive experience for women. These were based on a trusting and supportive relationship between the woman and her caregiver, in particular, her midwife. A total of 32 women (8.8%) identified issues related to their expectations for labour, including pain relief and the care environment.

Women with positive experiences made reference to staff being helpful and caring; good-quality and timely care; adequate pain relief; accurate information on what to expect in labour; good guidance and support in labour; and women feeling they could trust the caregiver to provide safe care. Women referred frequently to the relationship they had with the midwife providing their care and the skills and attributes of midwives.

Conclusions. Women's perceptions of care are strongly influenced by their expectations, which in turn are mediated by previous experiences, their preparation for labour, and the support that they receive from their caregiver in labour. Midwives were seen to have a vital role in supporting and guiding women through labour. Also, the importance of education during the antenatal period, to enable women to prepare adequately for labour and participate effectively in decision-making, was highlighted.

Key words: Care in labour, satisfaction, expectations, evidence-based midwifery

Introduction

Ireland has experienced a sustained growth in birth rate over recent years and currently has the highest birth rate in the EU – at 16.8 per 1000 of the population (Economic and Social Research Institute (ESRI), 2012). It has also seen increases in the rates of caesarean section (CS) births (27% nationally in 2011 (ESRI, 2012)). This places significant pressures on maternity services, particularly in the absence of additional resources. A key concern for maternity care providers is that services continue to meet the needs and expectations of women and their families. However, to date, there has been no 'substantial' research in Ireland on how maternity services meet women's needs (Larkin et al, 2012).

Satisfaction with childbirth is the most important qualitative outcome in the assessment of the childbirth experience (Harvey et al, 2002; Lomas et al, 1987) and is linked with postnatal emotional wellbeing (Harvey et al, 2002; Knapp, 1996; Green et al, 1990), self-esteem, early interaction with the infant, attachment, ability to care for the child, and the future growth and development of the family (Howarth et al, 2011; Harvey et al, 2002; Knapp, 1996; Green et al, 1990).

Satisfaction with care is a multifaceted concept and, despite extensive research, little agreement has been reached on what comprises satisfaction or how it can be measured effectively (Britton, 2012; Larsson and Wilde-Larsson, 2010; Christiaens et al, 2007; van Teijlingen et al, 2003; Dowswell et al, 2001). A key element in the perception of the experience and, therefore, satisfaction, is how closely the experience matches the woman's expectations of her care (Britton, 2012; Christiaens et al, 2008). Women's expectations are shaped by personal experiences, the birth stories of family and friends and messages received from the professionals providing their care, and are continuously redefined as they gather new information (Christiaens et al, 2008). Where experiences do not meet a woman's expectations, this may result in disappointment, a feeling of failure, or guilt (Gibbins

and Thomson, 2001). It may impact negatively on a woman's sense of herself as a mother and as a woman (Hauck et al, 2007). The impact of the experience of care goes beyond the specific pregnancy, influencing a woman's expectations for her second and subsequent pregnancies (Hauck et al, 2007).

Building on the findings of the literature review, this study set out to identify the issues surrounding women's experiences of care in labour, as identified by the women themselves. The study was conducted by a third-year BSc midwifery student, under the supervision of an academic midwife and midwifery managers, through a summer research scholarship scheme.

Method

This study aimed to explore women's experiences of care in labour at a large maternity hospital in Dublin. All women who were admitted to the delivery ward, between January 2011 and March 2011 who had delivered vaginally or had an emergency CS were eligible for inclusion in the study – those having an elective CS were excluded. Women were invited to complete a questionnaire seeking open-ended feedback on their experience of care in relation to four questions. Routinely these were handed to the women on transfer from the delivery ward between one to two hours post-delivery to collect data for quality improvement purposes. Most questionnaires were collected at discharge between day two and day five. A small number of women took the questionnaire home and returned it by post. Instructions were minimal, but women were informed that the details provided will be analysed and used to improve care at the hospital. The study involved the analysis of anonymous data and the collection and analysis of this data was pre-approved by the hospital ethics committee. This analysis focused on data collected in response to four open-ended questions:

- What do you think was good about the labour and the care you received?
- What aspect of your care could have been improved?
- How could you have been better prepared for your labour?
- Any other comments?

Data were entered into NVivo 9.0 for analysis using content analysis as described by Graneheim and Lundman (2004). This involved familiarisation with the data, identifying and labelling meaning units within the data (sub-themes), amalgamating related sub-themes into themes and categories, and the presentation of findings using a narrative style.

Findings

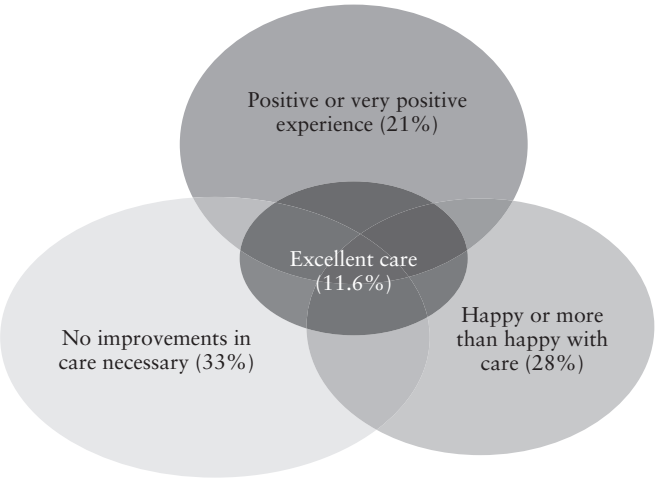
Data were collected from 360 evaluation questionnaires completed over the data collection period (January to March 2011). This equates to a 21.7% response rate. Just over 41% of the respondents were primiparous and 43.5% were multiparous (the parity of the remaining 15% was not recorded).

Three key categories were identified in the data relating to: satisfaction with care in labour; care in labour; relationships with healthcare professionals. These are discussed in the following sections.

Category one: satisfaction with care in labour

This category relates to comments about women's general experiences of, and satisfaction with, care received on the delivery ward. Comments were mostly positive, but included examples of issues of concern to women. Women also spoke about their expectations and how their experience compared with their experience of previous births.

Figure 1. Satisfaction with care in labour



Themes identified related to positive experiences, being happy with care, negative experiences, and feeling prepared for labour. A total of 75 (21%) women stated they had a positive, or a very positive experience (see Figure 1):

"My labour experience from start to finish was excellent as at every stage" (Q13).

"It was an amazing experience and very cared for throughout" (Q82).

Almost a third of women (n=101, 28%) mentioned that they were happy with their care and a similar number of multiparous and primiparous women eagerly expressed their contentment with the care provided. Some descriptions suggested care exceeded women's expectations, for example:

"Really grateful for all the care and attention we received, everyone was beyond helpful and caring" (Q131).

In their accounts, women also rated the care that they received. A total of 42 women (11.6%) reported having received *"excellent"* or *"quality"* care in a timely manner, particularly in difficult circumstances:

"Felt the care I received was top class, there was a very busy night when I came in and I still got the best treatment" (Q264).

"Efficient delivery of care in labour and pre-labour in unit [name]" (Q295).

When asked if any improvements could be made to their care, 33% of women (n=118) indicated none were needed:

"I could not honestly say that any area requires improvement, (so far the care and attention has been exceptional)" (Q155).

In total, 14 (3.8%) women described having a negative experience. Of these, five women identified concerns about the facilities on the delivery ward, including having to share a room in labour and staffing levels:

"Unfortunately the majority of my labour was in a shared room with no curtain divide, which was far from ideal for both parties involved" (Q354).

While 28 women (7.7%) reported feeling inadequately prepared for labour, including not being physically fit enough,

17 (60.7%) of these had not attended antenatal classes and said that if they had, they would have felt more prepared. A total of 69% of women who felt 'well prepared' had attended antenatal classes.

A small number of women related their experiences to previous experiences of pregnancy and labour, explaining that they knew what to expect from past events:

"Was prepared, my second baby so knew what to expect in some ways" (Q57).

"As this was my third labour, I was very prepared for it" (Q73).

"Been through it before so was prepared reasonably well" (Q118).

Some respondents, who were first-time mothers, noted that they could not be fully prepared, as they had never been through labour before:

"I feel I was as prepared as could be for my first labour experience" (Q13).

"I was fully prepared for labour but until you go through it, you can never imagine what it's like" (Q134).

"Nothing can prepare you for the intensity of labour pains, especially the effects of oxytocin" (Q40).

Category two: care in labour

Several comments related to specific aspects of care in labour. These included: preparation for and guidance in labour (see Table 1), support in labour, pain relief, and the number of vaginal examinations in labour.

A total of 15 respondents (4.1%) mentioned having quick labours, which they found contrary to what they were told in their antenatal classes, while 11 women (3%) highlighted the lack of information provided to women about what to expect and what to do in the early stages of labour:

"I believe I was prepared well. However a better understanding of the pre-labour stages of labour and timeframe may have helped me to be less anxious" (Q174).

"Only pre-labour was I very confused as I didn't understand the difference between medical labour and labour, so felt very confused about the pain I was experiencing" (Q248).

A small number of themes referred to the need for better guidance during labour on pushing and breathing techniques:

"Also midwife in labour ward was not explaining how to push properly" (Q10).

"Better help in labour with breathing etc from midwives" (Q308).

The majority of comments from women were in relation to support from a midwife, one-to-one care and individualised care. Support from a midwife was referred to by 105 women (29%), describing assurance or encouragement received from the midwife. Women also highlighted the importance of including partners in care for support:

"The midwifery team that encouraged me through my labour could not have provided me with any better support or encouragement" (Q327).

"This was my first pregnancy and with only knowing the main guidelines/signs of labour, the staff in the labour ward made me feel so comfortable and explained every aspect to me and my partner" (Q101).

One-to-one care was referred to by 28 women (7.7%) and all comments were positive:

"Constant one-to-one care and personal touch. Always felt more than just another patient" (Q216).

One woman suggested the support that she received and not being left on her own helped her to feel safe:

"The midwives were very nice and patient, very reassuring and did not leave me on my own at all – I felt very safe" (Q27).

Five women (1.4%) referred to individualised care, suggesting this approach provided much needed reassurance to each woman and her unique situation:

"Staff showed high levels of professional competence, alongside an intensely personal and caring approach to each individual case" (Q176).

A number of comments referred to women's experiences of pain relief. Some 16 women (4.4%) identified this as an area to be improved:

"Caring as the care experienced elsewhere, more sympathy and help in relation to pain relief and relaxing methods would be better" (Q23).

"…I had decided that this time I wanted an epidural. I felt I had to be very firm and clear to get this. It wasn't clear, when the best time to ask for it was and I felt if I hadn't been so clear I wouldn't have got it in time" (Q212).

In relation to improvements in care, one woman (0.3%) suggested fewer vaginal examinations in labour.

Category three: care received from midwives

This category contained three sub-themes related to the care that women received from midwives: relationship with midwives, attributes of midwives, and communication.

A total of 260 participants (72%) provided positive feedback related to a midwife who had looked after them. The relationship between woman and midwife was a particular theme for respondents, and 45 women (12.5%) referred to the trust that they had in the midwives:

"Always tried their best to put you at ease – you felt as a patient they were genuinely interested in you" (Q163).

"You really feel that you are in safe hands and getting the best of care for you and your baby" (Q226).

Midwives' swift responses to various situations were mentioned in several comments:

"The reaction, speed and actions taken once it was realised the baby was in distress were fantastic" (Q314).

While 41 women (11%) mentioned the professionalism and knowledge displayed by the midwives:

"[Name of midwife] was extremely professional and calming and made me feel safe in what was an extremely

Table 1. Preparation for labour

Better preparation required in relation to:
1. Preparation for a quick labour even though it is a first birth
2. What to expect and what to do in early labour
3. Guidance during labour a. Pushing b. Breathing techniques.

traumatic delivery" (Q12).

Student midwives were commended by seven women (1.9%), with all comments describing high standards of care:

"The student midwife was brilliant on the day – she was a huge help to me during the labour, helping me focus when I needed it the most" (Q236).

However, the attitudes of one midwife was raised as an issue by one woman:

"The midwife who did the delivery should take it easy with the patient, otherwise everything was good" (Q120).

A number of themes can be identified in this data that contribute to a positive experience (see Table 2). These related to one-to-one care, the relationship between the woman and the midwife and adequate pain relief.

Two sub-themes were identified in relation to communication: effective communication, partner included and questions answered. There were 180 data extracts describing effective communication. These related to the midwife listening to the woman, providing clear explanations of situations and procedures, and keeping the woman informed and updated on a regular basis. For example:

"The person assigned to monitor my labour was fantastic and explained and guided me through all aspects with skill, patience and understanding, which was much appreciated" (Q152).

A total of 18 examples were provided of ineffective communication, relating to feelings of not being listened to, not being provided with an explanation of procedures or events, and poor communication between the woman and midwife or obstetrician:

"More knowledge from midwives in labour about why certain procedures are followed" (Q308).

"Doctors should explain what they are doing more to you though" (Q292):

Six women (1.6%) also highlighted the need to include the woman's partner in communication.

Table 2. Experience of labour

Factors contributing to a positive experience in labour
• One-to-one care
• Support received from the midwife
• Attributes of the midwife: a) Helpful, patient, understanding, interested in the woman b) Competent, skilful, calming, woman made to feel in safe hands
• Not being left on own
• Relationship with the midwife
• Effective communication
• Adequate pain relief.

Discussion

The themes identified in this study provide some insight into the experiences of women and the issues that mattered to them in labour. The majority of comments were positive, providing insight into the factors that contributed to a positive experience for women including having a good experience throughout the episode of care; staff being helpful and caring; having good-quality and timely care (even when it is busy); having adequate pain relief and clarity about what is available; being provided with accurate information on what to expect in labour; being provided with good guidance on breathing and pushing in labour; having good support in labour, one-to-one care and individualised care; receiving care from midwives and doctors who are professional, knowledgeable and able to act quickly; and that women feel they can trust the caregiver to provide safe care. These themes are broadly consistent with the findings of Lavender and Walkinshaw (1999) and Proctor (1998).

A particular theme in the women's comments was their relationship with the midwives providing their care and the support that they gave to the woman and her partner. The encounter that the woman has with her caregiver and the relationship between the woman and midwives and clinicians have been identified as important factors in satisfaction with care (Hildingsson et al, 2013; Goberna-Tricas et al, 2011). Bluff and Holloway (1994) found the relationship with the midwife was important to women and was remembered over time. Women in the authors' study provided several examples of good and poor communication, highlighting the importance of listening, showing an interest in the woman, providing clear explanations, constantly updating the woman and including the woman's partner. Further, it is suggested that the communication and interpersonal skills of healthcare professionals are critical factors in establishing trust between women and care providers (Goberna-Tricas et al, 2011). Fraser (1999) examined women's perceptions of maternity care and found communication to be of paramount importance to women, in particular, 'the midwife's ability to empower the woman, to enable her to feel special, to help her to relax, be in control and, when necessary, to be the woman's advocate with the doctor' (Fraser, 1999: 102).

An important theme to emerge from Larkin et al's (2012) focus groups with women was the 'pivotal' role that the relationship with the midwife can have on a woman's experience of labour. Their findings highlight the mix of positive and negative experiences that women can have, depending on the midwife assigned to provide their care. Going back to the earlier discussion of expectations and how they influence women's perceptions of their care, Hauck et al (2007) found the relationship between the woman and her caregivers in labour to have the potential to mediate women's perceptions, particularly where expectations had not been achieved.

The findings from our analysis include women's accounts of midwives guiding them through labour, encouraging them and making them feel comfortable. Fraser (1999) found that 'unless women had a relaxed and trusting relationship with the caregivers, they tended to hold back, did not hear what was said, or felt in some way dissatisfied with their care' (Fraser, 1999: 105). Howarth et al (2011) identified the importance of establishing personal and caring relationships in their study of satisfaction with the childbirth experience. They identified the relationship with the midwife, with family and other support, and the inclusion of the partner as important factors. McCourt et al (2006) suggested becoming a parent for the first time can

be stressful and confusing for partners and involving them in the pregnancy and labour allows their new role to develop naturally. Women commented positively on one-to-one care, and individualised care. This endorsement is important in the context of the authors' study, as one-to-one care in labour is standard policy at the hospital concerned.

The personal attributes of midwives providing care also feature strongly in the accounts given by women. They referred to feeling safe, the competence and skills of midwives, and the importance of appropriate attitudes and personal attributes, such as patience and caring. Conversely, one woman singled out her experience of the harsh attitude of a midwife from an otherwise good experience of care. Fraser (1999), in her study of women's perceptions of midwifery care, identified a number of caregiver qualities that enhanced the childbirth experience. These included midwives being 'nice, caring, understanding, pleasant, and reassuring', having appropriate interpersonal skills, and 'having time' or 'being there' for the woman (Fraser, 1999: 103). The majority saw the midwife as both a friend and knowledgeable professional.

While the findings relating to the aspects of care that women endorsed in their accounts are useful in understanding what is important to women, the concerns raised by women are also important to identify issues that can hinder a positive experience. These included inadequate preparation for labour and inadequate pain relief or clarity about what is available. In the majority of cases where women felt inadequately prepared for labour, they had not attended antenatal classes and, in some comments, women linked their lack of preparation to not having attended classes. It is suggested that 'the aim of childbirth preparation is to enhance the woman's sense of confidence, by having accurate and realistic information, which will enable her to make informed choices and feel in control of her labour' (Gibbins and Thomson, 2001: 303).

While there is support for the idea that satisfaction is improved where a woman has realistic expectations for her labour, there are mixed views in the literature on the link between preparation for labour and satisfaction with care (Goodman et al, 2004). However, it is suggested that preparation for labour is important for women to feel they can participate in decision-making and feel in control in labour, which are promoted as important precursors to satisfaction with the experience of labour (Salmon and Drew, 1992). Particular concerns in this study related to women having unexpectedly quick labours and lack of information about early labour.

Women also commented about how their experiences differed from their expectations, particularly in relation to the progress of labour. In-depth qualitative studies have found that women's expectations can be very different to the actual experience of labour, with women either underestimating or overestimating what is involved (Larkin et al, 2012; Halldorsdottir and Inga Karlsdottir, 1996). Larkin et al (2012) identified a number of areas where women's experiences were different from their expectations in relation to labour events and the progress of labour. They also identified considerable confusion among women about early labour and that women had naïve and unrealistic expectations about what would happen at this time. They found that early labour was a time where women felt anxious, lonely and isolated.

Women's comments about pain mostly referred to positive experiences of managing pain. Being able to manage pain is an important factor in how women cope with labour (Gibbins and Thomson, 2001). However, there are mixed views on the impact that pain has on a woman's experience of birth. Schytt et al (2008) found women who reported lower levels of pain were more likely to have a positive birth experience, but Ranta et al (1995) found dissatisfaction with the childbirth experience was associated with instrumental deliveries, rather than the usage of analgesia. In this study, less than 5% of women stated their pain had not been managed adequately. Comparatively, this is low. For example, Ranta et al (1995) found 51% of women in their study (n=1091) complained of inadequate pain relief in labour. However, in the authors' study, women were not asked directly about their experience of pain and references to pain surfaced in response to an open invitation to report good experiences and concerns that they would have had about their labour, the care that they received and their preparation for labour. Women's experiences of pain and pain management are also related to expectations. In a systematic review of 32 studies of women's expectations and experiences of pain relief in labour, Lally et al (2008) concluded that women often have inaccurate or unrealistic expectations for pain in labour. They may underestimate the pain they will experience or may hope for a labour free of pain relief. However, in reality, they find they need it or benefit from it.

A small number of women in the authors' study also referred to poor communication (especially not being listened to) and poor information on what was happening, which contrasts with comments previously discussed around the midwife supporting, guiding and empowering women through their labours. A final source of dissatisfaction mentioned by five women was the care environment, with particular reference to privacy and staffing levels. Although only referred to by a small number of women, these concerns were significant enough for the women concerned to report them.

Limitations

One of the limitations of this study is the low response rate from a sample of women receiving care, collected over a three-month period. Although typical of response rates to satisfaction surveys conducted at the hospital, it is not clear whether those who responded had similar views and experiences to those who did not. It does however, provide some insight into women's experiences of care and the issues of importance to them. Data were collected using a questionnaire focused around four broad questions, allowing women the freedom to identify the issues important to them.

The instrument, which is routinely used to collect data for quality improvement purposes, could be developed further to include questions around the dimensions of intrapartum care identified in the literature. However, it is suggested that structured questionnaires are limited in relation to comprehensively examining women's satisfaction (Dencker et al, 2010) and need to be combined with in-depth qualitative methods to examine the expectations and preferences of women in greater detail. Qualitative methods provide the additional

flexibility to follow-up new issues raised by participants. Further research should also examine differences in the expectations and preferences of nulliparous and multiparous women. The study suggests further research is required into women's expectations and experiences of pain management in labour, and their perceptions of the care environment.

Conclusion

The findings suggest the majority of women in this study were satisfied with the care that they received in labour. Women's perceptions of care are strongly influenced by their expectations, which in turn are mediated by previous experiences, their preparation for labour, and the support that they receive from their caregiver in labour. Antenatal education is important for women to prepare adequately for labour and to enable them to participate effectively in decision-making. The midwife has an important role in supporting and guiding women through the process of labour. Women also need support in early labour – a time when they may feel particularly anxious and isolated.

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'Fear of childbirth' and ways of coping for pregnant women and their partners during the birthing process: a salutogenic analysis

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Abstract

Aim. To explore 'fear of childbirth' and its impact on birth choices among women and their partners in Northern Ireland.
Background. Despite a growing interest in other countries, research on the impact of childbirth-related fear on the experience of birth and on birth choices for anxious couples within the UK is limited.
Method. In-depth interviews were conducted with 19 women and 19 men between November 2009 and September 2010.
Analysis. Thematic content analysis of the interviews was carried out within the sense of coherence (SOC) theoretical framework (Antonovsky, 1987).
Findings. Three concepts underlying fear of childbirth were found, namely: 'riskiness', 'ways of coping', and 'being a good parent', which related to the comprehensibility, manageability and meaningfulness dimensions of SOC. Almost all of the women and men in this study (89%) expressed a desire to have a normal birth, but most of the participants (86%) appraised vaginal birth as risky. All the women feared the pain of childbirth and more than half (68%) feared they would not be able to achieve a normal birth, or that the baby would be injured during the birth process (58%). The most common fears for men were that their partner's mental health would suffer as a result of a traumatic birth (74%), that they would be unable to provide adequate support during labour (58%) and that their partner or baby would be injured as a result of the birth (47%). Most of the women and their partners (73%) identified medical interventions, such as early induction of labour, electronic fetal monitoring, epidural and planned caesarean section (CS), as resources to help ensure a safe birth. Four participants (11%) identified midwifery support as a resource to help them cope with birth.
Conclusions. Fearful parents choose medical interventions in birth as a means to cope with the uncertainties of birth and ensure a safe transition to parenthood. To promote normality in childbearing and reduce medical intervention in birth, midwives need to be more proactive in offering credible alternatives.

Key words: Fear of childbirth, sense of coherence, wellbeing, men, coping, medical intervention, evidence-based midwifery

Introduction

While pregnancy and childbirth are usually seen as a time of wellbeing and happiness, for some women and their partners this is not the case, as they suffer from anxiety and fear (Nilsson and Lundgren, 2009; Eriksson et al, 2006a). Although our knowledge of how women and men cope with fears related to childbirth is limited, a growing interest in this topic is beginning to improve our understanding (Maier, 2010).

Estimates of the incidence of fear of childbirth among women vary considerably between countries with 10% reported in Scandinavian countries (Waldenström et al, 2006) and 40% in Turkey (Körukcü et al, 2010). This may be caused by methodological issues, such as the lack of a clear operational definition of the fear of childbirth concept (Nilsson et al, 2010); different cultural perspectives or different birth practices between countries (Fenwick et al, 2009). There is, however, consensus within the literature that fear of childbirth is associated with adverse clinical outcomes for mothers, such as labour dystocia, increased incidence of medical interventions such as epidural use, CS, and operative vaginal delivery (Sydsjo et al, 2013; Adams et al, 2012; Handelzalts et al, 2012; Alehagen et al, 2005; Heinze and Sleigh, 2003).

During pregnancy, primiparous women are more likely to report fear of childbirth than multiparous women, but multiparous women more often experience intense fears (Ryding et al, 2009), which are closely related to negative birth experiences such as poor professional care received during birth, lack of support from a midwife, feelings of loneliness during birth, feeling incapable of giving birth, a perception of loss of control during the birth, vaginal instrumental delivery, and emergency CS (Størksen et al, 2013; Rilby et al, 2012; Nilsson et al, 2010; Rouhe et al, 2009).

'Tokophobia' is defined as morbid fear of childbirth (Bhatia and Jhanjee, 2012), and this diagnosis has recently been endorsed within the UK as an indication for planned CS (NICE, 2011). This decision seems contrary to current trends within maternity services that focus on promoting normality in birth (Gould, 2012). However, there have been concerns for some time among midwives that the conceptualisation of fear of childbirth as a pathological process, situates the problem within the individual woman, and deflects attention from maternity care provision (Walsh, 2002).

Men can also suffer from fear of childbirth, although most research to date has focused on mothers. Currently in western societies, men are expected to be fully involved in all aspects of childbirth (Longworth and Kingdon, 2011), but, for some men, fears related to childbirth can lead to feelings of distress and helplessness (Dellman, 2004). It has been estimated that between 11% (Bergström et al, 2009; Hildingsson et al, 2013) and 37% (Sjogren, 1997) of men experience significant fears.

One-third of the partners of women with 'fear of childbirth' expressed significant fear themselves (Hofberg and Ward, 2003). It is also known that fear of childbirth can lead fearful women and men to request medical interventions, such as planned CS (Hildingsson, 2014; Sahlin et al, 2013), and it is these preferences for medical procedures that make fear of childbirth such an important topic (Ayers, 2014).

Method

The paper describes a qualitative study that explored the effects of fear of childbirth on the birthing preferences for women and their partners. It builds on the theory of salutogenesis (Antonovsky, 1987), which focuses on how 'wellbeing' is developed and maintained. 'Wellbeing' is operationalised by what Antonovsky (1987) termed a 'sense of coherence' (SOC); a psychosocial concept involved in the mediation process between stressful life events, wellbeing and health. Antonovsky (1987) proposed that individuals with a strong SOC maintain wellbeing by managing the stressors of life better than those with a weaker SOC, who are more vulnerable to ill health. This is because individuals with strong SOC have the ability to find appropriate solutions to stressors and resolve conflicts through adaptability, leading to improved wellbeing (Lazenbatt and Thompson-Cree, 2009).

Central to building a strong SOC are coping resources called 'generalised resistance resources' (GRRs). These can be promoted by positive life experiences and in structures such as social support and family relationships (Antonovsky, 1996). Professional groups, such as midwives or obstetricians, could also be described as GRRs. According to Antonovsky (1987), when faced with stressful situations, individuals search among the GRRs at their disposal to find the resources needed.

Accessing healthy GRRs could provide a key to optimum childbearing for new parents. Identifying healthy GRRs could guide midwifery practice and research towards ways of encouraging successful coping for new mothers and fathers (Downe and McCourt, 2004). Salutogenesis offers midwives a conceptual way of thinking about how women and their partners could be supported to move towards health and wellbeing, rather than concentrating on avoiding risk factors (Sinclair and Stockdale, 2011).

Setting and sample

In 2010, a purposive sample of 19 pregnant women and 19 male partners (n=38) were recruited at the Royal Jubilee Maternity Service (RJMS) in Belfast – the largest maternity hospital in Northern Ireland (NI). No attempt was made to recruit couples who had specifically expressed fear of childbirth, but rather the study aimed to explore fear of childbirth with women, who were assessed to be of low obstetric risk, and their partners.

Potential participants were introduced to the study and its aims by midwifery staff at routine visits to the hospital. Those who expressed an interest were contacted by the research midwife to arrange an interview. Written informed consent was obtained from participants before the interviews took place. Although more than half of the men and women were couples, they were interviewed separately. (For the demographic profile of the participants, visit the RCM website.)

Procedure

Face-to-face in-depth interviews were carried out by a female researcher who is a midwife. The researcher was careful to ensure confidentiality, as well as sympathetic support, for those interviewed. The study used a semi-structured interview format which lasted, on average, one hour and was audio-taped. Interviews took place in a safe place, as defined by the participant. Most participants (n=25) were interviewed in a private room in the hospital, the others (n=13) were interviewed in their own homes.

An evidence-based topic guide, developed from the literature, was used to ensure consistency and focus (Arthur and Nazroo, 2003). The initial question participants were asked was: 'Will you tell me about any anxieties or fears you have about childbirth?' When participants raised fears or anxieties about childbirth, non-directional prompts, such as 'Why is this a worry for you?', were used.

Ethical considerations

Confidentiality was respected at all times and all names were removed from the data. Arrangements were in place with the lead clinical psychologist at the RJMS so that any study participant who reported significant fears could be referred for assessment and support. All were made aware of this, but none requested an appointment. Ethical approval for the research study was obtained from the office of research ethics committee NI. For purposes of data protection and in accordance with Queen's University research governance, the transcripts were stored on a private computer that was password protected.

Data analysis

An interpretive summary was written for each interview which was transcribed verbatim, and the full transcripts were imported into QSR NVivo 8. Thematic framework analyses based on 'salutogenesis' theoretical dimensions were used to explore participant fears and coping around the birthing process. SOC comprises three dimensions: comprehensibility, manageability, and meaningfulness. Comprehensibility means that whatever happens to a person, s/he is able to make cognitive sense of it and understand it as structured, predictable, and explicable. Manageability is a psychological component, which means that either internal resources are available to meet the demands posed by the stress, or there are ways to access resources externally. Meaningfulness is interpersonal and involves having a sense of meaning in the important areas of one's life or recognising these demands as challenges, worthy of investment and engagement.

Findings

All women and their partners were very motivated to have good births, to make good transitions to parenthood and be good parents (meaningfulness). However, the participants differed significantly in their assessment of the risks posed

by childbirth (comprehensibility), and in their choice of the resources to enable them to cope (manageability) with the birthing process. Fears about childbirth for the men and women in this study were concentrated in three main areas:

- Risks associated with vaginal birth
- Impact of pain during childbirth
- Mother or child being injured during the birth process.

Comprehensibility (cognitive)

For men and women the comprehensibility dimension was related to the individual's assessment of the risks and uncertainties associated with birth. The greater the perception of uncertainty or risk, the greater the fear:

"...that's what this whole thing is all about, isn't it. Nobody knows what'll happen or how it will go" (W17, prim).

Over half of the women (n=11) and almost half of the men (n=9) appraised labour and vaginal delivery as posing considerable risks to the physical health of the mother and baby. In total, 68% of the women and 42% of the men feared that their baby was too big to be born vaginally:

"...you see the baby on the scan and you see the head and you think... how could it get out of down there?" (W6, para 1).

Five (26%) of the women feared that they could be coerced into doing something they didn't want to during labour for the sake of the baby:

"*I think once you come into hospital it's all about the baby... they told my mother that... she didn't want the forceps, but she had to get them for our [brother's name]*" (W17, prim).

A total of 74% of the men (n=14) were fearful that their partner would be unable to cope with, and would be traumatised by the pain:

"She was already fragile with it... she couldn't... it was such a scar mentally for her... the way both of the births had went that if another bad one had of come along – we would have struggled... you know" (M19, third baby).

The men feared that being traumatised by the birth would affect their partner's postnatal mental health and impact negatively on the new family unit:

"My first relationship broke up because of the birth… and [led to] parenting difficulties and postnatal depression" (M13, second baby).

In contrast, with the perceived riskiness of vaginal birth, all the men and women (n=28) who expressed an opinion about CS said it was a safer mode of delivery for the baby and only four participants (11%) said it was more difficult for the mother than a vaginal birth:

"To be honest – they were talking about sections the other night – they don't scare me – because I feel it's a more controlled environment" (W8, prim).

"*Yes it would be quicker and more organised – and less for [partner] to worry about... it would be over in about half an hour"* (M7, first baby).

Perception of riskiness of vaginal birth was increased when there were previous negative birth experiences. One woman described how a negative experience of birth had affected her:

"...I was always so afraid of that happening to me again [painful episiotomy wound] that that's why I had a planned section with [second child]" (W18, para 2).

However, this woman (W18, para 2) went on to describe a very positive experience as birth partner for her sister and how this changed her mind:

"I went with my sister and she had her waterbirth and it was the most amazing experience of my life, it was absolutely an inspiration for me" (W18, para 2).

She was planning a normal birth during this pregnancy, demonstrating how positive birth experiences and positive birth stories can have the potential to reduce the perception of riskiness and increase the expectation of being able to cope with normal birth.

Manageability (psychological)

The manageability dimension was related to the perception of ability to access resources needed to cope with the birthing process. These were focused on accessing resources to cope with pain and resources to reduce the risk of injury to mother or baby during birth. The bigger the gap between the individual's assessment of their needs and their perception of the availability of resources, the greater the fear.

All the women anticipated they would have their partner's support during labour but more than half of the men (58%) feared they would be unable to provide adequate support:

"*I'm going to stand like a spare tyre at the side of the bed... you know. Holding her hand like but there's nothing much I can do for her"* (M12, second baby).

Four of the men expressed more confidence in their ability to provide practical help following a CS than support during active labour:

"Yes… there is more pain after a caesarean and then I can help her all the time… shopping and cooking... with the baby and get her to rest plenty. I have not to go to work for four weeks and I can help her very much... but I can't help her with the pains before the baby comes" (M4, first baby).

All the women feared the pain of labour and were reassured by the availability of a 24-hour epidural service. Despite this, the majority of the women (65%) expressed hope that they could labour without an epidural, although they lacked confidence in their ability to cope and feared the pain would be too severe. Six of the primigravidas in this study (40%) had already been advised to have an epidural during labour by family or friends and all the men wanted their partner to have as much pain relief as possible during the birth:

"She [her mother] said: 'If you want my advice, you get an epidural as soon as you go into labour because you'll never be able to cope.' You see they all know me and know what I'm like" (W10, prim).

As with epidural anaesthesia, the men were more positive about the use of medical interventions in birth than were the women. All of the men who expressed an opinion (n=18) were reassured by the availability of birth technologies and the majority (88%) were keen for them to be used in the expectation that it could make the birth easier and safer:

"…it's why you come to the hospital isn't it?... so they can watch out for that sort of thing... and sort it out... like there's so many monitors and scanners and that... if there's a problem they can get it sorted out fast" (M5, third baby).

All the women who expressed an opinion about medical intervention (n=17) were willing to accept it, if necessary for the wellbeing of their baby, but most (65%) hoped to be able to manage without it. The women who preferred normal birth expressed more confidence in the safety of the birth process than those who preferred CS:

"...it goes back to what I believe about birth, that that's the way babies are supposed to come into this world" (W6, prim).

These beliefs seemed to also boost the women's confidence that they had the internal resources to cope. These women were inclined to perceive birth as a challenge to be well met in order to make a good transition to motherhood. The desire to overcome that challenge motivated these women to achieve a normal delivery without intervention:

"I want to sort of enjoy the birth and the struggle to do it... if you know what I mean" (W5, prim).

Four participants (11%) identified midwife support as a resource to help them cope with birth. These were two multiparous women and partners. Recalling previous births, they described how the midwife had reduced their fears:

"...from what I could see, the midwife had everything under control and like it seemed ok... so I was pretty relaxed" (M3, third baby).

"I felt totally safe, even when I had just met [midwife's name], I just knew I was going to be ok" (W18, third baby).

The only participants in this study who had met the person who would provide their care during labour were the four couples who had private medical care. Both women and men found it reassuring and identified that person as a resource:

"A direct line... yes. It was good to have a friend who was at a high level... so he kept an eye for us... you know... it was a bit more reassuring for us that was" (M12, first baby).

Meaningfulness (motivational)

The meaningfulness dimension relates to motivation and all participants were motivated by a desire for a safe birth, a good birth experience and to be good parents. Fears associated with this dimension were related to uncertainty about the best way to achieve this and fear of making a wrong choice:

"Everybody tells you something different... and you don't know what to follow... it's all conflicting sort of stuff... and you sort of sit and go... what do I do here" (M3, third baby).

Consistent, reliable information from known and trusted healthcare professionals seemed to be the best resources to counteract these fears and guide new parents through the maze of conflicting advice and opinion. As one man explained:

"It's not that I don't trust, but I don't know them enough to know if I can trust them" (M2, third baby).

Discussion

These narratives provide a picture of fear of childbirth and challenges faced from the perspective of women and their partners, as well as the coping resources they utilise to meet these challenges in promoting a positive SOC. All participants were motivated (meaningfulness) to engage with the pregnancy and healthcare professionals in order to achieve a good birth and safe transition to parenthood. All participants had made a considered appraisal of the risks (comprehensibility) associated with childbirth and the extent to which they had the necessary resources to make a good transition to parenthood (manageability).

This study shows that the key components of fear of childbirth for pregnant women and their partners in NI are similar to those reported from other countries and confirms previous findings that women fear pain in childbirth (Geissbuehler and Eberhard, 2002; Melender, 2002), lack confidence in their ability to give birth vaginally (Rilby et al, 2012; Maier, 2010; Eriksson et al, 2006a) and fear birth injury to themselves and their baby (Faisal et al, 2014; Fenwick et al, 2010). It also confirms previous findings that men have fears about their partner coping with pain (White, 2007) and the safety of their partner and baby during the birth process (Eriksson et al, 2006a; 2006b).

The most frequently expressed fear among the men was that a very painful or traumatic birth would have a negative impact on their partner's mental health. This is the first time that concern for their partner's mental health has emerged as the most significant fear of childbirth among men. This may explain why men were keen for their partner to use epidural anaesthesia even though most of the women (65%) wanted to avoid it.

Concern for their partner's mental health may also explain men's positivity towards CS, which most perceived as safer, more controlled and easier to cope with than the uncertainties and potential for trauma they associated with vaginal birth. The men also expressed more confidence in their ability to provide practical support following a CS and a clearly identifiable role for themselves in the postnatal period seemed to impact positively on both the comprehensibility and manageability dimensions of SOC for the men. A medically managed birth, therefore, seemed to meet the needs of the men. However, it would also seem that men who are keen to support their partner through a normal birth would respond well to a more clearly defined role during labour and birth. There is a need for more research into how this could be facilitated.

Normal birth was still very alluring for most of the women in this study. It has been reported previously that women idealise normal birth while also rejecting it as dangerous (Maier, 2010). Most women in this study (89%) aspired to a normal birth but more than half (68%) feared they would not be capable of achieving it safely without medical intervention. Gould (2012) contends that this is a consequence of the language of risk that is used when offering birthing choices to women. This perception of riskiness reduces the comprehensibility dimension for women, and increases their need for resources to help manage birth.

Normal birth seemed to be a meaningful part of the transition to motherhood and the women were motivated to try to find resources to help them achieve it. However, it is a significant finding that only four participants identified a midwife as a resource to help them cope. A total of 15 of the women had care provided under the 'shared care scheme', where antenatal care is shared between the woman's GP and the obstetricians at the hospital. The other four women had

private medical care with an obstetrician. When antenatal care for low-risk women is led by medical staff, pregnant women and their partners seek medical solutions to help them to cope with their fears about birth.

There have been concerns for some time that the role of the midwife has been diminished by the way in which maternity services are organised (McCourt et al, 1998). It is not known from the data how much contact any of the participants had with a midwife before the interview, but all women in this study had been assessed as low obstetric risk, making them suitable for midwifery-led care. Better contact with midwives during pregnancy could have allowed alternative resources for managing birth without medical intervention. It is encouraging to see in NI that steps are being taken to increase midwifery-led care (Department of Health, 2012).

Fear of vaginal birth was prominent in this study and the impact of medicalisation of birth was apparent in the more fearful participants' appraisal of the risks and resources identified as available for coping, such as induction of labour, epidural anaesthesia and elective CS. Salutogenesis offers midwives theoretical pathways towards understanding fear of childbirth and guidance in helping women and their partners overcome fears.

In this analysis, fear of childbirth resides in the margin between the assessment of risk and coping resources. This suggests that to promote normal birth midwives need to reduce the perception of riskiness while increasing availability of midwifery resources to help women achieve more natural births. A two-pronged approach to reducing fear of childbirth and promoting normality in birth is therefore suggested by this study.

Increasing the comprehensibility dimension

This would involve reducing the perception of riskiness associated with normal birth. Such strategies could include:

- Better use of positive birth stories that focus on the potential for birth to go well
- Allocating time to review the events that occurred during birth with newly delivered mothers and their partners to allow them to ask questions about the birth
- Increasingly using midwives to provide antenatal care for low-risk women.

Increasing manageability

Alternative coping strategies that have been shown to promote normality in birth include interventions such as:

- A known midwife during labour (Sandall et al, 2013)
- Reassurance for all women that they will have continuous support during their labour (Hodnett et al, 2013)
- Antenatal mindfulness-based meditation and education programmes (Byrne et al, 2014)
- The use of complementary therapies, such as therapeutic massage (Smith et al, 2012)
- Hypnobirthing (Phillips-Moore, 2012)
- The use of birthing pools in labour (Cluett and Burns, 2009)
- Alternative birthing positions (Lawrence et al, 2013).

Limitations

This was a small qualitative study in a consultant-led hospital and the findings may have been very different if the study had been carried out in a different maternity setting.

Conclusion

This study has examined the unique experience of FOC for women and their partners in NI. By investigating the experience of FOC through a salutogenic wellbeing perspective rather than a pathogenic view of risk and illness, new insights have been found.

This analysis has highlighted the importance of offering prospective parents resources to make healthier choices about birth and it has given theoretical guidance about how this might be achieved. From this study, there are three key messages for midwives:

- Perceived riskiness of normal birth needs to be counter-balanced with more positive dialogues about normal birth
- The perception that medical interventions in low-risk pregnancy increases safety for mothers and babies needs to be challenged
- Fearful women and their partners need credible alternatives to medical interventions if they are to cope with childbirth in a more salutogenic way.

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Exploring students' and mentors' experiences of grading midwifery practice

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Abstract

Background. In 2009, the NMC published new standards for pre-registration midwifery education; one of the fundamental changes was that 'clinical practice must be graded' (NMC, 2009: 17). A systematic review (Gray and Donaldson, 2009) suggests grading clinical practice is problematic and often subject to grade inflation.
Aim. To explore qualitatively how grading student practice affects the student midwives and sign-off midwifery mentor relationships and authority.
Methods. An ethnographic approach was undertaken to investigate grading student practice. A pilot study of interviews with mentors (n=4) and three mixed trust focus groups were formed with 11 student midwives (n=11) in total (four, four and three respectively). These were held in conjunction with a critical review of the local midwifery curriculum and NMC documents. Ethical approval was granted from the university and NHS hospital research and development offices in addition to the local regional ethics committee.
Results. Students and mentors liked the coming together of theory and practice staff in the tripartite practice grading meeting. Neither students nor mentors felt grade inflation was problematic; often mentors raised the student's self-assessed grade. Friendships had the potential to develop between students and mentors; this was seen as having a positive effect on the practice grade. Mentors differed in their teaching styles and expectations and this affected students' learning. Strong mentor control with explicit expectations is associated with a performance or graded model of assessment and specific to that mentor or that placement only; whereas weak mentor control and implicit rules is aligned to a competence model that transfers across boundaries, between mentors and placements. Educators need to consider which areas of the midwifery approved curriculum should and can be assessed by which model.

Key words: Student midwives, grading practice, competence, performance, pedagogical discourse, evidence-based midwifery

Introduction

This paper reports the findings of a small scale research project, inspired by the UK NMC *Standards for pre-registration midwifery education* stating that 'clinical practice must be graded' (NMC, 2009: 17). The rationale for grading practice was to demonstrate equal value between theory and practice (NMC, 2006). Midwifery education is split between theory, taught in the university, and clinical practice, where students learn under the direction of a qualified midwife who has sign-off mentor status (NMC, 2008). The grading process and ability of the mentor to grade practice have been a concern (Smith, 2007). More recently a comprehensive systematic literature review (Gray and Donaldson, 2009) on grading practice across 14 professional groups suggested it is problematic. In a follow-up to their first paper, the authors conclude grade inflation is a phenomenon that has not been fully evaluated and cannot necessarily be controlled (Donaldson and Gray, 2012).

The local university offers pre-registration midwifery education with theory in one location and practice across three NHS trusts, as is common in the UK (NMC, 2011). Prior to 2009, the university was offering the diploma in higher education in midwifery. The students' practice was assessed with pass/fail competence assessment only, with academic credits awarded for practice. The introduction of the NMC (2009) standards meant two key changes: a rise in the educational level from Level 5 (diploma) to Level 6 (degree) (The Quality Assurance Agency for Higher Education, 2008) and the introduction of practice grading. The author was concerned about these changes, as she was new to lecturing, and wanted to explore the issues further.

Methods

An ethnographic approach was undertaken to investigate grading student practice. The aim was to explore qualitatively how grading influences and affects the student and sign-off midwifery mentor relationships and authority. Ethnography was understood in its broadest terms, not as a set of methods, but as the interpretation of actions between individuals (Forte, 2010; Toren, 1997), namely the student and her/his mentors. The data collection methods included interviewing midwifery mentors and student midwife focus groups (Anderson, 2011; Walford, 2007; McEvoy, 2002), in conjunction with an exploration of the curriculum and NMC (2009; 2008; 2006) documents. A semi-structured approach to the interviews and focus groups was undertaken. Questions about how the students were taught and assessed were asked, based on the four domains of midwifery practice (NMC, 2009).

Tensions between the author's role as a midwifery lecturer and as a researcher, insider/outsider status, were considered (Burns et al, 2012) and informed the data collection methods. Focus groups for the students were conducted to counteract a potential power imbalance with the researcher, who was one of their lecturers (Anderson, 2011; Liamputtong, 2011). Recognising that the students may have felt compelled to participate, the author reiterated the ethical principles of informed consent. All 16 students in the first cohort were invited to participate.

The author did not ask them to confirm their attendance, only to come if they wanted to participate on the given day; written consent was then obtained. One-to-one interviews with the midwives were recorded to hear individual experiences (Somekh

and Lewin, 2011). The mentors were interviewed individually, as the author considered the power imbalance between them and her status as a new lecturer was unlikely to adversely affect the data collection.

Ethical approval was granted from the university and NHS hospital research and development offices in addition to the local regional ethics committee. Recruitment posters were displayed in the maternity departments requesting midwife volunteers; this was supported by purposeful conversations with mentors who had recently graded students' practice. While the sample may be considered biased, it is consistent with an ethnographic approach. The entire first cohort of graduate level midwifery students (n=16) was invited by poster and this invitation was followed-up in class with explicit information. Non-participation would not affect their midwifery education and they had the right to withdraw at any time. The sample consisted of 11 students in three mixed trust focus groups (with four, four and three participants respectively). The students were in their third year and came from all three trusts. Each student was denoted by a number, trust and focus group (S,T, FG) to enable differentiation between individuals, trust sites and groups. The four midwives volunteered from one of the three local trusts. All were midwives with between five and 20 years' experience. Each of the mentors had graded a student midwife's practice. The mentors were denoted by number, trust and area of practice (M, T, hospital (H) or community (C)).

Findings

Students

The students were quite vocal in their opinions about assessments in practice. They felt there was too much emphasis on communication skills:

"You know it's… effective communication, communicates effectively with all women and members of staff, blah, blah, blah" (S5/T1/FG2).

In this group, students thought communication skills need not be repeated each year of their course:

"Why can't they take them out as you've passed them at your first year, you passed them in your second year so why are we repeating, there's just more to sign, more work to do" (S8/T3/FG2).

The underlying assumption that if you could not communicate, you would not be on the course, was explicit in another group:

"Treats women with respect, communicates well and then by the time you get to the third year, it still says the same thing" (S9/T2/FG3).

"If you're not doing that, you shouldn't be in the third year" (S9/T2/FG3).

Students expressed doubts that the mentors were fully prepared for their role:

"I think that the mentors need to be generally much clearer on all of the paperwork. They sit there and they don't really know what they're doing" (S3/T1/FG1).

This was reiterated by another student at the same trust:

"I think that's only because they haven't been trained" (S2/T1/FG1).

The students explained the problems with mentors assessing competence and understanding grading criteria:

"Yeah, and they're like which box shall I write in? Do I need to write that you've got, can you have that… for your first experience or not?" (S1/T2/FG1).

Another focus group also noted this:

"It's hard for us to know what they meant and some of the mentors just look at you as if to say, 'what?'" (S8/T3/FG2).

While there was confusion with the criteria, some students felt confident with the practice assessment process, particularly the grading process at the tripartite meeting. This meeting involves the student, mentor and university lecturer. The student self-assesses their practice performance independently, the mentor uses the same criteria to grade the student's practice and the final grade is negotiated between them at the assessment meeting, with the lecturer acting as moderator:

"I don't feel under pressure when I do a tripartite but then I think that's because pretty much what grade you are given yourself, you get, do you know what I mean? You don't feel nervous about waiting for the result" (S10/T3/FG3).

Another student did not find the process so comfortable:

"I felt really uncomfortable saying 'well actually I have been really proactive and I've been really enthusiastic and I think I deserve...'" (S4/T1/FG1).

One student thought this was to do with their culture:

"Well it's a British thing to do you know. We are, well I think I am, really quite good at that but I'll mark myself 15 out of 20, not 19 out of 20 because I'm not like a show-off" (S5/T1/FG2).

Perhaps this shows individual student personalities; but differing mentor styles also affected the students:

"It depends on who you work with again, doesn't it? Because if they're the kind of mentor that is approachable and you feel you can actually say 'well hang on a minute, I feel that I am doing this and that makes me this grade'" (S8/T3/FG2).

Students did not feel they were awarding themselves higher grades than they deserved:

"I think a lot of people under-grade themselves, don't they? And then when you got to your tripartite, and actually the midwife points out things that perhaps you've forgotten that have maybe stuck out to her" (S1/T2/FG1).

The mentor often raised the student's grade and this increased the student's confidence in their performance:

"If they can give you valid reasons why they think you're higher than you've marked yourself then that's like a boost to your confidence isn't it?" (S8/T3/FG2).

"Yeah, if you have comments saying, oh no, you think you're like that but I think you managed that situation really well" (S5/T1/FG2).

However, the relationship between the student and mentor was perceived to affect the grading process:

"I do worry that some people are really friendly" (S5/T1/FG2), followed by *"like they're bringing their friend along rather than their mentor"* (S8/T3/FG2). *"Yeah, because of course you've got to have a good relationship, but where do you stop at a good relationship and, you know, socialising with your mentor? Not that I do, but I know some people are quite close with their mentor"* (S5/T1/FG2).

There seems to be a boundary, which should be recognised and not be crossed, between an effective student-mentor relationship and a friendship. Becoming friends with the mentor was seen

as having an advantage, positively affecting the grade awarded.

The student's ability to demonstrate their learning (meet the criteria) was affected by the amount of time they had with each mentor. The NMC requirement is to work with a sign-off mentor for 40% of the time (NMC, 2008):

"I mean continuity of mentor is absolutely paramount" (S5/T1/FG2), and lack of continuity left more than one student feeling *"you're kind of going backwards"* (S7/T1/FG2).

This was reinforced in another group when a change in mentorship left one student feeling like she was *"starting at the beginning again"* (S2/T1/FG1).

Mentors

The mentor findings echo some of the student thoughts. They liked the tripartite assessment process, the bringing together of the university and practice staff:

"I like them being there (the lecturers) and I think it's good for them to hear how the student's doing and vice versa really and the university lecturers hearing how we're teaching them as well" (M1/T3/H).

This mentor felt students were unlikely to grade themselves too highly and admitted to raising the student grade:

"I've never known a student to upgrade themselves... and if a student is on a grade boundary, I will use the higher criterion" (M1/T3/H).

However, more often the mentor findings demonstrated variation in their knowledge of their role, which might explain some of the student perceptions that the mentors were not prepared.

Knowing the process of becoming and being a sign-off mentor (NMC, 2008) was clearly articulated by one midwife – almost every step required by the NMC was recalled:

"I did mentorship when I qualified straightaway five years ago, um and that was before sign-offs came in. So, I did do the signing off of students but wasn't an official sign-off and then did my update to become a sign-off mentor and have done some sign-off for two students" (M1/T3/H).

The other mentors were less clear about how they became sign-off mentors:

"I've been qualified for 10 years… usually have a student midwife work with me in some capacity" (M2/T3/H).

"I generally find I'm allocated students and then they're normally with me for a good amount of time" (M3/T3/H).

It was apparent in the interviews that all the mentors expected the students to demonstrate different attributes:

"I look for er, people that can use their initiative, common sense. Common sense is a huge thing in practice… if everyone is obviously busy and the phone is ringing, they can answer the phone. They don't have to give advice… but they can answer it" (M1/T3/H).

The attribute here is common sense. While this mentor may prioritise common sense knowledge, the student also has to learn the new specialised midwifery knowledge. Embedded within a common sense activity, such as answering the phone, is specialised midwifery knowledge and the student has to learn how to answer the phone within a maternity unit. The student needs to know what constitutes advice and what needs referring to a qualified midwife. While it may seem that answering the phone is a common sense activity, there are many rules the student has to learn before this is common sense:

"You can have a good student who, in my eyes, wants to learn, has set objectives, is keen to work, works well within the team... but not someone who's quite cocky. We get the odd one that comes through that you think, well, you keep saying things like that, you're going to really annoy people" (M3/T3/H).

This mentor wants the student to know and recognise the rules of wanting to learn, setting objectives and being keen. She also has to recognise when this may overstep the mark and become 'cocky' or things are said that will annoy other midwives.

When asked whether mentors are always effective role models for students, one mentor replied:

"*No, not always, I think some are. I think the difficulty is that as a qualified midwife you know… where you are safe to say certain things and you know from other qualified midwives that it won't go any further. You recognise that people have to let off stress… but you also know that the qualified midwife is then going to look after (the) patient and be totally professional. I think the trouble is that the students are at a level where they don't necessarily recognise the differences"* (M1/T3/H).

While the mentor thinks other midwives know and abide by the rules of appropriate behaviour, this may not be obvious to the student. This can lead to the student not fully understanding that their behaviour in one context, such as a staff room, is not appropriate in another – in front of a woman.

All four of the mentors had different styles of teaching. This mentor says how she enables student learning through questioning in the community setting in the car between visits:

"[I] asked them if they've understood everything that has gone on and just discuss… whatever it is we've seen... if they've done really well I'll let them get on with it and just watch... so hopefully the student will learn by example" (M4/T3/C).

Another mentor says:

"At the start of placement [I conduct] a sort of interview over and above what we do on paper. Just asking what their objectives are, personally what their experience is, so I know how to meet their learning objectives. And then at the end of placement, I like to just have a chat with them after the paperwork to see where they are" (M2/T3/H).

The mentor is placing the student in control of her learning, or giving the impression of this. By playing down the end of placement interview into a chat, as opposed to an assessment, this reduces the formality of the process. This feature, of using colloquial language for a formal interview or consultation, whether with mentors or with women, was also apparent in the students' discussions where essential specific midwifery knowledge is either dismissed or minimised, such as communication skills.

Documents

The curriculum is the planned course. Primarily, it has to meet the NMC *Standards for pre-registration midwifery education* (2009). The course is divided into units and time is spent in theory in the university and in practice. The ratio of theory to practice is determined by the NMC (2009) standards, with each university deciding upon how much time between strict parameters (theory is no less than 40% and practice up to 60% of the course). The

introduction of grading practice by the NMC within the UK pre-registration midwifery curriculum would seem to signal a shift from competence-based assessments to a performance-based evaluation of practice. However, the assessment of student practice has to meet all the NMC (2009) essential skills clusters in addition to grading. Thus, in the local validated curriculum both assessment models co-exist: assessments of ongoing competence demonstrated by achievement of the essential skills clusters in addition to a graded performance.

Discussion

To help analyse the data, a theoretical framework was used (Bryar and Sinclair, 2011). Bernstein's pedagogical discourse separates the analysis into three distinct areas: the curriculum, the pedagogy and evaluation (Bernstein, 2003) and links well to the interaction within the learning relationship between the student and mentor.

In each area of a learning environment, there are relationships between what is taught and counts as valid knowledge, how it is learned and the criteria for assessment (Bernstein, 2003). Bernstein uses the terms 'classification' and 'framing' to differentiate between the knowledge within the curriculum and how it is taught, respectively, and differentiates between two distinct models of evaluation: competence and performance. As this paper is a small part of a larger study, the use of Bernstein's theory as a deductive framework has been used to shape this paper, the inductive findings will be presented in due course.

The curriculum

The boundaries between theory and practice are physically and conceptually separated. What is taught in theory is not always seen by the students as relevant in practice (Utley, 2011). Bernstein uses the term 'classification' to explore what counts as valid knowledge within the curriculum. Where areas are clearly differentiated, the term he uses is 'strong classification' (Bernstein, 2003). Thus when examining the midwifery curriculum, theory and practice, which are separated by time, modules and placement and distance, are strongly classified. The opposite of strong classification is 'weak classification', when areas of the curriculum are brought together or there is no clear differentiation between various parts of the curriculum. To explain further, consider the skill 'normal labour and birth'. This would be considered in Bernsteinian terms to have strong classification: a student and midwife easily recognise when they are providing labour care. Normal labour and birth as an essential skill is separated from the initial consultation between the woman and the midwife, initiation and continuance of breastfeeding or medicinal products management (NMC, 2009), each of which has strong classification. Students and mentors recognise when they are providing different forms of care and demonstrating these four essential skills clusters. However, the first essential skill, communication, (NMC, 2009) seems to be more problematic from the empirical data collected, because it is weakly classified.

This is evidenced by the students who thought this essential skill was excessive within the curriculum. The students across all three trusts thought you either have communication skills or you do not. They did not think communication counted as valid knowledge within the curriculum because the assumption was that they already possessed those skills. The students wanted more specialised knowledge of areas, such as *"going into theatre"* (S9/T2/FG3) or *"performing an artificial rupture of membranes or catheterising women"* (S10/T3/FG3), all strongly classified skills they saw as essential for their future midwifery practice. Midwifery knowledge, therefore, can be interpreted as having different classifications within the one curriculum.

For mentors, it was not so much midwifery knowledge that was problematic, but their knowledge of the regulation that affected the curriculum, specifically, knowledge of the standards that regulate learning and assessment in practice (NMC, 2008).

The NMC (2008) document states four separate levels for teaching and assessing in clinical practice: stage 1, for all qualified midwives and nurses; stage 2, mentor status and an additional stage 2 sign-off status, which is required for all midwifery mentors; stage 3, for practice teachers who are not used in midwifery; and stage 4, for teachers in university, and not the practice setting.

Mentor 1 had explicit knowledge about how she achieved the required NMC status. However the other mentor statuses could be classified as weak: the boundary between being a midwife and a mentor are brought together and not kept apart. They were not explicitly sure of how they became sign-off mentors, although through experience they implicitly understood their own role. Mentor 2 said, *"in some capacity"*, reinforcing perhaps her knowledge that you can work with a student on an ad hoc basis, or as a sign-off mentor. This apparent gap in explicit knowledge of mentoring status was recognised by some of the students and this has the potential to change the authority between student and mentor. Students were acutely aware of a mentor's knowledge of the curriculum, especially weak classification.

There is evidence in the literature that supports these findings. Mentors need more overt recognition of their role (Fisher and Webb, 2008). The separation of theory from practice and the evidence-based principles of theory versus the traditional practices of some midwives in practice is problematic for students (Armstrong, 2010). And mentors have competing roles of supporting and assessing students, which may cause confusion (Bray and Nettleton, 2007).

Teaching and learning

Bernstein (2003) uses the term 'pedagogy' to define the transmission of knowledge. It includes the hierarchy between the student and mentor, the sequencing and pacing of knowledge transmission and who controls this. The term he uses is 'framing'. Where framing is strong, the transmitter (the mentor) has explicit control over the selection, pacing, sequencing and criteria; where it is weak, the student has more apparent control. Within the transmission of knowledge, there are two discourses: the regulative and the instructional discourse. The instructional discourse is the transmission of specialised midwifery knowledge, whereas the regulative discourse relates to the social order, the conduct, character and manner of the student. Bernstein (2000) asserts the regulative discourse is always dominant; therefore, it will be presented first.

If the student does not fulfil the mentor's expectations, this gives rise to labelling (Bernstein, 2003). With strong classification

of knowledge and strong framing, the 'recognition rule' and then 'realisation rule' are explicit (Bernstein, 2003). The student knows what is expected of them, is told when they do not meet the expectations and how to rectify this deficit. But recognising the difference between being keen and not too cocky, if not communicated to the student, is problematic. This leads to visible and invisible pedagogies (Bernstein, 2003). If the mentor is explicit in what she expects from the student, then expectations are visible (strong classification and framing). Where the mentor does not explain what they expect, this gives rise to an invisible pedagogy (Bernstein, 2003).

The rules are not always explicitly transmitted (visible). This is reiterated by the literature where mentors can be positive or negative role models for midwifery students (Hughes and Fraser, 2011). Students also labelled mentors as 'lenient' or 'good' in each of the three focus groups.

Labelling of mentors is seen in the wider literature, with 'hawks', who are considered strict mentors, and the 'lenient' doves (McManus et al, 2006). In the midwifery-specific literature, students label mentors as 'controlling' or 'guiding' hands (Hughes and Fraser, 2011) and use terms such as a 'good' midwife (Carolan, 2013), or she sort of 'shines' (Byrom and Downe, 2010) to explain their experiences of mentor types. Mentors labelled themselves too, aligning with the good, lenient or harsher mentor types. The comment by M1/T3/H, which acknowledged that *"we all know who the good mentors are"*, implied she was in this group; and M2/T3/H explicitly situated herself in this 'good' group by saying: *"I think the conscientious sort of midwives, and there are a lot of us."* In acknowledging that she took students *"under her wing"*, M3/T3/H implied that she aligned more with the dove characteristic whereas M4/T3/C perhaps aligned herself to the hawk: *"I'm probably harsh"*.

The second aspect of the pedagogy, the instructional discourse, is the sequencing and pacing of midwifery-specific knowledge (Bernstein, 2003). When framing is strong, the mentor is in explicit control. If the student asks what the mentor deems to be the right questions, she will decide the student is ready to undertake the next consultation. How and what the mentor did during the consultation is missing. The mentor expects the student to recognise what has happened by asking the right questions, so she can then enable (allow) the student to participate next time. This is an example of an invisible pedagogy (Bernstein, 2003).

With weak framing, the apparent control is with the student. With strong framing, the control is with the mentor. Labels are selected as a function of the framing. Where framing is strong, the label is likely to be conscientious and attentive. Where framing is weak, the label is often about the struggle to meet the expectations (Bernstein, 2003). The strength of classification and framing within the educational relationship has specific outcomes on the evaluation of practice and the interactions of those involved.

Evaluation

The last part of Bernstein's theory is the evaluation of practice (2003). This too can also be explicit and specific or implicit. Bernstein distinguishes between two models of assessment: performance and competence (Bernstein, 2000). For Bernstein, these models are contrasting not complementary. Each model will be explored.

Performance has gradable explicit criteria consistent with strong classification and strong framing (Bernstein, 2000). This means, when grading student practice, according to Bernstein's performance model, the criteria needs to be explicit and the teaching needs to be mentor led. From the literature, midwives who do not enable or allow students to practise hands-on care, or frequently took over, were seen as hierarchical and this style of mentoring was unhelpful (Licqurish and Seibold, 2008). While Licqurish and Seibold's study (2008) related to assessing competence not grading, it resonates with Bernstein's theories presented above with strong classification and strong framing, or mentor control, negatively affecting student learning.

The findings presented above demonstrated difficulty interpreting the assessment criteria, thus perhaps the criteria is not explicit. While the essential skills clusters (competencies) have been written by the NMC, the grading criteria are not and are developed by each university. The perception by some students that some mentors did not understand the paperwork, whether this was the curriculum or the assessment criteria, then enabled the student to have power or control in their assessments. This was reiterated by the students when discussing their practice assessment. They were not worried about their practice grade, as they had some influence in the process and more or less received the grade they expected, or higher. This seems to link the recognition and realisation rules, where the students recognise they should grade themselves slightly lower, to give the mentors control in the assessment and the ability to raise their final grade, which, in turn, boosts their confidence.

A performance grade is not transferrable (Bernstein, 2000), so a high grade in one setting, such as community, does not mean the student will perform equally well in another, such as a birthing unit. Not only will the criteria be different, but the mentor's teaching style and expectations will also be different, and this influences the student's performance. This means each placement would need to be graded separately for the grade to contribute meaningfully to the degree classification.

For competence, the skill is transferable. Competence does not have explicit criteria and is likely to have weak classification and framing. The students expressed concern that a weak boundary (friendship) between the student and mentor was detrimental to the grading process. This is evident in the wider literature too. The social process of grading was evident in Smith's (2007) study with students who got on well with their mentors receiving a favourable grade. It is also a key factor for grade inflation (Gray and Donaldson, 2009). For Bernstein, a weak boundary is necessary for a competence model, not grading.

The findings demonstrate the curriculum has elements of both weak and strong classification. There seems to be parts that lend themselves to a competence model, such as communication skills, and other areas that could be more explicit and graded. Mentors exhibit different strengths of knowledge about their status. The expectations each mentor has and their teaching style can be strongly or weakly framed. These aspects all affect and influence the assessment of practice. From the literature it is apparent that many of these issues have already been published, but not specifically from the viewpoint of how grading practice affects students and mentors alike.

Conclusion

The assessment of practice is complex. The interplay between many factors – time, student-mentor relationships, expectations and an understanding of the implicit and explicit criteria – affect its validity. But how does the grading of practice affect the student and mentor relationships, identities and authority? It is not grading or assessment of competence per se, that influences the relationships but rather the three factors within the educational encounter: the curriculum, the pedagogy and the evaluation. For a better understanding of grading within the pre-registration curriculum, defining what counts as valid knowledge, using strong and weak classification terms, might help educators decide which aspects should be graded to meet the NMC requirements.

Further discussions with mentors at mandatory updates on their teaching styles might be helpful. The teaching within clinical practice, the pedagogy or transmission of knowledge, could be more explicit, especially for first-year students until they recognise the rules and can start to realise them. This will lead to positive labelling as the pedagogy is visible. Invisible pedagogies (weak classification and weak framing) lead to negative labelling and this is not helpful for students or mentors. However, as the student progresses, the mentor should be able to step back for the student to demonstrate their skills but this then becomes a competence model with weak classification and framing.

The evaluation of practice will, unless the NMC (2009) regulation changes, need both competence assessment, as all the essential skills need to be demonstrated, and a graded performance. According to Bernstein, competence is transferable across clinical areas, whereas a performance assessment is specific only to the area in which it is assessed. As student midwives need to develop transferable skills across the spectrum of midwifery practice arenas, perhaps these models of assessment need to be considered further as differing mentor expectations and teaching styles affect the learner in diverse ways. As the criteria have already been explicitly stated for the essential skills clusters, perhaps there should be explicit UK criteria for grading too. Some aspects of the curriculum, such as knowledge of the common antenatal screening tests (NMC, 2009), could be graded according to explicit criteria, however, providing care that is warm, sensitive and compassionate (NMC, 2009) is going to be open to more interpretation, hence its weaker classification. What is clear though is that Bernstein's model of evaluation sees competence and performance as end products of differing strengths of relationships between knowledge and teaching; whether the two can or should co-exist as they presently do is not known.

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Information for authors

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News and resources

RCM annual conference returns to Telford

A raft of top expert speakers has been announced for the RCM annual conference. These include Debra Bick, Soo Downe and Denis Walsh, among many others. This year's theme is 'Better Births: United in Excellence' and the programme offers a range of research seminars and management masterclasses, plenary sessions and hands-on workshops. It allows RCM members the opportunity to have their say on the developments and key issues within the profession. Alongside the main event are the workplace representatives conference and the student conference, each of which will run for a single day. For more information, to view the programme or book tickets, visit: **rcmconference.org.uk**

Breastfeeding innovation grant opens soon

Application for the breastfeeding innovation grant is set to open on 8 September. The annual grant of £10,000, supported by RCM Alliance partner Philips Avent and administered by the RCM, has been provided to encourage the take-up and/or improved duration of breastfeeding. All practising UK midwives, who are RCM members, wishing to fund a new initiative to support breastfeeding, or the roll-out of a pilot project, will be eligible to apply once the grant is open. The scheme should focus on a defined population and have clear objectives and a process for evaluating outcomes. For more information, visit: **rcm.org.uk/breastfeedinggrant**

Florence Nightingale scholarships deadline approaching

The deadline for the Florence Nightingale Foundation scholarships is 24 September. The awards are for midwives who want to become leaders. The funding is aimed to develop skills and self-confidence. Recipients of the awards, which are up to £15,000, will undertake a bespoke programme for their individual needs. Applications are welcomed from those who aspire to a board position, or who may already be a HoM or consultant midwife. The applicant's organisation is expected to support the application. To apply, or for more information, visit: **florence-nightingale-foundation.org.uk**

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